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FOSTER CARE AND THE “SIGNIFICANT RISK” OF AIDS: APPLYING THE DIRECT THREAT EXCEPTION TO THE AMERICANS WITH DISABILITIES ACT AND THE REHABILITATION ACT IN *DOE V. COUNTY OF CENTRE*

I. INTRODUCTION

The Americans with Disabilities Act of 1990 (ADA)¹ offers federal protection for disabled persons.² Patterned after the Rehabilitation Act of 1973 (Rehabilitation Act),³ the ADA combats discrimination based on a person’s disabilities.⁴ However, under the direct threat exception to Title II of the ADA⁵ and Section 504 of the Rehabilitation Act,⁶ discrimination against

1. 42 U.S.C. §§ 12101-12213 (1999 & Supp. V 1999). According to Title II of the Americans with Disabilities Act, “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” 42 U.S.C. § 12132 (1994). A disability is defined, in part, as “a physical or mental impairment that substantially limits one or more of the major life activities of [an] individual.” 42 U.S.C. § 12102(2)(A) (1994).

2. GERALD J. STINE, *ACQUIRED IMMUNE DEFICIENCY SYNDROME: BIOLOGICAL, MEDICAL, SOCIAL, AND LEGAL ISSUES* 455 (2d ed. 1996).

3. 29 U.S.C. §§ 701-796 (1994 & Supp. V 1999). Section 504 of the Rehabilitation Act prohibits disability discrimination in federal programs. 29 U.S.C. § 794(a) (1994). *See* 29 U.S.C. § 705(9)(B) (Supp. V 1999) (using a definition of disability that is nearly identical to that of the ADA). According to the Supreme Court, the ADA and the Rehabilitation Act have complementary statutory meanings. *Bragdon v. Abbott*, 524 U.S. 624, 638 (1998) (“[T]he ADA must be construed to be consistent with regulations issued to implement the Rehabilitation Act.”). *See also* 42 U.S.C. § 12201(a) (1994) (“Except as otherwise provided in this chapter, nothing in this chapter shall be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973 (29 U.S.C. 790 et seq.) or the regulations issued by Federal agencies pursuant to such title.”); 28 C.F.R. § 36.103(a) (2001).

4. 42 U.S.C. § 12101(b)(1) (1994) (“It is the purpose of this chapter . . . to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities . . .”). Section 504 of the Rehabilitation Act prohibits discrimination against “otherwise qualified individual[s] with a disability.” 29 U.S.C. § 794(a) (Supp. V 1999).

5. 49 U.S.C. § 12182(b)(3) (1994). According to the direct threat exception to the ADA, [n]othing in this subchapter shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term “direct threat” means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.

Id.

6. 29 U.S.C. § 705(20)(D) (Supp. V 1999). According to the direct threat exception to the Rehabilitation Act, the Rehabilitation Act does not apply to an individual who has a currently contagious disease or infection and who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other individuals or who, by reason of the currently contagious disease or infection, is unable to perform the duties of

individuals with disabilities is permitted if the disability “poses a direct threat to the health or safety of others.”⁷

Courts have recognized persons with HIV-positive status as disabled persons within the meaning of the ADA and the Rehabilitation Act.⁸ The Human Immunodeficiency Virus, commonly known as HIV, is generally understood to be the cause of the Acquired Immunodeficiency Syndrome (AIDS).⁹ HIV is a retrovirus¹⁰ that “mutates at an unusually high rate.”¹¹ The virus can be transmitted through contaminated blood transfusions,¹² intravenous drug use,¹³ and sexual contact.¹⁴ In addition, neonatal infection¹⁵

the job.

Id.

7. 42 U.S.C. § 12182(b)(3) (1994). *See also* 29 U.S.C. § 705(20)(D) (Supp. V 1999). *See also infra* notes 37-42 and accompanying text (examining the congressional approach to the direct threat exception).

8. *See, e.g.,* Bragdon v. Abbott, 524 U.S. 624, 630-47 (1998) (finding that an asymptomatic HIV-positive individual was disabled within the meaning of the ADA). *See also infra* notes 44-45 and accompanying text (discussing the recognition of an asymptomatic HIV-positive status as a disability under federal and state law).

9. STINE, *supra* note 2, at 32-33. *But see id.* at 29-31 (discussing the minority view that HIV does not cause AIDS). The public first became aware of AIDS on June 5, 1981, when the “Centers for Disease Control (CDC) reported that five cases of a rare form of pneumonia . . . had been diagnosed in homosexual men . . . [P]ediatric AIDS, defined as AIDS in children younger than 13 years of age, was first described in 1983.” THEODORE J. STEIN, *THE SOCIAL WELFARE OF WOMEN AND CHILDREN WITH HIV AND AIDS: LEGAL PROTECTIONS, POLICY, AND PROGRAMS* 1 (1998). *See also infra* note 14 and accompanying text (noting that heterosexual contact accounts for ninety percent of HIV infection since 1990).

10. “Retroviruses . . . reverse the usual flow of genetic information within the host cell.” STINE, *supra* note 2, at 39.

11. *Id.* at 54.

12. “[P]rior to the nationwide implementation of a blood screening test in late 1985, infection via transfusion of contaminated blood or blood products . . . accounted for nearly 3% of AIDS cases in the United States.” THOMAS E. ANDREOLI ET AL., *CECIL ESSENTIALS OF MEDICINE* 749-50 (4th ed. 1997). Currently, the risk of becoming infected with HIV through blood transfusions in North America and Western Europe is “extremely small, but not absent.” *Id.* at 750.

13. “The sharing of needles used for drug injection transmits the virus efficiently and continues to be a major mode of spread of [HIV virus] infection in North America and Western Europe.” *Id.*

14. ANDREOLI ET AL., *supra* note 12, at 749-51. Furthermore,

[a]lthough AIDS was initially recognized among sexually active homosexual males and intravenous drug users in the United States, heterosexual contact has been the dominant mode of [HIV virus] transmission throughout most of the world, accounting for more than 90% of infections recognized since 1990. . . . The concurrent presence of other sexually transmissible diseases (STDs), especially those associated with genital ulcerations, strongly facilitates sexual transmission of [the HIV virus].

Id. at 749.

15. “It is estimated that about 20 to 30 percent of infants born to HIV-infected mothers are themselves infected with HIV.” Felissa L. Cohen & Wendy M. Nehring, *Foster Care of HIV-Positive Children in the United States*, PUB. HEALTH REP., Jan. 1994, at 60-61. However,

[b]y 18 months, children normally lose the antibodies acquired from their mothers, and about half of them become HIV-negative. . . . The practice, when children turn out healthy, is to move them away from the AIDS foster families into permanent homes, making room for more AIDS babies.

"may occur in utero, during labor, or, less frequently, after birth through breast-feeding."¹⁶ Generally, HIV attacks the white blood cells, and the disease progresses to AIDS when the white blood cell count reaches a certain level.¹⁷ The disease eventually compromises the immune system.¹⁸ However, HIV-positive individuals "are asymptomatic during most of the course of [HIV] infection . . . , and even seriously immunocompromised individuals often function productively between bouts of opportunistic infections."¹⁹ Although there are drug treatments that help decrease the amount of virus in an HIV-positive individual, there is no known cure.²⁰

In *Doe v. County of Centre*,²¹ the United States Court of Appeals for the Third Circuit held that according to an individualized evaluation of the "significant threat" posed by a household with an HIV-positive child to a foster child, such foster care placement would not automatically invoke the direct threat exception to the ADA²² or the Rehabilitation Act²³ against discrimination based on disabilities.²⁴ Therefore, a county policy prohibiting the placement of foster children with an infectious disease into households that did not have a member with the same infectious disease constituted impermissible disability discrimination.²⁵

This Recent Development examines the Third Circuit's treatment of the direct threat exception to the ADA and the Rehabilitation Act in *Doe v. County of Centre*. Part II examines the development of the law regarding the

Thus what the foster parents risk is loving the children and having to give them away, or keeping them to love through a slow death.

Richard Conniff, *Foster Children with the AIDS Virus: Families That Open Their Homes to the Sick*, TIME, Dec. 5, 1988, at 12.

16. ANDREOLI ET AL., *supra* note 12, at 750. See Cohen & Nehring, *supra* note 15, at 60 ("HIV disease has the potential to become the leading pediatric infectious cause of neurological and developmental handicaps, as well as a leading cause of death in children younger than 5 years . . .").

17. See ANDREOLI ET AL., *supra* note 12, at 755. "Progression of disease varies greatly among individuals and is also related to age at time of infection. Adolescents with HIV progress to AIDS at a slower rate than older persons, with fewer than 30% developing AIDS within 10 years after HIV infection." *Id.*

18. "When the [white blood cell] count drops below 200, patients are at high risk of developing multiple opportunistic infections." *Id.* at 755. Patients with white blood cell counts under 50 have severe immunodeficiency and have a "high mortality [rate] within the subsequent 24 to 36 months." *Id.* at 756.

19. *Id.*

20. ANDREOLI ET AL., *supra* note 12, at 757-58 (describing various treatments for HIV infection). Unfortunately, "it is likely . . . that HIV will eventually develop resistance to even the most potent antiretroviral regimens." *Id.* at 758. See also STINE, *supra* note 2, at 259.

21. 242 F.3d 437 (3d Cir. 2001) [hereinafter *Doe III*].

22. 42 U.S.C. §§ 12111, 12182(b)(3) (1994).

23. 29 U.S.C. § 705(20)(D) (Supp. V 1999).

24. *Doe III*, 242 F.3d at 448-52.

25. *Id.* at 444-45, 448-52.

direct threat exception to the ADA and the Rehabilitation Act, as well as the development of the law regarding HIV/AIDS in the context of the foster care system. Part III analyzes the Third Circuit's disposition in *Doe v. County of Centre*. Part IV concludes that the Third Circuit's decision furthers the judicial trend to recognize the HIV/AIDS condition as a disability under the ADA and the Rehabilitation Act, and apply the direct threat exception to those statutes for the purpose of combating "society's accumulated myths and fears"²⁶ about HIV/AIDS transmission. In addition, this Recent Development emphasizes the importance of individualized inquiries with regard to the direct threat exception in the context of foster care and HIV/AIDS. The threat of an incurable disease necessitates such individualized inquiries to balance the State's interest in the protection of foster children, the interest of disabled individuals in freedom from disability discrimination, and societal interest in its own public welfare.

II. HISTORY

A. *Development of the Law Regarding the Direct Threat Exception to the Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973*

1. *School Board of Nassau County v. Arline*

In 1987, the United States Supreme Court reconciled the competing interests of protecting persons with disabilities from discrimination and protecting the public from health and safety risks. In *School Board of Nassau County v. Arline*,²⁷ an elementary school teacher with a history of tuberculosis claimed that she had been wrongfully terminated because she was disabled under § 504 of the Rehabilitation Act.²⁸ Aware of irrational societal fears and biases regarding persons with disabilities, the Court chose not to interpret the Rehabilitation Act to permit overbroad discrimination against persons with contagious disabilities.²⁹ Instead, the Court determined

26. 480 U.S. 273, 284 (1987).

27. *Arline*, 480 U.S. 273 (1987).

28. *Id.* at 284-85.

29. *Id.* at 286 (noting that "the fact that a person with a record of a physical impairment is also contagious does not suffice to remove that person from coverage under § 504 [of the Rehabilitation Act]").

Allowing discrimination based on the contagious effects of a physical impairment would be inconsistent with the basic purpose of § 504, which is to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others. By amending the definition of "handicapped individual" to include not only those who are actually

that “only those individuals who are both handicapped *and* otherwise qualified are eligible for relief.”³⁰

The Court established a four-part test for courts to consider when making factual findings for the “significant risk” standard.³¹ First, courts should make findings regarding the nature of the risk, as presented by the transmission of the disease.³² Second, courts should find the duration of the risk by measuring the carrier’s infectious period.³³ Third, courts should determine the severity of the risk to third parties.³⁴ Fourth, courts should examine the probability that the disease will be transmitted from the carrier and cause “varying degrees of harm.”³⁵ After reaching the conclusion that the respondent was a disabled person under the Rehabilitation Act, the Court remanded the case back to the district court to determine whether she was otherwise qualified to retain her position as an elementary school teacher.³⁶

2. Congressional Approach to the Direct Threat Exception

In approval of the Supreme Court’s interpretation of the Rehabilitation Act, which permitted employers to refuse to hire a person who posed “a significant risk of communicating an infectious disease to others,”³⁷ Congress amended the statute to include the Court’s construction.³⁸ A few years later,

physically impaired, but also those who are regarded as impaired and who, as a result, are substantially limited in a major life activity, Congress acknowledged that society’s accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment.

Id. at 284.

30. *Arline*, 480 U.S. at 285. *See also id.* at 286 n.15 (“[C]ourts may reasonably be expected normally to defer to the judgments of public health officials in determining whether an individual is otherwise qualified unless those judgments are medically unsupportable.”).

31. *Id.* at 287 n.16 (“A person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk.”).

32. *Id.* at 288.

33. *Id.*

34. *Id.*

35. *Id.*

36. *Arline*, 480 U.S. at 289. On remand, the district court applied the factors suggested by the Supreme Court and found that “the decision to terminate Plaintiff because of her history of tuberculosis was not based on reasonable medical judgments, but rather, was based upon ‘society’s accumulated myths and fears about [tuberculosis].’” *Arline v. Sch. Bd. Of Nassau County*, 692 F. Supp. 1286, 1291-92 (M.D. Fla. 1988) (citing *Sch. Bd. of Nassau County v. Arline*, 480 U.S. 273, 284 (1987)). The district court found that the “[p]laintiff posed no threat of communicating tuberculosis to the schoolchildren she was teaching” and was therefore entitled to damages. 692 F. Supp. at 1292.

37. *Arline*, 480 U.S. at 287 n.16.

38. *Bragdon v. Abbott*, 524 U.S. 624, 649 (1998). *See* 29 U.S.C. § 706(8)(D) (1994). *See also supra* note 6 and accompanying text (direct threat exception to the Rehabilitation Act).

Congress codified the *Arline* rationale in the ADA.³⁹

The ADA and the Rehabilitation Act represent legislative efforts to offer federal protection to disabled persons through prohibitions against disability discrimination. However, Congress was concerned that ill-founded claims based on generalizations and speculations would lead to the over-invocation of the direct threat exception, thereby leaving an unguarded loophole that would allow disability discrimination.⁴⁰ Sensitive to the possibility of such blind and automatic decisions, Congress was careful to emphasize the importance of making decisions based on individualized determinations.⁴¹ In addition, for an invocation of the direct threat exception to be successful, an individualized inquiry must reveal that the risk, if it does exist, is indeed significant.⁴²

3. *Bragdon v. Abbott*

The Supreme Court addressed the issue of the ADA's direct threat exception in *Bragdon v. Abbott*,⁴³ a case in which a dentist refused to treat an HIV-positive patient. Despite the fact that the patient was asymptomatic,⁴⁴

39. *Bragdon v. Abbott*, 524 U.S. at 649. See 42 U.S.C. § 12182(b)(3) (1994) (direct threat exception to the ADA).

40. H.R. REP. NO. 101-485(III), at 45 (1990), reprinted in 1990 U.S.C.C.A.N. 445, 468.

41. "The purpose of creating the 'direct threat' standard is to eliminate exclusions which are not based on objective evidence about the individual involved." *Id.* There are a number of cases noting the importance of individualized inquiries about the risk posed by HIV-positive persons. See, e.g., *Holiday v. City of Chattanooga*, 206 F.3d 637, 643 (6th Cir. 2000) (holding that the lower court should not have relied on evidence that was not based on an "individualized inquiry [as] mandated by the ADA"); *Taylor v. Pathmark Stores, Inc.*, 177 F.3d 180, 192-93 (3d Cir. 1999); *Doe v. Dekalb County Sch. Dist.*, 145 F.3d 1441, 1446 (11th Cir. 1998). Compare *Bragdon v. Abbott*, 524 U.S. 624 (1998), with *Doe v. County of Centre*, 242 F.3d 437 (3d Cir. 2001) (utilizing an individualized inquiry to determine whether the direct threat exception applies).

42. See *Bragdon v. Abbott*, 524 U.S. 624, 649 (1998) ("Because few, if any, activities in life are risk free, *Arline* and the ADA do not ask whether a risk exists, but whether it is significant."). See also 42 U.S.C. § 12182(b)(3) (1994); *Arline*, 480 U.S. at 287 n.16 ("A person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk."); H.R. REP. NO. 101-485(III), at 46 (1990), reprinted in 1990 U.S.C.C.A.N. 445, 469 ("The plaintiff is not required to prove that he or she poses no risk."); H.R. REP. NO. 101-485(II), at 56 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 338 (stating that a "significant risk" must be more than a "speculative or remote risk").

43. 524 U.S. 624 (1998).

44. A significant number of courts have accepted the idea that "asymptomatic HIV infection satisfie[s] the Rehabilitation Act's definition of a handicap." *Bragdon v. Abbott*, 524 U.S. at 644. See *Doe v. Garrett*, 903 F.2d 1455, 1457 (11th Cir. 1990); *Ray v. Sch. Dist.*, 666 F. Supp. 1524, 1533, 1536 (M.D. Fla. 1987); *Thomas v. Atascadero Unified Sch. Dist.*, 662 F. Supp. 376, 380-81 (C.D. Cal. 1987); *Dist. 27 Cmty. Sch. Bd. v. Bd. of Educ.*, 502 N.Y.S.2d 325, 335-37 (N.Y. Sup. Ct. 1986). Other courts have not drawn a distinction between asymptomatic and symptomatic status when determining whether or not the definition of disability is met. See *Martinez v. Sch. Bd.*, 861 F.2d 1502, 1506 (11th Cir. 1988); *Chalk v. United States Dist. Ct., Cent. Dist. Of Cal.*, 840 F.2d 701, 706 (9th Cir. 1988);

the Court considered the patient's HIV status a disability under the ADA because her "HIV infection [was] a physical impairment which substantially limit[ed] a major life activity."⁴⁵

After a "rigorous and individualized inquiry into the risk of HIV transmission from patient to dentist,"⁴⁶ the Court questioned the credibility of studies addressing the transmission of the AIDS virus, and remanded the case to "permit a full exploration of the issue."⁴⁷ Relying on its earlier disposition in *School Board of Nassau County v. Arline*,⁴⁸ the Court noted the importance of ascertaining the significance of the risk, rather than addressing whether a risk existed.⁴⁹ Noting that the Court of Appeals for the First Circuit applied an objective standard in the case below, the Court expressed its concern that the First Circuit "might have placed mistaken reliance upon two . . . sources."⁵⁰ The insufficiency of the evidence persuaded the Court to

Doe v. Dolton Elem. Sch. Dist. No. 148, 694 F. Supp. 440, 444-45 (N.D. Ill. 1988); *Robertson v. Granite City Cmty. Unit Sch. Dist. No. 9*, 684 F. Supp. 1002, 1006-07 (S.D. Ill. 1988); *Local 1812, Am. Fed'n of Gov't Employees v. United States Dept. of State*, 662 F. Supp. 50, 54 (D.D.C. 1987). The Justice Department has added both asymptomatic and symptomatic HIV infection to the list of disorders constituting a physical impairment. 28 C.F.R. § 36.104(1)(iii) (2001). See also U.S. DEP'T OF JUSTICE, CIVIL RIGHTS DIV., THE AMERICANS WITH DISABILITIES ACT: TITLE III TECHNICAL ASSISTANCE MANUAL § III-2.2000 at 9 (Nov. 1993).

45. *Bragdon v. Abbott*, 524 U.S. at 641. The Court accepted the assertion of the Office of Legal Counsel of the Department of Justice (OLC) that "the life activity of procreation . . . is substantially limited for an asymptomatic HIV-infected individual." *Id.* at 643 (citing *Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals*, 12 OP. OFF. LEGAL COUNSEL 209, 216 (1988)). Congress accepted this assertion, as well as others made by the OLC. H.R. REP. NO. 101-485(II), at 52 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 334. See 42 U.S.C. § 12102(2)(A) (1994) (defining a disability as "a physical . . . impairment that substantially limits one or more of [an individual's] major life activities"). The Court noted that "HIV infection must be regarded as a physiological disorder with a constant and detrimental effect on the infected person's hemic and lymphatic systems from the moment of infection," but it declined to determine "whether HIV infection is a *per se* disability under the ADA." *Bragdon v. Abbott*, 524 U.S. at 637, 642. The Court was not able to rely on the Rehabilitation Act regulations for guidance. *Id.* at 639 (citing 45 C.F.R. pt. 84, app. A, at 334 (1997)). See generally Emily J. Carton, Comment, *Lethal but Not Disabled?—The Circuits Split on ADA Coverage of the Asymptomatic HIV-Positive Victim*, 103 DICK. L. REV. 129 (1998) (addressing the debate over whether an asymptomatic HIV-positive person is disabled under the ADA); Lawrence O. Gostin et al., *Disability Discrimination in America: HIV/AIDS and Other Health Conditions*, 281 JAMA 745 (1999); David W. Webber & Lawrence O. Gostin, *Discrimination Based on HIV/AIDS and Other Health Conditions: "Disability" as Defined Under Federal and State Law*, 3 J. HEALTH CARE L. & POL'Y 266 (2000) (examining the recognition of HIV/AIDS status as a disability under federal and state law).

46. *Doe III*, 242 F.3d at 437, 448 (3d. Cir. 2001).

47. *Bragdon v. Abbott*, 524 U.S. at 655.

48. *Arline*, 480 U.S. 273 (1987).

49. *Bragdon v. Abbott*, 524 U.S. at 649.

50. *Id.* at 651. The Court disagreed with the First Circuit's interpretation of the Center for Disease Control's Guidelines, Ctr. For Disease Control, U.S. Dep't of Health and Human Serv., *Recommended Infection Control Practices for Dentistry*, MORBIDITY AND MORTALITY WEEKLY REP.: RECOMMENDATIONS AND REP., May 28, 1993, at 1, and the 1991 AMERICAN DENTAL ASSOCIATION POLICY ON HIV (1991), in that the First Circuit read "implicit assumptions" regarding the level of risk

remand the case back to the Court of Appeals.⁵¹ While the Court acknowledged the possibility that the First Circuit could reach the same conclusion on remand, it emphasized the importance of a thorough inquiry.⁵²

B. Development of the Law Regarding HIV/AIDS in the Context of the Foster Care System

According to various studies, children in foster care account for twenty-seven to thirty-three percent of “children in families where the mother and/or child has HIV.”⁵³ HIV-positive children are often placed in foster care because of parental neglect.⁵⁴ Although most states have general foster care policies, less than half have foster care policies addressing the needs of children with HIV/AIDS.⁵⁵ In addition, commentators have criticized states for under-enrolling HIV-infected foster children in research studies that could lead to “HIV- and AIDS-related treatments particularized for children,”⁵⁶ and for discriminatory nontreatment of HIV-positive infants.⁵⁷

At the same time, there is very little case law regarding HIV/AIDS-infected persons in the context of foster care. The issue of placing foster children—healthy or otherwise—into households with an HIV/AIDS-infected child is a novel one. To date, the Supreme Court has not addressed this issue.

1. In re Interest of John T.

In the seminal case of *In re Interest of John T.*, the Nebraska Court of

where the Supreme Court found only a “recommendation that the universal precautions are the best way to combat the risk of HIV transmission.” 524 U.S. at 651-52.

51. *Bragdon v. Abbott*, 524 U.S. at 655.

52. *See id.* (“A remand will permit a full exploration of the issue through the adversary process.”).

53. STEIN, *supra* note 9, at 65. *See* Deborah Weimer, *Beyond Parens Patriae: Assuring Timely, Informed, Compassionate Decisionmaking for HIV-Positive Children in Foster Care*, 46 U. MIAMI L. REV. 379, 380 (1991) (noting that “[i]n 1990, 42% of children known to be HIV positive were not living with their parents; 26% had been placed in foster care, 9% were living with a relative, and 7% were living with someone other than a relative”).

54. Weimer, *supra* note 53, at 382.

55. Cohen & Nehring, *supra* note 15, at 62 (noting that 89.1% of the states surveyed had a general foster care policy, while only 38.2% of the states indicated that they had “specific foster care policies regarding the care of children with HIV-AIDS”). “Not surprisingly, most States developed their policies and procedures after a child with HIV was presented for placement in foster care.” *Id.* at 65.

56. Briar McNutt, *The Under-Enrollment of HIV-Infected Foster Children in Clinical Trials and Protocols and the Need for Corrective State Action*, 20 AM. J.L. & MED. 231, 232 (1994).

57. Mary A. Crossley, *Of Diagnoses and Discrimination: Discriminatory Nontreatment of Infants with HIV Infection*, 93 COLUM. L. REV. 1581 (1993).

Appeals examined the issue of whether a three and six-month-old child should be moved out of his foster home because his foster mother had been diagnosed with AIDS.⁵⁸ The court held that the preponderance of the evidence showed that it was in the child's best interests to remain with his foster parents.⁵⁹ In reaching its judgment, the court conducted a thorough and individualized analysis. The court examined the level of care that John T. received from his foster parents and noted that there was "virtually no risk that HIV [would] be transmitted to John through ordinary household contact."⁶⁰

III. ANALYSIS

In *Doe v. County of Centre*,⁶¹ the United States Court of Appeals for the Third Circuit confronted the novel issue of foster child placement in a household with an HIV-positive child. John and Mary Doe were an interracial couple with a large family of adopted children.⁶² When Mary Doe

58. *In re Interest of John T.*, 538 N.W.2d 761, 762 (Neb. Ct. App. 1995). The Department of Social Services also expressed concern that because John T. had a "biological family history of schizophrenia . . . such a trauma [of the foster mother's inevitable death] could accelerate the onset of schizophrenia, if he [was] going to be so afflicted." *Id.* at 769. However, the court noted that the medical expert suggesting this outcome had never met John T. in person. *Id.* at 770. See Jenny L. Plager, Note, *Foster Parents and AIDS: Considering the Best Interests of a Foster Child in In re Interest of John T.*, 4 Neb. Ct. App. 79, 538 N.W.2d 761 (1995), 77 NEB. L. REV. 617, 619 (1998) (criticizing the Nebraska Court of Appeals decision for placing the child's best interests "behind the social goal of discouraging discrimination in the judicial process against an individual with AIDS"). Notably, John T.'s foster mother died of AIDS seven months after the child was returned to the foster home. Butch Mabin, *Judge Says Man Can Sue Officials in Adoption Case*, LINCOLN J. STAR, Apr. 26, 1997, at 1C. See generally Pierce J. Reed & Laura Davis Smith, *HIV, Judicial Logic and Medical Science: Toward a Presumption of Noninfection in Child-Custody and Visitation Cases*, 31 NEW ENG. L. REV. 471, 473 (1997) (providing a "general overview of custody determinations involving parents infected with HIV").

59. *In re Interest of John T.*, 538 N.W.2d at 773. *But see* McNicholas v. Johnson (Matter of Adoption of Johnson), 612 N.E.2d 569 (Ind. Ct. App. 1993) (holding that it was in the child's best interest to allow biological mother to withdraw consent to adoption where both adoptive parents were HIV-positive).

60. *In re Interest of John T.*, 538 N.W.2d at 769. Although there was no case precedent regarding the removal of a foster child due to HIV or AIDS infection of one or more parents, the court accepted the persuasive authority from other states that there is "no risk of HIV infection through close personal contact or sharing of household functions." *Id.* at 771-72 (citing *Newton v. Riley*, 899 S.W.2d 509, 510 (Ky. Ct. App. 1995) (citing *Steven L. v. Dawn J.*, 561 N.Y.S.2d 322, 325) (N.Y. Fam. Ct. 1990) (quoting *Doe v. Roe*, 526 N.Y.S.2d 718, 725 (N.Y. Sup. Ct. 1988))). See also *Stewart v. Stewart*, 521 N.E.2d 956, 964 (Ind. Ct. App. 1988) (concluding that "the medical evidence and studies available at the time of trial showed that AIDS is not transmitted through everyday household contact"); *Jane W. v. John W.*, 519 N.Y.S.2d 603, 604 (N.Y. Sup. Ct. 1987) (referring to a study that found that "there has been no transmission of the AIDS virus within the close contact of familial groupings").

61. 242 F.3d 437 (3d. Cir. 2001).

62. *Id.* at 441. Mary Doe had "dedicated herself to the care of foster children with special needs" and eventually adopted seven of her eight foster children. *Id.* One child "was blind, retarded and had

adopted Adam—an infant who had contracted HIV from his birth mother—the virus developed into AIDS.⁶³ As a result, Adam experienced severe health problems that forced him to rely on the assistance of others for basic functions, including eating and attending to personal hygiene.⁶⁴ Adam suffered massive weight loss, exhibited “symptoms of autism and permanent learning deficits,” and required the use of a feeding tube for nourishment.⁶⁵ In March 1996, doctors implemented a regimen of aggressive drug therapy, which suppressed Adam’s viral load⁶⁶ to such an extent that he regained his health and “suffer[ed] no greater risk of opportunistic infection than a child without HIV.”⁶⁷ John and Mary Doe expressed a desire to participate in the Office of Children and Youth Services of Centre County (CYS) foster care program. They disclosed their son’s HIV-positive status to a CYS employee conducting home studies for prospective foster parents.⁶⁸ At the time, the CYS did not have a policy regarding foster child placement into a household with an HIV-positive member.⁶⁹ The CYS officials investigated Centre County foster care records and discovered a “pattern of physical and sexual abuse among foster children.”⁷⁰ Concerned about the possibility that a foster

cerebral palsy” and other children had histories of physical and sexual abuse. *Id.* Mary Doe often received recognition for her efforts, including being named Foster Parent of the Year by the New York State Foster Parents’ Association. *Id.*

63. *Id.* at 441. “In 49 States, foster parents could later adopt their foster child with HIV-AIDS.” Cohen & Nehring, *supra* note 15, at 65.

64. *Doe III*, 242 F.3d at 442.

65. *Id.*

66. The viral load of an HIV-positive person indicates the level of HIV virus present in the person’s blood. *Id.* at 442 n.2.

67. *Id.* at 442. At Adam’s present health state, he is no more vulnerable to becoming ill from a sickness or disease than any other healthy child. However, it should be noted that Adam’s HIV-positive status remains unchanged. *Id.*

68. See Wendy M. Nehring et al., *Disclosing the Diagnosis of Pediatric HIV Infection: Mothers’ Views*, J. SOC’Y PEDIATRIC NURSES, Jan.-Mar. 2000, at 5 (examining the results of a study identifying “to whom biological and foster mothers disclose the diagnosis of [pediatric] HIV infection”). See also Plager, *supra* note 58, at 636-37 (criticizing the Nebraska Court of Appeals’ de-emphasis of the foster parents’ “conscious deception” in not disclosing the HIV-positive status of the foster mother to the foster care agency).

69. See *Doe III*, 242 F.3d at 443 (“Prior to the Does’ application, CYS officials had never knowingly placed a child in a foster home where someone had HIV, and therefore had no policy to address the limitations, if any, applying to such a home.”). See also Cohen & Nehring, *supra* note 15, at 65 (“Not surprisingly, most States developed their policies and procedures after a child with HIV was presented for placement in foster care.”).

70. *Doe III*, 242 F.3d at 444. CYS officials concluded that “the emergency nature of foster child placement . . . [precluded adequate] time to assess each foster child for behavioral or emotional problems prior to placement.” *Id.* See also *Circuit Court Addresses Direct Threat Issue, Reverses HIV Foster Care Ban*, DISABILITY COMPLIANCE BULL., Mar. 23, 2001 (stating that the CYS defended the policy “[b]ased on data that 12 percent of the county’s foster children have a history of perpetrating some form of sexual abuse” and that “roughhousing with a child with HIV could lead to HIV infection”).

child could contract HIV by sexually assaulting Adam, the CYS director formulated a policy prohibiting the placement of a foster child with an infectious disease into a home unless a member of the home had the same infectious disease.⁷¹ The Board of Commissioners of Centre County adopted this policy, but allowed parents or guardians of the foster child to opt out of the policy by their informed consent.⁷² The Does brought a suit against Centre County, the CYS, the County Board, and CYS officials, claiming violations of various statutes, including the ADA.⁷³

The district court applied the four-factor test from *School Board of Nassau County v. Arline*⁷⁴ and concluded that Adam's HIV-positive status posed a significant risk to foster children who might sexually assault him.⁷⁵ The court's conclusion was based on general findings of fact regarding the nature, duration, and severity of the risk posed by HIV and AIDS to the carrier and third parties.⁷⁶ In addition, the court accepted the County's argument that there was a "high probability that [HIV] will be transmitted [through sexual contact] to children placed in foster care with the Does."⁷⁷

Under plenary review of the district court's grant of summary judgment to the County, the United States Court of Appeals for the Third Circuit held that there was a genuine factual dispute regarding the district court's finding that there was a high probability that HIV would be transmitted to foster children placed in the Does' household.⁷⁸ The Third Circuit assumed that the district court's finding was based in part on the CYS data showing that the "CYS foster children have a high propensity to sexually abuse other

71. *Doe III*, 242 F.3d at 444-45.

72. *Id.* The informed consent on the part of the child's parent or guardian would necessitate the voluntary agreement by "the foster parents . . . to release information to the [foster] child's parents that a member of the foster family ha[d] been diagnosed with a specific serious infectious disease." *Id.* at 445.

73. *Doe III*, 242 F.3d at 445. The Does also argued that the CYS policy violated Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000 (1994), and "equal protection guarantees under the United States Constitution." *Id.* The Does claimed racial discrimination was another reason for their rejection by CYS, because a CYS official informed them that race was a factor in foster child placement. *Id.* There were no African-American foster children available for placement at the time, and the CYS official explained that CYS "tries to replicate a foster child's original home environment . . . [because] [r]acial continuity minimizes disruption and change in the child's life." *Id.*

74. *See supra* notes 31-35 and accompanying text.

75. *Doe v. County of Centre*, 60 F. Supp. 2d 417, 428-29 (M.D. Pa. 1999) [hereinafter *Doe I*].

76. *Id.* The Third Circuit did not contest three of the District Court's findings regarding: (1) the nature of the risk (that "the HIV virus has been proven to be transmitted through sexual intercourse (homosexual or heterosexual), intravenous drug use, and transfusion of blood and blood products"); (2) the duration of the risk (that "AIDS is a terminal disease for which there is no cure . . . the risk [is] present until the carrier succumbs to the disease"); and (3) the severity of the risk (that "[t]he harm to third parties is life-threatening"). *Id.* at 428. *See Doe III*, 242 F.3d at 449.

77. *Doe I*, 60 F. Supp. 2d at 428.

78. *Doe III*, 242 F.3d at 449.

children.”⁷⁹ Reasoning that an application of the ADA’s direct threat exception requires an “individualized inquiry into the significance of the threat posed,”⁸⁰ the court criticized the lower court’s reliance on “a bland and generalized set of statistics, lacking in individual specificity.”⁸¹ The court conducted an individualized analysis of its own, finding that “foster children of tender age⁸² . . . are extremely unlikely to commit forcible sexual intercourse [sic] leading to the transmission of HIV.”⁸³ In addition, given Adam’s own tender age and frailty, it was not reasonable to expect that he would be a sexual aggressor capable of transmitting HIV to any foster child placed in his home.⁸⁴ In essence, the court took issue with the CYS official’s testimony that it was impossible to predict which foster children would become sexual assaulters.⁸⁵ According to the court’s rationale, children of tender age are a category of foster children exempt from identification as potential perpetrators of sexual assault.⁸⁶

The Third Circuit next addressed the district court’s concern that even if the risk of transmission during one instance of sexual contact was negligible, there was a risk nonetheless, and there was no way to ensure only casual contact between Adam and a foster child.⁸⁷ The County argued that “the direct threat test in *Arline* and *Bragdon* developed in the context of HIV-positive persons rightfully demand[ed] inclusion into the public sphere and into public life.”⁸⁸ Because the Does were requesting foster care placement into their private home, the County argued that the intrusion of the court was even more necessary because “the threat posed in a private home is much greater.”⁸⁹ However, the Third Circuit noted that the context of the private

79. *Id.* See also *Doe II*, 80 F. Supp. 2d 437, 441 (M.D. Pa. 2000).

80. *Doe III*, 242 F.3d at 449.

81. *Id.* The Third Circuit noted that although the statistics showed that “12% of the foster children have had histories of perpetrating some form of ‘sexual abuse,’ . . . the statistics broadly define ‘sexual abuse’ to include activities such as fondling and disrobing that carry no risk of transmitting HIV.” *Id.* See *Doe II*, 80 F. Supp. 2d at 441.

82. “Tender age” is understood to include “infants and children who have not reached puberty.” *Doe III*, 242 F.3d at 449. *But see id.* at 449 n.7 (noting that “the phrase ‘children of tender years’ has varied in social and legal contexts, with little direct connection to sexual development”).

83. *Doe III*, 242 F.3d at 449.

84. *Id.* at 449-50.

85. *Id.* at 449 (citing *Doe II*, 80 F. Supp. 2d at 442).

86. *Doe III*, 242 F.3d at 449-50.

87. *Id.* at 450-51. See *id.* at 449 (“[T]he statistics do not indicate how many children can be readily identified as being unable or unlikely to engage in high-risk behavior.”); *Doe II*, 80 F. Supp. 2d at 442 (“CYS cannot identify with any certainty at the time of placement which of its foster children will engage in assaultive behavior or those children who will be sexual perpetrators”). See also *id.* at 443.

88. *Doe III*, 242 F.3d at 451.

89. *Id.*

sphere presented monitoring difficulties and "involve[d] more intimate contact than would ordinarily take place in the public sphere," but such distinctions from the public sphere did not warrant a blanket policy.⁹⁰ Where an individualized risk analysis, as performed in the present case, indicated "tender-aged and disabled foster children who, by their inherent physical limitations, face negligible risk from an HIV-positive child such as Adam," factors such as lack of monitoring and propensity for intimate contact have "no material effect."⁹¹ Therefore, because "a reasonable fact finder could find that placement of at least some foster children in the Does' home would not entail a significant risk of harm,"⁹² the Third Circuit reversed the lower court's decision granting summary judgment against the Does' claims of disability discrimination and remanded the case for further discovery and factual findings.⁹³

Doe v. County of Centre is a sound decision. The Third Circuit based its rationale on a careful and intelligent application of the Supreme Court precedent set by *Arline* and *Bragdon* to the novel issue of foster child placement in households with an HIV-positive member. Based on the determination that not all foster children presented a significant risk, the court adopted an individualized inquiry and resisted a blanket policy that would discriminate against persons with serious infectious diseases.⁹⁴ After noting that the risk of transmission through casual contact is negligible, the court reasoned that tender-aged and disabled foster children were unlikely to sexually assault Adam⁹⁵ and that Adam himself was in no condition to be the perpetrator of a sexual assault.⁹⁶

In response to the County's argument that a broad policy is appropriate in the context of a devastating and incurable disease such as AIDS,⁹⁷ the court noted that some federal appellate courts had applied the ADA direct threat

90. *Id.*

91. *Id.* The court noted the testimony of a physician that "out of the 21,000 AIDS cases in Pennsylvania, there are no reported cases of virus transmission due to familial contact or fighting. Even intense physical activities create little risk of infection." *Id.* at 442. See *supra* note 60 (citing cases that agree that transmission of AIDS through ordinary household contact is very low). See also *Doe III*, 242 F.3d at 442 (noting that "Adam has not transmitted HIV to his brother, . . . nor to any children with whom he attends school").

92. *Doe III*, 242 F.3d at 441.

93. *Id.* at 458.

94. *Id.* at 451-52. See also *infra* notes 95-96 and accompanying text (describing the Third Circuit's argument against the County's blanket discriminatory policy).

95. *Doe III*, 242 F.3d at 449-50. See, e.g., *id.* at 449 ("Foster children of tender age . . . are extremely unlikely to commit forcible sexual inter course [sic] leading to the transmission of HIV.").

96. *Doe III*, 242 F.3d at 449-50.

97. See STEIN, *supra* note 9, at 77-78 (describing the state's responsibility to children in foster care).

exception because “any amount of risk through a ‘specific and theoretically sound means of transmission’ constitutes a significant risk.”⁹⁸ However, the court also found that other appellate courts required “some actual risk of transmission including documented cases.”⁹⁹ Agreeing with the latter courts, the Third Circuit interpreted the direct threat exception narrowly. Given the method of transmission of the infectious disease and the nature of the parties (i.e., Adam, who as an invalid relied on the assistance of others for basic care, and foster children who could potentially be tender-aged and/or disabled¹⁰⁰), the court found that a reasonable fact finder could not find, based on the record, “that an individual with HIV would *always* pose a significant risk to a foster child placed by the County in that individual’s home.”¹⁰¹ Therefore, although transmission of HIV was theoretically

98. *Doe III*, 242 F.3d at 450 (citing *Onishea v. Hopper*, 171 F.3d 1289, 1297-99 (11th Cir. 1999), which held that HIV-infected prisoners may be segregated from the general inmate population). Other courts have held that even a remote chance of transmission may be sufficient to justify discrimination based on HIV infection. *See* *Estate of Mauro v. Borgess Med. Ctr.*, 137 F.3d 398, 405, 407 (6th Cir. 1998) (upholding judgment against HIV-positive surgical technician despite a 1 in 42,000 to 1 in 420,000 chance of transmission during surgery); *Doe v. Univ. of Md. Med. Sys. Corp.*, 50 F.3d 1261, 1265-66 (4th Cir. 1995) (holding that a “minimal but . . . ascertainable” risk of transmission invoked the direct threat exception); *Bradley v. Univ. of Tex. M.D. Anderson Cancer Ctr.*, 3 F.3d 922, 924 (5th Cir. 1993) (per curiam) (“While the risk is small, it is not so low as to nullify the catastrophic consequences of an accident.”).

99. *Doe III*, 242 F.3d at 450. *See also* *Abbott v. Bragdon*, 163 F.3d 87, 90 (1st Cir. 1998) (holding that there was insufficient evidence to prove a significant risk of transmission); *Chalk v. United States Dist. Ct. Cent. Dist. of Cal.*, 840 F.2d 701, 711 (9th Cir. 1988) (concluding that “there is no evidence of any significant risk to children or others at the school . . . [and] [t]o allow the court to base its decision on the fear and apprehension of others would frustrate the goals of section 504 [of the Rehabilitation Act]”). In *Bragdon v. Abbott*, the petitioner claimed that

the use of high-speed drills and surface cooling with water created a risk of airborne HIV transmission [But the petitioner’s] expert witness conceded . . . that no evidence suggested the spray could transmit HIV. His opinion on airborne risk was based on the absence of contrary evidence, not on positive data. Scientific evidence and expert testimony must have a traceable, analytical basis in objective fact before it may be considered on summary judgment.

Bragdon v. Abbott, 524 U.S. 624, 653 (1998) (citation omitted).

100. No doubt one of the reasons why the court focused on tender-aged and disabled foster children in its counterargument against the generalized CYS policy is the fact that seven of the Doe’s adopted children were former foster children. Two of the children were adopted as infants, two had disabilities, and “[o]thers had been physically and sexually abused.” *Doe III*, 242 F.3d at 441. It is likely that the court foresaw the placement of similarly tender-aged and disabled foster children into the Doe family. *See id.* at 449 (“The Does have stated a preference for foster children under the age of 12.”). However, the court cautioned that although it “used tender-aged and disabled foster children to illustrate the shortcomings of the County’s policy, [the court’s] holding does not foreclose the possibility of placing other foster children with the Does, so long as there is no significant risk.” *Id.* at 452. The strict application of the direct threat exception under *Doe v. County of Centre* does not preclude, for example, the assignment of foster children who have other infectious diseases that are not transmitted through casual contact. For example, the hepatitis B virus is a serious infectious disease that attacks the liver. Like HIV, it is transmitted through tainted blood transfusions, intravenous drug use, and sexual contact. ANDREOLI ET AL., *supra* note 12, at 329-30.

101. *Doe III*, 242 F.3d at 451 (emphasis added).

possible, the court found that a reasonable fact finder would deem the possibility to be a “remote and speculative risk that is insufficient for a finding of significant risk, and insufficient for the invocation of the direct threat exception.”¹⁰²

The Third Circuit’s rationale necessarily invoked the public policy of supporting the state interest in the placement of foster children. The court was careful to acknowledge the County’s obligation to protect the safety of its charges by exploring existing policy. Although the court failed to find any policy that addressed the issue directly, it relied on a prohibition by the Philadelphia Department of Human Services barring discrimination against foster parents based on actual or perceived HIV/AIDS status.¹⁰³ Through its Office of Children and Youth Services, the County operated “under a statutory duty to investigate foster parent applicants in order to preserve the physical and emotional health of foster children.”¹⁰⁴ In light of the negligible risk of HIV transmission, the Third Circuit determined that the County’s investigation lacked the individualization necessary to avoid the discriminatory effect of a general policy.¹⁰⁵

The Third Circuit’s balancing of state and individual interests begs the question of whether the court’s conclusion is a fair result. Did the court sacrifice public welfare for the sake of political correctness? There is ample evidence that the court did not overcompensate for societal sensitivity to HIV/AIDS by an overly narrow interpretation of the direct threat exception to the ADA and Rehabilitation Act. Instead, the court made the rational determination that within the facts of *Doe v. County of Centre*, public welfare would not be endangered and was hardly implicated, given the private nature of the insignificant risk presented.

102. *Id.* at 450.

103. *Id.* at 444 (citing CHILDREN & YOUTH DIV., PHILA. DEP’T HUM. SERVICES, POLICY MANUAL §§ 1010, 5200 (“The Department . . . does not discriminate in . . . its recruitment or development of kinship caregivers, foster parents, adoptive parents, and contracted providers on the basis of . . . [their] living or [being] perceived as living with HIV/AIDS.”)).

104. *Doe III*, 242 F.3d at 443. *See* 23 PA. CONS. STAT. ANN. § 6344(d)(2) (1991 & Supp. 2001) (requiring foster family care agencies to require prospective foster parents to submit information relating to criminal history and child abuse). *See also, e.g.*, ALASKA STAT. § 47.14.100 (Michie 2000); GA. CODE ANN. § 49-5-8 (1998); IDAHO CODE § 16-1623 (Michie 2001); 20 ILL. COMP. STAT. 505/5 (2000), *amended by* Act of July 25, 2001, 2001 Ill. Legis. Serv. P.A. 92-154 (West); MONT. CODE ANN. § 52-2-603 (2001); N.Y. SOC. SERV. LAW § 384-b (Consol. 1994 & Supp. 2001); N.D. CENT. CODE § 50-06-05.1 (1999); OHIO REV. CODE ANN. § 5103.03 (Anderson 2000); PA. STAT. ANN. tit. 62, § 2175 (West 1996); S.C. CODE ANN. § 43-5-590 (Law. Co-op. Supp. 2000). *See generally* Abigail English, *The HIV/AIDS Epidemic and the Child Welfare System: Protecting the Rights of Infants, Young Children, and Adolescents*, 77 IOWA L. REV. 1509 (1992) (examining the obligations of child welfare agencies in the context of HIV/AIDS).

105. *See, e.g., Doe III*, 242 F.3d at 451.

IV. CONCLUSION

The Third Circuit's narrow, individualized application of the direct threat exception to the ADA and Rehabilitation Act furthers the efforts of previous courts to eliminate the remaining vestiges of society's bias against HIV-positive individuals and irrational fear of contagion.¹⁰⁶ Individualized inquiries enable courts to strike a fair balance between a series of competing interests. In *Doe v. County of Centre*, the Third Circuit managed to balance the State's interest in protecting foster children, the interest of disabled individuals vulnerable to discriminatory procedure, and society's interest in public health and safety. As a body of specifics, law is a collaboration of theories culminating into policy. Courts cannot afford to abandon their gatekeeper role because, as this case demonstrates, constant scrutiny acts as a countermeasure against the discriminatory effects of errant public policy.

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106. See *Circuit Court Addresses Direct Threat Issue, Reverses HIV Foster Care Ban*, DISABILITY COMPLIANCE BULL., Mar. 23, 2001 ("The Lambda Legal Defense and Education Fund Ind., which filed an amicus brief on behalf of 13 AIDS, public health and child advocacy groups, said that the ruling 'advances science and rationality over fears about HIV.'").

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