IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

CASE NO. 00-14896-AA

SPENCER WADDELL

Appellant

-vs-

VALLEY FORGE DENTAL ASSOCIATES, INC. and MONARCH DENTAL ASSOCIATES

Appellee

BRIEF OF APPELLANT SPENCER WADDELL

ON APPEAL FROM THE
UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA

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STATEMENT REGARDING ORAL ARGUMENT

Appellant requests oral argument. This case presents the important question whether a functionally capable HIV positive dental hygienist, diligently employing effective infection control measures, can lawfully be dismissed from his job under the Americans With Disabilities Act ("ADA") and the Rehabilitation Act on the ground that he constitutes a "direct threat" to health and safety. Counsel is aware of no case in which this Court has addressed the "direct threat" defense in the context of health care provided by a person with HIV. The applicable law refers reviewing courts to objective medical evidence to determine whether health care workers in the appellant-plaintiff's position present a "significant risk" of HIV transmission. This brief and the briefs of *amici curiae* present that information in some detail, but oral argument would facilitate presentation of the relevant arguments and assist the Court by allowing counsel to focus on the panel's particular concerns.

CERTIFICATE OF TYPE SIZE AND STYLE

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STATEMENT OF JURISDICTION

Jurisdiction over this appeal lies under 28 U.S.C. § 1291. In this appeal from a final judgment granting summary judgment to the Defendant-Appellee and denying the cross-motion for summary judgment filed by the Plaintiff-Appellant, jurisdiction lies to enter an order directing that summary judgment be granted in favor of the appellant. *See* 28 U.S.C. § 2106; *Fabric v. Provident Life & Accident Insurance Co.*, 115 F.3d 908, 914-15 (11th Cir. 1997), *cert. denied*, 523 U.S. 1095 (1998).

Statement of the Issue

This case presents the following question:

Whether a dental hygienist with HIV, exhibiting no functional impairments and diligently adhering to standard infection control measures, is entitled to summary judgment in his employment discrimination action under the Americans With Disabilities Act and the Rehabilitation Act despite his former employer's contention that he poses a "direct threat," where extensive, unrebutted testimony from public health experts based on information available at the time of his firing proves that his clinical practice poses essentially no risk of HIV transmission to patients.

Statement of the Case

1. Course of Proceedings and Disposition Below

Appellant Spencer Waddell filed this action in the United States District Court for the Northern District of Georgia on January 28, 1999, seeking redress for employment discrimination under Title I of the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 *et seq.*, the Rehabilitation Act of 1973, 29 U.S.C. § *791 et seq.,* the Civil Rights Act of 1991, 42 U.S.C. § 1981A, the Georgia Equal Employment for the Disabled Code, O.C.G.A. § 34-6A-1 *et seq.*; O.C.G.A. 30-1-2;

and O.C.G.A. § 51-1-6 (R. 1)[1]. The parties filed cross-motions for summary judgment. In an order entered August 14, 2000, the District Court, Hon. Charles A. Pannell, Jr., denied the Plaintiff-Appellant's Motion for Summary Judgment and granted the Defendant-Appellee's Motion for Summary Judgment (R. 35). The appellant timely appealed (R. 37).

2. Statement of Facts

a. Background and sequence of events leading to Mr. Waddell's termination

Spencer Waddell is a dental hygienist, licensed by the State of Georgia and practicing in Atlanta (R. 19: Exh. 1 (Waddell Aff.), ¶3). He performs what dentists refer to as "routine prophylaxis" on patients' teeth (*Id.*, ¶8). In lay terms, Mr. Waddell "cleans teeth."

Mr. Waddell is a superior hygienist who has the requisite knowledge, skills, and experience to perform his work (R. 19: Exh. 2 (Reznik Aff.), ¶5-6). He has been actively involved with professional organizations related to dental hygiene and has served as an officer of such organizations on both the state and local levels

[1]References to the record consist of the document number as reflected in the docket sheet; further identifying information where necessary or helpful to the reader; and the page or paragraph number cited.

(R. 19: Exh. 1, ¶5).

Mr. Waddell was employed by Dr. Eugene Witkin on two occasions, the second of which, from the beginning of 1996 until October, 1997, was under the auspices of Valley Forge Dental Associates, Inc, which acquired Witkin's practice and retained him as a manager.[2] Witkin admits that he performed his job well (R. 16 (Witkin Dep.), 8-9).

Mr. Waddell consulted with a doctor in September 1997 for treatment of a sinus infection. The doctor recommended that Mr. Waddell undergo an HIV test, and Mr. Waddell agreed to do so. A few days later, the doctor informed him that the test results were positive (R. 34 (Waddell Dep.), 15). On the same day, the doctor called Dr. Witkin and told him that Mr. Waddell was HIV positive (R. 16 (Witkin Dep.), 24-25). Dr. Witkin, his assistant, Jill Whelchel, and others, put Mr. Waddell on leave with pay while they decided what to do (R. 16 (Whelchel Dep.), 33-36). Eventually they offered him an office position at half the pay he had been earning; the new post involved no clinical duties (R. 34 (Waddell Dep.), 128). Dr. Witkin fired him when he refused to accept this position (R. 4 (Answer), ¶3).

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[2]After Mr. Waddell was terminated, Valley Forge Dental Associates was acquired by Monarch Dental Associates, which exists today and is Valley Forge's successor-in-interest (R. 16 (Witkin Dep.), 5). For convenience the defendant-appellee is referred to as "Valley Forge" throughout this brief.

Dr. Witkin admits that he removed Mr. Waddell from his position as a dental hygienist solely because he is HIV positive (R. 16 (Witkin Dep.), 27, 39). He testified that he terminated Waddell's work as a hygienist because he believed there was "a risk" of HIV-transmission to patients (*Id.* at 39). Witkin also testified that he believed he would lose patients in his practice if they found out that Mr. Waddell had HIV. He believed that patients would discover Mr. Waddell's health status and that "99.9%" of them would abandon the practice. (*Id*. at 53; 88.)

Dr. Witkin admitted that he has no training concerning HIV transmission (*Id.* at 15-16). He has never attended any seminars devoted to discussion of HIV and its impact on dentistry (*Id.* at 16). He has taken no classes on infection control (*Id.*) He admitted that he is not an expert in infectious diseases (*Id.* at 17). He does not know the criteria for diagnosing AIDS or which part of the immune system is affected by HIV (*Id.* at 18-19). He is not familiar with the opportunistic illnesses associated with AIDS (*Id.* at 20-21). He even confessed to uncertainty as to whether HIV is transmitted through sweat (*Id.* at 22).

Despite his lack of information concerning HIV, when confronted with the knowledge that Mr. Waddell was HIV positive, Dr. Witkin did not consult with an infectious disease specialist for more information (*Id.* at 40). He did not even consider contacting Mr. Waddell's infectious disease doctor, even though Mr.

Waddell told him the name of his specialist (not the doctor who administered the HIV test) (*Id.* at 40, 59; R. 16 (Whelchel Dep.), 44). Asked what public health literature he reviewed, he said he looked at "some" articles, but was unable to name them (R. 16 (Witkin Dep.), 20, 29.) He testified that "somebody" contacted the Centers for Disease Control [hereinafter, "CDC"] and was told that there was "a risk" (*Id.* at 31-32.) He based his decision on this alone:

> Q.: That's what made it your decision is the CDC says there's a risk that we can't eliminate to zero so this is my decision?
>
> A.: Correct. I could not get beyond that. That was the overriding factor.

(*Id.* at 39.) Dr. Witkin did not assess the magnitude of the perceived risk. Rather, he said, "It's irrelevant to me whether it's great or small" (*Id.* at 43).

Witkin's "deliberations" did not take into account Mr. Waddell's safe and successful practice history (*Id.* at 7-9, 44, 52), or his superior interest and involvement in adherence to infection control measures (*Id.* at 37). Dr. Witkin testified that he was justified in removing Mr. Waddell from his position as long as any risk existed, even though routine dental practice tolerates a higher risk of patient fatality every time a dentist administers anesthesia. He acknowledged that no risk involved in treatment can be reduced to absolute zero (*Id.* at 79-80; 82.).

Dr. Witkin also admitted that Valley Forge does not require its workers to

undergo an HIV test, so it is possible that it may have other dentists or dental hygienists with HIV and not be aware of their infection (*Id.* at 46-47). Nor does Valley Forge require patients to undergo HIV tests, and thus it is "likely" that Valley Forge has treated numerous patients with HIV (*Id.* at 54). Yet Dr. Witkin has tolerated those risks as well (*Id.* at 54-55).

Since he was terminated by Valley Forge, Mr. Waddell obtained other employment as a dental hygienist with the Grady Oral Health Clinic in Atlanta. According to his supervisor there, Dr. David Reznick, Mr. Waddell performs his job as a hygienist very well (R. 19: Exh. 2 (Reznik Aff.), ¶4-5).

b. The nature of a dental hygienist's work, and the infinitesimal risk of HIV transmission by a dental hygienist.

It is undisputed that HIV is not easily transmissible. It is a fragile pathogen that requires a coincidence of numerous factors to cause transmission to an uninfected person. Consequently, even when documented modes of transmission (such as blood-to-blood contact) occur, HIV infection usually does not result. (R. 27: Exh. 2 (Marianos Aff.), ¶ 16(b)).[3]

[3]Because they are so frequently referenced throughout the brief, the affidavits filed by Mr. Waddell's experts, Drs. Joseph Wilber, John Molinari, and Donald Marianos are cited in short form, i.e., with their surname and a paragraph number. The full citations are (R. 19: Exh. 3 (Wilber Aff.)); (R. 19: Exh. 4 (Molinari Aff.); and (R. 27: Exh. 2 (Marianos Aff.)). The full citation for a supplemental affidavit by Dr. Marianos is (R. 27: Exh. 1 (Marianos. Aff.)), which

HIV transmission from health care workers to patients in any medical or dental setting has almost never occurred. A retrospective study of 22,171 patients whose HIV status was known and who received care from health care workers with HIV showed that not a single one of the patients was found to have been infected with HIV as a result of the medical or dental care they received. Robert et al, "Investigations of Patients of Health Care Workers Infected with HIV," 122 ANN. INTERNAL MED. 9:653 (May 1, 1995).[4] Significantly, the vast majority of

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is cited only occasionally herein, under the short form, "Marianos Supp. Aff.)."

[4]Dr. Marianos, one of Mr. Waddell's expert witnesses, helped to conduct this study, which is but one of many pointing to the safety of receiving care from HIV positive medical or dental workers (Marianos Aff., ¶ 16(c)). As Mr. Waddell pointed out in the district court (R. 19: 18 n.8), the many articles that were readily available to anyone seriously seeking risk information in 1997 included: Dickinson et al., Absence of HIV Transmission From an Infected Dentist to His Patients, 269 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION [hereinafter "JAMA"]1802 (April 14, 1993) (involving 1192 patients, 9267 procedures); Rogers et al., Investigation of Potential HIV Transmission to the Patients of an HIV-Infected Surgeon, 269 JAMA 1795 (April 14, 1993)(1131 patients); von Reyn et al., Absence of HIV Transmission from an Infected Orthopedic Surgeon: A 13-Year Look-Back Study, 269 JAMA 1807 (April 14, 1993)(1174 patients); Danila et al., A Look-Back Investigation of Patients of an HIV-Infected Physician: Public Health Implications, 325 NEW ENGLAND JOURNAL OF MEDICINE 1406 (November 14, 1991) (336 patients); York et al., Determining the HIV Status of Patients of Three HIV positive Navy Dentists, 124 JOURNAL OF THE AMERICAN DENTAL ASSOCIATION 74 (June, 1993)(2887 patients); and Mishu, et al., A Surgeon With AIDS: Lack of Evidence of Transmission to Patients, 264 JAMA 467 (July 25, 1990) (616 patients). Among the authors of these studies were numerous public health officials.

procedures performed on dental patients in the study were more invasive than routine prophylaxis as performed by dental hygienists. They included oral and periodontal surgery, root canals, restorations, and crown and bridge work (Marianos ¶16(c)).

There are *no* reports in the literature of HIV transmission from a dental hygienist to a patient. In fact, to date, and worldwide, the only apparent case of HIV transmission to dental patients remains that of a Florida dentist who is believed to have transmitted HIV to six persons.[5] The only other report of transmission from *any* health care worker to a patient involves a French orthopedic surgeon who is believed to have transmitted HIV to a single patient during extensive surgery (Marianos ¶ 16(h)).

The highly invasive work of surgeons and dentists creates an infinitesimally small risk of HIV transmission. The risk attending hygienists' work is even smaller. "Routine prophylaxis" involves the removal of deposits and accretions from the teeth, and non-surgical removal of deposits and accretions below the

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[5]Dr. David Acer was the dentist implicated in the infection of Kimberly Bergalis and five other patients. CDC investigators came to believe that Acer infected the patients but were never able to determine how the virus was transmitted. Even homicide remains a possibility, as does the failure to sterilize instruments between patients — a practice that is anathema to the infection control procedures Mr. Waddell observes (Molinari ¶4; Marianos ¶16(e)). *See* Mark Carl Rom, FATAL EXTRACTION 156-60 (Jossey-Bass 1997).

gumline. This is the type of care that one routinely receives on bi-annual dental cleaning visits. Such non-surgical care provided by hygienists is distinguished from the more invasive procedures dentists are authorized to perform, including root canals, extractions, fillings, and bridge work. In fact, in Georgia, dental hygienists cannot even administer injections (*Id.,* ¶6, 7).[6]

In this case, Mr. Waddell presented undisputed testimony from renowned experts in dentistry and infection control that the techniques he employs do not present any real danger of HIV transmission to his patients. Dr. Marianos[7] testified:

> For a hygienist with HIV to infect a patient, he or she would have to suffer an injury and then place a significant amount of his or her blood in direct

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[6]Mr. Waddell does not contend and has never contended that accidents do not occur in the workplace. He candidly admitted in his deposition that he once cut his finger while a patient was in the chair (R. 34 (Waddell Dep.) at 110-13). His hand was nowhere in the vicinity of the patient's mouth, however.

[7]Dr. Donald Marianos holds a Master of Public Health degree and a Doctor of Dental Surgery degree. He currently teaches dental hygiene at Northern Arizona University (Marianos ¶1). From 1989 to 1997, Dr. Marianos was a Captain in the United States Public Health Service at CDC in Atlanta, where he was Director of the Division of Oral Health. While serving at the CDC, Dr. Marianos provided technical assistance to international, federal, state and local health organizations in the area of infection control and infectious diseases in dentistry (*Id.*, ¶ 2). Dr. Marianos participated in the development of CDC's 1991 protocol concerning the management of HIV positive health care workers (R. 18: Exh. J), and has worked with the Scientific Committee of the American Dental Association to develop its policies on infection control and HIV (*Id.,* ¶ 3).

> contact with an open wound or a mucous membrane of the patient. [Because] Georgia dental hygienists do not administer injections, [] any needlestick injury a hygienist may suffer will not present an opportunity for blood-to-blood or blood-to-membrane contact. Moreover, in Georgia and elsewhere, dental hygienists' fingers and sharp instruments are rarely simultaneously in the oral cavity. Indeed, the accepted technique for performing routine prophylaxis involves resting the hand outside the mouth, balancing or "fulcruming" the hand so that the hygienist's instrument, but not his or her hand, can enter the oral cavity. Simply stated, one reason that hygienists' tools may look so intimidating is that they are designed to reach places where the hand cannot go.
>
> Routine prophylaxis, including scaling and root planing, may conjure up images of copious blood, and indeed bleeding – on the part of the patient, not the hygienist – is a common consequence of the gum manipulations that occur in the course of regular treatment. However, when one understands how dental hygienists actually perform their duties, and considers that HCW-to-patient transmission would require both a significant injury to the HCW, despite the presence of adequate barriers, and sufficient bleeding into an open wound or mucous membrane of the patient, and the introduction of a sufficient quantity of virus to overcome the patient's natural defenses, one begins to understand why HIV transmission (or, for that matter, hepatitis B or "HBV" transmission) has never been detected from a hygienist to a patient. With increased attention to universal precautions in the years since 1991, with twenty years to study HIV, and with only one dental provider, not a hygenist, believed to have transmitted the virus to patients, one can reasonably say that hygienist-to-patient transmission of HIV is so unlikely that it remains non-detectable and theoretical at most.

(Marianos ¶ 14, 15).

As Dr. Marianos's reference suggests, the use of "universal precautions" lowers the chance of HIV transmission, which is already infinitesimally small, even further. "Universal precautions" refers to a method of infection control in which all human blood and certain human body fluids are treated as if known to be

infectious for HIV and other bloodborne pathogens (Molinari ¶4). In the context of dentistry, universal precautions require the use of protective clothing (gowns); barrier techniques (gloves); handwashing and care of the hands; proper handling of sharp instruments and needles so as to eliminate the risk of injury; sterilization or disinfection of instruments; and other measures (*Id.*; Marianos ¶16(f)).

Dr. Molinari[8] testified about the efficacy of universal precautions in preventing transmission of HIV and other pathogens as follows:

> Universal precautions block transmission of blood-borne pathogens by, among other things, reducing the likelihood of percutaneous injuries and protecting against their consequences. . . . In addition to reducing the total number of percutaneous injuries, and therefore the total number of opportunities for disease transmission, universal precautions also reduce the risk of blood-to-blood contact when such injuries occur. In particular, the wearing of gloves for all procedures diminishes the risk that an accident will produce enough blood outside of the barrier to accomplish infection.

(Molinari ¶ 16, 17).

Accordingly:

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[8]Dr. John Molinari is currently the Chairman and Professor at the department of Biomedical Sciences at the University of Detroit Mercy School of Dentistry. He has served as a consultant to the American Dental Association Council on Dental Therapeutic and the CDC on infection control and dentistry, the development of universal precautions, and the prevention of transmission of blood-borne pathogens, including HIV, in health care settings. He was Co-Chair of the committee that developed the State of Michigan's guidelines for management of HIV-infected health care workers. He is the co-author of the textbook, *Practical Infection Control in Dentistry* (Lea & Febinger, 2d ed. 1996). (Molinari ¶1).

> HIV transmission from a dental hygienist to a patient is not scientifically inconceivable, but it is frankly difficult to imagine how, with universal precautions in place, an accident involving enough blood and sufficient patient exposure could occur. The risk is, at most theoretical, and exponentially lower than such accepted complications as adverse reaction to anesthesia or allergic reaction to penicillin.

(Marianos ¶16(g)).

Dr. Marianos further testified that "[t]ermination of clinical duty or restriction of practice, on the basis of HIV infection alone, does not comport with accepted public health practice today, nor did it comport with accepted public health practice in 1997" (Marianos ¶21). Dr. Molinari concurs:

> Taken together, the unanimity of the published studies, the characteristics of HIV, and the efficacy of universal precautions as an additional safeguard against the highly unlikely occurrence of HIV transmission to patients [by a dental hygienist], all militate against practice restrictions, not to mention mandatory termination of practice, for a HCW solely on the basis of his or her HIV infection.

(Molinari ¶ 21).

a. Public Health Agencies' Positions on Health Care Workers With HIV

In 1991, CDC issued a set of recommendations for management of health care workers with bloodborne diseases. "Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures," MORBIDITY & MORTALITY WEEKLY REPORT 1991: 40 (RR-8): 1-9 (hereinafter "1991 Recommendations") (R. 18: Exh.

J). One of its authors was Dr. Marianos, who testified, "It was obvious in 1991 that the vast majority of HCWs posed no risk of infecting their patients with HIV. However, because of the scientific and epidemiologic uncertainty we confronted at the time, the document did include a definition of 'exposure-prone procedures,' a term describing procedures that had been implicated in transmission of HBV [hepatitis B virus] — not HIV — despite adherence to universal precautions" (Marianos ¶17). CDC did not list these procedures, but defined the term generally:

> Characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the HCW's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the HCW, and--if such an injury occurs--the HCW's blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes.

(R. 18: Exh. J at 4; *see* Marianos ¶17).

CDC did not recommend termination of any health care worker's practice solely because of HIV infection.[9] Its recommendations called on all health care

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[9]Dr. Witkin insisted on summary judgment that he "primarily" considered the 1991 Recommendations before firing Mr. Waddell (R. 21: Exh. (Witkin Decl.), ¶2, 4). The document, however, recommends an approach wholly at odds with Witkin's reflexive action (R. 18: Exh. J). *See* Marianos Supp. Aff., ¶4-5: ("The assertion that CDC officials or employees would have advised a supervising dentist to limit the practice of, or to discharge, a dental hygienist solely because he or she was found to be HIV positive is wholly contradicted by CDC's actual position on the issue, as well as by accepted public health practice in 1997 and in

workers to use universal precautions and to know their own HIV and HBV status. The "exposure-prone procedure" designation served to distinguish those workers who could practice without intervention from those who could not: those performing such procedures were to appear before an expert review panel for an individualized determination as to whether and under what conditions he or she could continue to perform those procedures (R. 18: Exh. J at 5).

Guidelines issued by the Georgia Division of Public Health in 1993, to which Mr. Waddell's expert Dr. Wilber[10] was a contributor (Wilber ¶12), likewise rejected *per se* exclusions from clinical practice. In greater detail than CDC had provided, Georgia directed its expert review panels to consider a number of individualized factors such as infection control measures employed in his or her practice, the worker's infectious disease history, and measures the individual can

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the present day. . . . CDC has never advocated total removal of a functionally capable health care worker, using universal precautions, from clinical duties solely on account of HIV status. There is not now, nor was there in 1997, a perceived epidemiological basis for such an action").

[10]Dr. Joseph Wilber holds a Doctor of Medicine degree from Harvard Medical School. He is currently a Medical Consultant in Internal Medicine and HIV/AIDS for the Northwest Georgia Public Health District. (Wilber ¶1). From 1990 to 1994, Dr. Wilber was the Director of the Epidemiology Section of the Division of Public Health, Georgia Department of Human Resources. From 1991 to 1994 he was also Director of the Communicable Disease Branch of the Division of Public Health, Georgia Department of Human Resources (*Id.* ¶2).

employ to ensure avoidance of transmission (R. 25: Exh. A, 6). Like the expert review panel aspect of the federal Recommendations, Georgia's review panel procedure is not even triggered unless the infected health care worker performs exposure-prone procedures (*Id.*). After reviewing the Georgia guidelines, Dr. Marianos averred that they are "squarely within the mainstream of public health theory and practice concerning HIV positive [health care workers]" (Marianos ¶22).

Dr. Marianos – an originator of the "exposure-prone procedure" concept – testified that Mr. Waddell does not perform exposure-prone procedures. Because proper techniques do not require the hygienist to place his hands in the patient's mouth, and because the mouth is not "considered 'poorly visualized' or confined by a hygienist accustomed to working intraorally," Marianos at ¶14, both parts of CDC's definition of the term remain unsatisfied by the routine prophylaxis techniques that Mr. Waddell is licensed to perform (which do not include injections). Marianos ¶19.

Mr. Waddell's experts also emphasized that health care workers' ability to practice safely depends on their individual characteristics, not on the label attached to the procedures they perform. Dr. Molinari, for example, testified:

The practice of an infected HCW should be evaluated by his or her

> physician and modified only if there is clear evidence that the HCW poses a risk of transmitting HBV or HIV through an inability to meet basic infection control standards, personal medical conditions, evidence of previous transmission of blood-borne infections, or because the HCW is functionally unable to care for patients.

(Molinari ¶22). Dr. Wilber concurs:

> It is the HCW's overall functional capacity, and practice history, as well as his or her knowledge of and diligence in following universal precautions, that determines whether the HCW is capable of practicing safely. Categorical decisions, based on the nature of the HCW's duties or the procedures he or she performs, are inappropriate given the variable nature of the above factors and the complete ability of a competent, diligent HCW to practice without any threat of HIV transmission.

(Wilber ¶12).

The upshot of this authoritative evidence is that so long as a dental hygienist with HIV is functionally capable of performing his duties, and scrupulously adheres to universal precautions, the likelihood that he will transmit HIV to a patient is virtually nil. And there is no dispute in this case that Mr. Waddell is functionally capable of performing as a dental hygienist – in fact he presently provides dental hygiene services to patients of the Oral Health Center at Grady Hospital, where his supervisor rates his skills as superior (R. 19: Exh. 2 (Reznik Aff.), ¶4-5). Nor is there any dispute that Mr. Waddell scrupulously adheres to standard infection control practices. (R. 16 (Witkin Dep.), 35-37; R. 19: Exh. 2

(Reznick Aff.), ¶6; Marianos ¶9; Molinari ¶23;).

All three experts testified that Valley Forge's action was contrary to accepted public health practice (Marianos ¶27; Molinari ¶23; Wilber ¶13). Against this array of expert, objective scientific opinion that Mr. Waddell presented no real risk of HIV transmission as a dental hygienist, Valley Forge presented *no* admissible evidence that Mr. Waddell's practice presents more than an almost non-existent, purely theoretical risk of HIV transmission to patients.[11]

b. Standard of Review

This Court reviews the district court's grant of summary judgment *de novo,*

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[11]With its motion for summary judgment, Valley Forge filed an unsworn letter from a single Texas physician who neither met Mr. Waddell nor observed the infection control procedures used at his former workplace (R. 18: Exh. M (Letter of Richard L. Harris, M.D.)). The district court properly ruled the letter inadmissible because it was not sworn or notarized (R. 35-10). *See* Fed.R.Civ.P. 56(e); *Nissho-Iwai American Corp. v. Kline,* 845 F.2d 1300, 1306 (5th Cir. 1988); *cf. United States v. Four Parcels of Real Property*, 941 F.2d 1428, 1444 (11th Cir. 1991) (en banc) (acknowledging requirement that summary judgment affidavits be sworn or otherwise authenticated).

Harris's opinion lacked a "credible scientific basis for deviating from the accepted norm," *Bragdon*, 524 U.S. at 650, because it offers no principled rationale for finding significant risk contrary to the consensus of experts. Harris, who is not a dentist, based his conclusion on his general understanding of dental hygienists' duties. He never spoke to Mr. Waddell and apparently knows nothing about his skills, overall health, and infection control record. *Bragdon* reaffirmed the rule that "merely colorable or not significantly probative" evidence is insufficient to raise a genuine issue of fact. *Id*. at 653-54. This Court, like the district court, should refuse to consider the Harris letter.

applying the same standards as the district court. *Harris v. H & W Contracting Co.*, 102 F.3d 516, 518 (11th Cir.1996). Summary judgment is appropriate if the pleadings, depositions and affidavits show that no genuine issue of material fact exists for trial and that the moving party is entitled to judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). The Court must view all the evidence and all factual inferences reasonably drawn from the evidence in the light most favorable to the nonmoving party. *Hairston v. Gainesville Sun Pub. Co.*, 9 F.3d 913, 918 (11th Cir.1993). *See Stewart v. Happy Herman's Cheshire Bridge*, 117 F.3d 1278, 1284-85 (11th Cir. 1997)

Summary of Argument

In a case that the Supreme Court says must be governed by objective medical evidence, Mr. Waddell provided the only admissible objective medical evidence. In a context where the Court has insisted on judicial deference to experts in public health, the district court acknowledged the unequivocal and undisputed testimony of these experts but then second-guessed them. No genuine issue of material fact exists here. Mr. Waddell has shown that the risk posed by his practice as a licensed dental hygienist is so close to zero as to be unrecognizable. In twenty years, no one in his position has ever transmitted HIV in the course of working. Because of safe techniques, effective precautions, and professionally accepted protocols for

practice review, in all likelihood no one ever will. Though the record contains ample public health evidence in support of Mr. Waddell and an evidentiary vacuum on behalf of his former employer, the district court deemed him, a competent hygienist, to be a threat, and granted summary judgment to the wrong party. The court could do so only because it departed from the governing legal standard, reaffirmed recently in a case involving the dental office setting and HIV, *see Bragdon v. Abbott*, 524 U.S. 624 (1998), and imported an altered analysis of risk forged in a radically different factual context. *Cf. Onishea v. Hopper*, 171 F.3d 1289 (11th Cir. 1999) (*en banc*), *cert. denied sub nom. Davis v. Hopper*, 120 S. Ct. 931(2000).

Under settled precedent, judges must evaluate the "direct threat" defense to disability-based discrimination under a four-factor test. *Bragdon*, 524 U.S. at 649; *see School Bd. of Nassau Co. v. Arline*, 480 U.S. 273, 288 (1987). Where a transmissible condition such as HIV is concerned, "direct threat" means a "significant risk" of transmission, taking into account the means and duration of infection, the harm it can cause, and the chance that harm will occur. Evaluating these factors with accuracy requires recourse to science, and the Supreme Court has insisted on objective medical evidence to ensure that fears and stereotypes about contagiousness do not overwhelm the ADA's anti-discrimination mandate.

Aware of the factors the district court would be required to consider, and faced with a "direct threat" claim as Valley Forge's primary contention, Mr. Waddell established his ability to practice without a cognizable risk of transmission. He presented testimony from experts who are intimately familiar with the public health information that was available at the time he was fired. These experts, eminent in the fields of oral health, dental infection control, and HIV epidemiology, collectively showed that several important safeguards exist against hygienist-to-patient transmission of HIV. Among these are the techniques that hygienists perform, which avoid placement of the worker's hand in the patient's mouth, and the infection control measures that they employ, which have thwarted transmission of the similarly transmitted, but much more infectious, hepatitis B virus. Taken together, these measures markedly decrease the possibility of an accident in which blood-to-blood exchanges could occur between hygienist and patient, and reliably shield patients from blood quantities sufficient to pass the fragile HIV pathogen.

Because these measures are so effective, knowledgeable public health officials now and in 1997 rejected categorical exclusions of hygienists from continued practice solely because of HIV status. Not only the particular procedures that one performs, but the characteristics of the individual provider, including his

or her overall physical and mental acuity, diligence with infection control procedures, and skill and practice history, determine the risk of disease transmission in the course of dental care. Formal recommendations and guidelines, issued by the very agency that the *Bragdon* Court deemed authoritative and by the public health authority of the state where Mr. Waddell worked, convey the importance of individualized assessments and disavow termination or restriction of practice solely on the basis of HIV infection.

Confronted with Mr. Waddell's substantial showing, Valley Forge adduced no admissible evidence from any public health authority, and certainly no evidence probative enough to raise a dispute of material fact. Its decisionmaker, Dr. Witkin, conceded under oath that Mr. Waddell's job was doomed because the risk from HIV positive providers exceeded absolute zero – there was some, if only theoretical, risk. Nothing else about Mr. Waddell was investigated or even mattered.

The district court seized upon Mr. Waddell's use of sharp instruments, designating his technique "exposure-prone" even though the definition for that term of art is manifestly inapplicable. Once the "exposure-prone" label was affixed, despite the testimony of one of its originators that the label does not apply and despite the public health consensus that some health care workers with HIV

can safely perform those procedures, the district court proceeded without more to find a "significant risk" of transmission. Having miscategorized Mr. Waddell's work, the court found that accidents involving exchanges of blood were not inconceivable in the course of patient care, and that nothing more was needed.

This analysis erroneously merged two parts of the four-part governing standard by finding that any risk, if it could lead to death, was "significant." It improperly adopted an aspect of *Onishea* that should not be carried over to the pristine setting of the dental office. In *Onishea*, the trier of fact had found unprotected anal sex and the sharing of needles by intravenous drug users to be "abound[ing]" and unpreventable. These clear modes of transmission, not merely "any risk," led to the "significant risk" holding in the prison setting. Here, the district court's resolution of the "significant risk" issue was erroneous as a matter of law. Reviewing the record *de novo*, this Court should hold that *Bragdon* sets forth the standard governing this case and that any vanishingly small risk posed by Mr. Waddell's practice falls far short of "significance" under the ADA.

Argument and Citations of Authority

BECAUSE THE RECORD IN THIS CASE, EVALUATED UNDER PROPER LEGAL STANDARDS, FORECLOSES VALLEY FORGE'S CLAIM THAT MR. WADDELL'S PRACTICE POSES A "SIGNIFICANT RISK" OF HIV TRANSMISSION, MR. WADDELL, AND NOT VALLEY

FORGE, SHOULD RECEIVE SUMMARY JUDGMENT

"The isolation of the chronically ill and of those perceived to be ill or contagious appears across cultures and centuries, as does the development of complex and often pernicious mythologies about the nature, cause, and transmission of illness." *School Bd. of Nassau Co. v. Arline*, 480 U.S. 273, 284 n.12 (1987). Perhaps because it is easier to identify and criticize past overreactions to disease than to recognize them in the modern day, the pernicious myths that Justice Brennan described in *Arline* persist. They have cost the appellant, Spencer Waddell, his job. HIV is mysterious, and therefore frightening, to many. When Congress passed the ADA, however, it decreed that employment decisions cannot rest on fear. The Supreme Court, likewise, has insisted that science be the yardstick for evaluating claims of contagiousness. The person who made the firing decision in this case knew little about HIV and did not bother to learn. He admitted facts showing that his decision was a fearful reaction, not a science-based judgment. As such, it violated the ADA.

Congress and the Supreme Court have rejected the "zero tolerance" approach to risk that Valley Forge employed here. Moreover, eminent public health experts have confidently explained that dental hygienists employing infection control measures and lacking functional impairments do not transmit HIV in the course of

their work. Because Mr. Waddell's clinical practice is safe, because the record allows no contrary conclusion, and because the lack of significant risk is the determinative issue in this case, the judgment must be reversed with directions to enter summary judgment for Mr. Waddell.[12]

A. This Case Turns on the Safety of Mr. Waddell's Practice

In order to prevail under the Americans With Disabilities Act and the Rehabilitation Act, Mr. Waddell must prove: (1) that he has a disability; (2) that he is qualified for the employment position he held; and (3) that he suffered adverse action because of his disability. 42 U.S.C. §12132; *Harris,* 102 F.3d at 519, 523-24; *see Sutton v. Lader*, 185 F.3d 1203, 1207 (11th Cir. 1999).[13] Valley Forge contended that Mr. Waddell is not disabled but failed to rebut his factual showing that HIV substantially limits him in several major life activities as the statutory

[12]Mr. Waddell's Motion was styled a Motion For Partial Summary Judgment because it sought a court determination of liability only, and not damages, from the district court (R. 18: 1 n. 1). After the district court granted summary judgment to Valley Forge on the "direct threat" issue, it held that 42 U.S.C. § 1981a has no independent significance, and it declined to exercise jurisdiction over Mr. Waddell's Georgia law claims (R. 35: 13-14). Mr. Waddell now seeks summary judgment on the issue of liability on all his federal causes of action.

[13]The standards for liability under these two statutes are the same. *Sutton*, 185 F.3d at 1207 n. 5. Section 504 of the Rehabilitation Act also requires that the defendant be a recipient of federal funds.

definitions require (R. 19: Exh. 1 (Waddell Aff.), ¶9).[14] Valley Forge admits that Mr. Waddell suffered adverse action on account of his HIV status (R. 4: ¶ 3; 16: Witkin Dep. at 27). The case turns, therefore, on whether he is qualified to perform the job he held. The parties agree that Mr. Waddell is generally qualified to work as a hygienist (R. 16: (Witkin Dep.) at 8-9; R. 19: Exh. 2 (Reznik Aff.), ¶ 5), so the dispositive issue is whether his clinical practice presents a "direct threat," that is,"a significant risk to the health or safety of others that cannot be eliminated through reasonable accommodation." 42 U.S.C. § 12111(3).

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[14]"A person who is infected with HIV is 'disabled' for purposes of the ADA, even if he has not developed AIDS." *Doe v. DeKalb County School Dist.,* 145 F.3d 1441, 1445 n.5 (11th Cir. 1999). The district court assumed without deciding that Mr. Waddell is disabled, acknowledging *Doe* but suggesting that a case-by-case inquiry rather than a *per se* rule is appropriate (R. 35:10). *See Sutton v. United Air Lines, Inc.*, 119 S. Ct. 2139, 2147 (1999). Whichever rule applies, Mr. Waddell is a person with a disability. He did not rely on *Doe* alone, but showed by affidavit that his HIV infection substantially limits him in one or more major life activities as required by the statutes (R. 19: Exh. A, ¶9). *See* 42 U.S.C. §12102(2) (ADA); 29 U.S.C. §706(8)(B) (Rehabilitation Act). Valley Forge did not rebut the factual allegations in his affidavit.

Had the *Bragdon* Court found it necessary to resolve the question, it would likely have held that HIV infection is a *per se* disability. On the same day that it issued *Sutton*, the Court in *Albertson's, Inc. v. Kirkingburg*, 119 S. Ct. 2162, 2169 (1999), spoke of the possibility that "some impairments may invariably cause a substantial limitation of a major life activity." In the same passage, the *Kirkingburg* Court cited *Bragdon*, calling to mind that case's detailed explication of the profound effects of HIV on the body, 524 U.S. at 634-37, and implying that HIV will be found to be substantially limiting in all cases. If, despite *Doe* and Mr. Waddell's undisputed evidence of disability, the Court believes that a genuine issue of fact exists on this element, it should reverse and remand the case for trial.

B. "Significant Risk" is a Legal Conclusion, Based on Objective Medical Evidence, About the Likelihood of Disease Transmission

The determination that a person presents a "significant risk" under the Americans With Disabilities Act and the Rehabilitation Act requires

> findings of fact, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk, (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.

Arline, 480 U.S. at 288; *see Bragdon v. Abbott*, 524 U.S. 624, 649 (1998) (affirming applicability of *Arline* standard to ADA case involving HIV transmission in dental setting). "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." *Id.* (citations omitted).[15] Because "the question under the statute is one of statistical likelihood," *id.* at 653, all four factors deserve meaningful weight. *See Arline*, 480 U.S. at 288-89 (lower court's failure to make finding on probability of transmission

[15] *See* S. Rep. No. 116, 101st Cong., 1st Sess. 23 at 27 (1989); H.R. Rep. No. 101-485, pt. 2 at 56 (1990), reprinted in 1990 U.S.C.C.A.N. 267, 338 (noting that "a speculative or remote risk" is insufficient to support a finding of a "significant risk"); *id*., pt. 3 at 46, reprinted in 1990 U.S.C.C.A.N. at 469 ("The plaintiff is not required to prove that he or she poses no risk"); *Chalk v. United States District Court,* 840 F.2d 701, 709 (9th Cir. 1988) (holding that it was error to require that every theoretical possibility of [HIV transmission] be disproved").

left "significant risk" issue unresolved, requiring remand). In this case, the parties agree that any risk of HIV transmission in the dental setting would arise from contact between Mr. Waddell's blood and an open wound or mucous membrane of a patient [factor (a)], and that HIV infection is indefinite given the current state of medical knowledge [factor (b)]. This case focuses, therefore, on factors (c) and (d) in the *Arline* calculus: the severity of the risk and the chance of transmission.

While "[t]he existence, or nonexistence, of a significant risk must be determined from the standpoint of the [decisionmaker]," the determination "must be based on medical or other objective evidence." *Bragdon*, 524 U.S. at 649. "As a health care professional, the [defendant dentist] had the duty to assess the risk of infection based on the objective, scientific information available to him and others in his profession. His belief that a significant risk existed, even if maintained in good faith, would not relieve him from liability." *Id.* What mattered was "whether [his] actions were reasonable in light of the available medical evidence." *Id.* And, said the Court, "[i]n assessing the reasonableness of [his] actions, the views of public health authorities, such as the U.S. Public Health Service, CDC, and the National Institutes of Health, are of special weight and authority." *Id*. at 650.

Having set these standards for evaluating claims of "significant risk," the *Bragdon* Court enforced the standards with rigor, issuing painstaking instructions

for the Court of Appeals to apply on remand. The public health policy statements and case studies submitted by the parties were to receive searching scrutiny. Even the defendant's evidence suggesting that seven dental workers may have suffered occupational exposure to HIV was held inconclusive on the "direct threat" question; indeed the Court expressed "doubt" that, "[s]tanding alone . . . it would meet the objective, scientific basis for finding a significant risk." *Bragdon*, 524 U.S. at 654. If proof of a risk that approximates zero were enough to establish a direct threat under the ADA, the Court would not have expressed these doubts, and the remand in *Bragdon* would have been superfluous.[16]

This Court has likewise recognized that the *Arline* test does not permit a finding of "significant risk" when the asserted danger is remote and speculative. Even *Onishea*, on which Valley Forge primarily relies and which we discuss *infra*, disclaims an "any risk" standard and holds that "speculative or fanciful" risks fail to establish "direct threat." 171 F.3d at 1299.[17] Over a decade ago, this Court

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[16]The few differences between this case and *Bragdon* are either irrelevant or helpful to Mr. Waddell. For example, *Bragdon* was brought under Title III of the ADA while this case arises under Title I; but the "direct threat" standard is the same. *Bragdon* involved an alleged risk of infection from patient to provider. This case presents the converse, but the experts' consensus is that the risk in this case is lower. Molinari ¶14.

[17]When courts enforcing legal protections for persons with transmissible diseases demand objective evidence of significant risk, they honor Congress's

enjoined a public school's segregation of a mentally retarded, HIV positive child from other children, holding the action unjustified where the transmission risk was merely theoretical. *Martinez v. School Bd. of Hillsborough County*, 861 F.2d 1502, 1506 (11th Cir. 1988). Outside a unique factual context where a district court found that conduct raising a cognizable transmission risk was "perpetually possible," *Onishea*, 171 F.3d at 1295, *Martinez* has consistently been followed, notably in employment cases involving HIV. *See Doe v. DeKalb Co. School Dist.*, 145 F.3d 1441, 1446 (11th Cir. 1998) (remanding for findings supporting district court's view that risk of transmission from HIV positive teacher to students, who had behavioral disorders, was remote); *E.E.O.C. v. Dolphin Cruise Line, Inc.*, 945 F. Supp. 1550, 1555 (S.D. Fla. 1996) (granting partial summary judgment for entertainer whose

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intent while protecting society. The science of public health fundamentally is focused on regulating risks, not by striving to eliminate remote or theoretical risks, but by using the best available scientific evidence to identify and mitigate those risks that are both serious and most likely to occur. *See* James G. Hodge, Jr., *Implementing Modern Public Health Goals Through Government: An Examination of New Federalism and Public Health Law*, 14 J. CONTEMP. H. L. & POLICY 93, 110 n.83 (1997). By focusing on risks that are objectively significant, sound public health policy substitutes rational risk assessment for the misunderstanding and fear that often distorts thinking about, and reaction to, infectious diseases and other risks posed by modern society. *See Onishea*, 171 F.3d at 1298 (Rehabilitation Act expressed Congressional intent to "uproot" unfounded fears and prejudices) (citing *Arline*, 480 U.S. at 285-87); *see also* Leonard H. Glantz et al., *Risky Business: Setting Public Health Policy for HIV-Infected Health Care Professionals*, 70 MILBANK QUARTERLY 43, 56-57 (1992).

contract for engagement on cruise ship was rescinded when his HIV status came to light).

Before *Bragdon* affirmed that minimal risks cannot satisfy the "direct threat" standard, several courts outside this Circuit addressed HIV positive health care workers' claims under the ADA. To the extent these cases permit findings of "significant risk" solely because of the gravity of the asserted harm, *Bragdon* undercuts their authority. They are distinguishable from this case, moreover, because each plaintiff's practice was found to include exposure-prone procedures unlike the techniques Mr. Waddell is licensed to perform. *See, e.g., Doe v. Univ. of Maryland Medical System Corp.*, 50 F.3d 1261 (4th Cir. 1995) (HIV+ neurosurgeon not "otherwise qualified" to perform job); *Bradley v. Univ. of Texas M.D. Anderson Cancer Ctr.*, 3 F.3d 922 (5th Cir. 1993), *cert. denied*, 510 U.S. 1119 (1994) (same re surgical technician); *Estate of Mauro v. Borgess Med. Center*; 137 F.3d 398 (6th Cir.) (surgical tech deemed to present significant risk to health and safety because he occasionally held back incised tissues to facilitate surgery), *cert. denied,* 525 U.S. 815 (1998); *Doe v. Washington University*, 780 F. Supp. 628 (E.D. Mo. 1991) (upholding dismissal of HIV+ student from dental school). Even if the *Bragdon* Court had never spoken, the contrast between the surgery, or oral surgery, these providers performed, and the far less intrusive procedures Mr. Waddell performs,

would counsel strongly against giving these cases controlling weight here.[18] That *Bragdon* later analyzed HIV transmission risks in the health care setting, in a manner inconsistent with these cases, further diminishes their value.

C. Mr. Waddell Must Prevail Because, Based on Evidence Admitting No Genuine Factual Dispute, He Poses No Significant Risk

Applying *Arline* and *Bragdon* to the evidence in this case exposes an erroneous grant of summary judgment to Valley Forge and, in fact, shows why Mr. Waddell should have been granted that relief.

The Court should not only reverse the district court's judgment, but should also direct entry of summary judgment for Mr. Waddell as to liability. Evidence that is "merely colorable or not significantly probative," *Stewart*, 117 F.3d at 1285 (citing *Anderson*, 477 U.S. at 249), does not suffice to defeat a motion for summary judgment.[19] Apart from Dr. Witkin's deposition testimony conceding that

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[18]Counsel believes that this is the first post-*Bragdon* case in which a health care worker plaintiff is confronting "direct threat" allegations. The Fourth Circuit has upheld the exclusion of an HIV positive child from a karate class in 1999, employing analysis similar to that in *Onishea*. But again, the case arose in a setting where the district court had characterized blood-to-blood exchanges as "extremely likely." *See Montalvo v. Radcliffe*, 167 F.3d 873, 877-78 (4th Cir.), *cert. denied*, 120 S. Ct. 48 (1999).

[19]The Supreme Court has cited this established principle in the course of reviewing an ADA defendant's "direct threat" contention. *Bragdon*, 524 U.S. at 653-54.

the existence of an indeterminate risk was all he needed to know, Valley Forge's response has consisted of the sort of mere allegations that fall far short of raising a genuine dispute of fact. *See Graham v. State Fam Mutual Ins. Co.,* 193 F.3d 1274, 1282 (11th Cir. 1999); *Stewart*, 117 F.3d at 1285. This Court should rule accordingly, for the evidence is that Mr. Waddell poses no threat.

Because patient bleeding during a routine dental checkup is a common experience, it seems plausible at first blush that a hygienist with HIV might pose a risk of transmission. An examination of competent hygienists' actual practice, however, reveals that the probability of HIV transmission – factor (d) in the *Arline* calculus – is so minuscule that courts must reject assertions of "significant risk" as a matter of law. HIV infection would be difficult to "accomplish" in the context of dental hygiene because of the techniques used and the near-zero probability of exposing enough blood to a patient's open wound or membranes.

While no one can say that hygienist-to-patient infection is utterly impossible, regardless of the hygienist's conduct, at some point it becomes wordplay rather than a fair description of the event's likelihood to insist that HIV transmission "can happen" in the course of a properly equipped hygienist's work. The chance of HIV transmission by Mr. Waddell, who is diligent in infection control and who shows no impairment of mental or physical function, is as low as the probability of any

bizarre occurrence that one can hypothesize.

"Diligence in infection control" and sound "mental and physical function," both prerequisites to safe clinical practice, are of course attributes of individuals. The public health agencies owed deference under *Bragdon* have protocols in place to ensure the continuing ability of HIV positive health care workers to practice. These guidelines allow restriction or termination of practice when a provider is functionally impaired but reject practice restrictions solely on the basis of infection. Their focus on individual attributes, rather than on broad classes of health care workers or modes of patient care, is a hallmark of accepted public health practice now, and was in 1997.[20] The persons who confirmed this under oath are Donald

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[20]It is also consistent with the mandate the ADA imposes on employers to conduct individualized assessments of their employees' qualifications. "Determining whether an individual poses a significant risk of substantial harm to others must be made on a case by case basis." Interpretive Guidance on Title I of the Americans With Disabilities Act, 29 C.F.R. pts. 900-1899 (App.), at 356 (1999). On the view that individualized determinations "lie[] at the heart of the ADA," courts have reversed grants of summary judgment to employers or prospective employers when the evidence has not reflected case-by-case consideration of the employee's ability. *See Holiday v. City of Chattanooga*, 206 F.3d 637, 645-46 (6th Cir. 2000) (reversing summary judgment for city in case of HIV positive police officer candidate who "failed" a required physical exam when reviewing physician indicated he was unfit for duty solely on basis of HIV); *Taylor v. Pathmark Stores*, 177 F.3d 180, 192-93 (3d Cir. 1999) (reversing summary judgment for employer on claim brought by employee with ankle injury incorrectly believed to bar continued work) ("[I]t is not reasonable for an employer to extrapolate from information provided by an employee based on stereotypes or fears about the disabled . . . . An employer with such a belief is

Marianos, who headed CDC's Oral Health Division and co-wrote that agency's recommendations on health care workers with HIV; Joseph Wilber, Marianos's state-level counterpart, who contributed to Georgia's cognate rules and personally supervised the state's investigations of health care workers with HIV; and John Molinari, an eminent microbiologist and consultant to the ADA, CDC, and others, who literally "wrote the book" on dental infection control. Required by *Bragdon* and *Arline* to meet these experts' objective opinions with a science-based response, Valley Forge has no answer.

1. Dental Hygiene Techniques and Infection Control Methods Thwart Transmission of Bloodborne Diseases

In twenty years of the epidemic, after millions of instances in which patients have received care, "[t]here are no reports whatsoever in the literature of HIV transmission from a dental hygienist" (R. 27: Exh. 2 (Marianos Aff.), ¶16(h)). Understanding why requires a grasp of the means by which HIV is transmitted and the extremely low probability that hygienists' procedures could accomplish transmission. In the district court Mr. Waddell showed that HIV is a "fragile

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failing to make an individualized determination, as the ADA requires . . . ."); *cf. LaChance v. Duffy's Draft House*, 146 F.3d 832, 836 (11th Cir. 1998) (employer assessed employee, "individually, rather than stereotypically"; summary judgment affirmed).

pathogen" that is not always transmitted even when infected material is exposed to the bloodstream or a mucous membrane (*id.,* ¶16(b); R. 19: Exh. 4 (Molinari Aff.), ¶12). Such exposures, moreover, do not occur during routine dental prophylaxis. Percutaneous (skin-piercing) injuries resulting in blood-to-blood contact theoretically provide opportunities for transmission, *id.*, ¶13, but there is no chance of infection unless the hygienist injures himself and then "place[s] a sufficient amount of blood in direct contact with a wound or membrane" (Marianos ¶14). Dr. Marianos explained that the accepted technique for performing "routine prophylaxis" requires that the worker's hand almost always remain outside the oral cavity, *id.*, so the conditions in which one might expect blood-to-blood contact virtually never arise. This is true of all competent dental hygienists, but Mr. Waddell and other Georgia hygienists bear even smaller risks because, unlike their colleagues in other states, they are not permitted to administer injections. *Id.* This limitation decreases the risk of needlestick injuries to the hygienist and, since he can handle needles only at a distance from the patient, eliminates the possibility that any patient would be affected if such injury occurred (*Id.*; Molinari ¶7). In sum, there is no "reasonably conceivable accident," Molinari ¶14, that could lead to HIV transmission in the course of Mr. Waddell's work. *See also* Marianos ¶ 14,

15.[21]

Responsible dental hygienists protect patients from exposure to bloodborne diseases not only through the manual techniques they employ, but also by observing infection control procedures. Dr. Witkin admitted that Mr. Waddell was especially conscientious with regard to infection control (R. 16 (Witkin Dep.) at 37). Describing the techniques used by competent hygienists, Dr. Molinari testified about the development of "universal" precautions, so called because their premise is that all persons should be treated as carriers of bloodborne disease. Molinari ¶4. Collectively, the precautions include protective attire, barrier techniques, protocols for disposal and disinfection of equipment and, most important, the use of gloves. *Id.*, ¶17.

Taken together, these precautions are highly effective. Molinari ¶16-17. The primary aim of dental infection control has been prevention of hepatitis B virus ("HBV") transmission, which is about 100 times as infectious as HIV. The two

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[21]Valley Forge's alarmist position below included references to an incident in which Mr. Waddell cut himself, trying to change an instrument tip that was not dislodging properly, while a patient was in the chair. It is, however, one thing to cite such accidents, and quite another to show how they could actually cause transmission despite the safeguards that are in place. Mr. Waddell's hand was not anywhere in the vicinity of the patient's mouth when he nicked himself; rather he had turned away from her. When the minor scratch he sustained bled slightly, he dismissed the patient and bandaged himself (R. 34 (Waddell Dep.), 110-13).

pathogens have the same modes of transmission, though, and public health knowledge about the effectiveness of universal precautions with respect to HIV is based on inferences drawn from HBV transmission rates. *Id.* at ¶5-6, 11. Universal precautions prevent disease transmission by 1) reducing the likelihood of percutaneous injuries from sharp instruments and 2) markedly diminishing the amount of blood to which a patient can be exposed if such an injury occurs. *Id.* at ¶16-17; *see* Marianos at ¶16(f). The results are tangible; the dental profession has experienced an observable decrease in injuries and has suffered not a single outbreak of transmissions of HBV – again, a much more infectious virus than HIV – since CDC highlighted the importance of universal precautions. *Id.* at ¶9, 16. Locally, during Dr. Wilber's tenure, routine monitoring by the Georgia Division of Public Health, which was aware that hundreds of health care workers in the state had AIDS, found no instances of HIV transmission to patients by providers employing universal precautions (R. 19: Exh. 3 (Wilber Aff.), ¶8, 9).

The consensus of the public health community is that the risk of HIV transmission from a patient to a provider – the risk at issue in *Bragdon*, where the Supreme Court insisted on a rigorous examination of risk, and where the HIV positive plaintiff prevailed – is greater than the risk at issue here, namely, provider-to-patient. Molinari at ¶14. Only six cases of *possible* HIV infection of dental

health care workers from patients have been reported in the course of the epidemic; this "dramatically low number . . . supports the view, held by the overwhelming majority of specialists in infectious disease, that the likelihood of infection of a *patient* during medical or dental care approaches zero when clinicians employ universal precautions." *Id.* at ¶15 (emphasis in original).

The correctness of the experts' judgment that infection of a patient by Mr. Waddell is "frankly difficult to imagine," Marianos at ¶16(g), and not "reasonably conceivable," Molinari at ¶14, becomes more and more evident as one considers each aspect of hygienists' clinical practice. To summarize: HIV transmission only infrequently results from an exposure; exposures could almost never occur anyway, because hygienists' techniques do not include placement of the hand inside the oral cavity; and universal precautions both reduce the risk of injury and insulate the patient from exposure in the unlikely event that an injury occurs. The "statistical likelihood," *Bragdon*, 524 U.S. at 653, of transmission diminishes to an imperceptible number as improbability is piled on improbability. Moreover, this conclusion is not supported merely by abstract calculations. It is consistent with the findings of the many studies, available in 1997, showing zero rates of infection among patients of HIV positive health care workers. *See, e.g.*, Robert et al, Investigations of Patients of Health Care Workers Infected with HIV," 122 ANN.

INTERNAL MED. No. 9:653 (May 1, 1995). Setting aside bizarre or fanciful scenarios, it is wholly within the bounds of commonplace language to say that dental hygienists will not transmit HIV to patients when they use universal precautions and suffer no functional impairments. Valley Forge produced no evidence to the contrary.

2. Public Health Authorities Agree That *Per Se* Practice Restrictions Are Unsound

The district court ignored the consensus of public health officials that existed at the time of Mr. Waddell's firing, which Mr. Waddell's expert affidavits set forth in detail. *Compare* Marianos at ¶21; R. 27: Exh. 1 (Marianos Supp. Aff.), *with* R. 35 (Judgment): 11-12. Simply stated, all three experts testified without contradiction that terminating one's clinical practice because of HIV infection alone did not comport with accepted public health practice in 1997 and does not comport with accepted practice today. Marianos at ¶21-22; Molinari at ¶22; Wilber at ¶12. Two of those experts, Marianos and Wilber, have headed the very federal and state public health offices that Witkin should have consulted.

Mr. Waddell's evidence shows that a health care worker's physical and mental ability and expertise, along with other individualized factors, determines whether his or her continued practice is safe. *See, e.g.*, Wilber at ¶12; Molinari at

¶22. Valley Forge failed to undertake any individualized analysis, but Mr. Waddell's affiants did not make the same error; they discussed with Mr. Waddell his health, training, skills, and infection control acumen before testifying that he should not have been removed from clinical practice. Wilber at ¶3, 13-14; Molinari at ¶3, 22-23. Dr. Marianos even viewed a videotape of Mr. Waddell performing prophylaxis and toured the office where he worked before rendering his opinion. Marianos at ¶5, 8-12, 27.

Obviously Mr. Waddell's experts assessed him in connection with this action, but the standards they used were easily discernible when Dr. Witkin fired him in 1997. CDC issued its Recommendations on the subject in 1991, and the State of Georgia released its Guidelines in 1993. Both were available to anyone willing to pick up the phone or head to the library.

CDC observed that the risk of HIV transmission from health care workers is extremely small (R. 18: Exh. J, 3-4), and affirmed the importance of universal precautions (*Id.* at 1-2). It found no basis for restricting workers' clinical practice solely on the basis of HIV infection (*Id.* at 5). The drafters of the Recommendations originated the concept of "exposure-prone procedures," referring to the techniques that had been implicated in the transmission of HBV, to distinguish the infected health care workers whose practices required no

intervention from those who should submit themselves to an expert review panel (*Id.)*. CDC did not list these procedures, but defined the term generally:

> Characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the HCW's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the HCW, and--if such an injury occurs--the HCW's blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes.

(*Id.* at 4; *see* R. 27: Exh. 2 (Marianos Aff.), ¶17).

Of critical importance, CDC did not say that HIV or HBV positive clinicians whose practice includes performance of these procedures should be terminated, or even that their practice should be automatically restricted. Rather, such a finding only triggered review by experts:

> HCWs who are infected with HIV or HBV (and are HBeAg positive) should not perform exposure-prone procedures unless they have sought counsel from an expert review panel and been advised under what circumstances, if any, they may continue to perform these procedures. Such circumstances would include notifying prospective patients of the HCW's seropositivity.

(R. 18: Exh. J at 5; *see* R. 27: Exh. 2 (Marianos Aff.), ¶18). Further, by recommending that expert review panels include the provider's personal physician, an infectious disease expert, and a specialist in the procedures performed by the subject worker, CDC strongly implied that the worker's personal characteristics

such as skill level and overall health would be highly relevant (R. 18: Exh. J at 5 n.*).

Dr. Marianos, who helped define the term, testified that Mr. Waddell's duties do not include performance of exposure-prone procedures (Marianos ¶14, 19). This is true despite the fact, which is obvious and which Valley Forge repeatedly emphasized below, that Mr. Waddell works with sharp instruments. It bears repeating that, *even if* he performed exposure-prone procedures, termination of Mr. Waddell's clinical practice would not have been justified under CDC's protocol; rather, an inquiry by Witkin would have led the agency to recommend that an expert review panel be convened to evaluate Mr. Waddell individually. But that is not the state of the record. Valley Forge expresses incredulity at Dr. Marianos's conclusion but offers no evidence to counter it. Its analysis, and the district court's, simply proceed from the assumption that exposure-prone procedures are at issue when they are not.

Georgia's Guidelines, issued in 1993, are even less restrictive than CDC's in that they hinge more explicitly on the infected health care worker's mental and physical acuity, adherence to universal precautions, and past record than on the list of procedures the worker performed. (R. 25: Exh. A-6). Like CDC, the Division of Public Health disavowed practice limitations based solely on the fact of infection

(*Id.*; *see* 19: Exh. 3 (Wilber Aff.), ¶12).[22] Far from referring to these guidelines or

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[22]It is helpful to understand the relationship between CDC's Recommendations and the state standards. First, CDC had sought the assistance of medical professional organizations in compiling lists of exposure-prone procedures for their respective specialties, but these bodies generally refused to validate the effort. They rejected the idea that lists of procedures, rather than a focus on the attributes of the person performing them, could predict the likelihood of HIV infection. *See* Lawrence O. Gostin, "A Proposed National Policy on Health Care Workers Living with HIV/AIDS and Other Blood-Borne Pathogens," 284 JAMA No. 15: 1965, 66 (October 18, 2000) [hereinafter "Gostin"]; 29 GOVERNMENT EMPLOYEE RELATIONS REPORT 1490 (BNA) (November 18, 1991); LESBIAN AND GAY LAW NOTES (November, 1991) at 76.

A 1991 statute conditioned Public Health Act funding on each state's adoption of the recommendations or their equivalent. Public Health and Welfare Act, P.L. 102-141, § 633, 42 U.S.C. § 300ee-2 (1991). Georgia was one of many states that, consistent with the views of professional organizations, departed from CDC's position by crafting policies more flexibly addressing HIV positive health care workers. These states' guidelines rebuffed the attempt to restrict health care workers' practices based on listed procedures, focusing instead on the diligence, skills, and experiences of the infected practitioner. *See, e.g.*, Molinari at ¶22 (describing Michigan guidelines he helped formulate). CDC implicitly conceded the validity of this approach, approving these states' policies as "equivalents" of its own Recommendations despite the decreased emphasis on so-called "exposure-prone procedures." Gostin at 1965-66; *see generally* DiMaggio, "State Regulations and the HIV-Positive Health Care Professional: A Response to a Problem That Does Not Exist," 19 AM. J. L. & MEDICINE 497 (1993).

The Presidential Advisory Council on HIV/AIDS recommended in 1995, and professional organizations soon agreed, that CDC's Recommendations should be modified to mitigate restrictions on health care workers with HIV because they were deemed arbitrary and conducive to discrimination in light of the remote risk of transmission. At this writing, CDC is considering modifications. Gostin at 1966. Given *Bragdon*'s focus on objective medical information, it is noteworthy that the district court interpreted the existing Recommendations too rigidly when the growing medical and public health consensus too that those Recommendations, even when correctly and more flexibly read, are too restrictive. Gostin, *supra*.

articulating a principled basis for evaluating Mr. Waddell differently, Dr. Witkin's assistant, with whom he consulted about the firing, admitted that she did not know the guidelines existed (R. 16 (Whelchel Dep.) at 46).

Under *Bragdon*, and in light of the importance of individualized assessments of health, skill, and diligence with infection control, this Court must not accept Valley Forge's insistence below that Dr. Witkin did all he was required to do (R. 21:16). Witkin was poorly equipped to evaluate transmission risks because he suffered from a surprising lack of basic information about HIV. And despite this deficit of knowledge, he took no steps to educate himself, declining, for example, to confer with an infectious disease expert as part of a "review panel" or otherwise. (R. 16: (Witkin Dep.) at 40.)

Witkin's failure to consider Mr. Waddell's fitness to work "individually, rather than stereotypically," *Lachance*, 146 F.3d at 836), does not present a close question. The evidence that he reacted solely to the perceived existence of a non-zero risk is unambiguous, and it comes from his own mouth; it was the "overriding factor"(R. 16 (Witkin Dep.) at 39; *see also id.* at 31-32.) He never attempted to quantify the risk because he pronounced it "irrelevant to me whether it's great or small." *Id.* at 43. Whatever Valley Forge's current claims might be about the articles Witkin supposedly read, his admissions reveal a knee-jerk decision wholly

at odds with the careful process that public health authorities would have recommended. The only thing "individualized" about his decision was that he singled out an individual with HIV for firing, despite his ability to practice safely.

D. *Onishea v. Hopper* Does Not Justify the Decision Below

Perhaps acknowledging the impossibility of rebutting Mr. Waddell's public health experts, Valley Forge relied on the proposition that persons with HIV present a direct threat to health and safety whenever there is a risk, however small, that they will transmit the virus. Under this view, even theoretical risks of fatality are "significant." The primary case on which Valley Forge relies in its attempt to support this view is *Onishea*. By its own terms, however, *Onishea*'s holding does not take Valley Forge where it wishes to go.

The plaintiffs in *Onishea*, HIV positive prisoners in Alabama, brought suit under §504 of the Rehabilitation Act to challenge their segregation from other inmates in "a host" of prison programs. Alabama defended on the ground that the prisoners posed a "direct threat" of transmission of HIV in the prison setting. 171 F.3d at 1293. The *en banc* Court sustained the segregation policy, holding that

> when transmitting a disease inevitably entails death, the evidence supports a finding of 'significant risk' if it shows both (1) that a certain event can occur and (2) that according to reliable medical opinion the event can transmit the disease. This is not an "any risk" standard; the asserted danger of transfer must be rooted in sound

> medical opinion and not be speculative or fanciful. But this is not a "somebody has to die first" standard, either; evidence of actual transmission of the fatal disease in the relevant context is not necessary to a finding of significant risk.

Id. at 1299.

Thus *Onishea,* like *Bragdon, see* 524 U.S. at 649, disavowed an "any risk" standard and emphasized that an "asserted danger" must rest on "sound" or "reliable" medical opinion to qualify as a significant risk. As just shown, however, the lopsided record before the district court establishes that sound, reliable medical opinion deems Mr. Waddell no danger at all. Whichever authoritative risk description one prefers – "non-detectable and theoretical at most," Marianos ¶15, "frankly difficult to imagine," *id.* at ¶16(g), "as close to zero as can be ascertained," Molinari ¶8, or "infinitesimal," *id.* at ¶20 – unrebutted evidence showed that fears of HIV transmission from Mr. Waddell to a patient are indeed "fanciful." 171 F.3d at 1299. In common parlance, he will not transmit the disease, because he employs universal precautions and exhibits functional competence. He does not contend that history's first transmission by a hygienist must occur before he can be fired on account of HIV. He only insists, consistent with *Bragdon*, that the ADA does not allow termination of his practice as a "safeguard" against a shadow of a chance of an accident.

Onishea's facts further illuminate its holding. After hearing evidence that "concededly high risk activity abounds in prison," including needle-sharing, anal sex, and bloody fights, *id*. at 1294, the district judge found that risky behavior is a "perpetual possibility" among inmates "and that prison life is inherently unpredictable." *Id*. at 1295. These findings served as the foundation for the Court's judgment that a significant risk of transmission existed in all the programs where segregation was challenged. *Id.* at 1299. The undisputed facts about Mr. Waddell's clinical environment and practice history present a starkly different picture, *see, e.g.*, Marianos ¶11-12 (describing tour of dental office); they could not be more different from a correctional setting in which numerous prisoners are housed, with no guarantees about their day-to-day conduct and too few staff to monitor them continuously. *See Onishea*, 171 F.3d at 1294.[23] Simply put, this case

[23]The unpredictability of prison life was a central theme in *Onishea* where this Court also affirmed the district judge's application of a legal standard according deference to correctional authorities. *See id.* at 1299-1301 (discussing *Turner v. Safley*, 482 U.S. 78 (1987)). The United States, commenting on the prisoners' petition for certiorari at the request of the Supreme Court, 120 S. Ct. 298 (1999), articulated the link between the prevalence of high-risk behavior and the need for judicial deference to prison authorities. "[T]the question does not concern the degree of deference that should be given to public health authorities in assessing the risks of certain kinds of behavior – the issue that underlay the analysis in [other "direct threat" cases]. [*Onishea*] presents instead the question whether behavior that is concededly high-risk is likely to occur if HIV positive and non-HIV positive prisoners are integrated in a number of prison programs. The answer to that question turns not on medical judgments about the risk inherent

cannot be "shoehorned" into *Onishea*'s rationale because it involves no risky activity. The *Onishea* opinion, at one point declaring that "death itself [from HIV disease] makes the risk 'significant'," 171 F.3d at 1297, seemed to erase *Arline*'s fourth factor, involving the probability of transmission, from its analysis, or to merge the magnitude of the harm with that factor. This approach opens the door for "any risk" to be labeled "significant," contrary to the Court's own admonition. *Id.* at 1299. Where risky behaviors are a "perpetual possibility," there may be little reason to question this condensed approach. In any other context, however, a four-factor approach in which each factor is distinct and meaningful – the approach reaffirmed in *Bragdon* – must continue to apply.

E. Summary Judgment for Mr. Waddell is Appropriate on This Record

The district court's faulty reasoning resides in a few passages in its opinion. First the court rewrote the definition of "exposure-prone procedure," and declared

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in certain behaviors, but on prison management judgments about the ability of prison authorities to control prisoners in various settings and programs" (Brief of United States as *Amicus Curiae* (R-25); Exh A, at 16). *See also id.* at 10: ("[T]he other ["direct threat"] cases . . . concern the evaluation of medical and scientific evidence that certain behavior (*e.g.,* the treatment of a patient by a doctor) poses a "significant risk" of transmission of the HIV virus [sic]. That issue is not directly presented in [*Onishea*], since the dispute [there] does not turn on medical or scientific evidence. Instead, [the prisoners'] claims turn on a practical evaluation of whether inmates are likely to engage in – or more to the point, can be prevented from engaging in – behavior that indisputably poses a substantial risk of transmission of the HIV virus").

the definition satisfied when the procedure involves sharp instruments:

> Mr. Waddell contends that because his hands are not simultaneously in the mouth of a patient at the same time as sharp instruments, the procedures he performs are not exposure-prone. Mr. Waddell, however, admits that he performs some procedures which entail the use of sharp instruments. The [CDC Recommendations] state[] that the "performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the health care worker, and – if such an injury occurs – the health care worker's blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes." [*See*] p.4. The court finds that the procedures performed by Mr. Waddell are exposure-prone because there is a risk that Mr. Waddell could suffer a percutaneous injury and his blood could contact any open wounds or exposed mucous membranes of the patient (R. 35: 11-12).

The court acknowledged, but discarded, the medical experts' undisputed evidence that Mr. Waddell's practice is not exposure-prone, using its own, lay interpretation of the term (R. 35:12). The court then leapt from its erroneous finding to the equally unfounded conclusion that Mr. Waddell presents a direct threat:

> The court finds that based on the objective medical evidence before it, there is a chance that Mr. Waddell could cut or prick himself and bleed into an open wound of a patient, and reliable medical opinions state that this event can transmit the disease. For these reasons, the court finds that Mr. Waddell, as employed as a dental hygienist, presents a significant risk to the patients of the defendants.

(R. 35:13) (citing *Onishea*, 171 F.3d at 1297).

Because the case turned on "direct threat," and because all the evidence

before the court showed that Mr. Waddell's clinical practice is safe, the judgment is erroneous as a matter of law. The district judge held an infinitesimal risk "significant" when it is not, erroneously applying *Onishea*'s legal standard and failing to adhere to the teachings of *Bragdon*. The proper remedy is not to remand the case for trial, but to grant summary judgment to Mr. Waddell. No disputes of material fact exist, and Valley Forge has defaulted entirely on its obligation to come forward with admissible evidence to support its contentions. *See Anderson v. Liberty Lobby, Inc.,* 477 U.S. 248, 249 (1986).[24]

The district court erroneously labeled Mr. Waddell's work "exposure-prone"

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[24]This Court has the power to direct entry of summary judgment for Mr. Waddell. The denial of his motion for summary judgment would not ordinarily be appealable, but "when an appeal from a denial of summary judgment is raised in tandem with an appeal of an order granting a cross-motion for summary judgment, [federal appellate courts] have jurisdiction to review the propriety of the denial of summary judgment by the district court." *Nazay v. Miller*, 949 F.2d 1323, 1328 (3d Cir. 1991). Where no factual disputes exist, this Court is free to make any appropriate disposition, including a grant of summary judgment to the appellant. *Id.; see Morgan Guaranty Trust Co. Martin*, 466 F.2d 593, 599-600 (7th Cir. 1972); 28 U.S.C. § 2106 (setting forth broad power of appellate courts to enter dispositional orders). In an appeal from an order granting summary judgment to one party, this Court has ordered entry of summary judgment for the other party despite that party's failure to move for such relief, noting that all the relevant facts were before the Court and that neither side had been denied the opportunity to develop its record on the dispositive issue. *Fabric v. Provident Life & Accident Insurance Co.*, 115 F.3d 908, 914-15 (11th Cir. 1997) (citing, *inter alia*, 6 MOORE'S FEDERAL PRACTICE ¶56.12; 10 Wright, Miller & Kane, FEDERAL PRACTICE & PROCEDURE § 2716 (2d ed. 1983)), *cert. denied*, 523 U.S. 1095 (1998).

because it used an incomplete definition of the term, not because there is any dispute of fact about the procedures he performs. (For the court, the mere fact that Mr. Waddell uses sharp instruments was enough to merit the "exposure-prone" label; R. 35:11-12). The erroneous designation is bound up with the court's failure to defer to the reasoned views of public health officials, a legal rather than a factual error; it poses no obstacle to a grant of summary judgment. Exercising *de novo* review, once the "exposure-prone" designation is cleared away, the wide gulf between Dr. Witkin's actions and the approach supported by the public health community comes into sharp relief. Valley Forge told Mr. Waddell he could not practice; but CDC and the State of Georgia recommend no restrictions whatsoever on health care workers whose jobs do not involve exposure-prone care.

Moreover, although the district court's analysis suggests otherwise, the "exposure-prone" issue does not decide this case. Dr. Marianos's testimony that Mr. Waddell's work does not fit CDC's definition only amplifies the larger point that his practice is safe when viewed in the light of objective science, and on that point, the evidence is "so one-sided that [Mr. Waddell] must prevail as a matter of law." *Graham*, 193 F.3d at 1282 (quoting *Anderson,* 477 U.S. at 251-52). On the other hand, a contrary finding would not require the court to declare Mr. Waddell's practice a "significant risk"; for public health authorities, whose expertise is

embodied in the CDC and State of Georgia guidelines, do not regard the "exposure-prone" designation as determinative of the larger issue of overall practice safety. The district court, choosing to adopt Valley Forge's protestations over Mr. Waddell's unimpeached evidence on this question and the larger ones behind it, granted summary judgment to the wrong litigant in this case.[25]

Conclusion

For the reasons stated herein, this Court should reverse the judgment of the district court and remand to that court with an order directing entry of summary judgment for Mr. Waddell on the issue of liability. In the alternative, should the Court find that a genuine issue of material fact exists, it should reverse the judgment and remand the case for trial.

Respectfully submitted this 29th day of November, 2000.

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[25]While the better view is that Mr. Waddell is entitled to summary judgment, this Court may believe that a genuine issue of material fact exists about whether the "exposure-prone" definition is satisfied. In that case, the district court's error lies in its violation of the hornbook rule that courts should not resolve factual disputes on summary judgment. *See Anderson*, 477 U.S. at 255; *Warrior Tombigbee Transportation Co., Inc. v. M/V Nan Fung*, 695 F.2d 1294, 1299 (11th Cir. 1983). If the Court sees the case in that light, it should remand the case for trial.

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