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ARTICLES

THE DISABILITY KALEIDOSCOPE

Mary Crossley*

I. INTRODUCTION

When Congress enacted the Americans with Disabilities Act\(^1\) (ADA or the Act) in 1990, it consciously chose to expand the universe of actors covered by federal disability discrimination law in accordance with Congress's intent that the ADA function as a "clear and comprehensive mandate" that all forms of disability discrimination be eradicated from American society.\(^2\) Prior to the ADA's enactment, only federal agencies and entities receiving federal financial assistance had been prohibited from discriminating based on disability under federal law—specifically section 504 of the Rehabilitation Act of 1973\(^3\)—but the ADA cast the net far more broadly, extending it to private employers, state and local governments, and public accommo-

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2 "It is the purpose of this chapter to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1) (1994).

3 The law states:

No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of his or her disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.

In enacting the ADA, Congress also chose to explain far more fully and broadly than it had in section 504 the types of action that it believed constituted discrimination based on disability. Section 504 simply states that a covered actor cannot take the following actions against an otherwise qualified individual with a disability: exclude him from participation in, deny him the benefits of, or subject him to discrimination under a covered program or activity. The ADA, by contrast, addresses in its statutory mandate the failure to provide reasonable accommodations, the segregation of people with disabilities into separate programs, and the use of criteria that screen out people with disabilities, among other examples of prohibited discriminatory behavior.

When it came to identifying who would be protected from discrimination under the ADA, however, Congress decided to leave well enough alone. It adopted the definition of handicap that had been used in the Rehabilitation Act since 1974 and adopted it essentially verbatim, only substituting the word "disability" for "handicap." Moreover, the statute itself directs that the ADA's definition of disability be interpreted no more narrowly than the meanings of handicap that had grown up out of the regulations issued under section 504, and the ADA's legislative history evidences Congress's intent that the

4 See 42 U.S.C. §§ 12101–17 (1994) (prohibiting in Title I discrimination by private employers); §§ 12131–50 (prohibiting in Title II discrimination by public services and public entities); §§ 12181–89 (prohibiting in Title III discrimination by public accommodations and services operated by private entities).


6 See 42 U.S.C. § 12112(b)(5)(A) (1994) (providing that covered employers must make "reasonable accommodations" for individuals with disabilities so long as such accommodation does not constitute an "undue hardship"); cf. § 12131(2) (referring to reasonable modifications in defining "qualified individual with a disability"); § 12182(b)(2)(A) (making it discriminatory for public accommodations to fail to make reasonable modifications in order to extend goods and services or make available facilities to individuals with disabilities).

7 See § 12182(b)(1)(A)(iii) (making it discriminatory to provide individuals with disabilities an accommodation different or separate from that provided to others unless necessary to ensure equal opportunity for those with disabilities).

8 See § 12182(b)(2)(A)(i) (making it discriminatory for public accommodations to use eligibility criteria that have a disparate impact on individuals with disabilities).

9 For a discussion of the definition employed by the Rehabilitation Act, see infra text accompanying notes 55–65.

10 See 42 U.S.C. § 12201(a) (1994): "Except as otherwise provided in this chapter, nothing in this chapter shall be construed to apply a lesser standard than the standards applied under Title V of the Rehabilitation Act of 1973 (29 U.S.C. § 790 et seq.) or the regulations issued by Federal agencies pursuant to such title."
term be interpreted in accordance with section 504 case law. Given that Congress, when it enacted the ADA, sought to maintain the status quo in terms of who was protected from discrimination, one might have anticipated that the question of who could bring suit under the ADA would provoke little litigation. One would have been wrong. It appears that the ADA turns the adage on its head, for when it comes to legal definitions of disability, "the more things stay the same, the more they change."

Who could claim protection from discrimination based on handicap was a question that was rarely litigated under section 504, and the relatively uncontroversial nature of the definition of disability continued for a number of years following the ADA's enactment. Indeed, as recently as 1996, one court that decided to address sua sponte the threshold question of whether the plaintiff had a disability refrained from chastising the parties for failing to raise the issue because, according to the court, "it is the rare case when the matter of whether an individual has a disability is even disputed." Over the past several years, however, the frequency of litigation over plaintiffs' status as individuals with a disability eligible to bring an action under the ADA has increased dramatically, so much so that one expert on ADA litigation estimated in March 1998 that the plaintiff's disabled status was a contested issue in over half of the ADA cases being litigated at that time.

Several factors may contribute to this rash of litigation over who has a disability. The timing of the increased litigation may reflect the lag time between when the ADA's employment provisions—which are the source of the vast majority of ADA claims—became fully effective and when lawsuits based on those provisions made their way to court. Moreover, rather than simply defending ADA suits on

11 See Pritchard v. Southern Co. Serv., 92 F.3d 1130, 1132 n.2 (11th Cir. 1996) ("Congress intended for courts to rely on Rehabilitation Act cases when interpreting similar language in the ADA.").

12 When Tudyman v. United Airlines, 608 F. Supp. 739 (C.D. Cal. 1984), was decided, the court noted that, more than ten years following the enactment of the Rehabilitation Act, only one court had previously found a plaintiff under section 504 not to be handicapped. See id. at 745.


15 ADA Title I provisions became effective, first for employers with 25 or more employees after July 26, 1992, then for employers with fifteen or more employees after July 25, 1994. See 29 C.F.R. § 1630.2(e)(1) (1998). Employers with fewer than fifteen employees are exempt from ADA coverage. See id. Claimants under Title I of the ADA must adhere to the administrative procedures outlined in Title VII. 42
grounds of employer motive or plaintiff qualifications, employers are increasingly challenging a plaintiff’s very right to the ADA’s protection, prompted in part by what has been characterized as a narrowing of the courts’ perspective on the meaning of disability.16

The amount—though not timing—of litigation is also undoubtedly attributable to the imprecision of the statutory definition itself and to the inherent difficulties of identifying members of the ADA’s “protected class.” The ADA prohibits discrimination against an “individual with a disability” and defines disability primarily as a “physical or mental impairment that substantially limits one or more of the ma-

U.S.C. § 12117(a) (1994). If the claimant lives in a state that has its own equal employment legislation, and its own agency to administer that legislation, he must first file a charge with that state agency. The state then has 60 days of exclusive jurisdiction over that claim. See § 2000e-5(c). If the state agency does not act on the charge, or terminates its jurisdiction for any reason, the claimant may then file his charge with the EEOC. See § 2000e-5(d). The EEOC then has 180 days of exclusive jurisdiction over the charge. See § 2000e-5(e)(1). Upon the expiration of that 180-day period, the claimant may request a “notice-of-right-to-sue” from the EEOC. At this point, the claimant may file his own private suit against the employer. See § 2000e-5(f)(1). Thus, it may take at least 240 days from the time the claim is made until a lawsuit is filed.

In September of 1977, the EEOC issued 29 C.F.R. § 1601.28(a)(2), authorizing the issuance of right-to-sue letters before the expiration of the statutory 180-day period if the EEOC determined that it would be unable to investigate the claim within that 180-day period. By 1996, citing a huge backlog of charges, the EEOC informally instituted a policy of issuing an early right-to-sue letter automatically when a charging party so requests. See King F. Tower, EEOC Changes “Right-to-Sue” Policy Amidst Legal Challenges, VA. EMPLOYMENT L. LETTER, July 1996. Thus, a “charging party may theoretically file an EEOC charge one day and successfully demand a right-to-sue letter the next.” Id. However, some courts have held that the issuance of an early right-to-sue letter may deprive the court of its jurisdiction, and thus render the claim invalid. See, e.g., Pearce v. Barry Sable Diamonds, 912 F. Supp. 149 (E.D. Pa. 1996) (certifying to the United States Court of Appeals for the Third Circuit the question of whether 29 C.F.R. § 1601.28(a)(2) authorizing the issuance of early right-to-sue letters is a valid regulation). Though the practice continues to be challenged in the courts, the EEOC maintains its unofficial policy of granting early right-to-sue letters upon request.

16 See Catherine A. Lanctot, Ad Hoc Decision Making and Per Se Prejudice: How Individualizing the Determination of “Disability” Undermines the ADA, 42 VILL. L. REV. 327, 328 (1997) (stating that as ADA filings increase in numbers, federal courts have grown hostile to disability discrimination claims); Steven S. Locke, The Incredible Shrinking Protected Class: Redefining the Scope of Disability Under the Americans with Disabilities Act, 68 U. COLO. L. REV. 107, 112–14 (1997) (explaining why and how employers have increasingly challenged the disability status of plaintiffs and the courts’ response).
jor life activities of such individual." The statute, however, neglects to define any of this definition’s constitutive elements. The result is a definition that is notoriously, albeit intentionally, vague and thus subject to varying interpretations. In addition, proving that she is an individual with a disability is part of a plaintiff’s prima facie case in a suit brought under the ADA, and courts have typically held that assessment of disability must be made on a case-by-case basis. Unlike other antidiscrimination statutes, in many cases it is not self-evident that a plaintiff even has the discrimination-prompting attribute. As defined by the ADA, disability is not a static state of being; nor need it be a fixed trait. Instead, the boundaries of the category called “disability” are permeable, with persons moving into and, potentially, out of the category over the course of their lives. Thus, an employer or other entity defending an ADA claim has both an incentive and op-

17 42 U.S.C. § 12102(2)(A) (1994). As will be discussed in greater depth in Part II, the ADA also protects persons who have a history of such an impairment or who are regarded as having such an impairment. See § 12102(2)(B)-(C).

18 See Arnold v. United Parcel Serv., Inc., 136 F.3d 854 (1st Cir. 1998) (“The statute does not itself define the terms ‘impairment,’ ‘substantially limits,’ or ‘major life activity,’ all of which could have more than one meaning. . . . [E]ven as to the ‘ordinary or natural meanings’ of the ADA’s words, reasonable minds can differ. . . .”).

19 See, e.g., MacDonald v. Delta Airlines, 94 F.3d 1437, 1443 (10th Cir. 1996); Kocsis v. Multi-Care Mgmt., 97 F.3d 876, 882 (6th Cir. 1996); Taylor v. Principal Fin. Group, 93 F.3d 155, 162 (5th Cir. 1996); Pritchard v. Southern Co. Serv., 92 F.3d 1130, 1132 (11th Cir. 1996).

20 In other words, a plaintiff who has diabetes cannot simply cite to a prior decision as establishing precedent that diabetes is a disability. Instead, he must prove that his diabetes is an impairment that substantially limits one or more of his major life activities. See, e.g., Homeyer v. Stanley Tulchin Assocs., 91 F.3d 959, 962 (7th Cir. 1996); Ennis v. National Ass’n of Bus. & Educ. Radio, Inc., 53 F.3d 55, 59 (4th Cir. 1995).

21 In other words, as Robert Burgdorf points out, statutes prohibiting discrimination based on race or sex protect all persons, not simply some protected class, from discrimination on these bases. See Robert L. Burgdorf, Jr., “Substantially Limited” Protection from Disability Discrimination: The Special Treatment Model and Misconstructions of the Definition of Disability, 42 VILL. L. REV. 409, 423–24 (1997). By contrast, the Age Discrimination in Employment Act, 29 U.S.C. §§ 621–34 (1994), does create a protected class of persons over the age of 40. See § 631(a). Determining whether a plaintiff falls within that protected class, however, is quite straightforward. Burgdorf argues that the ADA’s prohibition of discrimination based on disability should be understood, like Title VII’s prohibition of race or sex discrimination, as protecting everyone from discrimination based on the forbidden ground. See Burgdorf, supra, at 568–72. While well taken, Burgdorf’s point does not address the fact that, in order to claim the ADA’s protection, a plaintiff must prove that he satisfies at least one prong of the broad statutory definition of individual with a disability.

22 See infra text accompanying notes 226–28 for a discussion of the dynamic nature of disability.
portunity to dispute the plaintiff's status as an individual with a disability.

Whatever the reasons, the courts are currently encountering a spate of litigation over what constitutes a disability for purposes of the ADA. Plaintiffs with conditions ranging from a bent pinky, to seasonal affective disorder, to breast cancer have claimed protection under the ADA. In attempting to resolve the questions that arise—some novel and some recurring—courts have looked far and wide for guidance: to the ADA's language and legislative history, to regulations issued under the ADA and section 504, to cases decided under these statutes, and to guidelines issued by agencies charged with enforcing the ADA. None of these sources, however, provides a theoretical framework for putting into a larger perspective the question of whether disability exists in a particular case. Not surprisingly, perhaps, the torrent of decisions on defining disability are all over the board, and even where trends have emerged on a particular issue, those trends do not appear to fit into any larger understanding of whom the ADA should protect.

The lack of a theoretical framework underpinning legal decisions on who is disabled is itself not surprising. Disability is a topic that has been generally undertheorized. Compared to topics like race and gender, disability has in the past engendered fewer theoretical examinations. For the past few decades, and increasingly in the 1990s, however, scholars in the burgeoning field known as "disability studies" have been approaching the question of "what is disability" from philosophical and social science perspectives, gradually piecing together a framework for understanding disability as a phenomenon. Like

26 See, e.g., Bragdon v. Abbott, 118 S. Ct. 2196 (1998) (relying on the plain language of the ADA, on regulations issued under the Rehabilitation Act, on regulations and administrative guidelines issued by agencies administering the ADA, and on precedent interpreting the Rehabilitation Act and the ADA).
27 See Lennard J. Davis, Enforcing Normalcy: Disability, Deafness, and the Body xii (1995); cf. Simi Linton, Claiming Disability: Knowledge and Identity 147 (1998) (asserting that the liberal arts "have barely noticed disability").
28 See Peter Monaghan, Pioneering Field of Disability Studies Challenges Established Approaches and Attitudes, Chron. of Higher Educ., Jan. 23, 1998, at A15. Simi Linton describes the field of inquiry known as disability studies as follows:

Disability studies takes for its subject matter not simply the variations that exist in human behavior, appearance, functioning, sensory acuity, and cognitive processing but, more crucially, the meaning we make of those variations.
scholars in the fields of race and gender years before them, disability theorists dispute the assumption that "biology is destiny"\(^2\) and assert that the disadvantages suffered by persons with disabilities, like the disadvantages suffered by women and African-Americans, are the product of social practices and not the inevitable consequence of physical difference. Unlike its race and gender counterparts, however, disability theory by and large has not filtered into the legal literature on disability.\(^3\)

This Article's purpose is to bring these theoretical perspectives on disability to bear on some of the issues that have arisen with respect to defining disability for purposes of the ADA. Turning the "disability kaleidoscope" by adopting these perspectives may cause the picture—the ongoing struggles over who has a disability and can claim the ADA's protections—to shift and appear quite different. Looking at the law of defining disability through a disability studies lens may bring into focus how some legal decisionmakers continue to act on the assumption that biology is destiny when it comes to disability. More positively, infusing disability theory into the legal literature might enable legal decisionmakers to shift their own perspectives on the nature of disability and who should be considered disabled. That is the mission of this Article.

To that end, Part II sets the legal stage by laying out how federal statutory definitions of disability have evolved since the middle of this century, thus illustrating how Congress has endeavored to fit those

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The field explores the critical divisions our society makes in creating the normal versus the pathological, the insider versus the outsider, or the competent citizen versus the ward of the state. It is an interdisciplinary field based on a sociopolitical analysis of disability and informed both by the knowledge base and methodologies used in the traditional liberal arts, and by conceptualizations and approaches developed in areas of the new scholarship. Disability studies has emerged as a logical base for examination of the construction and function of "disability." These scholarly explorations and the initiatives undertaken by the disability rights movement have resulted in new paradigms used to understand disability as a social, political, and cultural phenomenon.

LINTON, supra note 27, at 2.

29 Id. at 143; cf. Susan M. Wolf, Beyond "Genetic Discrimination": Toward the Broader Harm of Geneticism, 23 J.L. MED. & ETHICS 345, 345 (1995) (challenging the assumption with respect to genetic differences).

definitions to their statutory purposes. Part II also describes briefly some of the recurring issues that have arisen in litigation over the definition of disability and considers what guidance the Supreme Court's recent decision in Bragdon v. Abbott\textsuperscript{31} will offer lower courts addressing these issues. Part III then sets the theoretical stage by examining nonlegal approaches to understanding disability. This Part looks first at widely accepted conceptual frameworks of disability and then focuses on the understanding of disability that has grown up out of the work of disability studies scholars over the past two decades. Part IV is the meat of the Article. It adopts the perspective of disability theory and examines how regulatory and judicial interpretations of disability often reflect traditional understandings of disability, rather than the civil rights approach to disability that the ADA purports to espouse. Specifically, Part IV critiques, from a disability studies viewpoint, how administrative and judicial lawmakers have given meaning to the term "impairment," which is one of the building blocks of the ADA's definition of disability. Focusing on the particular concept of impairment offers rich insights into lawmakers' understandings of what bodily characteristics may give rise to disability, and thus which persons may be entitled to legal protection. Part V concludes by stepping back and assessing more broadly what the impairment critique suggests with respect to the fundamental task of defining who should be able to claim the protection of disability discrimination laws.

II. THE LEGAL EVOLUTION OF THE TERM "DISABILITY"

Congress has used the terms "disability" and "handicap" in a number of legislative schemes during the second half of the twentieth century, but has taken various approaches to giving legal content to those terms. While the thrust of this Article is not primarily historical, reviewing the different legal meanings attached to the term "disability" over the past half-century may inform our understanding of the issues that continue to arise as the courts attempt to give concrete meaning to that term today in the context of ADA litigation. To that end, this Part will briefly describe the variety of meanings given to disability and handicap in major federal legislation since mid-century.

A. The Social Security Disability Insurance Program

During the 1950s, Congress created the first disability component of the Social Security Act, a disability insurance program that would extend cash assistance payments to persons who were unemployable

\textsuperscript{31} 118 S. Ct. 2196 (1998).
due to a disabling physical or mental impairment. Participants in the
debate over the feasibility of a disability insurance program recog-
nized that a core problem would lie in defining the term "disability." Developing this definition challenged lawmakers to balance providing
coverage to those who needed it with preventing abuse and fraudu-

tent claims. The definition of "disability" under the legislation ultimately en-
acted in 1956 emphasizes a clinical determination of physical or
tal impairment. Throughout the development of the Social Se-
curity Disability Insurance (SSDI) program, the Advisory Council of
the Social Security Board favored this approach, proposing to restrict
compensable disabilities to those "which can be objectively deter-
mined by medical examinations or tests." The statute's final formu-
lation of disability requires the applicant to have a "medically
determinable physical or mental impairment" evidenced by measurable outward signs of disability; patient reports of symptoms and pain
will not suffice unless supported by and consistent with objective
evidence.

In terms of substance, the Social Security definition of disability
focuses on the impact that an individual's impairment or combined
impairments have on her ability to work. The claimant must not only
be incapable of performing her previous job, she must be unable to
"engage in any other kind of substantial gainful work which exists in
the national economy." In determining an individual's em-
ployability, the statute allows consideration of factors in addition to

33 See S. Doc. No. 80-1621 (1948). For a detailed accounting of the development
of the disability insurance program, see DEBORAH A. STONE, THE DISABLED STATE
36 See § 423(d)(5). The 1967 amendments to the statutory definition of disability
attempted to make it even more objective, requiring that the impairment stem from
"anatomical, physiological, or psychological abnormalities which are demonstrable by
medically acceptable clinical and laboratory diagnostic techniques." § 423(d)(3).
37 § 423(d)(2)(A) (1995). The Commissioner of Social Security issues regula-
individual earning more than $500 per month from employment would not qualify as
The statute, however, does provide that the amount of earnings used to calculate
whether an individual is "disabled" shall not include any amount needed to provide
services, devices, and drugs necessary to control the disabling condition, within "rea-
sonable limits." 42 U.S.C. § 423(d)(4). For an examination of the boundaries of the
disability category under the statute, see Matthew Diller, Entitlement and Exclusion: The
the medically demonstrable impairment, including "age, education, and work experience."\textsuperscript{38} The SSDI program understands disability as total and permanent and does not contemplate the possibility that an impairment might limit an individual's employment options, or make work more difficult, without making it altogether impossible. Accordingly, temporary impairments do not qualify as disabilities for SSDI purposes: the disabling impairment must endure no less than one year, or must be of the type that normally ends in death.\textsuperscript{39}

In so crafting the definition of "disability" for use in the SSDI program, Congress sought to erect a clear dividing line between the "disabled" and the rest of society, so that assistance could be provided to those persons found unable to work without undermining the obligation to work generally borne by members of society. Accordingly, the Social Security definition understands disability as a status functionally equivalent to retirement.\textsuperscript{40}

\subsection*{B. The Rehabilitation Act of 1973}

In contrast to Congress's understanding of disability as a status that exempts one from the obligation to work—an understanding embodied in the SSDI program's definition of disability—federal legislation enacted in 1973 viewed disabled individuals as potentially capable of working. Congress enacted the Rehabilitation Act of 1973 in an attempt to broaden and improve existing vocational rehabilitation programs\textsuperscript{41} and to extend services to a broader range of individuals with disabilities, including those who might not obviously benefit vocationally.\textsuperscript{42} In particular, the Rehabilitation Act was intended to reach those individuals with the most severe handicaps, those which would require numerous vocational services over a prolonged period.\textsuperscript{43} In considering the legislation, the Senate Committee articulated the desire to commit the requisite time and money to ensure that any individual who could reach vocational goals would be empow-

\begin{itemize}
\item \textsuperscript{38} 42 U.S.C. § 423(d)(2)(A) (1995). By contrast, the Social Security Administration cannot consider whether eligible work exists in the region in which the claimant resides, or whether the claimant might face obstacles to being hired because of employer assumptions or stereotypes about his impairment.
\item \textsuperscript{39} See § 423(d)(1)(A).
\item \textsuperscript{40} See Matthew Diller, \textit{Dissonant Disability Policies: The Tensions Between the Americans with Disabilities Act and Federal Disability Benefit Programs}, 76 Tex. L. Rev. 1003, 1015–16 (1998).
\item \textsuperscript{41} For a description of federal rehabilitation legislation predating the Rehabilitation Act, see Drimmer, supra note 30, at 1364–71.
\end{itemize}
By eliminating the word "vocational" from the name of the bill, however, Congress simultaneously signaled a commitment to giving every handicapped individual the benefit of government rehabilitative services, without requiring eventual employability as a condition to the eligibility for services. Notwithstanding this apparent magnanimity, Congress justified government funding of these services in economic terms by focusing on freeing the caregivers of those with severe disabilities to reenter the workforce.

The Rehabilitation Act, however, went beyond simply expanding existing rehabilitation programs by demonstrating a new intent on the part of Congress to secure equal rights for individuals with disabilities. This intent is most amply illustrated by the inclusion of section 504 of the Act, which prohibited any program or activity receiving federal financial assistance from discriminating against any "otherwise qualified handicapped individual . . . solely by reason of his handicap." Thus, Congress provided a limited promise of civil rights to handicapped individuals as a complement to its promise of rehabilitation services.

Despite this inclusion of civil rights goals, the Rehabilitation Act's definition of persons covered by the statute retained a vocational focus. The Act defined a qualifying "individual with a disability" as a person whose mental or physical disability "constitutes or results in a substantial impediment to employment" and required that the "individual with a disability . . . benefit in terms of an employment outcome" from the services provided. This definition seems to belie Congress's stated intent to provide services for all those with disabilities, regardless of the foreseeable vocational outcome. Moreover, the employment focus of this definition was particularly problematic as applied to section 504. The "vocationally focused" definition left unprotected from discrimination any individual with a disability who

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45 See id. at 2092.
46 See id. at 2092-93.
50 § 706(8)(A)(ii).
51 In fact, the definition reflects a concession to President Nixon, who, in his veto message for a 1972 version of the bill, resisted shifting the legislation's focus away from vocational rehabilitation as a dilution of the resources and purpose of the Act and cautioned against adopting "welfare or medical goals." See S. Rep. No. 93-318 (1973), reprinted in 1973 U.S.C.C.A.N. 2086, 2089.
did not need, or was unable to benefit from, vocational rehabilitation.\textsuperscript{53} Thus, children with disabilities, individuals with the most severe disabilities, elderly persons with disabilities, and individuals who had successfully completed rehabilitation all remained unprotected from intentional discrimination.\textsuperscript{54}

\textbf{C. The 1974 Rehabilitation Act Amendments}

Recognizing that the original definition simply did not work in the context of prohibiting discrimination, Congress amended the Rehabilitation Act in 1974 to create a new definition of “handicapped individual” for purposes of section 504.\textsuperscript{55} In doing so, not only did Congress seek to remedy the defects of the earlier definition, it also wanted the new formulation to cover individuals discriminated against based on assumptions about physical or mental impairments, regardless of whether those individuals actually had an impairment.\textsuperscript{56} In the process, Congress eliminated all reference to employment in the definition of “handicapped individual”\textsuperscript{57} and sought to craft a definition that would embody “a broad government policy that programs receiving Federal financial assistance shall be operated without discrimination on the basis of handicap.”\textsuperscript{58}

The product was a three-pronged approach to defining “handicapped individuals,” which sought to address the variety of ways in which those individuals may be discriminated against.\textsuperscript{59} The first prong covers individuals who have “a physical or mental impairment which substantially limits one or more of such person’s major life activities.”\textsuperscript{60} Often called the “actual disability” prong, it requires a plaintiff seeking coverage under section 504 to prove three basic facts: that the individual has either a physical or mental impairment, that the impairment limits a major life activity, and that the limitation is substantial. The statutory language itself provides no clarification of the terms “impairment,” “major life activity,” or “substantially limits.”

The definition’s second prong protects individuals who have a record of an impairment that would substantially limit a major life activity.\textsuperscript{61} The purpose here is to cover individuals who have been

\textsuperscript{53} See id. at 6389.
\textsuperscript{54} See id. at 6388–89.
\textsuperscript{55} See id.
\textsuperscript{56} See id. at 6389–90 (expressing the intent to broaden coverage).
\textsuperscript{57} See id. at 6389.
\textsuperscript{58} Id. at 6390.
\textsuperscript{59} See id. at 6389.
\textsuperscript{61} See § 706(8)(B)(ii).
classified or labeled as having a disability, whether erroneously or correctly. Additionally, the second prong applies to persons who have recovered, either totally or partially, from a condition that constituted an impairment substantially limiting a major life activity. These individuals are included in the definition because Congress recognized the potential stigma that attaches once an individual is labeled as handicapped and the detrimental effects of that stigma on an individual's opportunities for employment and services. Thus, the “record of” prong acknowledges that stereotypes about disability may be as much a barrier to individuals with disabilities as the impairments themselves.

Similar concerns motivated Congress's inclusion of the third prong of the definition of handicapped individual, which covers individuals who are “regarded as” being handicapped. This prong covers both individuals who are erroneously believed to have an impairment and those who do have some impairment, but who are not substantially limited in any major life activity. Again, Congress broadened the definition in an attempt to protect persons from the negative effects of society's assumptions and stereotypes about disabilities, not simply from discrimination based on function-limiting impairments.

The Department of Housing, Education, and Welfare (HEW) issued regulations analyzing and interpreting section 504 of the Rehabilitation Act and clarifying some of the terms in the amended statutory definition of handicapped individual. Specifically, the regulations defined “physical impairment” as meaning any “physiological disorder or condition, cosmetic disfigurement, or anatomical loss” affecting any of the following bodily systems: “neurological; musculoskeletal; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine.” A “mental impairment” under the regulations was “any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.” The HEW regulations acknowledged the prohibitive difficulty of listing all the diseases and conditions encom-

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63 See id.
66 See 45 C.F.R. § 84.3 (1997).
67 § 84.3(j)(2)(i)(A).
68 § 84.3(j)(2)(i)(B).
passed by the regulatory definition of impairment, but offered an illustrative list. The HEW regulations also illuminated the meaning of "major life activities," giving as examples "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." The regulations, however, neglected to shed any light on the meaning of "substantially limits."

**D. The Americans with Disabilities Act of 1990**

Almost two decades after first prohibiting discrimination based on handicap, Congress enacted the Americans with Disabilities Act of 1990 and extended the prohibition of discrimination to the private sector. In the legislative findings included in the statute, Congress recognized individuals with disabilities as a "discrete and insular minority" who had been subjected to discrimination and "political powerlessness" based on their disabilities. In addition, the statute expressly acknowledges the existence of "stereotypic assumptions" about disability that are "not truly indicative of the individual ability of . . . individuals to participate in, and contribute to, society."

The ADA's stated goals are broader than the Rehabilitation Act's, for the ADA expressly seeks to "assure equality of opportunity, full participation, [and] independent living" for persons with disabilities. Nonetheless, like the Rehabilitation Act and the Social Security Act before it, the ADA falls back on economic justifications. Alongside its other goals, the ADA seeks to assure "economic self-sufficiency" for individuals with disabilities, presumably through gainful employment, and Congress's findings cite the desire to diminish the cost to society and


72 § 12101 (a)(7).

73 Id.

74 § 12101 (a)(8). For a further discussion of the relationship between the SSA and ADA definitions of disability, see Diller, supra note 40.

75 42 U.S.C. § 12101 (a)(8).
the national economy from individuals with disabilities "resulting from dependency and nonproductivity."76

To advance its goals, Congress adopted for the ADA virtually the same three-pronged definition of a handicapped individual used in the 1974 Amendments to the Rehabilitation Act, simply substituting the phrase "individual with a disability" for "handicapped individual."77 The ADA's drafters made clear Congress's intention that the ADA's definition of disability should be interpreted consistently with section 504's language and HEW's implementing regulations.78 Similarly, the ADA Committee Reports recite verbatim from HEW's section 504 regulations regarding the definition of "physical or mental impairment."79 Moreover, the ADA's legislative history specifies that the third "regarded as" prong of the disability definition seeks to protect individuals who are not actually disabled from adverse treatment based on "negative reactions," "misinformation," and "negative attitudes toward disability."80

As it did with the Rehabilitation Act, Congress resisted a "laundry list" of qualifying disabilities under the ADA as prohibitively difficult and potentially overly restrictive,81 but the legislative history of the ADA suggests the parameters of Congress's understanding of disability. The ADA Committee Reports reproduced HEW's illustrative list of covered impairments, with the addition of HIV infection,82 and rejected the idea that coverage should be limited to "traditional" disabilities.83 Nonetheless, Congress intended to exclude from the ADA's coverage "minor, trivial impairments,"84 and Congress further indi-


76 § 12101(a)(9).
80 Id. at 23–24.
cated that mere physical traits, such as eye or hair color, would not qualify as "impairments" contemplated by the ADA definition.\textsuperscript{85} The ADA definition similarly excludes any nonphysical, nonmental impairments, such as "environmental, cultural, and economic disadvantages."\textsuperscript{86}

More significant exclusions from the ADA's definition of "disability" resulted from debate on the Senate floor. Some senators attacked the ADA definition as creating an overly broad class of individuals who would be protected from discrimination.\textsuperscript{87} In fact, Senator Armstrong wanted to exclude all conditions listed in the \textit{Diagnostic and Statistical Manual of Mental Disorders} (DSM) of the American Psychiatric Association, a move that would have removed many mental impairments from protection.\textsuperscript{88} Only an ardent defense by other senators prevented conditions such as AIDS and HIV infection, manic-depression, and schizophrenia from being expressly excluded from the definition of "disability."\textsuperscript{89} Partly as a concession to appease senators favoring a restrictive definition of "disability" and partly as a compromise to obtain President Bush's signature,\textsuperscript{90} certain conditions were ultimately excluded from the ADA's coverage, including, among others, current use of illegal drugs, homosexuality, bisexuality, transvestitism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, compulsive gambling, kleptomania, and pyromania.\textsuperscript{91}

When it enacted the ADA, Congress also explicitly authorized several federal agencies—the Equal Employment Opportunity Agency (EEOC), the Department of Justice (DOJ), and the Department of Transportation (DOT)—to issue regulations implementing those provisions of the ADA for which each bore enforcement responsibility.\textsuperscript{92}

\begin{thebibliography}{92}
\bibitem{85} \textit{See id.}
\bibitem{86} \textit{Id.}
\bibitem{88} \textit{See} 135 \textit{Cong. Rec.} 19,871.
\bibitem{89} \textit{See} 135 \textit{Cong. Rec.} 19,897–93.
\bibitem{90} \textit{See} Burgdorf, \textit{supra} note 77, at 519.
\bibitem{92} \textit{See} 42 U.S.C. § 12116 (1994) (authorizing the EEOC to issue regulations implementing Title I), §§ 12134(a) and 12186(b) (authorizing the Attorney General to issue regulations implementing the public services provisions of Title II and the public accommodations provisions of Title III), and §§ 12149, 12164, and 12186 (authorizing the Secretary of Transportation to issue regulations implementing the transportation-related provisions of Titles II and III).
\end{thebibliography}
The resulting regulations provide a regulatory gloss on the meaning of disability.

The EEOC issued regulations and interpretive guidelines under Title I that reject a restrictive approach to defining "disability." Unlike the Social Security Act, the ADA—according to the interpretive guidelines—does not require that an individual be totally unable to work in order to qualify as disabled. Instead, an individual will be "substantially limited" in the "major life activity" of working if the individual is "significantly restricted in the ability to perform either a class of jobs or a broad range of jobs in various classes as compared to the average person having comparable training, skills and abilities." With respect to major life activities other than working, the regulations define "substantially limited" in relation to the abilities of the "average person in the general population." An individual's impairment will be deemed "substantially limiting" either if she is entirely unable to perform a major life activity that the "average" individual would be able to perform, if she can only perform it in a markedly altered manner, or if she can only perform it for a much shorter time. The regulations also designate factors to consider in determining whether a major life activity is "substantially limited." Those factors include the nature of the impairment, its severity, how long the impairment can be expected to last, and what type of permanent or long-term impact the impairment might be expected to have. In-
deed, the ADA Title I regulations expressly exclude impairments of short duration as insufficiently limiting.99

The EEOC regulations and interpretive guidelines also illuminate the third prong of the ADA’s “disability” definition, which deals with perceived disability. The regulations indicate that the “regarded as” prong covers (1) an individual who has an impairment that does not substantially limit a major life activity, but who is treated as if the impairment is substantially limiting; (2) an individual who has an impairment that substantially limits major life activities only as a result of others’ attitudes toward such impairment; and (3) an individual who has no impairment, but who is treated as if she does have a substantially limiting impairment.100 Moreover, the guidelines indicate that, if an employer makes an adverse employment decision against an individual because of “myths, fears and stereotypes” about disability, then its action would fall under the third prong of the “disability” definition, whether the employer’s perception was a universal or an idiosyncratic one.101 Thus, if an individual is treated differently because of “common attitudinal barriers” faced by individuals with disabilities—including assumptions about their productivity, reliability, or safety, increased costs resulting from accommodation, insurance, liability, or fears about the possible reactions from coworkers or clients—then that individual is regarded as having a disability and the discriminatory treatment is prohibited by the ADA.

E. Persistent Issues and Supreme Irresolution

Despite attempts by the agencies charged with enforcing the ADA to clarify and to provide interpretive guidance on the statute’s definition of “disability,” numerous interpretive issues relating to that definition have arisen in cases filed under the ADA. Some questions

99 See § 1630.2(j). In analyzing the factors for “substantially limited,” the interpretive guidelines provide that “temporary, non-chronic impairments of short duration, with little or no long term or permanent impact, are usually not disabilities.” The guidelines, however, provide no “bright line” test for determining how long an impairment’s disabling impact must last before it becomes substantially limiting. See id. By contrast, DOJ and DOT regulations do not impose durational requirements on disability. According to the DOT, any condition that meets the statutory definition is a qualifying disability under the ADA, regardless of its duration. See 49 C.F.R. § 37.3 (1997). The DOJ regulations, which do not define “substantially limits,” call for a case-by-case analysis of each impairment, which includes evaluating the impairment’s expected duration and the degree to which it actually limits the individual’s ability to conduct a major life activity. See 28 C.F.R. § 36.104, app. b (1998).
100 See § 1630.2(l).
touch on points that the agencies simply did not address, or at least did not attempt to answer precisely. For example, how should courts determine whether an activity is a "major life activity" if it is omitted from the agencies' illustrative list? Litigants have posed this question with respect to activities as diverse as reproduction, participation in interscholastic athletics, the elimination of bodily wastes and commuting to work. Other contentious issues arising in the gray areas left by the regulations include how long an impairment must last in order to avoid being found to be temporary (and therefore not covered); how broadly the "regarded as" prong of the definition should be interpreted; and how limited a person's employment options must be before she will be considered "substantially limited" in the major life activity of working.

Some persistent issues regarding the meaning of disability, by contrast, reflect the courts' skepticism of how the agencies interpret the statutory definition. One issue dividing courts is whether to defer to the EEOC's conclusion that the determination of whether an impairment exists, and whether it substantially limits a major life activity, should not take into account the availability of so-called "mitigating


104 See Ryan v. Grae & Rybicki, P.C., 135 F.3d 867 (2d Cir. 1997) (assuming, without deciding, that the ability to control the elimination of waste is a major life activity).


106 See Burgdorf, supra note 21, at 469–88 (discussing the temporary disability issue).

107 See Arlene B. Mayerson, Restoring Regard for the "Regarded As" Prong: Giving Effect to Congressional Intent, 42 Vill. L. Rev. 587 (1997).

108 See Burgdorf, supra note 21, at 439–69 (discussing the "exclusion-from-only-one-job problem"); Locke, supra note 16 (arguing that courts have erroneously required proof that the plaintiff is generally unemployable before finding substantial limitation).
measures.” For example, in considering the impact of diabetes on a person’s life, should a court take into account the effectiveness of insulin therapy in mitigating the effects of the disease? Courts have also questioned the EEOC’s conclusion that some impairments are so inherently and universally limiting that they should be considered per se disabilities. Some courts have rejected this judgment, finding instead that the ADA requires an individualized assessment of disability in all cases.

Because of the wide range of unsettled issues regarding the definition of “disability” and their frequent recurrence, many disability law observers were excited and hopeful for clarification when the Supreme Court agreed to review an ADA case that hinged on the meaning of disability. Specifically, the appeal from the First Circuit’s decision in Abbott v. Bragdon asked whether asymptomatic HIV infection was a covered disability under the ADA. Sidney Abbott, a woman infected with HIV, sued Randon Bragdon, a dentist, under the ADA’s public accommodations provisions when he refused, based on her HIV infection, to fill her cavity in his dental office. Bragdon defended in part on the grounds that Abbott was not protected by the

109 See 29 C.F.R § 1630.2(j), app. (1998) (“The existence of an impairment is to be determined without regard to mitigating measures such as medicines, or assistive or prosthetic devices.”); § 1630.2(j) (“The determination of whether an individual is substantially limited in a major life activity must be made . . . without regard to mitigating measures. . .”).

110 Compare Arnold v. United Parcel Serv., 136 F.3d 854 (1st Cir. 1998) (holding that diabetes should be evaluated without considering ameliorative effect of insulin), with Gilday v. Mecosta County, 124 F.3d 760 (6th Cir. 1997) (holding that mitigating measures must be taken into account in evaluating diabetes).

111 See 29 C.F.R. § 1630.2(j), app. (1998) (giving HIV infection as an example).

112 See Lanctot, supra note 16.

113 107 F.3d 934 (1st Cir. 1997), aff’d in part and remanded in part, 118 S. Ct. 2196 (1998).

114 Bragdon’s other defense posed the second question raised on appeal: Whether courts should defer to a private health care provider’s reasonable professional judgment that treating a patient would pose a direct threat to the health care provider. The Supreme Court remanded this question for further consideration, after finding that the record from the First Circuit’s decision affirming summary judgment for the plaintiff did not cite sufficient evidence for the Court to determine whether treating the plaintiff posed a direct threat to the dentist. The Court held that the First Circuit may have mistakenly given too much weight to the Centers for Disease Control’s Dentistry Guidelines, which do not assess the actual risks to dentists posed by treating HIV-positive patients, and to the American Dental Association Policy on HIV, which is not the work of a public health organization and does not indicate the scientific basis for its recommendations. In addition, the Court’s consideration of this issue was constrained as it did not have “briefs and arguments directed to the entire record” before it. Bragdon, 118 S. Ct. at 2200.
ADA because she was not an individual with a disability. Both the district court\textsuperscript{115} and the First Circuit rejected this defense, finding that Abbott's HIV infection was a disability within the meaning of the ADA even though it had not progressed beyond the asymptomatic stage of the disease.

The appeal presented the Supreme Court with several opportunities to resolve some of the questions persistently plaguing the lower courts. For example, the Supreme Court could have resolved whether the EEOC's view that HIV infection is a per se disability\textsuperscript{116} should be accepted as an authoritative interpretation of congressional intent. Similarly, because Sidney Abbott argued that her HIV infection limited her major life activity of reproduction partly as a result of the risk of transmitting the virus to a child and because the administration of antiretroviral therapy can lower that risk from approximately twenty-five percent to only eight percent,\textsuperscript{117} the Supreme Court could have discussed whether the extent of the limitation on reproductive activity should be assessed in light of the therapy's availability as a mitigating measure. Moreover, the case furnished the Court with an occasion to provide lower courts with some practical and specific guidance as to what makes an activity a "major life activity";\textsuperscript{118} it even gave the Court a chance to reflect on how the statutory definition of "disability" could be given meaning in a fashion consistent with the ADA's broader goals.

In affirming the decision that Sidney Abbott's asymptomatic HIV infection was a disability for purposes of the ADA, however, the Supreme Court by and large rejected these opportunities to broadly clarify the meaning of disability in favor of a fairly narrow decision specific to Sidney Abbott. Because it found that asymptomatic HIV infection was a disability for the plaintiff, the Court found it unnecessary to address whether HIV infection is a per se disability.\textsuperscript{119} Likewise, because it reasoned that "[i]t cannot be said as a matter of law that an 8% risk of transmitting a dread and fatal disease to one's child does not represent a substantial limitation on reproduction,"\textsuperscript{120} the Court found it unnecessary to settle the dispute regarding the relevance of mitigating measures.\textsuperscript{121} And finally, while the Court ap-

\textsuperscript{116} 29 C.F.R. § 1630.2(j), app. (1998).
\textsuperscript{117} Bragdon, 118 S. Ct. at 2206.
\textsuperscript{118} Bragdon, 118 S. Ct. 554 (granting certiorari on the question of whether reproduction is a major life activity).
\textsuperscript{119} See Bragdon, 118 S. Ct. at 2206.
\textsuperscript{120} Id.
\textsuperscript{121} See id.
proved the First Circuit’s resort to the dictionary to determine that describing a life activity as “major” denotes its “comparative importance” and “significance,” and rejected the contention that major life activities are limited to activities with a public, economic, or daily dimension,\textsuperscript{122} the opinion offered little further practical guidance to lower courts that are called on to decide whether abilities limited by an impairment should be deemed “major life activities.”

Despite the relative narrowness\textsuperscript{123} of its holding in the case, the Court’s opinion is worth scrutinizing for whatever light it might shed for future cases regarding the definition of “disability.” A notable feature of the opinion is the weight that the Court places on administrative interpretations of disability, particularly the regulations issued under section 504 of the Rehabilitation Act. Because Congress included in the ADA a directive that the statute not be construed to apply lesser standards than those applied under section 504 or its regulations, the Court felt bound “to construe the ADA to grant at least as much protection as provided by the regulations implementing the Rehabilitation Act.”\textsuperscript{124} Thus, the Court looked to section 504’s regulations to find a definition of “physical or mental impairment” and then had little trouble in concluding—after describing the course of the HIV disease—that HIV infection “must be regarded as a physiological disorder with a constant and detrimental effect on the infected person’s hemic and lymphatic systems from the moment of infection.”\textsuperscript{125}

Although the Court did not even look to regulations issued under the ADA until after it had announced its holding, it stated that the views of the agencies authorized by Congress to issue regulations implementing the ADA—the EEOC, DOJ, and DOT—are entitled to deference from the courts.\textsuperscript{126} Moreover, in proceeding to cite exam-

\textsuperscript{122} See id. at 2205.

\textsuperscript{123} An example of this narrowness is displayed in the Court’s holding regarding the major life activity constrained. The Court states: “Reproduction falls well within the phrase ‘major life activity.’ Reproduction and the sexual dynamics surrounding it are central to the life process itself.” Id. Thus, the Court’s holding does not require a lower court to find that a gay man with an asymptomatic HIV infection is an individual with a disability, for while the infection might limit the man’s sexual activity, gay or lesbian sexual activity (or, for that matter, sexual activity by a man who has had a vasectomy or by a postmenopausal or sterilized woman) might not be seen as part of the “sexual dynamics surrounding [reproduction].” The narrowness of the Court’s holding may be contrasted to the broad reading of “major life activity” suggested by the Court’s dicta. See infra text accompanying notes 124–27.

\textsuperscript{124} Bragdon, 118 S. Ct. at 2202.

\textsuperscript{125} Id. at 2204.

\textsuperscript{126} See id. at 2207 (citing Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984)).
amples of post-ADA administrative views consistent with its holding, the Court cited not only to notice-and-comment regulations issued pursuant to the Administrative Procedures Act, but also to the agencies' technical assistance documents and interpretive guidelines. Thus, the Court sent a strong message to lower courts to treat administrative interpretations of the definition of disability as authoritative.

In addition, even though it offered little practical guidance to lower courts trying to decide whether an activity should be deemed a "major life activity" the Court's conclusion that "[r]eproduction falls well within the phrase 'major life activity,'" suggests a broad reading of the phrase, with the key to an activity's inclusion being its importance or significance. The Court limited its analysis to reproduction as a major life activity because that was how Sidney Abbott framed her case. Nonetheless, the opinion signals the Court's willingness to consider whether HIV infection may substantially limit other major life activities.

Thus, while the Court limited its holding to the facts presented by the appeal and resisted urgings from the parties and amici to resolve some of the persistent issues that have arisen regarding the ADA's definition of "disability," the opinion's tone and the dicta suggest that the five-member majority might take an expansive view of disability in

128 Id. at 2204.
129 Of course, to determine whether an activity is "important" or "significant," one must ask the question: "Important or significant to what purpose?" The Court does not indicate any unifying objective for assessing importance. One might read the Court's conclusion that "[r]eproduction and the sexual dynamics surrounding it are central to the life process itself" as signifying that courts should look at whether an activity is important to the "life process." Limiting major life activities to those important to the life process, however, is clearly inconsistent with some of the illustrative major life activities, such as learning and working, included in the Rehabilitation Act regulations. See 45 C.F.R. § 84.3(j)(2)(ii) (1997); 28 C.F.R. § 41.31(b)(2) (1998).
130 The Court stated:

Given the pervasive, and invariably fatal, course of the disease, its effect on major life activities of many sorts might have been relevant to our inquiry. Respondent and a number of amici make arguments about HIV's profound impact on almost every phase of the infected person's life. . . . We have little doubt that had different parties brought the suit they would have maintained that an HIV infection imposes substantial limitations on other major life activities.

Bragdon, 118 S. Ct. at 2204-05.
131 Justice Kennedy wrote the majority opinion, in which he was joined by Justices Stevens, Souter, Ginsburg and Breyer. Chief Justice Rehnquist and Justices
other cases. This suggestion, however, is devoid of any broader conceptual understanding of who should be considered disabled for purposes of the ADA or of any theoretical framework for addressing that question. So it is to nonlegal sources that we look next for conceptual and theoretical insight.

III. Nonlegal Understandings of Disability

Even as the United States Congress and various administrative agencies sought to craft and refine a legal definition of disability for use in nondiscrimination laws, efforts were proceeding in nonlegal contexts to develop frameworks for clarifying the concept of disability for use in fields including medicine, rehabilitation, social services, and demographics. Somewhat more recently, scholars in the emerging field of disability studies have gone beyond these attempts to articulate a framework for identifying disability by delving into phenomenological questions that challenge our society's very understanding of what disability is. Neither of these fields of inquiry into the meaning and nature of disability, however, has to date figured significantly in discussions of the legal meaning of disability. Nonetheless, examining these theoretical discussions may prove instructive for both our efforts to diagnose why the existing legal definition is proving so troublesome and our search for a cure.

A. Conceptual Frameworks

The ADA's legal definition of "disability" does not refer explicitly to understandings of the term employed in the specialized applied fields most directly relating to persons with disabilities.¹³² The legal definition, however, bears a substantial resemblance to frameworks for identifying disability developed in these nonlegal contexts. Professionals in the applied fields have developed frameworks in an effort to enable clarity, precision, and consistency in the application of policies and programs relating to persons with disabilities, and these frameworks share with the legal definition a constitutive nature. In other words, these frameworks convey the meaning of disability by relating it to other concepts such as impairment, functional limitation,

¹³² These applied fields include, for example, special education, rehabilitation psychology, and physical therapy.
and handicap; they do not, however, provide measurable, objective criteria that indicate the presence of disability.\textsuperscript{133}

Several conceptual structures for identifying disability have proven influential. In 1980, the World Health Organization (WHO) put forth an International Classification of Impairments, Disabilities, and Handicaps (ICIDH), which describes and distinguishes among the concepts set forth in its title. According to the WHO classification, an impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function; a disability is any restriction or lack, resulting from an impairment, of ability to perform an activity in the manner or within the range considered normal for a human being; and a handicap is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfillment of a role that is normal for that individual, depending on age, sex, and social and cultural factors.\textsuperscript{134} This framework thus views disability as a lack of functional ability that flows from some bodily impairment; it distinguishes the concept of handicap, by contrast, as reflecting the interaction that persons with disabilities have with their environment. In this scheme, therefore, handicap describes the social disadvantage that results when cultural, physical, or social barriers limit the opportunities that a disabled person has to be a part of the life of the community.\textsuperscript{135} In this view, the progression from impairment to disability to handicap is not inevitable. Not all impairments will result in disability, and whether a disability produces a handicap depends at least in part on an individual’s social environment.

The WHO’s framework for disability has been used extensively in areas such as rehabilitation, education, statistics, demography, sociology, economics, and anthropology.\textsuperscript{136} Indeed, several European countries have officially adopted the ICIDH for use in administrative settings.\textsuperscript{137} The framework has also been used, although not always uncritically, by disability activists.\textsuperscript{138}

\begin{itemize}
\item \textsuperscript{134} See \textit{World Health Organization, International Classification of Impairments, Disabilities, and Handicaps} (1980).
\item \textsuperscript{135} See \textit{id}.
\item \textsuperscript{136} See \textit{United Nations, Standard Rules on the Equalization of Opportunities for Persons with Disabilities} (1994).
\item \textsuperscript{137} See \textit{Disability in America: Toward a National Agenda for Prevention} 76 (Alvin M. Pope & Alvin R. Tarlov eds., 1991) [hereinafter \textit{Disability in America}].
\item \textsuperscript{138} See Susan Wendell, \textit{The Rejected Body: Feminist Philosophical Reflections on Disability} 13 (1996); Anita Silvers, \textit{Disability Rights}, in 1 \textit{Encyclopedia of Applied}
\end{itemize}
In response to the experience gained since the ICIDH's adoption, the WHO is in the process of revising the ICIDH and has issued a draft, ICIDH-2. This draft builds on the original ICIDH, but adopts largely new terminology to describe the "dimensions" of disablement. The draft retains the foundational concept of impairment, but uses the terms "activity" and "activity limitation" (rather than "disability") to describe how the nature and extent of functioning at the level of the person can be limited. In addition, the draft uses the terms "participation" and "participation restriction" (rather than "handicap") to describe how the nature and extent of a person's involvement in life situations may be restricted by impairments and activity limitations. Finally, the draft recognizes the importance of so-called "Contextual Factors"—which may be either environmental (such as architectural characteristics or legal structures) or personal (such as gender or education)—in interacting with the foregoing dimensions in producing disablement. This revised approach seeks to provide a synthesis of the medical and social models of disability in order to provide "a coherent view of different dimensions of health at both biological and social levels."

The second major conceptual framework of disability, developed by Saad Nagi, uses ideas similar to those in the ICIDH, but different terminology. Nagi's schema traces the relationship between pathology, impairment, functional limitation, and disability. Pathology (a term for which the ICIDH has no analog) refers to the body's response to an interruption in its normal processes, resulting, for example, from infections, disease, or trauma. The term "impairment" indicates some loss or abnormality of mental, physiological, or biochemical function; this loss or abnormality relates to the specific functioning of an organ or organ system, not to the functioning of an individual as an entire organism. An impairment's impact on the functioning of a person as a whole, according to Nagi's framework, is captured in the concept of functional limitation. Finally, Nagi uses the term "disability" to describe a person's inability to perform or limitation in performing socially expected roles or tasks, if the inability or

Ethics 781 (1998). For some of the criticisms of the WHO definition, see infra discussion accompanying note 186. 

139 As of 1998, the draft ICIDH-2 is undergoing extensive international field trials. Data gathered from the trials will be analyzed and may lead to further revisions of the draft in 1999. The Governing Bodies of the WHO are expected to vote on final approval of the ICIDH-2 in 2000. See WHO, ICIDH Field Trials (visited Nov. 3, 1998) <http://www.who.int/msa/mnh/ems/icidh/brochure/fieldtrial.htm>.

limitation results from a functional impairment. Thus, disability (like handicap in the ICIDH framework) is a relational concept that expresses how functional limitations affect a person in relation to the demands of the social environment.141

An example may serve to give concrete meaning to Nagi's abstract concepts (and likewise to the WHO's conceptual framework). Trauma to an individual's arm may cause the arm's muscles to become denervated; this response to the trauma would be deemed a pathology. As a result of the denervation, the muscle atrophies; this loss of physiological function at the level of an organ system would be considered an impairment. This impairment (muscle atrophy) may cause the individual to be unable to pull with her arm; functional limitation describes this lack of an individual's ability to perform an action. Finally, the individual might lose a job that requires pulling with her arm or be rendered unable to swim recreationally. These limitations on performing socially defined activities and roles could constitute disabilities.142

In 1991, a committee of the Institute of Medicine (IOM) adopted Nagi's terminology in developing its own model of the disabling process.143 One reason the IOM committee gave for preferring Nagi's approach to that of the WHO was the committee's preference for the term "disability" over the term "handicap." Although the committee recognized that American lawmakers have often used the term "handicap" synonymously with "disability," the committee acknowledged that "handicap," as applied to individuals, is often viewed as denigrating and has largely receded from accepted usage in describing individuals with disabilities in the United States.144

141 See Nagi, supra note 133, at 2-3; Disability in America, supra note 137, at 79-81.

142 This example is taken from Disability in America, supra note 137, at 79. Certainly, reasonable persons could argue that an inability to swim recreationally does not render a person disabled, even under Nagi's framework, unless the ability to swim recreationally is socially expected and an inability to do so somehow renders an individual less able to meet the demands of his environment. Cf. Martinez v. City of Roy, No. 97-4095, 1998 U.S. App. LEXIS 5906 (10th Cir. March 26, 1998) (concluding that recreational swimming is not a major life activity).

143 The IOM committee added to Nagi's framework the concepts of risk factors and quality of life in developing a model of the disabling process. This process-oriented approach was deemed useful in identifying strategic points during the process for preventive intervention. See Disability in America, supra note 137, at 78.

144 See id. at 77-78 ("Much as the term 'cripple' has gone out of style, 'handicap' seems to be approaching obsolescence, at least among people with disabilities in the United States."). The choice of language to refer to persons who have disabling conditions has generated much attention, and the current accepted usage seems to be to
In describing its conceptual framework, the IOM committee also expounded on the interrelationship of the concepts of disease, impairment, and disability:

[D]isability begins with physical or mental health conditions that limit the performance of individuals in personally, socially, and culturally expected roles. The limitation may be total, rendering an activity unperformable, or it may be partial, restricting the amount or kind of an activity a person can perform. Although conceptually distinct, disability is often confused with disease and impairment. For example, specific diagnostic conditions and impairments, such as mental retardation, cerebral palsy, or multiple sclerosis, are erroneously referred to as disabilities. But depending on various factors, these conditions may or may not lead to disability. . . . Moreover, the scope and severity of limitation that follows even the most physiologically damaging disorders . . . vary among individuals, including those with the same condition.\textsuperscript{145}

On a basic level, the WHO's and Nagi's taxonomies may lend us some insight on how to understand the ADA's legal definition of "disability," for the legal definition echoes these frameworks' focus on the relationship between impairment and functional limitation (or impairment and disability, to use the WHO's terminology). Where the ADA's definition deviates from these conceptual approaches, however, is in its failure—at least in many cases—to include the last element in the conceptual trilogy: the element focusing on the relationship of a person with functional limitations to her social environment. Specifically, the ADA finds that an individual has a disability if she has an impairment that substantially limits a major life activity.\textsuperscript{146} Most of the regulatory examples given of major life activities, however, focus on function at the organismic level (e.g., walking, breathing, seeing, and hearing), rather than on an individual's functioning in a socially expected role. In other words, in contrast to the conceptual frameworks discussed above, the ADA’s definition of "disability" does not appear to require a showing that the impaired individ-

use "people first" language, that is, to refer to a person with a spinal cord injury, rather than to a quadriplegic, or to an individual with a disability, rather than a disabled individual. See Burgdorf, supra note 21, at 411 n.1. In the 1990s, "disabled people" has been used increasingly within disability studies to refer to the constituency group. See Linton, supra note 27, at 13. The choices that individuals living with disabling impairments make in how to refer to themselves, however, may defy these conventions. See Nancy Mairs, Waist-High in the World: A Life Among the Nondisabled 12–14 (1996) (explaining why she refers to herself as a "cripple"). \textsuperscript{145} Disability in America, supra note 157, at 83. \textsuperscript{146} For a description of the definition of disability contained in the ADA and its implementing regulations, see supra Part II.D.
ual suffers any kind of social disadvantage. The exception to this approach is the regulations' inclusion of "working" as a major life activity. An ADA plaintiff who claims to be substantially limited in the major life activity of working claims quite directly that her impairment disadvantages her, not solely on an organismic level, but in her ability to conform to societal expectations that she perform productive work.\footnote{ Cf. Locke, supra note 16 (arguing that working should be eliminated from the regulatory list of major life activities).}

**B. The Contribution of Disability Theory: Contrasting Models of Disability**

The foregoing description of widely accepted conceptual schema for identifying and understanding disability hints at some of the questions that have occupied disability theorists over the past two decades. For these frameworks imply, contrary to the traditional and still common understanding of disability, that disability does not lie purely in the body of the person who has some impairment, but that instead disability is found in that person's interaction with the social environment. In their writings, scholars in the field of disability studies have described several models of disability, or characterizations of different ways that disability can be understood in moral and philosophical terms. These models not only illuminate how our society does or might view disability, but they also suggest the moral relevance of disability to social policy. Although the scholars whom I include in the group "disability theorists" do not speak with one voice on the phenomenology of disability, their writings have described three primary models of disability: the medical model, the social model, and the minority group model.

1. **The Medical Model of Disability**

   The traditional understanding of disability held in our society, an understanding that has pervaded rehabilitative efforts, social policy, and federal legislation prior to the 1973 Rehabilitation Act, has been dubbed the "medical model" of disability.\footnote{Although most disability theorists use the phrase "medical model," the British theorist Michael Oliver uses the phrase "individual model." See Michael Oliver, Understanding Disability: From Theory to Practice 30 (1996).} The defining characteristic of the medical model is its view of disability as a personal trait of the person in whom it inheres. The individual is the locus of the disability and, thus, the individual is properly understood as needing aid and assistance in remediating that disability. Under this view, while the cause of impairments may vary, the disabled individual is viewed as...
innately, biologically different and inferior. The physical difference of the individual is often apparent, and the nondisabled see the individual's inferiority and resulting social disadvantages as flowing directly from that physical difference.

Thus, according to the medical model of disability, the disabled individual's problem lies in her impairment. Consequently, the best way to help the disabled individual is to use either medicine to cure or ameliorate the impairment or rehabilitation techniques to enable the individual to cope with or overcome the impairment's effects. Disabled persons are thus made dependent on health professionals for assistance in escaping or overcoming their disability, and their cooperation in the pursuit of a cure is socially expected. Persons with disabilities are dependent on physicians not only when they need medical or surgical treatment, but also when they need adaptive equipment, such as prosthetics or orthotics, which require a physician's prescription. In this fashion, individuals with disabilities are consigned to what the sociologist Talcott Parsons calls the "sick role"—because of their disability, they are exempted from normal social obligations such as working, but this exemption is socially legitimate only if they strive to become cured and, therefore, normal.¹⁴⁹ Those persons whose disabilities are not susceptible to cure, however, remain a potent symbol of the limitations and failures of modern medicine and thus may be shunned or abandoned by medical providers.¹⁵⁰

The power of health professionals over persons with disabilities does not lie solely in medicine's (often illusory) promise of a cure. In addition, under the medical model, society allocates to physicians the authority to validate the existence of disability and thus to provide an individual with access to whatever social assistance may be available to disabled persons. It is up to a physician to diagnose or categorize the cause of an impairment and to measure and document its functional impact. The individual's own subjective experience of impairment or limitation is irrelevant unless it can be professionally validated.¹⁵¹ Moreover, because they focus on classifying the nature and causes of impairment,¹⁵² medical professionals may have a tendency both to falsely universalize the impact of a particular impairment and to fail to

¹⁵⁰ Cf. Susan Wendell, Toward a Feminist Theory of Disability, in Feminist Perspectives in Medical Ethics 63, 72–73 (Helen Bequaert Holmes & Laura M. Purdy eds., 1992).
¹⁵¹ See id.
recognize that a given impairment may produce varying degrees of limitation in different people.\textsuperscript{153}

Congress’s creation of the SSDI program in the 1950s illustrates the medical model of disability in action.\textsuperscript{154} A key concern of Congress in enacting the program was that persons who were able to work would abuse the system by feigning disability in order to receive public support, but the lawmakers believed that abuse could be prevented by requiring a medical certification of disability. The rationale was that medical certification would limit coverage to disabilities that medical examinations could objectively diagnose.\textsuperscript{155} Although organized medicine initially objected to the medical certification requirement, once the program had been instituted the American Medical Association developed “Guides to Evaluation of Permanent Disability” to assist general practitioners in performing disability assessments.\textsuperscript{156} Political scientist Deborah Stone describes these guides as “based on a pervading faith that a phenomenon of functional impairment, totally independent of context, can be precisely measured.”\textsuperscript{157} Finally, consistent with the medical model, the receipt of disability benefits was conditioned on an applicant’s willingness to accept treatment or rehabilitation for her disabling condition.\textsuperscript{158}

In addition to treating disability as a personal, biological attribute that sets an individual apart from normal persons and granting the medical profession cognitive authority to identify and treat disabled persons, the medical model of disability also has significant implications for social policy regarding disability. According to the medical model, the disabled individual is the unfortunate victim of some twist of fate,\textsuperscript{159} and that misfortune is seen as essentially a personal or family matter—not a misfortune that society is obligated to remedy. For if disability is essentially biological, then the social disadvantages and exclusion that accompany the disability can be explained as natural and not ascribable to any social cause.\textsuperscript{160} Because disability is not socially caused, the disabled individual has no claim of right to social remedia-

\begin{footnotesize}
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\item[153] See Wendell, \textit{supra} note 138, at 71.
\item[154] For a description of the definition of disability used in this program, see \textit{supra} Part II.A.
\item[155] See Stone, \textit{supra} note 33, at 79.
\item[156] See id. at 80–82, 110–11.
\item[157] Id. at 113.
\item[158] See id. at 125.
\item[159] See Oliver, \textit{supra} note 148, at 32 (positing the “personal tragedy theory of disability”).
\end{enumerate}
\end{footnotesize}
tion, and any benefits or assistance that society chooses to bestow on persons with disabilities can be viewed as a charitable response of "doing special things." In a society that espouses the medical model, the primary thrusts of social policy regarding disability are both to eliminate as much disability as possible, by using medical technology to cure existing disability or prevent future disability, and to use rehabilitative techniques to help disabled individuals approximate dominant physical standards as closely as possible. Only if curative and rehabilitative efforts are unavailing should persons with disabilities receive financial assistance benefits. Finally, the medical model of disability justifies other, nondisabled members of society in labeling and stigmatizing the disabled person as naturally inferior, a process that implicitly supports the development of social and legal structures that exclude and devalue persons with disabilities.

This medical model of disability, while it has been increasingly challenged by disability theorists and disability-rights activists, persists in the popular understanding of disability, as well as in the legal commentary on disability. As one disability studies scholar points out, "Unlike other disadvantaged groups, citizens with disabilities have not yet fully succeeded in refuting the presumption that their subordinate status in society can be ascribed to an innate biological inferiority." Even commentators generally supportive of the ADA, which disability theorists view as taking at least modest steps away from the medical model, often reveal an understanding of disability largely consonant

163 See Hahn, supra note 152, at 51.
164 Historically, persons with disabilities have been viewed as inferior not only in physical terms, but also in moral terms. The belief that a bodily impairment is the result of a moral flaw—of either the impaired person or an ancestor—is long-standing, though less prevalent today. See Silvers, supra note 138, at 785 (calling this the "moral model" of disability). So too, persons with disabilities have often been grouped together with other individuals who are seen as departing significantly from accepted norms of social behavior and thus are deemed deviant. See Drimmer, supra note 30, at 1348–49 (describing the "social pathology model" of disability).
165 See Drimmer, supra note 30, at 1349–51.
166 Hahn, supra note 152, at 43; cf. Anita Silvers, Reconciling Equality to Difference: Caring (F)or Justice for People with Disabilities, Hypatia, Winter 1995, at 30 (stating that historically conditioned feelings of superiority over people with disabilities are deeply ingrained).
with the medical model. For example, one commentator argues that a person with an impairment that is potentially mutable should be entitled to employer-provided accommodations only if the person has taken reasonable steps to improve her condition.\textsuperscript{167} Echoing Congress's sentiments when it created the SSDI program,\textsuperscript{168} she asserts that an employer should be obligated to pay for accommodations "only if the individual with the disability has first made all reasonable efforts to help himself. This will eliminate any potential for abuse. . . ."\textsuperscript{169} Another commentator portrays disability as an innate, biological condition when he characterizes the ADA as posing the "seemingly intractable problem of how to treat the physical or mental disability of the person, which is neither social, artificial, nor irrational, but simply a 'stubborn fact' of nature itself embedded in that person's life experience."\textsuperscript{170} Thus, while the social and minority group models of disability described below increasingly challenge it, the medical model of disability still appears firmly ensconced in our collective societal understanding of disability.

2. The Social Model of Disability

   In contrast to the medical model of disability, which views disadvantages as flowing naturally from a defect located in an individual, the social model of disability sees disadvantages as flowing from social systems and structures. Because members of society historically have not viewed persons with disabilities as part of the societal norm, no attempts have been made to avoid the creation of physical and attitudinal barriers built into the very framework of society—barriers that

\textsuperscript{167} See Lisa E. Key, Voluntary Disabilities and the ADA: A Reasonable Interpretation of "Reasonable Accommodations", 48 Hastings L.J. 75 (1996). The idea that one ought to do what one can to help oneself before seeking accommodations, while facially appealing, can be quite deceptive in the rehabilitation context. A physician's judgment that a person can repair or surmount his impairment falls far short of a guarantee that such result is possible. If the person with the impairment follows the prescribed course and it fails, he will have paid in terms of pain, lost time, money, and possibly even a reduction in functioning. To condition the availability of accommodations on this effort casts the accommodation as compensation for the failure to be cured (i.e., the medical model), rather than as a reformation of the environment to make it more accessible (i.e., the social model).
\textsuperscript{168} See supra text accompanying notes 34--36.
\textsuperscript{169} Key, supra note 167, at 103.
\textsuperscript{170} W. Robert Gray, The Essential-Functions Limitation on the Civil Rights of People with Disabilities and John Rawls's Concept of Social Justice, 22 N.M. L. Rev. 295, 296 (1992); cf. Locke, supra note 16, at 139 (arguing that the definition of disability should be amended to clarify that disabilities are physical and emotional conditions measured in medical terms).
prevent persons with disabilities from fully participating in society.\textsuperscript{171} Thus, the disadvantaged status of persons with disabilities is the product of a hostile (or at least inhospitable) social environment, not simply the product of bodily defects.\textsuperscript{172}

Accordingly, a major premise of the social model of disability is the belief that disability is a creation of society (a "social construct"), rather than a biological phenomenon. As Susan Wendell, drawing on feminist work regarding the social construction of gender, writes: "Societies that are physically constructed and socially organized with the unacknowledged assumption that everyone is healthy, nondisabled, young but adult, shaped according to cultural ideals, and, often, male, create a great deal of disability through sheer neglect of what most people need in order to participate fully in them."\textsuperscript{173} A straightforward (and probably the most often used) example of how the construction of physical environments can create disability is the construction of buildings with stairs, rather than elevators or ramps. The exclusive reliance on stairs for moving people from one level to another reflects an implicit assumption that people using the building will be able to climb stairs and an implicit judgment that the presence of people who cannot climb stairs—for example, wheelchair users—is neither expected nor desired. So understood, the wheelchair user is disadvantaged not by her inability to walk, but by the way in which buildings are designed and constructed.\textsuperscript{174}

More subtle examples of how disability is physically, socially, and culturally constructed begin to reveal how pervasive are the barriers that persons with impairments encounter. Susan Wendell provides an example in an activity as mundane as grocery shopping: the simple lack of a place to sit and rest for a few minutes in the typical supermarket reflects an assumption that all shoppers should be strong and

\textsuperscript{171} See Feldblum, \textit{supra} note 161, at 36; Jane West, \textit{The Evolution of Disability Rights, in Implementing the Americans with Disabilities Act}, \textit{supra} note 161.

\textsuperscript{172} See Silvers, \textit{supra} note 138, at 785–86; Hahn, \textit{supra} note 152, at 45 (stating that the "sociopolitical" approach defines disability as the product of interactions between individuals and their environment, with the effects of disability primarily attributable to a disabling environment, rather than to personal defects or deficiencies).

\textsuperscript{173} \textit{Wendell, \textit{supra} note 138, at 39.} Wendell also asserts that disability may be socially constructed by social conditions, such as violent crime, contaminated water, and poverty, that straightforwardly create illnesses, injuries, and poor physical functioning. \textit{See id.} at 36–37. For a description of how public and collective actions in the late 19th and early 20th centuries limited the functions of physically impaired persons, see \textit{Claire H. Liachowitz, Disability as a Social Construct} (1988).

\textsuperscript{174} \textit{See Amundson, \textit{supra} note 160, at 109} (noting that a wheelchair user has virtually no mobility impairment in a building with ramps, but is greatly handicapped when his goals are located up or down a flight of stairs).
healthy—not easily fatigued or otherwise likely to need to rest during shopping—and effectively excludes those individuals who don’t fit the expected mold. Wendell also suggests that something as intangible as what she calls the “pace of life” can be disabling: as the pace of life in our society increases, more people tend to become disabled because fewer people can meet societal expectations for performance at the heightened pace.

Finally, disability may also be culturally constructed. The lack of realistic, cultural representations of the lives of persons with disabilities may reinforce the sense that disabled persons are somehow “other” and thus contribute to their exclusion. Instead of depicting individuals with disabilities as part of the mainstream and as human beings with whom viewers can identify, the media, particularly the movies, have typically portrayed individuals with disabilities as freaks or dangerous monsters. These stereotyped depictions tend to perpetuate societal prejudice and to bolster nondisabled persons’ fear of disabled people. Thus, disability is constructed not only by barriers

175 See Wendell, supra note 138, at 39; cf. S. Kay Toombs, Sufficient unto the Day: A Life with Multiple Sclerosis, in CHRONIC ILLNESS: FROM EXPERIENCE TO POLICY 3, 9 (S. Kay Toombs et al. eds., 1995) (describing how the fatigue that accompanies M.S. affects her ability to go grocery shopping).

176 See Wendell, supra note 138, at 37–38.

177 See id. at 42–43.


179 Because this Article is concerned with the meaning given to the term “disability” in federal disability discrimination legislation, it is worth highlighting that not all disability theorists use that term to describe the disadvantages that flow from the physical, social, and cultural environments that persons with various impairments live in. Instead, consistent with the WHO conceptual framework discussed above, see supra text accompanying notes 134–35, some authors distinguish between the concepts of disability and handicap. Under this taxonomy, disability describes the functional limitation experienced by an impaired individual, but the social disadvantage experienced when that individual interacts with his environment is captured by the term handicap. See Amundson, supra note 160; Andrew I. Batavia, Relating Disability Policy to Broader Public Policy: Understanding the Concept of “Handicap,” 21 POL’Y STUD. J. 735 (1993). Using this vocabulary, one may isolate a disability in an individual’s body, but handicap is necessarily a relational concept. Theorists adopting this vocabulary, however, are not simply espousing the medical model, for they recognize that the disadvantage experienced by the disabled individual is not inevitable, but instead flows from the fact that “we humans regularly construct our environments with a certain range of biologically typical humans in mind.” Amundson, supra note 160, at 110.
erected in the physical environment, but also by the barriers embedded in social structures and societal attitudes.\textsuperscript{180}

A corollary of the belief that disability is a social construct is the view that normalcy itself is a social construct. It is commonly recognized that—rather than being easily divisible into two distinct categories of ability and disability—the range of human functioning lies spread across a wide spectrum.\textsuperscript{181} That being so, creating the category of disability requires drawing a line somewhere on this spectrum to differentiate "normal" ability from disability. In this sense, as Lennard Davis puts it, "[t]he construction of disability is based on a deconstruction of a continuum."\textsuperscript{182} But drawing this line itself requires some shared understanding of what constitutes normal ability.

Disability theorists argue that, far from being a natural and obvious classification, the very concept of a "normal human being" is socially constructed and therefore socially and culturally relative. As its history is related by Lennard Davis, the concept of "normal" entered the English language only in the mid-nineteenth century in relation to the developing science of statistics, which focused on identifying a norm and deviations from that norm.\textsuperscript{183} But the concept of "normal" grew from being simply descriptive of a statistical finding to carrying with it a prescriptive force, implying that normality was to be desired and deviance from the norm was to be avoided.\textsuperscript{184} Yet the perimeter of human normality has been rearranged over time and among differ-

\textsuperscript{180} In discussing the social construction of disability, Michael Oliver makes a distinction between "social constructionists," who believe that the problem is located in the minds of nondisabled people, and "social creationists," who believe the problem is located in the institutionalized practices of society. See Michael Oliver, The Politics of Disablement: A Sociological Approach 78-94 (1990).

\textsuperscript{181} See U.S. Commission on Civil Rights, Accommodating the Spectrum of Individual Abilities 87-89 (1983).

\textsuperscript{182} Davis, supra note 27, at 11.

\textsuperscript{183} See id. at 24-29. Davis also makes an interesting comparison to the earlier development of the concept of the ideal, which by definition was beyond the attainment of any human. Accordingly, while all human bodies were nonideal, none was seen as deviant.

\textsuperscript{184} See id. Davis links this prescriptive force to the eugenics movement, which he views as an effort aimed at norming the population by getting rid of deviants. See id. at 30-31; see also Gina Maranto, On the Fringes of the Bell Curve, the Evolving Quest for Normality, N.Y. Times, May 26, 1998, at F7 ("reference to the normal has great force precisely because it so seamlessly joins description, which in the scientific view is value neutral, and evaluation, which entails making judgments about worth or moral status"); cf. Hiegel, supra note 91, at 1451 (arguing that disease and disability are normative concepts and that "the decision to categorize deviance as disability depends in large part on social values").
ent cultures, and as the construction of normality has changed, so has the construction of that form of deviance from the norm known as disability.

Indeed, it is for its failure to recognize the social and cultural relativity of disability that some disability theorists fault the WHO’s conceptual framework discussed above in Part III.A., for the WHO’s definitions of “impairment” and “disability” rely on the concepts of abnormality and “the normal human being.” These definitions, therefore, imply that an absolute, measurable standard or norm of human structure, functioning, and physical ability exists, without recognizing that the concepts of impairment and disability depend to some degree on the society generating the standards of normality. The philosopher Anita Silvers illustrates this relativity by pointing to the various modes that different cultures use to travel five miles and the corresponding impact on who is deemed disabled: “Where autos are abundant, the blind are dysfunctional travelers while the one-legged function nearly normally; where the prevailing mode of travel is to walk, the reverse is the case.” Thus, under the social model, the phenomenon of disability is both socially constructed and culturally relative.

While the social model’s belief in the social construction of disability draws on and finds company in critical analyses of gender and race, some disability theorists recognize disability-specific limits to, and criticisms of, the view that disability is a social construct. The fundamental shortcoming of the social model—one which at least some of its proponents acknowledge—is that, by focusing on environmentally caused disadvantages, it ignores limitations inherent in bodily impairments. For some impairments, such as severe mental retardation, severe brain injury, and rapidly deteriorating medical conditions, limitations inextricable from the condition and independent of social factors may seem to overwhelm any social discrimination faced by persons with those impairments.

185 See Maranto, supra note 184. For a fascinating discussion of how changing social structures affect our understanding of “normal” variations in temperament, see Lawrence H. Diller, The Run on Ritalin: Attention Deficit Disorder and Stimulant Treatment in the 1990s, Hastings Center Rep., Mar.–Apr. 1996, at 12.

186 See Wendell, supra note 138, at 14; see also Silvers, supra note 138, at 784 (criticizing the WHO framework as reifying “a relative benchmark into an absolute standard”).

187 Silvers, supra note 138, at 784.

188 See Philip Ferguson, The Social Construction of Mental Retardation, in Perspectives on Disability, supra note 178, at 203; Batavia, supra note 179, at 738. Ferguson, however, views the social model’s failure to account for the exclusion of the severely mentally retarded not as evidence of the invalidity of that model’s basic premise, but
But even for disabled persons whose disadvantage can be traced primarily to the social environment, the social model may give short shrift to the lived experience of impairment itself. A compelling criticism of the social model is that persons with disabilities do experience real limitations, and often suffering, in the daily experience of living in their bodies and that these limitations and sufferings exist independently of any disabling social environment. The social model does not speak to these experiences of the body and personal impairment.\textsuperscript{189} As a result, Susan Wendell distances herself from postmodern theorists who fail to recognize the difficult physical realities faced by persons with disabilities,\textsuperscript{190} and she acknowledges that not all the difficulties and limitations that accompany an impairment result from a disabling environment. Yet even this acknowledged limitation does not lessen the social model's force: the social model need not deny that some limitations flow directly from impairment in order to argue that externally imposed disadvantages should be remedied.\textsuperscript{191}

Not only does the social model's theoretical understanding of disability diverge from that of the medical model, the social model also has drastically different implications for public policy. While the main thrust of disability policy under a medical model is to get rid of disability by attempting to cure or rehabilitate the individual, the main thrust of policy under a social model is to get rid of disability by "rehabilitating" the social and physical structures and systems that serve to impose disadvantages on persons with impairments.\textsuperscript{192} This rehabilitation may be a straightforward matter of altering the physical environment (for example, by building ramps and cutting curbs), or it may involve modifying social systems or policies to enable persons with disabilities to participate in, and benefit from, opportunities commonly enjoyed by nondisabled members of our society. This approach sees socially created barriers as generating an "accommodation imperative," which requires affirmative efforts to

\textsuperscript{189} See Oliver, supra note 148, at 37-38.
\textsuperscript{190} See Wendell, supra note 138, at 45 ("The experiences of people with disabilities are as invisible in the discourses of postmodernism, which has the virtue of being critical of idealized, normalized, and universalized representations of bodies, as they are in discourses which employ concepts of bodily 'normality' uncritically.").
\textsuperscript{191} See Batavia, supra note 179, at 739 (acknowledging that while a person with an impairment may have a greater challenge in succeeding in any society than a person who enjoys all physical capabilities, "such internal limitations are not nearly as insurmountable as the external limitations that can truly handicap the disabled").
\textsuperscript{192} See Hahn, supra note 30, at 104 n.36.
make all aspects of social and economic life accessible.\(^{193}\) Thus, the social model’s attribution of disability-related disadvantage to societal causes indicates that disability may be amenable to societal remedy, an understanding that underpins yet a third model of disability, the minority group model.

3. The Minority Group Model of Disability

The minority group model of disability builds on the understanding of disability elaborated by the social model and transforms it into a political call to action. The minority group model goes beyond simple recognition that disability has social roots. It argues that the functional limitations associated with impairment vary directly with the degree to which society respects the differences of the minority group of impaired individuals,\(^{194}\) and it demands the eradication of exclusionary social practices and structures as a matter of civil rights for persons with disabilities. In this model, persons with disabilities face barriers to participation in society because historically they have not been viewed as part of the societal norm, but persons with disabilities have a civil right to be considered part of the societal norm and to be allowed to participate meaningfully.\(^{195}\) Consequently, this model is also called the civil rights approach to disability.

According to the minority group model, because society produced the historical exclusion experienced by persons with disabilities, their claim to remediation of exclusionary structures and practices is made as a claim of right, rather than as a request for special benefits.\(^{196}\) It is vital to recognize that the rights asserted are characterized as simple equality rights: disability activists argue that eliminating societal barriers—both physical and attitudinal—is indispensable to allowing persons with disabilities a level playing field.\(^{197}\) The presumption is that persons with disabilities are equally capable of flourishing in competitive environments if societally erected barri-

\(^{193}\) See West, supra note 171; see also Burgdorf, supra note 77, at 460.

\(^{194}\) See Silvers, supra note 138, at 786; Hahn, supra note 152, at 53 (laying forth as postulates of the minority group paradigm (1) that all aspects of the environment are fundamentally shaped by public policies, (2) that policies tend to reflect pervasive societal attitudes and values, and (3) that the primary source of problems for persons with disabilities lies in the unfavorable attitudes of nondisabled persons).

\(^{195}\) See Feldblum, supra note 161, at 36-37.

\(^{196}\) See Amundson, supra note 160, at 113 (“Someone whose disadvantage occurs as a result of a social decision has a more obvious claim for social remediation.”).

\(^{197}\) See Drimmer, supra note 30, at 1358; cf. Burgdorf, supra note 21 (arguing that reasonable accommodations should not be viewed as special benefits).
ers are removed. By framing the question as one of civil rights, proponents of the minority group model are also able to argue that policy choices about the remedy to be provided should be guided by “democratic principles” rather than “strict financial pragmatism.”

In promoting a minority group model of disability, advocates for disability rights seek to mobilize persons with disabilities politically by consciously drawing upon the civil rights movements of other disadvantaged minority groups. Advocates employ the language from those movements, decrying patterns of hierarchy and subordination based upon physical differences. Again drawing on other groups’ experience, disability theorists argue that, in order to emerge from roles of inferiority by exercising power, persons with disabilities should define disability for themselves, control the usage of the term, and choose when to identify themselves as having a disability. To that end, the disability rights movement has significantly influenced the usage of the term “disability” and the adoption of “people first” phraseology. In exercising authority over the usage of language, however, persons with disabilities wield a double-edged sword. Although self-identification as having a disability may entitle a person to financial benefits or protection under the ADA, labeling oneself as disabled may also expose one to prejudice and prove distasteful for persons

198 See Silvers, supra note 138, at 789. Even Silvers, however, recognizes that “the differences attendant upon serious impairment . . . resist being thus dismissed through social agreement,” id., and that it may be inappropriate to conceptualize individuals with severe impairments as identical to nondisabled persons in the absence of social barriers. See id.

199 See Harlan Hahn, Toward a Politics of Disability: Definitions, Disciplines, and Policies, 22 Soc. Sci. J. 87 (1985). But cf. Amundson, supra note 160, at 116 (noting that if any handicapping aspects of the environment are fully natural and not socially constructed, then claims for remediation will not have a civil rights basis, but will be based on distributive justice).

200 See Drimmer, supra note 30, at 1355 (linking disability rights movement to civil rights movements of 1950s and 1960s); Hahn, supra note 30, at 98 (linking disability studies to feminist thought). Commentators have also noted that a disproportionate number of persons with disabilities are also members of other disadvantaged groups and thus may be subject to dual discrimination.

201 See Drimmer, supra note 30, at 1357 (stating that the civil rights model rejects the use of difference to create hierarchical structures of superiority and inferiority upon which societal participation is premised); cf. Ruth Colker, Bi: Race, Sexual Orientation, Gender, and Disability, 56 Ohio St. L.J. 1 (1995) (linking group subordination of persons with disabilities to subordination of other groups).

202 See Davis, supra note 27, at xv, 4; Oliver, supra note 148, at 9; Wendell, supra note 138, at 25.
who have endeavored to avoid receiving a pejorative label from others.\textsuperscript{203}

While proponents of the minority group model generally agree that political action is required to remedy a history of prejudice and exclusion, they do not speak with one voice (or sign with one pair of hands) in explaining why persons with disabilities historically have been and continue to be disadvantaged and excluded. Two central strands, however, have emerged in the writings of disability theorists. One strand focuses on the impact of impaired functioning in leading to disadvantage, and the other focuses on the impact of physical difference in the treatment of persons with disabilities.\textsuperscript{204}

Assuming that at least some portion of the disadvantage experienced by persons with disabilities has social roots, one explanation for that disadvantage is simply that the physical and social environment was not built with disabled people in mind. Why not? Precisely because persons with disabilities always have been in the minority. Anita Silvers employs the exercise of “historical counterfactualizing” to demonstrate how our social landscape would look different if a dominant group in a society used wheelchairs, for example. Given that hypothetical state of affairs, it is indeed hard to imagine that buildings would have been constructed with stairs and narrow doorways that would exclude a majority of users. Silvers concludes from this exercise: “By hypothesizing what social arrangements would be in place were persons with disabilities dominant rather than suppressed, it becomes evident that systematic exclusion of the disabled is a consequence not of their natural inferiority but of their minority social status.”\textsuperscript{205}

To the extent that it focuses on both environmental and social inaccessibility resulting from the minority status of disabled people, this approach responds to physical, social, and economic barriers as a source of disadvantage, without directly accounting for the impact of attitudinal barriers. Other theorists, however, have linked functional

\textsuperscript{203} See Burgdorf, supra note 77, at 443.

\textsuperscript{204} Along these lines, Lennard Davis notes that “[d]isability presents itself to ‘normal’ people through two main modalities—function and appearance.” Davis, supra note 27, at 11. He argues that nondisabled persons’ understandings of disability, whether based on an inability to do something or on a different appearance, are socially constructed. See id. at 11–13.

\textsuperscript{205} Silvers, supra note 166, at 48. While the example given is of a physical barrier, it should be noted that historical counterfactualizing responds to any barrier that is the product of a social practice. For example, an instructor’s continuing to speak as she turns her back to students to write on the blackboard creates a barrier for deaf students. If the majority of people were deaf, the practice would not be accepted as it is today.
limitations to the development of negative attitudes towards persons with disabilities. Harlan Hahn, for example, uses the phrase "existential anxiety" to describe one response of nondisabled people to a person with a disability. The phrase captures how nondisabled people feel threatened by the fear that they might one day be "stricken" with a disability that would interfere with their physical capacities. Existential anxiety thus stimulates an unpleasant, negative response to the individual with a disability. So too, some persons equate impaired physical or mental functioning with impaired personhood and view persons with disabilities as somehow less than fully human, an attitude that feeds the growth of prejudice.

A second explanation for negative attitudes towards persons with disabilities is premised on their different physical appearance. Hahn suggests that differences in appearance may contribute more significantly to the stigma and disadvantage experienced by persons with disabilities than do differences in ability. The impact of a physical difference flows from its effect on nondisabled viewers; Hahn uses the phrase "aesthetic anxiety" to describe this impact. He posits that persons who are perceived as physically deviant or unappealing provoke a deep sense of discomfort that may cause other persons to avoid or shun them. Similarly, individuals who do not present conventional images of the human body are devalued and may be cast in subordinate roles based on their "strange" appearance. According to disability theorists, this discomfort with, and aversion to, physical difference is not a natural response, but is itself a socially conditioned response.

The role of physical appearance in creating disadvantage for persons with disabilities is bolstered by evidence suggesting the power of appearance in society. Perceptions of physical attractiveness are described as having a pivotal effect on evaluations in contexts ranging from academics, to employment, to personal relationships. Appearance contributes to social stereotyping, which in turn generates

207 See Hahn, supra note 30, at 106.
208 See Hahn, supra note 152, at 54.
209 See Hahn, supra note 206, at 37, 40.
210 See Davis, supra note 27, at 12-13; see also Harlan Hahn, Can Disability Be Beautiful?, in Perspectives on Disability, supra note 178, at 217 (describing historical acceptance of a variety of body types prior to the influence of religion and advertising).
expectations regarding ability. For example, researchers studied how nondisabled adolescents perceived the effects of facial surgery on children with Down’s syndrome, and found that the subjects who noticed an improvement in appearance following surgery also offered higher intelligence ratings to those Down’s syndrome children with improved appearances. Accordingly, some plastic surgeons justify performing radical facial surgery on children with Down’s syndrome to correct facial anomalies—even though such surgery has no effect on mental functions—simply on the grounds that emotional and behavioral responses to the children will improve following the surgery.

Based on the power of physical appearance, some disability theorists have linked negative attitudes and discrimination against persons with disabilities to corresponding attitudes and discrimination against other groups of people who deviate from cultural norms of physical appearance. Based on this linkage, Lennard Davis suggests using the phrase “physical minorities” to give more of a political sense to the importance of physical difference than does the term “disabled,” and Hahn adopts the term “physicalism” to describe the oppressive aversion to disability and intolerance of other forms of physical difference. Thus, according to these theorists, prejudice against, and exclusion of, persons with disabilities flows at least as much from their visible physical differences as from their limited abilities.

Although the burgeoning literature in disability studies has been elaborating the theoretical underpinnings of a minority group model of disability, several difficulties with understanding disabled people as a distinct minority group remain. First, unlike many members of other racial, ethnic, or religious minority groups, individuals with disabilities often have grown up in isolation from other persons with disabilities and thus have had little opportunity to develop the type of group consciousness or culture that has empowered other minority


213 See Carey, supra note 211, at 45. Of course, some may also view correcting physical anomalies as a benefit to society: “Reconstructive surgery has the objective not only of helping an abnormal individual achieve a kind of normalcy, but of ridding, if possible, society of a visible, uncomfortable exception.” Robert M. Goldwyn, Deformity and the Humane Ideal of Medicine, in The Tyranny of the Normal, supra note 211, at 86.

214 See Davis, supra note 27, at 3.

215 See Hahn, supra note 30, at 99.
groups.216 Similarly detracting from the likelihood of developing a minority group consciousness is the reality that disabled people are an extremely heterogeneous bunch. As a result, the experiences of disadvantage or subordination that individuals have encountered may be so diverse that group members may find themselves with little in common. Due to this heterogeneity, disability theorists are particularly sensitive to their inability to speak to the experience of all disabled people. Thus, essentialism in describing the lived experience of “the disabled” is particularly to be avoided.217

Aside from these obstacles to conceptualizing persons with disabilities as a discrete and cohesive minority group, disability theorists also have recognized that framing their political demands as purely a claim to equal treatment on a level playing field may sometimes be problematic. As discussed above in the description of the social model, it is imperative to recognize that for some persons with severe disabilities, the playing field can never truly be leveled, for not all of the limitations associated with their impairments are socially created. Moreover, as Anita Silvers points out, even if the playing field is leveled to the extent possible by removing barriers and providing accommodations, only the highest functioning impaired people will thrive.218 Thus, the civil rights model may prove a mirage for persons


217 See WENDELL, supra note 138, at 30, 31 (recognizing that living with disability is different for people with different disabilities, but finding common ground in experiences of social oppression); Hahn, supra note 30, at 111 (recognizing that no single “disabled viewpoint” exists but asserting that persons with disabilities do have in common that they do not experience the external environment in the same way as the nondisabled). But cf Fine & Asch, supra note 216 (reporting results of survey showing that 74% of people with disabilities do feel some common identity with one another and 45% see themselves as members of a minority group); Longmore, supra note 30 (discussing insider and outsider perspectives on medical treatment for persons with disabilities).

218 An example of the type of situation she contemplates may be found in Matthews v. Commonwealth Edison Co., 128 F.3d 1194 (7th Cir. 1997). In this reduction-in-force case, the employer used performance ratings from the previous year as the criteria for selecting which employees to retain. These ratings were based partially on the amount of work performed. Since the plaintiff missed a great deal of work because of his heart attack, and was forced to work a limited number of hours during his recovery period, his performance score was significantly lower and so he was let go. Despite this direct correlation between plaintiff’s physical impairment and his low performance rating, the court found that the plaintiff was not discharged because of his disability. Rather, according to the court, the company made a legitimate, pragmatic decision to retain those employees who provided the most value through their labor.
whose impairments make them incapable of competitive functioning.\textsuperscript{219} Despite these acknowledged limitations, however, the minority group model of disability provides the undergirding for current efforts to advance the rights of persons with disabilities.\textsuperscript{220}

4. Further Insights

In addition to refining the three models of disability described above, numerous disability theorists have discussed two additional notions that may be pertinent to this Article's consideration of how to

\textsuperscript{219} See Silvers, supra note 138, at 791.

\textsuperscript{220} The civil rights model also has its dissenters. A main argument against the civil rights approach to disability is that it is disingenuous: critics see the ADA as not an antidiscrimination law, but an imposition of a subsidy for individuals with disabilities, paid for by public and private entities. \textit{See Richard A. Epstein, Forbidden Grounds: The Case Against Employment Discrimination Laws} (1992); Andrew Kull, \textit{The Discrimination Shibboleth}, 31 San Diego L. Rev. 195 (1994). They argue that the “antidiscrimination” measures in the ADA in reality represent a public policy choice to promote the employment of those with disabilities, not to protect their civil rights. \textit{See id.} Such critics view the requirement of reasonable accommodations for individuals with disabilities not as the removal of arbitrary roadblocks to employment, but as an “affirmative obligation” for employers to provide more compensation to individuals with disabilities than to those without disabilities. \textit{See Epstein, supra, at 480; Mark A. Schuman, The Wheelchair Ramp to Serfdom: The Americans with Disabilities Act, Liberty, and Markets,} 10 St. John’s J. Legal Comment. 495, 504–05 (1995). This amounts to government imposing a “price floor” for entering into a contract with an individual with a disability. \textit{See id.} at 506–07. The labeling of this action as “antidiscrimination” has been characterized as a “linguistic diversion” used both to shield the pride of those benefited by the laws and to disguise a “back-door technique to subsidize people’s jobs.” Kull, supra, at 200.

In addition, Kull asserts that the ADA’s provisions differ from the prohibition of race discrimination in Title VII mostly in their costs to business and society, which both Kull and Epstein argue are higher than proponents of the ADA care to admit. \textit{See Epstein, supra, at 488; Kull, supra, at 200.} Kull also suggests that the equation of so-called disability discrimination with race discrimination obscures the true issues and impedes meaningful discourse about the meaning of and solutions to race discrimination.

Finally, Epstein argues that discrimination against the disabled isn’t really discrimination, but the logical effect of the increased costs of doing business with individuals with disabilities. \textit{See Epstein, supra, at 487.} He advocates an analysis of the costs to business and society of the ADA against the actual benefits enjoyed by all disabled individuals (not just those who are employable). \textit{See id. at 491.} He suggests that “antidiscrimination” laws be repealed, and, in their place, a system of budget-restricted government subsidies be instituted, which would be targeted to resolve specific issues facing those with disabilities. \textit{See id. at 493.} In other words, Epstein advocates calling the prohibition of discrimination on the basis of disability by what he sees as its right name: a subsidy for individuals with disabilities.
define "disability": the symbolic facet of disability and the dynamic nature of disability.

a. Disability's Symbolism

Many disability theorists concur that bodily impairment and visible physical differences carry with them a symbolic power that exceeds their effects on actual ability. For persons gifted with strong, able bodies, persons with disabilities may symbolize things dreaded: the vulnerability to aging, infirmity, and death and the inability to control one's body. Indeed, the symbolic content of disability may overwhelm the humanity and individuality of a disabled person in the eyes of a nondisabled individual. In other words, one sees not the person, but only the disability, and the disability identifies its bearer as "other," someone with whom nondisabled people cannot, and perhaps do not wish to, identify.221 Moreover, Anita Silvers argues, even if an able-bodied person attempts to identify with the experience of being impaired, it may be impossible to imagine what it is like to be disabled: "[P]erforming major life functions such as moving one's body is so intimate an element of the fabric of our experience that one cannot accurately imagine how to live otherwise."222 This inability is consequential, for it confounds the ability of nondisabled persons to reason morally about how they would wish to be treated if they were disabled.223

Another aspect of disability's symbolism is the meaning attached to an ability that is lost. For example, in our culture the act of walking has a symbolic significance that far exceeds its functional value. With the advent of the ADA and its accessibility requirements, the barriers faced by wheelchair users have significantly decreased; nonetheless, the goal of the rehabilitation system remains the encouragement of walking or near-walking.224 The symbolic importance attached to walking was vividly illustrated by James Brady's appearance at the 1996 Democratic Convention. After he rose from his wheelchair and walked the few steps to the podium to address the convention, thunderous applause erupted from the delegates. Clearly, James Brady could have made his speech no less eloquently seated in his wheelchair, but it was the sight of him walking, rather than his words, that

221 See Wendell, supra note 138, at 60–61; Wendell, supra note 150, at 70, 74; see also Hiegel, supra note 91, at 1451 ("[T]he human body is an important site of symbolic meaning about personhood.").
222 Silvers, supra note 138, at 783.
223 See id.
224 See Oliver, supra note 148, at 95–105.
captivated viewers. Thus, theorists recognize that the functional worth of a lost ability may be overshadowed by its symbolic value.

b. Disability’s Dynamism

Along with their understanding of disability as a construct reflecting social demarcations of normality and deviance, many disability theorists highlight disability’s dynamic nature. Because disability reflects the interaction between the environment and the body—both of which are constantly changing—it is mistaken to view an individual’s disability as a fixed trait that, once determined to exist, remains static.

This dynamic property of disability exacerbates the difficulty of setting boundaries around the concept of disability. Drawing lines somewhere on the continuum of human abilities is problematic, and all the more so when individuals’ abilities and impairments are often fluid. Yet both the law and popular understanding take a bipolar approach: an individual is either disabled or not. This all-or-nothing approach offends some disability theorists who would prefer the recognition of degrees of limited ability as being more closely in harmony with the reality of people’s lives. Yet even those who challenge the bipolarity of the common understanding of disability recognize that not all impairments and disabilities limit individuals’ capacity to participate meaningfully in society and that some impaired persons have stronger claims than others to societal remediation and protection from discriminatory behavior. Ultimately, the apparent necessity of drawing lines does not render the question of where and on what basis to draw those lines any less problematic. In the next Part, I turn to considering, through the lens of disability theory, how legal decisionmakers have attempted to draw lines around the concept of impairment.

225 See Doyle McManus & Sara Fritz, Democrats’ Emotional Night: Convention Opens with Brady, Reeve Casting Clinton as a Leader who Reaches Across Party Lines, L.A. TIMES, August 27, 1996, at A1 (observing that delegates and guests “fell reverently silent as Brady, grievously wounded in a 1981 assassination attempt against then-President Reagan, walked haltingly to the dais with the help of his wife, Sarah, and a cane”).

226 See supra note 182 and accompanying text.

227 See WENDELL, supra note 138, at 20–21; cf. Colker, supra note 201.

228 See WENDELL, supra note 138, at 50 (giving example of an inability to dance gracefully as not particularly important to full participation in the life of a society); cf. Colker, supra note 201, at 4 (asserting necessity of ensuring that programs designed primarily to assist individuals in overcoming a history of subordination are not used by individuals who have been insulated from that subordination by their presence in a “bi” category).
IV. DEFINING "DISABILITY": THEORETICAL PERSPECTIVES ON LEGAL IMPAIRMENT

Having described the understandings of disability that have grown up out of the field of disability studies, this Article now uses the lens of these theoretical understandings to examine more closely how the agencies and courts are interpreting the concept of impairment as a constitutive element of the ADA's definition of disability. The purpose of this examination is several-fold: first, to assess whether the ADA's definition of "disability," as applied, truly embodies the civil rights model of disability; second, to consider whether a greater appreciation of nonlegal understandings of disability might assist courts in giving content to the ADA's imprecise definition; and third, to develop strands of reasoning to use in the task that Part V undertakes—inquiring whether using a concept other than impairment as an element in defining "disability" might better accord with the evolving sociopolitical understanding of disability.

Numerous commentators have hailed the ADA as rejecting traditional understandings of disability that viewed the disabled individual as having something wrong with her and instead embodying a more enlightened civil rights approach that recognizes the social roots of disability.229 This characterization of the ADA is based chiefly upon the statute's express recognition that persons with disabilities have been subjected to discrimination and excluded from society as a result of stereotypes230 and its mandate that employers, public entities, and public accommodations provide reasonable accommodations to allow disabled individuals to participate meaningfully in society.231 A closer inspection of how agencies and courts approach the threshold concept of impairment, however, reveals that, by and large, the application of the widely acclaimed civil rights statute reflects a medical model understanding of disability.

Before beginning this inquiry, however, I should acknowledge the limitations of an approach that seeks to inform decisions about applying a legal definition by reference to scholarly theories from other disciplines about the nature of disability. Disability theorists de-

229 See, e.g., Burgdorf, supra note 77; Feldblum, supra note 161; Silvers, supra note 160.
231 See supra note 6 (citing statutory provisions requiring reasonable accommodations). But see Drimmer, supra note 30 (finding that standards such as "reasonable" accommodations and "readily achievable" modifications are inconsistent with the civil rights model's demand that "equal treatment and freedom from both attitudinal and structural discrimination be guaranteed without compromise").
scribe a phenomenon: why persons with disabilities suffer social, cultural, and economic disadvantage. Courts applying the statutory definition of disability make a threshold eligibility decision: whether an individual plaintiff claiming to have a disability falls inside or outside of the ADA’s protective realm. These different pursuits require differing degrees of precision. In essence, describing requires less precision than drawing lines. Even given these varying purposes, however, scrutinizing agency and judicial decisions through the lens of disability theory may turn the disability kaleidoscope and give us a fresh view of whether the ADA, as enacted, is likely to be effective in accomplishing Congress’s purpose of ending a history of exclusion and discrimination against disabled people.

As noted earlier, the ADA defines “disability” as having three elements: (1) a physical or mental impairment that (2) substantially limits (3) a major life activity. This Part focuses on the regulations and case law regarding the first element as a way of teasing out how the ADA’s definition, as applied, understands the phenomenon of disability. Like the conceptual frameworks discussed above in Part III.A., Congress employed the concept of impairment as an essential step towards finding disability. The ADA itself does not define the term, but regulations issued by the EEOC define physical impairment as “[a]ny physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine.” This definition, on its face, is extremely broad; it appears that “any condition . . . affecting” one of the listed body systems qualifies as an impairment.

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232 This limitation is implicitly acknowledged by scholars of disability, too. Simi Linton writes:
The question of who ‘qualifies’ as disabled is as answerable or as confounding as questions about any identity status. One simple response might be that you are disabled if you say you are. Although that declaration won’t satisfy a worker’s compensation board, it has a certain credibility with the disabled community. LINTON, supra note 27, at 12.

233 29 C.F.R. § 1630.2(h)(1) (1998). A mental impairment is defined as “[a]ny mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.” § 1630.2(h)(2). The EEOC adopted these definitions from the regulations implementing section 504 of the Rehabilitation Act at 34 C.F.R. pt. 104. See 29 C.F.R. § 1630.2(h), app. (1998). The regulatory definitions provided by the DOJ and DOT are in accord. See 49 C.F.R. § 37.3 (1997); 28 C.F.R. § 36.104 (1998).
Having planted this expansive definition of "impairment," the EEOC then attempts to prune some of its branches. In its Interpretive Guidance on the ADA's employment provisions and its Compliance Manual for agents investigating charges of disability discrimination, the EEOC tries to establish a basis for drawing lines between impairments and physical, psychological, environmental, cultural, and economic characteristics that are not impairments, and thus cannot support a disability finding. These documents exclude from "impairment's" broad definition several specific conditions or types of characteristics that the EEOC anticipated potential plaintiffs would try to represent as disabilities, including pregnancy, weight, personality traits, and advanced age. This Part first examines, through a disability theory lens, two of the specific conditions or characteristics that the EEOC excludes and the case law that has grown up in these areas, and then proceeds to analyze more generally how the courts and the agencies have construed the concept of impairment.

A. Pregnancy

1. The Law

At first blush, a straightforward reading of the regulatory definition of "impairment" would appear to include pregnancy as a "... condition ... affecting ... [the] reproductive [system]." Nonethe-

less, the EEOC—apparently ignoring the disjunctive between "disor-
der" and "condition"—has concluded that pregnancy is not an impairment because it is "not the result of a physiological disorder." Following on this line of reasoning, in 1995 the EEOC clarified that, while pregnancy plain-and-simple is not an impairment, complications resulting from pregnancy are impairments, presumably because they do reflect some physiological disorder.

By and large, the courts have followed the EEOC's rejection of pregnancy as an impairment. With the exception of a few cases seen as aberrant, courts applying the federal disability discrimination laws have been unwilling to find that pregnancy, in and of itself, is an impairment. Moreover, a number of courts have lumped "pregnancy and related medical conditions" together, finding that all such bodily changes aggregated do not constitute an impairment, at least

While a pregnant woman certainly has a physiological condition, it cannot be said that the condition affects any of the above body systems. The cases indicate that the body system must be affected in a negative manner, such that there are problems suffered as a result of the condition. . . . [T]here is no negative effect when a woman becomes pregnant. She still is able to reproduce, in fact she is reproducing when she is pregnant, thus it cannot be said that her reproductive system is negatively affected. . . .


238 29 C.F.R. § 1630.2(h), app. (1998).

239 See Compliance Manual, supra note 235, at § 902.2(c)(3). The example that the Compliance Manual gives of a pregnancy-induced complication is hypertension, a condition that is readily recognized as an impairment in nonpregnancy cases.


in the absence of "unusual circumstances." For example, in *Gudenkauf v. Stauffer Communications, Inc.*, the court found that the plaintiff, who during her pregnancy complained of morning sickness, stress, nausea, back pain, swelling, and headaches, did not have an impairment because her pregnancy was not unusual or abnormal. In reaching this conclusion, the court relied on the EEOC's interpretive guidelines regarding pregnancy and went on to reason as follows: "Pregnancy is a physiological condition, but it is not a disorder. Being the natural consequence of a properly functioning reproductive system, pregnancy cannot be called an impairment. . . . All of the physiological conditions and changes related to a pregnancy also are not impairments unless they exceed normal ranges or are attributable to some disorder." Several courts adopting this approach to exclude pregnant women from the ADA's coverage have reassured the plaintiff by reminding her that the Pregnancy Discrimination Act (PDA) and Title VII prohibit adverse employment actions based on pregnancy, by treating pregnancy discrimination as a form of sex discrimination rather than disability discrimination.

242 See, e.g., *Leahr*, 1997 WL 414104, at *4; *Jessie*, 926 F. Supp. at 616; *Lehmuller*, 944 F. Supp. at 1094 ("coverage of the ADA does not extend to normal pregnancies"); *Johnson*, 934 F. Supp. at 627 (noting that neither an employee's pregnancy nor its complications were a disability under the ADA); *Tsotselanos*, 893 F. Supp. 109 (finding that pregnancy complicated by ovarian cysts, which caused plaintiff to miss work, was not an impairment); *Villarea*, 895 F. Supp. at 152 (concluding that pregnancy and related medical conditions do not, absent unusual circumstances, constitute an impairment).


244 Although Gudenkauf believed she was disabled during the last trimester of her pregnancy, the court relied on the testimony of Gudenkauf's obstetrician that she had not experienced any complications or conditions not normally expected with pregnancy and that her complaints did not indicate unusual symptoms or unusually severe symptoms. See id. at 469.

245 Several of the courts rejecting pregnancy and related conditions as disabilities also rely on a statement in the EEOC's guidance manual that "temporary, nonchronic impairments of short duration, with little or no long term or permanent impact, are usually not disabilities." 29 C.F.R. § 1630.2(j), app. (1998). This statement is directed at explaining the phrase "substantially limits," not "impairment." See, e.g., *Martinez*, 1998 U.S. Dist. LEXIS 8499; *Leahr*, 1997 WL 414104, at *4; *Tsotselanos*, 893 F. Supp. at 119; *Villarea*, 895 F. Supp. at 152.


A few women experiencing pregnancy-related conditions, however, have managed to circumvent this line of cases by characterizing their disability not as their pregnancy, or even as pregnancy plus its manifestations, but instead as a separate condition, which just happened to accompany their pregnancy. For example, the plaintiff in *Patterson v. Xerox Corp.*\(^2\)\(^4\)\(^8\)\(^9\)\(^0\) alleged that severe back pain—which she suffered as a result of her pregnancy and the aggravation of a prior back injury—was her impairment and that it substantially limited her ability to sit at work for extended periods of time. While noting the line of case law holding that the ADA does not recognize pregnancy as a disability, the court held that Patterson had survived a motion to dismiss by alleging her disability to be severe back pain.\(^2\)\(^4\)\(^9\) Thus, by cleaving the disabling result of a pregnancy from the pregnancy itself, a plaintiff may be able to convince a court that her case really isn’t about pregnancy.

More recently, a number of courts have built on this judicial willingness to focus the impairment inquiry away from the simple state of pregnancy and onto its side effects, but have done so by distinguishing between “normal, uncomplicated pregnancies” and the complications that can arise out of a pregnancy.\(^2\)\(^5\)\(^0\) In *Cerrato v. Durham*,\(^2\)\(^5\)\(^1\) the plaintiff alleged that her experience of spotting, leaking, cramping, dizziness, and nausea during pregnancy qualified as disabilities. In denying the defendant’s motion to dismiss, the court embraced the distinction between an uncomplicated pregnancy and pregnancy complications as supported by medical science—specifically, a statement by the AMA that most women with uncomplicated pregnancies would be able to work until labor commenced, but that enumerated “substantial complications” might disable the pregnant woman from further work.\(^2\)\(^5\)\(^2\) Emphasizing that the case did not involve “an entirely

\(^{248}\) 901 F. Supp. 274 (N.D. Ill. 1995).

\(^{249}\) See id. at 278; see also Walker v. American NTN Bearing Mfg., No. 95-C1227, 1997 U.S. Dist. LEXIS 2919 (N.D. Ill. Mar. 10, 1997) (citing *Patterson* in accepting plaintiff’s contention that her impairment was not her pregnancy itself, but her headaches, nausea, and sleeping and eating problems attributable to her pregnancy); Garrett v. Chicago Sch. Reform Bd. of Trustees, No. 95-C7341, 1996 WL 411319 (N.D. Ill. July 19, 1996) (finding allegation of severe morning sickness as disability was sufficient to survive motion to dismiss).


\(^{252}\) Id. at 393 (citing Council on Scientific Affairs, *Effects of Pregnancy on Work Performance*, 251 JAMA 1995 (1984)).
normal, healthy pregnancy," the court concluded that Cerrato had sufficiently alleged a disabling impairment to withstand a motion for summary judgment.\textsuperscript{253}

Under this approach, courts consider whether a pregnancy-related complication can be seen as a disorder or abnormal (so that it might be deemed an impairment) notwithstanding that the complication is inextricably part of the pregnant woman's experience of pregnancy (which is deemed not an impairment). In assessing a plaintiff's argument that her premature labor was a disabling impairment, one court explained its reasoning:

Pregnancy is not considered a physiological disorder under [the EEOC regulations]. . . . However, the regulation does not explicitly exclude pregnancy-related impairments, provided they are the result of a physiological disorder. "Physiologic" is defined as "characteristic of or conforming to the normal functioning or state of the body or a tissue or organ." Thus, a physiological disorder is an abnormal functioning of the body or a tissue or organ. Clearly, plaintiff's condition was not a function of a normal pregnancy. It was a physiological disorder.\textsuperscript{254}

Similarly, in considering the claims of a woman who experienced severe back, uterine, and pelvic bone pain and painful uterine contractions, another court emphasized that these "conditions were not a function of a normal pregnancy, but rather a physiological disorder with disabling consequences."\textsuperscript{255} Thus, these most recent cases endeavor to draw the line between "impairment" and "not impairment" by distinguishing between pregnancies that are normal and those marred by abnormal complications.

2. Theoretical Response

So how does the law regarding a pregnant woman's ability to claim the ADA's protection look from the perspective of disability theory? It looks as if the EEOC and the courts are attempting to draw lines between the majority of pregnant women, who cannot complain under the ADA if they are discriminated against based on the bodily and emotional changes that accompany pregnancy, and those few women who experience conditions that deviate so far from what is considered normal for a pregnancy that the women are found to have an impairment under the ADA. This effort at categorizing is seen

\textsuperscript{253} Id.
\textsuperscript{254} Hernandez, 959 F. Supp. at 130 (citing Dorland's Medical Dictionary (27th ed. 1988)).
\textsuperscript{255} Darian, 980 F. Supp. at 87.
throughout the case law, whether it takes the form of an "unusual circumstances" or "abnormal complications" standard, and it essentially demands a finding that something is wrong with, or abnormal about, a pregnant woman's body before acknowledging an impairment. This reluctance to find impairment in pregnancy is premised on the understanding that a pregnancy itself represents the proper functioning of a healthy reproductive system; it also probably rests on a common perception that pregnant women are not typically viewed as having a disability. Nonetheless, a disability theorist might ask, if an employer (or other actor covered by the ADA) discriminates against a woman based on her pregnancy and related conditions, isn't that discrimination likely to be based on the deviation of the pregnant woman's body from cultural ideals of what the body should look like and how it should perform? And, if that is the case, how much does discrimination based on pregnancy really differ from discrimination based on disability?

As noted above, the earlier cases took a strongly exclusionary stance, reasoning that pregnancy and related medical conditions simply were not impairments absent "unusual circumstances"—a phrase that none of the courts explained or even illustrated. As many of these courts noted, pregnancy discrimination is discrimination based on sex, not disability, and it should stay in its proper box. But can these two possible reasons for discriminating really be so easily untangled? Does the employer who terminates a woman "based on her pregnancy" really do so because she is female (after all, only females become pregnant)? Or might the employer terminate the woman because she’s been late to work (because of morning sickness), missed several days (when she experienced spotting and her doctor put her on bed rest), and is often eating at her desk (in order to keep up her blood sugar and prevent nausea)? Or might all these elements come into play in a single decision?

Disability theorists might remark that the courts' desire to compartmentalize these cases into sex, but not disability, discrimination categories reflects an inability or unwillingness to recognize the frequency of dual discrimination encountered by women with disabilities. Nor is it always a real answer to say, as the courts often have, that pregnancy discrimination is indeed prohibited, but under the PDA, rather than the ADA. For the PDA, unlike the ADA, simply prohibits differential treatment based on pregnancy, but does not impose any obligation to provide accommodations for employees whose pregnancy-related conditions affect their ability to perform their job in the
manner required by their employer. Given this difference, the question bears addressing: if one of the ADA's purposes is to enable persons with functional limitations to obtain and retain employment by requiring employers to accommodate those limitations, doesn't the reasonable accommodations requirement make equal sense as applied to pregnant women? It is also worth noting, as one court has, that the PDA provides an alternative avenue of protection only in the employment context; it does not protect pregnant women discriminated against by public accommodations or public entities. Thus, a greater judicial willingness to find that pregnancy and its accompanying physical and mental changes qualify as impairments under the ADA would not simply duplicate protection already existing for pregnant women.

But the steps that some courts have taken to allow some pregnant women to claim protection under the ADA—whether by isolating an impairment such as back pain or morning sickness from its cause or


257 For examples of the range of accommodations requested by pregnant women, see Darian, 980 F. Supp. 77 (requesting that nursing student be required to see only one patient per day, be allowed to review patient records at home, and have a reduced course load); Jessie v. Carter Health Center, Inc., 926 F. Supp. 613 (E.D. Ky. 1996) (requesting that certified nursing assistant be placed on light duty work); Patterson v. Xerox Corp., 901 F. Supp. 274 (N.D. Ill. 1995) (requesting that receivables representative be allowed to take 5-10 minute walk every hour to relieve back pain).

258 See Darian, 980 F. Supp. at 86.
by viewing the complications of pregnancy as impairments—clearly reflect a medicalized view of disability. Demanding the artificial cleavage of an impairing condition from its source (the woman’s pregnancy), and considering it in isolation from the bundle of other physical changes experienced by a pregnant woman, reflects a medicalized understanding of human experience as describable in terms of symptomatology and disorder in discrete bodily systems or organs, rather than as a complexly integrated experience of the whole body in context. This approach is reminiscent of the method used in Social Security disability determinations that employs schedules or lists showing the percentage of impairment resulting from different conditions.259

The “more refined” analysis used in *Cerrato* and *Hernandez* is even more explicitly medicalized, for these courts rely on the “current state of medical knowledge” to draw a line between pregnancies that are normal and those that are not because of complications.260 Disability theorists likely would reject the medical profession as the arbiter responsible for drawing lines between normal and abnormal (or “complicated”) pregnancies. Instead, in assessing when pregnancy should be considered a disability, the proper questions are how women experience their pregnancies and all the accompanying changes—without attaching labels like “complicated” or “abnormal” or “unusual”—and how those changes affect women’s lives and ability to participate in the workplace and society more broadly. This approach would accord with the efforts of the women’s health movement over the past several decades to demedicalize pregnancy and childbirth and wrest control of those experiences from the predominantly male medical profession.261 It would be bitterly ironic, however, if the struggle to have pregnancy and childbirth understood as normal, healthy experiences rather than as medical problems were to contribute indirectly to de-
priving of legal redress pregnant women who are discriminated against because of their physical condition.

I make these points to illustrate how claims of disability by pregnant women have encountered a medical model analysis by the EEOC and the courts on the question of impairment. While disability theorists would be likely to discredit the legal analysis of pregnancy as a disability for these reasons, it is less clear that disability theorists would themselves view pregnant women who are discriminated against as disabled. The questions that those theorists ask, however, would not resemble the questions posed under the medical model. Rather than asking whether a woman's pregnancy is characterized by some physiological dysfunctioning or abnormality, some disability theorists would ask whether pregnant women, like people with disabilities, have been subjected to social oppression because of their bodies' deviations from cultural norms. Other theorists might focus on whether pregnancy significantly affects a woman's daily life and whether pregnant women present themselves to the world as disabled people. Ultimately, the question becomes how much alike, and how different from, disabled people are women whose pregnancies cause them to be subjected to discrimination. Thus, approaching the question from a disability theory perspective does not avoid the need to draw lines; it simply demands that the lines be drawn based on the social reality that people experience rather than based on medical classifications.

B. Obesity and Overweight

1. The Law

Cases in which plaintiffs assert violations of disability discrimination laws by alleging discrimination based on their weight provide

262 Cf. Hahn, supra note 30, at 108 (discussing aesthetic anxiety stimulated by physical differences as the basis for prejudice and exclusion).
263 Cf. Linton, supra note 27, at 13 (discussing Carol J. Gill, Questioning Continuum, in The Ragged Edge: The Disability Experience from The Pages of The First Fifteen Years of "The Disability Rag" 46 (B. Shaw ed., 1994)).
264 I think that few persons from any camp would argue that all pregnant women should be considered to have a disability throughout their pregnancies. It seems that women whose pregnancy causes their bodies not to look or perform the way that society expects bodies to look and perform—a failure that prompts discrimination—have the strongest claim to disability.
265 Cf. Martha Minow, Making All the Difference: Inclusion, Exclusion and American Law 3-4 (1990) (discussing importance of basis on which classifications are made).
266 For commentary on these cases, see Sharlene A. McEvoy, Tipping the Scales of Justice: Employment Discrimination Against the Overweight, 21 Hum. RTS. Q. 24 (1994)
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another example of how the medical model of disability influences legal application of the ADA's definition of "disability." Two types of cases have arisen claiming weight discrimination as disability discrimination. In the first, a morbidly obese\textsuperscript{267} plaintiff alleges that discrimination occurred and either that her obesity was an actual disability or that her employer (or other actor covered by the ADA) perceived her

\begin{itemize}
  \item (analyzing Cook v. Rhode Island, Dep't of Mental Health, Retardation, & Hosps., 10 F.3d 17 (1st Cir. 1993));
  \item Charles T. Passaglia, Appearance Discrimination: The Evidence of the Weight, 23 COLO. LAW. 841 (1994) (evaluating the possible impact of Cassista and Cook on obesity becoming recognized as a perceived disability);
  \item Steven Zielkowskki, The Status of Weight-Based Discrimination Under the Americans with Disabilities Act After Cook v. Rhode Island Department of Mental Health, Retardation, and Hospitals, 74 B.U. L. Rev. 667 (1994) (advocating amending EEOC regulations to address overweight conditions exceeding 20–30% over ideal weight);
  \item Andrea M. Brucoli, Comment, Cook v. Rhode Island, Department of Mental Health, Retardation, and Hospitals: Morbid Obesity as a Protected Disability or an Unprotected Voluntary Condition, 28 GA. L. Rev. 771 (1994) (emphasizing the need for case-by-case evaluation of each claim rather than a blanket recognition of all obese persons as disabled);
  \item Carolyn May McDermott, Note, Should Employers Be Allowed to Weigh Obesity in Their Employment Decisions? Cook v. Rhode Island, Department of Mental Health, Retardation & Hospitals, 44 U. KAN. L. Rev. 199 (1995) (recommending that protection of federal disability law be extended to those whose obesity results from systemic or metabolic factors, or whose obesity is of sufficient duration and impact);
  \item Milena D. O'Hara, Note and Comment, "Please Weight to be Seated": Recognizing Obesity as a Disability to Prevent Discrimination in Public Accommodations, 17 WHITTIER L. Rev. 895 (1996) (arguing that prevalence of discrimination against the obese mandates that obesity be protected as a disability, and proposing a "sliding-scale" approach to categorizing individuals as disabled);
  \item Scott Peterson, Comment, Discrimination Against Overweight People: Can Society Still Get Away with It?, 30 GONZ. L. Rev. 105 (1994) (advocating protection for the obese from widespread societal discrimination, yet acknowledging the logistical problems of extending disability legislation to cover the large number of overweight Americans);
  \item Shari Ronkin, Comment, Private Rights in Public Places: A Weighty Issue, 48 U. MIAMI L. Rev. 649 (1994) (arguing that obese plaintiffs should be offered redress under the ADA's "regarded as" prong when they can demonstrate that they have been treated differently due to societal stereotypes about obesity);
  \item Paula B. Stolker, Note, Weigh My Job Performance, Not My Body: Extending Title VII to Weight-Based Discrimination, 10 N.Y.L. SCH. J. Hum. RTS. 223 (1992) (arguing for Title VII protection for the overweight based on appearance discrimination);
  \item William C. Taussig, Note, Weighing in Against Obesity Discrimination: Cook v. Rhode Island, Department of Mental Health, Retardation & Hospitals and the Recognition of Obesity as a Disability Under the Rehabilitation Act and the Americans with Disabilities Act, 35 B.C. L. Rev. 927 (1994) (favoring federal protection of all obese individuals because of "societal perception that being overweight is a disabling condition.")
\end{itemize}

\textsuperscript{267} The medical definition of obesity is weight of 20% or more over the ideal body weight. Morbid obesity is defined as 100% over ideal weight. See Jeanine C. Cogan & Esther D. Rothblum, Outcomes of Weight-Loss Programs, 118 GENETIC, SOC., & GEN. PSYCHOL. MONOGRAPHS 885, 888 (1992); Barbara Lukert, Biology of Obesity, in PSYCHOLOGICAL ASPECTS OF OBESITY 1 (Benjamin Wolman ed., 1982).
obesity as a disability. In the second type of case, the plaintiff is not morbidly obese and may not even be obese; nonetheless, the plaintiff has suffered some adverse outcome as a result of a failure to meet weight guidelines or standards adopted by an ADA-covered entity. These plaintiffs allege that they have been discriminated against based on a perception that their failure to meet the standards makes them disabled.

The EEOC's interpretive guidelines take the position that the term "impairment" does not include "physical characteristics such as eye color, hair color, left-handedness, or height, weight or muscle tone that are within 'normal' range and are not the result of a physiological disorder." In its Compliance Manual, the EEOC goes on to explain that "[b]eing overweight, in and of itself, generally is not an impairment. . . . On the other hand, severe obesity . . . is clearly an impairment. In addition, a person with obesity may have an underlying or resultant physiological disorder, such as hypertension or a thyroid disorder. A physiological disorder is an impairment." Thus, the EEOC asserts that while a person's weight generally will not be deemed an impairment, it may be in two circumstances: (1) when the weight is attributable to or results in some physiological disorder or (2) when the weight falls outside the "normal" range, as in cases of morbid obesity.

Cases applying the ADA's definition of "disability" to claims of weight discrimination have generally followed the EEOC's approach to assessing when weight can be an impairment. Cook v. State of Rhode Island, Department of Mental Health, Retardation, and Hospitals provides an example of the cases in which a morbidly obese plaintiff

268 29 C.F.R. § 1630.2(h), app. (1998).
269 Compliance Manual, supra note 235, at § 902.2(c) (5) (i) (ii) (citations omitted).
270 In the interpretive guidelines explaining the phrase "substantially limits" as it is used in defining "disability," the EEOC also states, without explanation, "[T]emporary, non-chronic impairments of short duration, with little or no long term or permanent impact, are usually not disabilities. . . . Similarly, except in rare circumstances, obesity is not considered a disabling impairment." 29 C.F.R. § 1630.2(j), app. (1998). This reference to obesity, however, does not go to whether it should be considered an impairment.
271 In several cases, however, courts have either assumed that morbid obesity is a physical impairment, see, e.g., Nedder v. Rivier College, 908 F. Supp. 66 (D.N.H. 1995) (assuming arguendo that morbid obesity constitutes an impairment); Morrow v. City of Jacksonville, Ark., 941 F. Supp. 816 (E.D. Ark. 1996) (assuming implicitly that a combination of obesity and hypertension were impairments), or declined to decide the question, see Smaw v. Commonwealth of Virginia Dep't of State Police, 862 F. Supp. 1469 (E.D. Va. 1994).
272 10 F.3d 17 (1st Cir. 1993).
challenges an adverse employment action. Bonnie Cook was denied a position working as an attendant at an institution for persons with mental retardation. At the time she applied, Cook weighed over 320 pounds and stood 5'2" tall, which classified her as morbidly obese. In turning down her application, the defendant institution asserted that Cook's weight could affect her ability to evacuate residents in the event of an emergency and that her weight also created risks for her own health, which might lead to repeated absences and workers' compensation claims. Cook sued, alleging violation of section 504 of the Rehabilitation Act and arguing that, although she was capable of doing the job in question, the defendant perceived her as having a disability. The jury found for Cook and awarded her $100,000 in damages.

On appeal, the court affirmed, finding that the evidence supported the jury's verdict. In the course of assessing the evidence, the court concluded that the jury could reasonably have found that Cook had a physical impairment: "[A]fter all, she admittedly suffered from morbid obesity, and she presented expert testimony that morbid obesity is a physiological disorder involving a dysfunction of both the metabolic system and the neurological appetite-suppressing signal system, capable of causing adverse effects within the musculoskeletal, respiratory, and cardiovascular systems." In affirming, the court also rejected arguments by the defendant that the mutability and voluntariness of Cook's obesity prevented a finding that it was a legally cognizable impairment. Although the appeals court questioned the basic proposition that immutability is a prerequisite to finding an impairment, it found that the jury nonetheless had sufficient evidence from which it could find that the metabolic dysfunction that caused Cook's obesity was permanent, even if Cook could lose weight by fast-

273 In order to succeed on a perceived disability claim, the plaintiff may show the definition of "being regarded as having a disability" to be met in one of three ways:

(1) The individual may have an impairment which is not substantially limiting but is perceived by the employer or other covered entity as constituting a substantially limiting impairment;

(2) The individual may have an impairment which is substantially limiting only because of the attitude of others toward the impairment; or

(3) The individual may have no impairment at all, but is regarded by the employer or other covered entity as having a substantially limiting impairment.


274 Cook, 10 F.3d at 23. The court also found that the jury could have found from the evidence that although Cook was not handicapped, the defendant treated her as if she had a physical impairment because it treated her obesity as if it actually affected her musculoskeletal and cardiovascular systems.
ing. Likewise, the court found that the voluntariness of Cook’s obesity was not relevant to its status as an impairment, and that, even if it were, the jury could have found that the metabolic dysfunction was beyond Cook’s control.

In a case decided just a few months before Cook, the California Supreme Court more narrowly circumscribed when obesity could be deemed a “physical disability” under California’s Fair Employment and Housing Act, a phrase whose definition tracks the EEOC’s regulatory definition of “impairment.” Cassista alleged that the defendant had denied her employment because it perceived her to be disabled by her morbid obesity; after the defendant health food store declined to offer her a job, several employees expressed concern about whether Cassista’s weight would affect her ability to do the job. The California Supreme Court, however, rejected the proposition that simply showing that the defendant’s failure to hire Cassista was based on its perception that her weight disqualified her was sufficient to make out a showing of perceived disability. Instead, the court reasoned, because the “regarded as” prong of the disability definition refers back to the type of impairment that can give rise to a finding of actual disability, only a condition qualifying as an actual impairment can support a perceived disability claim. Moreover, the court interpreted regulations and case law under the ADA and Rehabilitation Act as standing for the proposition that weight unrelated to a “physiological, systemic disorder” cannot be a disability. As a result, the court concluded that, in order to succeed on a perceived disability claim based on weight, a plaintiff has to show that the defendant perceived her weight to be in the nature of a physiological disorder. Because Cassista had not presented evidence that her obesity was the result of a physiological condition or disorder affecting a body system, she could not succeed in her claim. Thus, under the California court’s approach in Cassista, even morbid obesity—a condition that falls

275 The court did suggest, however, that the mutability and voluntariness of an impairment could be relevant to determining whether it had a substantially limiting effect on major life activities. See id. at 23 n.7.
276 See Cassista v. Community Foods, Inc., 856 P.2d 1143 (Cal. 1993). The court pointed out that the statutory definition of “physical handicap” was modeled on the Rehabilitation Act’s and ADA’s definition of “disability” and looked to federal administrative and judicial interpretations of those statutes. See id. at 1150, 1153.
277 Accord Fredregill v. Nationwide Agribusiness Ins. Co., 992 F. Supp. 1082 (S.D. Iowa 1997) (stating, regarding perceived disability claim, that “evidence which consists only of a belief that a physical characteristic presents an undesirable image or appearance does not support an inference that [defendant] regarded [plaintiff’s] weight problems as connected to a physiological disorder”).
278 See Cassista, 856 P.2d at 1153.
outside the range of "normal" weights—is not an impairment unless it results from some physiological disorder.\textsuperscript{279}

This linkage between evidence of some sort of physiological disorder and a plaintiff's ability to demonstrate disabled status also shows up in the handful of cases in which plaintiffs who are not morbidly obese challenge weight standards used by employers.\textsuperscript{280} In these cases, the plaintiffs—a firefighter, a state trooper, and a flight attendant—claimed that they were fully able to perform their desired jobs, but that their employers' use of weight tables or guidelines as a basis for disciplining them showed that the employers perceived the plaintiffs to be disabled by their excess weight. In each of these cases the plaintiffs failed, with each court following a basic line of reasoning.

For example, in \textit{Francis v. City of Meriden},\textsuperscript{281} the plaintiff firefighter was suspended for repeatedly failing to keep his weight under a maximum acceptable weight established by a height/weight chart. The First Circuit acknowledged that, to succeed on a perceived disability claim, the plaintiff did not need to show that he had an actual disability. The court, however, went on to require an allegation that the employer believed (albeit erroneously) that the plaintiff suffered from a condition that, if it in fact existed, would qualify as an impairment under the actual disability prong. It is not enough, the court reasoned, that the plaintiff allege that the employer believes that some physical characteristic like weight makes the plaintiff unable

\textsuperscript{279} Karen Kramer and Arlene Mayerson criticize the California court's reading of the "regarded as" prong of the definition of disability as being too narrow. They suggest that, in order to show that an employer regarded an individual as having an impairment, it should be sufficient to show that the employer perceived her as having a physical condition "affecting" one of the "bodily systems." Thus, a plaintiff who could show that an employer refused to hire her because it believed her obesity (a physical condition) would cause her to have back problems (an effect on the musculoskeletal system) could proceed on a perceived disability claim. \textit{See} Karen M. Kramer & Arlene B. Mayerson, \textit{Obesity Discrimination in the Workplace: Protection Through a Disability Claim Under the Rehabilitation Act and the Americans with Disabilities Act}, 31 \textit{CAL. W. L. Rev.} 41, 62–63 (1994).

One district court has taken a similar approach in finding that a morbidly obese plaintiff had presented evidence of an actual impairment. \textit{See} Hazeldine v. Beverage Media, Ltd., 954 F. Supp. 697, 703 (S.D.N.Y. 1997) ("Hazeldine has shown that her obesity constitutes a physiological condition which affects at least her musculoskeletal, respiratory, and cardiovascular systems."); \textit{accord} Bryant v. Troy Auto Parts Warehouse, No. IP95-1654-C-D/F, 1997 U.S. Dist. LEXIS 22111, at *1 (S.D. Ind. Apr. 25, 1997).


\textsuperscript{281} 129 F.3d 281 (2d Cir. 1997).
to do the job or renders him somehow otherwise disabled.\textsuperscript{282} So, because weight is not an impairment unless it relates to a physiological disorder,\textsuperscript{283} the court found that no claim lay against an employer who took disciplinary action because an employee failed to meet weight guidelines.\textsuperscript{284}

Courts reaching this conclusion justify the outcome not only in terms of adherence to the EEOC's interpretation of the ADA, but also in terms of furthering that statute's broad purposes. The courts seem to fear that permitting suits that allege discrimination based on simple (albeit socially undesirable) characteristics such as excess weight will fling wide open the floodgates of specious ADA claims. Interpreting the ADA to cover such claims, as the First Circuit opined, "would make the central purpose of the statute[, to protect the disabled, incidental to the operation of the 'regarded as' prong, which would become a catch-all cause of action for discrimination based on appearance, size, and any number of other things far removed from the reasons the statute [was] passed."\textsuperscript{285}

In sum, reading together the cases challenging employer-imposed weight limits with those alleging discrimination based on actual or perceived morbid obesity, the courts—in accord with the EEOC—generally have agreed that a person's weight will be considered an impairment only if it reaches the level of morbid obesity\textsuperscript{286} (or is otherwise outside the normal range) or is related to a physiological

\textsuperscript{282} See id. at 285–86.

\textsuperscript{283} The court distinguished \textit{Cook} as a case involving discrimination based on morbid obesity and suggested that a plaintiff could proceed on a perceived disability claim if the employer perceived the plaintiff as being morbidly obese. See id. at 286.

\textsuperscript{284} See id.; accord \textit{Andrews}, 104 F.3d at 810 ("Because a mere physical characteristic does not, without more, equal a physiological disorder, where an employee's failure to meet the employer's job criteria is based solely on the possession of such a physical characteristic, the employee does not sufficiently allege a cause of action under these statutes."); \textit{Tudyman}, 608 F. Supp. at 746 (concluding as a matter of law that a bodybuilder flight attendant who exceeded weight limits was not a handicapped individual because his excess weight was not the result of physiological disorders, cosmetic disfigurement, or anatomical loss).

\textsuperscript{285} Francis, 129 F.3d at 287. See also \textit{Andrews}, 104 F.3d at 810 (stating that allowing coverage of discrimination based on physical characteristics unrelated to a physiological disorder would "debase the high purpose of the statutory protections available to those truly handicapped"); \textit{Tudyman}, 608 F. Supp. at 746 ("This court refuses to make the term handicapped a meaningless phrase.").

\textsuperscript{286} See Fredregill v. Nationwide Agribusiness Ins. Co., 992 F. Supp. 1082, 1090 (S.D. Iowa 1997) (stating, with respect to a morbidly obese plaintiff, "[plaintiff's] weight departs from the norm to such an extent it would not be beyond the realm of reason for the jury to conclude solely from his physical stature that his condition is an actual physical impairment").
disorder of some sort. What would a scholar from the disability studies field have to say about this method of drawing lines?

2. The Theoretical Perspective

A critic from the field of disability studies would likely point out that the two bases on which the EEOC and courts have chosen to segregate those people who can claim weight as an impairment are, respectively, arbitrary and medicalized. First, as noted above, a person may successfully assert weight as an impairment if that person is morbidly obese or her weight is otherwise beyond the "normal" range. This boundary raises questions of its own. How is "normal" weight to be determined? Should it be defined as less than a specified deviation from the ideal weights established by a particular height and weight chart But it becomes difficult to argue that assessments of normalcy should be based on ideal benchmarks when about twenty-five to thirty percent of Americans weigh twenty percent or more over their ideal weights.

Even if lawmakers were to decree that only weight rising to the level of morbid obesity deviates from the normal range enough to be deemed an impairment, a logical problem remains. Why should someone whose weight is one hundred percent more than her ideal weight be found to have an impairment when someone whose weight

287 One case to which the EEOC was a party, however, confounds this generalization somewhat. In EEOC v. Texas Bus Lines, 923 F. Supp. 965 (S.D. Tex. 1996), the defendant refused to hire a morbidly obese woman as a shuttle van driver after a physician refused to issue a Medical Examiner's Certificate required by Department of Transportation regulations. The EEOC took the position that the morbidly obese woman had no physical or mental impairment, but that Texas Bus Lines regarded her as substantially impaired. See id. at 968. The court found that the physician refused to provide medical clearance not based on any medical findings, but based on "myth, fear or stereotype" about the abilities of obese persons. The court concluded: "Texas Bus Lines regarded [the plaintiff] as disabled and, therefore, unable to work as a driver based on her alleged impaired mobility without the benefit of objective medical testing or findings." Id. at 979. This conclusion appears to be inconsistent with the holding in Francis, described in the text accompanying notes 281-84. Nonetheless, the two cases are distinguishable because the plaintiff in Texas Bus Lines was morbidly obese.

288 For example, weights beyond the normal range—or abnormal weight to put it more bluntly—could be established as a deviation of more than x% from the weights set forth in the Metropolitan Life Insurance Company height and weight tables. See Jane Byeff Korn, Fat, 77 B.U. L. Rev. 25, 28 n.18 (1997) (reproducing table). The term "obese" is medically defined in a similar fashion, as meaning 20% or more over ideal body weight. See id. at 25 n.1.

289 See id. at 28-29; accord Fredregill, 992 F. Supp. at 1089 ("A large segment of the population is obese to some degree, and obesity is a matter of degree.").
is a mere ninety-nine percent over her ideal weight does not have an impairment? Unless of course, her weight results from some physiological disorder, as will be discussed infra text accompanying notes 293–99. The present discussion centers on finding impairment in a deviation from the norm. See Korn, supra note 288, at 42 (objecting to blanket rule that protects someone who is 100% over her ideal weight, but not someone who is 80% over her ideal weight).

291 I am indebted to Professor Michael Masinter for making this point during a discussion of Francis v. City of Meriden in Counsel Connect’s ADA discussion group.

292 In light of the alternative way that weight can be deemed an impairment—if it is the result of a physiological impairment—one might speculate that the EEOC’s identification of morbid obesity as “clearly an impairment” reflects a res ipsa loquitur (“the thing speaks for itself”) approach. In other words, how could someone weigh 100% more than his ideal body weight if there’s not something wrong with him? Even if this theory accurately reveals an implicit rationale for the EEOC’s treatment of morbid obesity, it does not resolve the arbitrariness of the threshold chosen.

293 29 C.F.R. § 1630.2(h), app. (1998). In its Compliance Manual, the EEOC explains further: “[A] person with obesity may have an underlying or resultant physiological disorder, such as hypertension or a thyroid disorder. A physiological impairment is an impairment.” Compliance Manual, supra note 235, at § 902.2(c)(5)(ii).

should Bonnie Cook (who produced a diagnosis of what causes her morbid obesity) receive protection from employment discrimination when Toni Linda Cassista (who produced no evidence of a diagnosis) does not? Regardless of what caused these women’s morbid obesity, the social effects that they experienced were nearly identical: they were denied employment opportunities because employers believed that fat people couldn’t do the job.²⁹⁵

Moreover, simply delegating to medical professionals the responsibility for determining who has obesity attributable to a physiological disorder and thus may²⁹⁶ be qualified for ADA protection is particularly problematic given the high level of medical uncertainty regarding the causes of obesity. Medical science knows little about the etiology of obesity²⁹⁷ and thus is often incapable of stating with certainty whether a given person’s obesity is or is not the result of some physiological disorder. The courts’ insistence on identifying an underlying physiological disorder is also inconsistent with regulations issued under the Rehabilitation Act. According to guidelines clarifying these regulations, the term “impairment” includes “any condition which is mental or physical but whose precise nature is not . . . known.”²⁹⁸ Of course, this uncertainty regarding the causes of obesity may not persist forever. Recent research suggests that some cases of obesity may be caused by hormonal disorders and that genetic factors may play a contributing role.²⁹⁹ But if these causes of obesity are someday confirmed and become diagnosable, will they be considered physiological disorders and thus valid grounds for finding impairment? What if it is discovered that a genetic marker is shared by

²⁹⁵ For a discussion of Cook v. Rhode Island from a disability perspective, see Anita Silvers, Reprising Women’s Disability: Feminist Identity Strategy and Disability Rights, 13 BERKLEY WOMEN’S L.J. 81, 109–11 (1998) (emphasizing that Cook received protection from discrimination because the employer “falsely equated her physical condition with incompetence”).

²⁹⁶ Again, the reminder: even if a person satisfies the requirement of proving an impairment, that person will be an individual with a disability only if that impairment substantially limits one or more major life activities.

²⁹⁷ See Korn, supra note 288, at 45.

²⁹⁸ 34 C.F.R. pt. 104, app. A (1997) (clarifying 34 C.F.R. § 104.3(j)); 45 C.F.R. pt. 84, app. A. (1997) (clarifying 45 C.F.R. § 84.3(j)). Given the weight placed on Rehabilitation Act regulations by the Supreme Court in Bragdon v. Abbott, 118 S. Ct. 2196 (1998), it would seem that lower courts should pay closer attention to this interpretive guidance, even though it is not repeated in the ADA regulations or interpretive guidance.

²⁹⁹ See Crandall, supra note 294, at 883 (reporting that most research suggests that weight is primarily a function of genetic and metabolic factors); Gina Kolata, Researchers Find Hormone Causes a Loss of Weight, N.Y. TIMES, July 17, 1995, at A1.
many obese people—will that marker be deemed a physiological disorder and thus an impairment?

What a disability theorist is likely to come back to after pursuing this line of questions is a question of her own: why should all this matter? Both social science research and everyday experience demonstrate that fat people are commonly stigmatized and discriminated against based on their weight. Some portion of this discrimination likely flows from myths and stereotypes about how obesity affects a person’s physical capabilities. Some of the discrimination, however, is undoubtedly based on what Harlan Hahn calls “aesthetic anxiety” — the anxiety and discomfort provoked by the presence of a person who deviates from cultural norms of physical attractiveness. Each of these reasons for weight-based discrimination is closely akin to the reasons that disability theorists identify as explaining disability discrimination, and thus a disability studies scholar might conclude that fat people should be considered to be persons with disabilities.

This conclusion, however, begs a question of its own: how fat must a person be before her weight will be considered a disability? And how can the line drawn by disability theorists be any less arbitrary than the line drawn by the EEOC? Ultimately, a disability theorist would likely concede that all line-drawing ventures separating persons into categories based on physical characteristics or functioning are inevitably arbitrary to some degree. Nonetheless, that theorist might argue, forming categories based on how greatly persons have experienced social exclusion and disadvantage as a result of physical characteristics is a preferable basis for creating categories — however arbitrary their boundaries might be — than the medicalized approach employed by the EEOC.

300 See Kramer & Mayerson, supra note 279, at 64–72 (discussing stigmatization of and work-related stereotypes about obese individuals); cf. Ronkin, supra note 266 (discussing obese people’s denial of access to public accommodations).

301 See Kramer & Mayerson, supra note 279, at 65–66 (discussing studies showing stronger negative reactions by children and adults to pictures of obese persons than to pictures of persons with visible disabilities).

302 The points made in this section regarding the disability studies critique of the legal treatment of when obesity may be deemed an impairment (and thus the first step towards a finding of disability) would also apply to the EEOC’s exclusion of other physical characteristics from the definition of impairment unless they exceed the normal range or are attributable to a physiological disorder. For example, in discussing the potential that short stature may be a disability, the EEOC gives the following example:

[A] four foot, ten inch tall woman who was denied employment as an automotive production worker because the employer thought she was too small to do the work does not have an impairment. The woman’s height was be-
C. Deference to Medical Authority in Judging Impairment

Examples of how agencies and courts adopt a medical model of disability in assessing impairment are not limited to cases involving pregnancy and obesity. Instead, a medical model understanding of disability appears in a broad gamut of cases when courts look to physicians to validate the existence of a plaintiff's impairment. This deference to medical authority may be objectionable from a disability studies perspective for multiple reasons, as discussed in this section.

1. Subjectivity of Assessment

One common thread running through the regulatory approach to, and case law on, defining "disability" is the need for medical validation of the existence of an impairment. The EEOC's Compliance Manual points out to agents investigating charges of disability discrimination that when it is not obvious that the charging party has an impairment, the investigator should ask the charging party for medical documentation that describes the party's condition or contains a diagnosis of the condition. Likewise, courts considering whether a

low the norm, but her small stature was not so extreme as to constitute an impairment and was not the result of a defect, disorder, or other physical abnormality. On the other hand, a four feet, five inches tall man with achondroplastic dwarfism does have an impairment. The man's stature was the result of an underlying disorder, achondroplastic dwarfism, which is an impairment.

Compliance Manual, supra note 235, at § 902.2(c) (5) (i) (citations omitted). As with obesity, the question posed by disability theory would be why does the cause of short stature matter if the social experience of oppression is the same regardless of the cause? As a practical matter, in the example given by the EEOC, there might in fact be a difference in social experience if the person with achondroplastic dwarfism experienced greater prejudice and exclusion as a result of disproportion between trunk and limbs or other physical anomalies accompanying the dwarfism. The EEOC, however, does not identify this as the basis for treating one person differently from the other in assessing impairment. See generally Paul Steven Miller, Coming up Short: Employment Discrimination Against Little People, 22 HARV. C.R.-C.L. L. REV. 231 (1987).

303 I speak of "need" here not in the sense of medical validation being an absolute prerequisite for a finding of impairment and disability. I imagine that if a plaintiff who was a double amputee were to come to court in a wheelchair, the court would not require expert medical testimony before finding the plaintiff to have an impairment. For those plaintiffs whose impairments are not as subject to lay assessment, however, the need for medical validation is much greater.

304 See Compliance Manual, supra note 235, at § 902.2(b). The Manual also states that "[o]ther information, such as the charging party's description of his/her condition or statements from the charging party's friends, family, or co-workers, also may be relevant to determining whether the charging party has an impairment." Id. Thus, the EEOC does not exclude from consideration nonmedical evidence of imp-
plaintiff has an impairment typically cite to expert medical testimony (or the absence thereof) regarding the existence and nature of the plaintiff's condition.\textsuperscript{305}

The reliance on medicine to validate impairment, as a precondition for a finding of disability, is objectionable to disability theorists on a number of levels. As a political matter, disability studies scholars view the identifying or labeling of who is disabled as an exercise of unequal power,\textsuperscript{306} and have argued that the power to define who is disabled has historically been used to advance the interests of groups providing services to disabled people rather than to advance the interests or well-being of disabled people themselves.\textsuperscript{307} On an individual level, the requirement of medical validation of impairment may create problems for individuals whose experience of disabling bodily conditions is not accepted as real by medical professionals. Susan Wendell gives as an example women with pelvic inflammatory disease (PID), which can cause severe, prolonged disability in some cases. Instead of physicians recognizing the physiological basis of their intense abdomi-

Medical documentation is also identified by the EEOC as a "good starting point" for investigation of whether an impairment substantially limits a charging party's major life activities, and the discussion that follows applies equally to medical judgments regarding the substantially limiting impact of a patient's condition. \textit{See id.} at § 902.4(c)(1). The Manual, however, cautions agents evaluating whether an impairment substantially limits a major life activity not to rely solely on information contained in medical documentation. \textit{See id.} Of course, in the "real world," medical practice may not always make clean distinctions between decisions regarding the existence of an impairment and the manifestations of that impairment. For example, diagnosing chronic fatigue syndrome calls for the physician to report severe fatigue that is not the result of exertion, but is unexplained, of recent onset, unimproved by rest, and significantly disabling. \textit{See} Keiji Fukuda et al., \textit{The Chronic Fatigue Syndrome: A Comprehensive Approach to its Definition and Study}, 121 \textit{ANNALS OF INTERNAL MED.} 953 (1994).


\textsuperscript{306} \textit{See supra} text accompanying note 197.

\textsuperscript{307} \textit{See} Silvers, \textit{supra} note 166, at 44 (describing how disabled people came to be seen as part of the "deserving poor" and became a means of production for professional caregivers); \textit{Oliver}, \textit{supra} note 148, at 127 (arguing that the category of disability is a product of capitalistic society and that the workforce of professional caregivers has a "vested interest in producing its own product in particular ways and in exerting as much control over the process of production as possible").
nal pain, however, women with PID often receive psychiatric diagnoses and are treated as if the problem is all in their heads. Even aside from the possibility that a physician might discount a patient's description of her experience, diagnostic judgments of impairment may be far less precise and far more uncertain and unreliable than most lawmakers might recognize.

The effective delegation to medical professionals of the authority for determining whether a plaintiff in an ADA lawsuit has an impairment is particularly problematic when a significant aspect of the impairment alleged is not amenable to objective measurement and thus may not be readily validated. This problem may arise whenever a person experiences fatigue, shortness of breath, or anxiety associated with an impairment, but the difficulty is probably best recognized with respect to conditions that cause potentially disabling, but largely unmeasurable, pain. Pain is a highly subjective experience. Individuals experience the same pain-producing stimulus in different ways, and pain has differing impacts on individuals' abilities to function during pain. Moreover, recognized clinical methods of assessing pain in an individual are often of limited efficacy. These factors combine to produce a disturbing result: medical science has little ability to determine with certainty when a bodily condition will produce pain and what impact that pain has on the person's ability to function.

This predicament regarding medicine's limited ability to assess and characterize pain has been well-recognized in other contexts, most notably with regard to the disability determination process for

308 See Wendell, supra note 138, at 25. In making this point, Wendell is not concerned specifically with the inability of women with PID to access the protections of the ADA, but with their inability to receive support in their struggles with their bodies from families, friends, and society at large.


310 See Stone, supra note 33, at 134 ("Pain, fatigue, shortness of breath—and, one might add, anxiety—are all real and very powerful subjective phenomena, but they defy measurement.").

311 See Commission on the Evaluation of Pain, U.S. Dept. of Health & Human Services, Report of the Commission on the Evaluation of Pain, 54 (1986); see also Ber v. Celebrezze, 332 F.2d 293, 299 (2d Cir. 1964) ("What one human being may be able to tolerate as an uncomfortable but bearable burden may constitute for another human being a degree of pain so unbearable as to subject him to unrelenting misery of the worst sort.").

SSDI eligibility. There, Congress and the courts have engaged in an ongoing effort to establish clear and accurate standards for evaluating when pain is sufficiently severe to qualify an applicant for disability benefits.\textsuperscript{313} Of particular concern are cases in which the applicant cannot establish by objective medical evidence a condition that would be expected to cause the amount of pain alleged.\textsuperscript{314} The problem in the SSDI context is ultimately how to assess pain and determine a threshold of pain severity beyond which a person should not be expected to work;\textsuperscript{315} for purposes of defining "disability" under the ADA, the problem is how to determine when pain manifests an impairment and is so severe that it substantially limits a major life activity.

Weaknesses in medicine's pain assessment practices have also been noted as part of the increasing attention being paid to issues of adequate pain control and relief.\textsuperscript{316} While these discussions focus primarily on how physicians respond to pain, a necessary precondition to adequate pain relief is effective pain assessment.\textsuperscript{317} Research suggests, however, that physicians often do a poor job of evaluating a patient's level of pain. For example, one study found that health care providers


\textsuperscript{314} In the SSDI context, "excess pain" is the term of art used to describe pain above and beyond the level that a diagnosed medical impairment would normally be expected to produce. See Cotton v. Bowen, 799 F.2d 1403, 1407 (9th Cir. 1986). The courts have differed on whether or not excess pain can be the basis for a disability finding. See Rodgers, \textit{supra} note 313, at 178–82 (describing vacillation of Ninth Circuit on the question).

\textsuperscript{315} See Rodgers, \textit{supra} note 313, at 173–74; \textit{cf.} Stone, \textit{supra} note 33, at 134–38 (addressing the "special problem of pain" in disability determination).


\textsuperscript{317} This statement is true when medicine takes an "as needed" approach to pain control, that is, wait until the patient feels pain and then provide palliative medication as needed to relieve the pain. The "as needed" approach to pain control has predominated in American medicine, but a shift towards a preventative approach to control pain seems to be underway. Adoption of a preventative approach to pain relief seeks to prevent and relieve pain by improving physician-patient communications about pain and providing medication before the patient suffers pain. In 1992, the Agency for Health Care Policy and Research, a federal agency charged with promulgating advisory guidelines for medical practice, issued guidelines for pain relief that focused on improving the effectiveness of pain control techniques. See generally Crowley, \textit{supra} note 316.
tend to disbelieve patients who claim high levels of pain.\textsuperscript{318} While several barriers exist to effective pain assessment, the barrier of greatest interest to disability theorists is the role that subjective biases may play in physicians' assessment of pain. Health care providers assess patients' pain levels differently depending on whether the provider views the patient positively or negatively,\textsuperscript{319} and because the inadequacy of diagnostic techniques renders pain assessment largely subjective, the potential for physician bias to play a role is enormous. Research suggests that several types of provider bias may influence pain assessments,\textsuperscript{320} including attractiveness,\textsuperscript{321} gender,\textsuperscript{322} age,\textsuperscript{323} and ethnicity.\textsuperscript{324} Taken together, this research indicates that a physician's assessment of the pain experienced by a person claiming disability has a substantial probability of being innocently inaccurate at best and biased at worst. Given this possibility of inaccuracy and bias, disability theorists would be particularly troubled by the delegation of authority

\begin{itemize}
\item \textsuperscript{318} Stuart A. Grossman et al., \textit{Correlation of Patient and Caregiver Ratings of Cancer Pain}, 6 J. Pain & Symptom Mgmt. 53, 56 (1991) (finding that health care provider and patient agreement regarding level of pain was 79\% when patients reported low levels of pain, 37\% when patients reported moderate levels of pain, and 13\% when patients reported high levels of pain).
\item \textsuperscript{321} See Heather D. Hadjistavropoulis et al., \textit{Are Physicians’ Ratings of Pain Affected by Patients’ Physical Attractiveness?}, 31 Soc. Sci. & Med. 69 (1990) (concluding that attractive patients are viewed as generally more healthy than unattractive patients and thus receive lower pain assessments). This finding might be interpreted to mean that disabled patients, because they are commonly perceived as physically unattractive, are more likely to receive higher pain assessments than their nondisabled counterparts. That interpretation might hold true for persons with visible disabilities, but may be less true for persons with chronic medical conditions that do not perceptibly affect their physical appearance.
\item \textsuperscript{322} See Deborah Dillon McDonald & R. Gary Bridge, \textit{Gender Stereotyping and Nursing Care}, 14 Res. Nursing & Health 373, 376 (1991) (finding that nurses planned significantly more ambulation, analgesic administration, and emotional support time for male patients).
\item \textsuperscript{323} See Michael J. Ross et al., \textit{Age Differences in Body Consciousness}, 44 J. Gerontology Psychol. Sci. 28 (1989).
\item \textsuperscript{324} See Maryann S. Bates et al., \textit{The Effects of the Cultural Context of Health Care of Treatment of and Response to Chronic Pain and Illness}, 45 Soc. Sci. & Med. 1493 (1997) (interpreting studies as showing that cultural beliefs affect both the provider’s assessment of pain and the patient’s perception and communication of pain).
\end{itemize}
to medical professionals to opine on whether a person’s pain reflects an impairment and renders her disabled.

2. The Evolution of Medical Science

Disability theorists may also disapprove of the authority granted to medical professionals to determine the existence of impairment for a separate, but related reason. Congress rejected a laundry list approach to defining "disability" in part to ensure that, as new disabling conditions developed or were discovered, persons with those conditions would be able to claim protection under the ADA. Medical science, however, may at times be slow in accepting evidence of a new condition that, in time, comes to be well-established. Persons struggling with the disabling effects of a novel condition before the condition is validated by medical science may not be able to establish that they have an impairment.

An example of the process of increasing, but not yet universal, acceptance of a condition can be found in the growing recognition of multiple chemical sensitivity (MCS). MCS was first identified by allergist Theron Randolph in 1962 as a "general allergic syndrome" provoked in especially susceptible individuals by continuous exposure to chemicals in daily life. Thomas L. Kurt, *Multiple Chemical Sensitivities—A Syndrome of Pseudotoxicity Manifest as Exposure Perceived Symptoms*, 33 Clinical Toxicology 101, 101 (1995). Individuals suffering from MCS complain of headaches, fatigue, nasal congestion, cognitive problems, irritability, and mood swings. See E.E. Sikorski et al., *The Question of Multiple Chemical Sensitivity*, 24 Fundamental & Applied Toxicology 22, 23 (1995). Overall, the syndrome is characterized almost exclusively by subjective symptoms, which the patient claims were triggered by chemical exposure. See id. at 22. Because of the dearth of objective, reproducible signs of the disorder, and a lack of universal definitions or diagnostic criteria accepted by physicians treating sufferers, the medical establishment tends to believe that the symptoms derive from a psychological problem. See Claudia S. Miller, *White Paper: Chemical Sensitivity: History and Phenomenology*, 10 Toxicology & Indus. Health 253, 258 (1994).

in the 1990s of chronic fatigue syndrome (CFS).\textsuperscript{327} CFS is an unexplained disorder that causes severe, disabling fatigue for a period of over six months, along with a constellation of other symptoms, including, among others, impaired concentration, sleep disturbances, and musculoskeletal pain.\textsuperscript{328} After the reporting in the mid-to-late 1980s of increasing numbers of persons experiencing such symptoms with no explainable causes,\textsuperscript{329} the Center for Disease Control began providing a definition for CFS in 1988, which it has continued to revise since then. The Social Security Administration (SSA) recognizes CFS as a real and potentially disabling (for Social Security purposes) condition, with the actual existence of disability in persons claiming CFS to be evaluated on a case-by-case basis.\textsuperscript{330}


\textsuperscript{327} Other names for chronic fatigue syndrome include chronic fatigue immune dysfunction syndrome (CFIDS) and myalgic encephalomyelitis (ME). See Jesse A. Stoff & Charles R. Pellegrino, \textit{Chronic Fatigue Syndrome: The Hidden Epidemic} (1988).

\textsuperscript{328} See Fukuda et al., \textit{supra} note 304.

\textsuperscript{329} See generally Hillary Johnson, \textit{Osler's Web: Inside the Labyrinth of the Chronic Fatigue Syndrome Epidemic} (1996) (tracing cases of CFS during its "pandemic" period, early research efforts into its possible causes, and the struggles of physicians first diagnosing the syndrome to have it recognized by the mainstream medical establishment and the U.S. government).

Despite the official acceptance of CFS as a legitimate medical condition—which presumably would qualify it as an impairment for purposes of the ADA—its existence as a discrete syndrome remains a matter of dispute among medical professionals. Some doctors attribute CFS symptoms to depression, posttraumatic stress disorder, or other psychological ailments. This skepticism regarding CFS is compounded by the dearth of objective, measurable tests for CFS. A diagnosis of CFS requires the treating physician both to find that symptoms of CFS are present and to exclude other medical or psychiatric causes for the symptoms. No simple blood test for CFS exists; instead it is a diagnosis that follows when everything else has been ruled out.331 The relative newness of CFS, combined with the high level of uncertainty among medical professionals surrounding CFS diagnoses and a public perception that persons claiming CFS are merely malingerers and whiners,332 suggests that some persons who suffer from CFS's debilitating symptoms333 may experience difficulty in finding the medical validation necessary to be able to prove impairment for purposes of asserting rights under the ADA. Only time will tell whether CFS can be explained and objectively identified, but the possibility exists that persons who truly experience symptoms that substantially limit their major life activities have been and are deprived of legal protections because the law delegates to the medical profession the authority to validate the existence of impairment.

D. Judicial Confusion About Impairment's Not So Plain Meaning

This Part's discussion of theoretical perspectives on legal impairment has thus far focused on the numerous, specific ways in which legal assessment of impairment tends to embody a medicalized under-

331 See Fukuda et al., supra note 304. There do exist a few objective measures that are consistent with a diagnosis of CFS, but that do not establish a diagnosis. See Issam Bou-Holaigah et al., The Relationship Between Neurally Mediated Hypotension and the Chronic Fatigue Syndrome, 274 JAMA 961 (1995) (abnormally reduced heart rate and blood pressure after the patient has been sitting upright for forty minutes); STOFF & PELLEGRINO, supra note 327, at 74-84 (laboratory tests for low-functioning immune system, yeast infections, and chronic viral infections).

332 See, e.g., The Actively Sick, WALL ST.J., Aug. 26, 1997, at A16 (dismissing Chronic Fatigue Syndrome as a "psychologically grounded ailment[s]" or variety of depression which sufferers fraudulently tie to "exotic virus[es]" and "little brain lesions[s]," and supporting characterization of the illness as one of many "coping mechanisms and methods of escape" in "stressful times").

333 For a description of the progression and impact of CFS on one person, see Susan Wendell's description of her experience. WENDELL, supra note 138, at 1-5.
standing of disability. Yet even a limited review of the case law on defining "disability" reveals that courts' more general, and at times subjective, understandings of the concepts of impairment and disability are often inconsistent with a social or civil rights model of disability. This section illustrates how those subjective, nonlegal understandings appear in the cases and analyzes them from a disability theory perspective.

As any first-year associate in a law firm well knows, lack of clarity in directions can lead to confusion. That principle is equally true when Congress directs the body politic not to discriminate against people with disabilities. When Congress imported the ADA's definition of "disability" from the Rehabilitation Act, "impairment" was one of the murky terms that came along. Congress made clear when it enacted the ADA that it intended the statute to be interpreted in accordance with the Rehabilitation Act and the regulations issued thereunder (which included a regulatory definition of "impairment") and, since the ADA's passage, administrative agencies have issued regulations providing nearly identical definitions of "impairment." Nonetheless, some courts do not appear to understand the term as it is used in the ADA. If the courts themselves are not confused, then they at times use the term and its verb form "to impair" carelessly and in a fashion that is inconsistent with a sociopolitical understanding of disability.

1. Conflating Impairment and Limitations

One culprit for the courts' confusion lies in the subtle distinctions between the legal definition given to "impairment" for purposes of the ADA and the common usage of that term, particularly in its verb form, "to impair." To reiterate, for purposes of defining disability, "impairment" is legally defined as "[a]ny physiological disorder, or condition, cosmetic disfigurement, or anatomical loss" affecting one or more listed body systems. By contrast, the dictionary defines "impairment" as meaning "the action of impairing, the fact of being impaired; deterioration; injurious lessening or weakening" and defines "impair" as meaning "to make worse, less valuable, or weaker; to lessen injuriously; to damage, injure." In essence, the legal definition understands "impairment" as a disorder or condition that has an effect on the body, while the nonlegal definition understands "impairment" as a process of becoming worse, or weaker, or less valuable, or the status of having become worse, or weaker, or less valuable.

One example of a court’s conscious adoption of the common, nonlegal meaning of impairment is the Fourth Circuit’s en banc decision in Runnebaum v. Nationsbank of Maryland. In considering whether asymptomatic HIV infection was a physical impairment, the court found that impairment had a plain meaning—which the court found by looking in the dictionary—and concluded that in order to ascertain Congress’s intent, it did not need to consider the ADA’s legislative history, which listed HIV infection as an impairment. The majority’s opinion did not even address the regulatory definition of “impairment,” presumably because it believed that term was so clear that agency interpretations too were irrelevant. Based on the dictionary meaning, the court reasoned that an impairment, by definition, had to have “diminishing effects” on an individual. Because a person with asymptomatic HIV infection has not yet developed symptoms of HIV disease, the court concluded that asymptomatic HIV infection could never qualify as an impairment.

The precedential value of Runnebaum’s reliance on a dictionary definition of “impairment” is, of course, today extremely limited in light of the Supreme Court’s decision in Bragdon v. Abbott. There, the Court used the regulatory definition of “impairment” to reach its conclusion that HIV infection, from the moment of infection, is in fact a disorder that affects the body’s hemic and lymphatic systems. Nonetheless, the analysis and language courts use in determining whether an individual has a disability under the ADA at times reveal a more subtle lack of conceptual clarity regarding the concept of impairment. To state the ambiguity: is the impairment that the ADA refers to the disorder itself, or is the impairment found in the “diminishing effects” of the disorder on the individual’s body? To express the question in concrete terms, going back to the earlier discussion of obesity as an impairment, was Bonnie Cook’s impairment her metabolic disorder or was it her obesity? In addressing the mutability issue, the First Circuit in Cook cast its vote with the view that the impairment lies in the disorder itself. Other courts, however, appear to understand the ADA’s usage of impairment to refer to the

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336 123 F.3d 156 (4th Cir. 1997) (en banc).
337 See id. at 168.
338 See id. at 169.
340 Or condition, or cosmetic disfigurement, or anatomical loss. See 29 C.F.R. § 1630.2(h)(1) (1998).
341 See Cook v. Rhode Island, Department of Mental Health Retardation, & Hosps., 10 F.3d 17, 24 (1st Cir. 1993) ("[T]hough people afflicted with morbid obesity can treat the manifestations of metabolic dysfunction by fasting or perennial un-
manifestations of a disorder. For example, one district court, after taking judicial notice of the fact that the plaintiff's lupus was a physiological disorder affecting certain body systems, went on to state: "An illness cannot in and of itself be considered an impairment. Only symptoms and/or ramifications actually limit the inflicted person's ability to perform major life activities."342

On the one hand, this imprecision in the usage of impairment is easily understandable and perhaps harmless, for in many cases of disability—particularly in the most stereotypical cases of disability—the effects or manifestations of a physiological disorder or anatomical loss are spoken of as the impairment itself, because the two are so inextricably intertwined. For example, when courts speak of blindness as an impairment, they are describing the effect of some ophthalmological disorder or trauma-induced loss which, properly understood, is the true "impairment" as that term is legally defined.343 Similarly, if the courts speak of quadriplegia as an impairment, they are describing the manifestation of a spinal cord injury or neurological disorder. It is when a physiological disorder affects a body system in a way that is more remote or less easily observable that courts may reach the conclusion that the lack of visible "diminishing effects" means that no impairment is present, and therefore the plaintiff cannot claim the ADA's protection.

This miscomprehension of the term "impairment" might be alleviated were courts familiar with (or at least aware of the existence of) the conceptual frameworks of disability discussed above in Part III.A. Both the WHO and Nagi frameworks are built on the term "impairment," which each framework defines similarly to the EEOC's regulatory definition.344 With an awareness of these frameworks, courts
dereating, the physical impairment itself—a dysfunctional metabolism—is permanent.

342 Rodriguez v. Loctite Puerto Rico, Inc., 967 F. Supp. 653, 659 (D.P.R. 1997). When this portion of the court's opinion is read in context, it appears that what the court is attempting to express is that the plaintiff could not successfully argue that her Lupus was a disability unless she could show that its manifestations substantially limited a major life activity. So understood, the analysis is correct. Nonetheless, the language used displays confusion over the usage of the term impairment.

343 But for an example of a court that understands the distinction, see Doane v. City of Omaha, 115 F.3d 624, 627 (8th Cir. 1997) (concluding that plaintiff had a disability because "[h]is glaucoma caused permanent blindness in one eye which substantially limits [his] major life activity of seeing").

344 The WHO framework describes impairment as any loss or abnormality of psychological, physiological, or anatomical structure or function, and Nagi uses the term to indicate some loss or abnormality of mental, physiological, or biochemical function, which relates to the specific functioning of an organ or organ system, but not to
might be more likely to view “impairment” essentially as a term of art and thus be able to resist the temptation to use either the dictionary definition or their own personal understandings of the term. It might be anticipated, however, that disability theorists would object to greater judicial reliance on these definitions of “impairment,” for they reflect a medicalized approach to the concept by looking for something deviant or pathological in an individual’s body. After all, as Michael Oliver puts it succinctly: “Impairment is . . . nothing less than a description of the physical body,” suggesting implicitly that it need not be diagnosis of the body. Nonetheless, scholars from the disability studies field might be willing to accept a more explicit medicalization of impairment in order to prevent a potentially more disturbing problem: the conflation of the concepts of impairment and disability. Indeed, some disability studies scholars take impairment to refer to explicit kinds of biological anomalies in order to maintain the distinction between impairment and disablement.

It is easy to find in the case law instances when courts use the terms “impairment” and “impaired” to describe not the bodily condition of the plaintiff, but the disadvantage or deficit in ability that is associated with a bodily condition. For example, in Soileau v. the functioning of an individual as an entire organism. See supra text accompanying notes 134, 141.

An example of a court using its own understanding of impairment, without relying either on the regulatory definition or the assistance of a dictionary, can be found in Forrisi v. Bowen, 794 F.2d 931, 934 (4th Cir. 1986), where the court states: “The very concept of impairment implies a characteristic that is not commonplace and that poses for the particular individual a more general disadvantage. . . .” For discussion of courts’ understanding that a common condition cannot be an impairment, see infra Part IV.D.2.

See Silvers, supra note 138, at 784 (noting that the disability community has criticized the WHO’s conceptual framework as blaming the victim by locating the problem in the deficits of impaired individuals rather than in the failure of society to treat persons equitably).

Oliver, supra note 148, at 35 (emphasis added).

E-mail from Anita Silvers, Professor, San Francisco State University (Oct. 5, 1998) (on file with author).

See, e.g., Byrne v. Board of Educ., 979 F.2d 560, 564 (7th Cir. 1992) (“The statute’s inclusion of the limiting adjectives ‘substantial’ and ‘major’ emphasizes that the impairment must be a significant one.”); Sweet v. Electronic Data Sys., Inc., No. 95 CIV.3987, 1996 U.S. Dist. LEXIS 5544, at *16 (S.D.N.Y. Apr. 25, 1996) (“Plaintiff’s ability to engage in these activities shows that his ability to engage in the major life activity of seeing has not been ‘substantially impaired.’”); Trembcsynski v. City of Calumet City, No. 87-C0961, 1987 WL 16604, at *4 (N.D. Ill. Aug. 31, 1987) (“Plaintiffs admit they have worked successfully . . . for a number of years. Therefore, Plaintiffs were not impaired.”); cf. Sicard v. City of Sioux City, 950 F. Supp. 1420, 1438
Guilford of Maine, the First Circuit considered whether a plaintiff with a depressive disorder was disabled because, as the plaintiff alleged, his condition substantially limited his major life activity of getting along with others. The court first found that the plaintiff's disorder, dysthymia, was a mental impairment within the meaning of the ADA. Even assuming that getting along with others is a major life activity, however, the court found no evidence that the plaintiff was substantially limited with respect to that activity. The court reasoned: "The evidence does not establish that Soileau had particular difficulty in interacting with others, except for his supervisor. Impairment is to be measured in relation to normalcy, or, in any event, to what the average person does. . . . [The evidence] does not establish that the nature and severity of his impairment were substantial." Thus, the court uses impairment as synonymous with limitation. This equation of impairment with limitation is also apparent in cases demanding that a plaintiff's impairment be significant or severe because the ADA requires a substantial limitation of a major life activity. These courts fail to recognize that an impairment (i.e., bodily condition) that is quite severe, in the sense of threatening the health or well-being of an individual, may have (at least for some period of time) a relatively minor impact on an individual's functional capacities, while an impairment that is less severe may have a greater functional impact.

(N.D. Iowa 1996) (failing to recognize that mitigating measures might be disregarded in determining impairment, but taken into account in determining substantial limitation). There are also instances when it is unclear in which sense a court is using the term impairment. For example, in Roth v. Lutheran General Hospital, 57 F.3d 1446, 1454 (7th Cir. 1995), Judge Coffey states: "The key is the extent to which the impairment restricts a major life activity; the impairment must be significant one." Here, impairment may be referring either to the limitation on a major life activity or to a bodily condition. The sense of the sentence favors the former interpretation.

105 F.3d 12 (1st Cir. 1997).

See id. at 15.

Id. at 15–16 (emphasis added).

See, e.g., Sutton v. United Airlines, Inc., 130 F.3d 893, 898 (10th Cir. 1997) ("[T]he statute does require that the impairment 'substantially limit' a major life activity. Thus, the impairment must be significant, and not merely trivial.") (citation omitted); Sweet, 1996 U.S. Dist. LEXIS 5544, at *11 ("[T]he ADA protects only a limited class of persons—individuals who suffer from impairments significantly more severe than those encountered by the average person in every-day life.").

The conflation of impairment and the broader concept of disability likely results from the above-described confusion regarding impairment and limitation, but is it any cause for concern? Disability theorists would likely say yes. Once we begin to understand impairment as describing the ways in which a person's activities are affected by a bodily condition or deficit, it is but a short step to viewing all the disadvantages suffered by disabled people as being simply part and parcel of their impairments. This collapsing of the entire definition of "disability" into the concept of impairment is dangerous from the perspective of disability theory. To the extent that we conflate a description of the body with the social, political, and cultural disadvantages that accompany it, the latter start to appear to be caused by, and inextricably linked to, the former. But the belief that bodily inferiority naturally causes the disadvantages of disability reflects precisely the medical model of disability that disability theorists reject. Thus, when a court speaks of a plaintiff's impairment being a medical condition and then goes on to describe the person as being impaired in relation to her employment opportunities, the message sent by the choice of language is that the social disadvantage of decreased employment opportunities is but one side effect of a medical condition, and not the result of exclusionary social forces.

2. The Commonness of Impairment: Of Aging and Asymptomatic Genetic Conditions

While some courts have used the term "impairment" synonymously with limitation, other courts have understood the term "impairment" as including only conditions or disorders that are uncommon or not widely shared. One case widely cited for this proposition is Daley v. Koch,355 in which the Second Circuit reasoned that the allegedly disabling personality traits at issue "could be described as commonplace; they in no way rise to the level of an impairment."356 So too some courts have found that myopia (nearsightedness) cannot

355 892 F.2d 212 (2d Cir. 1989). Another widely cited case suggesting that the commonness of a condition may determine whether it should be deemed an impairment is Forrisi v. Bowen, 794 F.2d 931 (4th Cir. 1986). In an oft-quoted passage, the Fourth Circuit opined: "It would debase this high purpose [of the Rehabilitation Act] if the statutory protections available to those truly handicapped could be claimed by anyone whose disability was minor and whose relative severity of impairment was widely shared. Indeed, the very concept of an impairment implies a characteristic that is not commonplace. . . ." Id. at 934.

356 Daley, 792 F.2d at 215. See also Fenton v. Pritchard Corp., 926 F. Supp. 1437 (D. Kan. 1996) (finding that common personality traits such as a violent temper are not mental impairments); Clark v. Virginia Bd. of Bar Exam'rs, 861 F. Supp. 512 (E.D.
be an impairment because it is so widely shared. Courts that impose this kind of "uncommonness" criterion appear to do so based on their ordinary, nonlegal understanding of the term "impairment," for the regulatory definition of the term provides no such limitation.

To date, this view of impairment as something out of the ordinary has been expressed most often in cases involving personality traits and myopia. It has, however, notable implications for other conditions that could be characterized as disabilities, but that have not yet generated much ADA litigation. Specifically, age-related infirmities and the possession of genetic mutations spring to mind.

In the legislative findings included in the ADA's text, Congress recognized that aging and disability often go hand in hand. In its Interpretive Guidance regarding the definition of "impairment," however, the EEOC takes the position that advanced age, in and of itself, is not an impairment, but that "various medical conditions commonly associated with age, such as hearing loss, osteoporosis, or arthritis would constitute impairments." Thus, the EEOC approaches advanced age much as it does pregnancy or obesity: by themselves, these conditions are generally viewed as normal and thus not impairments. If a plaintiff can identify a medically determinable disorder associated with one of these conditions, however, then an impairment may be

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357 See Joyce v. Suffolk County, 911 F. Supp. 92, 96 (E.D.N.Y. 1996) ("The need for corrective eyewear could reasonably be characterized as 'commonplace.'"); Trembcszynski v. City of Calumet City, No. 87-C0961, 1987 WL 16604 (N.D. Ill. Aug. 31, 1987) (reasoning that being slightly myopic is a widely shared physical characteristic, not an impairment as contemplated by the Rehabilitation Act); cf. Venclauskas v. Connecticut, 921 F. Supp. 78 (D. Conn. 1995) (finding "plaintiff's visual 'impairment' [not] to be unusually severe or rare"). Another court has reasoned that the commonness of the need to wear corrective lenses means that a moderate vision impairment does not substantially limit a person's major life activities. See Sweet, 1996 U.S. Dist. LEXIS at *15-*16 (S.D.N.Y. 1996). The other issue that is typically discussed when visually impaired plaintiffs sue under the ADA is whether the measure of the limitations imposed by the impairment should take into account the availability of mitigating measures. In other words, does the court assess the impact of myopia on the plaintiff with his glasses off or on? Compare Wilson v. Pennsylvania State Police Dept., 964 F. Supp. 898 (E.D. Pa. 1997) (availability of mitigating measures should not be considered) with Sutton v. United Airlines, Inc., 130 F.3d 893 (10th Cir. 1997) (availability of mitigating measures should be considered).

Thus, an elderly woman whose arthritis prevents her from performing manual tasks and caring for herself would likely be seen as having a substantially limiting impairment under this approach. Likewise, an elderly man whose hearing loss substantially limits his ability to hear may have a disability.

But what would a court make of the fact that over half the people over the age of eighty-four years have impaired hearing? Would that mean that loss of hearing is too common, at least among elderly persons, to rise to the level of an impairment? At issue is whether we should have an age-relative understanding of impairment and disability for purposes of disability discrimination law. Ron Amundson, a disability studies scholar, suggests that in some cases we should. He sees medical normality as relative to age and argues that the narrowed range of opportunity associated with frailty is species-typical for elderly humans. As a consequence, Amundson sees this reduced opportunity as a natural part of aging and therefore different from the socially constructed narrowing of opportunity experienced by younger persons with disabilities.

Nonetheless, Amundson’s exclusion from the category of disability of some elderly persons with conditions that limit their social participation is premised less on the commonness of the condition than on the natural, rather than constructed, character of the limitations experienced. According to this reasoning, the eighty-five year old

359 See supra Parts IV.A and IV.B for a discussion of the EEOC’s approach to pregnancy and obesity. Some of the concerns about medicalization discussed in these parts may also apply to the ability of an old person to obtain a medical diagnosis identifying a particular disorder that causes the increasing, and disabling, frailty that may accompany advanced age. “[F]railty is very common at an advanced age. It is difficult to know the extent to which that frailty is the result of disease, of the aging process itself, and of disuse, often compounded by neglect and depression.” Edward W. Campion, The Oldest Old, 330 New Eng. J. Med. 1819, 1819 (1994). Cf. Sherwin B. Nuland, How We Die 43–44 (1993) (decrying the insistence of medical examiners that all death certificates state a “cause of death” when a person may simply have died of old age).

360 See Campion, supra note 359, at 1819 (“Half the people over the age of 84 years have impaired hearing; vision impairment, falls, hip fractures, stroke, cancer, and cardiovascular disease are also common. Nearly a third of the very elderly have some degree of dementia.”).

361 See Amundson, supra note 160, at 115. Amundson, however, recognizes that elderly persons with other impairments may face some of the same problems of disability as younger persons with the same impairments.

362 But see Wendell, supra note 138, at 18 (“It is not obvious to me that the reduction of opportunities experienced by the elderly are any more attributable to nature than the reduction of opportunities experienced by nonelderly people with disabilities.”).
who is hard of hearing might qualify as an individual with a disability for purposes of suing a fast food restaurant for failing to make electronic assistive technology available at its drive-through window. By contrast, the eighty-five year old who is extremely frail might not be deemed an individual with a disability for purposes of suing a retirement home for failing to provide a personal attendant to help her walk so that she can enjoy walking through the gardens like other, less frail residents. The distinction that Amundson might draw here is that the former person's inability to place a fast food order results from social structures that fail to account for the abilities of all people, while the latter's inability to stroll the gardens results from the natural processes of aging. Thus, from this perspective, the decision as to whether a person has a disability depends at least in part on the nature and source of the disadvantage encountered as a result of a bodily condition.

Another situation in which commonness might come into play in the assessment of potential impairment is when a person claims to have been discriminated against because that person has a genetic mutation or genetic marker associated with an increased risk that a disease or disabling condition will develop in the future. That situation raises the question whether the person is currently an individual with a disability protected from discriminatory treatment by the ADA. In its Compliance Manual, the EEOC takes the position that a person subjected to discrimination on the basis of genetic information relating to illness, disease, or other disorders falls within the "regarded as" prong of the definition of "disability." In adopting this stance, the EEOC appears to assume, without any analysis of the question, that a genetic sequence predisposing an individual to a disease or disorder can be considered an impairment for ADA purposes. The EEOC's position has prompted much commentary on the question of whether the mere possession of such a predisposing genetic sequence or muta-

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364 See Compliance Manual, supra note 235, at § 902.8(a). The Compliance Manual gives the following example: CP's genetic profile reveals an increased susceptibility to colon cancer. CP is currently asymptomatic and many never in fact develop colon cancer. After making CP a conditional offer of employment, R learns about CP's increased susceptibility to colon cancer. R then withdraws the job offer because of concerns about matters such as CP's productivity, insurance costs, and attendance. R is treating CP as having an impairment that substantially limits a major life activity. See id. For the EEOC's regulatory description of how a person can succeed on a perceived disability claim, see supra note 273.
tion can be considered a disability. Much of this commentary, however, has focused on the social and economic impacts of finding that persons genetically predisposed to serious conditions are protected by the ADA.

If we are to continue using the ADA's existing definition of "disability," however, it seems imperative to address directly the question of whether the presence within a person's genotype of gene(s) indicating an increased risk of future disease or disorder should be deemed an impairment. Thus, the question becomes whether a predisposing genetic sequence or genetic mutation can be understood as a "physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of [several] body systems." When one considers the nature of genetic mutations, they do not appear to fit easily within that definition.

A genetic mutation can be simply defined as a structural change in a gene. In other words, when we speak of a genetic mutation, we're talking about a variation from the typical sequence for a particular gene. Mutations can be either inherited from parents or created...


366 Compare Gostin, supra note 365 (arguing, inter alia, that failure to protect persons from genetic discrimination will create physical and economic dependence and will discourage individuals from being tested) with Dichter & Sutor, supra note 365 (arguing, inter alia, that protecting individuals with asymptomatic genetic disorders will increase litigation costs).

367 A gene is a single functional unit of hereditary material located upon a chromosome, which is the package in which a single strand of DNA is stored and transmitted. See Robert C. King & William D. Stansfield, A Dictionary of Genetics 136 (5th ed. 1997). An individual's genotype is the sum total of all the genes an individual receives from his parents. See id. at 141. No individual expresses every gene within his genotype, however; nor does he express the same genes throughout his life. An individual's phenotype, in contrast to his genotype, is the combination of physical traits displayed by an individual. See id. at 258. These include visible traits, such as eye color, height, and build, and invisible traits, such as the ability to make a particular enzyme.

368 With the exception of Alper, supra note 365, this question has been largely ignored in the commentary.

369 29 C.F.R. § 1630.2(h) (1998).
Each human being, on average, creates two new mutations, inherits eight mutated genes, and is at risk for at least one genetic disorder. Thus, if we view genetic mutations per se as impairments, then we all have these impairments. No one has a "normal" genotype in the sense of having a genotype without mutation.

One might argue, though, that the commonness, indeed universality, of mutations generally should not preclude categorizing as impairments those genetic sequences or mutations associated with diseases or conditions that, if expressed, would qualify as impairments. At least two difficulties with this argument spring to mind. First, the simple fact that a "physiological disorder...affecting a body system" may develop at some point in the future does not mean that the mere presence of a mutation is such a disorder. Unless the mutation is currently causing some impact on bodily systems, it does not seem to fit within the definition of "impairment." In this sense, some genetic mutations will be distinguishable from asymptomatic HIV infection—a condition to which asymptomatic genetic conditions...
are often analogized\textsuperscript{373}—for the Supreme Court found that HIV infection has an adverse impact on the body's lymphatic and hemic systems from the moment of infection.\textsuperscript{374}

The second problem with characterizing genetic mutations associated with diseases as impairments in and of themselves is the incredible uncertainty whether those mutations will ever express themselves phenotypically in a particular individual. It is only in relatively few cases of single gene disorders, for example cystic fibrosis or Huntington's disease, that the presence of a single gene (or pair of genes) predicts with certainty the eventual onset of a disease. Most diseases with genetic components, by contrast, are multigenic (they involve the presence of multiple genes) and multifactorial (they depend on the interaction of genetic factors with other biological or environmental factors). Moreover, even if a gene is expressed, most genes are characterized by variable expression; that is, the impact the gene may have on a person's body may range from quite mild to severe.\textsuperscript{375}

As a result of all this uncertainty about the predictive value of genetic information, trying to find current impairment in the presence of a mutation that may someday have some effect on an individual raises difficult line-drawing questions.\textsuperscript{376} How likely must it be that a mutation will express itself before the mutation can be deemed an impairment? How great must the likely severity of an expressed condition be? How likely must it be that any expression will be severe, rather than mild? Ultimately, because the predictive value of genetics today remains quite limited,\textsuperscript{377} predictions of future disease do not

\textsuperscript{373} See Gin, supra note 365, at 1423 (recognizing the similarities between HIV-positive status and Huntington's disease); see also Weaver, supra note 365 (arguing that asymptomatic genetic disorders are likely to fall within the third prong of the ADA's definition of "disability" because HIV has been found to do so).


\textsuperscript{376} Cf. Gin, supra note 365, at 1414–15 (acknowledging line-drawing problem).

\textsuperscript{377} See Ruth Hubbard & R. C. Lewontin, Pitfalls of Genetic Testing, 334 NEW ENG. J. MED. 1192, 1192 (1996) (arguing that current genetic testing technology cannot adequately take into account the complexity of genetic diseases); Pamela S. Karnes, Ordering and Interpreting DNA Tests, 71 MAYO CLINIC PROC. 1192, 1192–94 (1996) (stating that, for a majority of genetic disorders, accurate genetic testing currently cannot be performed due to the vast number of different mutations causing a particular disorder); Stephen G. Post et al., The Clinical Introduction of Genetic Testing for Alzheimer's Disease, 277 JAMA 832, 833–34 (1997) (stating that the inaccuracy of genetic tests for Alzheimer's has led numerous governmental and scientific committees to recommend against its use as a predictive assessment of asymptomatic individuals).
provide a firm foundation for findings of current impairment for ADA purposes.

To summarize, it becomes quite difficult to argue that genetic mutations or sequences that are not yet phenotypically expressed should be deemed impairments for purposes of the ADA's definition of "disability." If we argue that the simple fact of possessing a mutation equates to impairment, then impairment of this sort is ubiquitous. But if we try to characterize a mutation as an impairment by linking the mutation to its potential impact, the absence of any present impact on body systems and the unpredictability of any future impact weigh against a finding of current impairment. Under this analysis, the ADA appears to offer little shelter for persons discriminated against on the basis of genetic information.

Yet how might this analysis be viewed by a disability studies scholar? To begin, the scholar might relish the challenge that the foregoing discussion issues to the utility of the concept of impairment—as defined by the ADA regulations—as a precondition for a finding of disability. Delving into the depths of human genetics demonstrates that none of us is one hundred percent "normal." We all deviate in some way from what is typical, and the use of a medicalized concept of impairment as a means of cordonning off those whose deviance can potentially be viewed as a disability is likely to be unsatisfactory to a disability studies scholar.

That said, it bears noting that a disability studies understanding of the nature of disability—that disability is found in the disadvantages imposed by social and cultural systems and structures on persons with bodily or mental differences—suggests that some persons with genetic mutations might properly be considered persons with disabilities. The evidence is plentiful that discrimination based on genetic information has occurred. Thus, persons have been subjected to adverse differential treatment based on fears, prejudices, and stereotypes regarding a bodily characteristic. In that sense, the disadvantages experienced by persons whose genotype suggests an increased risk for a particular condition are similar to the disadvantages faced by persons with more "traditional" disabilities. One might argue, therefore, that we should rethink our understanding of impairment as a threshold requirement for showing disability protected under the ADA. The final Part of this Article offers some preliminary thoughts in that regard.

378 For a valiant, though to my mind ultimately unconvincing, argument to the contrary, see Alper, supra note 365, at 168-69 (arguing that "an altered genotype that is associated with a disease is both an anatomical loss and a physiological disorder").
V. WHAT TO MAKE OF ALL THIS: CONSIDERING ALTERNATIVES TO IMPAIRMENT

The discussion in the foregoing Part touches on several seemingly disparate features of how agencies and courts have treated the concept of impairment, as it is used in the ADA's definition of "disability." What ties these different observations together is that each is of interest, and potentially of concern, to disability theorists, for each has significant implications for our understanding of disability as a phenomenon and, by extension, our view of which persons should receive protection under disability discrimination legislation. Before going on to reflect on those implications, it may be worth summarizing three tendencies, illuminated in Part IV, on the part of courts addressing the existence of impairment.

First, courts that rely on the regulatory definition of "impairment" in assessing a plaintiff whose disability is disputed tend to employ a medicalized understanding of impairment. These courts are likely to require medical evidence of the plaintiff's condition and are likely to find impairment only when some physical disorder is diagnosed. For these courts, the mere fact that some bodily characteristic of the plaintiff prompted adverse treatment is insufficient; only if that bodily characteristic can be described in pathological terms can the plaintiff be protected as disabled.

Second, other courts, rather than focusing on how the regulatory definition of "impairment" applies to the plaintiff's situation, may use their own subjective, nonlegal understanding of impairment. These courts may tend to view impairment as something that is necessarily out of the ordinary or uncommon and thus disqualify as an impairment any bodily characteristic that is widely shared. As a result, anyone whose major life activities are substantially limited by such a common characteristic could not be an individual with a disability.

Third, some courts tend to extend the term "impairment" to describe not only the physical characteristic affecting a bodily system, but also the limitation experienced by the plaintiff with that characteristic. These courts speak of the disadvantage faced by the plaintiff as an impairment and thus seem to confuse the concept of impairment with the concept of substantial limitation. As noted, the danger (from a disability theory perspective) that this confusion creates is that the courts will conflate impairment, which describes the body, with disability, which describes socially caused disadvantage.

Of these three tendencies, the first two implicate what standard should be used in determining the existence of impairment for legal purposes. The third tendency, by contrast, is more significant as a
reflection of judges' mindset as they decide disputes about the existence of disability. A judge's confusion of the concepts of impairment and limitation seems to evidence an understanding of disability consistent with the medical model described in Part III.B.1, for it suggests that the judge understands the social or vocational limitation experienced by the plaintiff as part and parcel of her physical condition.

What can we learn about defining "disability" for purposes of disability discrimination law from looking at how courts have addressed the question of impairment? The most important lesson that flows from the discussion in Part IV is that defining "impairment," like defining the larger concept of "disability" for which impairment is a building block, unavoidably presents questions about where lines should be drawn. At what point and on what basis does a physical characteristic rise to the level of an impairment? The legal assessments of impairment discussed above suggest two possible responses. A certain level of deviance from normal bodily characteristics is one possible basis for drawing lines, one that the EEOC guidelines employ in determining when a simple physical characteristic like height or weight can be an impairment. The courts that refuse to find common conditions to be impairments also implicitly employ a deviance approach to impairment. As discussed above, however, trying to draw a dividing line between normal and deviant—or common and uncommon—anywhere along the spectrum of bodily characteristics and their frequencies is artificial and ultimately arbitrary.

Another possible basis for drawing lines between characteristics that are impairments and those that are not is to draw the lines based on medical diagnoses of disorder and dysfunction. An examination of the regulatory definition of "impairment" suggests, at first blush, that determining the existence of impairment simply involves an objective assessment of the physical body, which then produces a clear-cut response. Indeed, this is part of the appeal of a medicalized approach to impairment: simply let the doctor take a look at the plaintiff and perform objective tests, and the doctor can validate the existence, or confirm the nonexistence, of impairment. Thus, under an approach to impairment consistent with the medical model, the line-drawing dilemma is obscured, for the sheen of straightforward objectivity attaches to medical decisions.

Yet as we have seen, a medicalized approach to determining impairment has its own problems, both practical and political. Medical judgments are often far more imprecise, more subjective, and less certain than is popularly perceived. While physicians undoubtedly are able to make definite diagnoses in some cases, medical "science" is often quite tentative in its assessments. Thus, even a medical ap-
approach to identifying impairment raises line-drawing questions: how certain must it be that a plaintiff has a particular disorder? How well must scientists understand the nature and cause of a set of symptoms before those symptoms become the basis for diagnosing a disorder? To what extent must a diagnosis be based on objective, measurable evidence, and to what extent may it be influenced by the patient’s subjective description of her experience? The answer to each of these questions influences where and how lines are drawn when doctors are given the authority to assess impairment. Moreover, even if a medicalized approach to impairment solved the line-drawing quandary, it has a political drawback in that persons identifying themselves as disabled may object to a requirement that they submit to medical authority for professional validation of their self-description.

Since both the medicalized approach and the deviance approach to identifying impairment present difficult problems of line-drawing, we might well ask whether we should even retain the concept of impairment as the foundation for a determination of disability. But what else is there? Can we imagine other approaches, which do not depend on a finding of impairment, to identify who is disabled for purposes of disability discrimination law? Admittedly, thorough consideration of the wisdom of discarding our existing definition would require an in-depth understanding not only of the issues that have arisen with respect to impairment, but also of unresolved issues regarding the meaning of “substantially limit” and “major life activity”—issues that this Article has not addressed. Nonetheless, the experience with giving legal meaning to impairment is sufficient to support preliminary reflections on alternative approaches to defining “disability,” especially if we focus on what kinds of bodily characteristics are prerequisites to falling within the definition.

One alternative approach would be to open up the protection of disability discrimination law to anyone subjected to adversely discriminatory treatment on the basis of any physical characteristic. This approach would clearly broaden the group of persons protected, for the plaintiff could allege discrimination based on any condition that now falls within the definition of “impairment” or on traits such as short stature, baldness, or other aspects of nonpathological physical appearance. This approach would have the advantage of eliminating litigation over the existence of the plaintiff’s impairment; instead everyone could be a potential plaintiff. In addition, discarding the medicalized concept of impairment in favor of an approach that provides a remedy for body-based discrimination more broadly responds to the lack of logical justification for treating persons differently depending on
whether they can attach a medical label to their discrimination-prompting attribute.

While the fact that everyone could be a potential plaintiff is presented above as an advantage of this approach, it might equally well be characterized as a weakness. This is the floodgates argument: if anyone can bring a lawsuit alleging discrimination based on a physical characteristic, then virtually every employment dispute (or disagreement between a public agency or public accommodation and customer regarding the services provided) can turn into a vehicle for a discrimination suit. Courts that have drawn the line on their willingness to treat a physical characteristic as an impairment have drawn back from this very possibility. As the First Circuit warned in rejecting as an impairment overweight not rising to the level of morbid obesity, allowing claims of discrimination based on simple physical characteristics to proceed would permit the development of a “catch-all cause of action for discrimination based on appearance, size, and any number of other things far removed from the reasons the [ADA was] passed.”

Perhaps, however, we could imagine some device that would stanch the expected flow of litigants into court. Perhaps, in an attempt to make disability discrimination law harmonize more with disability theory, a qualifier might be attached to “physical characteristic.” For example, prohibited discrimination might include only actions taken based on a physical characteristic generally associated with social, cultural, or economic disadvantage. Under such an approach, discrimination based on obesity would be prohibited, but discrimination based on a person’s blue eyes would not be. This limit on prohibited bases of discrimination accords with the social model of disability in that it focuses on the social, cultural, or economic disadvantage that flows from bodily difference rather than on the functional limitations that flow from an impairment. To the extent that only those characteristics shared by a minority of persons are likely to result in disadvantage (according to Anita Silvers’ “historical counterfactualizing”380), this approach may also harmonize with the minority group model of disability.

But would such an approach represent an improvement in terms of clarity with respect to who is protected? Probably not. Courts will still have to draw lines if asked to apply a standard like “physical characteristic associated with social, cultural, or economic disadvantage.” They will still have to answer questions like “How serious must the

379 Francis v. City of Meriden, 129 F.3d 281, 287 (1st Cir. 1997).
380 See supra text accompanying note 205.
disadvantage be?" and "How close must the association be between physical characteristic and the disadvantage?" These kinds of questions echo the questions that courts are struggling with today regarding, for example, how limited a person's employment options must be in order to be substantially limited. Thus, any attempt to particularize the types of physical characteristics protected will create its own border disputes. Of course, if we are stuck having to draw lines, we should at least attempt to identify standards for drawing lines that comport with our understanding of whom we wish to protect. In other words, it might be perfectly rational to trade one set of line-drawing issues for another if we believe that the second set of issues is more closely directed to accomplishing our policy goals.

One possible way to avoid line-drawing questions about what kind of physical characteristics a person must possess in order to claim the protection of disability discrimination law is simply to list specifically those physical characteristics covered as per se disabilities. Congress rejected this approach in enacting the ADA, largely out of fear that any list would be underinclusive. What Congress apparently did not anticipate, however, was the fashion in which its broad and flexible approach to defining "disability" could be narrowly construed by the courts. Thus, while substituting a list of covered disabilities might be characterized as narrowing the coverage of disability discrimination law, a generously drawn list including not only "traditional" disabilities, but also serious medical conditions, genetic predispositions for serious conditions, and obesity (for example) could actually expand the scope of coverage currently available. Adopting a list approach would substantially decrease the amount of litigation on the question of who is an individual with a covered disability, but it would hypermedicalize the inquiry, for in many cases, medical records or expert testimony would be necessary to establish that the plaintiff indeed has a covered disability.

As Congress feared, a list approach to defining "disability" would be less flexible than the existing constitutive approach. Each individual plaintiff would be assessed to determine whether she possessed a condition listed as a disability, but if such a condition were found, the need for individualized assessment of the impact on a major life activity would vanish. This approach would ease the litigation path for plaintiffs with a listed condition; by contrast, it could pose an insurmountable barrier for persons who allege a condition that is unlisted, but that might nonetheless fall within the existing definition of "impairment." If this approach were taken, it would seem imperative to devise a mechanism for expanding and updating the list to include conditions as they are newly discovered or as their disabling effect is
recognized. Authority for list expansion might be delegated to an administrative agency, or an agency might be responsible for recommending expansions for congressional approval.

Although Congress rejected a list approach partly to ensure that more persons would be protected by casting the “individual with a disability” net broadly, some disability theorists supportive of the minority group model might actually prefer a list approach to the existing “disability” definition, for some theorists reject a continuum understanding of disability that seeks to push the boundaries of disability outward beyond that group of persons with “traditional,” societally recognized disabilities. These theorists might argue that a list approach can best be tailored to protect maximally the truly disabled—those persons who have historically been subjected to social disadvantage and who present themselves to society as having a disability.381

In terms of what goes on the list, some theorists might suggest the practice of historical counterfactualizing as a way of identifying what conditions subject their bearers to disadvantage as a result of society’s failure to take the needs of all persons into account. Likewise, evidence of social, cultural, and economic disadvantage gleaned by social scientists382 or demonstrated through testimony at congressional hearings could provide fodder for the list. From a disability studies perspective, however, drafting the list of covered conditions carries with it dangers of divisiveness, for disability studies scholars differ among themselves, for example, on whether chronic illnesses and age frailty should be understood as disabilities.383

In any event, a list approach to defining “disability” might,384 on balance, prove more inclusive than the existing definition of “disability,” as it has been applied by the courts. It would, however, also likely exclude individuals with nontraditional or marginal disabilities who might be able to succeed in proving disability under the current definition. Which brings us back full circle to the questions this Part started with: whom does our society truly want to protect from dis-

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381 See supra text accompanying notes 262–63.

382 See Hahn, supra note 152 (arguing for more social science research into the creation of disability).

383 Compare Amundson, supra note 160 (distinguishing chronic illness and age frailty from disability) with Wendell, supra note 138 (including chronic illness and age frailty in her discussion of disabilities).

384 The breadth of any actual list, of course, would depend on numerous factors that could affect the political dynamic involved in composing the list.
VI. Conclusion

The question of whom our society truly wants to protect from adverse discrimination based on bodily difference is ultimately a question for the body politic. The aim of this Article, by contrast, has been to use the analytical tools provided by scholars in the field of disability studies to scrutinize how lawmakers to date have understood the concept of impairment as one form of bodily difference. By viewing administrative and judicial treatments of impairment through a disability studies lens, I have sought to give the disability kaleidoscope a turn and thus to provide the reader with an altered view of impairment and, by extension, disability. The purpose of presenting this changed view is primarily to educate, rather than to persuade. In other words, it is less my aim to convince the reader that the social model or minority group model of disability is “right,” than to dispel the reader’s conviction that the medical model understanding is the only shape that the disability picture can take.

Ultimately, the Article’s goal is modest: to begin an examination, and hopefully a discourse, on how the legal community understands disability—specifically disability as an illegitimate basis for discriminatory treatment. Fleshing out this understanding is essential to resolving some of the uncertainty and division in the courts about who is an individual with a disability entitled to the ADA’s protection. But critically assessing the law’s understanding of impairment and disability has broader implications as well, for the legal decision to identify persons as protected by the ADA can broadcast a powerful message to society at large. One goal of the ADA is to change societal attitudes toward individuals with disabilities, and prodding lawmakers to think more critically about the very concept of disability may prove a first step towards encouraging members of society to scrutinize their own assumptions about disability.

385 I recognize that focusing on whom disability discrimination ought to protect is not the only way to respond to the current confusion in the courts. An alternative approach would be to focus on the type of action prohibited rather than on the type of person protected. Anita Silvers suggests false theorizing about the impact of an actual or putative impairment on a plaintiff’s abilities as one type of prohibited action. See Silvers, supra note 295.

386 See Dick Thornburgh, The Americans with Disabilities Act: What It Means to All Americans, 64 TEMP. L. REV. 375, 384 (1991) (“The ADA is social legislation to end barriers. . . . [W]e do need some consciousness-raising about Americans with disabilities, especially since our mistaken attitudes are often so well-meaning and so ingrained.”).