

FOCUS A GUIDE TO AIDS RESEARCH

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Whether To Take the Test: Counseling Guidelines

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As the availability and use of the AIDS antibody test become more widespread, many more individuals are evaluating the benefits and risks of learning their antibody status. Some of these individuals will seek counsel from mental health professionals to help them decide whether to take the test. Clients already involved in counseling may wish to discuss these issues as part of their ongoing work. In addition, clients whose physicians have recommended the test for medical reasons may want to discuss their concerns about the possible negative psychological and social effects of taking the test. We outline here guidelines to help mental health practitioners in their work with clients concerned about taking the test and coping with the results.

Background and History

In early 1983 researchers identified the virus (now named the Human Immunodeficiency Virus, HIV) believed to cause AIDS. Shortly thereafter, private companies developed a sophisticated laboratory test called ELISA (enzyme-linked immunosorbent assay) to detect antibodies to the virus. The primary purpose of the test was to screen blood and blood products for HIV contamination. The test in and of itself is not a test for AIDS and the test result does not reveal whether a person will develop AIDS.

Infection by the AIDS virus causes a response by the body's immune system. Part of this response is the production of antibodies which recognize and attach to specific proteins on the virus, called antigens. Since the antibodies are tailor-made for particular antigens, tests can be designed to detect these specific antibodies. Tests for antibodies include the ELISA, the IFA (immunofluorescence assay), and the Western Blot. Each of these tests is based on the same principle, and each uses different methods to detect the same antibodies. Thus, the IFA or the Western Blot can be used as a way to support results obtained by the less-expensive ELISA.

The antibody tests are all very sensitive, which means that they detect almost all of the positive sera. They are also very specific, seldom indicating negative sera as positive. While testing procedures may vary, the required repeat testing of positive tests increases the accuracy of the test. False reactions do occur for reasons that are not completely understood. A false negative result may occur because an individual has not yet

developed antibodies to the virus. Most people produce antibodies within 2 to 8 weeks after exposure; some, however, will take up to 6 months.

Conversely, a false positive reaction may occur if the antibodies have developed in response to other similar proteins in the blood. Also, antibodies may have developed in reaction to another part of the test system, such as the cells in which the virus is grown. This would be called a non-specific reaction.

For individuals with little risk, the probability that a positive result is a "false positive" is greater only because there seems little chance that such individuals would have been exposed to HIV. Especially in these cases, testing by another method or repeat testing in a few months should be encouraged. The recommended procedure for all positive results is to be tested by another method such as IFA or Western Blot. While false positive and false negative reactions may occur, accumulating evidence shows that the ELISA test is very accurate, especially for individuals at high risk.

Mental health professionals must examine their own bias about the test before they counsel persons about it . . . It is important to understand fully the limits of the test and to appreciate the real risks that the test presents to clients.

Concerned that people at high risk might donate blood to learn their antibody status, public health officials developed an alternative test site program providing either anonymity or at least strict confidentiality to participants. Over time other purposes of the test have emerged. These include diagnostic and epidemiological applications as well as use in family planning settings to help clients make informed choices about pregnancy, parenthood, and birth control. Many see the test as an important preventive education tool for use in helping people understand their risk of contracting and transmitting the AIDS virus.

Ever since the antibody tests were developed, confusion and conflict about individual civil rights and public health interests have prevailed. Several public health officials and medical investigators wanted to use the test to help track and control the spread of the disease and to study the effects of infection. Advocates for people at high risk for HIV infection emphasized that many of these individuals are already socially stigmatized and that further use of the test might foster discrimination against those with positive results. Others, such as employers and insurance companies, showed an interest in the test for their own purposes.

Fears of discrimination have a realistic basis. Individuals in high-risk groups, regardless of their medical status, have lost

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THE
**AIDS
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Guidelines . . .

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jobs, have been denied housing and insurance, and have suffered from disruptions in relationships with families, partners, and friends. Homophobia, racism, and dislike or fear of drug addicts have been exacerbated by the hysteria and panic that have accompanied the AIDS epidemic. It is no wonder then that individuals in high-risk groups have been distrustful and suspicious in regard to the use of the antibody test. Given these facts, mental health professionals who counsel clients about the antibody test should provide information about possible consequences of taking the test and ways of managing the test information to prevent later difficulties.

Preparation for Counseling

To prepare for counseling, mental health professionals should first become familiar with the test, what it means and does not mean, its level of accuracy, and the potential benefits and risks of knowing one's antibody status. It is helpful to have ready access to community resources that can provide updated information relative to the test. Government-sponsored test sites have been established in several communities to offer information about the test and to provide anonymous testing free of charge. Clients can receive basic information at these sites and then return to their primary mental health counselors to review the information and weigh the personal benefits and risks prior to making a final decision.

Mental health professionals must examine their own bias toward the AIDS antibody test before they counsel clients about it. Counselors should understand fully the limits of the test and the real risks that the test can present. Clients must understand that the test alone will not indicate if they have AIDS or ARC, and that it will not predict who will develop these diseases.

In some cases antibody testing has resulted in a positive psychological and behavioral adaptation to the threat of AIDS. For those who prove to be antibody negative, knowledge of their test results usually reduces unneeded anxiety, although some recipients may face problems with "survivor guilt" and extra stress about remaining negative. Many individuals who receive a positive result have been motivated to take their health more seriously and to improve their health behaviors. Since research has shown that most people with AIDS antibodies have active virus in their bodies, a positive result strongly implies that an individual is able to pass the virus to another. Knowledge of a positive status has motivated many individuals to be more judicious in following safer sex guidelines and in no longer sharing I.V. needles. However, for many individuals troubling psychological reactions to test results frequently accompany the news of seropositivity. These responses range from mild to moderate anxiety to full-blown anxiety and depressive disorders. Although adequate pre-counseling can lessen the likelihood of these reactions, it is no guarantee that these will not happen.

Outline of Benefits and Risks

The benefits of antibody testing include:

- (1) to protect the blood supply by testing individuals who are considering donating blood;
- (2) to ensure that organ donations are safe from HIV contamination;
- (3) to help support a medical diagnosis in individuals who exhibit unexplained symptoms that their doctors think might be related to a HIV infection;
- (4) to help women at high risk decide whether to become pregnant or give birth;
- (5) to help women with a history of risk behavior decide whether to breastfeed an infant or have an infant inoculated with vaccine produced from live virus;
- (6) to reduce anxiety in individuals who are at low risk for HIV infection yet who have extremely high anxiety about it;

- (7) to motivate individuals who continue to practice high-risk behavior and who feel that a positive test result may help them reduce these behaviors;
- (8) to help researchers design experimental treatment protocols and to help potential subjects determine whether or not to participate in the drug trials;
- (9) to help scientists determine the extent of HIV infection in the population at large and, by following seropositive individuals, to understand the natural history of HIV infection.

The risks of antibody testing include:

- (1) severe psychological reactions, including anxiety, nightmares, sleep disturbance, depression, and suicidal behavior;
- (2) disrupted interpersonal relations, including potential for rage reactions and their extreme manifestations, such as homicidal behavior;
- (3) social ostracism and self-imposed social withdrawal;
- (4) relationship problems (blaming partners, sexual dysfunction, disrupted ability to make plans as a couple);
- (5) stigmatization and discrimination if a positive antibody status is made known to others outside of guarantees of confidentiality;
- (6) problems with employment or insurance;
- (7) preoccupations with bodily symptoms; and
- (8) a false sense of security and denial if the test proves negative (for example, believing one is immune to infection and thus continuing with risk behavior).

The Counseling Process

The process for helping clients decide whether to take the antibody test should be based on three important elements: (1) accurate information about the test, (2) a systematic decision-making process, and (3) an action plan that will maximize benefits and minimize risk.

Although the availability of information about the antibody test varies from one location to another, basic information and the location of the nearest test site should be available at any Public Health Department office. Some clinicians feel that clients should take responsibility for locating and obtaining information; others feel more comfortable providing information directly. In any case, clinicians should emphasize the importance of not proceeding with the test without proper background knowledge.

Clinicians should take responsibility for providing a structure for facilitating the decision-making process. This may be a process that has been used already with ongoing clients or one which is geared specifically for the immediate purpose. One process that has been used successfully is based on a "benefit-risk analysis." The client is asked to list the potential benefits that might be involved with taking the test. Subsequently, the client lists the potential risks. For the benefits list, the counselor encourages the client to consider each item and determine whether the benefit can be received by some means (other than the antibody test) that does not have concomitant risk. For example, if an individual is taking the test to lower the risk of contracting the disease through sexual contact, understanding that the same guidelines hold true for those who test positive as those who test negative may obviate the need to take the test.

If a greater overall benefit has been established to proceed with the test, a careful review of risks must be undertaken. In some cases perceived risks are in fact groundless, such as the fear that someone could obtain an individual's name from an anonymous test site. (A participant's anonymity is protected at these test sites; the individual's name is never recorded). Other risks can be reduced somewhat by careful planning; for example, discussions by couples prior to testing about how they will cope with the test results.

After a careful examination of the benefits and risks, the final choice — an educated decision — is the client's own to make.

An Action Plan

If a client chooses to take the test, additional attention should focus on how to minimize risks once the results are known. Clients may begin to process their feelings and thoughts by imagining their reactions to receiving a positive result and developing strategies to cope with these reactions. This process may take several sessions before the client is psychologically prepared to take the test. Even this preparation is no guarantee that unexpected reactions may not overwhelm the client.

Clients can be encouraged to arrange for additional emotional support during the testing process, including the period of waiting for the results. A counseling session should be scheduled shortly after clients receive the test results so they have the opportunity to discuss their reactions. Additional resources may be needed in order to assist adaptation to the test results. Clients should also think beforehand about disclosure of information about being tested, and they should consider how to protect their civil liberties. For example, when possible, clients should be encouraged to use anonymous testing sites. In some cases negative psychological reactions have emerged some time after receiving a positive test result. Clients should be assured of continued availability of assistance if this should occur.

Follow-up counseling may also be required to help clients incorporate test results into a plan of action that will produce the anticipated benefit. For example, the person who feels that it is necessary to take the test in order to be shocked into compliance with risk guidelines may need to continue seeing a counselor to accomplish this goal realistically. Shock value is only effective in the short-term, and long-term strategies are essential with AIDS risk prevention. Such a counseling plan may be established prior to taking the test.

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Diagnosis/Treatment/Prevention

Heterosexuals and AIDS: Report from Atlanta

Michael Helquist

"AIDS has always been transmitted heterosexually; only our denial has kept this fact from us," asserted James Curran, MD of the U.S. Centers for Disease Control (CDC) during a recent presentation. The steady increase in media coverage of the threat of AIDS to heterosexuals has begun to challenge that denial. In February a major conference in Atlanta took that interest one step further and focused on the prevalence and prevention of AIDS in children, adolescents, and heterosexual adults.

Apparent among the nearly 800 conference participants was a consensus about how our understanding of the AIDS epidemic and our efforts to control it should be framed. Researchers and health officials appear to have adopted the notion that we should move away from the epidemiology of AIDS to an epidemiology of the HIV infection. Robert Redfield, MD of Walter Reed Medical Center advised his colleagues at the conference that "to focus on the number of AIDS cases today is to be five years out of date; the cases we record today tell us where HIV infection was five years ago."

General agreement has also developed about the need to emphasize high-risk behaviors rather than high-risk groups. Redfield suggested that the only realistic risk group is that one

comprised of humans with potential sexual, parenteral, or perinatal exposure to HIV. Even with this broader understanding of HIV transmission, the CDC monitors the spread of AIDS by looking at rates of increase among different population groups. Curran of the CDC explained that these rates have shifted during the period from 1985 to 1986. Among gay men there has been a 50% increase in the number of cases. That number corresponds with an 82% increase among bisexual men, a 63% rise for heterosexual men, and a 77% increase among women.

Although the current statistics clearly show the rise in overall numbers of AIDS cases among heterosexuals, researchers have yet to agree on the efficiency of the bidirectional transmission (from men to women and from women to men) of the virus. One recent study conducted at Walter Reed Medical Center showed that 44% of spouses of infected husbands became infected themselves as a result of unprotected sexual activity. While several researchers at the Atlanta conference asserted that HIV can be efficiently transmitted bidirectionally, other scientists regard male to female transmission as the more efficient route. One researcher noted that with many sexually transmitted diseases (STDs) there is a greater efficiency from men to women even though in every society STD prevalence is always greater in men.

Constance Wofsy, MD of San Francisco General Hospital suggested that the discussion of HIV transmission often reveals a bias that places major responsibility on women to control the spread of the AIDS virus. She cited the emphasis placed on prostitutes as supposed "reservoirs of infection," the expectation that women will adopt condom use in their sexual activities, and women's role in perinatal transmission. James Oleske, MD of the New Jersey College of Medicine in Newark called for men to share the responsibility of halting the spread of HIV. "Men are the major propagators of this disease," he said. Wofsy added that society must come to terms with its attitudes about prostitution. She posed the question, "Can we alter the existence of prostitution or can we make it safe?"

Pediatric AIDS

Oleske, who has worked with infants and children with AIDS for several years, estimated that by 1991 there will be 10,000 to 20,000 children with AIDS in the United States. In Newark alone Oleske and his staff are caring for 100 children now; by 1991 he expects that number to increase to 600. Oleske added, "Most pediatric cases are symptomatic, and the latency period is relatively brief for infants."

Other differences between manifestations of AIDS in children and in adults are the less common appearances of Kaposi's sarcoma (KS), B-cell lymphoma, and Hepatitis B in children. Oleske also reported that children frequently have severe lung involvement, that they may have normal T-cell ratios, and that neurological disease is secondary to primary HIV infection. Curran of the CDC announced during the conference that that agency is currently devising a classification system for pediatric symptoms.

Gwendolyn Scott, MD from the University of Miami noted that there appears to be a 30 to 50% chance that the fetus of an HIV-infected mother will also be infected. Sheldon Landesman, MD of the Downstate Medical Center in New York City said he believes there is no method at this time to determine readily the status of an infant whose mother is seropositive. "You will not be able to tell until the baby develops disease," he said. Landesman added that a foster care mother cannot be told whether a baby from an infected mother is itself infected since that baby is carrying the mother's antibodies. Scott of Miami mentioned that her studies showed that mothers do not follow predictable patterns: sometimes an infected mother will give birth to a well infant following the births of two infected infants.

Several researchers indicated that pediatric AIDS cases can be seen as the index of infection in the family, and they emphasized the importance of surveying the risk factors of the infant's mother and also those for the other family members.

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Prevention Among Adolescents

Richard Keeling, MD, chair of the AIDS Task Force for the American College Health Association, suggested that when planning AIDS education for adolescents, "We need to know who we are talking to and we must recognize that dealing with the problems of AIDS will involve not just education but also social justice."

Keeling advised his colleagues to consider three guidelines for their education efforts: (1) that adults cannot change the behavior of adolescents; only the adolescents themselves can change their behavior; (2) that community-based AIDS organizations, many comprised of gay men, have already dealt effectively with many questions about AIDS education and have much to teach those more recently involved in AIDS prevention; and (3) that while there is nothing wrong with choosing abstinence, there is nothing wrong with healthy sex.

Having worked mostly with college-age youth, Keeling concluded that what may work better than simple AIDS information campaigns is a comprehensive, multi-faceted education effort that emphasizes the development of self-esteem, self-respect, and accountability. "We will be more successful marketing AIDS education in the context of qualities important to the developing adolescent: winning, achieving, competing, succeeding, and fitting in," Keeling explained. "This kind of approach will allow for messages of choice, morality, and safety — rather than instruction, moralism, and warning."

The three-day conference was sponsored by the International Interdisciplinary AIDS Foundation, based in Atlanta.

Michael Helquist is the editor of FOCUS.

BRIEFS

Recent Reports

Women At Risk: Effect of HIV Antibody Testing and Notification. A San Francisco study has found that HIV Antibody Testing can be particularly problematic for women. As a result of structured, open-ended interviews with 37 women at risk for HIV exposure, researchers Jane Zones and Diane Beeson identified five specific areas of difficulty: (1) social isolation — women confront the risk of AIDS in a context of less social and personal support; (2) absence of formal support — difficulty in obtaining adequate medical care and social services, especially outside urban areas; (3) the stress of media reports — news related to AIDS is perceived as increasingly grim and is a constant source of stress; (4) safer sex — antibody testing itself does not ensure safer sexual practices among women who are positive or in relationships with seropositive men; and (5) worry about children — children are the focus of tremendous anxiety with particular worry centered on reproductive risk, infection of their children, leaving children motherless, having them taken away, and exposing them to social stigma. This study was supported by UC San Francisco, the San Francisco Department of Public

Health, and California State University at Hayward; current data was presented at the Bay Area Researchers' Conference on Women, Children, and AIDS, sponsored by the San Francisco AIDS Foundation.

AIDS Awareness and Risk Behavior: Discrepancy Among Heterosexual I.V. Drug Users. Members of the Sacramento, California AIDS-I.V. Drug Abuse Task Force found that local I.V. drug users (IVDU) were aware of HIV transmission via shared needles and unprotected sexual intercourse, but significant numbers did not translate that knowledge into behavior change. By means of two questionnaires and personal interviews, the researchers determined the knowledge and risk behaviors of 150 IVDUs attending local IV drug abuse programs. Some of the findings from the study included the following: 93% believed that HIV was present in some IVDUs in Sacramento; 93% believed they would eventually acquire HIV and AIDS through needle-sharing; 95% said they wanted to avoid acquiring HIV; 91% believed HIV could be spread heterosexually; and 64% believed that condoms could prevent the transmission of HIV. However, a review of the IVDU's behavior revealed that 77% of the time they shared their needle (rig) with someone else either before or after they shot up. Although 87% of the time, IVDUs said they cleaned their rigs between users, 87% of the time the cleaning only involved water. Of the 150 IVDUs 67% shared a rig 1-10 times in the last month, 13% approximately 30 times, and 7% approximately 50 times.

Reasons given for rig-sharing included general sociability, the criminal offense status of possessing a rig, and the cost of the equipment. The respondents said cleaning of their rigs between uses was complicated by perceived lack of disinfectant in immediate environment, compulsion to inject as quickly as possible, and a belief that the person with whom they were sharing wasn't infected with HIV.

Next Month

The higher profile in the scientific race against AIDS is given to experimental drugs and the development of a vaccine. At the same time, however, other scientists study the interrelationships among the immune system, the nervous system, and psychological stress for clues about vulnerability to the AIDS virus and the body's means to combat HIV infection. Current studies looking at how AIDS relates to a mind-body connection are part of a larger and established field of inquiry called psychoneuroimmunology.

In the May issue of FOCUS, George F. Solomon, MD, a pioneer in the field of psychoneuroimmunology, will consider questions relevant to HIV infection. These include whether an "immunosuppression-prone" personality can predispose one to HIV infection, whether stress can trigger HIV infection from a latent to an active state, and whether psychosocial factors are related to progression of disease. Solomon is a professor of psychiatry in residence at UCLA and an adjunct professor of psychiatry at UC San Francisco, where he has been a member of the Biopsychosocial AIDS Project since 1983.

FOCUS A GUIDE TO AIDS RESEARCH

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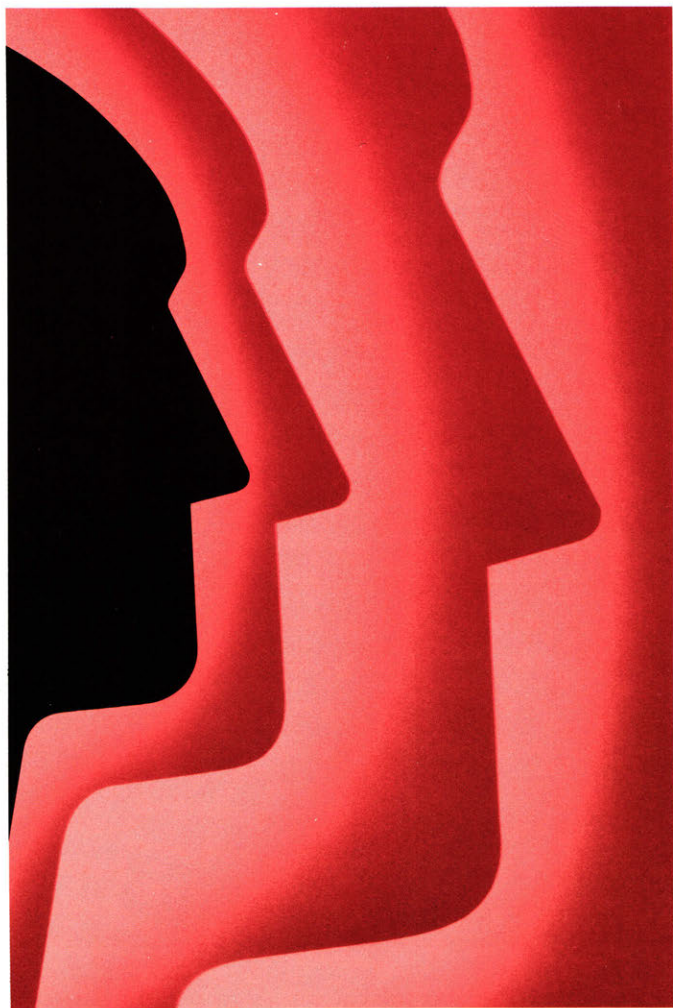
The amount of research information now appearing in the medical and lay press staggers most AIDS health care and service providers. The goal of FOCUS is to place the data and medical reports in a context that is meaningful and useful to its readers.

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AIDS...

**WHAT
EVERYONE
SHOULD
KNOW**



What Is AIDS?

"AIDS" is shorthand for the *acquired* (not inherited) *immune deficiency* (a breakdown of the body's defense system, producing susceptibility to certain diseases) *syndrome* (a spectrum of disorders and symptoms). People with the full-blown form of AIDS suffer from unusual, life-threatening infections and/or rare forms of cancer.

The virus that causes AIDS also produces milder, but often debilitating, illnesses called *AIDS-Related Complex*, or ARC. Persistent enlargement of lymph nodes, chronic fatigue, fever, weight loss, night sweats, and abnormal blood counts are typical features. Many people with ARC improve without treatment; others progress to have AIDS itself, and some remain the same.

The largest group of people infected with the AIDS virus, however, are not currently ill. Since they have no symptoms, these people can be identified only by a blood test for antibody to the AIDS virus. (See section on the HIV antibody test.) There is no certain way to predict whether an individual with a positive blood test and no symptoms will develop ARC or AIDS. The best estimates now available indicate that at least 20 to 30 percent of people with positive blood tests eventually will develop AIDS; this may take 5 to 10 years to happen. A similar or larger proportion of those with positive tests may develop ARC. These percentages may change as our experience with AIDS grows.

All people with a positive blood test for antibody to the AIDS virus must regard themselves as carriers of the virus; even though they may have no symptoms, they are probably infectious and may transmit the virus to others.

What Causes AIDS?

The virus that causes AIDS and AIDS-related conditions is now called *Human Immunodeficiency Virus (HIV)*. Other names for the same virus are *Human T-Lymphotropic Virus, Type III (HTLV-III)* and *Lymphadenopathy-Associated Virus (LAV)*. HIV is a retrovirus that must live and reproduce inside human cells. It is extremely fragile, and does not survive long outside the body. It is present in certain body fluids (notably in blood, semen, and vaginal secretions) of people who have been infected, whether or not they have symptoms. Although it is certainly transmitted by blood and semen, there is no evidence that the AIDS virus is transmitted by saliva or tears.

It is likely that certain "co-factors" influence the outcome of infection with HIV. The use of injected or inhaled recreational drugs, stress, and multiple exposures to HIV all seem to promote the development of AIDS or ARC. Although it is not clearly identified as a co-factor, alcohol may suppress the immune system, as well.

Who Gets AIDS?

Approximately two-thirds of people with full-blown AIDS are men who have had sex with other men. 17% are intravenous drug users who have shared needles with other people. 8% are people who fit into both of the first two categories—men who have both shared needles with people and had sex with other men. At least 4% of people with AIDS have acquired it through heterosexual sexual contact. However, this small percentage is misleading. The number of cases among heterosexuals has just begun to climb, because of the very long incubation period for AIDS and the fact that HIV entered the heterosexual population relatively recently. If people do not change their behaviors, there will be many more cases of AIDS among heterosexuals in the future.

Other groups of people at risk have included hemophiliacs (who receive blood products pooled from many donors) and patients who receive blood transfusions. The availability of the antibody test for HIV and new methods of processing blood products have sharply reduced the chance of transfusing HIV in blood or blood derivatives. The risk of transmitting HIV by blood transfusion is now estimated to be 1 in 100,000.

It is important to remember that "risk behaviors" are much more relevant than "risk groups." It isn't who you are, it's what you do, that matters. Increasing numbers of people who fit into none of the originally described risk categories are getting AIDS. HIV can be transmitted sexually between men and women, in either direction, and possibly between women. You are not safe from AIDS just because you're not gay and don't use drugs. All people, gay or straight, should know how to protect themselves.

Babies have gotten AIDS because HIV may be transmitted from an infected mother to her child before or during birth, or in breast milk after birth. Therefore, women with positive HIV antibody tests should protect against pregnancy; if they do have babies, they should not breast feed them.

How Is AIDS Transmitted?

AIDS is not an easy disease to get. HIV is a very fragile virus. There is no evidence that HIV can be transmitted by casual contact. People with AIDS, ARC, or a positive test present no danger to those with whom they go to class, share bathrooms, eat, work, or sit. Objects touched or handled by people with AIDS are not "contaminated" and need not be feared; the only exceptions are needles which might be shared. Any object or surface can be adequately disinfected with a 1:10 dilution of household bleach. There is no need for concern about the safety of swimming pools, whirlpools, saunas, or telephone booths because of AIDS. AIDS cannot be transmitted by coughing or sneezing. The virus is not transmitted in food handling. Those living with people with AIDS, ARC, or a positive blood test are at no extra risk unless they are sexual partners or they are sharing contaminated needles.

Under no circumstances can you get AIDS by donating blood or by getting hepatitis B vaccine.

AIDS is transmitted by intimate (sexual) contact and by exposure to contaminated blood. Normally, the body's protective barrier—the skin—prevents infection with agents like HIV; if the barrier is broken by injury or by needle puncture, fluid containing the virus may enter the body. HIV is easily transferred from one person to another in sexual activities that involve the exchange of body fluids, especially if minor injuries are involved.

Some sexual activities are more dangerous than others. Anal intercourse is especially risky, whether the recipient is male or female. Women may be infected through vaginal sex with a male carrier; men having vaginal sex with female carriers are also at risk. The risk of oral-genital sex on a male seems much lower, and oral sex is less risky if it stops before ejaculation. Oral sex on a female may be more risky during menstruation. Although HIV is occasionally present in the saliva of people with AIDS, there is no evidence that saliva can transmit the virus; large studies have shown no case to have been transmitted by kissing or other contact with saliva. If there is any risk of kissing, it would come from prolonged, deep or rough kissing, which may damage the tissues of the lips or mouth.

The AIDS virus is easily transmitted by shared or dirty needles, and people who share intravenous drugs and needles are exposing themselves to a serious risk of AIDS.

How Can I Protect Myself?

The risk of AIDS can be reduced by:

1. *Making careful choices about sexual activity* and negotiating with your partners for safer sexual practices. For those who are sexually active, a long-term, mutually monogamous relationship prior to which both partners have been safe is nearly risk-free. If you are not in such a relationship, your specific sexual practices are just as important as the number of partners you have. Unsafe, unprotected sex with one or two partners is more dangerous than safer sex with several. If your sexual contacts are risky, it is important to reduce the number of partners—and to learn safer sexual practices.
 2. *Knowing your sexual partners* well before having sex: it is a great idea to ask prospective partners about their health, sexual history, and awareness of safety precautions.
 3. *Using condoms during sex.* The proper use of condoms greatly reduces the chance of transmitting HIV, but it has not been proven that condoms eliminate the risk of AIDS. Be sure to put the condom on before genital or anal contact, use a water-based lubricant, and remove the condom carefully (before losing your erection) to prevent leakage or spillage. Spermicides (contraceptive jellies, creams, or foam) containing nonoxonyl-9 may further increase protection when used along with a condom.
 4. *Carefully avoiding any injury* to body tissues during sex.
 5. *Not using intravenous drugs* or sharing needles.
 6. *Avoiding the use of inhaled recreational drugs* such as "poppers", which can weaken the immune system.
 7. *Not mixing alcohol or other drugs with sexual encounters:* they may cloud your judgment and lead you to do things you wouldn't do with a clearer head—such as forgetting to use a condom. Alcohol and drugs may also suppress your immune system.
- Two ACHA brochures *Safe Sex* and *Making Sex Safer* provide important, specific risk-reduction suggestions for safer sexual encounters between people, whether you are gay or straight.

There are positive steps you can take to promote good health; these may be involved in determining what happens if you are exposed to HIV. Adequate rest, reduction of stress to manageable levels, good nutrition, regular exercise, and making conscientious decisions about your personal behavior—all are important.

The HIV Antibody Test

There is a lot of misunderstanding about the "AIDS Test." *The blood test available tests for the presence of antibody to HIV; it is NOT a test for AIDS or ARC.* There are many limitations to the test, which can produce both false positive and false negative results. A truly positive test reveals that the person has been exposed to HIV. It does NOT tell whether he/she has, or will develop, AIDS.

People who are deciding whether to take the test are advised to consult a knowledgeable health care professional or counselor for information and advice first. There are important medical, psychological, and social issues involved in being tested. Anyone considering the test should thoroughly understand its implications and limitations. Since people with positive tests may be victims of discrimination, it is vital that test results be strictly confidential—or anonymous. Thus, it is important to determine how the test results will be reported and handled, and who will have access to the information, before the blood is drawn. Your health care provider can direct you to confidential or anonymous testing sites in your area.

People at risk for AIDS should not donate blood, body organs, or semen—and should not use blood banks as a way to be tested. In making decisions about sexual practices, it is reasonable for a person who is at risk for AIDS but chooses not to be tested, to behave as though the test were positive. Women whose behavior may have created a risk of infection with HIV should consult a health care provider and have the antibody test done before getting pregnant.

A Special Message to People with a Positive Test: *Anyone with a positive test is probably infectious and should take appropriate precautions to protect others.* Even if you have no symptoms, you could transmit HIV to someone else through blood or unprotected sexual intercourse. Professional counseling regarding safer sexual behavior is essential. Measures to promote health and wellness may be of particular importance to you. Women with positive tests should protect against pregnancy, and no one with a positive test should donate blood, organs, or semen.

Symptoms of AIDS and ARC

Many of the early symptoms of AIDS or ARC are similar to those of common minor illnesses, such as the "flu." What distinguishes AIDS and ARC is the severity and duration of the symptoms. Of particular importance are:

1. persistent, excessive *tiredness* for no apparent reason
2. recurring *fevers*, chills, or night sweats
3. unexplained *weight loss* of more than 10 pounds
4. persistent enlargement of the *lymph nodes* (glands) in the neck, armpits, or groin
5. *sore throat* that does not go away, or white spots or patches in the mouth
6. a new, persistent *cough*
7. easy *bruising* or unexplained bleeding from any part of the body
8. persistent *diarrhea*
9. pink or *purple bumps* or blotches on the skin.

The presence of one or any combination of these symptoms for two weeks or more indicates the need for medical evaluation; never hesitate to see a health care provider for examination. If you're worried, have your concerns checked out.

Gay Men and AIDS

It is inaccurate and hurtful to assume that all gay men are promiscuous, or that all gay men have AIDS. Gay people did not cause AIDS, and the occurrence of this tragic disease is a biological event, not a moral comment.

There is no justification, medical or ethical, for avoiding ordinary contact with gay people during the AIDS epidemic. Although the association of AIDS with homosexuality has made some individuals less accepting of homosexuals, this is in fact a time when gay people are often very worried and could use understanding and support.

If you are uncomfortable about contact with gay men during this time, please consult someone at your health service for accurate information and advice. Some centers have groups for this type of discussion—called groups for the "worried well." In a time of considerable public anxiety about AIDS, a calm, reasonable approach will work best for everybody.

Women and AIDS

Increasing numbers of women are developing AIDS. HIV is transmitted to women through sexual contact and exposure to the blood of an infected person, just as in men. The heterosexual transmission of HIV from men to women and women to men is becoming more common; women may also transmit HIV to each other by sexual contact. It is possible for HIV to be transmitted to a woman during sexual assault.

Women face some unique issues in AIDS. A woman with a positive HIV antibody test—whether or not she has symptoms—should protect against pregnancy for two reasons: first, because of the likelihood of transmitting HIV to her child, and second, because pregnancy may speed up the development of the ARC or AIDS in the woman herself. There is a very slight chance that a woman could be infected with HIV by artificial insemination. Childbearing is important in the future plans of many men and women; the limitations imposed by HIV infection are very difficult and stressful.

People of Color and AIDS

Some people believe that AIDS is mostly a disease of gay white men, but AIDS is a serious problem for people of color. AIDS is almost twice as common among people of color as it should be, given their proportion in our population. Many women and most children with AIDS have been people of color. It is a terrible mistake to think that your racial background protects you against AIDS.

What If A Friend Has AIDS?

People with AIDS, ARC, or a positive test need the same kind of support and friendship you always provided before. They are likely to feel isolated, frightened, and uncertain about their relationships, their future, and their medical condition. You can help socially and psychologically by continuing to talk and share activities. At the same time, it is also important to recognize that a minor infection for you could prove to be much more serious for a person whose immune system is impaired—don't expose a friend with AIDS to what could be a dangerous illness for him or her.

Health Care Professions Students and Others in Health Care Settings

Health care workers do not have a high risk of getting AIDS as a result of their work with patients, even if they regularly care for people with full-blown AIDS in hospitals. The risk is associated with needlestick injuries. Guidelines for prevention of transmission of AIDS virus to health care workers are similar to those for transmission of hepatitis B. All health professions students should be aware of these guidelines and observe them scrupulously. Health care professionals who have positive AIDS antibody tests may continue to study or work; the Public Health Service has published specific recommendations for their activities. Your Health Service is prepared to explain all of these precautions to you.

For Further Information

Contact your health service or health care provider. Much additional information and support can be obtained from regional institutions known as "AIDS Projects" in major cities. The following national "hot line" services are also available:

Centers for Disease Control

Hotline: 1-800-342-AIDS

Public Health Service

Hotline: 1-800-447-AIDS

National Gay Task Force and AIDS Crisis

Hotline: 1-800-221-7044

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SECTION 504 OF THE REHABILITATION ACT: EMERGING ISSUES FOR COLLEGES AND UNIVERSITIES

LAURA F. ROTHSTEIN*

INTRODUCTION

Section 504 of the Rehabilitation Act¹ was enacted by Congress in 1973. It provides that "no otherwise qualified handicapped individual . . . 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 [f]ederal financial assistance."² A substantial percentage of institutions of higher education are recipients of federal financial assistance, and are therefore subject to this mandate.³ The regulations promulgated pursuant to the Act have addressed specifically the requirements for colleges and universities by

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¹ 29 U.S.C. § 794 (1982).

² *Id.*

³ Under a 1984 United States Supreme Court holding, only those programs that directly receive federal financial assistance are subject to Title IX. *Grove City College v. Bell*, 465 U.S. 555 (1984). This holding applies similarly to § 504. Proposed legislative amendments to Title IX, § 504, and other similar statutes may result in institution-wide applicability. Because of current Congressional proposals to amend these statutes, courts may have been reluctant to address the question not clarified by the "Grove City" decision — i.e., what is a program? This article will not attempt to analyze that issue, but will assume that the discussed activity falls within the meaning of a program receiving federal financial assistance.

It should also be noted that § 504 applies to recipients of federal financial assistance other than colleges and universities, and that regulations have been promulgated to cover the areas of public education, public facilities, transportation, health and welfare, employment, and a variety of other areas. For a detailed discussion of the applicability of § 504 and other handicap discrimination statutes, see L. ROTHSTEIN, RIGHTS OF PHYSICALLY HANDICAPPED PERSONS (1984) [hereinafter RPHP].

Section 503 of the Rehabilitation Act applies to federal contractors and has similar but not identical requirements. This article focuses on § 504 because colleges and universities are more likely to be subject to it. For a discussion of § 503 requirements, see RPHP, § 4.05-.09.

focusing on student-related issues.⁴ Additional regulations clarify the employment issues relevant to campus staff and faculty.⁵

The passage of the Act and the promulgation of regulations brought initial uncertainty to American campuses.⁶ But judicial clarification of many issues and increasingly sophisticated networks of information exchange between universities have increased handicapped persons' participation in postsecondary education.⁷ Besides these measures the special education provided to public schools through the Education for All Handicapped Children Act (EAHCA) of 1975 has increased the number of handicapped students on campus today.⁸ Children who received this special education early in their school years now are reaching college age in increasing numbers, and are better prepared for and more likely to seek admission to higher education.

The judicial clarification of several substantive issues and the presence of more handicapped students on campus have set the stage for resolution of several emerging issues in this area. For example, when does a particular condition make an individual handicapped within the Act, when is a person considered "otherwise qualified," and what reasonable accommodations are required in the college setting?

This article will review the early judicial and regulatory developments that have set the framework for what is required under the Act. It will then examine the emerging issues on college campuses today. While focusing on student-related issues, this article will also examine some of the issues particularly significant to college faculty and staff. Because this article focuses primarily on issues unique to colleges and

⁴ 34 C.F.R. § 104.1-61 (1985).

⁵ The original model HEW regulation is found at 45 C.F.R. § 84.1-99 (1985). Each agency granting financial assistance must promulgate regulations consistent with the HEW model regulations. For agency regulations currently in existence, see RPHP, *supra* note 3, at 9.

⁶ For a general overview of the early assessment of § 504 and its implications, see E. PHELPS, SECTION 504 AND ITS IMPLICATIONS FOR POSTSECONDARY INSTITUTIONS, NEW DIRECTIONS FOR STUDENT SERVICES, SERVING HANDICAPPED STUDENTS 1-8 (1980).

⁷ Precise statistics on the number of handicapped students on American campuses are difficult to obtain. The best estimate indicates that from 1978 to 1985 the percentage of college freshmen with disabilities increased from 2.7% to 7.7%. HIGHER EDUCATION RESEARCH INSTITUTE, AMERICAN FRESHMAN: NATIONAL NORMS FOR FALL 1985 (1985).

⁸ 20 U.S.C. §§ 1401-1461 (1982). For a detailed discussion of the requirements under the EAHCA, see RPHP, *supra* note 3, at § 2. The underlying principles of the EAHCA are that all children of school age are to be served, that they are to be provided special education and related services in the least restrictive appropriate setting, and that they are to receive this education at no cost. *Id.* The EAHCA contains detailed procedural safeguards that provide parents of handicapped students the opportunity for notice and a hearing whenever they disagree with the school's decision about identification or programming. *Id.* Many parents have consequently become accustomed to a much higher level of substantive and procedural protections available than was previously the case. These parents and the students themselves quite probably have expectations that similar services should be available at the postsecondary level.

universities, an in-depth discussion of several procedural issues is not included, although these issues are mentioned briefly for reference. Finally, this article will provide some guidance for university counsel and policymakers in establishing sound practices in addressing issues related to handicapped students, staff, and faculty. The focus of this article is primarily on federal law. However, state laws relating to education, public accommodations, and employment⁹ may well have additional implications for colleges and universities.

SECTION 504: EARLY JUDICIAL AND REGULATORY DEVELOPMENTS

Although Section 504 of the Rehabilitation Act was passed in 1973, not until 1978 did HEW issue model minimum regulations.¹⁰ These regulations, which covered all recipients of federal financial assistance, not just colleges and universities, required recipients to perform a self-evaluation within one year of the effective date of the regulations and to eliminate discrimination uncovered by that evaluation.¹¹ These self-evaluations revealed that most campuses had obvious substantial architectural barriers. Other types of barriers, however, were found in the admissions and recruitment process and in programs and services as well.¹² Early concerns about how to address these issues as well as about the cost of making the needed changes have been alleviated to some degree by the development of an information network and by the improved technology available over the past few years.¹³ The most significant development is universities' recognition that Section 504 does not require that all classrooms and buildings be accessible to handicapped persons but that "when viewed in its entirety, [the program be] readily accessible to handicapped persons."¹⁴

Early litigation in this area focused mainly on procedural issues. In *Grove City College v. Bell*¹⁵ the courts held that unless Congress passes legislation to amend several statutes relating to federal financial assistance, only those programs directly receiving federal financial assistance will be subject to Section 504. That same year, the United States Supreme Court clarified that the primary objective of federal

⁹ See RPHP, *supra* note 3, at §§ 2, 4, 5.

¹⁰ 43 Fed. Reg. 2132 (1978). These regulations are to be followed by other agencies in promulgating their own regulations.

¹¹ 34 C.F.R. § 104.6(c) (1985).

¹² For a discussion of the overall requirements of § 504 as they apply to colleges and universities, see RPHP, *supra* note 3, at § 3.

¹³ Two major organizations providing information about postsecondary education and handicapped persons are Higher Education and the Handicapped (HEATH) and the Association on Handicapped Student Service Programs in Post-Secondary Education (AHSSPPE). A bibliography of these and other resource materials is included, *infra* at appendix.

¹⁴ 34 C.F.R. § 104.22(a) (1985). See also RPHP, *supra* note 3, at § 3.12.

¹⁵ 465 U.S. 555 (1984).

financial assistance need not be employment in order for an individual to bring an action claiming employment discrimination.¹⁶ It would follow then, that the federal financial assistance need not be for student services in order for a student to bring a discrimination action, as long as the federal financial assistance was being received in the program in which discrimination is being claimed.

The use of federal grant programs to trigger "Grove City" jurisdiction raises another issue as yet unsettled by the Supreme Court: the degree to which Congress can impose conditions on recipients through grant programs. In 1981 the Court, in *Pennhurst State School and Hospital v. Halderman*,¹⁷ held that Congress must be unambiguous in imposing specific conditions on the receipt of federal funds. While the Court has since concluded that Congress was unambiguous in its requirements under the Education for All Handicapped Children Act,¹⁸ it is uncertain whether the requirements of Section 504 are similarly unambiguous.¹⁹

Two other procedural issues have recently been addressed by the Supreme Court. In *Alexander v. Choate*,²⁰ the Court held that policies with a disparate impact on handicapped persons do not necessarily establish a prima facie case of discrimination under Section 504. The Court did not, however, reject the use of the disparate impact test in all cases of handicap discrimination. Of potential significance to state universities is *Atascadero State Hospital v. Scanlon*,²¹ in which the Court held that acceptance of federal funds by state agencies is not a waiver of eleventh amendment immunity. While not yet settled by the Supreme Court, two related procedural issues under Section 504 have been resolved with substantial unanimity by lower federal courts. These courts substantially agree that a private right of action exists under Section 504,²² and that one need not exhaust administrative remedies before seeking redress in court.²³

¹⁶ Consolidated Rail Corp. v. Darrone, 465 U.S. 624 (1984).

¹⁷ 451 U.S. 1 (1981).

¹⁸ Hendrick Hudson Dist. Bd. of Educ. v. Rowley, 458 U.S. 176 (1982).

¹⁹ See generally, Wegner, *The Antidiscrimination Model Reconsidered: Ensuring Equal Opportunity Without Respect to Handicap Under Section 504 of the Rehabilitation Act of 1973*, 69 CORNELL L. REV. 401 (1984).

²⁰ 105 S. Ct. 712 (1985). For discussion of burden of proof, see RPHP, *supra* note 3, at § 3.20.

²¹ 105 S. Ct. 3142 (1985). See also *Lupert v. California State Bar*, 761 F.2d 1325 (9th Cir. 1985) (immunity under the eleventh amendment does not extend to nonmonetary injunctive, or declaratory relief). The result may differ if an individual employee is sued instead of the agency.

²² See also *Salvador v. Bell*, 622 F. Supp. 438 (N.D. Ill. 1985) *aff'd*, 800 F.2d 97 (7th Cir. 1986) (student has no private right of action against the Secretary of the Department of Education under the Rehabilitation Act). See generally RPHP, *supra* note 3, at § 3.18 n.170.

²³ See generally, RPHP, *supra* note 3, at § 3.19 n.176.

Because of initial judicial attention to the procedural issues of private right of action and exhaustion, most early reported decisions did not address the substantive requirements of Section 504. The major exception, *Southeastern Community College v. Davis*,²⁴ held that in order to be considered "otherwise qualified" and therefore entitled to the protections of Section 504, the individual must be able to meet the program's requirements in spite of the handicap.²⁵ The United States Supreme Court indicated that while the refusal to make some modifications or adjustments might constitute illegal discrimination, substantial modifications or fundamental alterations to a program were not required under Section 504.²⁶ More recent judicial opinions in cases involving employment discrimination in other contexts, including some in higher education, have begun to clarify the types of accommodations that will be required in certain instances.²⁷ Because so many different types and degrees of handicapping conditions are involved in these cases, and because the programs in question have such different requirements, it is difficult to draw on these cases as precedent for what is specifically required in the way of accommodation in a particular situation. Some general principles have begun to emerge, however, and these will be discussed more fully later in this article.²⁸ One of the issues, part of the larger issue of required accommodations, is payment for auxiliary services. Blind students needing readers and deaf students needing sign language interpreters may not qualify for vocational rehabilitation funding for such services,²⁹ may not be able to obtain these services through voluntary agencies, and may have limited personal resources to pay for the services. These persons may then look to their college or university to provide such services. *University of Texas v. Camenisch*³⁰ would have resolved whether Section 504 requires the college or university to pay for interpreter services, but the Supreme Court remanded the case on a procedural issue. A potential resolution of this question is discussed later.

²⁴ 442 U.S. 397 (1979).

²⁵ The case involved a hearing-impaired applicant to a nursing program. The Court found hearing a necessary qualification for admission. *Id.* at 413-14.

²⁶ More recent developments concerning whether one is "otherwise qualified" are discussed later in this article. See *infra* Section II (B).

²⁷ See *infra* Section II (C). See also RPHP, *supra* note 3, at §§ 3.01-14, 4.12, 4.20.

²⁸ See *infra* Section II (C).

²⁹ See RPHP, *supra* note 3, at §§ 4.15-18.

³⁰ 451 U.S. 390 (1981). For prior *Journal of College & University Law* discussions of this issue, see Orleans & Smith, *Who Should Provide Interpreters Under Section 504 of the Rehabilitation Act?*, 9 J.C. & U.L. 177 (1982-83); Tucker, *Perspective on Camenisch*, 8 J.C. & U.L. 409 (1981-82); see also *Walters v. Washington Dept. of Servs. for the Blind*, 106 S. Ct. 748 (1985) (blind individual choosing to study ministry at a Christian college was not precluded by the first amendment from receiving vocational rehabilitation assistance).

In sum, while some procedural questions have been resolved, much substantive law remains to be addressed. Both the influx of handicapped students at universities and individuals' greater awareness of the Rehabilitation Act as a potential source of protection from adverse treatment by students, faculty, and staff are likely to result in more litigation in which some of these substantive issues will be resolved. The next section will address those areas in which the potential for litigation seems greatest.

II. EMERGING ISSUES

The following section highlights three difficult areas of inquiry. Whether someone is handicapped under Section 504 resolves only the first issue. The individual must also be qualified for the program and, where accommodations are required, they must be reasonable.

A. Who is handicapped?

A handicapped person is defined by the Rehabilitation Act 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 Major life activities include "caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."³⁰ While some handicaps clearly fall within the meaning of the Act, in a number of recent cases defendants have claimed that the individual seeking protection is not handicapped within the Rehabilitation Act definition. State statutes variously define handicap,³¹ but state cases are useful in assessing how courts define handicap.

²⁹ 29 U.S.C. § 706(7)(B) (1982).

³⁰ 34 C.F.R. § 104.3(j)(2)(ii) (1985).

³¹ ALA. CODE §§ 21-7-1, -8 (1975); ALASKA STAT. § 18.80.220(a)(1) (1981); CAL. EDUC. CODE §§ 1413(h), 1420(a), 1432(Deering Supp. 1981); COLO. REV. STAT. § 24-34-801 (1982); CONN. GEN. STAT. §§ 1-1f, 46(a)-60 (1981); D.C. CODE ANN. § 6-1705 (1981); FLA. STAT. ANN. § 413.08(3) (West 1979); GA. CODE ANN. §§ 66-501, -506 (Harrison Supp. 1982); HAW. REV. STAT. §§ 378-1(7), -2, -9 (1976 & Supp. 1980); IDAHO CODE §§ 56-701, -707 (1976); ILL. ANN. STAT. ch. 68, §§ 1-102(A), 1-103(I), 2-102 (Smith-Hurd Supp. 1981); IND. CODE §§ 22-9-11 to -13 (1980); IOWA CODE ANN. §§ 601A.2(11), .6(1) (West 1975); KAN. STAT. ANN. §§ 44-1002(j), 44-1009(a)(1) (1981); KY. REV. STAT. ANN. §§ 207.130(2), .150(1) (Baldwin 1982); LA. REV. STAT. ANN. §§ 46-2251 to -2256 (West 1982); ME. REV. STAT. ANN. tit. 5, §§ 4553.7-A, 4572 (1979); MD. ANN. CODE art. 49B, §§ 49B-15(g), 16 (1957 & Repl. vol. 1979); MASS. ANN. LAWS ch. 149, § 24K (Law. Co-op 1976); MICH. COMP. LAWS §§ 37.1103, .1202 (1979); MINN. STAT. §§ 363.01(25), .03(2) (1980); MISS. CODE ANN. § 43-6-15 (1981); MO. CODE REGS. tit. 4, § 180-3 (1985); MONT. CODE ANN. § 49-1-102, -2-101(13), (16), 2-303 (1981); NEB. REV. STAT. §§ 48-1102(8), -1104, -1108(1) (1978); NEV. REV. STAT. §§ 813.330, .350(1), (2) (1979); N.H. REV. STAT. ANN. §§ 354-A:3(13), -A:8 (Supp. 1981); N.J. STAT. ANN. §§ 10:5-4.1, -5(q) (West Supp. 1981); N.M.

Many cases in the employment area involve claims of protection for persons with back problems, crossed eyes, injured knees, weak back muscles, and other conditions,³² but this section will focus only on those cases pertaining to postsecondary education. Handicap claims likely will emerge in higher education for conditions that include learning disabilities, mental conditions, alcohol and drug addiction, and health conditions.

1. Learning Disabilities

A learning disability is a "disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations."³³ Regulations under Section 504 specifically include learning disabilities as a handicap within the Act.³⁴ Nevertheless, problems arise in determining whether a person is actually learning disabled, who is responsible for making that assessment, and when the university must know of the learning disability before it can be accused of discrimination.

Despite a significant increase in the understanding of learning disabilities, the causes and manifestations of learning disabilities are complex, and much research still needs to be done in this area.³⁵ As more becomes known about learning disabilities, children in public schools are more likely to be identified as learning disabled and to receive special education programming under the Education for All Handicapped Children Act.³⁶ While an assessment in public schools under the EAHCA is not a binding determination of the existence of a learning disability, such a determination would carry a great deal of

STAT. ANN. §§ 28-10-9 to -12 (1978); N.Y. EXEC. LAW §§ 292(21), 296(1) (McKinney 1982); N.C. GEN. STAT. § 128-15.3 (1981); N.D. CENT. CODE § 14-02.4-01 to -21 (1983); OHIO REV. CODE ANN. §§ 4112.01(13), .02(A) (Anderson 1980); OKLA. STAT. tit. 25, §§ 1301.4, 1302-10 (1981); OR. REV. STAT. §§ 659.400(2), .425 (1981); PA. STAT. ANN. tit. 43, §§ 954(p), 955 (Purdon Supp. 1981); R.I. GEN. LAWS §§ 28-5-6(H), -7 (1979); S.D. CODIFIED LAWS ANN. § 3-6A-15 (1980); TENN. CODE ANN. § 8-50-103 (1980); TEX. HUM. RES. CODE ANN. § 121.003 (Vernon 1980); UTAH CODE ANN. § 34.35-6 (Supp. 1981); VT. STAT. ANN. tit. 21, § 495 (Supp. 1982); VA. CODE ANN. § 40.1-28.7 (1981); WASH. REV. CODE § 49.60.180 (1981); W. VA. CODE § 5-11-2 (Supp. 1982); WIS. STAT. §§ 111.32(5)(a), (f) (1979-1980). For a cumulative supplement listing recent case law developments see, RPHP, *supra* note 3, at § 4.20.

³² Even left-handedness has been claimed as a handicap. The court did not agree. *Torres v. Bolger*, 610 F. Supp. 593 (N.D. Tex. 1985).

³³ 34 C.F.R. § 300.5(b)(9) (1985).

³⁴ *Id.* at § 104.3(j)(2)(ii)(B) (1985).

³⁵ B. SCHEIBER & J. TALPERS, *CAMPUS ACCESS FOR LEARNING DISABLED STUDENTS: A COMPREHENSIVE GUIDE* 7-14 (1985). See *infra* at appendix for further information.

³⁶ 20 U.S.C. §§ 1401-1461 (1982). For an in-depth discussion of the EAHCA, see RPHP, *supra* note 3, at § 2; see also *supra* note 8 for a brief overview of the requirements.

weight because of the safeguards attending such a finding. Many students, however, do not discover their learning disability until they reach college.³⁹ In fact, students with learning disabilities are the "fastest growing group of students with disabilities on campus."⁴⁰ Of the 7.7% of all freshmen on American campuses who are disabled, 14.3% of that group are learning disabled. In 1978 only 4.7% of disabled freshmen were learning disabled.⁴¹

Those individuals with a record of the disability as a result of public school identification⁴² or of an assessment done by qualified professionals should have little difficulty in providing the college or university with the documentation necessary to indicate that a handicap exists. This should entitle the student to nondiscriminatory treatment and some accommodation.⁴³ The real problem arises when a student is admitted, does poorly, is placed on academic probation or has some other adverse academic consequences, and feels that the poor academic performance is due to a learning disability that is undocumented. Must the college or university pay for the cost of an assessment or provide the assessment service through its health care program? The answer to that question cannot be found in reported case law, in the statutes, or in any regulations. Forthcoming answers will probably be based upon the normal services of the campus health service program. If psychological assessment is provided through the campus health program, then assessment of a student for learning disabilities should be part of the services available to the student. If, however, such services are not available on a routine basis, the cost and burden of providing the documentation will be borne by the student. This issue may eventually be litigated because the cost of making these assessments is substantial.⁴⁴

A second issue arises for learning disabled students in cases of adverse action (rejection for admission, academic probation, etc.) when the college or university does not know that the learning disability exists. In *Salvador v. Bell*,⁴⁵ Arsenio Salvador claimed that Roosevelt University had discriminated against him by failing to make necessary modifications of the academic program, which failure denied him a

³⁹ See B. SCHEIDER & J. TALPERS, *supra* note 37, at 7-10. In addition, many older students re-entering postsecondary education may not have attended public schools while the EAHCA was in effect.

⁴⁰ HEATH 3, *supra* note 13 (May 1986).

⁴¹ AMERICAN FRESHMAN: NATIONAL NORMS FOR FALL 1985, *supra* note 7.

⁴² See generally, RPHP, *supra* note 3, at § 2.29.

⁴³ See *infra* Section II(A)(1).

⁴⁴ Such testing can cost as much as \$400-\$500 for some private consultants, depending on the tester. Telephone conversation with Laurie Began, Counselor, Texas Rehabilitation Commission, Houston, Texas (Sept. 25, 1986).

⁴⁵ 622 F. Supp. 438 (N.D. Ill. 1985), *aff'd*, 800 F.2d 97 (7th Cir. 1986).

Masters Degree.⁴⁶ The court did not specifically decide whether the university must know of the handicap, dismissing the complaint because it was brought against the Secretary of Education, rather than against the university itself. The opinion does specify, however, that the Letter of Findings of the Department of Education Regional Office for Civil Rights concluded that there had been no discrimination because Roosevelt University had never been informed that the plaintiff was learning disabled and required modifications. The Letter of Findings noted that any obligation to make modifications in an academic program was contingent upon awareness that the student is handicapped.⁴⁷ While *Salvador* cannot be directly cited as holding that a university must know of a handicap before it can be found to have discriminated, at least one reported case in an employment context does reach that conclusion. In *Walker v. United States*,⁴⁸ the court held that the FBI was not in violation of Section 504 because it was unaware of the claimed handicapping condition and had no duty to inquire into the existence of a handicap.

Colleges and universities not only have no duty to inquire into the existence of a handicap, but they are specifically prohibited from making preadmission inquiries about handicaps⁴⁹ except where the inquiry is for the purpose of remedial action or to overcome limited participation.⁵⁰ Because of current practices in flagging standardized tests, a procedure where the testing service reports special modifications made for a particular student,⁵¹ many learning disabled students will be identified through the admissions process, even if they do not self-identify.

In sum, learning disabled students are protected as being handicapped within Section 504. However, it is unclear whether they are protected if their learning disability is unknown. It seems probable, however, that unless disparate impact on learning disabled persons resulting from admissions policies or academic requirements results in a Section 504 violation (an unlikely result),⁵² plaintiffs will have to demonstrate that the institution knew of the learning disability before succeeding in discrimination claims. It is also probable that students will be required to provide at their own expense the documentation of the handicapping condition.

⁴⁶ *Id.* at 439.

⁴⁷ *Id.*

⁴⁸ 572 F. Supp. 100 (D.D.C. 1983).

⁴⁹ 34 C.F.R. § 104.42(b)(4) (1985).

⁵⁰ *Id.* at § 104.42(c). See also, RPHP, *supra* note 3, at § 3.05.

⁵¹ See *infra* Section II(B)(1).

⁵² See *Alexander v. Choate*, 105 S.Ct. 712 (1985).

2. Mental Conditions

Section 504 includes within the definition of handicapped individuals those who have mental impairments.³³ The regulations note that physical or mental impairments include "any mental or psychological disorder . . . such as emotional or mental illness."³⁴

Individuals may have conditions prohibiting them from performing the essential functions of a job or educational program and will not be considered "otherwise qualified." Therefore, they will not succeed in discrimination actions.³⁵ The following section is limited to the question of whether certain conditions qualify as mental impairments. A number of cases in both the student and the employment context at both federal and state levels are instructive in determining when a person with a mental condition is handicapped.

In probably the most well-known case involving higher education, *Doe v. New York University*,³⁶ a medical school applicant with serious mental disturbances was "regarded as having an impairment"³⁷ under Section 504.³⁸ Several cases have established a variety of mental impairments as within the definition of handicapped under federal or state law. These impairments include chronic paranoid schizophrenia,³⁹ uncontrollable behavior problems resulting from diabetes mellitus and a hyperactive thyroid,⁴⁰ manic depression,⁴¹ severe depression,⁴² and emotional problems resulting from multiple sclerosis.⁴³ In at least some of these cases, though, the plaintiff, despite falling within the applicable handicapped definition, lost because the individual was found not to

³³ 29 U.S.C. § 706(7)(B) (1982). For a complete definition of handicap, see *supra* text accompanying note 31.

³⁴ 45 C.F.R. § 84.3(j)(2)(i)(B) (1985).

³⁵ For a discussion of accommodations that may be required, see *infra* Section II(C)(5).

³⁶ 666 F.2d 761 (2d Cir. 1981).

³⁷ *Id.* Although she was found to be handicapped, she ultimately lost the case for reasons discussed *infra*, at Section II(B)(2).

³⁸ *Doe*, 666 F.2d 777 (2d Cir. 1981).

³⁹ *Swann v. Walters*, 620 F. Supp. 741, 746-47 (D.D.C. 1984) (employee of Veterans Administration was legally demoted after revocation of security clearance under § 501 of the Rehabilitation Act).

⁴⁰ *Pannell v. Wanke Panel Co.*, 618 F. Supp. 41, 43 (D. Or. 1985) (employer's motion for summary judgment granted in Oregon state law claim of wrongful discharge by warehouseperson).

⁴¹ *Gardner v. Morris*, 752 F.2d 1271 (8th Cir. 1985) (civil engineer in Saudi Arabia could not be accommodated reasonably by having an on-site physician and laboratory facilities in claim under §§ 501, 504).

⁴² *Carty v. Carlin*, 623 F. Supp. 1181, 1185 (D. Md. 1985) (Postal Service's motion to dismiss granted in claim under the Rehabilitation Act by a postal worker, court holding that reasonable accommodation did not require reassignment).

⁴³ *Pushkin v. Regents of the Univ. of Colo.*, 858 F.2d 1372 (10th Cir. 1981).

be otherwise qualified and/or reasonable accommodation could not be made under the circumstances.⁴⁴

In *Pressman v. University of North Carolina at Charlotte*,⁴⁵ a university professor who suffered from occasional episodes of stress, depression, and mental exhaustion requiring hospitalization was denied reappointment. His claim seeking damages and reappointment was denied on the grounds that he was not handicapped within the state's definition. The court held that because his mental illness had been cured, he no longer had a disability under state law which required that the disability be present and noncorrectable.⁴⁶ The same result would not be likely under Section 504 because it specifically includes persons with a record of impairment.⁴⁷ The case does reveal that fitting within the definition in the federal law does not automatically mean that the individual will be protected under state statutes.⁴⁸

State law failed to provide protection in *School District of Philadelphia v. Friedman*⁴⁹ because the plaintiff did not fit within the definition of handicap. In that case an employee in the data processing department was discharged because of chronic tardiness. The court found that a personality disorder causing chronic tardiness was not a mental disability under Pennsylvania law.⁵⁰ A strongly critical dissent noted that the plaintiff had a well-documented history of mental impairment resulting in chronic tardiness.⁵¹ In light of the dissent's persuasive argument that the plaintiff should have been considered handicapped; caution is advised in relying on this case. A different result is quite probable under federal law.

In another case involving higher education, *Martin v. Delaware Law School*,⁵² a law student claimed that based on his medical history of psychiatric care, he had been denied the opportunity to sit for the bar exam, in violation of the Rehabilitation Act. Because the plaintiff had not alleged that the defendants were recipients of federal financial assistance, however, the Rehabilitation Act claims were dismissed.⁵³

The courts have broadly defined the term "handicap" under federal law. It remains to be seen whether greater awareness of the Rehabili-

⁴⁴ See *supra* notes 59-62. For a more detailed discussion of reasonable accommodations, see *infra* Section II(C).

⁴⁵ 78 N.C. App. 296, 337 S.E.2d 644 (Ct. App. 1985). Claims were also brought under the first and fourteenth amendments and for breach of contract.

⁴⁶ *Id.* at 649.

⁴⁷ 29 U.S.C. § 706(7)(B)(iii) (1982). See also *Sites v. McKenzie*, 423 F. Supp. 1190 (N.D. W. Va. 1976) (history of mental impairment covered under § 504).

⁴⁸ For a listing of state handicap discrimination statutes, see *supra* note 33.

⁴⁹ 507 A.2d 882 (Pa. 1986).

⁵⁰ *Id.* at 886.

⁵¹ *Id.* at 890-91.

⁵² 625 F. Supp. 1288 (D. Del. 1985) (the plaintiff also sought relief under a number of other state and federal laws).

⁵³ *Id.* at 1298, 1302.

tation Act's potential protection will result in an increase of claims by students alleging that conditions such as exam anxiety have resulted in discriminatory action. In order to succeed on such a claim, a student will probably need a well-documented record indicating that the condition substantially interfered with school work. Even if such conditions are judged handicaps within federal or state law (and that is unlikely), current case law defining "otherwise qualified" and "reasonable accommodations" is a likely obstacle to complainants where discriminatory or negative action is taken against persons because of their mental conditions.

3. Alcoholism and Drug Addiction

A separate subsection is devoted to alcoholism and drug addiction because these conditions receive special treatment under Section 504 and many state laws, and also because their manifestations are often different from those of the mental impairments discussed previously.

The Rehabilitation Act was amended in 1978 to state that a handicapped individual under Section 504

does not include . . . an alcoholic or drug abuser whose current use of alcohol or drugs prevents such individual from performing the duties of the job . . . or whose employment, by reason of such current alcohol or drug abuse, would constitute a direct threat to the property or the safety of others.²⁹

The amendment focuses on employment, and this limitation arguably does not extend to other areas. Moreover, the language merely incorporates the requirements already in existence: handicapped individuals are only protected if they are "otherwise qualified," but if they are prevented by the alcohol or drugs "from performing the duties of the job" those individuals do not otherwise qualify under the Act. Because alcoholism and drug use among faculty members and students present serious problems,³⁰ whether alcoholism and drug addiction are handicaps is a relevant question.

The majority of federal courts hold that while alcoholism and drug addiction are handicaps,³¹ it is not illegal to treat adversely an individ-

²⁹ 29 U.S.C. § 706(7)(B) (1982).

³⁰ See McMillen, *The Alcoholic Professor: Campus is Ideal Environment for a Hidden Problem*, CHRON. HIGHER EDUC., Oct. 9, 1985, at 1, col. 2; Meyer, *One in Three College Students Tries Cocaine, Study Finds: Bennett Urges President to Crack Down on Drugs*, CHRON. HIGHER EDUC., July 16, 1986, at 1, col. 2 (citing study by University of Michigan's Institute for Social Research).

³¹ See Traynor v. Walters, 606 F. Supp. 391 (S.D.N.Y. 1985); Richardson v. United States Postal Serv., 613 F. Supp. 1213 (D.D.C. 1985); Walker v. Weinberger, 600 F. Supp. 757 (D.D.C. 1985); Johnson v. Smith, 39 F.E.P. Cas. 1106 (D.Minn. 1985); Whitlock v. Donovan, 598 F. Supp. 126 (D.D.C. 1984); Huff v. Israel, 573 F. Supp. 107 (M.D. Ga. 1983); Brady v. Daily World, 105 Wash. 2d 770, 718 P.2d 785 (1986).

ual whose conduct results from being intoxicated.³² For example, it would probably be impermissible to refuse admission to a student because of drug addiction, either current or past. But it would be permissible to discipline a student for campus offenses committed while the student was intoxicated.³³

Two other points, however, should be emphasized. First, states differ about whether their handicap rights statutes and case law apply to drug addicts and alcoholics.³⁴ Second, those colleges and universities considering drug and alcohol screening programs for athletes, other students, faculty, or staff need to be aware of the various legal, ethical, and medical repercussions of such programs.³⁵ The application of the Rehabilitation Act to screening programs reveals only one of many complex issues.

Someone addicted to drugs or alcohol clearly is handicapped under both the Rehabilitation Act and some state statutes. The more difficult issues are whether the individual is otherwise qualified and whether the college or university is required to make reasonable accommodations for these individuals. These issues are addressed later in this article.³⁶

4. Health Conditions

Numerous health conditions could cause the person to be considered handicapped within federal law either because the severity of the condition substantially limits a major life activity or because the condition causes the person to be regarded as having such an impairment. These health conditions vary widely.

In *State Division of Human Rights v. Xerox Corp.*,³⁷ a computer programmer was denied a job based solely on a physical examination indicating she was obese. The court found that under state law obesity could be considered a disability, noting that it did not matter whether the condition was treatable by a change in dietary habits or was otherwise caused.

This decision will be especially significant if courts follow it in interpreting the Rehabilitation Act. Although few students probably are

³² See Richardson, 613 F. Supp. at 1213; Huff, 573 F. Supp. at 107; and Brady, 105 Wash. 2d at 770.

³³ In Richardson an employee was terminated from the Postal Service for assaulting his wife with the intent to kill her. 613 F. Supp. at 1213, 1214-15. In Huff the discharge resulted from driving under the influence of alcohol. 573 F. Supp. 107, 108.

³⁴ See also state statutory citations, supra note 33. Compare Welsh v. Municipality of Anchorage, 34 E.P.D. No.34, 363 (Alaska Sup. Ct. 1984) (alcoholism not a handicap) with Consolidated Freightways v. Cedar Rapids Civil Rights Comm'n, 355 N.W.2d 522 (Iowa 1985) (alcoholism a handicap under municipal ordinance).

³⁵ M. Rothstein, *Screening Workers for Drugs: A Legal and Ethical Framework*, 11 EMPL. REL. L.J. 422 (1985-1986).

³⁶ See infra Section II(C)(5).

³⁷ 65 N.Y.2d 213, 480 N.E.2d 695 (1985). Contra Philadelphia Elec. Co. v. Commonwealth, 70 Pa. Commw. 343, 448 A.2d 701 (1982) (obesity not a handicap).

excluded from programs because of obesity, such cases may become more common.⁸³ In one case, not yet resolved, a nursing school applicant brought an action based not on a handicap rights statute, but on a breach of an implied contract theory. Because nursing programs and other medical academic programs require a showing of good health for admission, obesity and other health conditions may more commonly be the basis for exclusion in those types of programs.⁸⁴ For some health conditions, the risk to others may be the significant factor for rejection; in others, the rigor of the program and the impact on the person may be the primary concern.

It is simply too early to tell whether obesity is going to be consistently treated as a handicap.⁸⁵ However, policies that exclude on that basis are most likely to be upheld if the condition itself prevents the individual from performing the essential functions of the program or job even with reasonable accommodation.

Other debilitating diseases or medical conditions have received varying treatment by the courts. In *County of Los Angeles v. Kling*,⁸⁶ the most recent and significant holding in this regard, the district court found that Crohn's disease was not a handicap under Section 504. Although the Ninth Circuit reversed,⁸⁷ the United States Supreme Court in turn reversed the Ninth Circuit.⁸⁸ In spite of the Court's ruling in the *Kling* case, it is likely that health conditions like Crohn's disease will be considered handicaps because of that portion of the definition protecting individuals "regarded as" having an impairment.⁸⁹ The recent position statement of the Department of Justice that Acquired Immune Deficiency Syndrome (AIDS) is a handicap under federal law provides additional support for the statement that chronic diseases should be viewed as handicaps.⁹⁰

⁸³ See, e.g., *Russell v. Salve Regina College*, No. 85-628B (filed November 1985). See generally, *Beaton, Overweight Nursing Student Sues Over Ouster*, Nat'l L.J., Nov. 18, 1985, at 8.

⁸⁴ Many of the most significant holdings in the context of admissions in higher education relate to medical programs. See *Southeastern Community College v. Davis*, 442 U.S. 397 (1979) (nursing program); *County of Los Angeles v. Kling*, 106 S. Ct. 300 (1985) (nursing program); *Pushkin v. Regents of Univ. of Colo.*, 658 F.2d 1372 (10th Cir. 1981) (psychiatric residency program); *Doe v. New York Univ.*, 666 F.2d 761 (2d Cir. 1981) (medical school).

⁸⁵ In *Tudyman v. United Airlines*, 608 F. Supp. 739 (C.D. Cal. 1984), a body builder whose weight exceeded the maximum for flight attendants was held not to be handicapped under § 504. Since the plaintiff here was overweight due simply to muscle buildup, it is not clear whether the court would reach the same result with respect to an obese individual. Even if the court found obesity to be a handicap, weight requirements might be deemed a bona fide occupational qualification for a flight attendant.

⁸⁶ 106 S. Ct. 300 (1985).

⁸⁷ 769 F.2d 532, 534 (9th Cir. 1985).

⁸⁸ An in-depth discussion of this case is included *infra*, at Section II(B)(2).

⁸⁹ 29 U.S.C. § 706(7)(B)(iii) (1982).

⁹⁰ Opinion of Justice Department Office of Legal Counsel, Department of Justice, June 23, 1986. AIDS as a handicap is discussed more fully later in this section.

Persons with cancer or with a history of cancer may also fall within this category either because they are regarded as having an impairment or because they have a record of having an impairment. Some individuals with cancer also may be limited in one or more life activities. Concern about whether persons with cancer or a cancer history are protected under federal or state laws has led to recent efforts to enact a federal law specifically protecting persons with cancer or a history of cancer against discrimination.⁹¹ Because the proposed law amends Title VII,⁹² it would also reach most private employers rather than only those who receive federal financial assistance.

Contagious health conditions, including AIDS, tuberculosis, herpes, and infectious hepatitis, present special problems. Thus far, case law has provided protection for victims of infectious diseases.⁹³ A recent ruling of the Department of Justice, however, states that although the disabling effects of AIDS qualify a person as handicapped under Section 504, the ability to transmit the disease is not protected.⁹⁴ According to the Justice Department, this is true whether the transmitting ability is real or perceived. Whether this ruling would apply to other contagious diseases is unclear. The ruling has received much criticism,⁹⁵ and it may not be followed closely by employers because of potential challenge to such a ruling in the courts. The ruling on AIDS is particularly subject to challenge because of the current evidence that AIDS is not transmitted through casual contact. Although this does not necessarily mean that persons with AIDS cannot be treated differently, it is likely that as handicapped persons they would be entitled to reasonable accommodation where possible.⁹⁶

⁹¹ H.R. 1294, 99th Cong., 1st Sess., 131 CONG. REC. 815 (1985). For an in-depth discussion of the bill and cancer as a handicap, see Hoffman, *Employment Discrimination Based on Cancer History: The Need for Federal Legislation*, 59 TEMPLE L.Q. 1 (1986).

⁹² 42 U.S.C. §§ 2000e to e-17 (1982).

⁹³ See *Arline v. School Bd. of Nassau County*, 772 F.2d 759 (11th Cir. 1985), cert. granted, 106 S. Ct. 1633 (1986) (handicapped individuals include those suffering from chronic contagious diseases such as tuberculosis); *New York State Ass'n for Retarded Children v. Carey*, 612 F.2d 644 (2d Cir. 1979) (school children who were carriers of Hepatitis B virus could not be isolated because health hazard was only a remote possibility); *Graniner v. Board of Educ.*, 502 N.Y.S.2d 325 (1986) (automatic exclusion of students with AIDS violates equal protection); *Community High School Dist. 155 v. Denz*, 124 Ill. App. 3d 129, 563 N.E.2d 998 (1984) (child with infectious hepatitis must be mainstreamed in public schools).

⁹⁴ See *supra* note 90.

⁹⁵ See generally, 4 Employee Rel. Weekly 803-04 (BNA) (June 30, 1986); Reibstein, *Federal Ruling on AIDS Bias Confuses Firms*, Wall Street J., June 27, 1986, at 19, col. 3; Leonard, N.Y. Times, July 3, 1986, at 28, col. 4 (letter to the editor). Professor Leonard is a national expert on the topic of legal issues relating to AIDS.

⁹⁶ For a discussion of accommodations required for persons with AIDS, see *infra* Section II(C)(4).

B. Otherwise Qualified

Determining that an individual is handicapped within the applicable federal or state law is only the first step towards determining that the individual is protected under the law. Section 504 of the Rehabilitation Act protects individuals who are "otherwise qualified,"⁹⁷ and it is therefore necessary to establish that the individual is qualified. For colleges and universities, this means that the student is one "who meets the academic and technical standards requisite to admission or participation in the recipient's education program or activity."⁹⁸ For university and college employees, this means that the person must be able to perform the essential functions of the job with reasonable accommodations.⁹⁹

The United States Supreme Court has defined the term "otherwise qualified" in a higher education context. *Southeastern Community College v. Davis*¹⁰⁰ involved the admission of a hearing-impaired woman to a college nursing program. The Court held that an individual must be able to meet all of the program's requirements in spite of the handicap. In applying this standard to the plaintiff, the Court found that because Ms. Davis could not perform the program's requirements without fundamental alterations, she need not be admitted. The Court did note, however, that some modifications may be required, and a program's failure to make reasonable accommodations might be discriminatory in certain cases. A significant factor in *Davis* seemed to be the inability of the program to be reasonably accommodated to ensure patient safety,¹⁰¹ a factor that may have an impact on other accommodation questions.

Whether one is qualified raises significant questions in the admissions process, where the use of standardized tests may have adverse effects on students with certain impairments. The admission of students with certain health impairments also raises such questions. While a number of other issues could be addressed relating to whether someone is otherwise qualified,¹⁰² standardized testing and health impairments used to determine student qualifications are addressed here because of significant recent developments.

1. Standardized Tests

The admissions process at most institutions of higher education involves submitting an application form, providing certified documen-

⁹⁷ 29 U.S.C. § 794 (1982).

⁹⁸ 34 C.F.R. § 104.3(k)(3) (1985).

⁹⁹ *Id.* at § 104.3(k)(1) (1985).

¹⁰⁰ 442 U.S. 397, 407, 412-13 (1979).

¹⁰¹ *Id.* at 410.

¹⁰² See generally, RPHP, *supra* note 3, at § 3.03.

tation of grades, and taking a standardized test, the score of which is used in the admissions process. For students with learning disabilities, visual or hearing impairments, and certain physical impairments, a standardized test may present particular difficulties. Recent attention to this difficulty flowed primarily from a 1982 report which criticized many of the standardized tests.¹⁰³ As a result, most of the major testing services administering standardized tests have undertaken a great deal of research into the types of accommodations that can and should be made, and have begun to study the long term significance of the data that is being collected.¹⁰⁴ The research reports generally indicate that more research is needed before definite conclusions can be drawn.

Recent test administrations by the major services have provided a variety of accommodations, including large print versions, extra test time, and extra rest time. Because of good faith concerns with their comparability, predictability, and validity, test scores are currently being reported by most, if not all organizations, with a notation about the conditions under which the test was administered. These "flagged" test reports are currently permissible under an interim policy of the Department of Education.¹⁰⁵ It remains permissible to require that the standardized test be taken (although in practice many institutions waive the test in certain instances), but institutions must use criteria other than scores for making admissions decisions. This is probably the practice at most institutions anyway, and is recommended by the major testing services. Because of the current research efforts in this area, university counsel, admissions officers, and directors of disabled student services should closely follow the developing literature.

2. Health Impairments

Many programs of higher education require that one be physically fit. When the level of fitness required is not rationally related to the

¹⁰³ ABILITY TESTING OF HANDICAPPED PEOPLE: DILEMMA FOR GOVERNMENT, SCIENCE AND THE PUBLIC (S. Sherman & H. Robinson eds. 1982). For a review of this report, see Orleans, Book Review, 9 J.C. & U.L. 347 (1982-83).

¹⁰⁴ Several reports have been issued by the Studies of Admissions Testing and Handicapped People, a group sponsored by the College Entrance Examination Board, the Educational Testing Service, and The Graduate Record Examinations Board. Information on these reports can be obtained from the Educational Testing Service, Princeton, New Jersey 08541. The Law School Admissions Council has conducted a two year program of accommodation and research into the results of that accommodation. Information on that study can be obtained from the LSAC, Newton, Pennsylvania 18940.

¹⁰⁵ See RECRUITMENT, ADMISSIONS AND HANDICAPPED STUDENTS: A GUIDE FOR COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973 20 (1985). See *infra* at appendix. The use of standardized test scores for admission purposes requires the institution to conduct periodic validity studies. 34 C.F.R. § 104.42(c) (1985).

program, a potential conflict may arise as to whether an individual with a health impairment is otherwise qualified. In the most recent case to address this issue, *County of Los Angeles v. Kling*,¹⁰⁶ the United States Supreme Court, reversed without opinion a circuit court ruling that Section 504 had been violated when a nursing program denied Mary Kling admission to the program solely on the basis of her handicap. What makes the decision particularly troubling¹⁰⁷ is that in a case involving important disparities in the factual record, the Court granted review, but reversed the circuit court without opinion.¹⁰⁸ Understanding the result of the decision requires a review of the factual background and judicial opinions.

Mary Kling first applied to the Los Angeles County School of Nursing in 1976. She was advised that she could not be admitted because of health reasons, determined by the Student Health Physicians.¹⁰⁹ She did not challenge the decision at that time, but instead chose to enroll at Pierce Junior College, from which she graduated.

When her February, 1979, application was also denied, Mary Kling sought legal redress. She was admitted to the Los Angeles County School of Nursing in April of 1979, conditioned upon her demonstrating math proficiency. Before she had the opportunity to do so, however, she was advised that based on her physical examination, she would not be able to enroll.¹¹⁰

The physical examination upon which the rejection was based had shown that Mary Kling suffered from Crohn's disease, which is an inflammatory bowel disease resulting in weight loss, nausea, vomiting, headaches, and acute abdominal pain.¹¹¹ Mary Kling's personal physician stated that she should be able to meet the nursing program requirements, but the Nursing School accepted its own physician's assumption that someone with Crohn's disease does not have sufficiently sound and stable health to complete the program¹¹² because the program would be too stressful for her.¹¹³

Because Mary Kling believed that the denial of admission was based not on her math proficiency but on her condition, and that the

¹⁰⁶ 106 S. Ct. 300 (1985).

¹⁰⁷ *Id.* at 302.

¹⁰⁸ *Id.* at 302 nn. 3-4.

¹⁰⁹ *Kling v. County of Los Angeles*, 769 F.2d 532, 533 (9th Cir. 1985) (Reporter's Transcript (R.T.) from District Court decision, at 26).

¹¹⁰ The issue of her mathematics deficiency clouds the decision somewhat. A close examination of the record, however, indicates that the issue of her mathematics deficiency was never resolved one way or another, and that the sole reason for the denial was the handicap. R.T. 386-87. See also 633 F.2d 876, 877 (9th Cir. 1980); 106 S. Ct. 300, 302 n.4 (Stevens, J., dissenting).

¹¹¹ 769 F.2d 532, 533 (9th Cir. 1985).

¹¹² 633 F.2d at 879.

¹¹³ 106 S. Ct. at 300 (Stevens, J., dissenting).

Nursing School had violated Section 504 by its actions, she complained to the Department of Health, Education, and Welfare. She then brought an action in district court before any final determination had been made by HEW. She sought declaratory and injunctive relief, including a preliminary injunction to allow her admission for the spring semester.¹¹⁴

The district court denied the preliminary injunction based on a failure to exhaust administrative remedies. The case was reversed by the Ninth Circuit in 1980,¹¹⁵ and remanded to the district court for it to grant the preliminary injunction requested.¹¹⁶ On remand, the district court held that Kling had been denied admission because she was academically deficient, not solely because of her health status.¹¹⁷ It further found that because the program would be too stressful she was not qualified for health reasons.¹¹⁸ The court also held that Mary Kling was not handicapped under the Rehabilitation Act and that there had been no discrimination under 42 U.S.C. § 1983 or Section 504.¹¹⁹ The court found that no compensable harm had been suffered because of the rejection.¹²⁰

In the Ninth Circuit's second review of the case it found the district court's findings, based on evidence that was not substantially different from that which the Ninth Circuit considered in its first review, clearly erroneous.¹²¹ The court specifically held that Mary Kling was protected by Section 504, was otherwise qualified, and had been denied admission solely because of her handicap.¹²² The Ninth Circuit noted that the Nursing School's decision to deny admission had been based on erroneous general assumptions about individuals with Crohn's disease and not on Mary Kling's individual medical history. The district court had thus erroneously concluded that Mary Kling was not qualified.¹²³ The

¹¹⁴ 633 F.2d at 877.

¹¹⁵ *Id.* The Ninth Circuit followed the strong weight of authority at the time in allowing no private right of action under § 504. 633 F.2d at 878. This continues to be the majority position. See RPHP, *supra* note 3, at § 3.18.

Following *Cannon v. University of Chicago*, 441 U.S. 766 (1979), the Ninth Circuit also held that exhaustion of administrative remedies is not required. *Kling v. County of Los Angeles*, 633 F.2d at 879. Finally, since the plaintiff had shown a probability of success on the merits and that the balance of hardships tipped in her favor, the district court abused its discretion in failing to grant the preliminary injunction. *Id.* at 879-80.

¹¹⁶ *Id.* at 880.

¹¹⁷ *Kling v. County of Los Angeles*, 769 F.2d at 533.

¹¹⁸ *Id.*

¹¹⁹ *Id.* The court also denied her claim for damages and attorneys' fees that had been added when Kling rejected the Nursing School's offer to admit her, but without accepting her nursing school credits from Pierce Community College, which she had attended for the year and a half during litigation. *Id.*

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.* at 534.

court noted that the legal conclusion regarding damages as an appropriate remedy was equally wrong.¹²⁴

Unfortunately for Mary Kling, the Ninth Circuit in its opinion of only ten paragraphs failed to discuss the record in any depth.¹²⁵ Factual determinations are to be reversed only when clearly erroneous.¹²⁶ The Ninth Circuit, therefore, should have addressed the record in substantially greater depth. The United States Supreme Court's response to the circuit court's failure to analyze the findings is, however, equally, if not more, remiss. In an unusual move, the Court simultaneously granted certiorari and, citing but one case, reversed the Ninth Circuit, thus denying the parties the opportunity to file briefs.¹²⁷ The Supreme Court's ruling was strongly criticized by Justice Stevens because review was essential to disposition in that case, and because the Court had by its ruling engaged "in decision-making without the discipline and accountability that the preparation of opinions requires."¹²⁸

Because of this unusual procedure, the decision holds only that the Ninth Circuit failed to provide a sufficiently in-depth discussion of the record in concluding that the district court's finding was clearly erroneous. The Supreme Court cited only *Anderson v. City of Bessemer City*,¹²⁹ a decision on the "clearly erroneous" standard.¹³⁰

It is important that the decision not be cited for any of the following propositions:

- 1) A person with Crohn's disease is not handicapped under the Rehabilitation Act.
- 2) Damages are not allowed under the Rehabilitation Act.
- 3) Assumptions about persons with particular health conditions or disabilities can be used as the basis for denying admission to academic programs.

As has been discussed in a previous section,¹³¹ a person with Crohn's disease is probably handicapped under the Rehabilitation Act. The authorities conflict as to whether damages are available under the Rehabilitation Act.¹³² The third proposition relates to whether one is otherwise qualified.

The district court in *Kling* deferred to the school physician's decision that because the program would be too stressful Mary Kling was

¹²⁴ *Id.*

¹²⁵ The opinion was short because the decision was originally slated to go unpublished, a practice criticized by Justice Stevens in his dissent in the case. 106 S. Ct. 301 (Stevens, J., dissenting).

¹²⁶ *Id.* at 301.

¹²⁷ This is particularly "disturbing because the petitioner does not usually file the record with a petition for certiorari." *Id.* at 302 (Stevens, J., dissenting).

¹²⁸ *Id.* at 302-03.

¹²⁹ 105 S. Ct. 1504 (1985).

¹³⁰ *Kling*, 106 S. Ct. 300.

¹³¹ See *supra* Section II(A)(4).

¹³² See RPHP, *supra* note 3, at §§ 2.39, 3.36, 4.13.

not qualified.¹³³ Such assumptions about the abilities of handicapped persons and the concern about risk of safety and health to the person have been addressed in a number of decisions.¹³⁴ Most relevant to higher education is *Pushkin v. Regents of the University of Colorado*,¹³⁵ in which four faculty members decided on the basis of short interviews that an applicant to a psychiatric residency program would not have the necessary emotional stability to respond to patient reactions to his confinement to a wheelchair because of multiple sclerosis. The court found a decision based on such incorrect assumptions or inadequate factual determinations, violative of Section 504.¹³⁶ Other courts have reached similar conclusions where the bases of exclusion have been patronizing assumptions about risks and abilities of handicapped individuals.¹³⁷

A determination that one is not otherwise qualified is more likely to be upheld when its basis invokes risk of harm to others, not personal risk to the individual. Both *Southeastern Community College v. Davis*¹³⁸ and *Doe v. New York University*¹³⁹ involved exclusions from higher education programs because of public safety concerns. In *Davis*, the Court was concerned with the amount of supervision the clinical phase of the program would require for a hearing impaired applicant in order to ensure patients' safety.¹⁴⁰ In *Doe*, an emotionally unstable medical school applicant was held properly excluded¹⁴¹ because she presented an appreciable risk of recurrent violence toward herself and others. The court found, however, routine disqualification because of such conditions impermissible.¹⁴² In the *Kling* case, the determination that Mary Kling was unqualified for health reasons was based not on a concern for the safety of others, but on the assumption that the program would be too stressful for the applicant herself;¹⁴³ the precedents noted above make this kind of disqualification impermissible under Section 504.

¹³³ *Kling*, 106 S.Ct. 301.

¹³⁴ See *Kampmeier v. Nyquist*, 553 F.2d 296 (2d Cir. 1977); *Grube v. Bethlehem Area School Dist.*, 550 F. Supp. 418 (E.D. Pa. 1982); *Wright v. Columbia Univ.*, 520 F. Supp. 489 (E.D. Pa. 1981); *Poole v. South Plainfield Bd. of Educ.*, 490 F. Supp. 948 (D.N.J. 1980); *Kampmeier v. Harris*, 66 A.D.2d 1014, 411 N.Y.S.2d 744 (1978); see also *Dothard v. Rawlinson*, 433 U.S. 321, 335 (1977) (involving sex discrimination).

¹³⁵ 658 F.2d 1372 (10th Cir. 1981). For an in-depth discussion of the case, see Pavela, *Therapeutic Paternalism and the Misuse of Mandatory Psychiatric Withdrawals on Campus*, 9 J.C. & U.L. 101, 111-14 (1982-83).

¹³⁶ *Pushkin*, 658 F.2d at 1383.

¹³⁷ See *supra* note 134.

¹³⁸ 442 U.S. 397 (1979).

¹³⁹ 666 F.2d 761 (2d Cir. 1981). For an in-depth discussion of the case, see Pavela, *supra* note 135, at 106-14.

¹⁴⁰ 442 U.S. at 410.

¹⁴¹ 666 F.2d at 775.

¹⁴² *Id.* at 779 n. 10.

¹⁴³ *Kling*, 106 S. Ct. at 101 (Stevens, J., dissenting).

In an excellent analysis of the public and private safety defenses, Professor Judith Wegner notes that courts are currently applying differing tests.¹⁴⁴ Under the significant risk test (used in the public safety area as well), a significant justification for the exclusion must be shown.¹⁴⁵ A more stringent test, applied by at least one court, requires that qualifications that exclude handicapped persons be directly connected with and substantially promote "business necessity and safe performance."¹⁴⁶ It would appear that the district court in *Kling* did not require either test to be met.¹⁴⁷

The analysis applicable to admissions in the higher education context might be slightly different from that applicable to an employment situation. When a health condition results, for example, in the inability to attend classes, or to complete assignments, only the students themselves usually will be adversely affected through lower grades or failure to graduate. In an employment context, missed work or lower work performance can directly cause the employer lost productivity and health benefit costs.¹⁴⁸ Accordingly, in most cases it would seem that exclusion from a higher education program should place an even higher burden of proof on the institution because of the lesser adverse economic consequences if the institution's assumption about the individual's abilities should prove to be correct after admission. Indeed, different standards may apply to different higher education programs. For example, in medical school admissions, where the enrollment is more strictly limited and where the cost of providing the education to the student is very high and often not offset by tuition charges, concern

¹⁴⁴ Wegner, *supra* note 19, at 401, 463-74.

¹⁴⁵ *Id.* at 464 (citing *New York State Ass'n for Retarded Children v. Carey*, 612 F.2d 644 (2d Cir. 1979) (overturning school policy of excluding carriers of hepatitis from classroom), (*Strathie v. Department of Transp.*, 706 F.2d 956 (3d Cir. 1983) (finding evidence to refute the alleged risks of allowing hearing aid users to drive school buses)). Professor Wegner notes that the two cases indicate at least three factors to be taken into account in determining the legitimacy of the public safety concern and eligibility requirements: 1) a factual basis for the requirement; 2) a relationship between the requirement and the "essential nature" of the program; and 3) the risk to public safety. *Id.* at 466-67.

¹⁴⁶ See *id.* at 468 (citing *Bentivegna v. United States Dept. of Labor*, 694 F.2d 619, 622 (9th Cir. 1982)).

¹⁴⁷ The criteria, *supra* note 145, relate to public safety. The risk addressed by the nursing program in *Kling* was to the applicant herself. Nor does the record support a finding that the exclusion related to business necessity or a safe performance. In *Bentivegna*, 694 F.2d 619, the plaintiff was a diabetic who was excluded from a position as building repairer for not maintaining an appropriate blood sugar level. The exclusion violated the Rehabilitation Act because of an inadequate demonstration that the requirement was related to business necessity and safe performance.

¹⁴⁸ For a discussion of cost as a factor, see Wegner, *supra* note 19. It is unlikely that cost will be allowed to serve as a criterion for exclusion of a handicapped person where the cost relates to increased workers compensation insurance or health insurance. See *E.E. Black, Ltd. v. Marshall*, 497 F. Supp. 1088 (D. Haw. 1980).

for whether the applicant can complete the program may be more legitimate than in a case where withdrawal for health reasons after admission will have a limited impact on the use of resources available for the particular educational program.

Caution is advised, however, in applying this line of reasoning. Because the focus in most of the cases has been on finding the person not qualified because of a danger to self or others, little case law addresses whether scarce resources in an education program can be the basis for excluding a person because of a risk that the individual might be unable to complete the program because of health conditions. Although *Doe* noted the existence of scarce resources as a factor,¹⁴⁹ the risk factors would apparently have resulted in her exclusion from medical school regardless of the number of spaces available and the cost.

Because of the unusual circumstances attending the Supreme Court's ruling in *Kling*, it should not be viewed as permitting exclusion of individuals with health impairments where the basis for the exclusion is a "general assumption about the handicapped person's ability."¹⁵⁰ As Justice Stevens noted in his dissent, this is precisely what "Section 504 was designed to avoid."¹⁵¹ Exclusion of individuals because of health conditions—or on any other basis for that matter—should be based on factual evidence that the condition will prevent the completion of essential aspects of the program without the substantial risk of danger to self or others. Policies and practices based on such evidence should withstand challenge under Section 504.

C. Auxiliary Aids and Reasonable Accommodation

Section 504 compliance clearly is not achieved merely by opening the doors of the university. Although fundamental alterations to the nature of a program are not required,¹⁵² the fact that some modification is required cannot justify exclusion or other discriminatory treatment.¹⁵³ Modifications or reasonable accommodations take many forms, including simply rescheduling a class to a different time or to a different building. In some cases, architectural barriers may need to be removed. Changes in course requirements also may resolve the problem. Some students, however, may require supportive services such as a reader or sign language interpreter. Because the types and degrees of impairments vary extensively, and because educational programs also vary exten-

¹⁴⁹ The significant risk of recurrence "could properly be taken into account in deciding whether, among qualified applicants, it rendered *Doe* less qualified than others for the limited number of spaces available." 686 F.2d at 779 (emphasis added).

¹⁵⁰ *County of Los Angeles v. Kling*, 106 S. Ct. 301 (Stevens, J., dissenting).

¹⁵¹ *Id.*

¹⁵² *Southeastern Community College v. Davis*, 442 U.S. 397, 412 (1979).

¹⁵³ *Id.* at 412-13.

sively, it is difficult to develop more than general guidelines for the modifications appropriate in a particular case.

While a great deal is being learned about adapting the college campus for access to its programs, much progress still needs to be made. This section focuses on those areas to which recent case law or other developments indicate that particular attention should be paid. Numerous other issues relating to reasonable accommodation for students, faculty, and staff are also important, but apparently do not attract a great deal of attention.¹³⁴

The issues addressed here are limited to accommodations in testing; services for learning disabled students; provision of readers for visually-impaired students and interpreters for hearing-impaired students; accommodations for students with AIDS; and accommodations for students, faculty, and staff with alcohol or drug addiction and emotional problems.

1. Testing

For many students with disabilities the normal mode of testing can present prohibitive barriers. This is true of both the standardized test for admission and of the examination given in the classroom after admission. The test may be too long for the student to take in the allotted amount of time, it may be in a format that the student cannot readily use, or its location may present architectural barriers of one type or another.

Almost everyone is anxious when taking examinations, but for a learning-disabled, hearing-impaired, visually-impaired, or orthopedically-impaired individual, the experience can present insurmountable obstacles. For example, a blind student would be completely prevented from taking a standardized test which is not available on braille or for which a reader is not allowed. Even if the obstacle is not insurmountable, such as where the blind student was allowed to have a reader for the test, if the test is timed, the student requiring a reader is at a clear disadvantage. Even removing the time limitation or giving extra time does not completely obviate the disadvantage because of the exhaustion inherent in a lengthy test.

Theoretically, tests are supposed to measure one's abilities, and yet in certain cases, test results may not even closely reflect such abilities. Unfortunately for many however, convenience and efficiency have significantly influenced how testing services and college faculty measure

¹³⁴ See generally RHP, *supra* note 3, at § 3. These issues include accommodations to nonacademic programming (sports activities, counseling and placement, financial aid, health and insurance services, and campus organizations) (*id.* at § 3.11); access to the physical facilities of the campus (buildings, housing, and transportation) (*id.* at § 3.12) and restructuring of the work environment or other employment modification for faculty and staff (*id.* at § 4.12).

the abilities of applicants and students. Therefore, testing, and in particular, standardized testing, will be the preferred mode of examination for at least the foreseeable future.

Although the major test services do not receive federal financial assistance and are therefore not subject to the Rehabilitation Act, their utilization by so many colleges and universities subject to the mandates of the Rehabilitation Act¹³⁵ makes them responsive to the need for accommodation by handicapped test takers. As noted previously, many of the test changes took place as a result of criticism of ability testing.¹³⁶ Testing services currently provide a variety of accommodations, including additional time for completion of the test, large print versions, an amanuensis (a person to handle the materials), use of a typewriter, a reader, cassette versions, and special equipment such as scratch paper, ruler, or magnifying glass.¹³⁷ Under current practice, presently permissible under an interim policy of the Department of Education,¹³⁸ test scores sent to an institution for admissions purposes note any special circumstances under which the test was taken.¹³⁹ Known as "flagging," this practice indirectly permits what is not directly allowed—a preadmission inquiry about whether someone is handicapped.¹⁴⁰

Because Section 504 requires that reasonable accommodation be made, an admitting institution may waive altogether the taking of the test.¹⁴¹ On the contrary, the institution apparently may also require the taking of the test.¹⁴² If the test is required, however, the institution must take into account other factors such as grades in its admissions decision.¹⁴³

College faculty also will face increased requests for modifications to common testing procedures. Currently, little, if any, case law illuminates what types of modifications or accommodations are required in this area.¹⁴⁴ The only case law that is relevant suggests that a

¹³⁵ The regulations specifically address admissions testing, requiring that recipients of federal financial assistance among other things do the following: 1) Avoid, except in certain circumstances, testing or admissions criteria that have disproportionate adverse impact on handicapped persons. 2) Ensure that the test reflects abilities, not disabilities. 3) Ensure that the test is validated. See 34 C.F.R. § 104.42 (1985).

¹³⁶ See *supra* text accompanying notes 103-05; ABILITY TESTING OF HANDICAPPED PEOPLE: DILEMMA FOR GOVERNMENT, SCIENCE AND THE PUBLIC, *supra* note 103.

¹³⁷ See *supra* note 104.

¹³⁸ See *supra* note 105.

¹³⁹ See *supra* note 104.

¹⁴⁰ 34 C.F.R. § 104.42(b)(4) (1985).

¹⁴¹ Massachusetts recently enacted a law exempting learning disabled students from the SAT for admission to Massachusetts institutions of higher education. MASS. ANN. LAWS ch. 15A, § 19 (Law. Co-op. 1983).

¹⁴² See *supra* note 105.

¹⁴³ *Id.*

¹⁴⁴ The regulations speak to course examinations by requiring that testing reflect abilities, not disabilities. 34 C.F.R. § 104.44(c). See also *Brookhart v. Board of Educ.*, 534 F. Supp. 725 (C.D. Ill. 1982).

requirement to take a test to demonstrate competency is reasonable.¹⁶⁵

The specific modification appropriate in a given case will depend on the circumstances. Examples of appropriate modifications were noted above.¹⁶⁶ Students who have previously taken tests with accommodations in similar situations can be used as a resource in helping to suggest appropriate types of modifications. The modification needed is frequently additional time or a reader. Nevertheless, current research from the testing services is not yet conclusive regarding how much additional time is appropriate, what the scores mean, and what other nonstandard administrations mean. This situation raises the question of whether a notation on a student's transcript that a test or grade was achieved under nonstandard conditions is either required or permitted. Again, despite sparse case law, to answer this question, one can speculate on the inherent problems.

Although current policy on standardized tests allows "flagging,"¹⁶⁷ and some might argue that recording of nonstandard conditions of test taking should be similarly permitted, one major difference should be noted. In standardized testing situations, the practice is to "flag" all tests given under nonstandard conditions such as extra time, large print, or readers. Also, institutions and faculty frequently allow non-handicapped students to take examinations late (because of family or health crises or other scheduling problems). Similarly, students are often given extensions of deadlines for papers. In some situations, students are allowed to type rather than write exams. Unless the faculty member or the institution plans to make a notation in all cases where grades were given under nonstandard conditions, handicapped students whose transcripts were the only ones reflecting the nonstandard condition might prevail in a claim of equal protection or Section 504 discrimination. Flexibility in the system is desirable, but such flexibility should apply equally to handicapped students. Unless an institution thinks that a grade achieved under nonstandard conditions falsely reflects the student's competence, a policy of making notations on transcripts about nonstandard testing conditions only for handicapped students should be carefully considered before implementation. While prospective employers and others rely on the validity of grades shown on transcripts, handicapped students should not be unfairly prejudiced by being identified as handicapped through this notation without some demonstration that the grades do not reflect the students' abilities.

¹⁶⁵ See *Lupert v. California State Bar*, 761 F.2d 1325 (9th Cir. 1985) (a requirement that a first-year law student pass an exam before further study was constitutional; the interest involved was protecting persons from continuing study for which they are not qualified); *Brookhard v. Board of Educ.*, 697 F.2d 179 (7th Cir. 1983); *Debra P. v. Turlington*, 474 F. Supp. 244 (M.D. Fla. 1979) (upholding minimum competency testing).

¹⁶⁶ See *supra* text accompanying note 157.

¹⁶⁷ See *supra* note 105.

In sum, with respect to testing for admissions purposes, accommodations are currently being made and studied. With regard to classroom testing, faculty members who refuse to allow reasonable accommodation may find themselves or their institutions under attack for violating Section 504. Research in this area continues, and the results of that research should illuminate the significance of scores achieved by students taking tests under nonstandard conditions, both in the admissions process and in the classroom.

2. Services for Learning Disabled Students

Primarily as a result of the Education for All Handicapped Children Act,¹⁶⁸ more learning disabled students than ever populate the campus.¹⁶⁹ Many students now know they are learning disabled through the identification process under the special education laws, and, because of special education programming in public schools, more learning disabled individuals have the necessary qualifications to be admitted to postsecondary education.

When a student can provide appropriate documentation¹⁷⁰ of a learning disability, what must the institution do in terms of accommodation? Unlike the EAHCA, which mandates a program of special education and related service for handicapped children in public schools, Section 504 only requires reasonable accommodation. This means that the learning disabled student accustomed to special attention, tutoring and/or special programming may be surprised by the absence of such conditions on the college campus.

The types of accommodations a learning disabled student may need include: accommodations in taking examinations, additional time for completion of degree requirements, waiver or substitution of certain coursework, and auxiliary aids (such as taped books and readers). Learning disabled students may also feel that they could benefit substantially from the special training programs focused solely on developing the abilities of the learning disabled student. Although the technology and resources currently are available for virtually all of these services, the issue is whether the institution must provide them under Section 504, and how the cost of such services is to be allocated.

First, as to accommodations in the examination process, discussed in the previous section,¹⁷¹ it is clear that the regulations require some such accommodations,¹⁷² the only exception being an exam reflecting

¹⁶⁸ 20 U.S.C. §§ 1401-1461 (1982).

¹⁶⁹ See *supra* text accompanying notes 40-41.

¹⁷⁰ See generally, RPHP, *supra* note 3, at § 2.29.

¹⁷¹ See *supra* Section II(C)(1). See also *Stutts v. Freeman*, 694 F.2d 666 (11th Cir. 1983) (testing dyslexic in employment case).

¹⁷² 34 C.F.R. § 104.44(c) (1985).

a particular skill that is the factor being measured.¹⁷³ In many cases the modification to the exam will not be costly, and institutions will readily provide it. This may not be the case when auxiliary aids are required, a situation discussed more fully later in this section.

Academic adjustments to completion of degree requirements, such as a change in the length of time, substitution and/or waiver of specific courses, or adaptation in the specific coursework may also have little financial impact on the institution and, for that reason, institutions are less likely to resist making such accommodations. However, institutions are not required to make fundamental alterations of their programs.¹⁷⁴ A liberal arts program would probably be required to waive a music appreciation course (or adapt the course) for a hearing-impaired student, but certain basic mathematics skills could be found to be part of an essential program of instruction. If that were the case, a learning disabled student with mathematical difficulties might still be required to take the course. Perhaps a lighter than usual courseload could be required for the semester in which the student takes the course.

Some learning disabled students need a reader or the use of taped texts for some material. The difficult question is not whether the accommodation should be made, but who is to pay for the service. Because this issue is the same as the provision of auxiliary aids to blind and hearing impaired students, it is discussed in detail in that section rather than here.¹⁷⁵

The final accommodation mentioned with respect to learning disabled students was a special training program focused on the abilities of learning disabled students. Several model programs exist throughout the country,¹⁷⁶ but there does not seem to be any requirement in the regulations or in current case law that institutions of higher education have such a program on campus or; if the program is available, that it be provided at no cost.

Section 504 entitles learning disabled students to reasonable accommodation in testing and academic programming. Because of the different ways in which learning disabilities are manifested, the precise modifications must be determined on a case-by-case basis. While part of the modifications may include auxiliary aids, it is not certain who must bear the cost of these aids. Finally, learning disabled students will probably be unsuccessful in forcing postsecondary institutions to establish and operate special training programs for them.

¹⁷³ *Id.*

¹⁷⁴ See *Southeastern Community College v. Davis*, 442 U.S. 397, 413 (1979); 34 C.F.R. §§ 104.44(a), see also RPHP, *supra* note 3, at § 3.09.

¹⁷⁵ See *infra* Section II(C)(3).

¹⁷⁶ See B. SCHEIDER & J. TALPERS, *supra* note 37. (The appendix contains the address for obtaining a copy of the GUIDE. The GUIDE also provides a substantial amount of information about appropriate accommodations.)

3. Auxiliary Aids: Readers and Interpreters

While auxiliary aids include taped texts and classroom equipment, the most costly services are probably readers for visually impaired or learning disabled students and sign language interpreters for hearing impaired students. Because both institutions and individuals have limited resources, litigation eventually may determine who is ultimately responsible for the cost of these services.

Clearly, under the regulations, aids constitute academic adjustments that the handicapped student may use,¹⁷⁷ but who should pay for them is less clear. The regulations require the recipient "to ensure that no handicapped student is denied the benefits of . . . the program . . . because of the absence of educational auxiliary aids for students with impaired sensory, manual, or speaking skills."¹⁷⁸ This provision would have been clarified had the United States Supreme Court chosen to decide the merits of *University of Texas v. Camenisch*,¹⁷⁹ in which a deaf graduate student sought payment for interpreter service from the University although the University claimed that he was able to afford the cost himself. Because the case was remanded on a procedural basis, the Supreme Court has yet to resolve this difficult issue. Although the few courts addressing the issue have generally agreed that state vocational rehabilitation agencies have primary responsibility for the cost of interpreters, it is less clear who bears the cost if the student is not eligible for vocational rehabilitation services.¹⁸⁰

Eligibility for vocational rehabilitation services requires that the person's handicap substantially limit employment, and that the rehabilitation service be intended to promote the goal of employment.¹⁸¹ While the term "employable" is broadly interpreted,¹⁸² it generally does not cover graduate degree programs. In addition, unlike the Education

¹⁷⁷ 34 C.F.R. § 104.44(d) (1985).

¹⁷⁸ *Id.* at § 104.44(d)(1).

¹⁷⁹ 451 U.S. 390 (1981). See also *United States v. Board of Trustees*, C.A. No. 86-C-1779-S (N.D. Ala., filed Sept. 24, 1986), in which it is claimed that the University of Alabama violated § 504 by charging a fee for auxiliary aids to those students who could afford to pay. See *Orleans & Smith*, *supra* note 30; *Tucker*, *supra* note 30. Statistics from Gallaudet College indicate that as of the Fall of 1985, 7,031 full- and part-time hearing-impaired students were enrolled in postsecondary programs for deaf students. This did not include students in programs without support services. Letter from David R. Schleper, Information Assistant, Gallaudet National Information Center on Deafness to author (July 16, 1986).

¹⁸⁰ See *Jones v. Illinois Dep't of Rehabilitation of Serv.*, 689 F.2d 724 (7th Cir. 1982); *Schorstein v. New Jersey Div. of Vocational Rehabilitation Serv.*, 519 F. Supp. 773 (D.N.Y. 1981), *aff'd mem.*, 688 F.2d 824 (3d Cir. 1982), see also RPHP, *supra* note 3, at § 3.10.

¹⁸¹ 29 U.S.C. § 706(5)(b) (1982); 34 C.F.R. § 361.32(a) (1985), see also RPHP, *supra* note 3, at §§ 4.15-4.18.

¹⁸² 34 C.F.R. § 361.1 (1985).

for All Handicapped Children Act,¹⁸³ which provides service to all children of school age, state vocational rehabilitation programs operate on a priority basis¹⁸⁴ and are not required to serve all eligible individuals if funding is not available. Whether state vocational rehabilitation programs have any obligation to give priority to the provision of auxiliary aids to college students has not been resolved by the courts, the administrative agencies, or Congress. Two circuit courts have held that state vocational rehabilitation agencies have the primary responsibility to provide interpreters.¹⁸⁵ However, a strong argument can be made that this incorrectly interprets the relevant statutes.¹⁸⁶ Because this issue remains unresolved by the United States Supreme Court, and because of the shrinking resources of both students and institutions, this area remains ripe for litigation.

The courts may ultimately take into account the resources of the institution in deciding whether the cost of readers and interpreters must be borne in whole or in part by the institution. This conclusion is based upon an examination of recent cases relating to reasonable accommodation in the employment context involving both the Rehabilitation Act and other antidiscrimination statutes.

Section 504 allows cost to be considered by stating that reasonable accommodations posing an undue hardship need not be provided.¹⁸⁷ Cost is also discussed in a recent law review article that noted the statistics on the cost of implementing Section 504 on the university campus,¹⁸⁸ and explored recent case developments in employment contexts involving the Rehabilitation Act, the Age Discrimination Act, and Title VII.

This article concluded that cost alone is unlikely to be a defense for failing to provide accommodations under Section 504.¹⁸⁹ Two other factors, however, may be considered—"the incapacity to bear the cost

¹⁸³ 20 U.S.C. §§ 1401-1461 (1982).

¹⁸⁴ 29 U.S.C. § 721(a)(5)(A) (1982).

¹⁸⁵ *Jones v. Illinois Dep't of Rehabilitation Serv.*, 689 F.2d 724 (7th Cir. 1982); *Schornstein v. New Jersey Div. of Vocational Rehabilitation Serv.*, 688 F.2d 824 (3d Cir. 1982).

¹⁸⁶ For an in-depth discussion of this issue, see Orleans & Smith, *supra* note 30.

¹⁸⁷ 34 C.F.R. § 104.12(c)(3) (1985). Other factors include the size of the program (including number of employees, number and type of facilities, and size of budget) and the type of operation. *Id.* at § 104.12(c).

¹⁸⁸ Wegner, *supra* note 19, at 446.

¹⁸⁹ *Id.* at 473-74, 479-81, 495-97. Cases discussed in this article most relevant to the provision of interpreters and readers are *Nelson v. Thornburgh*, 567 F. Supp. 369 (E.D. Pa. 1983) (services for blind workers must be provided where cost was "minute fraction" of administrative budget); *Upshur v. Love*, 474 F. Supp. 332 (N.D. Cal. 1979) (dicta indicating that school district would not be required to hire an aide for a blind teacher); *Barnes v. Converse College*, 436 F. Supp. 635 (D.S.C. 1977) (cost not a factor in requiring college to provide sign language interpreter for college lectures for hearing impaired student).

of accommodation and the inadequacy of the benefits received in light of the costs incurred.¹⁹⁰ Although courts have not reacted favorably to defendants even in these cases,¹⁹¹ a small college with limited resources facing a demand for a sign language interpreter may be able to claim successfully an undue hardship. This will probably be the case when the college has made good faith efforts to facilitate services for handicapped students in general, and where efforts have been made for the particular student to obtain outside services through vocational rehabilitation or voluntary agencies.

Modern technology will affect claims of undue hardship. For example, the services of a personal reader for a blind student may have been extremely costly in the past, but the technology of a Kurzweil reading machine that can be used by a number of students makes these services much less costly today.

Final conclusions about whether a college or university must pay for interpreter and reader service are premature. First, whether the service itself is required under the regulations has yet to be resolved. Second, even if Section 504 generally requires the provision of interpreters and readers, it remains unclear whether cost will be weighed by the courts as a part of undue hardship.

4. Accommodations for Persons with AIDS

An in-depth discussion of the broad array of issues that are involved with students, staff, and faculty who are victims of AIDS or AIDS-related conditions is beyond the scope of this article. But the American College Health Association (ACHA), the American Council on Education (ACE), and others are closely monitoring research developments in this area and are developing ongoing informational services to colleges and universities about AIDS on campus.¹⁹² The current material distributed by the ACHA and ACE includes suggested policies for institutions on how to deal with students, faculty, and staff in light of the AIDS situation. These policies could also be included as reasonable accommodations because they address the means of allowing persons with AIDS and AIDS-related conditions the maximum participation on campus while avoiding risk to others. The most significant advice in the recommended policies is to retain flexibility and deal with cases on an individual basis.¹⁹³ Current ACHA task forces are exploring residential life issues, confidentiality issues, educational priorities, administrative issues, including athletic competition, institutional employees, public

¹⁹⁰ Wegner, *supra* note 19 at 479.

¹⁹¹ *Id.*

¹⁹² Steinbach, *AIDS on Campus: Emerging Issues for College and University Administrators*, 16 C.L. Dig. 113 (1985).

¹⁹³ *Id.* at 117.

relations, testing, support and counseling, and clinical issues for health services.¹⁹⁴

University counsel must remain current on developments in this area not only for Rehabilitation Act implications but also in light of potential tort liability.¹⁹⁵

5. Accommodations for Persons with Alcoholism, Drug Addiction or Emotional Problems

Reasonable accommodation with regard to alcoholism, drug addiction, and emotional problems may require counseling or therapy. This does not necessarily mean that the school must provide the program, although under the analysis discussed with regard to auxiliary aids, the cost may rest ultimately on the institution. At the least, however, the institution must take into account in its actions the fact that a student, staff member, or faculty member is undergoing good faith efforts to address the problem. For example, if a student who was dismissed for conduct relating to alcohol abuse demonstrates good faith participation in a rehabilitation program, a college or university may be required to readmit the student as long as the misconduct does not continue. An alcoholic professor who is unable to teach because of his alcoholism, however, need not be kept in the classroom. Rather, a reasonable leave of absence should be permitted or a program of counseling provided to allow reasonable time for rehabilitation. A similar policy should apply for the student with emotional problems. While misconduct resulting from the problems need not be tolerated, a student undergoing counseling in good faith should be allowed to participate in the academic programs, at least absent danger to self or others.

Recent case law in the employment context has addressed several cases involving alcoholism and emotional problems. The cases generally support a requirement of reasonable accommodation, but not necessarily one of continued participation.¹⁹⁶ The accommodation required will

¹⁹⁴ Further information can be obtained from Task Force on AIDS, American College Health Association, 15879 Crabbs Way, Rockville, MD 20855; (301) 963-1100.

¹⁹⁵ Steinbach, *supra* note 192, at 117.

¹⁹⁶ See *Walker v. Weinberger*, 600 F. Supp. 757 (D.D.C. 1985) (forgiveness of past induced misconduct should be in proportion to willingness to undergo treatment); *Gardner v. Morris*, 752 F.2d 1271 (8th Cir. 1985) (reasonable accommodation does not require on-site physician and laboratory facilities for a civil engineer in Saudi Arabia whose manic-depressive condition required the availability of such services); *Richardson v. United States Postal Serv.*, 613 F. Supp. 1213 (D.D.C. 1985) (permissible to discharge employee for off-duty conduct although conduct may have been related to plaintiff's alcoholism); *Huff v. Israel*, 573 F. Supp. 107 (N.D. Ca. 1984), *vacated*, 732 F.2d 943 (11th Cir. 1984) (permissible to discharge due to driving under the influence of alcohol); *School Dist. of Philadelphia v. Friedman*, 507 A.2d 822 (Pa. 1986) (chronic lateness not required to be accommodated).

likely depend on the type of participation sought (student attendance or teaching, for example), the extent of the problem, the efforts by the individual to make changes, and the assistance of the institution in making changes.

The duty to accommodate persons with alcohol or drug related problems or persons with emotional problems raises additional considerations. First, the college or university should recognize its potential liability relating to alcohol intoxication on campus.¹⁹⁷ Because of judicial and public policy trends, universities must be increasingly careful about allowing alcohol-related conduct on campus simply because they are trying to accommodate an individual's alcohol addiction.

Second, persons who have been injured by a student with emotional problems might seek recovery against the college or university on the theory of a duty to warn when the institution had reason to foresee that an emotional problem might result in violent behavior. Reliance on such a theory, based on *Tarasoff v. Regents of the University of California*¹⁹⁸ and its progeny,¹⁹⁹ may well be misplaced because a number of factors affect the application of such a theory in a given case. A duty to warn may apply only to the physician or therapist, not to the university. However, the institution may be liable under respondent superior if the physician or therapist is providing services through it. Additional problems exist such as whether the university has a duty to the public at large, or whether its duty relates only to identified victims.²⁰⁰ Indeed, the whole issue of the foreseeability of violent behavior has been criticized as reflecting "a naive confidence in psychiatry and psychology . . . not supported by the professional literature."²⁰¹

Finally, any duty to protect people on campus from dangerous behavior may limit the degree to which the most fundamental accommodation—allowing the student to remain on campus—is required. When removal of the student is deemed appropriate, consideration should be given a psychiatric or administrative withdrawal rather than a disciplinary suspension or expulsion.²⁰² The larger question remains: Whether the university's duty to protect others extends beyond the campus. Even absent a legal duty to protect the world beyond the campus, universities certainly are faced with other ethical questions.²⁰³

¹⁹⁷ Roth, *The Impact of Liquor Liability on Colleges and Universities*, 13 J.C. & U.L. 45 (1986).

¹⁹⁸ 118 Cal. Rptr. 129, 529 P.2d 553 (1974); 17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 P.2d 334 (1976).

¹⁹⁹ These cases are discussed in detail in Woods & Steadman, *Bradley Center, Inc. v. Wessner: The Psychotherapist's Duty to Warn*, 10 J.C. & U.L. 293 (1983-84).

²⁰⁰ *Id.* at 297-302.

²⁰¹ Pavela, *supra* note 135, at 101, 135.

²⁰² *Id.* at 142-47.

²⁰³ *Id.* at 146-47.

In conclusion, because of the severity of these problems, universities and colleges should consider either maintaining a counseling service capable of providing the services needed or of referring these persons to agencies that can provide the needed services.

III. SUMMARY AND CONCLUSIONS

The number of handicapped students on American campuses is increasing. While statistics are not readily available, the number of handicapped staff and faculty most likely is increasing also. In addition, people are becoming more aware of the Rehabilitation Act and state handicapped rights laws as the basis for protection.

The issues thus generated will vary with the type and severity of the handicap involved and the academic program or employment position involved. For example, persons with mobility impairments may need the removal of architectural barriers. Students with learning disabilities may need readers. Individuals with alcohol or drug addiction may need counseling. Information networks and new technology have responded well to these new demands. Prejudice, ignorance, and shrinking resources, however, continue to inhibit full participation in higher education programming for handicapped persons. University counsel can take a number of steps in preparing to confront the issues affecting handicapped persons and to avoid liability.

First, counsel should keep current on cases involving handicap discrimination claims. The law in this area is burgeoning, with an increasing number of cases being decided at appellate levels.

Second, university counsel must recall that not just students, but faculty, staff, and others as well are protected under the Rehabilitation Act. For example, in planning a new auditorium, designers may be sensitive to the needs for accessible audience seating, but forget that the stage should be accessible to those in wheelchairs.

Third, a good working relationship with the office for Disabled Student Services is important. Individuals in that office usually keep abreast of current technology and major legal developments in their field. Working with them to develop a good program can prove valuable.

Fourth, university counsel, by working with the Office for Disabled Student Services, can be an important force in developing and implementing workshops, training sessions, and other information networks. These programs should be provided to deans, faculty, administrators, student leaders, recruitment and admissions officers, placement directors, housing officers, facilities planners of all kinds, providers of student health service, affirmative action officers, and transportation officers.

Fifth, university counsel should ensure the creation of a handicap accessibility committee whose functions could include the following:

- 1) involvement at every stage, and as early as possible, in the planning, development, or renovation of any major structure,

including, but not limited to residence halls, classroom buildings, athletic facilities, administrative facilities, recreational facilities, living facilities other than residence halls, libraries, parking facilities, and medical facilities;

- 2) consultation about placing programs in facilities;
- 3) involvement at an early and ongoing stage in campus-wide projects such as changing traffic patterns or locating major facilities;
- 4) the initiation of programs such as liaison training and substantive programming affecting improved accessibility for handicapped persons.

The committee must not be a rubber stamp for university projects, and a clear system of reporting is crucial, so that the work of the committee does not get lost in the shuffle. The committee should include students, faculty, and staff, including both individuals who are handicapped themselves and those with expertise in the area of accessibility. The committee's expertise can provide a valuable asset to a campus, particularly for projects having a significant impact on the handicapped.

Universities following these suggestions should demonstrate to courts their good faith in complying with Section 504 and applicable state law. While good faith does not preclude litigation, it will probably prevent a significant amount. Compliance with Section 504 often requires creativity, flexibility, and sensitivity. Campus officials with these attributes need not fear the mandates of the Rehabilitation Act.

APPENDIX

LIST OF RESOURCES FOR INFORMATION ABOUT PROVIDING SERVICE TO HANDICAPPED COLLEGE AND UNIVERSITY STUDENTS, STAFF, AND FACULTY

CAMPUS ACCESS FOR LEARNING DISABLED STUDENTS: A COMPREHENSIVE GUIDE, by Barbara Scheiber and Jeanne Talpers, available for \$17.95 from Closer Look, Parents' Campaign for Handicapped Children and Youth, 1201 16th Street, N.W., Washington, D.C. 20036. This gives practical advice on a broad range of topics including college choice, programming, admissions processes, classroom accommodation and support services, new technology, and strategies for personal and social adjustment.

CREATING AN ACCESSIBLE CAMPUS, edited by Maggie Coons and Margaret Milner, available for \$12.50 from Association of Physical Plan Administrators of Universities and Colleges, 11 Dupont Circle, Suite 250, Washington, D.C. 20036. This is an illustrated guide to accessible design for handicapped persons.

DIRECTORY OF COLLEGE FACILITIES AND SERVICES FOR THE DISABLED (2d ed.), available for \$95.00 from Oryx Press, 2214 North Central, Phoenix, AZ 85004. Contains information about more than 2,000 institutions of higher education in the United States and Canada, and includes information about the approximate numbers of handicapped students, accessibility on campus, and services available.

HANDBOOK OF CAREER PLANNING FOR SPECIAL NEEDS STUDENTS, by Thomas Harrington, available from Aspen Systems Corporation, Rockville, MD. Includes information on career planning concepts, goals and resources; on the unique career development issues for the disabled population; and on facilitating strategies, approaches, and information.

HEATH RESOURCE CENTER DIRECTORY, single copies available at no charge from HEATH Resource Center, One Dupont Circle, Suite 670, Washington, D.C. 20036-1193. Contains resource listings about disability awareness groups, architectural accessibility, program accessibility, career preparation, employment, technological devices, independent living, legal resources, and directories, and provides an agency index.

HOW TO CHOOSE A COLLEGE: GUIDE FOR THE STUDENT WITH A DISABILITY, available from HEATH Resource Center (address in preceding entry). A booklet for high school students containing general information about how to find specific information of importance for disabled students.

RECRUITMENT, ADMISSIONS AND HANDICAPPED STUDENTS: A GUIDE FOR COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973 (Sept., 1985), available from HEATH Resource Center (address in entry on HEATH RESOURCE CENTER DIRECTOR).

Two organizations of importance are:

HEATH Resource Center

One Dupont Circle, N.W., Suite 670

Washington, D.C. 20036-1193

(202) 939-9320

(800) 54-HEATH

Higher Education and the Handicapped (HEATH) provides an information exchange about educational support services, policies, procedures, adaptations, and opportunities on American campuses and in vocational-technical schools, adult education programs, independent living centers, and other training entities. It also operates the National Clearinghouse on Postsecondary Education for Handicapped Individuals as a program of the American Council on Education.

AHSSPPE

P.O. Box 21192

Columbus, OH 43221

(614) 488-4972

The Association on Handicapped Student Service Programs on Postsecondary Education (AHSSPPE) sponsors workshops and conferences focusing on services for handicapped students in postsecondary institutions.

Sex in the Age of AIDS Calls for Common Sense and 'Condom Sense'

ANY MAYPOLE erected today ought to be covered with a condom. That's the conclusion one might well reach after talking with physicians and others concerned with the expression of sexuality in 1987. Sheathing the ancient fertility symbol would negate its *raison d'être*, but it would surely focus attention on the horrific truth that the male member now may convey the seeds of death as well as of life.

Getting people to recognize this fact and take the necessary steps to protect themselves and/or their partners from sexually transmitted diseases (STDs)—foremost among them acquired immunodeficiency syndrome (AIDS)—during coitus was the aim of a recent conference in Atlanta. The meeting was the first of its kind to be held in this country, according to its sponsors, the Centers for Disease Control (CDC), American Social Health Association, and Family Health International.

Participants in the conference, titled "Condoms in the Prevention of Sexually Transmitted Diseases," presented evidence of efficacy and arguments for use of a device that was first mentioned in Egyptian papyri, according to introductory speaker Michael J. Rosenberg, MD, MPH, executive director of the American Social Health Association. Tracing its development means relying on much that is anecdotal, but the subject has been investigated seriously (Himes NE: *Medical History of Contraception*. New York, Gamut Press Inc,

1963) and not so seriously (Sinclair P [ed]: *Johnny Come Lately*. London, Journeyman Press, 1987).

Rosenberg says the first indisputable published reference to prophylactic use derives from the Italian anatomist Falloppio, who in the mid-16th century wrote about a linen sheath moistened with lotion for protection against venereal infection. Shortly afterward, 16th-century French essayist Michel de Montaigne voiced a still-current complaint when he called such a sheath "armor against enjoyment, gossamer against infection."

The origin of the word *condom* is unknown, although one often-told story is that a (French or English) Dr Condom gave his name to the penis cover he devised to curtail the proliferating bastard progeny of England's King Charles II. By the 18th century, such writers as Casanova and Boswell recorded their own use of condoms—usually made of the cecum of sheep or other animals—and although they were rather costly, they were used widely by the upper classes throughout Europe.

The Modern Era

The vulcanization of rubber in the mid-19th century allowed condoms to be made of that material and brought their price within reach of many more people. Although occasional moralists inveighed against their use from the beginning and preached self-control as the only barrier to infection (they didn't

even mention contraception), according to Rosenberg, the copulating populace embraced condoms so heartily that by the 1930s more than 300 million—by then mostly made of latex—were sold annually in the United States.

With the advent of other methods of contraception and of cures for venereal infection, interest in and use of condoms in this country declined drastically—until fear of AIDS influenced their recent much-publicized resurgence. Rosenberg said the actual production of condoms worldwide today is unknown, but manufacturing capacity is about 5 billion devices annually. In the early 1980s, about 5 million were manufactured annually in this country. Although the figure is undoubtedly higher now, no accurate data are available.

According to the most recent detailed survey (Sherris JD, Lewinson D, Fox G: Update on condoms—products, protection, promotion. *Popul Rep H*, September-October 1982, pp 121-156), they are used most in Japan (among spouses of half of all married women of reproductive age) and least in Africa (less than 1% of spouses of such women). In the developed world overall, the rate of condom use was about 13%—which is also approximately the rate in this country. Frequency of use was not recorded.

Standards, Sizes, Styles, and Sales

Most condom manufacturing and importing countries have national standards for quality control. At Ansell, the

largest US producer, for example, Bradley Pugh, vice president for research and development, oversees quality-control testing that includes stretching every condom produced over a metal form and passing high-voltage electricity through it. "If there are any holes," he explains, "it will burn right through." In addition, a random statistical sample of condoms in every batch made are filled with water, to see if they will leak. "Both electrons and water molecules are much smaller than HIV [which at 120 nm in diameter is a small-sized STD infectious agent, compared with the largest, *Neisseria gonorrhoeae* at 1000 nm, and with tiny hepatitis B surface antigen at 22 nm]," Pugh says, "and when they don't get through, we're sure the HIV can't get through." (Sperm, incidentally, are huge compared with STD agents; a single sperm is 3000 nm in diameter.)

Condom size and width standards vary slightly among different nations, Rosenberg says. Only two sizes are produced here, although conference speakers said there should probably be three or four to ensure good fit for penises of various configurations. The smaller size is promoted in this country as "offering a snugger fit for greater sensitivity." One company calls them "Huggers." In this regard, another conference speaker said that the promoters of condom use must take into account men's insecurities. "Perhaps," she suggested, "they could be marketed in sizes like olives: super, colossal, jumbo."

Styles, at any rate, vary greatly. They may be dry or lubricated, plain tip or reservoir end, straight or shaped, smooth or textured, and natural or brightly colored. Packaging appears to be important in attracting users and gaining market share, and the 50 or so brands sold by the five condom companies in the United States come wrapped in everything from discrete gold foil that makes them look like special after-dinner mints to glamorous erotic photos with coy copy to match.

All but about 1% of condoms made in the United States are of latex (American companies also distribute condoms made in other countries, such as Japan), and sell for about \$1.50 to \$2 for a pack of

three (or \$5 to \$6 per dozen). Like most other products, they cost more at specialty stores (local pharmacies) and less at discount outlets (large chain drug-stores).

Increasingly, latex condoms are being offered for sale in this country in such places as university bookstores and dormitory and rest-room vending machines, as well as by mail order. Many are distributed free by public or private clinics. Speakers in Atlanta said that while there have been laws against the public sale of condoms in parts of the United States, they were unaware of any legal restrictions against their sale here today. In Europe, they have long been readily available in such venues and at newspaper kiosks, tobacconists, and vending machines near pay telephones and bus stops.

In Great Britain, according to conference speaker Malcolm Potts, president of Family Health International, Research Triangle Park, NC, condoms are often purchased at barbershops. There, he says, after the customer has had his hair cut, the barber's murmured question, "Will there be anything else, sir?" is understood to mean "Do you wish to buy any condoms?" This civilized procedure allows shy persons, rather than making a perhaps difficult request, simply to murmur in return the number required and pocket a package of protection.

The small number of natural-membrane condoms manufactured in the United States are made of lamb cecum imported from New Zealand. They are three or four times the price of latex condoms and, though often much preferred by the relatively few men who are familiar with them, according to conference speakers, may offer less protection against disease.

Attempting to appeal to the unprecedented variety and sophisticated demands of consumers now suddenly interested in their product, the four old-line US condom manufacturers—Ansell Inc, Dothan, Ala; Carter-Wallace, New York City; Circle Rubber Co, Newark, NJ; and Schmid Products Co, Little Falls, NJ—have their research and development departments working to produce condoms that look, smell, taste,

feel, and of course perform their prophylactic function better than these products ever have before.

A fifth, and highly visible, company, Mentor Corp, Minneapolis, does not manufacture condoms. Mentor, which primarily makes external catheters, buys condoms from another manufacturer and, using a process adapted from experience in fitting external penile catheters, transforms them into what it calls "self-adhering" condoms that, says the company, guarantee a snugger fit at the base than is possible with other types. Introduced only last year, Mentor condoms are "an important innovation that has gained acceptance among many men," according to conference speaker Philip Harvey of Population Services International.

Harvey says that with sales of \$2.5 to \$3 million per year, "the condom business in the United States is a very small business—it's roughly equivalent to making ball bearings for bicycles."

How Well Do They Really Work?

Until the recent revival of interest, so slumberous had the industry become that there was little (internal) technological innovation or (external) product assessment. The only reference in the literature that addresses the question of quality and cost of competing brands, and then only indirectly, is a preference survey published in *Consumer Reports* in October 1979. Conference speakers said it is inapplicable to the situation today, and agreed that an up-to-date evaluation of condoms from both the user's and the scientist's point of view is long overdue.

Some scientists have begun this process. Admonitions to employ condoms so as to enjoy "safer sex" are based on more than wistful wishing. They are based on several studies that have demonstrated the impermeability of condoms to STD agents. For example, Marcus Conant, MD, professor of dermatology at the University of California, San Francisco, and colleagues have conducted studies that prove condoms to be effective barriers against the transmission of herpesvirus (*Sex Transm Dis* 1984;11:94-95) and human

immunodeficiency virus (HIV) (*JAMA* 1986;255:1706).

Recently, Conant concluded a laboratory study of 12 varieties of latex and natural-membrane condoms as barriers against the transmission of herpesvirus 1 and 2, cytomegalovirus, and HIV. None of the viral agents passed through the latex, he said in an interview, while there was occasional leakage with the natural condoms. "This leads to the recommendation that people should use latex condoms for sexual intercourse with persons at high risk, such as homosexuals in San Francisco," he says. "Heterosexuals in the Midwest with few partners, on the other hand, might feel comfortable using the natural type."

Lest this option seem irresponsible, Conant emphasizes that risk factors are just that; people have to make a choice about their sexual behavior, and outside of a long-term monogamous couple—both of whom are known to be free of HIV—there is no such thing as completely safe sex anymore: "If one chooses to be sexually active with more than one partner, one tries to minimize the risk."

Concerning the "failure rate" of condoms used for contraception—10% is an often-cited figure—Conant says flatly that a study has never been done. His clinical impression (corroborated by many other researchers interviewed for this article) is that noncompliance with recommendations for proper use of condoms, rather than product failure, is responsible.

When the issue is pregnancy, people either forget to use a condom and then, when interviewed, "forget" that they forgot, or they indulge in extended foreplay before putting on a condom, or they remove it carelessly, or the condom breaks. When disease transmission is the issue, unprotected foreplay again may be at fault or the couple may engage in other intimacies, such as oral sex, without using a condom.

Although family planning experts say breakage is rare, there have been some reports in the literature concerning a high rate of condom tearing, particularly during anal intercourse. According to Mary Guinan, MD, the CDC's acting assistant director for science, there are

no established data on the breakage rate, nor on whether condoms made of thicker latex are less likely to tear than the superthin ones. A study that would address these issues is needed, she says.

According to Conant, who is also in private practice in an area that borders on Haight-Ashbury and the Castro district in San Francisco, "an even bigger issue is what happens when people fall in love." People who are extremely careful in their sexual behavior and use condoms when they are dating various members of a group will abandon all caution, and all barriers, he says, when they meet their "one true love, because how can you believe that this wonderful person can give you this terrible thing [AIDS]?" People have got to believe it, he says, and his strictures apply to heterosexuals as well as homosexuals.

Theresa L. Crenshaw, MD, of San Diego, president of the American Association of Sex Educators, Counselors, and Therapists, goes a step further. "For the sake of health, casual sex and multiple partners must be abandoned," she said in testimony presented to Congress this February at hearings on condom advertising. Admitting that "condoms in combination with spermicides are a valuable resource in our fight against AIDS," Crenshaw emphasizes the importance of behavior modification over resignation to the threat of AIDS and calls for avoidance of sexual activity with any partner outside of a "committed relationship." The message Crenshaw and her group stress is that "sexual behavior can change, but not unless we expect it and recommend it."

Physicians can help greatly, Conant maintains, by simply talking to every patient about how to avoid exposure to AIDS. He says he was astounded to learn at a recent national meeting how few did so, giving as their reason that "the patient didn't look gay" or "I work in a public health clinic and we don't have the personnel."

Organized medicine should be demanding from state and federal governments emergency funding to hire such personnel, Conant says.

And as for patients not looking gay, the Institute of Medicine's report, *Con-*

fronting AIDS: Directions for Public Health, Health Care, and Research, issued late last year, estimates that 1.5 million Americans, heterosexual as well as homosexual, have now been exposed to HIV. It estimated that the rate of exposure would increase in heterosexuals at least through 1991, and recommended "a massive continuing educational and public health campaign to decrease the spread of the virus and . . . expanded research efforts" (*JAMA* 1987;256:3332-3333).

Among the research on HIV transmission supported by condom manufacturers is a study recently completed by Frank Judson, MD, director of public health and professor of medicine, University of Colorado Health Sciences Center School of Medicine, Denver, and Nelson M. Gantz, MD, professor of medicine and microbiology and clinical professor of infectious diseases, and John Sullivan, MD, professor of pediatrics, molecular genetics, and microbiology, both of the University of Massachusetts Medical Center, Worcester.

With the technical work performed in Sullivan's laboratory by Susanne Scesney, the group made three determinations, as described by Gantz in an interview: (1) latex condoms are impenetrable to HIV; (2) the spermicide nonoxynol 9, as proved earlier, kills HIV in vitro; and (3) when a condom containing nonoxynol 9 in the tip is torn, the spermicide kills the virus in two thirds of all cases. Gantz said that why the virus survives in the other one third of cases is unclear, but nonoxynol 9 is a sticky substance that must adhere to the virus to kill it, and in those cases it may not have reached all of the virus present.

Gantz said the results support his view, which is similar to that of most other researchers, that latex condoms prevent transmission of HIV and that natural condoms should not be used for that purpose.

Other studies have also proved the impenetrability of latex condoms. At the Atlanta meeting, Gerald Minuk, MD, University of Calgary Faculty of Medicine, Alberta, reported on his studies showing their efficacy in vitro with hepatitis B virus as well as with

(Continued on p 2266)

(Continued from p 2263)

cytomegalovirus and herpesvirus. He counseled against using natural condoms for disease prevention.

The real question, of course, is whether condoms are protective against HIV and other STDs in vivo. The answer appears to be yes. The Swedish experience of aggressively promoting condom use and seeing an 80% decrease in the incidence of gonorrhea (*Bull NY Acad Med* 1976;52:1004-1011), and the experience (reported by medical personnel, if not in the literature) of the US armed forces in World War II, which learned, perhaps to its surprise, that servicemen given condoms came down with much less venereal disease than those given moral lectures (whose venereal-disease rate went up), are but two examples. There are many others.

In addition, the CDC, in its *Sexually Transmitted Diseases Summary 1986*, advises using condoms to prevent infection with *Chlamydia trachomatis*, *Ureaplasma urealyticum*, *Trichomo-*

nas vaginalis, *Candida albicans*, herpes simplex virus types 1 and 2 (when lesions are on the penis or the female genital area), human papilloma virus, *Treponema pallidum*, *Haemophilus ducreyi*, and human T-cell lymphotropic virus type III/lymphadenopathy-associated virus (the name used previously for HIV).

Promoting "Condom Sense"

So the case is pretty well proved. All that remains to be done is to get people to use condoms—properly. (Please see accompanying article.)

At the Atlanta meeting, ideas for how to do so abounded. Their very number made it obvious that there was no one simple strategy for so profoundly affecting human sexual behavior. Suggestions ranged from holding workshops, as is done in San Francisco's gay community, on "The Ins and Outs of Condom Use," to teaching communication skills because "to get the condom out of someone's pocket or purse and onto the penis, someone has to say something" (a

somewhat dubious assertion, some thought), to encouraging focus groups that would emphasize such positive facts as "using a condom can help make intercourse last longer," to producing video instructions with actors using language to appeal to those blacks and Hispanics who contract AIDS in disproportionate numbers. One speaker suggested—not very much in jest—that the millennium would arrive when all cigarette vending machines were replaced with ones dispensing condoms.

Perhaps the overriding thought to emerge from the conference was that to get everyone who should do so to use condoms, the emphasis on HIV prevention should be removed from groups at risk and placed on risk behavior.

Conant, who has been battling the AIDS epidemic from the very beginning, spoke for all when he said, "Physicians must persuade every patient to practice safer sex. We'll lose lots more kids if we don't take what we've learned in San Francisco and apply it elsewhere."—by Marsha F. Goldsmith

Some Advice on Using Condoms Against STDs: What Every Man (and Woman) Should Know

TO PREVENT sexual transmission of disease, it's important to use condoms, and use them properly. Robert Hatcher, MD, MPH, professor of gynecology and obstetrics at Emory University School of Medicine, Atlanta, says many people are trying them for the first time and don't know what they should do to make the best use of condoms.

The following checklist is taken from Hatcher's book *Contraceptive Technology 1986-1987*, ed 13. New York, Irvington Publishers, 1987. It gives physicians a guide to follow in discussing condom use with male patients. It may also be used as a guide for discussing, with female patients, how they may initiate condom use to protect themselves and their partners from sexually transmitted diseases.

Hatcher's "Condom Sense" Rules

1. Use a condom every single time you have intercourse. There is no "safe" time with regard to transmitting disease.
2. Put the condom on as soon as erection occurs. Unprotected contact with any orifice—vagina, mouth, or rectum—is unsafe.
3. Roll the condom's rim all the way to the base of the penis before insertion into the partner. If the condom lacks a reservoir tip, leave a small empty space at the tip to catch semen.
4. For lubrication, do not use petroleum jelly, vegetable shortening or oil, because they may deteriorate the latex. Neither is saliva recommended. Sufficient lubrication is needed so the con-

dom will not tear; if more lubrication is required, use water or spermicidal jelly or spermicidal foam, preferably containing nonoxynol 9.

5. After intercourse, hold onto the rim of the condom as the penis is withdrawn, being careful not to spill any semen. Withdraw the penis from the partner soon after ejaculation, because if the erection is lost the condom may slip off, allowing semen to escape.

6. Do not use a condom more than once. Dispose of it safely—so that no one (a youngster, for example) has access to it.

7. Store condoms in a cool, dry place. Do not keep them in a wallet or other hot place for a long time because heat can deteriorate the latex.

—by Marsha F. Goldsmith

\$2-Billion Program Urged for AIDS ✓

National efforts to combat AIDS need better coordination and management; more resources should be devoted to public education, Institute of Medicine reports

EFFORTS to combat AIDS will require at least \$2 billion a year by 1990, more than five times the present level of expenditure, according to a new study by the Institute of Medicine and the National Academy of Sciences.* About half the funds should be spent on research, but perhaps the most pressing need is to put more resources into explicit and extensive education programs, the report says.

The product of an intensive, 7-month effort, the report is perhaps the most comprehensive analysis yet undertaken of national programs to combat AIDS. Although it contains few surprises, it is likely to prove influential as the federal government and other groups grapple with issues ranging from the structure of federal AIDS programs to policies for screening people for antibodies to the AIDS virus.

The report identified "as a major concern a lack of cohesiveness and strategic planning throughout the national effort." It therefore recommends that a National Commission on AIDS be created to monitor and offer advice on national programs and to stimu-

late interaction between government, academic, and private groups. Although the report is somewhat vague on exactly how the commission would function, it would be appointed either by the President or jointly by the President and Congress and it would issue public reports. In addition, the report urges the President himself to take a strong leadership role in the national effort against AIDS. So far, AIDS has not been prominent on President Reagan's personal political agenda.

The report's main message is that AIDS "isn't something confined to a subpopulation. It's a very serious problem for the whole community," says Sheldon Wolff, chairman of the department of medicine at Tufts University School of Medicine and co-chairman (with David Baltimore, director of the Whitehead Institute at MIT) of the committee that produced the report.

The committee generally accepts government projections that perhaps a quarter of a million people will develop AIDS over the next 5 years—ten times the number reported in the past 5 years—and that about 74,000 new cases will be diagnosed in 1991 alone. Moreover, with perhaps 1.5 million people in the United States already infected with the AIDS virus, "disease and death . . . are likely to be increasing 5 to 10 years from now and probably into the next century," the committee notes.

Public education is likely to remain the best (perhaps the only) weapon to curb spread of infection with the AIDS virus over the next few years, but the committee identified major shortcomings in this area. Current federal education programs are "woefully inadequate," it says, and in spite of the blaze of publicity given to AIDS in recent years, there is still a good deal of ignorance about how it is transmitted.

For example, the report cites a survey of high school students in San Francisco, an epicenter of the disease, in which 40% said they were unaware that AIDS is caused by a virus, one-third thought the disease is casu-



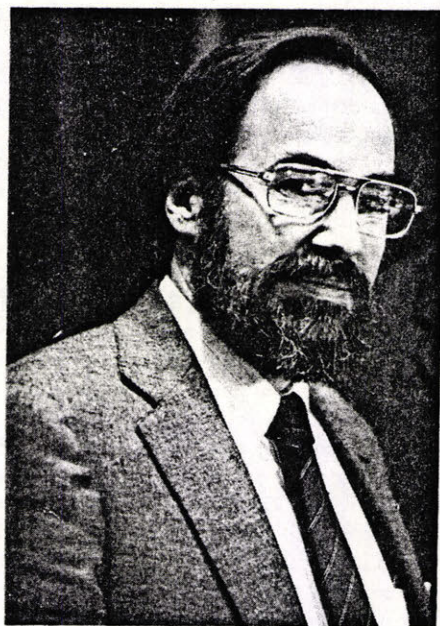
Sheldon Wolff. Cochaired committee and headed panel on public health.

ally transmitted, and 40% did not know that use of a condom during sexual intercourse decreases the risk of infection.

The committee therefore recommends a "massive, coordinated" campaign to convey information in explicit and unambiguous terms about how AIDS is and is not transmitted. At least \$1 billion a year, the bulk of it from the federal government, should be spent by the early 1990's on public health and education activities, the report recommends.

Education efforts should avoid vague terms, and they should include information and guidance on both risky and safe sexual practices. "If government agencies continue to be unable or unwilling to use direct, explicit terms in the detailed content of educational programs, contractual arrangements should be established with private organizations that are not subject to the same inhibitions," the committee says. This is a reference to the fact that federal education programs in the past have been restricted to the use of terms that are unlikely to give offense.

Although current high-risk groups are the



David Baltimore. Cochaired committee and headed panel on AIDS research.

*"Confronting AIDS: Directions for Public Health, Health Care, and Research," National Academy Press, 2101 Constitution Avenue, NW, Washington, D.C. 20418.

obvious targets for education campaigns, the committee also argues that efforts to reach the general population should be greatly stepped up—especially in the schools. “Sex education in the schools is no longer only advice about reproductive choice, but has now become advice about a life-or-death matter,” the report says.

Shortly before the report was released, Surgeon General C. Everett Koop issued his own report on AIDS[†]. Written by Koop himself in clear, unambiguous prose, it contains much of the kind of information the committee says should be made generally available. Koop, who had been briefed on the Institute of Medicine study, said in a statement that “There is now no doubt that we need sex education in schools and that it include information on sexual practices that

put our children at risk for AIDS.” He suggested that such programs should be introduced as early as the third grade.

In other public health areas, the committee encourages voluntary testing for antibodies to the AIDS virus but argues against mandatory screening, either of the general population or members of high-risk groups. Mandatory screening, it says, “would be impossible to justify now on either ethical or practical grounds.” Asked whether that recommendation applies to the controversial issue of testing for life insurance, Wolff acknowledged that the committee found that to be a “sticky issue.” In general, he said the committee felt such testing could be discriminatory. However, the report deals with the matter by not addressing it directly.

As far as research is concerned, the committee notes that there have been impressive advances in understanding the cause and spread of the disease, but it is not sanguine

about the near-term prospects of producing effective therapies or vaccines. It recommends a steady increase in federal funds from about \$300 million appropriated by Congress for fiscal year 1987 to at least \$1 billion a year by the early 1990’s.

In addition to increased funding for basic research and targeted programs for vaccine development and drug testing, the committee argues for more support for high-containment facilities, efforts to expand animal resources and conserve chimpanzee stocks, social science and behavioral research, and epidemiologic studies. It also notes with some concern that the proportion of funds spent by the National Institutes of Health on investigator-initiated research on AIDS has declined recently. “A more balanced growth of support is needed to promote the involvement of the nonfederal basic research community,” the report states. ■

COLIN NORMAN

[†]“Surgeon General’s Report on Acquired Immune Deficiency Syndrome,” available free of charge from: AIDS, P.O. Box 14252, Washington, D.C. 20044.

NIH Begins Year-Long 100th Birthday Party

NIH, which began in a one-room lab and \$300 grant, celebrates centennial of biomedical research with a budget that tops \$6 billion. The year’s events will culminate in a grand ball in Washington

IN 1887, a physician named Joseph J. Kinyoun received \$300 from the federal government to establish a hygiene laboratory in an attic room at the Marine Hospital on Staten Island, thereby laying the groundwork for what was to become the National Institutes of Health.

One hundred years later, at a centennial ceremony on the institute’s 300-acre campus in Bethesda, Maryland, Senator Lowell P. Weicker (R-CT) told assembled researchers that “What you do is the greatest of all activities of government,” adding that the proper way to celebrate the NIH centennial is not with “fireworks or ceremonies” but with money. “Nothing reflects priorities as unerringly as the federal budget,” Weicker observed. “I hope that the celebration will be one of dollars,” he said to resounding applause.

With an increase of more than 15% in funds for fiscal year 1987, just begun, the



Senator Weicker: “Nothing reflects national priorities as unerringly as the budget. I hope the NIH centennial celebration will be one of dollars.”

NIH budget has climbed to an all-time high of \$6.2 billion, thanks in large part to Weicker’s own determined efforts to see that Congress provided substantially more than the \$4.9 billion that the Reagan Administration sought. It’s not a bad start.

“Many people who are reasonably well acquainted with the NIH find it hard to believe that we are approaching our 100th birthday,” NIH director James B. Wyngaarden observed at the centennial opening. “Most would date our beginning as sometime around World War II.”

However, the first 50 years of NIH were in many ways like the modern institutes, on a lesser scale. The work of Kinyoun, who is regarded as NIH’s first director, recalls that from the very outset the link between basic research and medical needs was strong. When the government provided for the establishment of the Laboratory of Hygiene in 1887, cholera and other lethal infectious diseases were major threats to the public health. Kinyoun, fresh from Germany where he studied what was then modern bacteriology under the tutelage of Robert Koch, used his federal money for research that led him to discovery of the bacterium that causes cholera; as a result, he was widely credited with preventing major epidemics.

In 1891, Kinyoun’s laboratory was moved from Staten Island to Washington, D.C., a move, Wyngaarden notes, that “underscored the status of the laboratory as a national resource.” A decade later, its national role was further recognized when Congress appropriated what was probably

COMMUNICATION #2-4

To: All Members of ACHA Task Force on AIDS

From: Rich Keeling

Date: September 29, 1986

Method: Federal Express

WE GOT IT! THIS IS GOING OUT BY FEDERAL EXPRESS BECAUSE I WANTED ALL TO KNOW AS SOON AS POSSIBLE THAT WE GOT THE NATIONAL INSTITUTES OF MENTAL HEALTH CONTRACT FOR THE PRODUCTION OF MATERIALS FOR PROFESSIONALS IN COLLEGE HEALTH AND COUNSELING CENTERS! I was notified late Friday afternoon, September 26, that the NIMH contracts officer had given a verbal commitment to Gail Bassin, the Project Manager at Johnson, Bassin, and Shaw, our consulting firm. A formal written commitment and meeting with the NIMH contract officer will follow next week, and then we will begin to deal with schedules, timetables, and the like. For the moment, though, we can all smile and feel proud that the ACHA has gotten its first federal contract ever, that the credibility of the organization and our Task Force is such that the award was possible, and that we were recognized as being the most capable group to perform this important work. All of that speaks well for all the work we've done, and, as your loyal Chairman, I want to thank all of you again.

AmFAR GRANT: The Grants Office at AmFAR has notified me that they received our materials on time and in good order; they have assigned us an identification number, and now we just have to sit and wait for their decision. Not that there won't be things to do in the meantime, such as working on the NIMH contract...please see enclosed copy of the AmFAR Grant Application for your information.

Working Group on Support Services: I have almost completed the re-word-processing of Chris Lyman's draft, and, within the next day or two, it will be going out to members of the Working Group for their comments and suggestions. That same working group will then need to begin organizing not only to complete the draft, but also to work on the NIMH materials. Well, gang, here we go...Howard, Chris, Annie, Terry, Cathy, Bob, no rest for the weary.

Working Group on Clinical Issues: Paul Grossberg came down to Charlottesville on Wednesday, September 24 during his trip to Washington for the ACHA Program Planning Group meeting. We spent several hours together and were able to get some good work done on the clinical material. We have some ideas for formats, range of content, style, and types of material which I will be sharing soon with the members of the Working Group. I've been talking to Lee Wessel

frequently, too, and some written stuff will be flying around the country soon. We're having some trouble with meeting dates, because of complexities of my travel schedule, Paul's responsibilities in Platteville, Lee's work with the anti-Lyndon Larouche people in California, etc. I do hope at least to be able to meet with Sue Cowell at Lake Placid during the New York State College Health Meeting in October and with Lee during his trip East in early November. Want to come to lake Placid, Joy? Anyway, an earthquake of activity in this Working Group is imminent.

Working Group on Education: I heard from Jeff Gould, who is hot to work, and I predict great things from the Group. Say, Jeff, by the way, great letter you wrote -- both the one to me and the one to the Vice-Chancellor -- I'll drop you a note about it soon.

AIDS Information Survey: Bob Wirag and a colleague of his in Psychology at Arkansas have put together a survey proposal which would allow for assessment of students' knowledge about AIDS. In the development of the draft, they seek comments and feedback from several of us on the Task Force concerning the questions, accuracy of information, etc. I plan to circulate their materials to 6 or 7 of you over the next week or so and would appreciate any help you can give Bob and Dr. Feilstein at Arkansas.

Howard Surface's Birthday: Howard was shocked and mortified by Bob Wirag's failure to recognize and observe in some appropriate manner the anniversary of his birth. As you may not realize, Howard turned 41 on September 23; the absence of fireworks in the sky over Fayetteville has deeply offended him...

Media Coverage: I enclose a copy of the Rolling Stone article on AIDS on the college campus. This article, much of which is not about AIDS at all but about homophobia (which is at least as big a problem), includes comments from me and from Cathy Kodama. We both feel tremendously flattered to be in the issue with Don Johnson on the cover. You may also have caught the New York Times article on the same subject on September 22; it was, in fact, better. The author, John Nordheimer, interviewed Lee (in San Diego) and me (by phone) and came up with a good story. Similarly, the Campus Network, which is a syndicated, satellite-distributed TV news operation for college stations, did a short interview in Berkeley that included Terry Weisser, Cathy, and me. In the wake of the New York Times article, I was interviewed (live, in living color, at 7:45 AM) on the CBS Morning News. I must say that even after all the TV and radio spots I've done in the past year, being live on national TV caused me a little queasiness. They were very nice, though, and it went OK, though I thought I looked like a cadaver on TV. Feel

free to disagree with that if you'd like to make me feel better. Coming up: Independent News Network, next week.

Travel Schedule: Just to let you know, in case any of you will be nearby and could get there: I'll be in Washington on October 6; in Princeton, NJ on October 9 and 10; in Harrisonburg, VA on October 13; in Salisbury, MD October 14 and Blacksburg, VA October 15. Then to Albany on October 21 and Lake Placid October 22. Details? Call me.

Enclosures: In addition to the Rolling Stone article, I've enclosed a copy of the AmFAR proposal, for all of your information, and one of the recent NEWSWEEK article that profiled Dr. Jerry Friedland of Montefiore Hospital in New York. Please note in the AmFAR proposal that we could not, for reasons of their restrictions, include the names of the entire Task Force on the "key people" list; please don't be offended or take as significant in any way if your name isn't there. Mostly I included the names of those of us who are thus far actively involved in Working Group efforts this Fall. That does not in any way mean to ignore or exclude the rest of us, so please don't think so; they only let me put in half of our names.

Usual Entreaty: I'm still here. So call me, write me, or something. Stop in and see me during one of the trips. Invite me to go on a trip to someplace warm, sunny, and relaxing. Send me good jokes. Share your favorite chocolate brownie recipe or your best chili directions. Send Howard a belated birthday card, preferably one that insults him in regard to his age. Sympathize with Annie for all the work she's doing/going to be doing. And, most of all, be proud of yourselves for the work which got us the recognition and confidence of the NIMH.

Thanks, all, and keep in touch.