NO. 04-1397

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

JOHN COUTURE,

Plaintiff-Appellant,

-v.-

BELLE BONFILS MEMORIAL BLOOD CENTER,

Defendant-Appellee.

Appeal from the United States District Court for the District of Colorado
Honorable Robert E. Blackburn, United States District Judge
District Court Civil Action No. 02-RB-2319 (OES)

BRIEF OF *AMICI CURIAE* AMERICAN CIVIL LIBERTIES UNION, AMERICAN CIVIL LIBERTIES UNION OF COLORADO, AIDS ALLIANCE FOR CHILDREN, YOUTH & FAMILIES, ASSOCIATION OF NURSES IN AIDS CARE, BOULDER COUNTY AIDS PROJECT, NORTHERN COLORADO AIDS PROJECT, AND WHITMAN-WALKER CLINIC

IN SUPPORT OF APPELLANT JOHN COUTURE AND REVERSAL OF THE DISTRICT COURT

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INTRODUCTION

Defendant-appellee Belle Bonfils Memorial Blood Center terminated plaintiff-appellant John Couture from his position as a phlebotomist solely because of defendant's fear of negative public reaction and its misguided beliefs about the risk of transmission of the human immunodeficiency virus (HIV) to blood donors. Despite clear Supreme Court caselaw to the contrary, Bonfils argued below that where the risk involved is the transmission of HIV, *any* risk that is not medically impossible, no matter how small or theoretical the chance of that risk occurring, excuses discriminatory treatment. When standard universal precautions are followed, however, the phlebotomy procedures at issue can be performed safely by an individual with HIV, and are readily distinguishable from other contexts in which courts have found that HIV-positive health care workers pose a threat to the public.

As public health organizations and organizations committed to ending discrimination because of HIV and AIDS, *amici* have first-hand knowledge of the prevalence of exaggerated fears and misperceptions about the transmission of HIV, and the ways in which those fears have been used to justify discrimination against people with HIV. *Amici* respectfully submit this brief to ensure that the assessment of whether an individual such as Mr.

Couture poses a direct threat to the health or safety of others is based on accurate medical evidence, using a legal standard that both prohibits irrational discrimination against people with HIV and protects public health.

INTERESTS OF AMICUS CURIAE

AMERICAN CIVIL LIBERTIES UNION and THE ACLU OF COLORADO

The ACLU is a nationwide, nonprofit, nonpartisan organization with more than 400,000 members. The American Civil Liberties Union of Colorado is the local affiliate of the ACLU in the state of Colorado. The ACLU of Colorado is a nonpartisan, nonprofit organization with over 9,000 members. Since its founding in 1920, the ACLU and its affiliates have devoted their resources and energies to protecting the constitutional rights and individual liberties of all Americans.

Over the last four decades, the ACLU and the ACLU of Colorado have appeared in numerous cases involving the proper interpretation of civil rights laws, both as direct counsel and as *amicus curiae*. The ACLU has advocated for interpretations of civil rights laws, including the Americans with Disabilities Act (ADA), that will ensure that all individuals have equal access to the workplace and are not disadvantaged because of protected characteristics such as race, sex, or disability. This case involves the scope

of the protections afforded by the ADA to people with HIV. The proper resolution of that question is a matter of significant concern to the ACLU and its members throughout the country.

AIDS ALLIANCE FOR CHILDREN, YOUTH AND FAMILIES

AIDS Alliance for Children, Youth & Families is a national nonprofit organization which advocates for the needs of women, children, youth and families affected or infected by HIV/AIDS. AIDS Alliance represents more than 650 organizations providing health care and supportive services to over 53,000 women, children, youth and family caregivers. AIDS Alliance believes that access to a discrimination and stigma-free workplace is essential for people living with HIV to be able to lead healthy lives, manage home life, and raise children while coping with the effects of HIV/AIDS.

ASSOCIATION OF NURSES IN AIDS CARE

The Association of Nurses in AIDS Care (ANAC) is a nonprofit professional nursing organization committed to fostering the individual and collective professional development of nurses involved in the delivery of health care to persons infected or affected by HIV and to promoting the health, welfare, and rights of all HIV-infected persons.

BOULDER COUNTY AIDS PROJECT

The Boulder County AIDS Project (BCAP) serves Boulder, Broomfield, Gilpin and Clear Creek Counties in the state of Colorado. BCAP's mission is twofold: to provide support, advocacy and education to those in our community who are infected with or affected by HIV and to serve as an outreach and information center to prevent further transmission of HIV and the resulting Acquired Immune Deficiency Syndrome (AIDS). BCAP provides case management, emotional support, practical help, legal assistance through pro bono attorneys, and limited financial assistance to clients. Because many BCAP clients have experienced discrimination in the workplace, housing and in other areas of their lives, BCAP is aware of the prevalence of misinformation, misperceptions and exaggerated fears about HIV and its transmission in our society, and is committed to ending the devastating effects of the discrimination that results from this prejudice.

NORTHERN COLORADO AIDS PROJECT

The Northern Colorado AIDS Project ("NCAP") serves men, women and children living with HIV/AIDS infection in Northern Colorado, while working to reduce the further spread of the virus. NCAP's constituent base consists of 8 counties: Larimer, Weld, Washington, Yuma, Sedgewick, Morgan, Logan, and Phillips. NCAP advocates on behalf of those who are

discriminated in housing, access to health services and employment, and believes that employment decisions must be based on science and empirical data, and not discrimination and misinformation. One of NCAP's charter goals is to "erase misconceptions, prejudice, and discrimination associated with HIV/AIDS."

WHITMAN-WALKER CLINIC

Whitman-Walker Clinic is a nonprofit community-based health clinic that serves the District of Columbia, Northern Virginia, and six Maryland counties in the greater Washington metropolitan area. Founded in the 1970's as a gay and lesbian health clinic, Whitman-Walker Clinic has become a principal provider of outpatient medical services to people with HIV and AIDS in the National Capitol Area, regardless of sexual orientation. Whitman-Walker Clinic also offers testing for sexually transmitted diseases, including HIV.

The Clinic employs phlebotomists as well as other medical professionals, and oversees thousands of instances every year in which patients' blood is drawn for testing for diagnostic purposes by its employees and by volunteer medical professionals. Like other medical providers, Whitman-Walker Clinic has a strong interest in patient safety and adheres to rigorous safeguards to protect patients and health care workers from

exposures to blood-borne infections such as HIV and hepatitis. The Clinic's consistent experience has been that HIV infection in a phlebotomist poses no significant risk to patients or to co-workers, provided the phlebotomist is appropriately trained and adheres to appropriate infection control precautions. Whitman-Walker Clinic has employed phlebotomists living with HIV without any adverse effect on patient health and safety, and strongly believes that discrimination against HIV-infected phlebotomists is utterly unjustified.

ARGUMENT

I. PROOF OF DIRECT THREAT REQUIRES SHOWING A SIGNIFICANT RISK OF SUBSTANTIAL HARM

The Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101 *et seq.*, balances the protection of individuals with disabilities with public safety by providing employers with an affirmative defense if employing an individual poses a "direct threat to the health or safety of other individuals in the workplace." 42 U.S.C. § 12113(b). A "direct threat" is defined as "a significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation." 29 C.F.R. § 1630.2(r); *see also* 42 U.S.C. § 12182(b)(3) (applying identical definition in the context of public accommodations).

"[B]ecause few, if any, activities in life are risk free, . . . the ADA do[es] not ask whether a risk exists, but whether it is *significant*." *Bragdon v. Abbott*, 524 U.S. 624, 649 (1998) (citations omitted and emphasis added). Factors to be considered in determining whether a person poses a significant risk include: "(1) The duration of the risk; (2) The nature and severity of the potential harm; (3) The likelihood that the potential harm will occur; and (4) The imminence of the potential harm." 29 C.F.R. § 1630.2(r). Specifically, courts must examine data that "assess[es] the level of risk," because "the

question under the statute is one of statistical likelihood." *Bradgon*, 524 U.S. at 652.

"The determination that an individual poses a 'direct threat' shall be based on an individualized assessment of the individual's present ability to safely perform the essential functions of the job. This assessment shall be based on a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence." 29 C.F.R. § 1630.2(r). "The existence, or nonexistence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation, and the risk assessment must be based on medical, or other objective evidence." *Bragdon*, 524 U.S. at 649. Even when the employer is a health care provider, the ADA requires that courts "assess the objective reasonableness of the views of health care professionals without deferring to their individual judgments." *Id.* at 650.

In applying this standard to persons with HIV, several circuits have held correctly that where the likelihood of transmission of HIV in a particular occupation is speculative and unsupported by medical evidence, a direct threat does not exist. *See Abbott v. Bragdon*, 163 F.3d 87 (1st Cir. 1998) (holding on remand that an HIV-positive dental patient was not a direct threat to her dentist, despite the dentist's arguments that the

documented instances of transmission of HIV to health care workers suggested that there was some possible risk); *Chalk v. U.S. Dist. Ct. Cent. Dist. Cal.*, 840 F.2d 701, 709 (9th Cir. 1988) (holding that an HIV-positive teacher could not be barred from teaching in a classroom with hearing-impaired children because of his HIV status, and holding that "it was error [for the district court] to require that every theoretical possibility of harm be disproved").

Similarly, the Third Circuit has held that a "remote and speculative risk" of transmission of HIV was "insufficient for a finding of significant risk, and insufficient for the invocation of the direct threat exception." *Doe v. Cty. of Centre*, 242 F.3d 437, 450 (3d Cir. 2001). In *Doe*, a county required parental notification and consent before it would place any foster children in the plaintiffs' home because another child in the plaintiffs' home was HIV-positive. The court expressly rejected the county's arguments that the theoretical possibility of sexual or violent contact between the children was sufficient to establish a significant risk of transmission of HIV.[1]

[1] While the Third Circuit stated that it need not determine whether "any amount of risk through a 'specific and theoretically sound means of transmission' constitutes a significant risk," *id.* at 450, the court's holding impliedly rejects this standard. By dismissing the contention that sexual abuse by a foster child was a theoretically sound means of transmission (given that it was undisputed that HIV could be transmitted through sexual contact), the court's decision requires showing non-speculative evidence that transmission will occur. This, of course, is inconsistent with a rule that any risk of transmission of HIV, no matter how unlikely, is significant as a matter of law.

Despite the Supreme Court's holding in *Bragdon*, Bonfils argued below that *any* medically possible risk of transmission of HIV, no matter how small or theoretical the chance of that risk occurring, constitutes a significant risk as a matter of law. *See* Aplt. App. at 110, 113-14.[2] In support of this position, Bonfils relied heavily on an Eleventh Circuit case, *Waddell v. Valley Forge Dental Assocs., Inc.*, 276 F.3d 1275 (11th Cir. 2001).[3]

In *Waddell*, the Eleventh Circuit found that there was a risk of transmission of HIV under circumstances that are fundamentally different from the phlebotomy procedures at issue here.[4] Specifically, the court found that a dental hygienist with HIV posed a direct threat because the medical

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[2] References to "Aplt. App. at __" are to the appendix submitted in support of plaintiff-appellant's brief on appeal.

[3] Several other decisions involving HIV-positive individuals are inapposite because they were decided before *Bragdon* clarified that the gravity of the potential harm from HIV does not eliminate the need for objective evidence of a statistically meaningful risk, and involved circumstances where the risks of transmission occurring were significantly higher than the risk present here. *See Estate of Mauro v. Borgess Medical Cent.*, 137 F.3d 398 (6th Cir. 1998) (HIV-positive surgical technician); *Doe v. Univ. of Md.*, 50 F.3d 1261 (4th Cir. 1995) (HIV-positive neurosurgery resident); *Bradley v. Univ. of Tex. M.D. Anderson Cancer Cent.*, 3 F.3d 922 (5th Cir. 1993) (HIV-positive surgical technician). More recently, the Fourth Circuit found that an HIV-positive child who sought to take karate classes posed a direct threat to other children in the class, relying on evidence that there was frequent blood-to-blood contact by students in the specific classes in which the plaintiff sought to enroll. *See Montalvo v. Radcliffe*, 167 F.3d 873 (4th Cir. 1999).

[4] *Waddell*, in turn, relied on *Onishea v. Hopper*, 171 F.3d 1289 (11th Cir. 1999) (HIV-positive prison inmates challenging segregation from general population), in which the court found a significant risk of *intentional* conduct by prisoners that could result in transmission of HIV, which could not be eliminated.

procedures were "exposure prone," as defined by guidelines issued by the Center for Disease Control, because a dental hygienist might have his or her hand inside a patient's mouth during the cleaning process. In contrast, as discussed in greater detail below, phlebotomy procedures plainly are not exposure prone, and the risk of exposure to HIV during these procedures is so minimal as to be essentially non-existent.

Adopting a standard that holds that any conceivable risk is "significant" is contrary to both the express statutory language of the ADA and the mandate of *Bragdon v. Abbott.* First, the ADA itself requires both that the risk be significant and that the harm be substantial. Interpreting the term "significant risk" effectively to mean "any risk" would be to re-write the statute and impermissibly change its meaning. *See* H.R. Rep. No. 101-485(III), at 46 (1990) ("The decision to exclude cannot be based on merely 'an elevated risk of injury.' This amendment adopted by the Committee sets a clear, defined standard which requires actual proof of significant risk to others."), *reprinted in* 1990 U.S.C.C.A.N. 445, 469; *see also Lovejoy-Wilson v. NOCO Motor Fuel, Inc.*, 263 F.3d 208, (2d Cir. 2001) ("An employer . . . is not permitted to deny an employment opportunity to an individual with a disability 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.") (quoting *Hamlin v. Charter Tp. of Flint*, 165 F.3d 426, 432 (6th Cir. 1999)).

Second, the "theoretical risk" standard is inconsistent with the Supreme Court's ruling in *Bragdon*, which requires assessment of objective likelihood in determining the significance of the risk. Indeed, had evidence of a purely theoretical risk of transmission been sufficient, the Supreme Court in *Bragdon* would not have remanded to the First Circuit, as it was undisputed in that case that while the risk of transmission to a dentist from a patient approaches zero, it cannot be said with scientific certainty that there is absolutely no possibility that exposure could occur.

Finally, the theoretical risk approach is also inconsistent with this Circuit's prior cases on the direct threat defense. This Court's prior holdings emphasize the importance of an individualized assessment of the individual's ability to perform his or her job safely in determining whether a person poses a direct threat. In making that assessment, this Court has carefully considered the nature of the employee's duties as well as any objective medical evidence of risk of harm. *See, e.g.*, *Doebele v. Sprint/United Mgt. Co.*, 342 F.3d 1117, 1134 (10th Cir. 2003) (no direct threat despite the supervisor's unsupported belief that an employee with bi-polar disorder and attention-deficit disorder posed a physical threat to other

employees); *McKenzie v. Dovala*, 242 F.3d 967, 975 (10th Cir. 2001) (fact issue existed as to whether former patrol officer with post-traumatic stress disorder who had fired her gun at her father's grave, cut her own wrists, and overdosed on drugs requiring several hospital visits posed a direct threat to others); *Borgialli v. Thunder Basin Coal Co.*, 235 F.3d 1284 (10th Cir. 2000) (a mine-worker who had been diagnosed with depression and somatic disorders and had threatened suicide posed a direct threat because he worked with explosives, his doctor had not cleared him to work with his supervisor, and he had refused to go see another doctor at the company's request).

In *McKenzie,* for example, the Court held that "[t]here is no evidence suggesting in what way, once [the plaintiff] had undergone rehabilitation and been cleared by her doctor, employing [the plaintiff] in a position that does not require the use of force would create a direct threat to the public or to her co-workers." 242 F.3d at 974-75. If a purely speculative or remote risk of substantial harm constituted a "significant" risk under the ADA, however, this Court would not have rejected the employer's argument in *McKenzie* that the plaintiff was a safety risk, given that she had been diagnosed with post-traumatic stress disorder and previously engaged in self-destructive and violent conduct. Thus, this Court has already recognized that a purely

theoretical risk of significant harm is insufficient as a matter of law to entitle an employer to the direct threat defense.

The ADA's balancing of public safety and the protection of people with disabilities requires assessing whether an individual would pose a significant risk of substantial harm to others. In applying that standard in the context of HIV, this Court should consider objective scientific evidence not only of the possibility but also of the probability of transmission. As discussed below, rather than evidence of a risk of transmission, Bonfils offers only baseless speculation to justify its discriminatory treatment.

II. PLAINTIFF WOULD NOT POSE A DIRECT THREAT WERE HE ALLOWED TO WORK AS A PHLEBOTOMIST

As previously stated, factors to be considered in determining whether a person poses a significant risk of substantial harm include: "(1) The duration of the risk; (2) The nature and severity of the potential harm; (3) The likelihood that the potential harm will occur; and (4) The imminence of the potential harm." 29 C.F.R. § 1630.2(r). Here, *amici* focus on the third factor, the likelihood that the potential harm will occur. Considering current objective medical evidence, the risk of exposure to HIV under the circumstances here is so remote and theoretical as to provide no basis for concluding that Mr. Couture poses a direct threat.

Under current guidelines regarding the transmission of HIV by health care workers promulgated by the Centers for Disease Control ("CDC") and objective medical standards, there is no scientific basis for excluding an HIV-positive individual from performing the functions of a phlebotomist. The CDC's "Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures"[5] analyze the history of health care procedures that had resulted in the transmission of Hepatitis B Virus (HBV), which is far more communicable than HIV. Erring on the side of caution, the CDC recommends that all health care workers adopt certain universal precautions to prevent the transmission of disease to patients.

In addition, the CDC Recommendations distinguish between the broad category of "invasive" procedures, and a more limited subset of "exposure-prone" procedures. Invasive procedures range from the insertion of an intravenous line to performing most surgery, while exposure-prone procedures are invasive procedures in which there is an additional risk of percutaneous (skin-piercing) injury to the health care worker. Although the CDC Recommendations do not identify specific exposure-prone procedures, they provide the following definition:

[5] M.M.W.R. Vol. 40, pp. 1, 3-4 (July 12, 1991) (hereinafter "CDC Recommendations").

> Characteristics of exposure-prone procedures include digital palpation of a needle tip *in a body cavity* or the simultaneous presence of a [health care worker's] fingers and a needle or other sharp instrument or object *in a poorly visualized or highly confined anatomic site.* Performance of such exposure-prone procedures presents a recognized risk of percutaneous injury to the [health care worker] and – if such injury occurs – the [health care worker's] blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes. Thus, the CDC recommends that health care workers with HIV or Hepatitis B not perform *exposure-prone* procedures.

Id. (emphasis added). In considering this definition, courts have recognized that a wide range of activities are not exposure-prone, including firefighters who perform mouth-to-mouth resuscitation and first aid, *see, e.g.*, *Roe v. District of Columbia*, 842 F. Supp. 563, 570 (D.D.C. 1993), and rough-housing by children, *see, e.g.*, *Cty. of Centre*, 242 F.3d at 450. Courts have also found that the CDC Recommendations provide useful guidance about appropriate medical standards in considering whether an individual poses a direct threat. *See, e.g.*, *Bragdon*, 167 F.3d at 89 ("[T]he [CDC] Guidelines are competent evidence that public health authorities considered treatment of the kind that Ms. Abbott required to be safe, if undertaken using universal precautions.").

Applying this definition to the procedures at issue here, it is clear that the medical procedures performed during phlebotomy are not exposure-prone. When drawing blood, the health care worker's fingers are on the patient's arm, not in a body cavity or a poorly visualized or confined

anatomic site. *See* Declaration of Steven A. Jenison, M.D., Aplt. App. at 259-61. Thus, the CDC Recommendations, which are objective evidence of standards of public health and safety, indicate that plaintiff can safely perform the duties of a phlebotomist. *See* CDC Recommendations ("Currently available data provide no basis for recommendations to restrict the practice of HCWs [health care workers] infected with HIV or HBV who perform invasive procedures not identified as exposure-prone.").

Significantly, although millions of people give blood each year,[6] there is no known instance of transmission of HIV from a phlebotomist to a blood donor. *See* Aplt. App. at 113, 157, 262-63. Giving blood is a safe procedure, and if universal precautions are followed, there is no medically sound reason to restrict a person with HIV from working as a phlebotomist. Indeed, there is agreement among the parties that the risk of transmission of HIV under these circumstances is extremely low. *See* Aplt. App. at 113, 227, 278.

Bonfils nonetheless contends that because the risk that Mr. Couture could expose a donor to HIV is impossible to quantify but "not zero," and "cannot be completely eliminated," it must be allowed to discriminate

[6] The American Association of Blood Banks estimates that 8 million people donate blood annually. *See http://www.aabb.org/All_About_Blood/FAQs/aabb_faqs.htm* (last visited Dec. 30, 2004).

against him. *See* Aplt. App. at 278, 113. Raising fanciful hypothetical situations, Bonfils suggests, for example, that an HIV-positive phlebotomist could puncture his or her own skin and then, in a jerking motion, spastically stick a donor. *See* Aplt. App. at 111. Bonfils' arguments, however, are supported by no evidence as to the likelihood of occurrence of these purely speculative situations. Instead, Bonfils relies solely on its erroneous view that any imaginable risk is significant. Applying the proper legal standard, in contrast, the objective medical studies demonstrate that the risk of transmission is so small as to be essentially zero, and certainly is not a "significant risk." *See, e.g.*, *Doebele,* 342 F.3d at 1134 (holding that there was no evidence that the employee was a direct threat where there was "no indication [that the supervisor's] belief that [the employee] posed a physical threat to coworkers was based on a reasonable medical judgment.").

Working with sharp instruments such as needles involves a very small risk that the health care worker may puncture his or her own skin. In response to concerns about infection of health care workers with HIV and other blood-borne diseases, numerous studies have been conducted about the rate of needlesticks of health care workers and ways to reduce the number of occurrences. A two-year study of the American Red Cross Blood Services Centers in Massachusetts and Maine found an incidence of .0165 percent for

needlestick accidents among blood collection staff (approximately one per 6,000 blood collections). Approximately 72 percent of those needlesticks occurred during the filling of small pilot tubes used after blood had already been collected from the donor, or removing needles from those pilot tubes, at which time the donor was no longer at even a theoretical risk of exposure. In fact, fewer than 1 percent of the injuries occurred during the process of performing venipuncture on a donor.[7] The risk of a *double* needlestick in which the phlebotomist first punctured his own skin and then went on to puncture the skin of a patient is so minimal as to be purely hypothetical,

[7] *See* J. McGruff, & M.A. Popovsky, "Needlestick injuries in blood collection staff. A retrospective analysis," *Transfusion*, Vol. 29 (issue 8), 693-695 (Oct. 1989). More recent studies have found even lower incidence rates. For example, a retrospective study involving 683 healthcare facilities found that the median rate of needlestick injuries associated with phlebotomy procedures was slightly fewer than 1 per 10,000 procedures. *See* P.J. Howanitz, R.B. Schifman, "Phlebotomists' safety practices: A College of American Pathologists Q-Probes Study of 683 Institutions," *Arch. Pathol. Lab. Med.*, Vol. 118, 957-962 (1994). Another study conducted in Taiwan found an injury rate for health care workers performing blood drawing procedures of 13.3 per 100,000 procedures. *See* Lukas Jyunh-Hsiarn Lee, et al., "Procedure-Specific Rates for Needlestick Injuries in Health Care Workers," *J. of Occ. Health*, No. 43, 278-80 (2001). A CDC study of phlebotomy procedures performed in a hospital setting found that percutaneous injuries to health care workers occurred at an even lower rate of approximately 4 per 100,000. *See* Centers for Disease Control and Prevention, "Evaluation of Safety Devices for Preventing Percutaneous Injuries Among Health-Care Workers During Phlebotomy Procedures: Minneapolis-St. Paul, New York City, and San Francisco, 1993-1995," M.M.W.R., Vol. 46, No. 02 (Jan. 17, 1997). The CDC also found that the use of safety devices further reduced the risk of percutaneous injury during phlebotomy. *Id.*

particularly when the placement of the fingers while performing venipuncture in a controlled environment is considered.[8]

Further, even in the unlikely event that a double needlestick were to occur in the order necessary to expose a patient, the medically documented risk of transmission from an infected needle is only .3 percent (3-5 per 1,000).[9] The combination of the low level of the virus in Mr. Couture's blood and the availability of post-exposure prophylaxis further reduces the risk that transmission could occur in the event of exposure.[10] In other words, based on available scientific data, the odds of an HIV-positive phlebotomist transmitting HIV to a donor are far, far less than one in a million.[11]

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[8] *Amici* are unaware of any studies that measure the risk of such a double needlestick occurring, further suggesting the minimal nature of the risk.

[9] *See* Centers for Disease Control and Prevention, "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV and HIV and Recommendations for Post-Exposure Prophylaxis," M.M.W.R., Vol. 50, No. RR-11, p. 1-52 (June 29, 2001).

[10] Defendant's expert witness agreed that a low viral load makes HIV less infectious. *See* Aplt. App. at 247. Further, studies show that proper administration of post-exposure prophylactic treatment with HIV anti-retroviral medications can reduce the rate of transmission by an additional 81 percent. *See* Aplt. App. at 264. Thus, with post-exposure prophylactic treatment, the risk of acquiring HIV from exposure to an HIV-infected needle is approximately 6 in 10,000.

[11] This figure is based on the most conservative data for the risk of a single needlestick (1/6,000), which is then is then multiplied by the risk of infection upon exposure to an HIV-infected needle, assuming that post-exposure prophylaxis is promptly administered (6/10,000), resulting in a chance of 1 in 1,000,000 that a health care worker could contract HIV from a *patient* through a needlestick (if all those patients were HIV-positive). Obviously, the odds of a health care worker transmitting HIV through a double needlestick in which the health care worker first sticks herself and then sticks a patient are substantially lower.

In light of this undisputed medical evidence, there is simply no objective basis to support the conclusion that employing Mr. Couture as a phlebotomist would pose a significant risk of substantial harm to others. When the medical data is considered and the actual risk of harm is quantified, the refusal to employ Mr. Couture is revealed as resting on nothing more than exaggerated fear. Accordingly, *amici* submit that plaintiff is entitled to summary judgment on the defendant's direct threat affirmative defense.[12]

III. FINDING THAT MR. COUTURE POSES A SIGNIFICANT RISK OF SUBSTANTIAL HARM TO THE PUBLIC IS INCONSISTENT WITH PUBLIC POLICY AND THE REMEDIAL PURPOSE OF THE ADA

Adopting a standard that allows discrimination against a disabled person if she cannot prove the absence of a theoretical risk would further the prejudices and stereotypes that the ADA was intended to prevent, while providing no meaningful incremental protection to the public.

In *School Board of Nassau County v. Arline*, a case involving a teacher who was susceptible to tuberculosis, the Supreme Court observed that "society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual

[12] Or, at a minimum, there is a disputed issue of fact. The merely theoretical possibility of injury – without any consideration of probability – cannot be deemed a significant risk as a matter of law.

impairment. Few aspects of a [disability] give rise to the same level of public fear and misapprehension as contagiousness." *Sch. Bd of Nassau Cty. v. Arline*, 480 U.S. 273, 284 (1987).[13] In order to eliminate "discrimination on the basis of mythology – precisely the type of injury Congress sought to prevent," *id.*, the ADA requires that determination of whether a person poses a direct threat must be based on objective medical evidence. In this way, "irrational fears" are replaced "with actions based on reasoned and medically sound judgments." *Id.* at 285. This concept that employment decisions cannot be based on unfounded public prejudice is fundamental to our civil rights laws. *See, e.g., Fernandez v. Wynn Oil Co.*, 653 F.2d 1273, 1277 (9th Cir. 1981) (holding that under Title VII, "stereotyped customer preference" cannot "justify a . . . discriminatory practice").

Here, upon learning that Mr. Couture was HIV-positive, Bonfils terminated him from the phlebotomist position and subsequently offered him a job with significantly different duties. *See* Aplt. App. at 220-21, 368-69, 394-96. Bonfils' management explained that they were concerned about negative public reaction if the public learned that Bonfils employed an HIV-positive phlebotomist. *See, e.g.*, Aplt. App. at 159, 194. Rather than

[13] Although *Arline* was brought under the Rehabilitation Act of 1973, 29 U.S.C. § 794, the direct threat analysis set forth in that decision is the basis for the affirmative defense under the ADA. *See Bragdon*, 524 U.S. at 632.

attempting to educate the public as to the remoteness of any risk, Bonfils catered to the public prejudices and fears about HIV by terminating Mr. Couture and offering him a job with no contact with the public. This reaction flies in the face of the basic mandates of the ADA. *See* H.R. Rep. No. 101-485(III), at 45 (1990) ("A person with a disability must not be excluded, or found to be unqualified, based on stereotypes or fear. Nor may a decision be based on speculation about the risk or harm to others."), *reprinted in* 1990 U.S.C.C.A.N. 445, 468.

Medically sound judgment can take the place of irrational fears and prejudices, as the ADA intended, only if the direct threat inquiry looks to whether there is a *significant* risk that an individual with a disability will cause harm to another person if he or she is allowed to work in a particular job. If, in contrast, all that need be shown is that a person *could possibly* harm another person, no matter how remote or unlikely the risk that this would occur, irrational fears will be encouraged. Here, the risk posed by the plaintiff is extraordinarily low – far less than one chance in a million of transmission. As discussed above, a whole constellation of individually unlikely events would have to occur simultaneously before another individual could be infected by plaintiff. Employers cannot single out

people with disabilities and assume, based not on evidence but on fear, that unlikely things are likely to happen to them.

There is, of course, some risk in all activity. In any situation, it is possible to imagine a scenario in which a potential for injury exists, but we do not live our lives cowed by fear of these speculative and remote risks. If, however, disabled employees are required to prove with certainty that no remote or speculative possibilities could occur if they are employed, they alone will face the burden of guaranteeing the impossible. *Cf. Bragdon*, 524 U.S. at 653 (rejecting the position that the absence of contrary evidence can be equated with positive data showing that a risk exists); *Chalk*, 840 F.2d at 707 (describing requirement of proving the impossibility of transmission of HIV as "an impossible burden of proof" and noting that "[l]ittle in science can be proved with complete certainty"); *see also* H.R. Rep. No. 101-485(III), at 45 ("The plaintiff is not required to prove that he or she poses no risk.").

In light of the extraordinarily low risk of transmission of HIV during phlebotomy, adopting a standard that permits discrimination if any conceivable instance that might theoretically result in transmission can be imagined would significantly reduce the protections of the ADA without providing any improvement in protection for public health and safety. It is

in precisely these circumstances – where the public perception of risk has no correlation with the actual likelihood of harm – that the protections of the ADA are most necessary. To prevent myths and assumptions about the contagiousness of HIV from triumphing over fact, consideration must be given to the actual likelihood of transmission under the circumstances in which the employee will be working.

This Court should adopt the standard that appropriately balances protection of people with disabilities with the protection of public safety by assessing the likelihood of transmission in determining whether an individual with HIV poses a direct threat. In holding that employment decisions must be based on medical fact, rather than sheer speculation, this Court would affirm the fundamental purposes of the ADA to protect disabled individuals from employment decisions based on irrational prejudice and fear.

CONCLUSION

For the foregoing reasons, *amici* respectfully request that the judgment of the district court be reversed, and summary judgment be entered for the plaintiff on defendant's affirmative defense.

Dated: January 6, 2005

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

As required by Fed. R. App. P. 32(a)(7)(C), I certify that this brief is proportionally spaced, in 14 point font, and contains 5,754 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). I relied on my word processor to obtain the count and it is Microsoft Word.

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CERTIFICATE OF SERVICE

I, Rose A. Saxe, hereby certify that on January 6, 2005, two hard copies of the foregoing brief and an electronic copy of the brief on CD-ROM were served by first class mail, postage prepaid, upon counsel for plaintiff, Andrea E. Faley, The Legal Center for People with Disabilities and Older People, 455 Sherman Street, Suite 130, Denver, CO 80203, and upon counsel for defendant, Matthew J. Rita, Holme Roberts & Owen LLP, 1700 Lincoln Street, Suite 4100, Denver, CO 80203.

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