**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MAINE**

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| **SIDNEY ABBOTT,** | ) | |
| **Plaintiff,** | ) | |
| **v.** | ) | **Civil Action No. 94-0273-B** |
| **RANDON BRADGON, M.DM.D.** | ) | |
| **Defendant.** | ) | |

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**UNITED STATES' OPPOSITION TO DEFENDANT'S MOTION FOR SUMMARY JUDGMENT**

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## INTRODUCTION

Plaintiff Sidney Abbott alleges that Defendant Randon Bragdon has violated the Americans with Disabilities Act ("ADA") by refusing to provide routine, in-office dental care to her because she is HIV-positive. There is no dispute that the refusal occurred and both Abbott and Bragdon have moved for summary judgment. Bragdon has also moved for summary judgment on the grounds that Congress lacks the authority to regulate the discriminatory conduct at issue. The United States, as intervenor, has moved for summary judgment on the constitutional defenses asserted by Bragdon, and as amicus curiae, has urged this Court to grant Plaintiff's motion for summary judgment on liability.

This Court should conclude that Bragdon has violated the ADA if it finds (1) that Abbott is an individual with a disability; (2) that Bragdon refused to treat her on account of her disability; (3) that treating her in his office would not constitute a "direct threat" to the health and safety of others;[1] and (4) that Congress has the constitutional power to prohibit disability-based discrimination in the transaction at issue here. The material facts necessary to make these determinations are not in dispute. Defendant Bragdon readily concedes that he refused to provide Abbott with routine dental care in his office, solely because she acknowledged testing positive for HIV. Def.'s Sum. Judg. Mem. at 3. In fact, Bragdon admits that if Abbott had not disclosed her HIV-positive status to him, he would have filled her cavity in his office. Deposition of Randon Bragdon, June 13 & 14, 1995, at 27; attached as U.S. Exhibit F. Bragdon

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[1] Because the direct threat provision is an exception to the general nondiscrimination rule in title III, it is an affirmative defense. Contrary to Bragdon's position, he, not Plaintiff, bears the burden of proof on this issue. See United States v. Morvant, __ F. Supp. __, 1995 WL 131093, *4 (E.D. La. March 22, 1995); Cf. __ F.2d __, D.B. v. Bloom, 1995 WL 490481, *3 (D.N.J. 1995)(ruling in favor of plaintiff where plaintiff only proved that he was an individual with a disability, that defendant was a place of public accommodation, and that plaintiff was denied services); Howe v. Hull, 873 F. Supp. 72 (N.D. Ohio 1994)(same).

also concedes that a) the risk of transmission of HIV in the dental office is small (Def.'s Sum. Judg. Mem. at 19); b) there has never been a documented case of HIV transmission from infected patient to dental health care worker or other patient in the dental setting (id. at 13); and c) many persons who are infected with the AIDS virus are "completely unaware" of their HIV-positive status (id. at 4). Moreover, it is not disputed that both the Centers for Disease Control and the American Dental Association maintain that patients with HIV infection may and should be safely treated in private dental offices where universal precautions are utilized. U.S. Statement of Uncontested Facts in Support of its Motion for Summary Judgment on Constitutional Issues (hereinafter "U.S. Facts").

The only issues, therefore, are legal ones, properly resolved by summary judgment.[2] This Court must determine: (1) whether Sidney Abbott, as an individual who is HIV-positive but not symptomatic for AIDS, is a person with a disability within the meaning of the ADA, (2) whether providing routine in-office dental treatment to patients like Abbott who are HIV-positive constitutes a "direct threat," and (3) whether Congress has the constitutional authority to prohibit discrimination in the transaction at issue here. As we discussed in our opening brief and below, these issues should be resolved in favor of Plaintiff and the United States.

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[2] See Little v. Norris, 787 F.2d 1241, 1243 (8th Cir. 1986)(where defendants admit a policy and the only issue is whether it violates Federal law, summary judgment is appropriate).

## ARGUMENT

### I. SIDNEY ABBOTT IS A PERSON WITH A DISABILITY

First, Sidney Abbott is a person with a disability within the meaning of the ADA.[3] It is undisputed that Ms. Abbott has a physical impairment (infection with HIV, a virus that impairs the hemic and lymphatic systems).[4] Moreover, there is direct evidence that HIV disease substantially limits Ms. Abbott in the major life activity of reproduction; she has testified that she made the decision not to have children because of her HIV infection. Deposition of Sidney Abbott, May 16, 1995 (hereinafter, "Abbott Dep."), at 79, attached as U.S. Exhibit A.[5] Therefore, Sidney Abbott is entitled to protection by the Act.[6] Bragdon argues that the courts in United States v. Morvant, __ F. Supp. __, 1995 WL 131093 (E.D.La. 1995), and Howe v. Hull, 873 F. Supp. 72 (N.D. Ohio 1994), erred in concluding that asymptomatic HIV is a disability under the ADA. These decisions do not stand in isolation, however. Many other federal courts have concluded that HIV is a disability under the ADA and Section 504 of the

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[3] See 42 U.S.C. § 12102(2)(a) (1994) (definition of "disability" includes "a physical or mental impairment that substantially limits one or more of the major life activities of [an] individual").

[4] The ADA regulation defines "impairment" as including HIV, whether symptomatic or asymptomatic. 28 C.F.R. § 36.104 (1994). See infra n.9 and 28 C.F.R., pt. 36, App. B. at 584 ("asymptomatic HIV disease is an impairment that substantially limits a major life activity").

[5] A substantial limitation is one that restricts the conditions, manner, or duration under which a major life activity can be performed as compared with most people. 28 C.F.R., pt. 36, App. B at 584-85.

[6] The fact that Ms. Abbott is otherwise in good health and able to carry out other major life activities, see Def. Sum. Jug. Mem. at 25, does not remove her from the Act's protections. An individual with a disability need only be limited in one major life activity for coverage. 42 U.S.C. § 12102(2)(a). Many individuals with disabilities -- individuals who are blind or deaf or missing a limb, even those with degenerative impairments -- are in good general health in respects other than their substantially limiting condition.

Rehabilitation Act of 1973.[7] Moreover, the conclusion that asymptomatic HIV is a disability is fully supported by the ADA's legislative history,[8] and by the position not only of the Department of Justice but also of the Equal Employment Opportunity Commission.[9]

In fact, several courts have concluded that asymptomatic HIV-positive individuals are substantially limited in the major life activity of reproduction and/or procreation. See Doe v. Kohn, Nast & Graf, 862 F. Supp. at 1321; Doe v. District of Columbia, 796 F. Supp. at 568; Thomas v. Atascadero Unified School Dist., 662 F. Supp. at 379 (dictum); cf. Cain v. Hyatt, 734 F. Supp. 671, 679 (E.D.Pa. 1990)((dictum) coverage under state law); Doe v. Dolton Elementary Sch. Dist. No. 148, 694 F. Supp. 440, 444 (limitations in reproduction because of AIDS).[10]

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[7] See, e.g., D.B. v. Bloom, __ F. Supp. __, 1995 WL 490481, *3 & n.4 (D.N.J. 1995); Austin v. Pennsylvania Dept. of Corrections, 876 F. Supp. 1437, 1465 (E.D.Pa. 1995); Doe v. Kohn Nast & Graf, 862 F. Supp. 1310, 1321 (E.D.Pa. 1994); Doe v. District of Columbia, 796 F. Supp. 559, 568 (D.D.C. 1992); Thomas v. Atascadero Unified School Dist., 662 F. Supp. 376, 379 (N.D.Ca. 1987) (dictum); cf. Harris v. Thigpen, 941 F.2d 1495, 1524 n.46 (11th Cir. 1991) (noting emerging consensus finding asymptomatic HIV coverage under 504); Glanz v. Vernick, 756 F. Supp. 632, 635 (D.Mass. 1991) (coverage not contested, but noting courts have found HIV qualifies as a disability); Ray v. School Dist. of DeSoto County, 666 F. Supp. 1524 (M.D.Fla. 1987) (granting preliminary injunction to HIV-infected students without specifically addressing coverage). The ADA and Section 504 contain the same definition of disability, but 504 uses the word "handicap," rather than disability. See 29 U.S.C. § 706(7)(B).

[8] See U.S. Sum. Jug. Mem. at 19 & n.23; see also 136 Cong. Rec. S9696 (daily ed. July 13, 1990) (statement of Senator Kennedy) "[T]here is a substantial limitation of some major life activity from the onset of HIV infection").

[9] See supra n.4; EEOC, Technical Assistance Manual on The Employment Provisions (Title I) of the Americans with Disabilities Act, at T-II (January 1992)("Some impairments, such as blindness, deafness, HIV infection or AIDS, are by their nature substantially limiting.") Reasoning that HIV substantially limits the major life activity of reproduction, the Department of Health and Human Services has taken the position that HIV is a disability under 504. See In Re Westchester County Medical Ctr., H.H.S. Civ. Rts. Reviewing Authority, Decision No. 1357, at 10-12 (Sept. 25, 1992).

[10] Contrary to Bragdon's claim, the Kmiec Memorandum's position that asymptomatic HIV is a disability -- a position based largely on the limitation of the major life activity of procreation -- was not a mere DOJ staffer opinion, but an official interpretation of the Attorney General. See

Bragdon nevertheless maintains that Abbott's limitation on her reproductive capacity does not qualify her as a person with a disability. Def. Sum. Judg. Mem. at 26. Remarkably, given his attempts to inflate the potential risk of HIV transmission from patient to dentist, Bragdon seeks to downplay the magnitude of the potential risk of transmission from an HIV-positive mother to her unborn child. Whereas the risk of HIV transmission to health care workers (including those regularly in contact with substantial amounts of blood) is so small as to be beyond quantification or measure,[11] Bragdon argues that it is "a fortiori" not credible for this Court to consider a 25% or even an 8% risk that Abbott would infect her baby. Def.'s Sum. Judg. Mem. at 26. In any event, Ms. Abbott has testified that the risk of infection to her child is only one of several HIV-related factors influencing her decision not to procreate. Abbott Dep. at 79. She is also concerned about the effect that carrying and bearing a child would have on her own immune system;[12] and she is concerned that she would not be able to care for the child through the years because of her HIV infection. Abbott Dep. at 79.[13] Bragdon's challenge lacks merit, and this Court should find that Sidney Abbott is protected by the ADA.

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Def.'s Sum. Judg. Mem. at 7 n.5. Kmiec was the Acting Assistant Attorney General in charge of the Office of Legal Counsel, which sets policy for the Department. The Memorandum has been treated as an official DOJ interpretation by Congress, see U.S. Sum. Jug. Mem. at 19, and by courts, see, e.g., Doe v. Kohn Nast & Graf, 862 F. Supp. at 1321; Doe v. District of Columbia, 795 F. Supp. at 567 n.10; Harris v. Thigpen, 941 F.2d at 1524.

[11] Supplemental Affidavit of John A. Molinari, Ph.D. (hereinafter "Molinari Supp. Aff."), at ¶¶ 3, 6, attached to Plaintiff's Opposition to Defendant's Motion for Summary Judgment.

[12] See Thomas v. Atascadero Unified School Dist., 662 F. Supp. at 379 (noting that for asymptomatic individuals, procreation and childbirth is dangerous to themselves and others).

[13] Bragdon's reference to Dr. Craven's deposition testimony regarding the limitations on his asymptomatic patients' life activities is unavailing. See Def.'s Sum. Judg. Mem. at 25. Dr. Craven believes that "HIV positivity substantially affects and limits an HIV-positive woman's decision and ability to procreate safely." See Supplemental Affidavit of Donald E. Craven, M.D. at ¶¶ 4, 5, attached to Plaintiff's Opposition to Defendant's Motion for Summary Judgment. In his

## II. THE UNDISPUTED FACTS DEMONSTRATE THAT TREATMENT OF HIV POSITIVE DENTAL PATIENTS DOES NOT CONSTITUTE A "DIRECT THREAT"

In his motion for summary judgment, Bragdon ignores the uniform line of cases holding that the refusal to provide medical care -- and in particular, dental care -- on the basis of a patient's HIV-positive status constitutes unlawful discrimination. See D.B. v. Bloom, __ F. Supp. __, 1995 WL 490481 (D.N.J. 1995); United States v. Morvant, 1995 WL 131093 (E.D.La. 1995); Howe v. Hull, 873 F. Supp. 72 (N.D. Ohio 1994).[14] Nor does Bragdon acknowledge that these cases uniformly reject the direct threat defense. Instead, Bragdon confuses the issues, relying first, on unsupported conjecture and supposition that have no basis in science, and second, on legal decisions involving HIV-infected health care workers that do not apply to the facts before this Court.

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deposition, Dr. Craven was not testifying as to a legal term of art, nor is he qualified to draw legal conclusions.

[14] See also Minnesota v. Clausen, 491 N.W.2d 662 (Minn. App. 1992); Barton v. New York City Comm'n on Human Rights, 531 N.Y.S.2d 979 (N.Y. Sup. Ct. 1988); G.S. v. Baksh, Charge No. 1987CPO113, slip op. (Illinois Human Rights Commission July 8, 1994); Lewis v. Runkle, Docket No. 92-154-PA(N), slip op. (District of Columbia Commission on Human Rights July 1, 1993); Allen v. Brottman, AIDS Litig. Rep., March 9, 1993, at 9657 (New York Commission on Human Rights Jan. 26, 1993); Estate of Campanella v. Hurwitz, AIDS Litig. Rep., August 23, 1991, at 6800 (New York Commission on Human Rights July 31, 1991). Other courts, while not reaching the merits, have observed that the denial of medical care solely on the basis of a person's HIV-positive status constitutes discrimination under section 504 of the 1973 Rehabilitation Act. See Woolfolk v. Duncan, 872 F. Supp. 1381 (E.D. Pa. 1995); Miller v. Spicer, 822 F. Supp. 158 (D. De. 1993); Glanz v. Vernick, 756 F. Supp. 632 (D. Mass. 1991).

Defendant argues that it is generally inappropriate for parties to cite unpublished opinions from other circuits in unrelated cases. We urge the Court to consider the analysis presented in these cases, however, because, while they are not binding precedent for this Court, they are directly on point, they provide a full rationale for their conclusions, and there are no cases to the contrary. Moreover, the Court and Bragdon have been provided with complete copies, and thus Bragdon is not unfairly prejudiced by their use.

### A. Defendant Relies on Conjecture, Hypotheticals, and Unsubstantiated Assertions Rather than Facts to Make a Claim of "Direct Threat"

Bragdon attempts, through his distortion of the factual record, to prey upon the fears and misapprehensions surrounding HIV and AIDS. He mischaracterizes the practice of general dentistry as a highly dangerous one, describing the ordinary dental office more like a bloody emergency room. As discussed below, his argument includes mischaracterizations of much of the deposition testimony, statements of affiants who have no personal knowledge of the "facts" they assert, assertions not based on any facts in the record at all, and statements of opinion or speculation presented as "facts."[15] The scientific evidence in the record shows that the practice of dentistry (including the treatment of persons with HIV/AIDS) is safe for both dental health care workers and patients.

"One of the principal purposes of the summary judgment rule is to isolate and dispose of factually unsupported claims or defenses." Celotex Corp. v. Catrett, 477 U.S. 317, 323-24 (1986). See August v. Offices Unlimited, 981 F.2d 576, 580 (1st Cir. 1992) ("mere allegations, or conjecture unsupported in the record, are insufficient to raise a genuine issue of material fact"); Wynne v. Tufts Univ. School of Medicine, 976 F.2d 791, 794 (1st Cir. 1992), cert. denied, 113 S.Ct. 1845 (1993); Mack v. Great Atl. & Pac. Tea Co., 871 F.2d 179, 181 (1st Cir. 1989). See also E.P. Hinkel & Co., Inc. v. Manhattan Co., 596 F.2d 201, 205 (D.C. Cir. 1974)(if a party has credible evidence for its position at summary judgment, it must make the existence of such evidence known). In support of his motion for summary judgment, Bragdon has failed to provide any "credible evidence" to support his direct threat defense. His unsupported claims and defenses should be rejected accordingly.

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[15] Finally, Bragdon offers as "fact" statements which are actually improper or unsupported legal conclusions. See, e.g., Defendant's Rule 19 Statement of Undisputed Material Facts

### 1. Bragdon Mischaracterizes Testimony About the Risk of HIV Transmission From Patient to Dentist

The linchpin of Bragdon's argument is that the risk of transmission of HIV from patient to dentist is greater than the risk of transmission of HIV from dentist to patient. Def.'s Sum. Judg. Mem. at 15. Bragdon ignores the context for this assessment. All of the experts cited by Bragdon underscore that the relative risk assessment is made within the context of an environment where the overall risk is "very small." See John A. Molinari, Ph.D., "HIV, Health Care Workers and Patients: How to Ensure Safety in the Dental Office," Journal of the American Dental Association, (Oct. 1993), at 51, attached to Def. Facts as Defendant's Exhibit A, (hereinafter "Molinari article"); Deposition of Donald W. Marianos, D.D.S., Aug. 10, 1995 (hereinafter "Marianos Dep."), at 56, attached as U.S. Exhibit B; Deposition of Deborah Greenspan, BDS, DSc, ScD(hc), FDS RCSEd (Hon.), July 25, 1995, at 19, attached as U.S. Exhibit C. Indeed, the conclusion of the Molinari paper upon which Bragdon's risk statement relies is that dental health care workers should adhere to universal precautions and not let their guard down, as that they might be inclined to do, because the risk is so low:

> Our [dental care providers'] routine aseptic, barrier, disinfection and sterilization infection control protocols have gone a long way in providing high standards of practice safety for both treatment providers and those receiving care. These standards should not be compromised just because HIV does not seem to be a significant occupational pathogen.[16]

The critical fact, which Bragdon also ignores, is that all of the individuals whom he cites believe that it is safe to treat HIV-positive patients in a private dental office. See Molinari article; Supplemental Declaration of Donald W. Marianos (hereinafter "Marianos Supp. Dec."), at ¶ 1, attached as U.S. Exhibit D; Supplemental Declaration of Deborah Greenspan, BDS, DSc,

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(hereinafter "Def. Facts") at ¶¶ 4, 21.

[16] Molinari article at 51, 52 (emphasis added).

ScD(hc), FDS RCSEd(hon.) (hereinafter "Greenspan Supp. Dec."), at ¶ 1, attached as U.S. Exhibit E. This position is supported by the Centers for Disease Control and Prevention ("CDC") and the American Dental Association. See U.S. Facts at ¶ G.

**2. Bragdon Mischaracterizes the Dental Practice and Injuries Occurring There**

Bragdon argues that treating dental patients with HIV creates "an obvious risk" of transmission from patient to dentist -- either when a "dentist accidentally nicks or cuts himself with a sharp instrument or needle," (generally referred to as a "sharps" or "percutaneous" injury) or by blood-to-mucous membrane exposure. Def.'s Sum. Judg. Mem. at 12-13. The undisputed scientific evidence in the record does not support this allegation.

Numerous studies have demonstrated that, on average, dentists incur only 3 to 4 sharps injuries per year. Greenspan Supp. Dec. at ¶ 8; Marianos Dep. at 21, lines 23-25.[17] The vast majority of these incidents will involve patients who are not HIV-positive. Furthermore, in 99.7% of the instances in which a health care worker actually received a needlestick from a needle contaminated with HIV-infected blood, the health care worker did not acquire HIV. Marianos Supp. Dec. at ¶ 4; Greenspan Supp. Dec. at ¶ 8; Bragdon Dep. at 437. The chance of acquiring HIV from any other type of sharps injury is significantly smaller; solid instruments transfer even less blood than the smallest needle and have never been shown to transmit a virus of such low infectivity as HIV. Molinari Supp. Aff. at ¶ 11.

In describing the way he administers injections and the possible accidents that may result, Bragdon suggests that it is "inevitable" that he will suffer needlesticks during the course of his

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[17] Bragdon asserts, however, with no citation to credible authority that "other types of sharps injuries [i.e., other than those that occur when he is administering a local anesthetic] occur routinely, often several times a week." Def. Facts at ¶ 9. This figure is not supported by anything in the record except Bragdon's own self-serving statements.

practice. Def.'s Sum. Judg. Mem. at 11. However, Bragdon can virtually eliminate any such risk of injury by employing safer work practices, such as retracting a patient's cheek with a dental instrument (rather than his hand) when he administers an injection, or by using only one hand to recap a needle. Marianos Supp. Dec. at ¶ 2; Greenspan Supp. Dec. at ¶ 7; Molinari Supp. Aff. at ¶ 10. These safer work practices are consistent with the recommendations of the CDC and OSHA. Marianos Supp. Dec. at ¶ 2; Declaration of Donald W. Marianos, D.D.S., at ¶ 6 (hereinafter "Marianos Dec."); attached to U.S. Facts; 29 C.F.R. Pt. 1910.1030(d)(2)(vii)(A).

Perhaps most importantly, research has shown that in the rare cases where a health care worker has acquired HIV occupationally from a percutaneous injury, the injury generally "involved a fairly large volume of blood or other body fluids containing HIV, with a fairly large bore needle which would not only induce significant trauma, but expose the person to much larger inoculum than you might see with a smaller gauge needle."[18] Deposition of John A. Molinari, Ph.D., Aug. 19, 1995 (hereinafter "Molinari Dep.") at 41, attached as U.S. Exhibit G. These conditions are not present in general dentistry. Id. See Marianos Dec. at ¶ 14.

Bragdon also argues that "the risk of transmission from patient to dentist" includes: a) the risk posed by the "aerosol mist" generated by the dental drill; b) "the danger of blood-to-mucous membrane transmission, as for example, when a drop of blood or bloody saliva enters the dentist's nose or mouth or area around the eyes, directly, or by passing through small defects in masks"; and c) "the danger posed by a drop of blood or bloody saliva touching an ear with dermatitis or a scratch or an abrasion somewhere on the dentist or his assistant of which neither may be aware." Def.'s Sum. Judg. Mem. at 12. None of these hypotheticals is supported by the record.

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[18] In the past 14 years, there are only 36 cases of health care workers (including physicians, nurses, hospital housekeeping staff, morticians, and emergency personnel, among others) who have been documented as having acquired HIV occupationally by a percutaneous injury.

There is no evidence that HIV can be transmitted by aerosolization. Indeed, Bragdon's own expert, Dr. Kuvin, specifically rejected this theory. Deposition of Sanford Kuvin, M.D., July 20, 1995, attached as U.S. Exhibit H, at 55.[19] See also Marianos Supp. Dec. at ¶ 3; Greenspan Supp. Dec. at ¶ 9.

Similarly, there is no evidence that HIV can be transmitted through the nose, or the mouth, or through defects in the dental mask. Greenspan Supp. Dec. at ¶ 9. The only testimony upon which Bragdon relies for this assertion that is even remotely supportive states: "[i]t has never been shown that a small volume of blood containing HIV could transmit HIV. Theoretically, it's possible." Molinari Dep. at 40.[20] However, even though "many things are theoretically possible," current scientific evidence shows that barrier precautions (protective eyewear, dental masks and/or face shields) work. Marianos Dep. at 155. There is no evidence that HIV has ever been transmitted by these hypothetical methods. Greenspan Supp. Dec. at ¶ 9.

Finally, Bragdon's suggestion that the "risk also includes a drop of blood or bloody saliva touching an ear with dermatitis or a scratch or an abrasion somewhere on the dentist or his assistant" has no merit. Universal precautions require that Bragdon and his staff wear protective attire, including a gown, gloves, and protective face wear, and that they cover any cuts or broken

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[19] Similarly, Bragdon asserts that he requires a respirator for safe treatment of HIV-positive patients. Def.'s Sum. Judg. Mem. at 23. Respirators, however, are only necessary to protect against air-borne pathogens, which HIV is not. Greenspan Supp. Dec. at ¶ 10; Marianos, Supp. Dec. at ¶ 3.

[20] See also Molinari Dep. at 111 (emphasis added):

Q: So it's possible, when there are defects in the masks just like when there are defects in the gloves, for HIV to pass through the mask?
A: Yes. But that's not the way this virus has been transmitted.

Neither of the two pages that Bragdon cites from Dr. Marianos' deposition support Bragdon's contention.

skin (such as that from dermatitis) before treating a patient. Greenspan Supp. Dec. at ¶ 9. Universal precautions also require that regardless of whether a dental health care worker's gloves are visibly contaminated with blood, he or she must remove those gloves before touching any part of his or her body. Id. Bragdon has testified that he utilizes universal precautions. U.S. Facts at ¶ E.

Bragdon speculates about the risk of transmission through "scratches or abrasions" about which the dental health care worker is unaware. Again, he is conjuring up a theoretical risk with no basis in fact. As with percutaneous injuries, for HIV transmission to occur through contact between blood and non-intact skin, there needs to be a significant cut or scratch to enable a sufficient quantity of infected blood to enter the bloodstream of the dental health care worker. Greenspan Supp. Dec. at ¶ 9.; Molinari Dep. at 40. The likelihood of such an abrasion a) not being covered by the requisite protective gear, and b) being unknown or undetected by the dental health care worker, is virtually non-existent.[21]

As Defendant concedes, there has never been a documented case of HIV transmission from patient to dental health care worker. Def.'s Sum. Judg. Mem. at 13. In the absence of credible evidence, Bragdon relies on scientifically unsupportable hypotheticals.

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[21] The testimony that Bragdon cites in support of this last assertion is tangentially relevant at best. Dr. Marianos testified that he "remember[ed] some discussions of the possible transmission at one point in time involving a health worker from dermatitis on the ear." When asked if such a transmission was theoretically possible, Marianos answered "I see no reason why it wouldn't be theoretically possible." Marianos Dep. at 147-48 (emphasis added). Similarly, Dr. Craven's entire testimony was that "theoretically, it's possible" that HIV can be transmitted if a drop of blood lands on an exposed abrasion. Craven Dep. at 117. Dr. Molinari testified about a health care worker who may have acquired HIV from a blood-to-mucous membrane exposure, but the exposure occurred when blood showered the face and eyes of a phlebotomist, who was drawing blood from an infected patient, and the rubber stopper of the tube blew off. Molinari Dep. at 40.

### 3. Bragdon's Suggestion that "Many" Dentists May Have Acquired HIV Occupationally is Unsupportable

Lastly, Bragdon attempts to shore up his theories by challenging the CDC's epidemiology, alleging that the CDC data does not accurately reflect the number of health care workers who have acquired HIV occupationally. Id. While Bragdon criticizes the CDC's methodology, he does not point to any credible evidence suggesting that there are health care workers who acquired HIV occupationally and who do not appear in the CDC data.

First, Bragdon challenges the criteria employed by the CDC to document a case of occupationally acquired HIV.[22] He then suggests that:

> [T] here can be no "documented" case of HIV transmission from patient to dentist if the HIV is transmitted through, for example, a drop of blood going up the nose of a dentist, or a drop of blood landing on a cut or scratch of which he was unaware.

Def.'s Sum. Judg. Mem. at 13-14. Indeed, Bragdon alleges that "such transmissions may be occurring with alarming frequency." Def.'s Sum. Judg. Mem. at 14. This wholly unsupported statement is another attempt to conjure up misplaced fear and apprehension. As stated above, there is no evidence that HIV can be transmitted via any of these modes. Moreover, if the health care worker was exposed to enough blood for a transmission to actually occur, then the health care worker would presumably report the incident as an exposure, and, if HIV transmission actually occurred, it could be documented.

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[22] For a case to be documented by the CDC as an occupational transmission of HIV in the health care setting, there must be: a known incident in which the health care worker was exposed to blood or body fluids, a negative baseline test at the time of the incident (i.e., the health care worker tested HIV-negative); and an HIV-positive test within six months of the incident. Marianos Dep. at 27-28.

To further "support" his speculations, Bragdon cites to the 42 documented cases of occupational transmission in the health care setting generally.[23] Bragdon then baldly asserts that "[a]lthough no dentist is yet among them, this will likely change." Def.'s Sum. Judg. Mem. at 14. Again, there is no scientific basis for this conjecture.[24]

Bragdon also notes that there are six cases where it is "possible" that a dental health care worker acquired HIV occupationally. The CDC identifies "possible" cases as those in which "health care workers have been investigated and are without identifiable behavioral or transfusion risks; each [health care worker] reported percutaneous or mucocutaneous occupational exposures to blood or body fluids . . . but HIV seroconversion specifically resulting from an occupational exposure was not documented." Marianos Supp. Dec. at ¶ 13. Thus, while

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[23] This extremely low number applies to all health care workers, nationwide. It includes every medical procedure that has ever been performed in the past 14 years, as well as a number of procedures only tangentially related to the practice of medicine (e.g., embalming a corpse). As noted above, these accidental transmissions involved a fairly large volume of blood or other body fluids containing HIV, under conditions not generally present in dentistry.

[24] Instead, Bragdon points to the fact that among health care workers with HIV, approximately six to eight percent of the cases have no known risk factors identified. Def.'s Sum. Judg. Mem. at 14. "No risk reported or identified" cases involve persons with no reported history of exposure through any of the routes listed in the hierarchy of exposure categories. Marianos Supp. Dec. at ¶ 9. "Risk not identified" cases include persons who are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category. Id. At any given time, there will be a number of cases with no identified risk. Among those, the majority will fall into the category described above as "currently under investigation." The follow-up investigation for a majority of these cases eventually will reveal an identified risk factor (e.g., it will be determined that the infected individual will have engaged in male to male sex, heterosexual sex with an infected individual, intravenous drug use, or other relatively higher-risk activity), and the case will be appropriately reclassified. Id. at ¶ 10. Most important, it is likely that a number of health care workers listed as "no identified risk" actually had nonoccupational risk factors that they did not report or recognize. Id. at ¶ 11.

it is possible that these dental health care workers acquired the virus occupationally, it is just as possible that they did not.[25] Inexplicably, Bragdon concludes that "(l)ogic dictates that these practitioners, and others, who may not even know they have HIV, were probably infected in the office by blood-to-mucous membrane transmissions, despite the use of barrier precautions." Def.'s Sum. Judg. Mem. at 15. There is no support for the contention that these practitioners acquired HIV via blood-to-mucous membrane exposure, nor even any support that these practitioners were using universal precautions.

Finally, Bragdon mischaracterizes the facts of the one case of documented transmission of HIV in the dental care setting. He states that "the transmission of HIV from a Florida dentist to several of his patients (occurred) despite the use of barrier precautions." Def.'s Sum. Judg. Mem. at 15, 16. The salient facts Bragdon ignores, but which are clearly stated in the very authorities he cites, include the following: 1) "after he was diagnosed with AIDS, [the dentist] frequently experienced fatigue, a factor which may have increased the likelihood of injury;" 2) there is evidence that the Florida dentist did not always heat sterilize his instruments; 3) "the investigation [of the dentist's practice] determined that those attempts to follow universal precautions were not uniformly adhered to;" and 4) "no studies have determined if [the transmissions that occurred] were accidental or intentional." Carol Cieleski, M.D., Donald Marianos, D.D.S., M.P.H., et. al, "Transmission of the Human Immunodeficiency Virus in a Dental Practice," attached to Def.'s Sum. Judg. Mem. as Def. Exhibit B, at 803; Molinari Dep. at 31; Marianos Dep. at 54; Marianos Dec. at ¶ 18, respectively.

In sum, Bragdon concedes the material facts at issue in this case: a) the risk of transmission of HIV in the dental office is small, and b) there has never been a documented case

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[25] See n.24 supra.

of HIV transmission from infected patient to dental health care worker or other patient in the dental setting. Def.'s Sum. Judg. Mem. at 13, 19. His theories, suppositions, and fears about HIV transmission are not facts and cannot be a basis for summary judgment.

### B. Based on Undisputed Facts, This Court Should Conclude that Treating Sidney Abbott in Bragdon's Office Would Not Constitute a "Direct Threat"

When all is said and done, Bragdon's twenty-five page argument can be reduced to three simple sentences. 1) The risk of transmission of HIV from infected patient to health care worker is "greater than" that from infected health care worker to patient. 2) Some courts have characterized the risk of HIV transmission from a health care worker to his or her patients as "significant." 3) Because the risk of transmission from patient to provider is greater than that from provider to patient, the risk associated with treating HIV-positive patients "must" be "significant," and Bragdon may legally deny these patients dental care.

The logic of Bragdon's argument, albeit appealing in its simplicity, is, ultimately, wrong. If the only issue before this Court were a comparison of two immeasurably small risks, then Bragdon's argument might be more persuasive.[26] But that is not the issue at hand. Rather, this Court must determine, as others before it already have, whether the minimal risk associated with providing dental care to patients with HIV is significant enough to justify the denial of care to those in need.

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[26] See Molinari Supp. Aff., at ¶ 3, attached to Plaintiff Sidney Abbott's Opposition to Defendant's Motion for Summary Judgment (noting that while the relative or comparative risk of transmission from patient to dental health care worker is greater than from dental health care worker to patient, the two risks are so infinitesimally small as to be immeasurable). When the incidence of opportunity for exposure is factored in, the cumulative risk from infected provider to patient might, in fact, be greater than that from patient to provider. While, on average, an HIV-infected patient will only visit the dentist two to three times per year, the infected dental health care worker will, over the course of his or her lifetime, perform numerous invasive dental procedures.

In other words, before this Court can determine whether the provision of dental care to persons with HIV/AIDS constitutes a "direct threat," it must conduct the individualized assessment dictated by School Board of Nassau County, Fla. v. Arline, 480 U.S. 273, 288 (1987) and 28 C.F.R. § 36.208(c). It must determine -- in this particular factual context -- whether the "nature, severity, and duration" of the risk of transmission outweighs the extremely low "probability" that such transmission will actually occur. In this particular factual context, where we are looking at HIV-infected patients rather than providers, the balance tips in favor of the immeasurably small risk of transmission, and the direct threat defense must fail.

First, in conducting the direct threat analysis, deference must be paid to the reasonable medical judgments of public health officials, specifically "public health authorities such as the U.S. Public Health Service [and] the Centers for Disease Control." 28 C.F.R. pt. 36, App. B at 600 (1994); Arline, 480 U.S. at 288. In the context of infected patients, the CDC unequivocally maintains that when universal precautions are utilized, HIV-positive patients can and should be safely treated in private dental offices. Marianos Supp. Dec., at ¶ 1.[27]

In contrast, the CDC's position with respect to infected health care providers leaves it up to individual medical institutions to determine, on a case-by-case basis, whether infected providers should perform procedures that the institutions identify as "exposure prone." The conclusion of the infected health care worker cases is consistent with this position. See, e.g., Doe v. University of Maryland, 50 F.3d 1261, 1226 (4th Cir. 1995)(finding that defendant's

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[27] See also Morvant, 1995 WL 131093 at *9 (relying on guidance from the CDC and finding no direct threat in the dental treatment of persons with HIV/AIDS). Cf. American Dental Association, 132nd Annual Session of the ADA, Annual Session Report, (Oct. 1991)("Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures provide protection for patients and dental personnel.").

determination that plaintiff, a neurosurgical resident, should not perform exposure-prone procedures was consistent with CDC recommendations); Doe v. Washington University. 780 F. Supp. 628, 629 n.2 (E.D.Mo. 1991) (citing 1987 CDC recommendations).

Second, health care providers, including dentists, are ethically obliged to treat those in need, including those with HIV/AIDS:

> A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual has AIDS or is seropositive, based solely on that fact, is unethical.

American Dental Association, Principles of Ethics and Code of Professional Conduct, Principle-Section 1, Advisory Opinion, American Association of Dental Schools (Jan. 1993); Revised Policy Statement, III B 2 (March 1993)("No dental personnel may ethically refuse to treat a patient solely because the patient is at risk of contracting, or has, an infectious disease, such as Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome or hepatitis B infection. . . .").[28]

Health care providers, also have an ethical obligation to "do no harm." Thus, in the context of the infected health care provider, even though the risk of transmission is minimal, the provider's ethical obligation may require him not to treat. See, e.g., Estate of Behringer v. Medical Center, 592 A.2d 1251, 1277-83 (N.J. Sup. Ct. 1991)(analyzing the ethical obligations owed by providers to their patients and concluding that "even the presence of a low risk of

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[28] See also American Medical Association, Code of Medical Ethics 55 (1994 ed.)("It is unethical to deny treatment to HIV-infected individuals because they are HIV seropositive or because they are unwilling to undergo HIV testing . . . "); American Association of Oral and Maxillofacial Surgeons, Position Paper on Acquired Immune Deficiency Syndrome (AIDS), 2 (Sept. 1991) ("...refusal to treat a patient because that patient has or may have an infectious disease such as AIDS is unethical"); Association of State and Territorial Health Officials and the Association of State and Territorial Dental Directors, Guide to Public Health Practice: HIV and the Dental Community, 7 (Oct. 1991)("[Dental Health Care Workers] have an ethical obligation to provide dental care to HIV-infected individuals, or those perceived to be at risk of HIV-

transmission justifies the adoption of a policy which precludes invasive procedures when there is 'any' risk").[29]

Third, the infinitesimally small risk of occupationally acquiring an infectious disease during the practice of dentistry cannot be eliminated by refusing to treat those who acknowledge their infectious status.[30] Many who are infectious with HIV and other bloodborne pathogens do not know their status; many who do choose not to disclose it. By definition, therefore, when one enters the health care profession, one accepts a certain level of risk.[31] In contrast, as the courts in the infected health care provider cases noted, patients do not expect to be exposed to any risks other than those directly related to their care. See Mauro v. Borgess Medical Ctr., 886 F. Supp. 1349, 1353 (W.D.Mich. 1995) (patients should not be treated by HIV-infected providers when

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infection, in the same manner as they would to other patients.").

[29] See also id. at 1282 (emphasis added) (quoting Keyes, "Health Care Professionals with AIDS: The Risk of Transmission Balanced Against the Interests of Professionals and Institutions" 16 J. of Coll. and Univ. Law 589, 605 (1990)):

> Health-care providers and institutions should consider ethical aspects of the doctor-patient relationship in examining the risk posed by health-care providers infected with HIV. The patient and doctor occupy unequal positions in the relationship. The doctor is trained to recognize, diagnose, and avoid contracting the patient's disease. The doctor stands in a position of trust -- a fiduciary position -- in relation to the patient. A small but palpable risk of transmitting a lethal disease to the patient gives the doctor an ethical responsibility to perform only procedures that pose no risk of transmission. The patient, on the other hand, has no corresponding ethical duty to the doctor. The patient is neither trained nor expected to ascertain the provider's health status. While secretive patients may transmit their diseases to unwary doctors, doctors are responsible for both their own health and the health of their patients.

[30] Nor is it reduced by treating HIV-positive dental patients in a hospital setting. See U.S. Sum. J. Mem. at 23.

[31] See Greenspan Supp. Dec. at ¶ 5 (noting, for example, that when Bragdon graduated from dental school, dentists knew that they were at risk of occupationally acquiring Hepatitis B, a disease that is much more infectious than HIV and that kills approximately 200 health care workers per year).

"(1) there is no patient care reason for doing so, and (2) the risk can be eliminated"); Scoles v. Mercy Health Corp. of Southeastern Pa., 887 F. Supp. 765, 772 (E.D.Pa. 1994) (patient must be apprised of all attendant risks prior to surgery, including surgeon's HIV-positive status); Behringer, 592 A.2d at 1280-81 (same).

Fourth, it is axiomatic that HIV-positive patients require routine medical care, including dental care. See Declaration of Deborah Greenspan, D.D.S., attached to U.S. Facts, at ¶ 3 ("Persons with HIV and persons with AIDS have a continuing need for routine dental services").[32] HIV-infected providers, however, do not similarly need to perform exposure-prone invasive procedures. There are other opportunities in the health care profession that they may pursue. Indeed, many health care professionals (e.g., internists, radiologists, opthamologists, pediatricians, psychiatrists, etc.) do not perform any invasive procedures at all. See, e.g., Washington University, 780 F. Supp. at 634 (commending defendants for extending "opportunities to the Plaintiff to further his medical career by offering alternative programs not requiring invasive techniques").[33]

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[32] Cf. Kuvin Dep. at 99, 188.

[33] Cf. Behringer, 592 A.2d at 1282 (quoting Keyes, "Health Care Professionals with AIDS: The Risk of Transmission Balanced Against the Interests of Professionals and Institutions," 16 J. of Coll. and Univ. Law at 603-04, n.114):

> Society and the law have a significant interest in promoting access to medical care. . . . While society must protect the availability of vital services, there is no need to protect the services of any one provider. Generally, there will be many noninfected providers to replace those who have been restricted from performing invasive procedures. . . .

. . . the restrictions on HIV-positive physicians from providing services, where there is a chance of transmittal from injury and transfer of blood spillage into a surgical site, would have a limited effect on practitioners; the HIV-positive physicians could still practice medicine although precluded from performing invasive procedures.

This Court should therefore reject the analysis in the infected health care worker cases and find that, in the context of HIV-infected patients, the immeasurably low risk of transmission outweighs its severity, and the risk is not "significant." Indeed, every court that has considered whether persons with HIV/AIDS pose a direct threat, in every context other than the infected provider context, has reached this result.[34] Moreover, Congress envisioned this conclusion when it enacted the ADA:

> The public accommodations title of the ADA will also offer necessary protection for people with HIV disease. This title prohibits discrimination in such areas as doctors' offices, dentists' offices, lawyers' offices, and various other service providers. . . . [A] doctor or dentist could not require that a person demonstrate that he or she was not HIV-infected, for example, by requiring that the individual take an HIV test, unless meeting that criterion was necessary to provide services to that individual. Under current medical and scientific judgments, including current CDC guidelines, there is no reason to require proof of HIV-negativity in any public accommodation setting. Thus, title III will finally offer needed protection to individuals with HIV disease.

136 Cong. Rec. S9697 (daily ed. July 13, 1990)(statement of Sen. Kennedy)(emphasis added). See also 136 Cong. Rec. H4625 (daily ed. July 12, 1990)(statement of Rep. Edwards).

Public policy concerns further support this argument. If this Court were to conclude as a matter of law that the attendant risks of filling the cavity of a person with HIV rises to the level of a direct threat, then people with HIV/AIDS may readily be excluded from the other, more invasive, critical care they require. Dentists and other health care providers would have free license to discriminate -- not only against those who disclose their HIV status, but against those

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[34] See note 14, supra, and accompanying text (discussing the unbroken line of authority holding that dental patients with HIV/AIDS do not pose a direct threat); U.S. Sum. Judg. Mem. at 28-29 n.33 (discussing cases under the ADA and section 504 of the 1973 Rehabilitation Act that held that HIV-infected prisoners, schoolchildren, schoolteachers, firefighters, and pharmacists, among others, do not pose a direct threat, despite the potential risk of transmission via blood and/or saliva).

suspected of being HIV-positive, be it because of their sexual orientation, their ethnic background, or their physical appearance.[35]

As a result, many persons would be denied access to necessary dental and medical care, solely because they were, or were perceived to be, infected with the AIDS virus. Others, fearing discrimination, would not even attempt to seek such care. See Bloom, 1995 WL 490481, at *5 ("defendants must recognize that such an experience [the discriminatory denial of dental care] could inhibit HIV-positive persons from seeking important medical services, thus discouraging them from obtaining what they need even more than the average person -- regular, careful, health monitoring"). Still others would seek care when necessary, but would not disclose their HIV-positive status, potentially putting themselves at risk.[36]

In fact, if health care providers can lawfully refuse to care for persons with HIV/AIDS, solely on that basis, many persons may refrain from getting tested for HIV altogether. Such an outcome would have adverse public health implications. As the Presidential Commission on the Human Immunodeficiency Virus Epidemic noted:

> HIV-related discrimination is impairing this nation's ability to limit the spread of the epidemic. Crucial to this effort are epidemiological studies to track the epidemic as well as the education, testing, and counseling of those who have been exposed to the virus. Public health officials will not be able to gain the confidence and cooperation of infected individuals or those at high risk for infection if such individuals fear that they will be unable to retain their jobs and their housing, and that they will be unable to obtain the medical and support services they need because of discrimination based on a positive HIV antibody test.

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[35] See Carol Kunzel and Donald Sadowky, Assessing HIV-Related Attitudes and Orientations of Male and Female General Dentists, 126 JADA 862 (July 1995)(attached to Def. Sum. J. Mem. as Exhibit 4)(discussing dentists' reluctance to treat patients with HIV/AIDS); U.S. Sum. J. Mem. at 5 (discussing the reluctance of health care providers generally to treat patients with HIV/AIDS).

[36] Physicians might misdiagnose the presenting conditions of such patients and/or might prescribe medications contraindicated by other medications the patients are already taking.

> As long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling, and care. This fear of potential discrimination will limit the public's willingness to comply with the collection of epidemiological data and other public health strategies, will undermine our efforts to contain the HIV epidemic, and will leave HIV-infected individuals isolated and alone.

Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic, 119 (June 24, 1988)(emphasis added).[37]

As the Court noted in Arline, 480 U.S. at 284 n.12, the "isolation" of persons with contagious diseases "appears across cultures and centuries, as does the development of complex and often pernicious mythologies about the nature, cause, and transmission of illness." Bragdon's entire argument is based upon such pernicious myths. For all the reasons listed above, this Court should find that the dental treatment of persons with HIV/AIDS does not pose a direct threat.

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[37] During the ADA floor debates, Congress repeatedly cited the findings of the Presidential Commission as one of the bases for establishing protections against discrimination for persons with HIV/AIDS. See, e.g., 135 Cong. Rec. S10718 (daily ed. Sept. 7, 1989)(statement of Sen. Kennedy)("This bill implements the key recommendation of the Presidential Report on the HIV Epidemic. In his report, Adm. James Watkins referred to anitdiscrimination protections for people with AIDS and HIV as the linch-pin of our ability to control the spread of this virus."); 135 Cong. Rec. S10794 (daily ed. Sept. 7, 1989)(statement of Sen. Moynihan) ("Without the protections this legislation provides our successful efforts to control and bring to an end this epidemic will be seriously hampered."); 135 Cong. Rec. S10722 (daily ed. Sept. 7, 1989)(statement of Sen. Cranston)("the Presidential Commission on the HIV Epidemic, as well as numerous public health officials, concluded that Federal protection from discrimination is essential to furthering public health efforts to stop the spread of AIDS"); 135 Cong. Rec. S10800 (daily ed. Sept. 7, 1989)(statement of Sen. Simon)("Actions with regard to people with AIDS and HIV infection will no longer be allowed to be governed by myths, stereotypes, and misperceptions, but rather will be governed by objective medical evidence and facts. This is one of the best steps forward that we can take to fight the AIDS epidemic.").

## III. THE ADA IS CONSTITUTIONALLY APPLIED TO BRAGDON'S PRACTICE OF DENTISTRY

Title III of the ADA is constitutional as applied to Bragdon's dental practice. The prohibition of disability-based discrimination by health care providers is within Congress' power to regulate commerce. Moreover, application of the ADA does not violate Bragdon's constitutional right to be free from unjustified state intrusions on his personal safety, nor his constitutional right of freedom of contract.

### A. The ADA is a Constitutional Exercise of Congress' Commerce Clause Authority as Applied to Bragdon

The United States agrees that this case, like anti-discrimination cases preceding it, should be analyzed under the substantial effects test. See Def.'s Commerce Mem. at 1; Katzenbach v. McClung, 379 U.S. 294 (1964), Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241 (1964). Accordingly, our summary judgment memorandum demonstrates that the operations of Bragdon's dental practice substantially affect interstate commerce. U.S. Sum. Judg. Mem. at 6-8. Bragdon argues, however, that the Supreme Court in United States v. Lopez, 115 S.Ct. 1624 (1995), changed the analysis of as-applied commerce clause challenges to require a showing of the effect on commerce of an entity's proscribed conduct, rather than its operations. Def.'s Commerce Mem. at 2. Nothing in Lopez supports such a departure. Instead, the opinion corroborates the United States' reading of the requirement:

> [W]e have upheld a wide variety of congressional Acts regulating intrastate economic activity where we have concluded that the activity substantially affected interstate commerce. Examples include . . . restaurants utilizing substantial interstate supplies, (citing Katzenbach v. McClung, supra); inns and hotels catering to interstate guests (citing Heart of Atlanta Motel, supra) . . . These examples are by no means exhaustive, but the pattern is clear. Where economic activity substantially affects interstate commerce, legislation regulating that activity will be sustained.

Id. at 1630.[38]

In the context of its prior anti-discrimination decisions, therefore, the Court considered as dispositive not the effect on commerce of discrimination in the particular hotel or restaurant, but the utilization of substantial interstate supplies, and the service of interstate guests. Far from being "legally irrelevant," as Bragdon suggests,[39] the substantial effects on commerce of Dr. Bragdon's dental practice are similarly dispositive. See U.S. Sum. Judg. Mem. at 6-7 n.5 (citing several opinions applying the same analysis).[40]

Thus the Court need not address Bragdon's additional challenge, that the ADA overreaches Congress' power because it is not designed to regulate commerce, per se. Def.'s Commerce Mem. at 2. In any event, the challenge is without merit. To support his argument, Bragdon mischaracterizes the prohibited conduct in this case, calling it in one instance Congress' regulation of the pricing of tooth fillings, which he suggests Congress could regulate, and, in

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[38] Recently, a federal court of appeals upheld, as a legitimate exercise of Congress' commerce clause authority, a criminal statute similar to that in Lopez, where the statute had a "jurisdictional element" that ensured a case-by-case nexus to interstate commerce. U.S. v. Bishop, 64 U.S.L.W. 2168 (3rd Cir. 1995) (upholding the Federal Carjacking Statute, 18 U.S.C. § 2119). The ADA has such a jurisdictional element. 42 U.S.C. § 12181(7); See U.S. Sum. Judg. Mem. at 10.

[39] See Def.'s Commerce Mem. at 2. Bragdon also argued that the Court in Lopez did not discuss respondent's out-of-state connections such as "just [flying] in from out-of-state," id. at 2, but the Court specifically noted that, "[r]espondent was a local student at a local school; there is no indication that he had recently moved in interstate commerce." Lopez, 115 S.Ct. at 1634; see id.

[40] In Lopez, the Court considered the general nexus of the proscribed conduct to interstate commerce -- in order to determine whether Congress had the authority to enact the law in the first place. Id. at 1631-34. See Katzenbach, infra, 32-33; see also U.S. Sum. Judg. Mem. at 3-5 (for discussion of Congress' authority to enact title III).

another instance, Congress' regulation of the practice of dentistry, which he implies is analogous to the traditional state activity at issue in Lopez. Id. at 2.[41]

The ADA is an anti-discrimination statute; it prohibits the discriminatory treatment of individuals with disabilities. Accordingly, the regulated conduct in this case is Bragdon's discriminatory refusal to serve Sidney Abbott on the basis of her HIV-positive status. Congress' power under the Commerce Clause to reach discrimination by private entities is well established. Katzenbach v. McClung, 379 U.S. 294 (1964); Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241 (1964). While the ADA may have an effect on select aspects of the practice of dentistry, it proscribes a discrete range of activities and leaves the regulation of dental practice and associated standards, in general, to the states.[42]

A showing of an effect on commerce caused by a particular entity's discrimination is, as we have established, not required. But the Court and Congress have recognized that discrimination can have an adverse effect on commerce, and Congress acts properly within its commerce clause authority to address that discrimination:

> That Congress was legislating against moral wrongs . . . render[s] its enactments no less valid. In framing Title II [prohibiting discrimination in public accommodations] Congress was also dealing with what it considered a moral problem. But that fact does not detract from the overwhelming evidence of the disruptive effect that racial discrimination has had on commercial intercourse. It was this burden which empowered

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[41] In Lopez, the Court was especially concerned with the fact that the federal enactment of a criminal statute created a general federal police power, thereby usurping the most basic authority reserved by the states. See id. at 1631 n.3, 1634. By contrast, a nationwide civil rights act is a quintessential area of federal concern.

[42] Defendant quotes from Lopez for the proposition that Congress may not regulate the state activity of education, and, by implication, may not also regulate the practice of dentistry, see Def.'s Commerce Mem. at 2, but Defendant attaches his own conclusion to the Court's language. The Court concludes that the commerce clause authority, "though broad, does not include the authority to regulate each and every aspect of local schools." Lopez, 115 S.Ct. at 1633 (emphasis added). Similarly, here, Congress is regulating discrimination by public accommodations, including dental offices, but it is not regulating each and every aspect of the practice of dentistry.

> Congress to enact appropriate legislation, and, given this basis for the exercise of its power, Congress was not restricted by the fact that the particular obstruction to interstate commerce with which its was dealing was also deemed a moral and social wrong.
>
> Heart of Atlanta Motel, 379 U.S. at 257-58. [43]

Even if this Court were to consider the effect on commerce of Bragdon's discriminatory policy, the ADA is constitutionally applied to his practice. First, while in Lopez the Court found no nexus between the targeted conduct (carrying a gun near a school) and commercial activity, here the targeted conduct is discrimination in what is clearly a commercial transaction (provision of professional dental services). See U.S. Sum. Jug. Mem. at 9-10. Second, given Congress' findings of the nationwide scope of discrimination against individuals with disabilities, this Court must examine Bragdon's policy as one "representative of many others throughout the country." See Katzenbach, 379 U.S. at 300-01; see also U.S. Sum. Judg. Mem. at 1, 4-5 (Congress' findings that discrimination is a nationwide problem). Certainly, discriminatory policies like Bragdon's burden the local dental industry by decreasing the availability of health services to individuals with HIV or AIDS. Cf. Summit Health, Ltd. v. Pinhas, 500 U.S. 322, 331 (1991) ((Sherman Act) boycotting a single opthamologist affects interstate commerce because "'as a matter of practical economics'" there will be a reduction of opthamological services in the Los Angeles market). Moreover, the aggregation of discriminatory policies regarding the treatment of individuals with HIV or AIDS results in an overall decline in dental and health services nationally. See Katzenbach, 379 U.S. at 300-01; Wickard 317 U.S. at 127-28; U.S. Sum. Jug. Mem. at 5 n.4 (studies showing effects of discrimination in dentistry).

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[43] Accord Hodel v. Virginia Surface Mining & Reclamation Assn., 452 U.S. 264, 281-2 (1981); Preseault v. Interstate Commerce Comm'n, 494 U.S. 1, 17-19 (1990); United States v. Darby, 312 U.S. 100, 114 (1941). See Lopez 115 S.Ct. at 1628 (quoting from Wickard v. Filburn, 317 U.S, 111, 125 (1942), for the proposition that the prohibited activity need not be "commercial:" "[E]ven if appellee's activity be local and though it may not be regarded as

Lastly, Bragdon suggests that the ADA is not constitutionally applied to his practice because it interferes with his professional judgment. See Def.'s Commerce Mem. at 2. The ADA does not hamper the legitimate exercise of professional medical judgments; it merely prohibits the refusal to treat an individual with a disability on the basis of disability.[44] In this case, Bragdon refused to treat an individual whom he had the professional skills to treat within the normal course of his practice; Bragdon routinely performs tooth fillings in his office for individuals without HIV.

Moreover, what Bragdon would name a "reasonable medical judgment" is substantially out of sync with the opinions of the dominant medical authorities in the field.[45] Indeed, professional obligations and norms require a dentist to treat HIV-infected individuals where, as here, the dentist is capable of providing the treatment the patient seeks.

**B. The ADA Does Not Infringe Bragdon's Due Process Liberty Interests**

**1. Bragdon's Personal Safety is Adequately Addressed in the Act**

Bragdon's reliance on Roe v. Wade, 410 U.S. 113 (1973), and Shapiro v. Thompson, 394 U.S. 618 (1969) -- privacy and right to travel cases dealing with clearly-established fundamental rights -- for the argument that this Court should apply strict scrutiny to the ADA is misplaced. Def.'s Sum. Judg. Mem. at 27. Even in contexts where the Court has found a "significant" or "substantial" right to personal safety, it has not applied strict scrutiny. See, e.g., Washington v. Harper, 494 U.S. 210, 223 (1990) (prison; rationality review); Youngberg v. Romeo, 457 U.S.

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commerce, it may still, whatever its nature, be reached by Congress").

[44] Thus, health care providers may refer to a different physician, or as here, treatment setting, if the provider would make a similar referral for an individual without the disability. See 28 C.F.R. § 36.302(b)(2). See U.S. Sum. Jug. Mem. at 21.

[45] See discussion supra, (the CDC and the American Dental Association maintain that it is safe to treat HIV-infected patients in the private dental office).

307, 322 (1982)(institutionalization; review that is "lower than 'compelling or substantial necessity test'"). Therefore, any lesser personal safety interest asserted by Bragdon is not subject to heightened scrutiny by this Court. See Boyle v. Turnage, 798 F.2d 549, 552 (1st Cir. 1986)(citing Youngberg for general interest in personal safety, and applying rationality review, to uphold a Veteran's Administration requirement that agents must be subjected to a stream burst of mace).

The ADA does not infringe Bragdon's liberty, however. The Act's requirements are a far cry from the abuses of government power in the case Bragdon cites and the cases discussed therein. Def.'s Sum. Judg. Mem. at 27; see Wood v. Ostrander, 879 F.2d 583 (9th Cir. 1989) (police arrested driver and abandoned passenger in high crime area, resulting in passenger's rape); Nishiyama v. Dickson Co., Tenn., 814 F.2d 277 (6th Cir. 1987) (en banc) (permitting a convicted violent felon to drive himself unaccompanied back to prison in a police car, resulting in him stopping a woman and beating her to death); Russell v. Steck, 851 F. Supp. 859 (N.D.Ohio 1994) (forcing an intoxicated man to drive, resulting in subsequent convictions). See also Collins v. City of Harker Heights, Tx., 503 U.S. 115, 127 n.10 (1992) (due process doctrine was "'intended to secure the individual from the arbitrary exercise of the powers of government'" (citation omitted)).[46]

More to the point, the ADA protects Bragdon's personal safety by providing that health care workers do not have to serve individuals with disabilities who present a significant risk to health or safety. See U.S. Sum. Judg. Mem. at 15-16 (discussion of the rationality of Congress'

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[46] Courts extend protection of personal safety as a liberty interest where the government affirmatively restrains an individual "through incarceration, institutionalization, or other similar restraint of personal liberty." Deshaney v. Winnebago County Social Servs. Dept., 489 U.S. 189, 200 (1989) (emphasis added).

provisions). In addition, as explained supra, it is the collective opinion of public and private health associations that universal precautions are the appropriate response to any risk of exposure to HIV, and that if those precautions are implemented, it is safe to provide routine care to such individuals in a dental office. See U.S. Sum. Judg. Mem. at 23.

**2. There is no Fundamental Liberty of Contract and Title III is Not Arbitrary or Irrational**

Bragdon's citation of Meyer v. State of Nebraska, 262 U.S. 390 (1923), for his assertion that the Court should apply strict scrutiny to this case is misleading: the Court in Meyer specifically applied a rational relationship test to the criminalized conduct at issue (teaching a foreign language in a school). Id. at 400. Def.'s Sum. Judg. Mem. at 27.[47] Indeed, in few areas of Court's jurisprudence has the repudiation of a once-recognized fundamental liberty been more explicit than in the Court's post-Lochner liberty of contract decisions. See U.S. Sum. Judg. Mem. at 14. Today, legislation that allegedly implicates such economic rights is presumptively valid, and may be overturned only if "stunningly" arbitrary or irrational. See id. Given Congress' findings about the serious problem of discrimination against individuals with disabilities in health care services, and of individuals with HIV and AIDS, its requirement that health care providers cease discrimination is entirely legitimate and rational.

Nevertheless, Bragdon cites state law cases from the 1950s and 1960s for the general proposition that a hospital or a doctor may select its patients. Def.'s Sum. Judg. Mem. at 28. The ADA does not affect this general prerogative: it narrowly proscribes the discriminatory exclusion of a patient based on that patient's disability. This federal prohibition of discrimination

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[47] Meyer is often cited in a long line of privacy cases for the protection of freedom of choice in the areas of procreation, marriage, and family life, but not for the proposition of liberty to contract. See Harrah Independent Sch. Dist. v. Martin, 440 U.S. 194, 198 (1979).

supersedes the cases Bragdon cites. In fact, in Agnew v. Parks, 343 P.2d 118, 123 (1959), the court stated that at that time there was "no established public policy or legal requirement" that doctors treat certain patients, but here, there is an established public policy plainly articulated in federal legislation.[48] Bragdon has no due process right to continue to discriminate on the basis of disability, and the ADA is, therefore, constitutionally applied to his practice.

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[48] Defendant cites Montero v. Meyer, 790 F. Supp. 1531 (D.Colo. 1992), for the proposition that the state cases create a liberty interest under the Federal Constitution, but Montero deals with procedural, not substantive, due process liberties, id. at 1537, and with a statutory requirement of notice related to a proposed constitutional amendment, id. at 1536. Here, Bragdon asserts a substantive due process right. The Supreme Court has been reluctant to expand substantive due process and examines each asserted interest to determine if it merits such protection. See Regents of the University of Michigan v. Ewing, 474 U.S. 214, 229 (1985) (Powell, J., concurring). Even assuming that Bragdon asserts a cognizable liberty claim based on state law, he still bears the burden of showing that the ADA is an arbitrary or irrational use of government power, which, as we have demonstrated, he can not do. See Collins v. City of Harker Heights, Texas, 503 U.S. 115, 128 (1992); Harrah Independent Sch. Dist., 440 U.S. at 198.

## CONCLUSION

For the above reasons, the Court should deny Defendant's motions for summary judgment and should, instead, grant summary judgment to the United States on the constitutional defenses asserted. In addition, the Court should grant Plaintiff's Motion for Summary Judgment on Liability.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, the undersigned, attorney for the United States of America, do hereby certify that I will serve upon all counsel in this matter, by first class mail postage prepaid true and correct copies of the foregoing United States' Motion and Memorandum for Summary Judgment on Constitutional Issues and Memorandum in Support of Plaintiff on Statutory Issues. Exhibits A through H will be served by the Disability Rights Section of the Civil Rights Division, U.S. Department of Justice

SO CERTIFIED this __ day of _____, 1995.

_____

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