## QUESTIONS PRESENTED

1. Did the Court of Appeals err by holding, in conflict with other Circuits, that the "direct threat" defense to a discrimination claim under the Americans With Disabilities Act – which applies when a plaintiff with a disability poses a "significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation," 42 U.S.C. § 1211(3) – is established as a matter of law when there is even an immeasurably low and purely theoretical risk of an event occurring that could cause death?

2. Did the Court of Appeals err by holding, in conflict with other Circuits, that the plaintiff has the burden of disproving the "direct threat" defense as part of the plaintiff's *prima facie* case of discrimination under the American With Disabilities Act?

## PARTIES TO THE PROCEEDING

The parties to this proceeding are Spencer Waddell, Petitioner, and Valley Forge Dental Associates, Inc., Respondent.

Valley Forge Dental Associates was acquired by Monarch Dental Associates and is its successor-in-interest.

## TABLE OF CONTENTS

## TABLE OF AUTHORITIES

### CASES

**STATUTES**



**OTHER AUTHORITIES**

The Petitioner, Spencer Waddell, respectfully seeks a writ of certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit.

## OPINIONS BELOW

The unreported decision of the federal district court is *Waddell v. Valley Forge Dental Associates, Inc.*, 99-00262-CV-CAP-1 and is reprinted in the appendix. (App. A15). The opinion of the Eleventh Circuit Court of Appeals is *Waddell v. Valley Forge Dental Associates, Inc.*, 276 F.3d 1275 (11th Cir. 2001) and is reprinted in the Appendix. (App. A1).

## JURISDICTION

The Eleventh Circuit Court of Appeals entered its judgment on December 21, 2001. Jurisdiction is conferred upon this Court by 28 U.S.C. § 1254(1).

## STATUTORY PROVISIONS INVOLVED

42 U.S.C. § 12111 (3) provides:

> The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation.

42 U.S.C. § 12111 (8) provides in relevant part:

> The term "qualified individual with a disability" means an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that

such individual holds or desires.

42 U.S.C. § 12112 (b) provides in relevant part:

[T]he term "discriminate" includes –
(1) limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee because of the disability of such applicant or employee; ...
(3) utilizing standards, criteria, or methods of administration –

> (A) that have the effect of discrimination on the basis of disability;...

(6) using qualification standards, employment tests or other selection criteria that screen out or tend to screen out an individual with a disability or a class of individuals with disabilities unless the standard, test or other selection criteria, as used by the covered entity, is shown to be job-related for the position in question and is consistent with business necessity;...

42 U.S.C. § 12113 provides in relevant part:

**Defenses**
(a) In general
It may be a defense to a charge of discrimination under this Act that an alleged application of qualification standards, tests, or selection criteria that screen out or tend to screen out or otherwise deny a job or benefit to an individual with a disability has been shown to be job-related and consistent with

> business necessity, and such performance cannot be accomplished by reasonable accommodation, as required under this title.
> (b) Qualification standards
> The term "qualification standards" may include a requirement that an individual shall not pose a direct threat to the health or safety of other individuals in the workplace.

## STATEMENT OF THE CASE

The petition for *certiorari* seeks this Court's review of two issues of law that are central to the interpretation of the Americans With Disabilities Act: *first*, whether a near-zero, purely theoretical risk causing eventual death is sufficient as a matter of law to establish that an individual with a disability poses a "direct threat" to others; and *second*, whether a defendant in an ADA case bears the burden of proof for establishing that a plaintiff's disability poses a direct threat. The facts relevant to the resolution of these questions are set out below; the appeal sought, however, turns on issues of law and not issues of fact.

### A. Spencer Waddell's Termination

Dr. Eugene Witkin employed Spencer Waddell over several different periods from 1993 until 1997; between early 1996 and October, 1997, Mr. Waddell worked under the auspices of Valley Forge Dental Associates, Inc, which acquired Dr. Witkin's practice and retained him as a manager.[1] According to Dr. Witkin, Mr. Waddell performed

[1]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"

his job well. (R. 16 (Witkin Dep.), 8-9).

Mr. Waddell is licensed by the State of Georgia as a dental hygienist and performs routine prophylaxis on patients' teeth. (R. 19, Exh. 1 (Waddell Aff.), ¶¶3, 8). As distinguished from the type of care dentists provide, "routine prophylaxis" involves the removal of deposits and accretions below the gumline. (R. 19, Exh. 2 (Marianos Aff.), ¶¶13, 15). Dental hygienists licensed in Georgia do not administer injections. (*Id.,* ¶¶6,7).

In September 1997, Dr. Witkin learned that Mr. Waddell is HIV positive (R. 16 (Witkin Dep.), 24-25). Mr. Waddell was removed from patient care and offered a clerical position at half the pay he had been earning, then was fired when he refused to accept this position. (R. 16 (Whelchel Dep.), 33-36; R. 34 (Waddell Dep.), 128; R. 4 (Answer), ¶3). Dr. Witkin removed Mr. Waddell from his position as a dental hygienist solely because he is HIV positive. (R. 16 (Witkin Dep.), 27, 39). He feared that there was a risk of HIV-transmission to patients and that he would lose patients if they found out that Mr. Waddell has HIV. (R. 16, 24). Dr. Witkin confirmed that he "could not get beyond" his understanding that the risk of HIV transmission could not be eliminated to zero, and that it was "irrelevant" to him whether the actual risk was great or small. (R. 16 (Witkin Dep.), 31-32). [2]

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throughout this brief.

[2] Dr. Witkin has no training concerning HIV transmission, and has never attended any seminars devoted to discussion of HIV and its impact on dentistry or taken any classes on infection control. (R. 16 (Witkin Dep.), 16). He thinks it is possible that HIV is transmitted through sweat. (*Id.,* 22). Dr. Witkin claimed that he reviewed "some" journal articles, but was unable to describe them, (*Id.*) and that somebody at Valley Forge contacted the Centers for Disease Control and Prevention [hereinafter, "CDC"] and was told that there was "a risk" (*Id.* at 20, 29, 31-32.). Dr. Witkin also claimed that he relied on the CDC's 1991

B. The Expert Evidence

The objective, expert medical evidence in this case consisted of testimony that unanimously concluded that Mr. Waddell does not present any real danger of HIV transmission to his patients. Dr. Marianos[3,4] testified, for example, that:

> [D]ental hygienists' fingers and sharp instruments are rarely simultaneously in 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,

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guidelines on health care workers with HIV and hepatitis B.

[3] 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 the 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).

[4] 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.)); it is referred to herein as "Marianos Supp. Aff."

> 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 ... transmission would require both a significant injury to the health care worker, 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 ... has never been detected from a hygienist to a patient....[O]ne 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, 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. John Molinari[5] concurs:

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[5] 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,

> 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 [health care worker] solely on the basis of his or her HIV infection.

(Molinari ¶21).

It is undisputed that HIV, a fragile pathogen, is not easily transmissible and requires a coincidence of numerous factors to cause transmission. Consequently, even when exposures involving documented modes of transmission (such as blood-to-blood contact) occur, HIV infection usually does not result. There are *no* reports in the literature of HIV transmission from a dental hygienist to a patient.

In 1991, the 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. The CDC did not identify any specific procedures that are "exposure-prone,"

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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 R.19, Exh. 4 ¶1).

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).

The CDC did not recommend termination of any health care worker's practice solely because of HIV infection.[6] Under the CDC guidelines, those performing what the agency characterized as "exposure-prone" procedures should appear before an expert review panel for

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[6] Dr. Witkin insisted on summary judgment that he primarily considered the 1991 Recommendations before firing Mr. Waddell (R. 21, Exh. D (Witkin Decl.), ¶2, 4). The document, however, recommends an approach wholly at odds with Dr. 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 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").

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).[7]

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

> 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.

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[7] Guidelines issued by the Georgia Division of Public Health in 1993, to which Mr. Waddell's expert Dr. Wilber was a contributor (Wilber ¶12), likewise reject *per se* exclusions from clinical practice. 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 – emphasized 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 ¶14), both parts of CDC's definition of the term remain unsatisfied by the routine prophylaxis techniques that Mr. Waddell is licensed to perform. (Marianos ¶19).

(Wilber ¶12). *See also* Molinari ¶22.

There is no dispute in this case that Mr. Waddell is functionally capable of performing well as a dental hygienist. He currently 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 (Reznik 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).[8]

C. The Decisions Below

On the basis of the record described above, the district court ruled that "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 ... presents a significant risk to the patients of the defendants." (App. A26).

The Eleventh Circuit Court of Appeals affirmed. Under the standard which the Eleventh Circuit employed, Mr. Waddell poses a "direct threat" because "when

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[8] The American Dental Association, American Dental Hygienists' Association, Infectious Diseases Society of America, Association of State and Territorial Dental Directors, National Alliance of State and Territorial AIDS Directors, HIV Medicine Association of the Infectious Diseases Society of America, American Association of Public Health Dentistry, Organization for Safety and Asepsis Procedures, American Public Health Association, and Association of Schools of Public Health also concurred in two *amici curiae* briefs to the Eleventh Circuit Court of Appeals that a dental hygienist with HIV does not pose a significant risk of transmission when normal infection control procedures are in place.

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." (App. A7).

Acknowledging the experts' testimony that a hygienist's fingers and a sharp instrument are rarely simultaneously in a patient's mouth, the court observed that "Waddell still is unable to refute the assertion that an inadvertent bite or some other accident during a cleaning" might lead to events that could pose a risk of transmission. (App. A12-13). The court emphasized that "[n]one of Waddell's medical experts...appear to dispute that transmission theoretically could happen, even though the risk is small and such an event never before has occurred." (App. A12). The court concluded that "[t]his is enough to constitute a significant risk..., given that HIV has catastrophic effects and is inevitably fatal if transmitted to a patient." (App. A12).

## REASONS FOR GRANTING THE WRIT OF CERTIORARI

This case raises two important questions of federal law. The first is whether a vanishingly small, purely theoretical risk of serious harm, including eventual death, constitutes a "direct threat" as a matter of law under the Americans With Disabilities Act (ADA). The Eleventh Circuit's theoretical risk standard is in sharp conflict with this Court's decision in *Bragdon v. Abbott*, 524 U.S. 624, 649 (1998), a case involving a dentist's refusal to treat a patient with HIV, where this Court recognized the guiding principle that "few, if any, activities are risk-free" and consequently that the inquiry is not "whether a risk exists, but whether it is significant." The Eleventh Circuit's approach also conflicts with decisions of other Circuits and

threatens to extinguish protections against disability-based discrimination for any individual whose disability can be theorized to pose a serious harm to others.

The second question is whether a defendant who raises a "direct threat" defense in an ADA case has the burden of proof on that defense. The Eleventh Circuit's assignment of this burden to the plaintiff reflects a sharp disagreement among the Circuits. This issue merits the Court's resolution in view of its fundamental impact on what constitutes a *prima facie* case.

## I. This Court Should Grant Certiorari Because the Eleventh Circuit's Holding That As A Matter of Law An Almost Zero, Purely Theoretical Risk of Harm Resulting in Eventual Death Constitutes a Direct Threat Is in Conflict With Controlling Decisions of This Court.

The Eleventh Circuit Court of Appeals unequivocally held that, as a matter of law, any theoretically supportable theory of HIV transmission will support a "direct threat" finding under the ADA, no matter how minuscule the chance that transmission actually will occur. According to the Eleventh Circuit, "death itself makes the risk 'significant.'" 276 F.3d at 1281 (App. A7). The court's central holding finds no support in this Court's decisions.

The Americans With Disabilities Act ("ADA") provides a defense to a discrimination claim that an employee is a qualified individual with a disability when the plaintiff "pose[s] a direct threat to the health or safety of others." 42 U.S.C. § 12113(b) (Title I); 42 U.S.C. § 12182(b)(3) (Title III). The ADA defines "direct threat" in the workplace as "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation."

This Court first identified the appropriate standard

for determining when an individual with a disability poses a "significant risk" to others, *School Bd. of Nassau County v. Arline*, 480 U.S. 273 (1987), which requires:

> [findings of] facts, 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.

*Id.* at 288. The ADA's direct threat defense is based on the standard articulated in *Arline*. *Bragdon*, 524 U.S. 624, 649 (1998).

Aware of these factors, and faced with a "direct threat" claim as Valley Forge's primary contention, Mr. Waddell independently established that his HIV had no impact on his ability to clean teeth without a measurable, significant risk of harm to patients.[9] For reasons that mirror the expert testimony in this case, knowledgeable public health officials now and in 1997, when Mr. Waddell was terminated, also rejected categorical exclusions of hygienists from continued practice solely because of HIV status.

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[9] Mr. Waddell presented testimony from experts who are intimately familiar with the public health science and data that were 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 the nature of Mr. Waddell's practice, the rarity of transmission even in the event of an actual exposure, and the effective safeguards that exist virtually eliminate any theoretical risk of hygienist-to-patient transmission of HIV.

Nonetheless, the Eleventh Circuit failed to follow *Bragdon's* guidance and declined to rely on this "prevailing medical consensus," not because of "a credible scientific basis for deviating from the accepted norm," *Bragdon*, 524 U.S. at 650, but because of the failure of Mr. Waddell and his experts to prove that HIV transmission was impossible. Because "[n]one of Waddell's medical experts...appear to dispute that transmission theoretically could happen, even though the risk is small and such an event never before has occurred," the Eleventh Circuit stated, "[t]his is enough to constitute a significant risk...." 276 F.3d at 1283, (App. A12). This standard is in striking conflict with *Bragdon*, which reaffirmed that "*Arline* and the ADA do not ask whether a risk exists, but whether it is significant," and indicated that risk assessments were to be based not "on the absence of contrary evidence" but on "positive data." 524 U.S. at 649, 653.

Proper balancing of the elements of the ADA's direct threat defense contemplates that the statistical likelihood sufficient to establish a direct threat that a harm will occur will become smaller in inverse proportion to the seriousness of the harm that is risked. Nothing in the ADA or this Court's opinions, however, suggests that *any* risk of death greater than absolute zero constitutes a direct threat. Neither does the EEOC's definition of direct threat specify a particular type of risk that conclusively renders that risk significant or insignificant.[10] Removing statistical likelihood from the analysis when the harm is a potentially fatal infection is inconsistent with the four-element framework of the direct threat analysis. Indeed, the harm itself has to be "substantial" before there is even any basis to maintain the

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[10] *See* 29 C.F.R. § 1630.2(r)(discrimination is not permitted "merely because of a slightly increased risk. The risk can only be considered when it poses a significant risk, i.e., high probability of substantial harm; a speculative or remote risk is insufficient.").

analysis should proceed to all four elements. 29 C.F.R. § 1630(r). The standard applied in this case marks a result-altering departure from the standard for determining direct threat developed by this Court.

Evaluating the elements of a direct threat defense with accuracy requires recourse to science, and this Court has insisted on objective medical evidence to ensure that fears and stereotypes about contagiousness do not overwhelm federal anti-discrimination mandates. *See Arline*, 480 U.S. at 287-88. While this Court did not address directly the level of weight to be afforded the "probability" factor of the ADA standard in *Bragdon*, it did provide significant guidance as to the nature of the medical evidence required to establish, or rebut, the existence of a direct threat. After a careful analysis of the record evidence on the possibility that HIV would be transmitted in the course of providing dental care, the Supreme Court in *Bragdon* remanded the case with instructions to evaluate particular pieces of evidence before determining whether Bragdon had created an issue of material fact as to whether he faced a significant risk in providing dental care to a patient with HIV. The Court ordered remand so that risk calculations could be performed with rigor and scientific integrity, without reference to subjective, non-specific notions of risk. *See Bragdon*, 524 U.S. at 649-653.

In addressing whether the dental patient in *Bragdon* posed a "direct threat to the health or safety of others," the Court made explicit one of *Arline*'s fundamental assumptions: "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." 524 U.S. at 649. An inquiry into whether an HIV-positive patient poses a significant risk to a health care provider must "assess the level of risk," and consider the "statistical likelihood" of transmission. *Id.* at 652.

In *Bragdon*, the fact that the risk of HIV transmission

was greater than zero was the backdrop for the Court's discussion of the issue. The defendant dentist's evidence of possible transmission of HIV to seven dental workers fell short of the proof of "significant risk" that the Court demanded. *Id.* at 653. The Court's direction to "assess the level of risk," *id.* at 652, and its remand order, would have been wholly superfluous if mere proof of a theoretically recognized risk of fatality were enough to establish a direct threat. The *Bragdon* standard, if applied to the undisputed facts of this case, undoubtedly would have produced a different result.

The heart of the direct threat determination, then, involves an assessment of medical and scientific data on whether, in view of the seriousness of the harm and the statistical likelihood that the risked event will occur, that risk is significant. If medical opinion unchallenged by qualified experts concludes that a risk has almost no statistical chance of occurring, the reviewing court is without power under either the ADA or this Court's relevant decisions to discard that conclusion—no matter how serious the harm might be—because of its belief that there is some basis for finding a theoretical possibility of it happening.

Were this not the case, a host of imaginable disasters could be hypothesized to exclude virtually any individual with a disability, regardless of an individualized assessment of a particular plaintiff's impairment, skills, or specific job requirements. The Eleventh Circuit rejected evidence that a particular harm had never occurred as unimportant, *Waddell*, 276 F.3d at 1280 (App. A8), and saddled plaintiffs with the virtually impossible burden of proving that something that never has happened won't occur in the future.

Consequently, the Eleventh Circuit's analysis has implications far beyond health care assistants such as Mr. Waddell. It threatens to insulate from challenge virtually any discrimination against persons with disabilities in employment, health care, education, and every other aspect

of community life. To prevail, all an employer must argue is that the plaintiff's disability poses some imaginable, non-zero risk of a catastrophic occurrence resulting in possible death. *Waddell's* reasoning permits, for example, an employer's refusal to hire an HIV positive applicant for an office job because of the remote risk that she might cut herself on a staple and expose a co-worker to her blood, a scenario impossible to definitively disprove. A teacher with HIV also would be unable to prove that no child in her classroom is capable of suddenly seizing his arm, biting it, and having the sufficient confluence of blood, high viral load and breaks in the skin of the mouth to accomplish the statistically extremely unlikely event of HIV transmission. A firefighter with hepatitis C can not prove that, in the course of a rescue, he will never be unable to use infection control equipment on a victim in need of resuscitation and that it will be impossible to transmit his disease. A wheel-chair bound day care manager could not prove that he will never be needed to assist a worker in getting children out of a building in the case of a fire and that nothing will interfere with his ability to do that.

*Bragdon* applied a four-prong test that demands positive evidence on each prong; the Eleventh Circuit applied a different standard altogether. The dissonance of the Eleventh Circuit's approach is perhaps most apparent in the context of *Bragdon* itself. Application of the Eleventh Circuit's theoretical-risk standard to the record in *Bragdon*, which included known reports on documented HIV transmissions from patient to health care worker, coupled with an ability to hypothesize events producing a scientifically sound, if theoretical, possibility of infecting Dr. Bragdon, would have produced the result that as a matter of law Sydney Abbott posed a direct threat, rendering a remand unnecessary.

## II. This Court Should Grant Certiorari Because the Eleventh Circuit's Opinion Increases the Confusion Among the Courts of Appeals As To Whether A Purely Theoretical Risk of Serious Harm, Including Death, Is Sufficient to Constitute A Direct Threat As A Matter of Law.

The Eleventh Circuit's approach marks not only a parting from this Court's opinions, but also reflects a larger disagreement among the Circuits on how risk should be quantified under the ADA when the harm at issue poses potentially fatal consequences. In their most recent rulings on the issue, the Eleventh and Fourth Circuits have concluded that any risk of death, however remote and speculative, is significant, while the First, Fifth, Sixth, and Ninth have declined to find that even the risk of death is significant if the probability that it will occur is extremely small.[11]

Similar to the Eleventh Circuit's approach, the Fourth Circuit weighted the factor of harm from HIV infection to such a degree that *any* risk that death or

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[11] As discussed below, the Sixth Circuit's most recent ruling on this issue rejects a "no theoretical risk" application of the *Arline* standard. In an earlier case involving an HIV positive surgical assistant, however, the Sixth Circuit found in the context of considerable testimony from both parties that evidence of an extremely small probability of occurrence is sufficient as a matter of law when the possible transmission of HIV was involved. *See Estate of Mauro v. Borgess Med. Ctr.*, 137 F.3d 398, 405, 407 (6th Cir. 1998) (affirming summary judgment against surgical technician despite evidence that employee rarely had his fingers in the vicinity of a surgical incision, and even though CDC estimated the odds of transmission from a surgeon to a patient as in the 1 in 42,000 to 1 in 420,000 range). Consequently, it is unclear whether the Sixth Circuit's more recent decision in *Hamlin v. Charter Township of Flint*, 165 F.3d 426 (6th Cir. 1999) reflects its current view of the appropriate standard in all cases, or the fact that serious infectious disease prompts application of a more exacting (and inappropriate) test.

transmission will occur, even if never previously documented in the setting at issue, is sufficient basis for a finding of direct threat. In *Montalvo v. Radcliffe*, 167 F.3d 873 (4th Cir. 1999), *cert denied*, 528 U.S. 813 (1999), addressing the exclusion of an HIV positive child from a group karate class, the court found that because of the mere theoretical *possibility* of HIV infection "from blood splashing into the eyes or onto seemingly intact skin," the youngster posed a direct threat to other children. 167 F.3d at 877-78. The court never addressed the *statistical likelihood* of whether HIV can be transmitted through blood contact during athletic activity.[12]

In contrast, as this court noted, "for the most part" the First Circuit Court of Appeals in the initial *Bragdon* appeal "followed the proper standard in evaluating the petitioner's position and conducted a thorough review of the evidence." 524 U.S. at 650. In *Bragdon v. Abbott*, 163 F.3d 87 (1st Cir. 1998)(decision after remand), *cert. denied*, 526 U.S. 1131 (1999), 119 S.Ct. 1805 (1998), the First Circuit again rejected a dentist's argument that providing routine dental care to a patient with HIV created a direct threat to himself and others. The defendant dentist in that case had presented expert evidence to support his position and relied principally on forty-two documented cases of HIV transmission from patients to health care workers, seven cases of "possible" HIV transmission from patients to dental workers, and a CDC report of likely transmission from a dentist to six patients.

In its first decision, the First Circuit had found that this evidence was not sufficient to create a triable factual

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[12] In fact, the Centers for Disease Control and Prevention (CDC) reports that "[t]here are no documented cases of HIV transmitted during participation in sports." Centers for Disease Control and Prevention, *HIV/AIDS Prevention Update* (Nov. 30, 1998), http://dvd.gov.nchstp/hiv_aids/pubs/faq/faq30.htm (visited June 18, 1999).

issue of the existence of "significant risk," assessing each piece of evidence in turn as not comparable to the setting and personnel at issue, as "too speculative," or as failing to "quantitate the risk of HIV transmission." *See Abbott v. Bragdon*, 107 F.3d 934, 946, 947 (1st Cir. 1997), *aff'd in part, vacated and remanded in part*, 524 U.S. 624 (1998). On remand, the First Circuit reexamined the evidence according to this Court's direction, and readopted its previous holding:

> We previously held that [the evidence of documented and possible cases of HIV transmission in the health care setting] was insufficient without a documented showing that the risks to dentists and other health-care workers are comparable, *see* 107 F.3d at 947, and the appellant offers us no cogent reason to change our view...Our assessment of Dr. Bragdon's, and his amici's, other reprised arguments similarly remains unchanged. Each piece of evidence to which they direct us is still "too speculative or too tangential (or, in some instances, both) to create a genuine issue of material fact." *Id*. At 948.

*Bragdon v. Abbott*, 163 F.3d at 90.

The Fifth Circuit, in *Rizzo v. Children's World Learning Ctrs.*, 84 F.3d 758 (5th Cir. 1996), also applied the four-prong direct threat test in a manner that took into account the factor of the probability that harm, including death, could occur. Reversing a decision to remove a hearing-impaired employee from her school van driving responsibilities on the basis that she might not hear a choking child in the back of the bus, the court acknowledged that any risk of harm to children "will greatly impact the consideration of '[t]he nature and severity of the potential

harm,'" 84 F.3d at 764. However, the Fifth Circuit held that the lower court had not properly considered whether the harm in question was *significantly likely* to occur. *Id.* The Court remanded the case for a trial on whether the school could in fact establish that Rizzo's relative abilities to hear and respond to a choking child in fact made her a direct threat to the children she transported.

In *Hamlin v. Charter Township of Flint*, 165 F.3d 426 (6th Cir. 1999), the Flint Township Fire Department defended its termination of Hamlin, a firefighter, after he had suffered a heart attack and had to avoid strenuous physical activities by arguing that Hamlin posed a direct threat as a consequence of his physical inability to engage in active firefighting duties. Flint pointed to the unpredictability of a firefighter's work environment, and the possibility that the "first responder" to a scene might be needed to rescue someone trapped inside a building. The Sixth Circuit Court of Appeals rejected this line of reasoning, stating that it is a violation of the ADA to deny an opportunity to a person with a disability "merely because of a slightly increased risk":

> The risk can only be considered when it poses a significant risk, i.e., a *high probability* of substantial harm; *a speculative or remote risk is insufficient*. Flint failed to show that there was "a high probability of potential harm...or that the alleged risk was anything more than speculative or remote."

*Id.* at 432.

The Eleventh Circuit's application of *Arline* and *Bragdon* also conflicts with that of the Ninth Circuit in *Chalk v. United States Dist. Court*, 840 F.2d 701, 709 (9th Cir. 1988). Applying the *Arline* test to a Rehabilitation Act case, the court held that "it was error to require that every theoretical possibility of harm be disproved." *Chalk* held

that a schoolteacher with AIDS should not have been removed from the classroom because he did not pose any real risk to his students. While acknowledging that the risk that the teacher would transmit HIV to any student was minimal, the district court had concluded that the risk nonetheless was "significant" because of the severe consequences of infection. Reversing, the Ninth Circuit found that the district court had failed to follow *Arline* by discounting scientific evidence that the likelihood of transmission was very slight. 840 F.2d at 708-09.

Several years after this Court's decision in *Bragdon*, the lower courts interpret the four-prong direct threat standard in a manner that effectively ensures that the same plaintiff with the same facts can expect very different outcomes depending on the circuit in which he finds himself, revealing a lack of clarity with significant consequences that this Court should address.

## III. Certiorari Also Is Necessary to Resolve The Conflict Among the Courts of Appeals As To Which Party Bears the Burden of Proof On A Direct Threat Defense.

Most of the Courts of Appeals have addressed the issue of which party bears the burden of proof on the existence of a direct threat under the ADA; what has emerged is a confusing divergence of opinion on the proper interpretation of a central part of the statute. With many of these cases resolved on summary judgment, the resolution of this dispute is of critical importance to parties with ADA claims, and one that requires this Court's intervention.

The Circuits' handling of the burden of proof on direct threat reveals confusion on a matter that affects the threshold issue of what constitutes a plaintiff's *prima facie* case. The Eleventh Circuit in this case, *see* 276 F.3d at 1280, and the First Circuit, in *EEOC v. Amego, Inc*., 110

F.3d 135 (1st Cir. 1997) place the burden on the plaintiff as part of a *prima facie* case demonstrating that the plaintiff with a disability also is qualified. Taking the opposing view that, consistent with the position of the EEOC, places the burden of proving a direct threat defense squarely on the employer are the Fifth Circuit, *see Rizzo v. Children's World Learning Ctrs., Inc.*, 213 F.3d 209 (5th Cir. 2000); the Seventh Circuit, *see Dadian v. Vill. of Wilmette*, 269 F.3d 831 (7th Cir. 2001); *EEOC v. AIC Sec. Investigations, Ltd.*, 55 F.3d 1276 (7th Cir. 1995); the Eighth Circuit, *see Stafne v. Unicare Homes,* 266 F.3d 771 (8th Cir. 2001); the Ninth Circuit, *see Hutton v. Elf Atochem N. America, Inc.*, 273 F.3d 884 (9th Cir. 2001); and the Tenth Circuit, *see Hartog v. Wasatch Acad.*, 129 F.3d 1076 (10th Cir. 1997).

The confusion as to which party must establish the presence or absence of a direct threat, and as basic a question as what burdens of proof an ADA plaintiff must assume in making a *prima facie* case, impair the ability of parties to an ADA case to litigate their claims in an effective and efficient matter. The Court should grant *certiorari* to resolve this unpredictability in a fundamental aspect of the statute.

## CONCLUSION

For the reasons set forth above, the petition for writ of *certiorari* should be granted.

Respectfully Submitted,

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