No. 96335-5
[Ninth Circuit No. 16-35205]

IN THE SUPREME COURT OF THE STATE OF WASHINGTON

CERTIFICATION FROM UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

IN

CASEY TAYLOR and ANGELINA TAYLOR, husband and wife and the marital community composed thereof,

Appellants,

v.

BURLINGTON NORTHERN RAILROAD HOLDINGS, INC., a Delaware Corporation licensed to do business in the State of Washington, and BNSF Railway Company, a Delaware Corporation licensed to do business in the State of Washington,

Respondents.

BRIEF OF *AMICI CURIAE* NATIONAL ASSOCIATION OF MANUFACTURERS, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, ASSOCIATION OF WASHINGTON BUSINESS, AND WASHINGTON POLICY CENTER

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I. INTRODUCTION

The National Association of Manufacturers (NAM), the National Federation of Independent Business (NFIB), the Association of Washington Business (AWB), and the Washington Policy Center (WPC) respectfully submit this brief *amici curiae* contingent on the granting of the accompanying motion for leave. The brief urges the Court to adopt the position advocated by BNSF that obesity can qualify as an "impairment" (that is, a legally-protected disability) under the Washington Law Against Discrimination only if the individual's weight is the result of a physiological disorder.

This Court's answer to the certified question will have potentially far reaching effects. A ruling that obesity constitutes a legally-protected disability *per se* would encompass 40 percent or more of the adult population based on weight and height alone, regardless of medical condition or need. This would impact a wide variety of a business's interactions because the Washington Law against Discrimination prohibits disability discrimination not only in employment but also in public accommodations, real-estate transactions, credit transactions, insurance transactions, and the independent contracting relationship. Moreover, the Washington Law Against Discrimination does not merely prohibit discrimination against individual with disabilities; it also obligates businesses to provide affirmative reasonable accommodations with little limitation on overall cost. As such, defining

obesity as being, *per se*, a protected disability would impose new and uncertain obligations on businesses in their dealings with members of the general public, customers, suppliers, and contractors, as well as with applicants and employees.

As BNSF has explained, the position that a physiological cause is required is supported by the language and history of the relevant Washington statutory terms, which demonstrate the Legislature's intent to follow the ADA model on this issue, extending protection only to those with actual medical impairments. Answering the certified question in this way will avoid improperly burdening business, and will also avoid drawing conclusions about the medical significance of an individual's body mass index that are not supported by the medical literature.

II. IDENTITY, INTEREST, AND FAMILIARITY OF *AMICI CURIAE*

The National Association of Manufacturers (NAM) is the largest manufacturing association in the United States, representing small and large manufacturers in every industrial sector and in all 50 states. Manufacturing employs more than 12 million men and women, contributes $2.25 trillion to the U.S. economy annually, has the largest economic impact of any major sector, and accounts for more than three-quarters of all private-sector research and development in the nation. The NAM is the voice of the manufacturing community and the leading advocate for a policy agenda that helps manufacturers compete in the global economy and create jobs across the United States.

The National Federation of Independent Business (NFIB) is the nation's leading small business association, representing members in Washington, DC, and all 50 state capitals. Founded in 1943 as a nonprofit, nonpartisan organization, NFIB's mission is to promote and protect the right of its members to own, operate, and grow their businesses. NFIB represents small businesses nationwide, and its membership spans the spectrum of business operations, ranging from sole proprietor enterprises to firms with hundreds of employees. While there is no standard definition of a "small business," the typical NFIB member employs 10 people and reports gross sales of about $500,000 a year. The NFIB membership is a reflection of American small business.

The Association of Washington Business (AWB) is Washington State's Chamber of Commerce, State Manufacturing & Technology Association, and principal representative of the state's business community. AWB is the state's oldest and largest general business membership federation, representing the interests of approximately 8,000 Washington companies who, in turn, employ over 700,000 employees, approximately one-quarter of the state's workforce. AWB members are located in all areas of Washington, represent a broad array of industries, and range from sole proprietors and very small employers to the large, recognizable, Washington-based corporations which do business in all parts of the state and world. AWB members include all types of employers that conduct business both in and out

of state. Its members rely on the consistent application of laws in every jurisdiction.

The Washington Policy Center (WPC) is an independent, non-profit think tank that promotes sound public policy. WPC improves the lives of Washington State's citizens by providing accurate, high-quality research for policymakers, the media and the general public. Headquartered in Seattle with satellite offices and full-time staff in Olympia and Eastern Washington, WPC's eight research centers, which include their Center for Small Business, publish studies, sponsor events and conferences, and educate citizens on the vital public policy issues facing the region.

The members of NAM, NFIB and AWB are employers who have a vested interest in the outcome of this matter. As leading national and state-wide associations of employers, these *amici* are keenly familiar with workplace disability issues. The WPC has an interest in the outcome of this matter due to its purpose of providing input on matters of public policy. These *amici* file this brief to assist the Court in evaluating both the reasonableness and potential real-world consequences of the parties' positions. These *amici* are uniquely situated to address these considerations and support the Court's decision making.

III. ARGUMENT

A. The Consequences of Defining All "Obesity" as Being Legally Protected Would Be Substantial, and Would Conflict With Legislative Intent.

1. Forty Percent (40%) or More of the Adult Population Can Be Considered "Obese."

American adults are increasingly heavy. The most recent study by the National Center for Health Statistics at the Centers for Disease Control and Prevention concluded that 39.6% of adult Americans are currently obese (37.9% for men and 41.1% for women). Craig M. Hales, Margaret D. Carroll, Cheryl D. Fryar, and Cynthia L. Ogden, PREVALENCE OF OBESITY AMONG ADULTS AND YOUTH: UNITED STATES, 2015–2016, CDC NCHS DATA BRIEF, NO. 288 (October 2017), https://www.cdc.gov/nchs/data/databriefs/db288.pdf. This study follows earlier studies that show an ongoing progression of the weight of adult Americans.[1]

Moreover, certain professions have even higher rates of obesity, particularly

[1] A 2008 study published in the Journal of the American Medical Association (JAMA) estimated that the obesity rate among adult Americans was 32.2% for men and 35.5% for women. Flegal KM, Carroll MD, Ogden CL, Curtin LR, Prevalence and Trends in Obesity Among US Adults, 1999-2008, Journal of the American Medical Association 303(3): 235 (January 20, 2010), https://jamanetwork.com/journals/jama/fullarticle/185235; Cynthia L. Ogden and Margaret D. Carroll, PREVALENCE OF OVERWEIGHT, OBESITY, AND EXTREME OBESITY AMONG ADULTS: UNITED STATES, TRENDS 1960–1962 THROUGH 2007–2008, DIVISION OF HEALTH AND NUTRITION EXAMINATION SURVEYS (June 2010), https://www.cdc.gov/nchs/data/hestat/obesity_adult_07_08/obesity_adult_07_08.htm. In 2014, a NCHS/CDC study concluded that more than one-third (36.5%) of U.S. adults (those 20 and older) were obese. Cynthia L. Ogden, Margaret D. Carroll, Cheryl D. Fryar, and Katherine M. Flegal, PREVALENCE OF OBESITY AMONG ADULTS AND YOUTH: UNITED STATES, 2011–2014, CDC NCHS DATA BRIEF, NO. 219 (November 2015), https://www.cdc.gov/nchs/data/databriefs/db219.pdf.

sedentary jobs. For example, it has been estimated that 86% of the 3.2 million truck drivers in the United States are overweight or obese. Abby Ellis, A Hard Turn: Better Health on the Highway, N.Y. Times, November 21, 2011, http://www.nytimes.com/2011/11/22/health/a-hard-turn-truck-drivers-try-steering-from-bad-diets.html.

Further, if any amount of weight over what is considered to be the "normal" range is deemed to be obese, over 70% of U.S. adults are obese under this measure. Cheryl D. Fryar, Margaret D. Carroll, and Cynthia L. Ogden, PREVALENCE OF OVERWEIGHT, OBESITY, AND EXTREME OBESITY AMONG ADULTS AGED 20 AND OVER: UNITED STATES, 1960–1962 THROUGH 2013–2014, DIVISION OF HEALTH AND NUTRITION EXAMINATION STUDIES (July 2016), https://www.cdc.gov/nchs/data/hestat/obesity_adult_13_14/obesity_adult_13_14.pdf.

Washington State's level of obesity is comparable. According to data collected by the Washington Department of Health report in 2016, 29% of adult Washingtonians were obese at that time, and the rate was increasing. OBESITY DATA: HOW COMMON IT IS – PREVALENCE, TRENDS, AND DISPARITIES, WASHINGTON DEPARTMENT OF HEALTH (last accessed January 14, 2019), https://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/Obesity. Another 35% were overweight, meaning that a combined 64% of adults

in our state had higher than "normal" BMIs. CENTER FOR DISEASE CONTROL AND PREVENTION, NUTRITION, PHYSICAL ACTIVITY, AND OBESITY: DATA, TRENDS AND MAPS, WASHINGTON STATE, https://nccd.cdc.gov/dnpao_dtm/rdPage.aspx?rdReport=DNPAO_DTM.ExploreByLocation&rdRequestForwarding=Form (last visited January 14, 2019).

As shown in BNSF's brief, the language and history of the relevant Washington statutory terms demonstrate the Legislature's intent to follow the ADA model on this issue, extending protection only to those with actual medical impairments. In that light, it is unreasonable to conclude that the Washington Legislature intended to automatically define 40% or more of the adult population as having a legally-protected disability based on nothing more than their body mass index, with no showing of medical impairment.

2. If All Obese Employees Are Considered Disabled, Employers Will Face Significant Burdens in Accommodating Disability.

If this Court holds that individuals are automatically disabled based on nothing more than the ratio between their height and weight, the practical impact on businesses would be immediate and profound. Newly legally-protected obese workers struggling with physically strenuous aspects of the job – such as retrieving supplies from shelves or drawers or simply walking from one end of a production floor to another – could seek any number of accommodations to relieve them of these

tasks. Others might demand different accommodations, such as custom furniture, specially-made uniforms, modifications to manufacturing equipment with restricted access, and travel accommodations. Given the substantial proportion of adults who are obese, businesses could easily become overwhelmed by such requests, diverting time and resources from the needs of individuals with conditions that, without question, qualify as legally-protected disabilities.

Moreover, individuals sometimes seek unreasonable accommodations. Businesses that deny such requests may ultimately prevail against a discrimination claim by proving the request was unreasonable, but not before expending the time and expense of litigating such suits. By enacting the Washington Law Against Discrimination, the Legislature accepted a certain social cost in the form of unfounded litigation in order to obtain the benefit of accommodating qualified individuals with disabilities. The Legislature did *not* choose to subject businesses to the significantly increased potential for litigation that would arise if conditions are considered to be protected disabilities that do not involve any medical impairment.

Further, if obesity is inherently a disability, then businesses would be forced to treat all heavy individuals as being potentially disabled. Innocent acts of attempting to comply with the law by engaging in the interactive process would lead to claims by individuals unhappy about having been asked about their weight, or who assume that the business treated the individual differently because of weight.

And equally, individuals could claim a business ***should*** have assumed their disability, thrusting businesses between Scylla and Charybdis. Again, this would be inconsistent with the Washington Legislature's intent.

B. Treating "Obesity," Without More, as a Medical Impairment Is Not Supported by the Medical Literature.

1. Origin and Flaws of BMI as a Defining Factor.

The body mass index (BMI) was developed almost two centuries ago for reasons that had nothing to do with obesity or medical science. Adolphe Quetelet, a Belgian astronomer and mathematician, sought to define the characteristics of the "normal man" that fit into the bell-shaped "normal statistical distribution" curves with which he was obsessed. To that end, he devised a ratio of weight over height squared. Eknoyan G, Adolphe Quetelet (1796-1874) – The Average Man and Indices of Obesity, Nephrology Dialysis Transplantation Vol. 23, Issue 1 (January 2008), http://doi.org/10.1093/ndt/gfm517. He never suggested that a ratio falling outside what his bell curve declared "normal" from a statistical perspective carried any implications for health and ability. He simply posited based on his studies that people who might be considered "obese" were a statistical minority.

150 years later, Quetelet's statistical ratio became the "body mass index" or "BMI." In 1972, physiology professor Ancel Keys published his "Indices of Relative Weight and Obesity." Keys A, Fidanza F, Karvonen MJ, Kimura N, Taylor HL, Indices of Relative Weight and Obesity, Journal of Chronic Diseases. Vol 25(6)

(July 1972), reprinted with permission in International Journal of Epidemiology, Volume 43, Issue 3, Pages 655-65 (June 2014), http://www.doi.org/10.1093/ije/dyu058. Examining various height-weight formulas, Keys determined that Quetelet's ratio best matched a subject's body-fat percentage. But Keys expressly rejected the idea that BMI should be used to diagnose individuals because it ignored actual health considerations and risk factors. *See, e.g.*, Keys at 664.

BMI and obesity began to be used as markers for health because such a designation was profitable. The size of the diet industry and the promotion of certain body images in the media are well known. But the use of weight-height ratios to track ***health,*** rather than a position in a statistical bell-curve distribution, began in the insurance industry. Realizing that the composition and nature of human bodies, with associated health implications, varied widely, the Metropolitan Life Insurance Company created an index in 1912 that crudely categorized policyholders into "ideal" or "desirable" weights and their contrary "undesirable" opposites to facilitate actuarial decision-making. Eknoyan, *id*.

While BMI has certain correlations with some health conditions, and its use thus can be useful in some circumstances, overall it does not constitute a precise measure of a particular person's current health or ability.[2] Accordingly, the

[2] For example, that a BMI of 40 or higher or 'severe obesity' is correlated with specific adverse

academic literature is consistent with Keys in rejecting the use of BMI as a diagnostic tool for health or ability. Moreover, BMI does not adequately distinguish fat from muscle and bone, and does not account for factors like age, gender, ethnicity, and fitness, and as such it cannot reliably indicate an individual's body composition. Lukaski H, Commentary: Body Mass Index Persists as a Sensible Beginning to Comprehensive Risk Assessment, International Journal of Epidemiology Vol. 43, Issue 3 (June 2014), https://doi.org/10.1093/ije/dyu059. Accordingly, it certainly cannot establish a given individual's health or ability.

Indeed, because BMI cannot even show a person's body composition, even the healthiest individuals could be considered obese by its terms. The Court need only turn on a Seahawks game to see this fact in action. Many, and on some teams most, NFL football players would be defined as "obese" based on BMI alone. Angus Chen, If BMI is the Test of Health, Many Pro Athletes Would Flunk, NPR, February 4, 2016, https://www.npr.org/sections/health-shots/2016/02/04/465569465/if-bmi-is-the-test-of-health-many-pro-athletes-would-flunk. Concurring, the Mayo Clinic explains, "BMI doesn't directly measure body fat, so some people, such as muscular athletes, may have a BMI in the obese category even though they don't have excess body fat." Obesity, Mayo Clinic, https://www.mayoclinic.org/diseases-

health outcomes of concern in the safety-sensitive railroad working environment, as BNSF evidently has concluded, does not make that level of weight/height an appropriate or workable standard as a determinate, standing alone, of what is a disability under the WLAD.

conditions/obesity/symptoms-causes/syc-20375742 (last accessed January 12, 2019).

Consistent with this view, studies strongly suggest that popular stereotypes about the assumed ill health of obese Americans are inaccurate. "Most epidemiological studies find that people who are overweight or moderately obese live at least as long as normal weight people, and often longer." Linda Bacon, Lucy Aphramor, Weight Science: Evaluating the Evidence for a Paradigm Shift, Nutrition Journal 10:9 (January 2011), http://www.nutritionj.com/content/10/1/9 (citing amongst others a nationally representative study published in JAMA and approved by the Centers for Disease Control and Prevention and the National Cancer Institute). Dr. Deborah Burnet, a professor of medicine at the University of Chicago, relegates BMI to a position as "a preliminary screening tool. Higher BMI is associated with higher health risk, but it's not a health state." Chen, *id*. Similarly, the (now withdrawn for other reasons) EEOC Compliance Manual explains that "[b]eing overweight, in and of itself, generally is not an impairment." *EEOC Compliance Manual* Section 902.2(c)(5).

These factors demonstrate why obesity is entirely distinct from the methadone use at issue in *Clipse v. Commercial Driver Services, Inc.*, 189 Wn. App. 776, 358 P.3d 464 (2015). There the Washington Court of Appeals held that the side effects of methadone use could constitute an impairment and thus a disability. Those side

effects, whether real or perceived, impaired the user, and there was an underlying physiological disorder: addiction. Here, there is no evidence that BMI *per se* causes adverse medical outcomes. This argument is medically unsound. And as scholars and obesity advocates have argued, it is also dangerous.

2. Assuming a Link Between Obesity and Ill Health is Dangerous to Obese Individuals and to Society

The movement of the medical and epidemiological communities away from tired actuarial assumption that obesity causes negative outcomes has arisen in concert with an interdisciplinary civil rights movement called Health at Every Size ("HAES"). Scholars and advocates who identify with the HAES model stress body positivity, and critique "fatphobia" and the assumptions it entails. In doing so, they argue that the stigmatization of obesity as an unhealthy state does not help obese individuals lose weight and may instead be the cause of, or correlated with, negative health outcomes.

HAES-based interventions, like encouraging intuitive eating rather than strict diets, have become commonplace in treating eating disorders. Bacon, http://www.nutritionj.com/content/10/1/9. Medical literature has shown that providers who assume that obesity is unhealthy may have themselves threatened the health of obese individuals.

Much of this literature focuses on the phenomenon of weight cycling, wherein heavy individuals repeatedly gain and lose weight as a result of prescribed dieting.

These scholars explain, based on their research, that weight cycling puts the individual at greater risk for the diseases associated with obesity than the obesity itself. *Id.* Specifically, they discuss how weight cycling causes increased inflammation, which in turn causes hypertension, insulin resistance, and dyslipidemia. *Id.* The linkage between such conditions and diagnoses for cardiovascular disorders and diabetes is obvious. Indeed some scholars have gone so far as to suggest "[w]eight cycling can account for all of the excess mortality associated with obesity." *Id.*

HAES scholars, reviewing this literature, derive certain sociological conclusions. First, the lives of obese persons are intersectional. People in low income neighborhoods are not only obese at levels beyond the national average, but obese individuals amongst them are at higher risks of morbidity than those in more affluent neighborhoods. *Id.*; Kristen Cooksey-Stowers, Marlene B. Schwartz, and Kelly D. Brownell, Food Swamps Predict Obesity Rates Better Than Food Deserts in the United States, , Intl. J. Environ. Res. Public Health 14(11): 1366 (November 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5708005/. The reasons for this have been much discussed. These neighborhoods are often either food deserts or food swamps, where healthy food is inaccessible, and cheap fast food or junk food is everywhere. *Id.* Additionally, poverty creates stress and its own associated morbidities. Thus when scholars control for all these factors, they find much lower

associations between obesity and morbidity. The State of Washington acknowledges all this, and the Department of Health implements various programs to expand access to healthy foods.

https://www.doh.wa.gov/CommunityandEnvironment/Food/AccesstoHealthyFoods (last accessed January 12, 2019). These are the interventions Washington needs, unimpaired by prejudicial and unsound assumptions about the health of overweight people.

Second, stigma creates negative health outcomes. Weight cycling and all its associated health consequences are the strongest example. Society tells overweight individuals that they are unhealthy (regardless the state of their health) by virtue of the mere fact of their weight. Propelled by shame or others' good intentions, individuals diet aggressively, and suffer as described above. Further, the stress that such shame produces has undoubted effects on cardiovascular and other bodily systems. Bacon, *id*., http://www.nutritionj.com/content/10/1/9.

As Taylor notes, "[i]t is societal views about what it means to be impaired that may be stigmatizing." *Reply Brief on Certified Question* at 8. A new-found definition of being impaired based only on size would force businesses to join in this stigmatization, making all sorts of judgments about individuals and their abilities and limitations.

IV. CONCLUSION

Obesity, as such, should not be considered to be a legally-protected disability. Instead, proof of a physiological cause should be required. This would be consistent with the Washington Legislature's intent to protect those with medical impairments, not to automatically extend legal protections to 40% of the population (and much more depending on the threshold used) based on nothing more than the ratio of their height to their weight. This outcome would also avoid stigmatizing substantial numbers of Washington citizens as unhealthy based on their BMI alone.

January 14, 2019

Respectfully submitted

s/ Jeremy F. Wood

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CERTIFICATE OF SERVICE

I hereby certify that on January 14, 2019, I electronically filed and caused to be served on all counsel of record the foregoing **Brief of *Amici Curiae***.

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