

LEGAL RIGHTS OF STUDENTS WITH DIABETES UTAH STATE BAR ANNUAL MEETING - 2008

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WHAT HELP DO DIABETIC CHILDREN AND THEIR FAMILIES NEED FROM SCHOOLS?

These children and their families need diabetes care to continue at school as their doctors have taught them to do it at home. This involves calculating (or estimating) carbohydrate intake then balancing that intake against offsetting insulin injections. This process requires calculating an appropriate offsetting amount of insulin, injecting the insulin, and monitoring the results. These steps must be done several times per day. Type I diabetes management also involves knowing and applying appropriate corrective measures in the event these steps do not work as intended and blood sugar levels go too high or too low. I can't imagine a high school student who – absent a hypoglycemic emergency – wouldn't be capable of carrying out these management steps without assistance; but I can't imagine a kindergartener who would be able to accomplish that.

This paper reviews the rights/responsibilities of these families and their schools regarding diabetes management. This paper is written to apply specifically to Type I diabetes with its need for constant blood sugar readings, carbohydrate calculations and insulin injections, but the legal principles would also apply to a child with Type II diabetes. Type II differs from Type I primarily in that Type II involves an impaired ability to effectively use insulin rather than Type I's total inability to produce any insulin. Management of Type II may or may not involve insulin injections. Type II is rare in school-age children.

Young children need assistance from school personnel to carry out the tasks outlined above. As children become capable of taking responsibility for their own diabetes management, they need school personnel not to obstruct their ability to properly care for themselves (for example: they need school personnel not to take away their insulin or glucagon) and they need school personnel to be prepared to assist them in those hopefully rare instances such as a low blood sugar episode where they temporarily lose the ability to care for themselves. I think it's useful to divide the legal rights of these children and their families into those which would be used as part of a cooperative strategy; and those which would be used as part of coercive strategy. These strategies are not mutually exclusive. A strong showing of ability to claim accommodation under what I'm calling the coercive statutes will almost surely motivate cooperation.

A COOPERATIVE STRATEGY AND RIGHTS WHICH SUPPORT IT

School districts, school principals, school nurses and school teachers differ widely in willingness to help children manage their diabetes. Rationalizations heard from the less cooperative typically include fear of liability, fear of causing injury to a child, and an array of exaggerated or fabricated prohibitions along the lines of “the law prevents” – needles at school, drugs (if you label insulin a drug, it sounds scary) are not allowed in school, etc.

Utah has several statutes which nullify these concerns.

Section 53A-11-604 Utah Code says “A public school shall permit a student to possess and self-administer diabetes medication . . .” as long as the student's healthcare provider provides a written statement that it is medically appropriate for the student to possess self-administer the diabetes medication and the parents also acknowledge that the student is capable of possessing and self-administering diabetes medication.

Section 53A-11-601 provides that public or private schools (grades K through 12) may provide for administration of medication, by designated trained employees to any student during periods when the student is under control of the school subject to a written statement from the student's physician describing method, amount and time schedule for administering medication, together with a statement that administration of the medication by school employees during periods when the student is under the control of the school is medically necessary. Written request and authorization from a student's parent or guardian is also required. Section 53A-11-601 gives immunity from civil or criminal liability to school personnel who administer medication under the statute. The Good Samaritan statute also provides immunity.

Section 53A-11-603 establishes procedures for training volunteer school personnel in the administration of glucagon. Glucagon is a naturally occurring hormone which, when injected, is the best and fastest remedy for a low blood sugar emergency in which the victim loses brain function and consciousness. Think of glucagon as the Heimlich maneuver for this emergency. The statute provides that the school may not obstruct the identification or training of such volunteers. The statute requires public schools to permit a student or school personnel to possess or store prescribed glucagon so it will be available for administration in an emergency and authorizes trained volunteers to administer glucagon to students in the event they exhibit symptoms (low blood sugar) or warranting administration of glucagon. The statute provides civil and criminal immunity for school personnel who provide or receive training regarding glucagon injections.

Section 53A-11-603(9) expressly provides that physicians, nurses or pharmacists who in good faith train non-licensed volunteers to administer glucagon do not violate the unlawful or unprofessional conduct provisions of Title 58 Occupations and Professions.

Unfortunately, school nurses and their professional association responded to the 2006 enactment of the glucagon administration statute by trying to get the Division of Occupational Licensing to in effect nullify 53A-11-603(9) by enacting an administrative rule effectively prohibiting school nurses from providing this training. This effort was defeated and the recently proposed Rule 156-31b-701 Delegation of Nursing Tasks expressly provides that it is appropriate for nurses to provide training to unlicensed lay personnel in the routine scheduled or correction injection of insulin, whether by needle or by pump. The rule further provides that it is appropriate for nurses to provide training to non-medical personnel in the administration of glucagon in an emergency situation.

A COERCIVE STRATEGY AND ITS SUPPORTING LAW

Primary sources of coercive legal rights are The Americans With Disabilities Act (ADA) 42 U.S.C. § 12101-12213, Section 504 of The Rehabilitation Act (29 U.S.C. § 794) Individuals With Disabilities Education Act (IDEA) (21 U.S.C. § 1400-1487).

THE IDEA

The IDEA will probably be the least helpful of the three statutes unless the child in question has some other disability in addition to diabetes. IDEA requires states and school districts to provide special education and related services to certain categories of students with disabilities as a condition for receiving some federal funding. A student with Type I diabetes is not likely to need special education services. Students who are able to handle and benefit from a school's standard curriculum and classroom arrangements do not qualify for IDEA benefits. Attorneys should be aware that school personnel may be tempted to apply the IDEA ability to benefit coverage test to justify refusing to acknowledge the student's rights under ADA and Section 504. A school principal determined to make this mistake will look at a student's satisfactory report card, conclude the student is able to benefit from the school's standard

program, and conclude there is no need to consider the student's rights under ADA or Section 504.

ADA/SECTION 504

The Rehabilitation Act, including Section 504, is a 1973 statute widely acknowledged as the ADA predecessor. The Rehabilitation Act was passed in 1973, the ADA in 1990. Courts interpreting the ADA have consistently held that the ADA is virtually synonymous with The Rehabilitation Act. Both statutes state that schools may not deny a person who has a disability the opportunity to participate in or benefit from an aid, benefit or service afforded to non-disabled students. Students with disabilities must be given equal opportunity to participate in school programs or activities and must be provided reasonable modifications or accommodations necessary to allow that participation.

While attorneys will read Section 504 in the ADA as saying the same thing, Section 504 has a way of catching school bureaucrats attention. Section 504 applies to schools because they receive federal financial assistance and loss of federal funds is a potential 504 remedy. Even school bureaucrats who know little about how 504 or the ADA really work are reflexively conditioned to know there is something so powerful about 504, they cannot safely ignore a request from those who invoke its power. The school bureaucracy also has procedures in place to process "504" accommodation requests.

To invoke Section 504's power and make it stick, there is a threshold burden of proof – prove disability. Section 504 and the ADA apply only to individuals with a disability. This means disability under the statutory definition, which has received restrictive judicial interpretations. The same disability definition applies both in the employment and school context.

Toyota Motor Mfg. v. Williams, 534 U.S. 184, 293 (2002), requires proof of impairment substantially limiting one or more major life activities. This definition is to be interpreted strictly to create a demanding standard for qualifying as disabled. Toyota Motor, 534 U.S. at 197. To invoke coverage, a plaintiff must prove an impairment that prevents or severely restricts activities of central importance to most people's daily lives. Health conditions that cause moderate limitations on major life activities do not constitute ADA disabilities. Orr v. Wal-Mart Stores, 297 F.3d 720, 724 (8th Cir. 2002). (Mr. Orr was a Wal-Mart pharmacist with Type I diabetes.) Even where an impairment may cause pain and significant inconvenience, those facts are not sufficient to establish an ADA disability. Scheerer v. Potter, 443 F.3d 916, 920 (7th Cir. 2006). Plaintiff cannot rely solely on a medical diagnosis but must instead offer evidence, individualized to the plaintiff's life, establishing substantial limitation of major life activities. Albertsons Inc. v. Kirkingburg, 527 U.S. 555, 567 (1999). Mitigating measures such as insulin must be taken into account in determining disability. Sutton v. United Airlines, 527 U.S. 471 (1999).

This threshold proof issue confronts diabetic families with a tough choice. They and their children almost certainly want to believe the child can live a normal life despite diabetes. They want their children to see themselves as, and to be treated by other children as, healthy normal children. Unfortunately, a recalcitrant school or district will refuse to assist the child in the absence of proof that the child's life is substantially impaired. Help resolving this dilemma may be the most useful service attorneys can offer these families.

It is clear that merely stating that a child has been diagnosed with Type I diabetes will not meet the ADA/504 threshold standard. Reading cases on this issue has convinced me that

detailed knowledge of diabetes, combined with good medical evidence, combined with high-quality advocacy, is critical.

Although Type I diabetes is pretty consistent in how it affects its victims. The law has not yet reached a consistent understanding of when diabetes is covered by Section 504/ADA. In addition, in those instances where cases find diabetes is a disability, we cannot discern a consistent rule explaining why.

Some plaintiffs have successfully shown substantial limitation of the major life activity of eating. The leading cases are Lawson v. CSX Transportation, 245 F.3d 916 (7th Cir. 2001) and Fraser v. Goodale, 342 F.3d 1032 (9th Cir. 2003). Both cases rely on medical histories of serious trouble regulating blood sugar. Thus, a person with good blood sugar control and no instances of passing out from low blood sugar and no instances of requiring emergency treatment for the consequences of high blood sugar may face an argument that these cases are distinguishable. There is clearly a body of cases holding that people with well-controlled glucose levels have failed to prove substantial impairment of one or more major life activities.

Plaintiffs in Lawson and Fraser were adults. Young school children should have a much easier time meeting the threshold disability test. These children are not able to do the glucose metering, carbohydrate calculation, correction dose calculation (if necessary), insulin dose determination and insulin injection required to effectively manage their blood sugar levels. These cases, as they present in the school setting, involve a child who quite clearly cannot ingest, digest and use nutrition as other children do. If “eating” is taken to encompass this entire process, young school children would seem to have an easy time proving they are impaired in the major life activity of eating. (Note, however, the dissent in Fraser interprets eating to mean

putting food in the mouth, chewing and swallowing. That interpretation of “eating” would defeat the “eating” approach to establishing ADA/504 coverage.)

There is, however, good authority for establishing ADA/504 coverage for school-age children. As indicated above, the young Type I child presents at school with a disease which will prove fatal if the child eats food without injecting an appropriate offsetting amount of artificial insulin. It seems safe to assume that no court would hold that death does not substantially impair some major life activities. The young child’s case then hinges on whether insulin mitigates the effect of these impairments sufficiently to defeat ADA/504 coverage under the Sutton v. United Airlines holding. For the youngest school-age children, it will be easy to show they are incapable of carrying out the procedures and calculations required to safely use insulin. As demonstrated in the first part of this presentation, an improperly calculated insulin overdose quickly creates a serious danger.

Section 504 is enforced by The Department of Education’s Office for Civil Rights. After the Sutton decision, that office issued a document called Investigative Guidance: Consideration of “Mitigating Measures” in OCR Disabilities Cases, U.S. Department of Education Office for Civil Rights (September 29, 2000). These guidelines specify that mitigating measures, including insulin, may be taken into account in making the disability determination only where the student can use the mitigating measure independently in the school setting. If the resulting assessment shows the child is not able to mitigate diabetes independently, 504 coverage will almost certainly follow.

Any assistance provided by the school (whether voluntary or otherwise) goes on the scale in determining the issue of whether the school has provided reasonable and effective

accommodation, but may not be used by the school to defeat 504 coverage. Following this analysis, OCR commonly finds students with diabetes to be disabled.

The best example I've yet seen illustrating skillful advocacy and detailed knowledge of diabetes to establish ADA/Rehabilitation Act coverage even where the plaintiff had well-controlled blood sugar levels is Branham v. Snow, 392 F.3d 896 (7th Cir. 2004). Appellant's brief in that case is attached as Exhibit A. Note the full and careful development of how diabetes impacts the plaintiff. Note that these facts were pled in detail and were supported by medical evidence in the record. These attorneys succeeded in reversing the District Court's summary judgment ruling for the IRS.

Fiscus v. Wal-Mart, 385 F.3d 378 (3rd Cir. 2004) shows a distinctly different approach to proving disability. Plaintiff in Fiscus had kidney disease. The District Court granted summary judgment for Wal-Mart; the Third Circuit reversed. (Justice Alito, now of the U.S. Supreme Court, was on the Fiscus panel, as was Justice Michael Chertoff, now Secretary of Homeland Security).

Fiscus held that kidney disease was an impairment (it is well settled that diabetes is an impairment); Fiscus held that cleansing and eliminating waste from the blood was the impaired major life activity. (If cleansing and eliminating waste from the blood is a major life activity, then so is getting blood sugar into the body's cells to provide energy for all body functions—including thinking—and that's what Type I impairs.)

Fiscus reasons that Bragdon v. Abbot, 524 U.S. 624 (1998) rejects any dispositive difference between internal largely autonomous physical activities (like breathing) and external largely volitional activities. If Fiscus has read Bragdon correctly, then there is no need for the major life activity impairment to manifest itself in something visibly apparent. A Type I diabetes

diagnosis is not subjective—it's based on objective medical tests. I know of no case which has applied Fiscus' reasoning to diabetes, but its logic readily reaches diabetes. I would plead Fiscus as an alternate theory to establish disability.

WHAT HELP SHOULD SCHOOLS PROVIDE?

First and foremost, schools should not hinder or obstruct their students' diabetes management. That, unfortunately, needs to be said because some Utah schools and districts have taken actions which can only be described as obstruction. That said, these families' doctors will have taught them a set of procedures to be followed in their efforts to maintain the best possible control of blood sugar levels. The new Administrative Rule R156-31b-701 regarding delegation of nursing tasks in the school setting refers to those instructions as an Individual Health Plan (IHP), so let's use that terminology. The essential elements of an IHP should include:

1. Procedure for determining the number of grams of carbohydrate in each meal and in each significant snack;
2. Procedure and timing for testing blood sugar levels;
3. Identification of the type of insulin to be used (there are today at least four different types of insulin, each with a different speed);
4. The dose ratio, specific to the individual, specifying how many units of insulin are to be given to offset a given number of grams of carbohydrate intake;
5. Correction dosage, specific to the particular individual, specifying how many additional units of insulin are to be injected in the event a pre-meal/pre-snack reading is outside the desired blood sugar range for that patient;
6. Procedures to be followed in the event blood sugar readings remain above a specified level for long enough to require testing for the presence of ketones (example: test urine

for presence of ketones after two consecutive blood sugar readings at twice the upper limit of the desired range);

7. Instructions regarding preparation and injection of glucagon in a low blood sugar emergency.

The family will have been trained to follow these procedures. The family will work to get the diabetic student to be able to understand and carry out these actions. The family will want school personnel to agree to provide assistance necessary to help students carry out the steps in their individual health plan while at school.

The family and their counsel need to be sure they get a written IHP from their healthcare provider which specifies at least these details of the medical care plan the family and the healthcare provider have agreed on. Past experience indicates that in the event any aspect of the health plan is left open for interpretation, rather than being expressly spelled out, the school nurses will likely refuse to cooperate in training school personnel to help with that part of the plan.

The Americans With Disabilities Association makes a variety of very helpful materials available to help with this topic. For example, a publication from The U.S. Department of Health & Human Services: *Helping the Student With Diabetes Succeed—A Guide for School Personnel*. The ADA Website has an impressive selection of other helpful materials, but I want to mention one particularly impressive document. In October 2005, the ADA filed a class action lawsuit against the California Department of Education and two California school districts. Some 1,500 hours of pro bono lawyer time later, the California Department of Education capitulated. As part of the settlement, the California Department of Education signed off on and sent to every school district in the state a thorough and detailed statement of the legal rights of

school children with diabetes. The document reads as if it were a brief in support of a motion for summary judgment against the school districts prepared by lawyers representing kids with diabetes. The California Department of Education instructs its school districts on their responsibilities under both state and federal law. On certain key questions like nurse practice rules, it tells its school districts that the ADA and Section 504 trump restrictive state law provisions regarding school nurses power/duty to instruct non-medically trained school personnel in how to assist school children with their diabetes care. I cannot imagine a more powerful document with which to educate a recalcitrant school district. It is readily available on the ADA website.