NO. 10-60940

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

DAVID ATKINS

Plaintiff-Appellant

V.

KEN SALAZAR, SECRETARY,
DEPARTMENT OF THE INTERIOR

Defendant-Appellee

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF MISSISSIPPI
(EASTERN DIVISION)
NO. 1-10-cv-0040SA-JAD
CIVIL PROCEEDING

BRIEF OF THE AMERICAN DIABETES ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF APPELLANT

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualifications or recusal:

1. **Amicus curiae in support of Appellant:** The American Diabetes Association

2. **Appellant:** David A. Atkins

3. **Appellee:** Ken Salazar

4. **Attorney for Amicus:** Brian East

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

REGULATIONS

OTHER AUTHORITIES

INTEREST OF THE AMERICAN DIABETES ASSOCIATION

The American Diabetes Association ("Association") is a nationwide, nonprofit, voluntary health organization founded in 1940, and has over 485,000 general members, 15,000 health professional members, and 1,000,000 volunteers. The mission of the Association is to prevent and cure diabetes and to improve the lives of all people affected by diabetes. Presently, there are 25.8 million Americans with diabetes, 26% of whom take insulin to help treat their diabetes.[1] The Association is the largest, most prominent nongovernmental organization that deals with the treatment and impact of diabetes. The Association establishes and maintains the most authoritative and widely followed clinical practice recommendations, guidelines, and standards for the treatment of diabetes.[2] The Association publishes the most authoritative professional journals concerning diabetes research and treatment.[3]

One of the Association's principal concerns is the equitable, fair, and legal treatment of persons with diabetes in employment situations. The Association knows through long experience that employers frequently restrict employment

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[1] Centers for Disease Control & Prevention, *National Diabetes Fact Sheet* (2011).

[2] American Diabetes Ass'n, *Clinical Practice Recommendations 2011*, 34 Diabetes Care S1 (2011).

[3] The Association publishes four professional journals with widespread circulation: (1) Diabetes (original scientific research about diabetes); Diabetes Care (original human studies about diabetes treatment); (3) Clinical Diabetes (information about state-of-the-art care for people with diabetes); and, (4) Diabetes Spectrum (review and original articles on clinical diabetes management).

opportunities for people who use insulin based on prejudices, stereotypes, unfounded fears, and misinformation concerning diabetes and insulin in the workplace. The Association believes that each person with diabetes should be individually considered for employment based on the requirements of the specific job, the particular qualifications of the individual, and the capacity of that individual to fully and safely perform that job. The Association advocates the following policy:

> Any person with diabetes, whether insulin [treated] or non–insulin [treated], should be eligible for any employment for which he/she is otherwise qualified…. Employment decisions should not be based on generalizations or stereotypes regarding the effects of diabetes.[4]

Consistent with this policy, the Association appears as *amicus curiae* in cases throughout the United States involving prohibitions or restrictions on the employment of persons with diabetes.[5]

BACKGROUND INFORMATION ON DIABETES

Diabetes is a chronic and incurable and disease of the endocrine system. Diabetes results from either the failure of the pancreas to produce enough insulin or the failure of the body to effectively use whatever insulin is produced. Insulin is

[4] American Diabetes Ass'n, *Position Statement, Diabetes and Employment*, 34 Diabetes Care S82 (2011).

[5] For example, this Court cited approvingly the Association's contributions as *amicus curiae* in *Kapche v. City of San Antonio,* 176 F.3d 840, 847 (5th Cir. 1999) (noting that Association provided "cogent support" for its position through evidence of improvements in diabetes management).

a hormone that drives glucose from the bloodstream into the body cells where it is metabolized. Without insulin, glucose stays in the bloodstream, resulting in abnormally high blood glucose levels (hyperglycemia).

Although extreme hyperglycemia can cause medical problems including coma and death, because it develops gradually, it does not pose an immediate risk of sudden incapacitation.[6] For most individuals with diabetes, the most serious impact of hyperglycemia is that it leads to an increased long-term risk of heart disease, kidney disease, nerve disease, lower limb amputations, and blindness.

In contrast, the main short-term risks of diabetes result from abnormally low blood glucose (hypoglycemia). If people who use insulin to treat their diabetes take too much insulin, it can quickly cause the body's cells to absorb too much glucose, resulting in hypoglycemia, defined as a blood glucose concentration of less than 70 mg/dl.[7] Hypoglycemia can be caused by taking too much insulin, eating or absorbing too little food, or too much activity or stress. Symptoms of mild to moderate low blood glucose include sweating, tremors, lightheadedness, and hunger. Virtually all people who use insulin experience some hypoglycemia. However, through self-monitoring, most can recognize the early warning signs of hypoglycemia and take immediate corrective action, e.g., consuming a quickly-

[6] American Diabetes Ass'n, *Diabetes and Employment*, *supra* at S84.
[7] American Diabetes Ass'n, *Defining and Reporting Hypoglycemia in Diabetes*, 28 Diabetes Care 1245, 1247 (2005).

absorbed form of sugar such as candy, fruit juice, or soft drink. They quickly return to their previous activity with minimal disruption.

If these early warning signs are ignored, severe hypoglycemia can result. The Association defines severe hypoglycemia as: "An event requiring assistance of another person to actively administer carbohydrate, glucagon, or other resuscitative actions."[8] Severe hypoglycemia is the principal diabetes safety risk in the workplace. However, most cases of severe hypoglycemia can be avoided with the aid of advances in medicine and science such as the ability to perform frequent self-monitoring of blood glucose levels and the use of modern varieties of insulin. Additionally, during an emergency or when snacks are unavailable, individuals can let their blood glucose levels run somewhat high without any immediate harm, guarding further against any possibility of experiencing severe hypoglycemia. Accordingly, the vast majority of people who use insulin to treat their diabetes are able to successfully work with no risk to their safety or the safety of others.

[8] *Id.*

THE DIABETES OF DAVID ATKINS

David A. Atkins began working for the National Park Service ("NPS"), an agency of the Department of the Interior ("DOI"), in 1984. After his diagnosis in 1986 until 2005, he successfully managed his diabetes with insulin while performing the demanding duties of a law enforcement Park Ranger at Natchez Trace Parkway in Mississippi. These duties included patrolling the park and making arrests, working as a first responder on numerous motor vehicle accidents, and serving as a qualified wild land firefighter. (R. 22.) Because of the constant, daily effort he put into caring for his diabetes, he suffered no diabetes-related complications or physical limitations.

For nearly two decades, he never suffered an episode of hypoglycemia that put him or the people he served in any danger. (R. 159.) Rather, Atkins was consistently vigilant, ensuring that his blood glucose always remained at a safe level. Unlike some individuals who are unaware of approaching hypoglycemia, Atkins consistently recognized and self-treated the mild hypoglycemia he experienced.

Nevertheless, in September 2005, Atkins' law enforcement commission was permanently stripped due to DOI's mistaken belief that he was a safety risk since he did not stop his blood glucose level from fluctuating—the very definition of

diabetes—to DOI's satisfaction. (R. 177.) Because DOI believed that Atkins had "uncontrolled diabetes," which, as discussed below, is undefined and undefinable, it refused to consider, as required under the Rehabilitation Act, either Atkins' exemplary safety record or the current medical knowledge about diabetes, both of which clearly showed he posed no risk.

SUMMARY OF THE ARGUMENT

The Rehabilitation Act of 1973 (Rehabilitation Act) prohibits employers from making employment decisions about individuals with disabilities on the basis of ignorance, unfounded fears, and stereotypes about safety risks. All individuals with diabetes are entitled to be judged on their ability, not on the fact that they have diabetes. As such, employers must make safety-related assessments that are reasonable, based on the most current medical knowledge, and that consider the best objective evidence about the specific situation. Employers must take into account the fact that individuals with diabetes pose different risks of experiencing impairing hypoglycemia. Regardless of whether they screen out individuals with diabetes through use of a medical qualification standard, or allege that a particular individual cannot safely do the job, employers always retain the burden of proving

that their actions are based on "[real] risks and not the product of stereotypical assumptions."[9]

DOI clearly failed to conduct a proper safety assessment when it revoked Atkins' law enforcement commission. Because it ignored the medical consensus of how to conduct an appropriate evaluation, and refused to consider objective evidence indicating Atkins posed no elevated safety risk, it cannot justify its decision to demote Atkins under any theory of the case.

However, even if this Court accepts the evidence on which DOI relies, Atkins has at the very least raised a clear question of material fact as to whether he posed a safety risk. Atkins presented uncontroverted evidence that he performed his job safely for more than 19 years since he began using insulin to treat his diabetes, and rebutted DOI's contention that the way he managed his diabetes increased his likelihood of causing harm to himself or others. Granting summary judgment for DOI on this issue was clear error. This case should be remanded to the district court for trial.

[9] *Equal Employment Opportunity Comm'n v. Exxon Corp*., 203 F. 3d 871, 875 (5th Cir. 2000).

ARGUMENT

I. DOI Failed to Consider Current Medical Knowledge and Objective Evidence in Determining Atkins Was a Safety Risk

A. Employers and Courts Must Make Safety-based Decisions Based on Medical Knowledge and Objective Evidence

Under the Rehabilitation Act, employers may require individuals to perform all their job duties without posing a significant safety risk to themselves or others. However, it is equally clear that employers may not lightly make the decision that individuals pose such a risk. While there are two ways for employers to establish that individuals pose an unacceptable risk, in each case, employers still carry the burden to demonstrate that they are not excluding individuals based on misconceptions or fears about their disability.[10] Employers may defend their decision on the grounds that it is "job related and consistent with business necessity" under 42 U.S.C. § 12112(b)(6) and § 12113(a).[11] Alternatively, they can show that individuals pose a "direct threat" under § 12113(b). Distinguishing the two, this Court has explained that "[d]irect threat focuses on the individual

[10] DOI attempted to defend its decision on the theory that it had a legitimate non-discriminatory reason for its decision, "that reason being the safety of the public and its workers." (R. 218.) However, the district court properly ignored this argument as this defense is inapplicable when a claim is based on direct evidence of discrimination. *Rizzo v. Children's World Learning Ctrs., Inc.,* 84 F.3d 758, 762 (5th Cir. 1996).

[11] Atkins brought his disability discrimination claim against the Government under § 501 of the Rehabilitation Act (29 U.S.C. § 791). Claims under § 791 are analyzed under the same standards, including the same statutory provisions, regulations, and case law, as employment claims brought under the Americans with Disabilities Act ("ADA"). 29 U.S.C.§ 791(g); *Pinkerton v. Spellings*, 520 F. 3d 513, 516–517 (5th Cir. 2008).

employee, examining the specific risk posed by the employee's disability. In contrast, business necessity addresses whether the qualification standard can be justified as an across-the-board requirement." *Equal Employment Opportunity Comm'n v. Exxon Corp.*, 203 F. 3d 871, 875 (5th Cir. 2000) (internal citation omitted). However, the similarities are even more important: "Either way, the proofs will ensure that the risks are real and not the product of stereotypical assumptions." *Id.*

In the present case, DOI failed to prove that Atkins poses any real risk under either theory. Atkins argues that DOI should not be granted summary judgment on either business necessity or direct threat because it failed to properly raise them. The Association agrees with Atkins on this point. However, regardless of the Court's ultimate resolution of this procedural issue, DOI's failure to conduct a proper safety assessment under either theory establishes that it was clear error to grant summary judgment in its favor on this basis alone.

The direct threat defense is arguably most applicable because, according to both official policy and purported practice of DOI, individuals with diabetes who use insulin are evaluated on a "case-by-case basis," with some continuing to maintain their law enforcement commissions.[12] Employers may assert this

[12] DOI's endocrine and metabolic systems standard, which includes insulin treated diabetes, explicitly specifies that "[c]ases will be reviewed on a case-by-case basis." (R. 63.) DOI

affirmative defense to liability if an individual with a disability poses a "direct threat." 42 U.S.C. § 12113(b). The term "direct threat" is defined as "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation." 42 U.S.C. § 12111(3). A determination that an individual with a disability poses a "direct threat" must be made through consideration of the following factors: (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) (1993). *See also*, *School Bd. of Nassau County, Fla. v. Arline*, 480 U.S. 273, 288 (1987). "This is a complicated, fact intensive determination, not a question of law. To determine whether a particular individual performing a particular act poses a direct risk to others is a matter for the trier of fact to determine after weighing all of the evidence about the nature of the risk and the potential harm." *Rizzo v. Children's World Learning Ctrs., Inc*., 84 F.3d 758, 764 (5th Cir. 1996).

The inquiry into these factors "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). Medical professionals must evaluate the risks posed by individuals with disabilities based on objective

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acknowledges that several individuals with insulin treated diabetes have in fact maintained their law enforcement commission. (R. 311.)

scientific and medical evidence, and "courts should assess the objective reasonableness of the views of health care professionals without deferring to their individual judgments." *Bragdon v. Abbott*, 524 U.S. 624, 649–650 (1998). When a physician misinterprets or ignores what is understood in the relevant field to be the best evidence regarding the disease or its risk, or relies on evidence that is rejected in the field as being obsolete or irrelevant, this is an improper inquiry. *Rodriguez v. ConAgra Grocery Prods.*, 436 F.3d 468, 484 (5th Cir. 2006); *Doe v. Deer Mtn. Day Camp*, 682 F. Supp. 2d 324 (S.D.N.Y. 2010).

Guided by fundamental misunderstandings about the nature of diabetes and its fear of a worst case scenario, DOI failed to conduct a proper direct threat assessment and relied on irrelevant considerations to strip Atkins of his law enforcement commission.

Even if analyzed under business necessity, DOI failed to present evidence that would allow any court to properly "evaluat[e] whether the risks addressed by a safety-based qualification standard constitute a business necessity [because] the court should take into account the magnitude of possible harm as well as the probability of occurrence." *Exxon Corp.*, 203 F. 3d at 875.

As demonstrated below by a detailed comparison of what medical knowledge and objective evidence was actually considered with what should have been considered, DOI made its decisions based not on real risks, but on

"stereotypical assumptions" that the district court shared and relied upon in granting summary judgment. *Id.*

B. There Is An Established Medical Consensus as to How to Assess the Safety Risks Individuals Who Use Insulin Pose

The primary safety risk posed by people who use insulin to treat their diabetes is that they will experience severe hypoglycemia, leading to incapacitation, seizure, coma, or even death. A consensus has been established as to how to assess whether individuals with diabetes are at risk for incapacitating hypoglycemia.

The Association's position statement on *Diabetes and Employment* synthesizes this consensus, identifying the factors that should and should not be considered in making an assessment of whether an employee presents a safety risk.[13] This statement is a peer-reviewed document designed to provide employers with the latest objective scientific knowledge about diabetes and its management to help them develop appropriate qualification standards and conduct sound evaluations of individuals with diabetes.

The statement identifies several factors as *not relevant* to a proper safety evaluation: speculation about future complications; A1C test results; "compliance" with therapy in and of itself; and whether an individual's diabetes is described as

[13] American Diabetes Ass'n, *Position Statement, Diabetes and Employment*, 34 Diabetes Care S82 (2011).

"uncontrolled" or "brittle."[14] All of these factors played a role in DOI's decision, despite agreement in the medical community that they should not.

In contrast, the employer *should* consider: self-monitoring of blood glucose; history of severe hypoglycemia; existence of hypoglycemia unawareness; and presence of diabetes-related complications.[15] Yet these factors were ignored or discounted by DOI in its decision, as described below.

C. DOI Failed to Consider Factors Relevant to Safety Risk and Relied on Improper Factors

1. The key factors the DOI relied on are irrelevant to a proper safety assessment

DOI focused on criteria that are irrelevant in assessing an "individual's present ability to safely perform the essential functions of the job." 29 C.F.R. 1630.2(r). In demoting Atkins—an excellent worker with a flawless safety record—based on his hemoglobin A1C test result and the finding that he had "uncontrolled" diabetes and was not "compliant" with treatment, DOI violated the Rehabilitation Act.

i. Uncontrolled diabetes

DOI's principal justification for demoting Atkins was that his "uncontrolled diabetes" made him a safety risk. (R. 178.) DOI and the district court treated the

[14] *Id*. at S84–85.
[15] *Id.* at S84.

term "uncontrolled" as if it had independent legal significance, which it does not; it does not even have uniform *medical* significance.

It is important to emphasize that diabetes treatment regimens seek to manage both short-term and long-term complications of the disease. Indeed, diabetes treatment goals are often focused on these long-term complications, which can cause blindness, amputation, and early death, among other things. This is the danger of using the word "control." Employers and courts may assume that "control" refers to the prevention of severe hypoglycemia and other short-term complications of the disease (just as one may speak of "control" of seizures due to epilepsy). However, many physicians typically define "control" with reference to preventing long-term complications. The blood glucose levels needed to reduce these risks are not the same as those needed to prevent severe hypoglycemia. Due to the multiple goals of diabetes treatment, there is no clear medical definition of "control" in diabetes.[16]

Whatever its meaning, having "uncontrolled" diabetes is not synonymous with posing a safety risk. Because this term is used in imprecise and inconsistent ways, it is recommended clinical practice to avoid the term whenever possible. According to the Association's position statement:

[16] The Association does set treatment goals for diabetes which, as described further below, are focused on avoiding long-term complications. These goals never speak of "control" or describe those who do not meet them as "uncontrolled."

> Sometimes an individual's diabetes is described as "uncontrolled," "poorly controlled," or "brittle." These terms are not well defined and are not relevant to job evaluations. As such, giving an opinion on the level of "control" an individual has over diabetes is not the same as assessing whether that individual is qualified to perform a particular job and can do so safely. Such an individual assessment is the only relevant evaluation.[17]

Therefore, it is improper to allow employers claiming that an individual poses an unacceptable safety risk to obtain summary judgment simply by asserting that the individual has uncontrolled diabetes. "Uncontrolled" means a different thing in each case, based on the facts of the individual's situation. Rather than relying on this term, courts must look beyond it, examining whether the employer has considered factors relevant to assessing an individual's risk of experiencing severe hypoglycemia. *See Rodriguez v. ConAgra Grocery Prods.*, 436 F.3d at 475 (internal citations omitted) ("ConAgra's blanket policy of refusing to hire what it characterizes as 'uncontrolled' diabetics violates this fundamental tenet of ADA law; it embraces what the ADA detests: reliance on 'stereotypes and generalizations' about an illness when making employment decisions.").

ii. A1C tests

The results of hemoglobin A1C tests ("A1C tests") are similarly of little value in determining if an individual with diabetes poses a safety risk. This test measures mean average blood glucose levels over time, and cannot show whether

[17] American Diabetes Ass'n, *Diabetes and Employment*, *supra* at S85.

an individual's blood glucose levels have ever been dangerously high or low. Two people with the same A1C level might have dramatically different blood glucose histories, with one person demonstrating dramatic fluctuations, while the other has more consistent blood glucose levels with no evidence that he or she is dangerously high or low. Accordingly, this test is an inappropriate tool with which to assess an individual's ability to safely perform his or her job. The Association's position statement explains that:

> A1C…values provide health care providers with important information about the effectiveness of an individual's treatment regimen but are often misused in assessing whether an individual can safely perform a job. Because they identify only averages and not whether the person had severe extreme blood glucose readings, A1C . . . . results are of no value in predicting short-term complications of diabetes and thus have no use in evaluating individuals in employment situations. The American Diabetes Association recommends that in most patients A1C levels be kept below 7% . . . . This recommendation sets a target in order to lessen the chances of long-term complications of high blood glucose levels but does not provide useful information on whether the individual is at significant risk for hypoglycemia or suboptimal job performance and is not a measure of "compliance" with therapy.[18]

As this quote emphasizes, while A1C results may be used to evaluate the overall effectiveness of an individual's diabetes treatment regimen, they cannot be used to establish whether that individual is at increased risk for severe hypoglycemia or other short-term complications.

[18] *Id.* at S84–85.

Despite the medical consensus that A1C tests are an inappropriate tool with which to measure the likelihood of safety risks, Atkins' high A1C tests directly contributed to his demotion. To determine whether Atkins was medically qualified to do his job, DOI referred Atkins to its Medical Review Board for the National Park Service for evaluation. (R. 177–179.) In DOI's August 12, 2005 letter to Atkins, notifying him of the Medical Review Board's determination that he was not medically qualified, DOI explained that one of the reasons for this decision was these test results:

> Dr. Martin [Atkins' treating physician] hoped to stabilize your HGB A1C as stated, "the American Diabetes Association recommended goal for this value is less than or equal to 7.0 and this will be my personal goal for his level of control", (letter dated May 22, 2001) however most of your HGB A1C levels have remained consistently above 8.0 and as high as 10.2, which demonstrate you have not controlled your diabetes.

(R. 178–179.). The issue is not whether Atkins can keep his A1C levels at a particular number (which may reduce the risk of complications in his retirement years), but whether he posed an unacceptable safety risk that could not be eliminated through a reasonable accommodation.

iii. Noncompliance

Conclusory statements that a person with a disability is "noncompliant" in the manner in which they care for their health must not be permitted to serve as evidence that such a person poses an unacceptable safety threat. Allowing such

evidence gives courts and employers license to make decisions based not on individualized assessment of risk, but on their own notions of what is acceptable medical self-care, or even moral judgments about whether an individual is sufficiently "diligent" or "disciplined" in treating the disease. Of course, many people do not follow every recommendation given by their physician, or do everything they can to improve their health. Individuals who smoke or who fail to maintain a diet or exercise regimen often do so in spite of their physician's recommendation, and in doing so put themselves at increased risk of long-term health complications. But there can be no argument that such people are, merely by virtue of their noncompliance, unacceptable safety risks. Where the evidence shows that individuals adequately manage their diabetes so as to avoid safety risks from hypoglycemia, failure to lower blood glucose levels even further to meet targets set by a physician cannot render them a safety risk.

Nevertheless, DOI made precisely this determination—that Atkins' "noncompliance" with the terms of his waiver is relevant to its finding that he represented a safety risk: "According to the medical file, your blood sugar fluctuations are largely due to your failure to maintain a proper diet and nutrition as required to control your diabetes." (R. 178–179.) In essence, it argues that because Atkins could do more to improve his health, he therefore poses an unacceptable safety risk. However, no negative health consequences have been

suffered by Atkins as a result of his failure to "control" his diabetes, casting doubt on the notion that he takes care of himself in an inadequate way. Fundamentally, the evidence shows that he has managed his disease well enough to have avoided any safety risks from his diabetes for over 19 years.

2. The factors relevant to evaluating safety risk were ignored by DOI

DOI should have used the following factors to evaluate Atkins' ability to safely perform his job: his lack of even a single incident of severe hypoglycemia; his lack of hypoglycemia unawareness; and his successful self-monitoring of his blood glucose. However, although there was evidence that all three factors pointed *against* Atkins being found a safety risk, it was ignored by both DOI and the district court.

An absence of a history of severe hypoglycemia can help establish that an individual is not a safety risk. *Branham v. Snow*, 392 F.3d at 908. Although hypoglycemia is defined as a blood glucose level of less than 70 mg/dl, *severe hypoglycemia* is not defined by a number, but by the impact on the individual person. It is an "event requiring assistance of another person to actively administer carbohydrate, glucagon, or other resuscitative actions."[19]

[19] American Diabetes Ass'n, *Defining and Reporting Hypoglycemia in Diabetes*, *supra* at 1245.

Throughout its medical assessment of Atkins, DOI was aware that he never experienced an episode of hypoglycemia requiring the assistance of others or otherwise impairing his ability to carry out all of his critical law enforcement duties. (R. 167.) However it did not consider this evidence relevant.

DOI's concern about an isolated period of about two weeks when Atkins regularly had low blood glucose readings—readings which met the Association's technical definition of hypoglycemia as blood glucose levels of less than 70 mg/dl—was misplaced because there is no evidence that these episodes impaired his ability to immediately take care of himself or caused any danger to himself or others. (R. 155, 161–64.) Additionally, even if concern over these readings, in and of themselves, was warranted, DOI should have examined them in light of Atkins' explanation that they were due to the illness he experienced during this time.[20] (R. 162.)

Hypoglycemia unawareness is a condition in which some individuals with diabetes are no longer able to perceive signs of mild hypoglycemia. This means that, unless they check their blood glucose levels, they may not be aware of hypoglycemia until it causes cognitive impairment or more severe symptoms.

[20] "An appropriate evaluation should be undertaken by a health care professional with expertise in diabetes to determine the cause of the low blood glucose, the circumstances of the episode, whether it was an isolated incident, whether adjustment to the insulin regimen may mitigate this risk, and the likelihood of such an episode happening again." American Diabetes Ass'n, *Diabetes and Employment*, *supra* at S82.

However, only a minority of people with diabetes ever develop hypoglycemia unawareness. *Onken v. McNeilus Truck & Mfg*., 639 F. Supp. 2d 966, 971 (N.D. Iowa 2009) ("Plaintiff is among a small percentage of diabetics who are often unable to detect a low blood sugar level from their physical symptoms.").

There is no evidence that Atkins had developed hypoglycemia unawareness. On the contrary, during his appearance before the Medical Review Board, in response to questions by its medical advisor, Dr. Larry Saladino, MD, Atkins consistently maintained he was always able to feel the signs and symptoms of hypoglycemia and treat himself immediately:

> Dr. Saladino: Did you know that sometimes diabetics lose that feeling after 20 years? They stop feeling the lows unless they get like very low?
> …
> Dr. Saldino: That's what I'm worried about, that maybe you're not feeling these lows. Feeling twitchy; I don't know.
>
> Mr. Atkins "Like I said, when I feel that, I have my stuff with me that I take. But I've never had the problem to where I've needed to, you know, use my emergency tablets or use my emergency gluco-gun. [21]

(R. 167.) Had Dr. Saladino uncovered any indication that Atkins was experiencing hypoglycemia unawareness, this, combined with other factors, could be evidence that Atkins presented a safety risk. However, DOI produced no such evidence, and

[21] The Association recommends that individuals who use insulin should carry a glucagon emergency kit, referred to by Atkins as a "gluco-gun." This can be used by another person to provide immediate treatment to individuals experiencing incapacitating hypoglycemia, which prevents them from treating themselves.

the mere possibility that Atkins might, at some point in the future, develop hypoglycemia unawareness cannot justify DOI's decision.

In sum, when it evaluated whether Atkins was a safety risk, DOI refused to consider the factors that provided it with the best evidence as to whether Atkins could continue to serve as a Park Ranger.

Evidence that individuals responsibly self-monitor their blood glucose while working in a challenging job also can help establish the lack of a safety risk. More important than the level of any particular blood glucose test is whether individuals consistently use this tool to ensure that they avoid severe hypoglycemia. *E.g.*, *Kapche v. City of San Antonio*, 304 F.3d 493, 500 (5th Cir. 2002) (noting advancements in blood glucose testing technology); *Branham*, 392 F.3d at 907 (internal citation to record omitted) (considering testimony that "Branham tests his blood sugar levels several times a day, has exceptional control over his blood glucose levels and has 'full awareness of all his reactions,' allowing him to respond promptly to low blood sugar levels.").

However, because blood glucose levels fluctuate throughout the day, in response both to changing daily activity and to stress and sickness, sporadic tests are of little use in assessing safety risk. *See Equal Employment Opportunity Comm'n v. Chrysler Corp.*, 917 F. Supp. 1164, 1170–1171 (E.D. Mich. 1996), *rev'd on other grounds*, 172 F.3d 48 (6th Cir. 1998) (district court refused to grant

summary judgment to employer based on claim that the results of three blood sugar tests showed plaintiff posed unacceptable safety risk); *See also Rodriguez,* 436 F.3d 468 (granting summary judgment to plaintiff in case in which job offer was retracted based on results of single urine glucose test).

DOI failed to consider that Atkins maintained a testing regimen that allowed him to work safely for more than 19 years. Rather, it focused only on a short period of approximately two weeks when Atkins had abnormally low blood glucose, but no symptoms of severe hypoglycemia, which Atkins explained were due to a bout with the flu that had prevented him from eating sufficiently or digesting properly. (R. 155, 161–64). Even here, the evidence demonstrates that Atkins took corrective action to prevent any possibility of a safety risk to himself or others.

II. Atkins Has Presented Sufficient Uncontroverted Evidence to Raise a Genuine Issue of Material Fact as to Whether Plaintiff Presents a Safety Risk

Even if the Court accepts DOI's arguments as relevant to establishing a safety risk, there is sufficient evidence in the record to raise a question of material fact on this issue, making summary judgment inappropriate. When a party moves for summary judgment, it must demonstrate the absence of a genuine issue of material fact. *Celotex Corp. v. Catrett*, 477 U.S. 371, 323 (1986). DOI has failed to demonstrate this, as the record shows that Atkins presented both uncontroverted

evidence relevant to a proper safety assessment and adequate evidence to rebut DOI's conclusion that he posed a safety risk.

A. The District Court Should Have Given Weight To Uncontroverted Evidence that Atkins Safely Worked as a Law Enforcement Park Ranger for a Very Long Period

DOI raised no dispute as to whether Atkins' diabetes ever impaired his ability to perform all aspects of his law enforcement job. Since his diagnosis with diabetes in 1986 through the revocation of his law enforcement commission, a period of 19 years, the evidence establishes that Atkins was a highly performing employee whose diabetes never interfered with his ability to perform his job. (R. 32.)

In its opinion granting DOI's motion for summary judgment, the district court improperly discounted Atkins' uncontroverted evidence that he balanced taking care of his diabetes with fulfilling his duties as Park Ranger, and instead relied on speculation that he may potentially pose a risk in the future, contrary to the requirements of the Rehabilitation Act: "[Atkins] argues that he has never had a severe hypoglycemic event at work. However, the law does not require NPS to put the lives of Atkins, his fellow Park Rangers, and the citizens they serve at risk by taking the chance that he will not experience a hypoglycemic episode on the job." (R. 363.) This was error. Contrary to the district court's assertion, many courts have found that an absence of a history of severe hypoglycemia is relevant,

particularly at the summary judgment stage. *Branham*, 392 F.3d at 907; *Simms v. City of N. Y.*, 160 F. Supp. 2d 398, 405 (E.D.N.Y. 2001); *Chrysler Corp*, 917 F. Supp. at 1169.

B. Atkins Presented Evidence That Rebutted DOI's Contention that He Represented a Safety Risk

The district court also failed to consider the contrary evidence and plausible explanations Atkins provided to refute DOI's concerns that he presented a safety risk. Atkins came forward with evidence from his treating physician, Dr. Sherry Martin, demonstrating that she had "no medical reservations regarding his ability to perform his job." (R. 43.) However, the district court improperly failed to take this into account in granting summary judgment to DOI. *See Branham v. Snow*, 392 F. 3d at 908 (denying summary judgment to defendant in case where plaintiff's doctor opined that he could perform the essential functions of the job and that his ability to monitor his blood glucose levels and respond appropriately put him at little risk of harm).

Similarly, Atkins provided plausible explanations for why the specific characteristics of his diabetes management, contrary to DOI's concerns, did not point to any safety risk. Although DOI expressed concern about his somewhat high A1C levels, Atkins' presented evidence from his treating physician that a plausible

explanation of this was that he was deliberately managing his diabetes to minimize the risks of severe hypoglycemia. (R. 43.)

While DOI presented evidence that during a solitary and anomalous two-week period Atkins had several blood glucose readings that met the technical definition of hypoglycemia, Atkins explained that he experienced minimal disruption to his activities due to these readings, and, in any case, they were caused by an isolated event, his flu, not any shortcoming in his diabetes management. Although he missed some work, he explained that it was due to this sickness, not his diabetes. (R. 163–164.) Determining whether this evidence was persuasive should have been left to the jury, rather than decided by the court on summary judgment.

DOI's concern that Atkins might have hypoglycemia unawareness was nothing more than speculation. This is reflected in the following statements made by Dr. Saladino: "Did you know that sometimes diabetics lose that feeling after 20 years? They stop feeling the lows unless they get like very low? . . . . That's what I'm worried about, that maybe you're not feeling these lows. Feeling twitchy; I don't know." (R. 167.) Atkins refuted these concerns by explaining that he was always able to perceive mild hypoglycemia: "Like I said, whenever I feel that, I have my stuff with me that I take. But I've never had the problem to where I've needed to, you know use my emergency [glucose] tablets or use my emergency

gluco-gun. Well, your gluco-gun is for if somebody finds you. But you know, I've had those tablets for years and I've never had any problems." (R.167.) DOI presented no evidence to rebut Atkins' testimony that he does not experience hypoglycemia unawareness. Speculation that a condition might develop in the future because it occurs in some (but not most) individuals with diabetes cannot be a basis for a determination that an individual presently poses a safety risk. Atkins demonstrated that he was squarely in the majority of individuals who use insulin without hypoglycemia unawareness.

Combined, these explanations refute DOI's argument that Atkins' failure to "comply" with all of its recommendations as to how he should manage his diabetes somehow made him a safety risk. Instead, they demonstrate that he was at all times vigilant in taking every possible step to avoid severe hypoglycemia, the real safety risk for workers who use insulin. As explained regarding his A1C levels, there is evidence Atkins focused on managing his diabetes such that he would be at further reduced risk for hypoglycemia. He demonstrated that even when he technically experienced hypoglycemia, it was in no way a significant disruption. He also explained that he consistently followed basic safety precautions, including wearing a medical bracelet and always keeping an emergency source of quick-acting carbohydrates (glucose tablets) and a glucagon emergency kit with him, although he never needed them.

In these circumstances, the district court's grant of summary judgment was clearly not harmless error, but of a type "seriously affect[ing] the fairness, integrity, or public reputation of judicial proceedings." *Rizzo v. Children's Learning Center Ctrs., Inc.*, 173 F.3d 254, 262 (5th Cir. 1999) (quoting *Highlands Ins. v. National Union Fire Ins.,* 27 F.3d 1027, 1032 (5th Cir. 1994)) (reversing summary judgment where there was a genuine issue of material fact as to whether plaintiff presented a direct threat and defendant conceded it had failed to properly raise this issue before the district court).

CONCLUSION

For the reasons set forth above, the district court's order granting DOI summary judgment should be reversed, and this cause should be remanded for trial. Failure to do so will give employers license to circumvent "[t]he thesis of the [ADA which] is simply this: That people with disabilities ought to be judged on the basis of their abilities; they should not be judged nor discriminated against based on unfounded fear, prejudice, ignorance, or mythologies; people ought to be judged on the relevant medical evidence and the abilities they have." *Smith v. Chrysler Corp.*, 155 F.3d 799, 805 (6th Cir. 1998) (quoting 136 Cong. Rec. S 7422–03, 7347 (daily ed. June 6, 1990) (statement of Sen. Harkin)). If this decision is allowed to stand, it will put the 25.8 million Americans who live with diabetes each day at further risk of discrimination solely due to their diagnosis.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that today, February 23, 2011, I served the foregoing Brief of the American Diabetes Association as *Amicus Curiae* in Support of Appellant on counsel listed below through the Fifth Circuit's CM/ECF system:

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 6466 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word software in Times New Roman 14-point font in text and Times New Roman 12-point font in footnotes.

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