

How the Biological/Social Divide Limits Disability and Equality

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INTRODUCTION

What *is* disability? That question has been central to the struggle for substantive justice for people with disabilities. The standard approach focuses on sorting social function from biological status to determine “real” disadvantage. However, this division confines and confuses prevailing visions of equality not only for disability but also for race, gender, and sexual orientation.

To advance disability rights, advocates have often sought to replace a medical model of disability with a model of disability as socially constructed.¹ That revised framework presents disability inequality as a problem not of inherent physiological limitation but of social disparagement analogous to race discrimination.² For both race and disability, prejudice creates irrelevant biological differences as marks of inferior identity, legitimating systematic sociolegal penalties. Despite broad acceptance of the idea that inequality is partly a social problem,³ most theory and law continues to assume

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1. For an explanation of the medical and social models of disability, and how the social model helped shape a civil rights perspective on disability, see Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 653–62 (1999).

2. See Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L.J. 1, 12 (2004) (explaining the development of a disability rights movement focused on antidiscrimination).

3. See Adam M. Samaha, *What Good Is the Social Model of Disability?*, 74 U. CHI. L. REV. 1251, 1252 (2007) (questioning how the social model has come to be seen as the

that inequality in the context of disability also stems from real biological disadvantages that can be eliminated only through affirmative accommodation of difference. The persisting, central division between social and biological causes of disability has developed into a bind that impedes meaningful analysis and reform of injustice.

This Article examines two separate areas marked by controversy over the legal definition of “disability”: workers’ compensation and the Americans with Disabilities Act (“ADA”).⁴ These two areas appear to take opposing approaches. In workers’ compensation, law reforms have emphasized a medical definition, while prominent ADA jurisprudence has rejected a medical model in favor of social context (until recent statutory reforms).

Despite this superficial divergence, both legal regimes converge to reinforce the disadvantageous status of disability. The choice between biological status or social function in disability law echoes the choice of equal treatment versus special treatment of gender “difference” in traditional equality doctrine long criticized by feminist legal theorists.⁵ The equal-treatment principle focuses on ignoring irrelevant gender-based differences as the way to overcome disadvantages linked to gender.⁶ Conversely, the special-treatment principle focuses on recognizing and responding to gender-based differences as the way to overcome gender inequality.⁷

foundation of disability civil rights).

4. 42 U.S.C. §§ 12101–12213 (Supp. 2009).

5. For a discussion of the equal versus special treatment dilemma in feminist theory, see Lucinda M. Finley, *Transcending Equality Theory: A Way out of the Maternity and the Workplace Debate*, 86 COLUM. L. REV. 1118, 1142–44 (1986). See also Martha T. McCluskey, *Rethinking Equality and Difference: Disability Discrimination in Public Transportation*, 97 YALE L.J. 863, 870–73 (1988) (comparing feminist critiques of the equal-special treatment division to disability discrimination law prior to the ADA).

6. See Wendy W. Williams, *Equality’s Riddle: Pregnancy and the Equal Treatment/Special Treatment Debate*, 13 N.Y.U. REV. L. & SOC. CHANGE 325, 352–70 (1985) (explaining the advantages of an equal treatment approach to discrimination against pregnant women).

7. See Linda J. Krieger & Patricia N. Cooney, *The Miller-Wohl Controversy: Equal Treatment, Positive Action and the Meaning of Women’s Equality*, 13 GOLDEN GATE U. L. REV. 513, 518–22 (1983) (arguing for affirmative sex-based protection of pregnant women in the workplace).

This seemingly logical choice presents a double bind for gender equality.⁸ Either way, women lose, as Catharine MacKinnon argued, because whether women are treated the same as men or different from men, this framework positions men as the standard against which women are measured.⁹ For example, a classic equal treatment-special treatment dilemma asked whether women workers with family care responsibilities should be treated as equal to traditional working men or different from those men. In response, feminists argued that gender equality would be better advanced by asking whether the workplace normally should be structured to assume workers have little or no family caretaking responsibilities.¹⁰

This problem of covert biased norms underlying the sameness-difference dilemma extends to other kinds of status hierarchies. African American boys, for instance, or transgendered youth, or working mothers may constitute groups whose particular gendered interests and identities are interpreted as deviations from an unstated and normalized gender baseline in certain contexts. By implicitly accepting that particular needs or interests count as disadvantageous “differences,” in contrast to an assumed baseline in which a specific characteristic is normal and normative, either a sameness or a difference-based approach will be likely to reinforce a status-based hierarchy.

The double bind of the equal treatment-special treatment framework is repeated in the choice between defining disability as a problem of biological status or a problem of social functioning. A particular physiological condition can be treated as an essential disadvantage precluding productive functioning or as a tangential social contingency that can be overcome through productive functioning. Either way, disadvantages of disability are constructed

8. See Martha T. McCluskey, *Subsidized Lives and the Ideology of Efficiency*, 8 AM. U. J. GENDER SOC. POL’Y & L. 115, 122–26 (1999) (comparing the equal-special treatment framework to the bad choices constructed by the efficiency-redistribution division).

9. CATHARINE A. MACKINNON, *TOWARD A FEMINIST THEORY OF THE STATE* 221 (1989).

10. See JOAN WILLIAMS, *UNBENDING GENDER: WHY FAMILY AND WORK CONFLICT AND WHAT TO DO ABOUT IT* 1–3 (2000) (analyzing the problem of combining market work and family responsibilities as the result of problematic gender ideology and institutional structures separating a sphere of domesticity from market work).

against assumed and often covert baselines of normal and normative social and biological functioning that, to a large extent, legitimate the inequality of disability.

As Martha Fineman argues in the context of gender, obsession with the *origins* of difference—is it biological or social?—diverts attention from the *effects* of difference.¹¹ Categorizing difference along this divide has little benefit for efforts to reduce the disadvantages of “difference,” because both biology and society can be amenable to or resistant to change; both are subject to political and moral interpretation.¹² In the case of disability, as with gender, the positivist inquiry into what the relevant difference *is* cannot be separated from the normative inquiry into what the relevant difference *should be*.

The focus on separating essential from contingent difference—whether of gender or disability—implicitly reinforces the idea of “true” difference as non-ideological and non-political. Any harms (or benefits) associated with that difference then appear natural and normal rather than unjust. The diverging definitions of disability in workers’ compensation and ADA law exemplify how the legal focus on sorting out social from biological, regardless of which is chosen as “most real,” begs the deeper questions about when the disadvantages of difference should be understood as public injustice. That is, the underlying question of inequality should not be who is really different or whose real differences deserve special accommodation. Instead, we must ask whose potentially disadvantageous differences are systematically privileged as public concerns deserving public support and whose are penalized as private problems.

Part I of this Article outlines the standard division of equality into two scales, one formal and one substantive, and explains how a problematic division between biological identity and social functioning has been used to support these scales and to rank disability, race, and gender.

Part II turns to the example of workers’ compensation law reforms to criticize what appears to be a medical approach to defining

11. MARTHA ALBERTSON FINEMAN, *THE NEUTERED MOTHER, THE SEXUAL FAMILY AND OTHER TWENTIETH CENTURY TRAGEDIES* 34–35 (1995).

12. *Id.* at 35.

disability. Part III examines the contrasting social approach to disability in the ADA rulings, showing the similar flaws of this slippery attempt to focus on social functioning separate from biological status. The Article concludes that by rejecting a focus on sorting biological from social cause of disability's disadvantage, we might better advance equality.

I. EQUALITY THEORY

A. Formal Equality's Hierarchy: Race, Gender, and Disability

1. Correcting the Disadvantages of Irrelevant Difference

In the classic legal antidiscrimination paradigm, inequality is a formal problem of distinguishing sameness from difference.¹³ The traditional equality doctrine focuses on weeding out false or irrational correlations between formal biological difference and functional sameness.¹⁴ That formal equality paradigm produces a hierarchy of equality protection, whereby the difference of race gets the greatest legal protection (strict scrutiny),¹⁵ sex gets an intermediate level of protection,¹⁶ and disability a lesser level of protection (rational basis review).¹⁷ That ranking follows from the assumption that the apparent physical differences of race are almost never rationally related to functional difference, while the physical differences of gender are sometimes relevant, and the physical differences of disability are often relevant. In other words, formal equal protection increases as biological difference decreases.¹⁸

In this scheme, discrimination on the basis of race, gender, or disability is "legitimate" if based on function rather than physical

13. *See, e.g.,* *City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 439 (1985) (denying heightened scrutiny for disadvantageous treatment of mental disability on the theory that equal protection directs "that all persons similarly situated should be treated alike").

14. *Id.* at 478 (Marshall, J., concurring in the judgment in part and dissenting in part).

15. *Id.* at 440.

16. *Id.* at 440-44.

17. *Id.* at 446.

18. *Id.* at 440-44 (distinguishing the legal treatment of the "real and undeniable" differences of mental retardation from usually irrelevant and prejudice-based differences of race and frequently irrelevant differences of gender).

form, fact rather than value. The move from race to disability on this scale marks a move from weaker to greater relationship between merely formal appearances of difference and the functional socioeconomic reality of different ability. Because this scale assumes functional differences are potentially measurable facts, differentiating on the basis of functional characteristics appears rational. Differentiations based on pure status—apart from function—appear irrational, because maintaining status divorced from functional purpose is assumed to be an unreasonable and illegitimate government purpose.

On this traditional scale, because disability differences are most “real”—or most behavioral-differentiation based on disability appears least likely to involve irrationality or problematic value judgments such as hostility or subordination for its own sake.¹⁹ This Article’s goal is not to defend disability’s place at the bottom of this hierarchy, but rather to counter the retrenchment of disability rights (and of equality more broadly) by returning to the earlier critical project of challenging this hierarchy and the equality paradigm that produces it.

2. The Social Substance of Formal Biological Difference

Critical analysis of the problem of race and sex inequality has shifted the focus from formal difference to substantive subordination.²⁰ Feminist critiques of the choice between equal and different treatment have been part of a broader effort to explore the disparate substantive effects of facially neutral treatment.²¹ In a social

19. *Id.* at 443 (explaining that the presence of relevant immutable functional difference in the context of disability and the history of legislative protection makes prejudice unlikely). For a critique of this analysis, see McCluskey, *supra* note 5, at 868–70.

20. *See, e.g.*, Jack M. Balkin & Reva B. Siegel, *The American Civil Rights Tradition: Anticlassification or Antisubordination?*, 58 U. MIAMI L. REV. 9, 11–14 (2003) (discussing historical support for the antisubordination interpretation); Ruth Colker, *Anti-Subordination above All: Sex, Race, and Equal Protection*, 61 N.Y.U. L. REV. 1003, 1003 (1986) (advocating a move from antidifferentiation to antisubordination as the framework for equality law); Owen M. Fiss, *Groups and the Equal Protection Clause*, 5 PHIL. & PUB. AFF. 107, 107–08 (1976) (distinguishing between an anticlassification approach to equal protection and an antisubordination approach).

21. *See, e.g.*, Fiss, *supra* note 20, at 141–46 (1976) (advocating extending equal protection to disparate impact on the theory that the problem of inequality is systemic harm not simply misclassification).

historical context in which unequal treatment of a particular identity becomes systematically and pervasively entrenched in institutions, culture, and policies, it is logical to expect that inequality on the basis of such an identity would come to appear natural, rational, and neutral.²² This means a narrow focus on formal equality will be less effective the more severe the problem of unjust inequality.

The seemingly formal task of determining sameness and difference always requires reference to a substantive purpose. Whether a table is really the same as or different from a chair or a cat depends on whether the purpose of the categorization is, for instance, to sell furniture or to collect one person's belongings. As Martha Minow wrote in her analysis of disability discrimination and equality, difference always exists in the social context of relationship rather than as either an essential status or functional fact inherent in an individual.²³ Inequality creates real difference as much as real difference creates inequality.

Strict judicial scrutiny for explicit governmental racial discrimination gets its logic not solely from the formal principle of "treating likes alike," but also from substantive judgments about the relative harm of racial classification compared to other classifications, or about the relative harms of racial exclusion compared to alleged harms of racial integration.²⁴ Further, strict scrutiny doctrine rests on substantive judgments about when discrimination should be categorized as related to or separate from "race" and when racial discrimination should be categorized as caused by or separate from government action.²⁵

22. See Catharine A. MacKinnon, *Feminism, Marxism, Method, and the State: Toward Feminist Jurisprudence*, 8 SIGNS: J. WOMEN IN CULTURE & SOC'Y 635, 654 (1983) (discussing how hostility toward women becomes routine rationality); Martha Minow, *The Supreme Court, 1986 Term: Foreword: Justice Engendered*, 101 HARV. L. REV. 10, 68 (1987) ("Power is at its peak when it is least visible, when it shapes preferences, arranges agendas, and excludes serious challenges from discussion or even imagination.").

23. MARTHA MINOW, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW 1-4, 22 (1990).

24. See Herbert Wechsler, *Toward Neutral Principles of Constitutional Law*, 73 HARV. L. REV. 1, 34 (1959) (identifying the substantive normative judgments inevitable to constitutional rulings desegregating schools); Finley, *supra* note 5, at 1150 (explaining in the context of sex discrimination that formal equality analysis is indeterminate without substantive judgments about ultimate social aims).

25. For example, compare the majority opinion and dissent in *Milliken v. Bradley*, 418

Similarly, turning to disability, if a person with paraplegia is excluded from a public bus with steps, we must go beyond simple fact and formal logic to conclude that this exclusion results from “real difference” rather than from false stereotype. Judgments about whether that person is “really” different from people who can climb up bus steps depend on what we consider the substantive purpose of the bus: transportation for the public, or transportation for members of the public who can climb steps? Determining whether the exclusion at issue is neutral treatment with disadvantageous effects on those who are “different” or biased treatment based on prejudice against persons with disabilities depends not on the physiological fact of a particular mobility limitation, but on substantive moral and political decisions about whether buses should normally and naturally be designed for entrance via steps rather than by ramps or lifts.²⁶

Such facially neutral decisions can represent and reinforce assumptions of unequal status and animus just as effectively as overt expressions of hostility directed at physical difference. Feminist critique has argued that a society in which mothers count as normally productive workers would treat employment leave for childbirth and childcare as normal and neutral to productive work rather than as a special accommodation.²⁷ Similarly, a society that viewed wheelchair users, stroller users, or shopping-cart pushers as important or normal examples of the general public for whom public services should be designed might normally and cost-effectively construct transportation systems free of steps.²⁸ Disability law scholarship has similarly analyzed how substantive accommodations can overlap with formal neutral treatment,²⁹ rendering the normative distinction between

U.S. 717, 749–52, 761–62 (1974) (Douglas, J., dissenting) (disagreeing about whether racial segregation of Detroit schools stemmed from government racial policies).

26. McCluskey, *supra* note 5, at 872–73.

27. Finley, *supra* note 5, at 1168.

28. McCluskey, *supra* note 5, at 873.

29. See Christine Jolls, *Antidiscrimination and Accommodation*, 115 HARV. L. REV. 642, 698 (2001) (showing that the standard antidiscrimination law sometimes imposes substantive requirements similar to the ADA’s reasonable accommodation requirement). See generally Mary Crossley, *Reasonable Accommodation as Part and Parcel of the Antidiscrimination Project*, 35 RUTGERS L.J. 861 (2004) (analyzing the similarity between removal of social barriers through reasonable accommodations and removal of barriers through equal treatment); McCluskey, *supra* note 5, at 878–80 (arguing that disability discrimination doctrine should treat accommodations for disabilities as a form of the disparate impact approach to

formal protection against discrimination and substantive accommodation ultimately shaky.³⁰

Given the inevitably substantive nature of formal equality, some critics have argued that moving from antidiscrimination to antisubordination would explicitly address rather than avoid the competing substantive values necessarily at issue.³¹ Yet the effort to advance substantive equality by identifying and remedying substantive subordination often has ironically tightened rather than loosened the biological versus social bind.

B. Substantive Equality's Hierarchy: Disability, Gender, and Race

1. Correcting the Disadvantages of Real and Relevant Difference

Courts sometimes have applied formal equality doctrine with a vigorously critical eye toward uncovering the substantive judgments underlying claims of functional and natural differences.³² However, instead of pushing the boundaries of formal equality further toward open and careful analysis of its entanglement with substantive results, substantive equality has largely gained ground as a separate approach focused on alleviating the harmful disadvantages of “real” difference. By largely reinscribing rather than resisting the dichotomy between formal equal treatment and substantive accommodation of individual difference, this expanded substantive equality framework helps narrow both formal equality and substantive equality.

The ADA's reasonable accommodation requirement is a paradigmatic example of an explicitly substantive approach to equality. In the mainstream view, this accommodation requirement is largely distinct from and opposed to antidiscrimination principles,

antidiscrimination); Michael Ashley Stein, *Same Struggle, Different Difference: ADA Accommodations as Antidiscrimination*, 153 U. PA. L. REV. 579 (2004).

30. See Samuel R. Bagenstos, “Rational Discrimination,” *Accommodation, and the Politics of (Disability) Civil Rights*, 89 VA. L. REV. 825, 830–31 (2003).

31. See Colker, *supra* note 20; Fiss, *supra* note 20.

32. See, e.g., *United States v. Virginia*, 518 U.S. 515, 531–33 (1996) (scrutinizing sex-based exclusion from a state educational institution for overgeneralization, ties to historically suspect gender ideology, post-hoc rationalization, and closeness of fit between means and ends).

tracking the special versus equal treatment divide.³³ Conventional wisdom holds that accommodation involves different treatment, in response to functionally relevant differences, while antidiscrimination involves similar treatment, reflecting “blindness” to difference.

In the conventional model of substantive equality, legal protection increases with increased biological difference, reversing the hierarchy of formal equality. Disability is typically ranked as the most deserving of substantive protection; gender is in the middle, and race is the least deserving of substantive protection.³⁴ In the standard view, the differences of disability commonly involve “real” limits on substantive social functioning, making accommodation, rather than antidiscrimination, the more appropriate approach to addressing disadvantages of disability. Similarly, because the differences of gender are conventionally assumed to involve a mixture of “real” functional differences and “false” social stereotypes, gender equality can logically require a mixture of accommodation and antidiscrimination protections. Finally, the standard view holds that affirmative accommodation of racial difference is almost never appropriate, because this view assumes the differences of race are almost never a matter of “real” functional limits.

Following this substantive hierarchy, the ADA focuses centrally on accommodation as the leading legal strategy for promoting equality in the context of disability. For gender equality, requirements for substantive accommodation such as the Family and Medical Leave Act³⁵ have gained a place alongside traditional civil rights laws as a means to alleviating functional differences related to gender. In the context of racial equality, however, recent doctrine has sharply limited explicit (and perhaps implicit) accommodation of

33. See Samuel Issacharoff & Justin A. Nelson, *Discrimination with a Difference: Can Employment Discrimination Law Accommodate the Americans with Disabilities Act?*, 79 N.C. L. REV. 307, 311 (2001) (grounding analysis of ADA in an assumption that its reasonable accommodation requirement is in tension with antidiscrimination principles).

34. *City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 440–41, 446 (1985).

35. 29 U.S.C. § 2612(a) (2006) (requiring employers to provide up to twelve weeks of unpaid leave for certain family and medical reasons).

race-based differences to achieve substantive outcomes, even in the face of morally or politically compelling substantive purposes.³⁶

2. The Biological Form of Substantive Dominance

Critics of substantive approaches to equality argue that claims of beneficial response to “real” difference have long rationalized some of the worst injustices in the context of race, gender, and disability.³⁷ Distinguishing benign from malign accommodation of difference is just as subject to contested and covert substantive judgments as distinguishing between “real” and “false” difference. If one assumes a history and context of systemic, normalized prejudice and institutionalized subordination, laws claiming to correct substantive dominance actually may serve to entrench that dominance (intentionally or accidentally).

This separate and reversed scale of substantive equality addresses the dilemma of substantive dominance by returning to the same formalistic division between biological and sociological difference that masks the substantive bias it is supposed to solve. In the standard analysis, benign and malign recognition of difference is least likely to be confused in the case of disability, somewhat more likely in the case of gender, and most likely in the case of race. As this framework presumes the disadvantages of disability represent “real” functional limitations rather than systematic hostility, accommodations to compensate or mitigate these disadvantages will seem less likely to create harmful stigmas or constructions of difference. In contrast, this framework assumes that accommodations aimed at compensating or mitigating disadvantages associated with race (or at reconstructing alleged “disadvantages” into productive “diversity”) will be more likely to produce than to prevent harmful differentiation. Because this standard view assumes racial disadvantages primarily result from socially stigmatizing and stereotyping racial differences, any social

36. *See, e.g.*, *Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701, 748 (2007) (ruling that voluntary school integration plans violated equal protection).

37. *See, e.g.*, *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 226 (1995) (holding that strict scrutiny applies to all race classifications regardless of purpose, because “it may not always be clear that a so-called preference is in fact benign” (citations omitted)). *See generally* Wendy W. Williams, *Notes from a First Generation*, 1989 U. CHI. LEGAL F. 99 (1989).

“intervention” to alleviate (or celebrate) racial difference is likely to further reinforce those social perceptions of functional inferiority.

Disability’s position at the top of the substantive equality hierarchy has sometimes been interpreted as a sign of stronger and more substantive support for disability equality than for race or gender equality. That conclusion assumes too simplistically that the scale values rather than shortchanges equality.³⁸ By linking the most substantive equality with the identity most identified with individual biological status, the substantive scale targets the most substantive protection to the seemingly most privatized and naturalized constraints. The scale identifies unequal status primarily with constrained autonomy and then further identifies individual biology as the clearest substantive constraint on that autonomy. This emphasis on individual biology therefore appears to make equality a question of separating dependent victims in need of support from independent rational actors capable of free choice.³⁹

Framed this way, the substantive equality scale elevates disability by reaffirming its subordinated status as an identity of “real” victimhood, dependence, and incapacity for rational action. Those who *really* deserve substantive intervention to alleviate disadvantage are those whose own choices have not produced that disadvantage. If those victims or dependents are deemed *really* incapable of successful functioning (in market, state, or family), however, then the substantive intervention they deserve is, by definition, a deviation from normally rational processes. By presenting substantive accommodations as a way of compensating for “real” and rational functional constraints (dependency), this scale defines those accommodations as presumptively and essentially irrational (i.e., costly and constraining) for society as a whole. For example, in a leading analysis of the meaning of substantive equality under the ADA, Christine Jolls defines “accommodation” as a requirement that

38. See, e.g., Mark Kelman & Gillian Lester, *Ideology and Entitlement*, in LEFT LEGALISM/LEFT CRITIQUE 135 (Wendy Brown & Janet Halley eds., 2002).

39. For a nuanced and insightful analysis of how a feminist focus on substantive “dominance” became interpreted to equate feminism with women’s victimization, see Kathryn Abrams, *Songs of Innocence and Experience: Dominance Feminism in the University*, 103 YALE L.J. 1533, 1552–57 (1994) (reviewing KATIE ROIPHE, *THE MORNING AFTER: SEX, FEAR AND FEMINISM ON CAMPUS* (1993)).

employers (or others) “incur special costs in response to the distinctive needs (as measured against existing market structures) of particular, identifiable demographic groups” in circumstances without intentional animus based on irrelevant group membership.⁴⁰

The view of substantive equality as costly support for distinctively needy dependents casts the question of substantive accommodations as a policy choice to favor “redistribution” over “efficiency” within the prevailing economic paradigm.⁴¹ That paradigm defines “efficiency” as the functioning of the “free market” presumed to normally and naturally produce maximum societal well-being.⁴² In this view, formal antidiscrimination law can be compatible with “efficiency” to the extent it eliminates “irrational” actions with no relevance to social function. In contrast, this prevailing economic paradigm defines substantive accommodations in response to socioeconomic functioning as the “redistribution” of societal resources away from overall socioeconomic well-being in order to benefit a subset of society: those who are disadvantaged.

This definitional framework leads to the tautological conclusion that substantive accommodations—like those in the ADA—must be sharply limited to advance equality as well as other public interests, such as economic productivity. If accommodations are defined as costly to overall societal well-being, then, by definition, accommodations risk increasing rather than redressing inequality. Following this circular logic, as the costs of accommodation drain other benefits to public welfare, fewer societal resources will be available to support costly accommodations. As a result, the supposed beneficiaries of substantive accommodations will eventually be worse off (along with society in general). Like the concept of “special treatment” critiqued in feminist theory, the concept of “redistribution” is a way of *defining* substantive social change as normatively harmful based on abnormal individual

40. Jolls, *supra* note 29, at 648.

41. See, e.g., Issacharoff & Nelson, *supra* note 33, at 310–11 (explaining the ADA rulings narrowing the definition of disability as the result of the ADA’s heightened focus on redistribution, in tension with antidiscrimination).

42. For a critique of the concept of “efficiency” distinct from “redistribution,” see Martha T. McCluskey, *The Illusion of Efficiency in Workers’ Compensation “Reform,”* 50 RUTGERS L. REV. 657, 716–67 (1998).

“difference” or “disadvantage,” and only grudgingly available as a limited last resort for individuals or groups who cannot help their substandard functioning.⁴³ Indeed, Samuel Bagenstos has analyzed how reducing “redistributive” welfare payments to people with disabilities was one of the purposes emphasized by proponents of the ADA, and he shows how this anti-dependency purpose sets up an inherent tension that sharply limits the law’s protection even as it justifies it.⁴⁴

In short, disability’s position at the top of this substantive scale means the limitations of disability are presumptively burdensome and deserving of correction only if not “undue.”⁴⁵ Although this scale decrees that some accommodation is “due” to help overcome the real burdens of disability, it also sets up a double bind where the most deserving accommodations can appear the most costly. Substantive accommodations appear to be “due” particularly to those whose functional incapacity appears so severe as to demand unduly undoing those functions of society deemed essentially normal and beneficial.⁴⁶ This bind means that, although the ADA sometimes can bring vital gains in substantive equality in practice, its potential for redressing the disadvantages of disability has also been sharply constrained and vigorously contested. In short, the ADA’s substantive equality requirements represent not so much a clear victory for disability rights, but instead reflect a continuing confusion and contest over whether equal rights or unequal charity is the best answer to disability’s disadvantage.

This substantive equality scale, like the formal equality scale it supplements, obscures our ability to see how substantive inequality is

43. See McCluskey, *supra* note 8, at 121–28.

44. Samuel R. Bagenstos, *The Americans with Disabilities Act as Welfare Reform*, 44 WM. & MARY L. REV. 921, 956–57, 1023–26 (2003).

45. 42 U.S.C. § 12112(b)(5)(A) (2006) (providing “undue hardship on the operation of the business” as a defense exempting employers from the ADA’s reasonable accommodation requirement); *see also id.* § 12111(10) (defining “undue hardship” as “an action requiring significant difficulty or expense”).

46. For a critical analysis of judicial reasoning portraying accommodations for less severely disabled employees as unjustified “handouts,” see Samuel Bagenstos, *Subordination, Stigma, and “Disability,”* 86 VA. L. REV. 397, 470 & n.277 (2000); Matthew Diller, *Judicial Backlash, the ADA, and the Civil Rights Model*, 21 BERKELEY J. EMP. & LAB. L. 19, 48 & n.170 (2000).

not simply a problem of inherently costly individual limitations, constraining differences, or external domination precluding individual choice. Instead, substantive inequality can be a problem of social and political decisions to privilege some individual constraints or choices while penalizing others. Critiques of the equal treatment-special treatment dilemma explain that if a group's particular limitations, needs, or interests are recognized, supported, and valued as part of normally beneficial functioning, a person in that group can appear formally equal *and* substantively different at the same time.⁴⁷ Similarly, if a group's particular (biological or social) limitations, needs, or interests are recognized as normative baselines or natural aspects of human functioning, a person identified with that group can appear both to deserve substantive support *and* to be an autonomous rational actor enhancing overall public well-being.⁴⁸

Is the human need for sleep, for example, a costly limitation or status of dependency in need of substantive accommodation in work hours for those particularly unable or unwilling to take sufficient drugs to maintain close to twenty-four-hour wakefulness? Similarly, are demands for workplace toilets requests for special treatment by those unwilling or unable to use catheters or diapers to eliminate bodily waste at work?⁴⁹ It misses the mark to ask whether workers' needs for daily sleep or for toilets count as biological or social constraints in need of costly accommodation, on the one hand, or freely chosen social "differences," on the other. Instead, a more meaningful question would ask about the substantive merits of requiring workplaces to support daily sleep and toilet use. In the contemporary U.S., status or conduct as a daily sleeper or as a toilet user is not typically perceived as disadvantageous dependence or difference precisely because both the social choices and the

47. McCluskey, *supra* note 8, at 128–29.

48. For an extended discussion of disability discrimination as a problem of social prejudice based on problematic construction of normal human functioning, see Bagenstos, *supra* note 46, at 436–50; *see also* McCluskey, *supra* note 5, at 872–73 (arguing that equality doctrine should be based on the idea that "disability is normal").

49. *See generally* MARC LINDER & INGRID NYGAARD, VOID WHERE PROHIBITED: REST BREAKS AND THE RIGHT TO URINATE ON COMPANY TIME (1998) (discussing changing policies toward restroom breaks in the workplace).

biological constraints involved generally are deemed normal and beneficial despite any associated costs.

Similarly, Laura Kessler astutely explains how the biological versus social construction question wrongly reduces substantive inequality to a question of individual constraint versus choice in employment discrimination cases involving workers' family caretaking.⁵⁰ For example, a court denied the sex discrimination claim of a breast-feeding worker who was demoted and harassed for taking work breaks (with her employer's approval) to pump her breasts, reasoning that any disadvantage was the result of real and relevant female physiological difference, rather than gender stereotypes.⁵¹ Despite criticizing this biological determinism, Kessler analyzes how a shift to social constructivism also tends to legitimate workplace penalties for family caretakers.⁵² If caretaking women are seen as disadvantaged at work by culture, rather than by biology, then this harm appears to be the product of changeable individual behavior, rather than fixed gender identity.⁵³ Because breast-feeding workers can always "choose" not to breast-feed to avoid employment penalties, any resulting workplace detriments may be attributed to individual choice rather than to sex discrimination. But if we counter such conclusions by stressing constraints on women's capacity for meaningful choice, we risk reinforcing policies promoting control and exclusion more than accommodation and support.⁵⁴ Kessler concludes that neither social nor biological approaches challenge the problematic presumption that family caretaking represents social or biological inferiority.⁵⁵ She advocates grounding substantive accommodation not in private incapacity but instead in public

50. See Laura T. Kessler, *The Attachment Gap: Employment Discrimination Law, Women's Cultural Caregiving, and the Limits of Economic and Liberal Legal Theory*, 34 U. MICH. J.L. REFORM 371, 447, 452–53 (2001).

51. *Id.* at 405–06 (discussing *Martinez v. N.B.C., Inc.*, 49 F. Supp. 2d 305, 310 (S.D.N.Y. 1999)). The court in *Martinez* also denied the plaintiff's claim that disadvantageous treatment based on breast-feeding constituted disability discrimination under the ADA, reasoning that breast-feeding, while biological, is not a physiological disorder. *Martinez*, 49 F. Supp. 2d at 308–09.

52. See Kessler, *supra* note 50, at 405–07.

53. *Id.* at 443.

54. *Id.* at 448–49.

55. *Id.* at 437.

capacity for advancing social and moral well-being.⁵⁶ Just as equality is not a question of who is “different” but of whose differences are normally privileged, equality is not simply a question of who can freely choose but of whose “choices” are normally privileged.

C. Tipping The Equality Scales: Sexual Orientation

Adding sexual orientation destabilizes both equality scales by foregrounding the limits of the biological/social inquiry into false difference or real constraint on choice. Formal protection against irrational attributions of “difference” on the basis of *status* as gay or lesbian will seem difficult to distinguish from claims for substantive accommodation of difference on the basis of gay or lesbian *conduct*. Even if sexual orientation is viewed as an irrelevant immutable biological status subject to false attributions of difference,⁵⁷ like race, sex, and disability (in the problematic mainstream view), this different status involves changeable social conduct by those challenging their subordinate status. The potentially irrelevant difference of sexual orientation is generally understood as socially invisible without some action by the individual marked as different (such as coming out as “gay” or having a same-sex intimate relationship).

This confusion of identity and action grounds arguments that laws prohibiting discrimination on the basis of sexual orientation confer “special rights” (substantive accommodation of different functioning) rather than “equal rights” (formal protection for sameness).⁵⁸ As with disability or gender, this supposed “accommodation” can appear unjustified because the “different” functioning of sexual orientation appears to involve contested individual, cultural, and moral choices rather than simply biological constraint.

56. *Id.* at 452–53.

57. See Janet E. Halley, *Sexual Orientation and the Politics of Biology: A Critique of the Argument from Immutability*, 46 STAN. L. REV. 503 (1994) (critiquing arguments relying on biological immutability as the basis for constitutional equal protection of lesbians and gay men).

58. See Peter J. Rubin, *Equal Rights, Special Rights and the Nature of Antidiscrimination Law*, 97 MICH. L. REV. 564, 588–89 (1998); *Romer v. Evans*, 517 U.S. 620, 637–38 (1996) (Scalia, J., dissenting) (arguing that prohibiting discrimination on the basis of sexual orientation can lead to special rights for “homosexual conduct”).

Focusing on sexual orientation as a window into broader problems with equality law, Kenji Yoshino argues for expanding the vision of equality to protect against imposed sameness, not just forced difference.⁵⁹ Yoshino describes the heavy costs of “covering” gay identity to show that problematic social ascription of sameness as well as imposed difference lies at the heart of status inequality.⁶⁰ Explaining a continuum of unjust constraints on the choice to be or act “different,” Yoshino argues that meaningful equality requires going beyond protecting a gay man as long as he “converts” to heterosexuality, “passes” as straight (as in the military’s don’t ask, don’t tell policy), or sufficiently “covers” his identity as gay (coming out without “flaunting it”).⁶¹

The conventional equality paradigm always confers protection for changeable conduct, even though on the surface it limits protection to essential status (whether status as “really” the same under formal equality, or status as “really” different under substantive equality). As Yoshino concludes, in the context of race and gender as well as sexual orientation, civil rights laws are fundamentally about *who should change* their attitudes and behavior (or the identity those actions constitute): the white supremacist or the person of color? The woman or the misogynist? The lesbian or the homophobe?⁶² As the Supreme Court infamously concluded in dismissing segregation’s harm as a problem of bad attitudes on the part of those categorized as black in *Plessy v. Ferguson*, racial segregation involves both an imposition of formal biological status and also a social act interpreting this status as harmful.⁶³ The Court’s reasoning was

59. See generally KENJI YOSHINO, COVERING: THE HIDDEN ASSAULT ON OUR CIVIL RIGHTS 74–110 (2006).

60. *Id.* at 107.

61. *Id.* at 18–19.

62. Kenji Yoshino, *Covering*, 111 YALE L.J. 769, 938 (2002). Critical race scholar Angela Harris similarly discusses how a contemporary shift from categorical racism (based on ancestral identity) to colorism (based on a complex hierarchy of racial appearance) might heighten racial stigma for those who do not or cannot avoid certain racially-coded appearances or behaviors. Angela P. Harris, *From Color Line to Color Chart?: Racism and Colorism in the New Century*, 10 BERKELEY J. AFR.-AM. L. & POL’Y 52, 64 (2008).

63. *Plessy v. Ferguson*, 163 U.S. 537, 551 (1896) (infamously reasoning that if laws mandating racial segregation are perceived as a badge of inferiority, that “is not by reason of anything found in the act, but solely because the colored race chooses to put that construction upon it”).

flawed not because segregation's harm is purely biological, but because the Court affirmed the wrong social interpretation of segregation.

Disability discrimination's position at the top of the substantive scale highlights this question of who should change by explicitly identifying equality with limited accommodation. Yet that substantive question is inevitable to the formal antidiscrimination scale.⁶⁴ Both formal and substantive equality scales limit analysis of the question who should change by using a simplistic division between a fixed biological core and contingent social response. By imagining an unchangeable biological core without relevant substance, the formal equal treatment principle makes its prohibition of unequal treatment appear to be free from (rational and relevant) substantive cost or controversy. On the other hand, by imagining a biological status that is unchangeable but relevant to beneficial substantive functioning, the substantive accommodation principle presents its requirement of "different" treatment as generally costly and therefore normally sharply limited.

As Kessler and Yoshino show, reducing inequality to biological constraints on individual action legitimates inequality on both formal and substantive scales because—on closer examination—every instance of protected biological constraint can logically appear to involve unprotected social choice.⁶⁵ The social constructivist alternative is simply the other side of this problem. The formal equality scale justifies change to the extent harm results from immaterial social ideas, and the substantive equality scale justifies change to the extent social interpretation is immaterial to the harm. Equality will logically appear suspect when founded on social immateriality, however, because in the real world, judgments of harm involve social ideas about what matters and how.

In short, the biological/social divide provides an uneasy justification for change that advances equality, rendering any such change logically suspicious, because the objective line it attempts to draw is too thin and slippery to provide satisfactory support for change. This tension is especially clear in the context of disability,

64. Bagenstos, *supra* note 30, at 830.

65. See Kessler, *supra* note 50, at 448–49.

because its position at the top of the substantive equality scale most explicitly and directly frames the question of equality as a tradeoff between positive and negative substantive changes. By examining how the biological/social divide fosters this tension to undermine disability rights, we can better understand the problems of the broader equality paradigm.

II. LIMITING WORKERS' COMPENSATION THROUGH BIOLOGICAL STATUS

The legal right to workers' compensation benefits is not generally framed as a right to equality for persons with work-related disabilities. As Matthew Diller explains, disability law has divided into two prongs, with government benefits separated from equality. The separation has developed precisely because the disadvantages of disability have been framed as problems of biology separate from social prejudice.⁶⁶ Workers' compensation tends to be construed not as an issue of civil rights, but as part of the social safety net providing substantive income assistance. In that view, workers' compensation benefits help alleviate the real and relevant socioeconomic harm deemed to result from changes in a physiological condition caused by workplace injury.⁶⁷ However, by positioning the disadvantages of disability as a problem of substantive equal rights, the ADA breaks down the division between the "civil" rights identified with equality and the welfare state's "social" rights correcting substantive disadvantages.⁶⁸ For that reason, examining workers' compensation's changing definition of disability can help shed light on the more overt confusion about substantive equality in the ADA.

66. Matthew Diller, *Dissonant Disability Policies: The Tensions between the Americans with Disabilities Act and Federal Disability Benefit Programs*, 76 TEX. L. REV. 1003, 1006 (1998).

67. See Kenneth S. Abraham & Lance Liebman, *Private Insurance, Social Insurance, and Tort Reform: Toward a New Vision of Compensation for Illness and Injury*, 93 COLUM. L. REV. 75, 98 (1993) (situating workers' compensation in a fragmented fabric of social welfare and tort protections).

68. See Diller, *supra* note 66, at 1082 (concluding that the neat division between disability benefits and civil rights represents outdated views of disability that the ADA aimed to change).

A. Compensating Medical "Impairment," Not Work Disability

Beginning in the late 1980s, insurers and employers mobilized a nationwide campaign to reform state workers' compensation laws.⁶⁹ One goal was to change the method of defining disability in compensation awards for workers sustaining permanent partial injuries, which make up the bulk of workers' compensation benefit costs.⁷⁰ For many permanent injuries and illnesses, states traditionally determined benefit amounts through individualized estimates of injured workers' future wage loss, considering not only the nature of the injury but also workers' age, skills, education, and local labor market conditions.⁷¹ Reform advocates instead promoted medical impairment, separate from socioeconomic factors, as the basis for calculating compensation amounts.⁷² Consistent with this goal, most states now require or recommend use of the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, commonly known as the *AMA Guides*, as a key part of determining workers' compensation benefits.⁷³

Political efforts to increase use of the *AMA Guides* in workers' compensation have continued through the first decade of the twenty-first century.⁷⁴ Substantial changes in the *AMA Guides*' methodology

69. McCluskey, *supra* note 42, at 704–08.

70. *Id.* at 830–34.

71. *Id.* at 833.

72. *Id.* at 835–41. For a discussion of the questions raised by using medical status as the definition of disability for determining social security benefits, see Lance Liebman, *The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates*, 89 HARV. L. REV. 833, 842–47 (1976).

73. AM. MED. ASS'N, GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT § 2.1(a), at 20 (Christopher R. Brigham & Robert D. Rondinelli eds., 6th ed. 2008) [hereinafter *AMA GUIDES*, 6th ed.] (noting forty-four states and two commonwealths requiring use of the *AMA GUIDES*); see also *AMA GUIDES RES. CTR., OCCUPATIONAL INJURIES AND ILLNESSES: AMA GUIDES HANDBOOK* tbl.1 (2009), http://www.lexisnexis.com/documents/pdf/20090916052048_large.pdf (identifying thirty-one states with statutes directing use of the *AMA Guides*).

74. See Impairment Resources, National Presentations on Driving Accurate Impairment Ratings, May 2009, <http://www.impairment.com/NationalPresentationsOnDrivingAccurateImpairmentRatings.htm> (reporting that the Senior Contributing Editor of the *AMA Guides* received standing ovations for featured speeches advocating the impairment ratings as a cost-cutting measure to two leading workers' compensation insurance trade associations at their 2009 annual meetings); Todd D. McFarren, *AMA Guides, Sixth Edition Arrive on the Scene*, LEXISNEXIS WORKERS' COMP. LAW CTR., Dec. 18, 2008, http://law.lexisnexis.com/practice_areas/Workers-Compensation-Law-Blog/Workers-Compensation/AMA-Guides-Sixth-Edition-

and impairment ratings have fueled ongoing controversy and confusion.⁷⁵ The Sixth Edition of the *AMA Guides*, published in 2008 (and supplemented with extensive corrections shortly afterward),⁷⁶ declares itself as a “paradigm shift” from the Fifth Edition.⁷⁷ As of 2009, nine or ten states had adopted the Sixth Edition, but the Fifth Edition (2001) of the *AMA Guides* remained the most commonly authorized version, while a number of states continued to require use of the Fourth Edition (1993) or Third Edition (1988) or did not specify which edition to use.⁷⁸ Some states using the *AMA Guides* have explicitly rejected the Sixth Edition due to concerns about benefit reductions, cost, complexity, or validity.⁷⁹

The *AMA Guides* provide standardized directions for physicians to quantify the degree of impairment of various specific body parts and organs, and to then translate these ratings into more general numerical ratings of larger body regions.⁸⁰ The ratings are converted to a measurement of “whole person” impairment for use in legal proceedings.⁸¹ For example, the Sixth Edition tells an evaluating

Arrive-on-the-Scene (reporting that the updated edition of the *AMA Guides* accelerates a dangerously successful political effort to reduce workers’ benefits, and noting that California reformed its workers’ compensation laws in 2005 to adopt the *AMA Guides*’ disability determinations).

75. For a summary of state controversies concerning the Sixth Edition, see Diana Ferriter, Bureau Chief, Workers’ Compensation Claims Assistance, Mont. Dep’t of Labor & Indus., 6th Edition of the *AMA Guides* to Permanent Impairment, Aug. 20, 2009, http://erd.dli.mt.gov/wcstudyproject/sixth_ed_ama_guides_permanent.pdf.

76. See *AMA Guides*, 6th ed., *supra* note 73; Am. Med. Ass’n, *Guides to the Evaluation of Permanent Impairment, Sixth Edition, Clarifications and Corrections* (2008) (providing fifty-two pages of errata).

77. *AMA GUIDES*, 6th ed., *supra* note 73, § 1.1, at 2.

78. See *AMA GUIDES RES. CTR. STAFF*, *supra* note 73 (counting nine states using the sixth edition as of July 2009); Impairment Resources, *Use of the AMA Guides by State*, http://www.impairment.com/Use_of_AMA_Guides.htm (counting ten states using the Sixth Edition).

79. See, e.g., DWIGHT T. LOVAN, COMM’R, KY. OFFICE OF WORKER’S CLAIMS, COMMISSIONER’S REPORT (2009), <http://www.labor.Ky.gov/NR/rdonlyres/DC046C16-F0FF-4BB5-98B8-7C1CE7E92D02/0/CommissionerReportonAMAGuides.pdf> (concluding that the state should continue to use the Fifth Edition); IOWA ADMIN. CODE r. 876-2.4 (2009) (regulation directing use of the Fifth Edition); 2009 NEV. STAT. 3030 (amending law directing use of the most recent edition to instead require use of the Fifth Edition, in legislation enacted over the governor’s veto in 2009).

80. *AMA GUIDES*, 6th ed., *supra* note 73, § 2.1(a), at 20, (discussing the typical use of the *AMA Guides*).

81. *Id.*

physician that a fracture of a particular bone in the middle finger, treated surgically and resulting in permanent mild deformity and pain, rates a six percent impairment of the finger.⁸² In the Sixth Edition, a six percent middle finger impairment dictates a two percent impairment of the hand, which in turn equals a one percent upper extremity impairment and then a one percent impairment rating for the “whole person.”⁸³ The “whole person” percentage rating is the same regardless of social and environmental factors such as what that “whole person” does for a living. A bank president and a meatcutter would get the same impairment rating for a fractured finger even though the meatcutter is likely to lose her job (and her means of income) due to the injury while the bank president’s income is likely to be unaffected.

The argument for relying on the *AMA Guides*’ impairment ratings rather than general evidence of wage loss holds that the *AMA Guides* more accurately and easily sort real from illegitimate claims of disability.⁸⁴ The change from wage loss to impairment determinations appears to ground workers’ compensation in objective health status, scientifically determined by experts, with the mushy sociolegal factors peeled away. Estimations of future wage loss are inevitably subjective, contingent, and contestable, dependent on workers’ behavior, on employers’ behavior, and on broader social conditions. By relying on medical impairment status instead, proponents of the *AMA Guides* argue that states will reduce administrative costs and fraudulent claims, thereby benefiting truly disabled workers as well as their employers.⁸⁵

The *AMA Guides*’ professed value depends on carefully differentiating its medical impairment ratings from sociolegal disability determinations. The *AMA Guides*’ stated goal is “to provide

82. *Id.* at 413 ex.15-2, 393 tbl.15-2 (giving a conversion factor from middle finger to hand of twenty percent).

83. *Id.* at 413 ex.15-2.

84. See McCluskey, *supra* note 42, at 838–39 & n.755 (discussing and criticizing this argument). For a critical discussion of similar reasoning and resulting questions about the use of medical status to define disability for determining social security benefits, see Liebman, *supra* note 72, at 842–47.

85. McCluskey, *supra* note 42, at 838 & n.755 (citing arguments and giving contrary evidence).

a standardized, objective approach to evaluating medical impairments⁸⁶ separate from the contingent, complex social and economic factors that go into determining “work disability.”⁸⁷ The *AMA Guides* draw on the social model of disability to explain that, unlike impairment, “disability” is “context specific, not inherent in the individual, but a function of the interaction of the individual and the environment.”⁸⁸ In bold print, the Fifth Edition explains that “disability” is an “alteration of an individual’s capacity to meet personal, social or occupational demands or statutory or regulatory requirements because of an impairment.”⁸⁹

The Sixth Edition of the *AMA Guides* somewhat revises this conceptual framework by defining disability as “activity limitations and/or participation restrictions in an individual with a health condition, disorder, or disease.”⁹⁰ This definition partially retreats from the previous overt placement of “impairment” as the determining cause of broader socioeconomic limitations.⁹¹ The Sixth Edition recognizes that the relationships between bodily functions and activities or participations are not “linear or unidirectional.”⁹² Yet the *AMA Guides* continues to reinforce and privilege the idea of a core objective biological status measurable apart from these subjective and tangential social actions (activities and participation). The Sixth Edition explains that its impairment ratings enable physicians to give a “quantitative estimate of losses to the individual as a result of their health condition, disorder, or disease.”⁹³ It distinguishes this medically measured loss from assessments of “the full array of human functional activities and participations that are required for comprehensive disability determinations.”⁹⁴

86. AMA GUIDES, 6th ed., *supra* note 73, § 1.2(a), at 20; AM. MED. ASS’N, GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT 1 (Linda Cocchiarella & Gunnar B.J. Andersson eds., 5th ed. 2001) [hereinafter AMA GUIDES, 5th ed.].

87. AMA GUIDES, 5th ed., *supra* note 86, § 1.2a, at 4–5; *see also id.* § 1.2b, at 8–9 (distinguishing work disability from impairment); AMA GUIDES, 6th ed., *supra* note 73, § 1.3d, at 5 (distinguishing impairment, based on medical expertise, from disability determinations).

88. AMA GUIDES, 5th ed., *supra* note 86, § 1.2b, at 8.

89. *Id.*

90. AMA GUIDES, 6th ed., *supra* note 73, § 1.3d, at 5.

91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.*

The *AMA Guides* explains that impairment refers to “functional limitations,”⁹⁵ or more precisely, the decrease in an individual’s overall ability to perform activities of daily living.⁹⁶ But what distinguishes this functional incapacity for activities that counts as the scientifically measurable health status, from the contextual functional incapacity identified as disability?

The *AMA Guides* defines impairment as “a loss, loss of use, or derangement of any body part, organ system or organ function.”⁹⁷ A “loss, loss of use, or derangement” is further defined as “a change from a normal or ‘preexisting’ state.”⁹⁸ But how do the *AMA Guides* decide what functioning counts as “normal”? It determines the “range or zone representing healthy functioning,” a status which the *AMA Guides* explains “varies with age, gender, and other factors such as environmental conditions.”⁹⁹ In this circular reasoning, the *AMA Guides* distinguishes the inherent biological condition from contextual social functioning by measuring that biological condition in light of expectations about the individual’s ability to function in particular social contexts. Health status does not neatly precede functional ability; instead, functional ability determines and precedes status.¹⁰⁰

95. AMA GUIDES, 5th ed., *supra* note 86, § 1.2a, at 4.

96. *Id.*

97. *Id.* § 1.2a, at 2. The Sixth Edition inserts the word “significant” before “loss.” AMA GUIDES, 6th ed., *supra* note 73, § 1.3d, at 5.

98. AMA GUIDES, 5th ed., *supra* note 86, § 1.2a, at 2; *see also* AMA GUIDES, 6th ed., *supra* note 73, § 1.3a, at 3 (also defining impairment as physiological functions and body parts that “can vary from the normal state, in terms of loss or deviations”).

99. AMA GUIDES, 5th ed., *supra* note 86, § 1.2a, at 2; *see also* AMA GUIDES, 6th ed., *supra* note 73, at 612.

100. The diagram introducing the Fifth Edition fudges this contradiction, drawing “impairment” distinct from and presumably placed prior to functional limitation, with one-way arrows pointing from impairment and functional limitation to disability, but then also suggesting possible reverse causation by adding another set of arrows running both ways between impairment and functional limitation. AMA GUIDES, 5th ed., *supra* note 86, § 1.2b, at 8. The Sixth Edition explicitly rejects the traditional unidirectional scheme moving from pathology to impairment to disability. AMA GUIDES, 6th ed., *supra* note 73, at 4 fig.1.2. Instead, it offers a more complex diagram, with two-way arrows connecting body functions and structures (on the left) to activities (in the center) and then to participation (on the right), along with two-way arrows linking all of these to underlying categories of “environmental” and “personal” factors. *Id.* However, this diagram links this entire scheme (with two-way arrows) to an overarching category at the top marked “Health condition, Disorder or Disease,” which suggests that medical status remains at the core and also the dominant factor. *Id.* § 1.3, at 3.

The *AMA Guides* is therefore problematic for determining disability benefits not simply because it excludes some socioeconomic factors relevant to measuring income loss. More fundamentally, medical impairment ratings fail to measure physiological health status separate from disability. In her historical analysis of the ideology and politics of disability, Deborah Stone concludes that the distinction between impairment and disability is “liturgical cant”: it gets its validity from repetition and faith, not empirical evidence or logic.¹⁰¹ The concept of impairment inevitably incorporates and depends on social judgment, as legal scholar Ellen Smith Pryor wrote in reviewing the *AMA Guides*’ Third Edition.¹⁰² Just as the formalistic determination of “difference” in equality law requires an assumption of a substantive norm for differentiating, the formalistic determination of impaired function in laws governing substantive benefits requires an assumption of a substantive norm for determining functioning. With disability, as with race and sex, the biological or scientific core status has meaning only in relation to functioning in a particular social, economic, and political context. Indeed, the concept of “medical impairment” seems primarily useful as a strategy for removing contested judgments about disability from political, social, and legal scrutiny.

The *AMA Guides*’ ratings perform a sleight of hand, offering “impairment” as a fixed medical status, more objectively measurable than contingent social functioning. But then the *AMA Guides* switches to contingent functional *impact* as the more objectively measurable medical fact necessary to reveal an ever-elusive underlying biological status. The *AMA Guides* makes continual normative decisions about which functions to measure as deviations from “normal” bodily function according to which standards, and under which conditions.

Even at the micro level of individual anatomical parts or organs, the *AMA Guides* cannot escape tricky and contested value judgments

101. DEBORAH STONE, *THE DISABLED STATE* 107–08 (1984). Similarly, disability studies scholar Simi Linton calls for a deconstruction of impairment to match the deconstruction of disability. SIMI LINTON, *CLAIMING DISABILITY: KNOWLEDGE AND IDENTITY* 138 (1998).

102. Ellen Smith Pryor, *Flawed Promises: A Critical Evaluation of the American Medical Association’s Guide to the Evaluation of Permanent Impairment*, 103 *HARV. L. REV.* 964, 968 (1990) (book review).

about what counts as normal bodily functioning. Pryor's critique of the *AMA Guides* compared how the Third Edition ignored loss of sensation in rating female genital functioning but counted loss of sensation in rating male genital functioning.¹⁰³ Beyond such obviously discreditable bias, even generally accepted social norms are little help in resolving many contestable judgments of normal physiological functioning. For example, in measuring the degree of impairment from a given level of muscle weakness in a hand, should it matter whether you are measuring the person's dominant hand? The *AMA Guides* Fifth Edition concludes it does not.¹⁰⁴

Similarly, should age and individual interest matter in determining deviation from normal function of a body part? When measuring hearing loss, the *AMA Guides* determines it does not; impairment ratings are not lowered for old age¹⁰⁵ or raised for bird watchers,¹⁰⁶ but instead are based on a standardized assumption of capacity to hear "everyday sounds."¹⁰⁷ Nonetheless, when it comes to penile injuries, the *AMA Guides* gives physicians the discretion to consider both age and individual activities, allowing extra impairment points for men under forty deemed to have active sexual functioning prior to the injury, while advising downward adjustment of impairment

103. *Id.* at 969–70. In an audio interview with senior contributing editor Christopher R. Brigham, an attorney asked why the Sixth Edition rates male loss of sexual function as a fifteen percent whole person impairment but loss of female sexual function as twenty percent, to which the senior editor responded "I have no explanation for that" and admitted the ratings were "far from perfect." Interview with Dr. Christopher Brigham, Senior Contributing Editor, *AMA GUIDES* (Apr. 28, 2008), <http://legaltalknetwork.com/podcasts/workers-comp-matters/2008/04/workers-comp-the-ama-guides-6th-edition/>; see also *AMA GUIDES*, 6th ed., *supra* note 73, at 141–49, 151–52 (giving fifteen percent as the maximum whole-person rating for male reproductive disease and giving twenty percent as the maximum whole-person rating for female reproductive disease).

104. *AMA GUIDES*, 5th ed., *supra* note 86, § 16.1, at 435 (noting hand dominance is relevant to assessing disability rather than impairment).

105. *AMA GUIDES*, 6th ed., *supra* note 73, § 11.2c, at 249 (instructing assignment of rating regardless of age or noise exposure); see also *id.* § 11.2d, at 250 (disregarding individual hobbies or occupations).

106. *Id.* § 11.2d, at 250 (disregarding individual hobbies or occupations).

107. *Id.* § 11.2c, at 249 (instructing assignment of rating regardless of age or noise exposure); *id.* § 11.2d, at 250 (disregarding individual hobbies or occupations); *id.* § 11.2e, at 251 (explaining "everyday" sounds and conditions as basis for the standards).

ratings for penile injuries in men over sixty-five or for men perceived as having histories of lower levels of sexual functioning.¹⁰⁸

How should impairment ratings count medical treatment affecting the functioning of a given bodily part, organ, or system? The *AMA Guides* measures hearing loss without considering the mitigating functional impact of corrective devices (hearing aids),¹⁰⁹ reflecting the theory that impairment is an underlying physiological state extracted from corrective behavior. Nonetheless, the Sixth Edition's rating system recognizes that medical treatment can be the main burden on normal functioning for endocrine conditions such as diabetes.¹¹⁰ Furthermore, the Sixth Edition changes previous editions' assumption that surgical treatment is evidence of severity of musculoskeletal impairment, instead decreeing that surgical treatment is evidence of improved functioning.¹¹¹ A medical expert on Iowa's task force studying the Sixth Edition explained how this approach produces illogical results.¹¹² For workers appropriately diagnosed and surgically treated for carpal tunnel syndrome, the *AMA Guides* would direct the physician to reject the previously correct diagnosis of carpal tunnel once surgery is complete, and to instead attribute any continuing symptoms to a much lower rated diagnosis of "nonspecific wrist pain."¹¹³

A further normative issue involves the *AMA Guides*' choice among various methods of measuring degree of functional loss. In prior editions, musculoskeletal ratings (which constitute almost ninety percent of impairment ratings)¹¹⁴ focused on the individual's range of motion and strength. For example, the Fifth Edition instructed physicians to test the grip and pinch strength of an

108. *Id.* § 7.7, at 143.

109. *AMA GUIDES*, 5th ed., *supra* note 86, § 11.1a, at 246; *AMA GUIDES*, 6th ed., *supra* note 73, § 11.1, at 248.

110. *AMA GUIDES*, 6th ed., *supra* note 73, § 1.8, at 16.

111. Interview with Dr. Christopher Brigham, *supra* note 103.

112. John Kuhnlein, Iowa Div. of Worker's Comp., Member Report for the Iowa Task Force Regarding the *AMA Guides* to the Evaluation of Permanent Impairment, Sixth Edition, 2008 Iowa *AMA Guides* Task Force Process Report 6-7 (2008).

113. *Id.*

114. Videotape: *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition: New Concepts, Challenges and Opportunities* (Christopher R. Brigham ed., 2008), available at <http://www.impairment.com/6/orientation-flash.htm>.

individual's hand at repeated intervals during an examination with the injured person sitting in various specified positions.¹¹⁵ In contrast, the Sixth Edition determines musculoskeletal ratings primarily through a formal grid of diagnostic classifications, such as whether the hand injury is located in the muscle, ligament, or bone, with only minor adjustments for physical examination, clinical measurements, or functional history.¹¹⁶ By emphasizing fixed classifications over functional clinical measurements, the Sixth Edition presumably aims to reduce variations in measurement due to contextual factors such as effort of the injured person, physician skill, and the testing environment.

But, while it seems logical to rate decreasing measurements of grip strength along an increasing scale of impairment severity, the basis for numerically ranking various formal diagnostic categories appears less clear, or at least less clearly grounded in medicine rather than socioeconomic interests.¹¹⁷ For example, the Sixth Edition gives a cervical fusion injury a zero to six percent whole person impairment rating based on its new ranking scheme, while a similar injury could produce a twenty-five percent whole person rating under the Fifth Edition.¹¹⁸ Similarly, in one example of compressive penile injury used in both editions, the Sixth Edition downgrades the organ level impairment rating to three percent (compared to five percent in the Fifth Edition) because the Sixth Edition assigns a lower rank to losses classified as involving sensation than to losses classified as involving "insufficient erection."¹¹⁹ The connection between the *AMA Guides'* ratings of relative functional loss and medical expertise is especially tenuous when the diagnostic criteria for impairment rating do not track medical criteria used for treatment, as in the carpal

115. AMA GUIDES, 5th ed., *supra* note 86, § 16.8, at 508.

116. See AMA GUIDES, 6th ed., *supra* note 73, § 15.2, at 387 (discussing this new diagnostic-based impairment approach for upper extremities).

117. For example, one medical expert noted concern that previous editions decided not to use percentage numbers for rating mental disorders because those numbers "may not translate very well into reality" and that by assigning numerical percentages, the Sixth Edition "implies a certainty that doesn't exist." Letter from James Gallagher, Diplomate, Am Bd. of Psychiatry & Neurology, to Peter Thrill, Att'y, Betty, Neuman & McMahon, P.L.C. (July 10, 2008); available at <http://www.iowataskforce.org/wc/amataskforce/jamesgallagher.pdf>.

118. KUHNLEIN, *supra* note 112, at 3.

119. AMA GUIDES, 6th ed., *supra* note 73, at 143, ex.7-25; 144 tbl.7-6.

tunnel example discussed above. One member of Iowa's task force on the *AMA Guides*' revisions reported that the Sixth Edition involves "little, if any, attempt to actually 'measure' anything," and that the *AMA Guides* would be just as valid and far simpler if one random numerical rating were assigned to all classes of impairment.¹²⁰

Indeed, the *AMA Guides* derives its numerical impairment ratings not from any testable empirical or clinical evidence or medical expertise, but from a "consensus" of socioeconomic intuitions from the *AMA Guides*' contributors.¹²¹ In a 2001 ruling under the federal Longshore and Harbor Workers' Compensation Act, an administrative law judge decided that the *AMA Guides*' ratings failed to satisfy the *Daubert*¹²² standard for admissibility of scientific evidence, citing testimony from the Fifth Edition's lead author for the upper extremities chapter, who agreed that when it comes to rating a finger impairment as a certain percent of the body as a whole, "there isn't any science about it."¹²³

The "consensus" that grounds the ratings has not included legal experts or representatives of workers' interests, nor has it represented a broad or scientific sample of medical expertise.¹²⁴ In its analysis of the Sixth Edition, Iowa's task force asked the AMA to clarify the composition of the consensus group for each chapter, but the AMA declined to provide this information.¹²⁵ Instead, the AMA provided only the general list of fifty-three chapter contributors in the *AMA*

120. MATTHEW DAKE, IOWA DIV. OF WORKER'S COMP., *AMA GUIDES TASK FORCE-REPORT OF MEMBER MATTHEW DAKE* 8-9, <http://www.iowaworkforce.org/wc/amatastaskforce/dakereport.pdf>.

121. See *AMA GUIDES*, 6th ed., *supra* note 73, § 1.3d, at 5 (defining impairment rating as a "consensus-derived percentage estimate of the loss of activity reflecting severity for a given health condition"). A diverse group of independent experts (not directly linked to the insurance industry) criticized the Fourth Edition of the *AMA Guides* for lacking validity, internal consistency, reliability, comprehensiveness, and accessibility. See Emily A. Spieler et al., *Recommendations to Guide Revision of the Guides to the Evaluation of Permanent Impairment*, 283 *JAMA* 519, 519-23 (2000).

122. *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 597 (1993).

123. *Hodgkinson v. Elec. Boat Corp.*, 35 Ben. Rev. Bd. Serv. (MB) 459 (May 18, 2001) (discussing testimony of Dr. Frank Jones).

124. DAKE, *supra* note 120, at 2-3 (discussing flawed process of producing "consensus" without consultation with legal experts).

125. KUHNLEIN, *supra* note 112, at 9.

Guides' preface without any identification of individual chapter authorship or level of involvement.¹²⁶ Upon questioning by the task force, the *AMA Guides'* senior medical editor explained that the consensus group for each chapter was drawn from those with national membership in the relevant medical specialty who also “were interested enough in the development of an impairment rating process to volunteer their time and efforts.”¹²⁷ He also explained that the editorial panel was chosen to agree with the lead editors’ proposed paradigm shift.¹²⁸ Further undercutting the asserted “consensus,” one state’s workers’ compensation medical director withdrew from participation in the Sixth Edition because of disagreement with lead editors over content and methodology.¹²⁹ Another physician on the *AMA Guides'* advisory committee, who was a past president of the American Academy of Disability Evaluating Physicians, expressed concerns to Iowa’s task force about “hidden agendas and biased allegiances” in the process of developing the Sixth Edition.¹³⁰

What contested legal and political judgments hide under these dubious claims to scientific consensus? In rating “whole person” impairment, the *AMA Guides* purports to measure capacity to perform the “activities of daily living,” but distinguishes the allegedly scientific “impairment” measure from subjective “disability” by considering the loss of ability to perform activities other than work.¹³¹ In short, “impairment ratings” are largely ratings of non-work disability that then become presented as an “objective” basis for evaluating work disability. In effect, the impairment ratings assume a standard of “normal functioning” based on a person who does not normally include wage work among their daily activities—or a

126. *Id.* For the list of chapter contributors, see *AMA GUIDES*, 6th ed., *supra* note 73, at vii–viii.

127. HELENJEAN M. WALLESER, DEPUTY COMM’R, IOWA DIV. OF WORKERS COMP., 2008 *AMA GUIDES TASK FORCE PROCESS REPORT 4* (2008), <http://www.iowaworkforce.org/wc/amatastaskforce/2008amaguidesprocessreport.pdf> (reporting the response of Robert D. Rondinelli, M.D.).

128. *DAKE*, *supra* note 120, at 3.

129. *KUHNLEIN*, *supra* note 112, at 11 (noting the withdrawal of Dr. Alan Colledge as ground for concern about the “consensus”).

130. *Id.* at 9 (reporting comments of Douglas Martin, M.D., as evidence of problems with the *AMA Guides'* “consensus” ratings).

131. *AMA GUIDES*, 6th ed., *supra* note 73, §§ 1.3d & 1.3e, at 5–6.

normal person for whom work activities make no significant bodily demands beyond those encountered in nonwork activities.

Proponents of the *AMA Guides* have long deflected such criticism by insisting that the *AMA Guides* should be used only for measuring medical conditions, not for directly estimating the sociolegal condition of work disability. But despite previous editions' warnings—in bold print—against sociolegal use,¹³² the *AMA Guides* have no medical use.¹³³ Instead, the *AMA Guides*' only real purpose is the sociolegal determination of disability, particularly work disability. The AMA created the *AMA Guides* in 1958 as a sociolegal strategy aimed at making private doctors, rather than government staff physicians, the source of expertise in social security disability hearings.¹³⁴ Indeed, the Sixth Edition departs from previous editions by removing the bold print warning and adding a section acknowledging and affirming the *AMA Guides*' sociolegal function for determining workers' compensation benefits.¹³⁵ Nonetheless, this edition retains traditional disclaimers against such use, insisting that its ratings are only a “first step”¹³⁶ that should be supplemented with socioeconomic factors.¹³⁷

With the promulgation of the Sixth Edition, the *AMA Guides* has become a highly commercialized private business, and its links to the AMA appear superficial or at least obscure.¹³⁸ The Sixth Edition's senior contributing editor, Christopher R. Brigham, is the chairman of

132. See, e.g., AMA GUIDES, 5th ed., *supra* note 86, at 13.

133. AMA GUIDES, 6th ed., *supra* note 73, at 20 (stating that “this book is not likely to be used in the practice of therapeutic medicine”); DAKE, *supra* note 120, at 2 (“Failing to acknowledge that the Guides are used exclusively for litigation purposes, represents a fundamental intellectual dishonesty.”).

134. STONE, *supra* note 101, at 111–12.

135. AMA GUIDES, 6th ed., *supra* note 73, at 20 (stating that “the primary purpose of the *Guides* is to rate impairment to assist adjudicators and others in determining the financial compensation to be awarded to individuals who, as a result of injury or illness, have suffered measurable physical and/or psychological loss”). See LOVAN, *supra* note 79 (noting the Sixth Edition changes position on the *AMA Guides*' use).

136. AMA GUIDES, 6th ed., *supra* note 73, at 20.

137. See *id.* at 6 (stating that “The *Guides* is not intended to be used for direct estimates of work participation restrictions” and that impairment rating “must be further integrated with contextual information”).

138. See DAKE, *supra* note 120, at 2–3 (noting that *AMA Guides*' editors and authors speaking to Iowa's task force studying the Sixth Edition “always made certain to specify they were not speaking for the AMA”).

a company focused on the *AMA Guides*: Impairment Resources, LLC.¹³⁹ His business charges high prices for copies of the *AMA Guides* and also for a product line of interpretive materials and trainings likely to be necessary for meaningful use of the Sixth Edition's dauntingly complex and error-prone rating system.¹⁴⁰ Although the *AMA Guides* are incorporated as public law in most states, the cost of these interpretive materials lies well outside the reach of most unrepresented injured workers and most legal professionals, scholars, and physicians who do not specialize in workers' compensation.¹⁴¹

Further, Brigham's Impairment Resources company combines its economic interest in producing and interpreting the *AMA Guides* with an overriding business and political interest in reducing workers' compensation benefit costs for insurers and employers.¹⁴² The company's self-description states:

Impairment Resources, LLC (formerly Brigham & Associates) provides you with unique, proven strategies that drive accurate impairment ratings and result in a superb return on investment. Statistics demonstrate that most impairment ratings are erroneously inflated and cost insurers and employers nationally billions of dollars. Before the development of the suite of services offered by Impairment Resources, LLC, adjusters,

139. Impairment Resources, Profiles, <http://www.impairment.com/profiles.htm> (last visited July 10, 2010).

140. Impairment Resources, Products, <http://www.impairment.com/products.htm> (last visited July 10, 2010).

141. See KUHNLEIN, *supra* note 112, at 8 (reporting that physicians should expect to spend twenty-five to thirty hours of self-study and eight hours of training to learn the Sixth Edition, and that tracking the errata alone took one doctor 3.5 hours); Marlon D. Mormann, IOWA DIV. OF WORKER'S COMP., THE AMA GUIDES SIXTH EDITION TASK FORCE MEMBER REPORT (2008) (discussing the costly impact of the Sixth Edition's complexity on physicians, claimants, attorneys, and administrators); LOVAN, *supra* note 79, at 6–7 (reporting testimony from medical experts that fewer physicians would be willing to perform impairment ratings under the Sixth Edition due to its increased complexity).

142. See KUHNLEIN, *supra* note 112, at 11–12 (noting that Dr. Brigham denied his defense-side business orientation in discussions with the Iowa task force but that these ties are clearly evident from his publications and from his company's web site); see, e.g., DVD: Christopher R. Brigham et al., Symptom Magnification, Deception, and Malingering: Identification through Distraction, Tests and Other Techniques (SEAK, Inc. 2000) (focusing on methods for challenging workers' injury claims).

physicians and attorneys had limited tools available to cost effectively analyze and resolve such inaccuracies.¹⁴³

Aside from the *AMA Guides'* socioeconomic purposes, an important effect of its slippery construction of objective "impairment" distinct from subjective disability is to undermine the political and legal legitimacy of many individual claims for permanent work disability. By presenting a highly technical and seemingly scientific numerical rating of biological status, the *AMA Guides'* ratings serve to skew disability determinations even if those determinations supplement the ratings with socioeconomic evidence. The thing most understandable about "impairment" is that it is supposed to be "more objective" than claims of work disability. The *AMA Guides'* impairment ratings mainly function to prove that work disability is a suspect status produced by subjective attitudes and behavior that must be sharply limited and only grudgingly rewarded.

B. Discovering Impairment and Covering Disability

This shift to impairment status in workers' compensation echoes the "covering" requirement that Yoshino describes in the context of sexual orientation. Consider the example of Gary Brummett, a construction worker without a high school diploma, who suffered a permanent back injury on the job in Kentucky, after that state adopted an impairment rating system in the 1990s.¹⁴⁴ Before his injury, he earned \$35,000 a year and owned a three bedroom home.¹⁴⁵ Under the prior wage-loss system, his employer would have been responsible for assuming or mitigating the risk that Brummett's back injury would be more costly than a similar injury for someone not dependent on back strength for his or her income. Under that previous system, Brummett could have received a \$73,000 lump sum award, giving him a chance at moving to another middle-class career

143. Impairment Resources, About Us, http://www.impairment.com/about_us.htm (last visited July 10, 2010).

144. James N. Ellenberger, *The Battle over Workers' Compensation*, in 10 *NEW SOLUTIONS: A JOURNAL OF ENVIRONMENTAL AND OCCUPATIONAL HEALTH POLICY* 217, 217–36 (2000) (discussing and criticizing the change from wage loss to impairment ratings for determining permanent partial benefits).

145. *Id.* at 217.

(e.g., by funding advanced education or the development of a small business).¹⁴⁶ Instead, Brummett received only \$7,400, because the *AMA Guides* ranked his medical impairment as minimal, despite his severe socioeconomic loss.¹⁴⁷ This system forces injured workers like Brummett to bear the high injury costs that might have been avoided had they chosen a different career, in a different location, with a different level of education. With this low award, Brummett's employer not only does not have to compensate the actual wage loss, but also has reduced incentives to mitigate such losses (for example by improving safety or by providing workplace accommodations that would allow reemployment after injury).

Like the gay man required to cover for the mutable, cultural aspects of his identity—to bear the costs of acting straight—the injured worker is required to cover for the mutable, cultural aspects of his or her identity, despite the cost. In this case, Brummett mitigated or “accommodated” his wage loss by ruining his credit, losing his house, and subsisting on a minimum wage job delivering pizza. In short, workers like Brummett deserve protection for their incapacitated status, but that status is reduced to a fixed core impairment, requiring them to cover for supposedly peripheral behavioral contingencies and choices.

In the case of disability, “covering” paradoxically ends up serving to “uncover” at the same time, tightening the double bind of substantive equality. For the injured worker, the requirement of covering—mitigating non-essential constraints—ironically works to reinforce the covered person's status as different and incapable of rational choice. The mitigation that most seriously injured workers in manual jobs are able to achieve without more economic support involves taking low-paying work, giving up financial security, depending on non-work income from relatives and taxpayers, or all of the above. This “covering” requirement then means many workers with serious, permanent disabilities from work must accept the loss of their status as middle-class workers, or even as financially independent workers. That result, of course, is precisely the longstanding status problem that the workers' compensation and

146. *Id.* at 218.

147. *See id.*

disability rights movements arguably aimed to correct. Those movements challenged the view that disability normally and naturally leads to socioeconomic subordination, and instead argued that law reforms could create the conditions for greater social and economic capacity.¹⁴⁸

III. LIMITING DISABILITY DISCRIMINATION THROUGH SOCIAL CONSTRUCTION

As many scholars have analyzed extensively, judicial narrowing of the definition of “disability” has stymied the ADA’s push toward substantive equality.¹⁴⁹ In particular, critics focused on four Supreme Court cases that tightened the threshold requirement of who counts as a person with a disability protected under the ADA.¹⁵⁰ Responding to efforts to restore that substantive promise, Congress redefined “disability” in the ADA Amendments Act of 2008 (“ADAAA”), which took effect at the beginning of 2009.¹⁵¹ The ADAAA directly rejects the Court’s social constructivist narrowing of disability, but also takes steps to resist a medical impairment model of disability. In doing so, the ADAAA suggests some avenues for moving beyond the biological/social divide toward a more meaningful substantive vision of disability and equality.

148. For a theory of law focused on enhancing human capacity, see MARTHA C. NUSSBAUM, *FRONTIERS OF JUSTICE: DISABILITY, NATIONALITY, SPECIES MEMBERSHIP* (2006).

149. See, e.g., Ruth Colker, *Winning and Losing Under the Americans with Disabilities Act*, 62 OHIO ST. L.J. 239, 247–57 (2001) (finding evidence that outcomes for plaintiffs under the ADA are worse than outcomes for plaintiffs under other civil rights statutes); Diller, *supra* note 46, at 47–48; Chai R. Feldblum, *Definition of Disability under Federal Anti-Discrimination Law: What Happened? Why? And What Can We Do about It?*, 21 BERKELEY J. EMP. & LAB. L. 91, 100 (2000); Bonnie Poitras Tucker, *The Supreme Court’s Definition of Disability under the ADA: A Return to the Dark Ages*, 52 ALA. L. REV. 321, 321, 370–74 (2000) (criticizing the 1999 Supreme Court rulings restricting the definition of disability); Linda Hamilton Krieger, *Foreword: Backlash against the ADA: Interdisciplinary Perspectives and Implications for Social Justice Strategies*, 21 BERKELEY J. EMP. & LAB. L. 1, 7–8 (2000) (summarizing scholarship criticizing the narrow judicial interpretation of the ADA).

150. See *Albertson’s, Inc. v. Kirkingburg*, 527 U.S. 555 (1999); *Murphy v. United Parcel Serv., Inc.*, 527 U.S. 516 (1999); *Sutton v. United Air Lines, Inc.*, 527 U.S. 471 (1999) *Toyota Motor Mfg., Ky., Inc. v. Williams*, 534 U.S. 686 (2002).

151. ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553.

A. Protecting Social Functioning, Not Impairment Status

Relying on the impairment versus disability distinction, the original and amended versions of the ADA define disability as a “physical impairment that substantially limits one or more . . . major life activities,” “a record” of such an impairment, or as “being regarded as having” such an impairment.¹⁵² This definition suggests the core physiological condition as the primary cause of disadvantage (whether real or perceived), with the incapacity for social functioning as a contingent effect.

In three cases decided in 1999, the Court ruled that the plaintiffs were not persons with disabilities protected by the ADA because they were able to take adaptive steps to mitigate the limiting effects of their physical conditions.¹⁵³ By denying that the plaintiffs’ physical limitations satisfied the threshold requirement of a “disability,” the Court did not reach the substantive questions of whether the detrimental employment action was due to unlawful disability discrimination or instead to the plaintiffs’ failure to satisfy legitimate job qualifications with or without reasonable accommodations. In *Sutton v. United Air Lines*, for example, the Court denied disability status to two airline pilots who had visual impairments correctable by eyeglasses;¹⁵⁴ in *Murphy v. United Parcel Service*, the Court denied disability status to a mechanic with high blood pressure controlled by medication;¹⁵⁵ and in *Albertsons, Inc. v. Kirkingburg*, the Court denied disability status to a truck driver with monocular vision who could make subconscious cognitive adjustments to compensate for his visual condition.¹⁵⁶ In *Sutton*, Justice O’Connor explained it would be too hypothetical and speculative to determine disability based on medical status alone, without looking at the workers’ actual behavior and social context,¹⁵⁷ even though the real problem in the case was that the employer did exactly that in deciding the pilots were unqualified for the job.

152. 42 U.S.C. § 12102(1)(A)-(C) (Supp. 2009).

153. *Albertson’s, Inc.*, 527 U.S. 555; *Murphy*, 527 U.S. 516; *Sutton*, 527 U.S. 471.

154. *Sutton*, 527 U.S. at 475.

155. *Murphy*, 527 U.S. at 518.

156. *Albertsons, Inc.*, 527 U.S. at 558–59, 565–66.

157. *Sutton*, 527 U.S. at 483.

In contrast to workers' compensation, the Court looked for real disability by focusing on contingent social functioning instead of underlying physical status. Ironically, these ADA decisions use social constructivism to reinforce rather than to resist the medical model's idea that the "real" harm triggering protection against inequality comes from an essential individual biological impairment, real or perceived. The Court seems to assume that once an employee's contingent actions have mitigated the (real or perceived) functional impact of the core biological harm, no harm remains for protection from discrimination.

In *Sutton*, that understanding of social overlay on a biological core explained the Court's medicalized approach to defining disability under the alternative "regarded as" prong of the ADA's threshold requirement for establishing protected status as disabled. Commentators had long assumed the "regarded as" option was designed precisely for the problem raised by these cases—that discrimination may include stereotypical social perceptions of disability status not based on the person's specific functional abilities.¹⁵⁸ Nonetheless, *Sutton* held that the airline pilots with correctable impaired vision failed that alternative test for disability.¹⁵⁹ The vision-impaired pilots were not "regarded as" having impairments that substantially limited major life activities because there was no evidence that the employer perceived their impaired vision limited them from doing anything more than the particular job at issue.¹⁶⁰ The Court assumed that there was not even any *perceived* harm left to protect when an employer's contingent perceptions of the worker's biological status do not proceed to attribute sufficiently substantial and broad functional harm to that biological condition.¹⁶¹

In these cases, the Court uses the division between social function and biological essence to erode *formal* equal treatment protection as well as substantive equality. The Court's analysis reveals how that division undermines the two equality scales it appears to support.

158. See Feldblum, *supra* note 149, at 157-59.

159. *Sutton*, 527 U.S. at 488-89.

160. *Id.* at 489-93.

161. See Jill C. Anderson, *Just Semantics: The Lost Readings of the Americans with Disabilities Act*, 117 YALE L.J. 992 (2008) (using linguistic analysis to explain and critique *Sutton*'s interpretation of the "regarded as" prong).

This framework creates a bind in which the more a person successfully acts to satisfy functional requirements for a job *despite* a potentially disabling physiological condition, the less protection they have against harmful treatment based solely on prejudiced views about the functional impact of their biological condition. Because the Court reduces disability's *essence* to real or perceived individual functional limitations, it deems irrelevant any unequal treatment directed at socially imposed disability *status* rather than on individual functional limits (whether biological or social). As Jill Anderson argues, that misguided logic could lead to the result that the law fails to protect what might appear to be the penultimate instance of disability discrimination: an employer who simply refuses to hire anyone identified as disabled, regardless of specific function or condition, real or perceived.¹⁶²

In the 2002 case of *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*, the Court further narrowed the threshold definition of protected disability status.¹⁶³ *Toyota* extended the individual contingencies that cancel disability status to include not just adaptive equipment, medical treatment, or enhanced functional abilities, but also the "choice" of an occupation requiring work-specific functional capacity. In *Toyota*, the Court again ruled that medical status was not a sufficient basis for disability because of the potential for individuals to eliminate the difference or limitation constituting that status by compensating for their medical conditions.¹⁶⁴ The Court decided that an assembly line worker with carpal tunnel syndrome was not disabled within the meaning of the ADA, even if her medical condition actually limited her physical ability to do her job.¹⁶⁵ The Court established that an inability to perform manual tasks associated with a specific job not common to most people, as opposed to ordinary personal or household tasks, is not a substantial limit on a major life activity.¹⁶⁶ Again writing for the Court, Justice O'Connor reasoned that the manual tasks of an assembly line job are not of

162. *See id.* at 1061–63 (explaining the intent of the ADA to cover discrimination per se or discrimination by proxy).

163. *Toyota Motor Mfg., Ky., Inc. v. Williams*, 534 U.S. 184, 198 (2002).

164. *See id.*

165. *Id.* at 187–88.

166. *Id.* at 200–02.

central importance to most people's daily lives, unlike bathing, eating, or brushing one's teeth.¹⁶⁷ The implicit logic of the decision is that the injured worker in the case had the obligation to mitigate the functional limitations of her medical condition by withdrawing from her assembly line job and sticking to the limited gardening and housework she could still perform.¹⁶⁸

With this decision, the Court's social constructivist reasoning comes full circle to tighten the bind against substantive equality as well as narrowing formal equality. Strong evidence that a physiological condition *really does* substantively constrain a person's functional capacity at work does not help to establish that she is potentially deserving of substantive accommodation, or even that she has a real disability deserving of at least minimal formal protection against bare prejudice. The Court assumed that the fact of real functional disadvantage demonstrates that the problem is the injured person's attempted functioning (i.e., trying to retain her assembly line job) rather than her physiological status. Although this logic could be extended to completely eviscerate employment discrimination protections—one can never be essentially disabled for purposes of employment, because work is always a contingent behavior—the Court does allow broad non-work functional incapacity to constitute proof of disability status worthy of workplace protection. If the central harm of inequality is assumed to be real or imagined relevant individual biological failure, both formal and substantive equality will always seem suspect to the degree the individual's functioning is mediated through his or her contingent social action outside the context of disability.¹⁶⁹

B. Discovering Conduct, Covering Impairment Status

For disability, as with sexual orientation, the threshold step of formal recognition of protected status blurs into substantive

167. *Id.* at 201–02.

168. *See id.* at 202 (noting that evidence suggested that after her condition worsened the plaintiff could still “tend her flower garden, fix breakfast, do laundry, and pick up around the house”).

169. *See* YOSHINO, *supra* note 59 and accompanying text; Kessler, *supra* note 50 and accompanying text.

judgments about the merits of affirmatively accommodating that status. Formal recognition of identity itself will seem like undeserved affirmative special accommodation for particularly problematic behavior or ideas if we start from a presumption that an identity category (such as sexual orientation or disability) is a sign of failed individual functioning that can be legitimately penalized or pitied. That is, if the disadvantages of disability are presumed to largely result from relevant individual failures rather than social prejudice or structural injustice, then the protected status as disabled will tend to seem more suspect than employers' harmful treatment.

As with the paradigm of forced heterosexual assimilation that Yoshino criticizes, the Court's social constructionist approach to disability assumes the disadvantaged individual should be expected to "cover" for her or his real or perceived loss of functioning. In *Toyota*, the Court's doubts about the reasonableness of the plaintiff's disability claim may have reflected its deeper doubts about the reasonableness of her decision to seek accommodations for her work-related disability when she could instead "cover" that functional loss by quietly withdrawing to the more "normal" work of tending to her garden and kitchen.¹⁷⁰ Applying Yoshino's schema of forced assimilation in sexual orientation law,¹⁷¹ the Court's reasoning seems consistent with a problematic judgment that if medical treatment and enlightened attitude cannot "convert" an assembly line worker with carpal tunnel injuries to pain-free hand movement, then at least she should not "flaunt" her condition by demanding that her employer affirmatively recognize and respond to her disability as normal and deserving of structural change.

For both the ADA and workers' compensation, this implicit "covering" requirement reflects an assimilationist judgment that workers deserve protection against the disadvantages of disability only to the extent workers comport with workplace norms that normally and naturally disadvantage persons with disabilities. By making elusive "real" biological constraint the basis for both threshold formal status and for substantive protection, the Court's

170. See *supra* notes 163–68 and accompanying text.

171. See YOSHINO, *supra* note 59 and accompanying text.

social constructivist approach to the ADA does the same work as the biological impairment under workers' compensation.

*C. ADAAA: Restoring Medical Impairment or Resisting
Social/Biological Division?*

The ADAAA directly overrules social constructivist interpretations by explicitly prohibiting consideration of mitigating measures in determining whether a person satisfies the definition of disability.¹⁷² What matters for the threshold determination of disability status is the presumed underlying biological condition, without considering how the presumed effect of that condition on social functioning might be lessened by the use of assistive devices, medical treatment or services, compensating behavior or functional capacities.¹⁷³ In part, this definition seems to focus protection on a fixed biological condition measured in terms of apparently unmediated functional impact. The ADAAA pushes back against the Court's social constructivist reasoning by clarifying the functional impact that defines impairment: the major life activities counting as normal functioning include not just socially relevant behaviors such as working, dressing, talking, and walking, but also physiological processes like normal cell growth, immunity, and reproduction.¹⁷⁴ In addition, it clarifies that an impairment that is episodic or in remission qualifies as a protected disability if it would substantially limit a major life activity when active, again recognizing an underlying biological status even when that status is not fixed.¹⁷⁵

Nonetheless, the ADAAA to some extent resists the medical model of disability by partly displacing individual biology as the core constraint subject to protection against discrimination. The ADAAA

172. 42 U.S.C. § 12102(4)(E)(i) (Supp. 2009); *see also* ADA Amendments Acts of 2008, Pub. L. No. 110-325, 122 Stat. 3553, 3556 (specifying the amendments' purpose of overturning the Supreme Court's rulings); Chai R. Feldblum et al., *The ADA Amendments Act of 2008*, 13 TEX. J. C.L. & C.R. 187, 204 (2008) (explaining the concerns and efforts leading to this statutory reversal of the decisions narrowing the definition of disability).

173. 42 U.S.C. § 12102(4)(E)(i). The ADAAA specifies one exception for the use of "ordinary eyeglasses or contact lenses," so that a normal eyeglass-wearer is deemed to have normal functioning rather than identity as disabled. *Id.* § 12102(4)(E)(ii).

174. *Id.* § 12102(2)(A)-(B).

175. *Id.* § 12102(4)(D).

overrides the Court's cramped approach to the "regarded as" prong of the disability definition. It provides, somewhat awkwardly, that the "regarded as" definitional prong is satisfied by a showing that an actual impairment is perceived without the need to further show that this impairment is regarded as substantially limiting a major life activity.¹⁷⁶ This clarification recognizes that the harm of false or irrational perceptions of disability can be about problematic externally imposed social status, not just mistaken ideas about specific individual functional failures.

The Act also specifically restricts employment criteria based on uncorrected vision,¹⁷⁷ thereby taking a step toward changing the focus of social construction of disability status from the question of whether a biologically impaired individual can nonetheless act normal to the question of whether facially neutral and normal social policies and structures can nonetheless be dysfunctional. Finally, the ADAAA prohibits discrimination against "a qualified individual *on the basis of* disability,"¹⁷⁸ replacing the prior prohibition on discriminating against "a qualified individual with a disability *because of* the disability of such individual."¹⁷⁹ This change displaces the individual's status as the essential source of the problematic treatment and more directly emphasizes that such a status can be the contingent result of external imposition of unjust limitations. More generally, the ADAAA affirms Congress's intent to shift the focus of the law from deciding who is "really" disabled to deciding whether discrimination on the basis of disability has occurred.¹⁸⁰

Nonetheless, the ADAAA partly continues to focus on sorting biological from social status. It explicitly removes any substantive accommodation requirement for those plaintiffs who rest their disability status on social construction under the "regarded as" prong, rather than on proof of sufficient actual functional limitation.¹⁸¹ This change risks entrenching the bifurcation of disability into formal and substantive equality tracks in a way that undermines both. In the

176. *Id.* § 12102(3)(A).

177. *Id.* § 12113(c).

178. *Id.* § 12112(a) (emphasis added).

179. ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553, 3557.

180. *See id.* at 3553-54.

181. *Id.* at 3557-58.

implicit logic of this change, if the disadvantage at issue involves social status rather than a real functional limitation, then no “substantive” social change is necessary to alleviate that disadvantage. In this narrow view, without a “real” biological limitation relevant to social functioning, equality need only ensure that the person perceived as disabled is treated the same as those not so perceived. However, as critical theory has shown outside the context of disability, the line dividing formal equality from substantive accommodation is slippery and subjective, so that efforts to require neutral treatment will often seem like demands for undeserved special accommodation.

For example, prior to the ADAAA, the Eleventh Circuit ruled that the ADA could require an employer to make reasonable accommodations for a plaintiff who could only establish her status as disabled under the “regarded as” prong of the Act’s disability definition.¹⁸² The plaintiff had successfully performed her job as a product transporter in a fish factory despite suffering from vertigo.¹⁸³ The court decided she did not establish an actual disability within the meaning of the statute because of a lack of evidence of any impairment other than her ability to stare continuously at moving objects.¹⁸⁴ Nonetheless, the court agreed that her lack of “real” disability status did not bar her claim for a workplace accommodation after a new supervisor modified her job to include conveyor belt work, which she argued was not essential to her position as product transporter.¹⁸⁵ The court’s decision recognizes that employment policies appearing neutral on their face and as applied—such as the decision to restructure factory work duties—might sometimes be imposed without substantial legitimate reason, thereby rendering a person disabled who might not otherwise be.¹⁸⁶ For example, the new supervisor may have imposed the conveyor belt duties over the fish

182. *D’Angelo v. ConAgra Foods, Inc.*, 422 F.3d 1220, 1235 (11th Cir. 2005).

183. *Id.* at 1222.

184. *Id.* at 1226–27, 1234.

185. *Id.* at 1234–39.

186. The court supported its reasoning by referring to a Supreme Court ruling requiring consideration of reasonable accommodations for a teacher who satisfied only the “regarded as” definitional prong of section 504 of the Rehabilitation Act, on which the ADA was modeled. *Id.* at 1236.

factory worker's objections, not out of real evidence of (or concern for) any impact on factory productivity, but simply because of irrational fear, disgust, or callous indifference toward the plaintiff based on her perceived bodily weakness or abnormality.

Under the ADAAA, the "regarded as" status could preclude judicial scrutiny of such job policies and structures, so that, ironically, workers' lack of *real* disability would in some cases mean their employment disadvantages are attributed to *real* individual biological impairment rather than social stereotypes. Disability rights advocates argue that the expanded definition of *actual* disability means many such plaintiffs nonetheless will have a right to reasonable accommodation on the ground that they have sufficiently substantial *real* physiological impairments.¹⁸⁷ For example, because episodic impairments are included under the actual disability prong, and because bodily functions are included as major life activities, a plaintiff's vertigo could reasonably be deemed a "real" rather than perceived disability.¹⁸⁸ But this means the amendments will partly work to reinforce emphasis on the individual person's "real" functional failure rather than on workplace bias.

In addition, some biological conditions—like facial scars—may arguably have no impact on "real" bodily functioning but may be particularly susceptible to harmful prejudice.¹⁸⁹ Although the expanded "regarded as" prong will extend coverage to those whose disability is more clearly a perceived status than a real function, without the "reasonable accommodation" requirement, the substantive protection provided is less clear. A retail store policy requiring employees to have straight teeth and unscarred skin might readily be understood as discrimination based on perceived disability rather than on "real" and relevant job qualifications. As Christine Joll has discussed, these cases most obviously blur the purported line between formal and substantive equality, because changing such policies may have substantive costs for employers in a society where stereotypes of disability are pervasive (such as customers' judgments

187. Feldman et al., *supra* note 172, at 237–38 & n.184.

188. *See id.* at 238.

189. *See* Anderson, *supra* note 161, at 1044 (providing an alternative reading of perceived impairment).

linking the value of retail products to salesclerks' ability to embody a "normal" or even "perfect" appearance). That blurry, and ultimately incoherent, line between "formal" bans on discrimination and substantive accommodation creates some risk that courts may treat challenges to such overtly prejudicial status-based policies as requests for affirmative accommodation outside the bounds of the amended law's "regarded as" prong.¹⁹⁰ To clearly reach these egregious examples of unequal treatment—based purely on status regardless of physiological function—we need to move equality beyond the division between "real" biological difference and contingent social overlay.

IV. MAKING SUBSTANTIVE SOCIAL CHANGE NORMATIVE

The medical model of disability powerfully impedes efforts to challenge pervasive substantive injustice by ascribing functional disadvantages primarily to real and relevant individual deficient status. Yet as *Plessy* demonstrated in the context of race, the move to a social constructivist model can reinforce that barrier by making status-based harm seem insubstantial—a contingent choice or subjective attitude.¹⁹¹ Unless disadvantaged individuals face perfectly determinate biological constraints, placing the burden of change on the disadvantaged individual will tend to seem substantively easier and less costly than changing the external social environment (except when the social harm is also highly individualized in the form of isolated intentional bad actions).

Adam Samaha argues that the shift from a medical to a social model of disability's *causes* does not, in itself, justify a shift in the public policy *response* to disability.¹⁹² He argues that stronger legal protections require further analysis of moral principles explaining why socially caused harm to people with disabilities should lead to societal duties to correct that harm.¹⁹³ This Article suggests a more fundamental intellectual problem with the focus on disability's

190. See Bagenstos, *supra* note 46.

191. See Bagenstos, *supra* note 46, at 452–54.

192. See Samaha, *supra* note 3, at 1253.

193. *Id.* at 1284–85.

causation. Equality is hindered not so much by the lack of principled support for social change. The greater barrier is the prevailing assumption that the question of changing the status quo does not deserve serious intellectual or legal scrutiny. For disability and other disadvantaged identities, rigorous inquiry into the merits of substantive social change tends to be undermined by stereotypes, animus, indifference, or self-interest on the part of those who benefit from the status quo. The questions and presumptions that frame the moral debate about social change are as important as the moral principles applied within the debate.

The social model of disability provides a vital step in opening the door to more serious analysis of social change by helping us imagine that perhaps things *could* be substantively different, and dramatically so. The harms of the status quo might be neither fully determined by individual nature nor a fully random and neutral fact of life undeserving of our attention, debate, and action.¹⁹⁴ Nonetheless, the social model can block consideration of social change when presented as a supplement to a biological model within an overarching framework designed to sort “real” from “contingent” status. In the context of disability, that division between social functioning and biological status has helped foreclose a rigorous substantive debate about “who should change” by leading us into a rationally dubious debate about “who is really disabled.”

If we start instead with the presumption that individual biological and social identity and functioning are thoroughly entangled and inseparable, we might better evaluate the merits of social change in the context of disability and beyond. Formal equality should prohibit not just differentiation based on socially *irrelevant* biological appearances but also differentiation that is highly relevant to *illegitimate* substantive social goals, such as the bare desire to harm.¹⁹⁵ By collapsing wrongful discrimination into the problem of patently purposeless attention to biological form, the conventional

194. See Robert W. Gordon, *Some Critical Theories of Law and Their Critics*, in *THE POLITICS OF LAW: A PROGRESSIVE CRITIQUE* 641, 657 (David Kairys ed., 3d ed. 1998) (explaining the value of critical theory in general as imagining that things could be better).

195. Bagenstos, *supra* note 30, at 848–70 (explaining that prohibitions on “rational” discrimination are central to antidiscrimination law).

formal equality scale narrows our view of antidiscrimination to blindness toward individual identity, blocking our attention to structural change.

When we reorient the antidiscrimination principle away from a fundamental separation between biological status and social functioning, disability is not so clearly relegated to the bottom of the formal equality scale. If the question is not which physical differences are socially irrelevant, but which socially interpreted physical differences are relevant to *legitimate* substantive social functions, then the “real” functional differences of disability can be just as susceptible to prejudicial differentiation as the illusory functional differences of racial identity. A stairs-only entrance to a recently renovated courthouse could be as much a problem of formal unequal treatment as a whites-only sign on that same entrance. For example, that design could be due to the illegitimate assumption that wheelchair users are not normal courthouse users, or to the biased assumption that facilitating wheelchair users’ normal, visible entrance would threaten a traditional appearance of dignity and order.

Further, rejecting the biological versus social division would help undermine the presumption that protected disability status should be presumptively and naturally limited to those with real or perceived impairments. If biological and social status are intertwined, then a direct social identity as disabled—just like a socially imposed identity as nonwhite—can be the object of illegitimate differentiation even when the substantive biological content of that identity is unarticulated or ambiguous.

Finally, an integrated social and biological view of antidiscrimination could help bolster the formal equality scale itself, not just raise disability’s position on that scale. As Robert Hayman and Nancy Levit have astutely analyzed, the assumption of a biological essence separable from social functioning limits the theory and doctrine of race discrimination.¹⁹⁶ Although the conventional equality framework presumes that racial differentiation reflects suspect social construction, it positions this social construction as an

196. Robert L. Hayman, Jr. & Nancy Levit, *Un-Natural Things: Constructions of Race, Gender, and Disability*, in *CROSSROADS, DIRECTIONS, AND A NEW CRITICAL RACE THEORY* 159, 177–81 (Francisco Valdes et al. eds., 2002).

overlay on a “real” physical essence. This biological/social division helps narrow formal racial equality to colorblindness by making it seem that the harm of racism disappears once we turn our gaze from irrelevant physical differences like “color” toward relevant social functioning. If we instead position “real” racial identity as social as well as biological, then it is easier to see that the “race” classifications deserving scrutiny for prejudice should be expanded to include facially neutral functional criteria with racially disparate impact.¹⁹⁷ This is not because racially disparate functioning has any biological basis. Rather, if race is understood as a *social* category tied to but not solely determined by physiological features, problematic racial discrimination can operate through ideas about social functioning that do not explicitly or consistently reference particular biological features.

Substantive equality can also be strengthened by rejecting the biological/social frame. In the conventional view, substantive disadvantage tends to collapse into constraints on individual agency. The medical model emphasizes biological limits, while the social model emphasizes the social limits preventing individuals from succeeding despite biological limitations. This means both sides tend to skew the debate toward the question of individuals’ limits rather than toward the question of the merits of social change. Both sides of this divide risk reinforcing the premise that individual physiological weaknesses are abnormal individual failures, and that individuals who cannot overcome those failures are abnormally dependent on social or legal assistance. Moreover, both sides of the divide focus on excusing individuals of responsibility for their disadvantages in order to defend shifting to others the burden of alleviating those disadvantages (through compensation or accommodation). By doing so, both approaches risk reinforcing the presumption that social change alleviating those disadvantages will be burdensome rather than beneficial.

Martha Fineman’s theory of substantive equality as support for widely shared vulnerability provides an alternative to both sides of

197. See Owen M. Fiss, *A Theory of Fair Employment Laws*, 38 U. CHI. L. REV. 235, 299 (1971) (explaining that protection against facially neutral criteria with disparate racial impact reflects the fact that such criteria are often the functional equivalent of race).

this divide.¹⁹⁸ Following her model, we need not sort biological from social harm or essential from contingent incapacity in order to justify social support for alleviating the harm of vulnerability.¹⁹⁹ Instead, Fineman suggests a vision where the question of who should change begins from the assumption that vulnerable persons are normal and valued members of society.²⁰⁰ Fineman analyzes the ideal of individual autonomy as a myth used to penalize societal support for some people's limitations and needs while privileging support for others.²⁰¹ By replacing this myth with the premise of human vulnerability, we can better recognize affirmative public support for physical and social disadvantage as pervasive and fundamental to overall societal well-being, not an exceptional response to those whose incapacity is essentially biological or essentially social.²⁰²

Applying this vulnerability theory to disability rights, Ani Satz explains how a civil rights analysis of disability blends into questions of social welfare policy.²⁰³ Consistent with that view, this Article's comparison between workers' compensation and the ADA shows how neither equality rights nor social welfare goals will provide strong support for substantive social change without challenging the premises underlying both.

The focus of substantive support must shift away from defining social change as costly "redistribution" or "accommodation" and then limiting those costs by narrowing the definition of "real" vulnerability. Instead, meaningful equality and social justice requires more careful evaluation of the costs and benefits of substantive support for those whose identities as "different" or "impaired" have

198. Martha Albertson Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 YALE J.L. & FEMINISM 1 (2008).

199. *See id.* at 8–9 (discussing vulnerability as a recognition of socially mediated universal embodiment focusing on shared potential for dependency rather than distinguishing dependent from independent persons).

200. *See id.* at 10–15.

201. *Id.* at 19; *see also* MARTHA ALBERTSON FINEMAN, *THE AUTONOMY MYTH: A THEORY OF DEPENDENCY* 49–52 (2004).

202. *See id.* at 20–22 (advocating an approach to equality premised on the state obligation to respond to vulnerabilities with equal regard and provide individuals meaningful opportunities to develop their assets in the face of inevitable human vulnerability).

203. Satz explores an approach blending social welfare and antidiscrimination. Ani B. Satz, *Disability, Vulnerability, and the Limits of Antidiscrimination*, 83 WASH. L. REV. 513, 550–66 (2008).

elicited systematic social prejudice and exclusion. The presumption that modifying buses to provide wheelchair access involves “abnormal” substantive costs depends on an unexamined baseline decision that fails to count the costs of first deciding to build an inaccessible bus or the costs of providing seats compared to wheelchair securement devices.²⁰⁴ Similarly, compensating injured workers for actual work loss may seem less costly than compensating “impairment” if we consider that higher compensation could increase incentives for increasing long-term savings through greater safety or workplace accommodations for injured workers. Elizabeth Emens shows how prevailing approaches to the ADA fail to sufficiently consider how reasonable accommodations often bring a range of substantial social benefits to others.²⁰⁵ These benefits go beyond the particular person defined as disabled to include, for instance, improved working conditions for presumably nondisabled or differently disabled coworkers, enhanced productivity to employers from reduced job turnover or from technological innovation, and reduced irrational social stigma and stereotyping of disability.²⁰⁶ The idea of universal design goes further than the concept of “accommodation” to shift the focus to how the social environment can be constructed to better respond to a broad range of particular human capacities and incapacities, for the benefit of all.²⁰⁷

Neither the ADA’s shift to civil rights nor a return to social welfare will open the question of substantive social change to serious normative debate without moving beyond a biological/social inquiry. For both equality and social welfare policy, the analysis should move away from scrutinizing individuals for failure, whether biological or social, or whether identified as low functioning or low status. Instead, the emphasis should be on more seriously considering the benefits of

204. See Bagenstos, *supra* note 30, at 868–69 (explaining that changing the time frame of analysis reveals many of the apparently “real” costs of substantive change are instead the product of biased attitudes); McCluskey, *supra* note 5, at 880 & n.119 (noting a case where calculations of cost were scrutinized for social bias and the court found that providing wheelchair access to city buses was *not* more costly than constructing inaccessible buses).

205. Elizabeth F. Emens, *Integrating Accommodations*, 156 U. PENN. L. REV. 839, 845–48 (2008).

206. See *id.* at 846–58 (summarizing types of “second party” and “third party” benefits).

207. Satz, *supra* note 203, at 542.

restructuring social institutions to better alleviate both physiological and social disadvantages for more people.