

NO. 04-2170

**IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT**

BRENT DARNELL,

Plaintiff-Appellant,

v.

THERMAFIBER, INC.,

Defendant-Appellee.

**ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF INDIANA
SOUTH BEND DIVISION
THE HONORABLE ROBERT L. MILLER, JR., PRESIDING**

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

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CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 04-2170

Short Caption: Brent Darnell vs. Thermafiber, Inc.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party or amicus curiae, or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statement be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P 26.1 by completing item #3):

American Diabetes Association

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

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(3) If the party or amicus is a corporation:

i) Identify all its parent corporations, if any; and

Not applicable

ii) list any publicly held company that owns 10% or more of the party's or amicus' stock:

Not applicable

Attorney's Signature:  Date: September 24, 2004

Attorney's Printed Name: John W. Griffin

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). Yes No

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RULE 29(a) STATEMENT

Appellant consents to the filing of this brief, and Appellee is opposed to the filing of this brief. A copy of Appellant's consent is in the addendum to this brief.

STATEMENT OF INTEREST OF *AMICUS CURIAE*

The American Diabetes Association (“Association”) is a nationwide, nonprofit, voluntary health organization founded in 1940. The mission of the Association is to prevent and cure diabetes and to improve the lives of all people affected by diabetes. The membership of the Association consists of persons with diabetes, health professionals, research scientists, and other concerned individuals. The Association is the largest, most prominent nongovernmental organization that deals with the treatment and impact of diabetes.¹ The Association establishes and maintains the most authoritative and widely followed clinical practice recommendations, guidelines, and standards for the treatment of diabetes that are updated yearly.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 and legal treatment of the millions of Americans with diabetes in employment situations. The Association knows

¹ The Association has more than 430,000 general members, 18,000 health professional members, and more than 1,000,000 volunteers.

² American Diabetes Association: Clinical Practice Recommendations 2004, *Diabetes Care*, Volume 27, Supplement 1, S1-S150 (January 2004).

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); *Diabetes Spectrum* (review and original articles on clinical diabetes management); (3) *Clinical Diabetes* (information about state-of-the-art care for people with diabetes); and (4)

through long experience that employers frequently restrict employment opportunities for persons with diabetes based on prejudices, stereotypes, unfounded fears, outdated medicine, and misinformation concerning diabetes. 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 has adopted the following policy:

Any person with diabetes, whether insulin-dependent or non-insulin dependent, should be eligible for any employment for which he or she would be otherwise qualified.

[B]ecause the effects of diabetes are unique to each individual, it is inappropriate to consider all people with diabetes the same. People with diabetes should be individually considered for employment based on the requirements of the specific job. Factors to be weighed in this decision include the individual's medical condition, treatment regimen (medical nutritional therapy, oral glucose-lowering agent, and/or insulin), and medical history, particularly in regard to the occurrence of incapacitating hypoglycemic episodes.⁴

⁴ American Diabetes Association Position Statement: Hypoglycemia & Employment/Licensure, *Diabetes Care*, Volume 27, Supplement 1, S134 (January 2004).

Consistent with this policy, the Association appears as *amicus curiae* in cases throughout the United States involving unjustified prohibitions or restrictions on the employment of persons with diabetes, bringing to bear its vast medical knowledge of diabetes and diabetes-related discrimination issues.⁵

The Association is an advocate for employees and an information resource for employers to help them understand that persons with insulin-treated diabetes can be qualified, productive, and safe workers in a wide range of employment situations.

BACKGROUND INFORMATION ABOUT DIABETES⁶

Diabetes is a non-curable metabolic disease affecting a person's ability to make or use insulin. It involves the inability of the body to properly regulate the amount of glucose present in the bloodstream. The cells of the body use glucose derived from food as their energy source. Insulin, a hormone, enables glucose to move from the bloodstream into cells. If insulin is not present or not working properly, cells cannot utilize the glucose from the food that a person eats into energy, and glucose builds up in the blood stream, causing severe

⁵ The Association has participated as *amicus curiae* in the U.S. Supreme Court, many circuit courts of appeal (First, Third, Fifth, Seventh, Eighth, and Ninth Circuits), and a number of district courts. In a landmark case which ended the practice of blanket bans on those with insulin treated diabetes, the Fifth Circuit acknowledged the Association's contributions as an *amicus curiae* in its opinion. See *Kapche v. City of San Antonio*, 176 F.3d 840, 847 (5th Cir. 1999) ("In its amicus brief to this court, the American Diabetes Association offers cogent support for [ending blanket bans].")

⁶ See generally: *Bombrys v. City of Toledo*, 849 F.Supp. 1210, 1213-1214 (N.D. Ohio 1993); Bayler, *Dulling a Needle: Analyzing Federal Employment Restriction on People with Insulin-Dependent Diabetes*, 67 Ind. L.J. 1067, 1068-1074 (1992).

and possibly fatal consequences.

Presently, there are more than 18,000,000 Americans with diabetes, including over 4,000,000 persons who take some insulin to help treat their diabetes.⁷ The two most common forms of diabetes are known as type 1 and type 2. Type 1 diabetes (the type that appellant Brent Darnell⁸ has) results from the destruction of the beta cells of the pancreas, which are responsible for producing insulin.⁹ Without insulin, blood glucose (also known as blood sugar) levels become dangerously high (a condition known as hyperglycemia). Since Darnell's body cannot produce insulin, he must inject himself with insulin to stay alive. Administering insulin through injections or an insulin pump is the only way for a person with type 1 diabetes to lower the level of glucose in the blood. The goal of diabetes management is to avoid the short term and long term problems associated with both high blood sugar (hyperglycemia) and low blood sugar (hypoglycemia). Understanding the difference between hypoglycemia and hyperglycemia is important to resolving the issues in this appeal, as they involve two distinct conditions with different symptoms, treatments, and possible repercussions.

Generally, eating raises blood glucose levels while taking insulin or increasing physical exertion lowers them. If a person with diabetes takes too much insulin or takes it

⁷ Centers for Disease Control & Prevention, *National Diabetes Fact Sheet* (2003).

⁸ Brent Darnell's diabetes is well explained in Appellant's Brief, and this brief will not restate them in detail. Brief of Appellant, Statement of Facts, pp. 1-3. The facts about Darnell's diabetes cited in this brief are taken from appellant's brief.

⁹ In Type 2 diabetes, by contrast, the body develops a resistance to the effects of insulin. See American Diabetes Association Position Statement: Standards of Medical Care in Diabetes, *Diabetes Care*, Volume 27, Supplement 1, S15 (January 2004).

at the wrong times relative to meals and snacks, low blood sugar can result. Low blood sugar can develop quickly and, therefore, is the principal risk created by diabetes in the workplace. Symptoms of mild to moderate low blood sugar include tremors, sweating, lightheadedness, irritability, and drowsiness. Severe low blood sugar may lead to severely impaired cognitive functioning, unconsciousness, and convulsions, and can be life threatening if not promptly and properly treated. However, these symptoms are not an inevitable result of low blood sugar. People with diabetes are able to recognize when their blood glucose level is dropping below its target range and are thus able to respond by taking a quick-acting source of sugar such as a sugared soda, juice, or hard candy which raises blood glucose levels. There is uncontroverted testimony in the record that Darnell recognizes the symptoms of low blood glucose and that he has never had incapacitating low blood sugar.

High blood sugar, on the other hand, generally causes *long-term* complications, not short term difficulties. While prolonged dangerously high levels of blood glucose can produce conditions such as kidney disease or vascular complications, experiencing high blood sugar levels does not increase the immediate safety risk of an individual like Darnell who has had no long term complications.

Because of the potential safety risks posed by low blood sugar and high blood sugar, which include some long-term complications of diabetes, *some* individuals with diabetes may be unable to safely perform some jobs. However, such a determination cannot be made without an individual assessment based upon sound medical information. There was no

individual assessment of Darnell, thorough or otherwise, much less one based upon current medical practices.

In order to evaluate Thermafiber's medical assessment of Darnell, it is important to understand some basic facts about the advancement of diabetes treatment that occurred prior to Dr. McCann's evaluation of Darnell in 2001. Although there is no cure for diabetes, in the past decades there have been a number of dramatic improvements in diabetes care and assessment.

Tragically, until insulin was discovered in 1921, all people with type 1 diabetes simply died. In later years, insulin therapy was primitive, and animal insulin was used for injections. Unfortunately, patients had no way to know the level of their blood sugar. A crude *urine* test was used to try to somehow extrapolate a patient's *blood* sugar levels. Urine glucose tests measure the amount of glucose present in the *urine*, on the theory that these values have some rough correlation with blood glucose values.¹⁰ Prior to the mid-1970s, urine glucose tests were used to attempt to monitor glucose levels. Although this was better than no information at all, the urine test was not a reliable or accurate measure of blood glucose levels. Scientists and the American Diabetes Association searched for the holy grail of blood glucose management: to actually measure the real-time amount of glucose in the *bloodstream*.

In the late 1980s and early 1990s affordable, portable blood glucose monitoring

¹⁰ American Diabetes Association Position Statement on Urine Glucose and Ketone Determination, *Diabetes Care*, Volume 18, Supplement 1, S20 (January 1995).

systems became available to patients. Using this device, an individual obtains a drop of blood using a lancet and the blood is placed on a strip which is read by a portable glucose meter, providing a reading of the actual amount of glucose in the bloodstream. As these devices have developed, today a person such as Darnell can carry a small portable meter with him and know his blood sugar level at any time. Similarly, a doctor such as McCann can easily obtain an accurate blood glucose reading. This diabetes management tool has transformed the ability to assess and manage blood glucose levels..

In sum, it has long been standard practice for decades to monitor *blood* glucose, not urine glucose, and the means to do so are widely available to patients, let alone health care providers. Recognizing these developments, the American Diabetes Association's Clinical Practice Recommendations have long recommended monitoring of blood glucose, rather than urine glucose testing, for all persons with diabetes.

There have been other major advancements, such as the use of a lab test called a glycosylated hemoglobin test, commonly known as an A1C test. This test provides a measure of the average amount of glucose in the bloodstream over the past 90 days.¹¹ Insulins have also been dramatically improved to closely track human insulin's rapid absorption and no longer must be refrigerated after opening.

Terms like "controlled" and "uncontrolled" are sometimes bandied about to describe particular individuals with diabetes, as in this case. Thermafiber has attempted to label

¹¹See American Diabetes Association Position Statement: Diagnosis and Classification of Diabetes Mellitus, *Diabetes Care*, 27: S20 (2004).

Darnell as “uncontrolled”. However, there is no objective standard that correlates with this term. Labeling an individuals “controlled” or “uncontrolled” without any basis does not create evidence of a condition that would rise to a direct threat. Simply labeling Darnell “uncontrolled” does not make him so, especially in light of Thermafiber’s failure to perform an individual assessment. Fortunately, advancements in diabetes care and the Association’s Clinical Practice Recommendations are now benefitting millions of patients and physicians all over the world. These advancements have made urine tests obsolete in the management of blood glucose levels and they have added many tools to allow reliable assessment of whether an individual poses a direct threat in the workplace. However, this case is proof that obsolete practices are still being used by some employers, with predictably erroneous results.

SUMMARY OF THE ARGUMENT

The Americans with Disabilities Act (“ADA”) guarantees that an individual is evaluated for a position based upon his or her ability to perform the essential functions of the job, and not upon outdated or ignorant medical knowledge, stereotypes, or obsolete fears about safety risks. An individual with diabetes is entitled to be judged on his or her ability, not the fact that he or she has diabetes. To that end, Congress, through the ADA, has provided that employers, before banning a worker from the workplace, must conduct an individualized assessment of that person’s ability to perform the job, and that assessment must be based on the most current medical knowledge, must be reasonable, and must be based on the best objective evidence about the patient. It is particularly important to focus on the individual capabilities of the person who has diabetes because different people with

the disease will pose different risks of dangerous low or high blood sugar and will manage their diabetes in different ways. Likewise, Congress squarely placed the burden of proof on an employer whenever it contends that an otherwise qualified worker is a direct threat because of their disease¹²

An employer asserting a direct threat affirmative defense must conduct a medically sound individualized assessment before rejecting an individual with diabetes, but there was no such assessment here. Thermafiber did not perform an individualized assessment of Darnell, and actually refused to employ current medical knowledge or the best objective evidence. A thorough review of the record in this case reveals that Thermafiber did not even create a fact issue on the issue of its affirmative defense of direct threat, *much less* establish that claim as a matter of law. Granting summary judgment for defendant on this issue was clear error. This case should be remanded to the district court for trial.

¹²In *Rizzo v. Children's World Learning Centers, Inc*, 84 F.3d 758,764 (5th Cir. 1996),the Fifth Circuit held that like “all affirmative defenses, the employer bears the burden of proving that the *employee* is a direct threat.” See also, *Rizzo v. Children's World Learning Ctrs., Inc.*, 173 F.3d 254, 260 (5th Cir.1999), *aff'd en banc*, 213 F.3d 209 (5th Cir.2000). See also *Dadian v. Village of Wilmette*, 269 F.3d 831 (7th Cir.2001)

ARGUMENT

THERMAFIBER FAILED TO PERFORM THE REQUIRED INDIVIDUALIZED ASSESSMENT IN ORDER TO ESTABLISH THAT DARNELL WAS A DIRECT THREAT

The Association firmly supports the proposition that well-qualified individuals with diabetes have a right to work, while those whose diabetes renders them unable to do the job in question should be rejected. This determination concerning an individual with diabetes cannot, and must not, be done without the individualized assessment that Congress and this Court have required. This case turns on whether Thermafiber's reason for refusing to hire Darnell, which was based on a single fifteen minute examination and an obsolete urine test, is sufficient as a matter of law to prove that Darnell would have posed a direct threat to the health or safety of himself or others if he had been permitted to return to Thermafiber, an issue upon which Thermafiber had the burden of proof at all times.

The Association has filed this *amicus* brief because, based on the arguments and the opinion below, it is evident that Thermafiber and the district court failed to consider the characteristics of diabetes as a disease and the need to focus on the way diabetes affects a particular individual in making a direct threat determination. Thermafiber relied on generalizations and labels, rather than conducting the kind of individualized assessment, based on medical evidence, that would have allowed it to determine whether Darnell himself actually posed a significant safety risk. The Association therefore seeks to emphasize the need to gather sufficient reliable information about how diabetes affects an individual before concluding that such an individual poses a direct threat, to outline the accepted methods for

assessing the effectiveness of an individual's management of diabetes, and to show how these methods were not followed by Thermafiber in this case.

It is particularly necessary to focus on the individual when evaluating a person with diabetes because the disease affects each person differently. Unquestionably some individuals with diabetes difficulties *may* pose a safety risk, but this conclusion can never be reached without the objective assessment Congress requires. Even where an employee or potential employee has diabetes issues, there are a number of factors related to an individual's diabetes that bear on whether or not an individual will have a low blood sugar or high blood sugar episode on the job.

First, people with diabetes can recognize the warning signs of low and high blood glucose and can respond accordingly. Some individuals, however, have greater difficulty in sensing an oncoming low blood sugar episode and therefore may possibly be a safety risk. There is no evidence that *Darnell* was one of those individuals. Instead the evidence in the record indicates otherwise. Furthermore, an assessment, based upon the medicine and tests outlined above, take these issues into account, but none was done here.

It is not often that an employer actually ties the hands of its paid medical examiner by prohibiting the individual assessment Congress mandated. Here, this occurred. In an incongruous comedy of errors, Thermafiber did order a *urine* test, which Thermafiber's examiner admits "means nothing".¹³ He boldly stated that "I don't care about the urine,

¹³ McCann Depo., p. 21, ll. 14-25 at Add. 5.

that's non-significant. It is the *blood* sugar under tight control, that's what is important."¹⁴

Then he was asked this predictable question:

Question: If you don't take a blood sugar measurement, how can you determine whether it's high or low [blood glucose level]?

Answer: Thermafiber didn't ask me to check any blood. Thermafiber didn't pay to have Mr. Darnell's blood checked.¹⁵

Incredibly, a person with diabetes was rejected without even an examination of his blood sugar level. The Association is unaware of a single reported case anywhere in this country where an applicant with diabetes was disqualified without any measurement of blood glucose values. Part of McCann's failure to do an adequate individualized assessment was due to the fact that he did not have authorization from Thermafiber to pay for gathering the necessary data. When asked why he did not even look at Darnell's medical chart, he replied, "Thermafiber didn't ask me to."¹⁶ This is remarkably similar to his testimony that Thermafiber would not even allow or pay him to determine Darnell's blood glucose level. However, reluctance to pay for needed evaluation (if Thermafiber was in fact reluctant) is no excuse for rejecting Darnell's application without any individualized assessment. Thermafiber was insisting on performing its own medical assessment of Darnell and was, therefore, required to do an adequate examination before rejecting him for employment.

Thermafiber, having failed to check his blood sugars, also failed to give Darnell an

¹⁴ McCann Depo., p. 30, ll. 18-25 at Add. 7.

¹⁵ McCann Depo., p. 31, ll. 10-12 at Add. 7.

¹⁶ McCann Depo., p. 33, ll. 6-11 at Add. 8.

A1C test. Similarly, Dr. McCann did not review Darnell's *past* A1C test results.¹⁷ When asked what he had done with respect to that test, the examiner stated, "I did nothing, no I did not."¹⁸ As discussed above, while a blood glucose test shows the amount of glucose in the blood at that particular moment, the A1C test gives a rough estimate of glucose levels over the prior three months. An A1C result, along with a series of blood glucose test results taken over a period of time, can give a good picture of a person's level of glycemic control. Dr. McCann also did not review Darnell's medical chart, although Darnell's physician (Dr. Levine) was right in the same building as Dr. McCann.

Not only did he not have an A1C test, the examiner failed to review Darnell's past history in performing the job duties that would be required. When told that Darnell had successfully done the exact job that the examiner feared he could *not* do without hurting himself, replied "I didn't know he did."¹⁹ Of course, under the law, if an individual has proven that he or she has actually performed the kind of work that the employer fears he or she cannot safely perform, this creates a fact issue on the question of whether the individual is qualified or a direct threat²⁰.

The Association strongly points out that it requires an individualized assessment by

¹⁷ Thermafiber argued at the court below that Darnell's medical records contain two A1C readings, yet it is undisputed that he examiner never even received them.

¹⁸ McCann Depo., p. 13, ll. 12-13 at Add. 3.

¹⁹ McCann Depo., p. 32, l. 25 at Add. 7.

²⁰ See *Holiday v. City of Chattanooga*, 206 F.3d 637, 645 (6th Cir.2000) [holding that the fact that an ADA plaintiff currently holds a position similar to the one from which he was previously terminated constitutes sufficient evidence to create a factual question as to whether the plaintiff was qualified to perform the essential functions of the job].

appropriate personnel of the risks that a person with a disability would actually pose in the workplace. The employer cannot rely on generalizations but must assess the individual's present ability to safely perform the essential functions of the job. An employer must evaluate the probability of harm by gathering *objective, current* medical data or other evidence. Medical judgments must be *reasonable* and must be based on the most current medical knowledge as well as the individual's own track record. According to the Equal Employment Opportunity Commission, in the context of diabetes, the individualized assessment "must be based on objective, factual evidence, including the best recent medical evidence and advances to treat and control diabetes."²¹ As summarized by the 5th Circuit in a case involving diabetes:

To constitute a direct threat, an individual must pose a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation. According to the EEC's implementing regulations, the determination that a person poses a direct threat shall be based on an individualized assessment of the person's "present ability to safely perform the essential functions of the job. [citations omitted]"²²

An employer, under the law, may not simply label a person with diabetes a direct threat without some proof. The ADA's direct threat defense requires a real individualized assessment based on gathering medically-appropriate data, not merely a doctor's impressions based on a brief patient interview. In this case, Thermafiber had no such objective proof. Although it claims to have done an individualized assessment, this assessment was not supported by any valid objective data. The only objective data upon which Thermafiber

²¹ 29 C.F.R. § 1630.2(r).

²² *Kapche v. City of San Antonio*, 176 F.3d 840,844 (5th Cir.1999) (*Kapche I*).

based its rejection of Darnell was a single, unhelpful *urine* glucose test, an assessment tool that is no longer used by diabetes professionals for assessing current blood glucose levels, let alone overall diabetes management. Dr. McCann himself stated that he believes that the urine glucose measurement “mean [t] nothing” in this case.²³

It is elementary in diabetes care that blood glucose measurement is the first and foremost indicator of glycemic control.²⁴ The first step toward getting this kind of information, which Dr. McCann failed to take, was to measure the patient’s blood glucose level on the day of the examination. The next step would have been to review the patient’s recent logs of blood glucose test results (or, if no such logs were available, to ask the patient to keep such logs over a period of time and then view those results). Dr. McCann did not do this either. There can be no true individualized assessment of a person with diabetes without some knowledge of the individual’s blood glucose levels. Finally, A1C tests are considered in reviewing blood sugar values.

Clearly, then, Dr. McCann failed to gather the amount and type of medical data about the actual effect of diabetes on Darnell that would have allowed him to make an individualized assessment.²⁵ Yet this failure was not due to ignorance of what was needed. What makes this case all the more remarkable is that Thermafiber’s own doctor agrees with the Association’s view of the many components necessary to make a proper assessment of

²³ McCann Depo., p. 21, ll. 14-25 at Add. 5.

²⁴ Standards of Medical Care in Diabetes, *Diabetes Care*, Volume 27, Supplement 1, S15, S20 (January 2004) at Add. 15.

²⁵ He also failed to gather other objective data about factors such as Darnell’s work history, as is described in appellant’s brief.

a person with diabetes. These are the following:

1. Blood sugar test results.²⁶
2. Review of patient logs of blood sugar test results.²⁷
3. Review of A1C results.²⁸
4. Prior history of low blood sugar (hypoglycemia).²⁹
5. Amounts and type of insulin administration.³⁰
6. Visual impairments, if any.³¹
7. Other complications of diabetes, if any.³²

While the Association’s “Standards of Medical Care in Diabetes” include many facets of diabetes care, the issues listed above are key in any individualized assessment of a person with diabetes for the purpose of making an employment evaluation. Thus, there was no careful assessment of the “factors to be weighed in this decision [which] include the individual’s medical condition, treatment regimen, and medical history, particularly in regard to the occurrence of incapacitating hypoglycemic episodes.”³³ The chart below shows exactly why the assessment that Dr. McCann performed was neither individualized nor reasonable:

	Elements of an Individualized Assessment	Thermafiber Assessment	ADA Standards of Diabetes Care
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²⁶ McCann Depo, p. 10, l. 10 at Add. 2.

²⁷ McCann Depo, p. 16, ll. 7-25 at Add. 3.

²⁸ McCann Depo. p. 16, ll. 8-10 at Add. 3.

²⁹ McCann Depo. p. 10, ll. 9-14 at Add. 2.

³⁰ Id.

³¹ Id.

³² Id.

³³ American Diabetes Association Position Statement: Hypoglycemia and Employment/Licensure, *Diabetes Care*, Volume 27 Supp. 1, S134 (January 2004) at Add. 9.

1	Blood sugar reading	Not done: Thermafiber would not pay for it. ³⁴	Required
2	A1C test	None done or reviewed. ³⁵	Required
3	Review of Medical History	Not done: Thermafiber would not pay for it. ³⁶	Required
4	Review of treatment regimen such as insulin, oral medications etc.	Not done. ³⁷	Required
5	History of dangerous high blood sugar levels; i.e. ketoacidosis, if any.	None documented. ³⁸	Required
6	Analysis of the essential functions of the job.	Not done. ³⁹	
7	Analysis of the past track record of the individual	The examiner did not know Darnell had done the job successfully and had passed the exam. ⁴⁰	Required.

There was no careful assessment of the “factors to be weighed in this decision [which] includes the individual’s medical condition, treatment regimen, and medical history, particularly in regard to the occurrence of incapacitating hypoglycemic episodes.”⁴¹

There cannot be an individualized assessment of a person with diabetes without

³⁴ McCann Depo., p.31, ll. 1-12 at Add. 7.

³⁵ McCann Depo., p. 13, ll. 12-13 at Add. 3.

³⁶ McCann Depo., p. 33, ll. 7-11, 25; p. 34, ll. 1-4 at Add. 8.

³⁷ Id.

³⁸ McCann Depo., p. 13, ll.14-16 at Add. 3.

³⁹ McCann Depo., p. 32, ll. 23-25 at Add. 7.

⁴⁰ Id.

⁴¹ Hypoglycemia and Employment/Licensure, 27 Diabetes Care Supp. 1 at 134 (January 2004) at Add. 9.

knowing the individual's blood sugars, and without the required review of the individual's medical history. Incredibly, none of this was done. Thermafiber had numerous options and tests at its disposal to make such an individualized assessment, but decided that it did not want to spend the money, or worse, just did not want to make the effort. This is in direct contravention to the dictates of Congress. Therefore, the district court inappropriately concluded that Thermafiber's direct threat claim was established as a matter of law. To the contrary, there was *no evidence* whatsoever of the mandated individualized assessment, much less of direct threat.

CONCLUSION

This Court should not be the first appellate court in the land to hold that an employer may prove a direct threat affirmative defense in a diabetes case without a single measure of blood glucose values. To prove that an employee is a direct threat, an individualized assessment is mandated under the law. This requires more than a superficial fifteen minute examination devoid of any objective evidence. There was no individual assessment here, or even a scintilla of evidence of one. Without such an assessment, there can be no direct threat affirmative defense. Thermafiber clearly failed to meet its burden under its affirmative defense and the summary judgment standard. This case should never have been resolved by summary judgment on the affirmative defense, and should be reversed, and the case remanded for trial.

Respectfully submitted,

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RULE 32 CERTIFICATE OF COMPLIANCE

I, John W. Griffin, the attorney of record in this matter, do hereby certify that this brief complies with the type-volume limitation for briefs established by the Federal Rules of Appellate Procedure and the Rules of the United States Court of Appeals for the Seventh Circuit. The word count is 5,484.

John W. Griffin

CERTIFICATE OF SERVICE

I, John W. Griffin, hereby certify that one original and fourteen paper copies along with one electronic copy of the Brief of the American Diabetes Association as *Amicus Curiae* in Support of Appellant were sent this 24th day of September, 2004, via overnight commercial carrier to:

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and one paper copy and one electronic copy of said Brief were mailed to the following attorneys, via overnight commercial carrier:

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UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

BRENT DARNELL
Plaintiff-Appellant

vs.

THERMAFIBER, INC.,
Defendant - Appellee

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NO. 04-2170

CONSENT FOR AMICUS CURIAE
BRIEF

Pursuant to Federal Rule of Appellate Procedure 29(a), Petitioner Brent Darnell, by and through his counsel of record, consents to the filing of a brief as *amicus curiae* by the American Diabetes Association.

Dated this 21 day of September, 2004.



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