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“CORRECTIVE” SURGERY
AND THE AMERICANS WITH DISABILITIES ACT

*Jeannette Cox**

Imagine a potential Americans with Disabilities Act plaintiff named Sarah. Sarah is a deaf individual who declines to describe herself as “disabled,” preferring instead a framework that regards deaf individuals as comprising a cultural minority for which American Sign Language is the primary language.¹ She has forgone cochlear implant surgery, a procedure that might enable her to process sound, because she regards deafness not as a disease that needs a cure but as just one among many forms of physical variation that naturally occur in the human population.² However, despite Sarah’s conception of herself as a person without a disability, Sarah encounters an employer who denies her a job for which she is fully qualified based on his discomfort with Sarah’s difference, his unwillingness to challenge his existing employees’ animus toward deaf persons, and his erroneous belief that Sarah’s deafness will limit her productivity.³

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¹ Disability Studies scholar Harlan Lane explains that:

From the vantage point of Deaf culture, deafness is not a disability. British Deaf leader Paddy Ladd put it this way: “We wish for the recognition of our right to exist as a linguistic minority group . . . Labeling us as disabled demonstrates a failure to understand that we are not disabled in any way within our own community.”

Harlan Lane, *Constructions of Deafness*, in *THE DISABILITY STUDIES READER* 153, 159 (Lennard J. Davis ed., 1997) (citation omitted). As Lane’s discussion indicates, Deaf culture scholarship often denotes “deafness” or “deaf” as a physical condition with a lower case “d,” and “Deafness” or “Deaf” in the cultural sense with an upper case “D.” See CAROL PADDEN & TOM HUMPHRIES, *DEAF IN AMERICA: VOICES FROM A CULTURE* 2 (1988).

² See J. William Evans, *Thoughts on the Psychosocial Implications of Cochlear Implantation in Children*, in *COCHLEAR IMPLANTS IN YOUNG DEAF CHILDREN* 307, 307 (Elmer Owens & Dorcas K. Kessler eds., 1989) (“In an informal survey (Evans, unpublished raw data), prelingually deafened adults were asked whether they would choose to have an implant if it were possible that some hearing could be restored. The response was approximately 85 percent negative.”).

³ See H.R. REP. NO. 101-485, pt. 2, at 71 (1990) (“Every government and private study on

If Sarah chooses to challenge the employer's decision under the Americans with Disabilities Act (ADA), the legal consequences of Sarah's choice to forego cochlear implant surgery are unclear.⁴ While some courts would conclude that Sarah clearly falls within the category of persons the ADA aims to protect from employment discrimination,⁵ other courts suggest that Sarah's decision not to employ medical technology to reduce the effects of her deafness may exclude her from the ADA's protected class.⁶ They appear to regard any discrimination Sarah may experience not as a wrong that the ADA should remedy, but as a consequence Sarah should avoid by undergoing corrective surgery.⁷ In effect, they regard Sarah's refusal to ascribe negative value to her deafness as precluding her from the ADA's protection from disability discrimination.

This split in opinion regarding whether refusing "corrective" surgery removes an individual from the ADA's protected class is ripe for

the issue has shown that employers disfavor hiring persons with disabilities because of stereotypes, discomfort, misconceptions, and unfounded fears about increased costs and decreased productivity."); *Bd. of Trs. of the Univ. of Ala. v. Garrett*, 531 U.S. 356, 374–75 (2001) (Kennedy, J., concurring) ("Prejudice, we are beginning to understand, rises not from malice or hostile animus alone. It may result as well from insensitivity caused by simple want of careful, rational reflection or from some instinctive mechanism to guard against people who appear to be different in some respects from ourselves. Quite apart from any historical documentation, knowledge of our own human instincts teaches that persons who find it difficult to perform routine functions by reason of some mental or physical impairment might at first seem unsettling to us, unless we are guided by the better angels of our nature. There can be little doubt, then, that persons with mental or physical impairments are confronted with prejudice which can stem from indifference or insecurity as well as from malicious ill will.").

⁴ *See Sever v. Henderson*, 381 F. Supp. 2d 405, 414–15 (M.D. Pa. 2005) (noting a circuit split on the question of whether the ADA affords discrimination protection to individuals who decline medical technology).

⁵ *See, e.g., Nawrot v. CPC Int'l*, 277 F.3d 896, 904 (7th Cir. 2002); *Finical v. Collections Unlimited, Inc.*, 65 F. Supp. 2d 1032, 1037–38 (D. Ariz. 1999).

⁶ *See, e.g., Mont-Ros v. City of W. Miami*, 111 F. Supp. 2d 1338, 1356–57 (S.D. Fla. 2000) (denying ADA protection because plaintiff's "sleep apnea condition is treatable and can be corrected"); *Pangalos v. Prudential Ins. Co. of Am.*, No. 96-0167, 1996 WL 612469, at *3 (E.D. Pa. Oct. 15, 1996) (suggesting that a person would not receive the ADA's protection if "the disabling condition he allege[d] could readily be remedied surgically"); *Roberts v. County of Fairfax, Va.*, 937 F. Supp. 541, 548 (E.D. Va. 1996) ("Roberts' refusal to seek the recommended and available treatment precludes him from [falling within the ADA's protected class].").

⁷ Although these courts have not yet examined a case involving forgone cochlear implant surgery, their conclusions surrounding other types of forgone medical treatment suggests that they would regard Sarah's decision to decline cochlear implant surgery as removing her from the ADA's protected class. *See, e.g., Franklin v. U.S. Postal Serv.*, 687 F.Supp. 1214, 1218 (S.D. Ohio 1988) ("The choice [not to employ medical technology] being [the plaintiff's], it seems difficult if not impossible to understand why the actions of the defendant should be deemed to be discriminatory.").

examination because the recently enacted ADA Amendments Act, although not focused on the corrective surgery issue, effectively moots many courts' stated rationales for concluding that the ADA's protected class excludes persons who have declined corrective surgery.⁸ When these amendments go into effect in January 2009, courts will have to revisit and more squarely confront the assumption that the ADA requires persons with disabilities to undergo corrective surgery as a precondition to membership in its protected class.⁹

Thus far, the question of whether the ADA's protected class excludes persons who decline corrective surgery has received limited attention because commentary related to corrective surgery has primarily advanced the claim that courts may limit employers' accommodation duty where available medical procedures would render accommodations unnecessary.¹⁰ Due to this overriding focus on limiting the ADA's accommodationary burden on employers, the law review literature has largely sidestepped the more basic question of whether the ADA's protected class generally excludes persons who reject medical procedures designed to eliminate or mask their disability.

This question—whether the ADA's protected class excludes persons who decline corrective surgery—has both practical and theoretical importance. It is important practically because, as Sarah's situation indicates, not all potential ADA claimants who reject corrective surgery need employer-provided disability-based accommodations to perform the jobs they hold or desire. However, in spite of their ability to work without such accommodations, they may nonetheless experience the types of

⁸ See ADA Amendments Act of 2008, H.R. 3195, 110th Cong. (2008), *available at* <http://www.govtrack.us/congress/billtext.xpd?bill=h110-3195>.

⁹ See *id.*

¹⁰ See Jill Elaine Hasday, *Mitigation and the Americans with Disabilities Act*, 103 MICH. L. REV. 217, 234–35 (2004) (arguing that courts should require individuals with disabilities to reasonably mitigate their disability when doing so would obviate the need for employer-provided accommodations); Bonnie Poitras Tucker, *Deaf Culture, Cochlear Implants, and Elective Disability*, 28 THE HASTINGS CENTER REP. 6, 10 (1998) (“When most deafness becomes correctable, which for many people has already occurred and for others may well happen in the near future, an individual who chooses not to correct his or her deafness (or the deafness of his or her child) will lack the moral right to demand that others pay for costly accommodations.”); Lisa A. Key, *Voluntary Disabilities and the ADA: A Reasonable Interpretation of “Reasonable Accommodations,”* 48 HASTINGS L. J. 75, 103 (1996) (arguing that if “an individual with a mutable impairment has [not] taken all reasonable actions to minimize his condition” then “it will not be reasonable under any circumstances for his or her employer to bear the cost of an accommodation”). *But see* Elizabeth F. Emens, *Integrating Accommodation*, 156 U. PA. L. REV. 839, 878 (2008) (noting that “instead of demanding that employees assimilate, [the ADA] seems to require the environment, rather than the individual, to change”).

discriminatory employment decisions, harassment, and retaliation that the ADA is designed to redress. The question is also theoretically important because, as Sarah's reasons for declining cochlear implant surgery suggest, some persons who decline corrective surgery hope to demonstrate that their physical difference is not an inherently negative trait that must be "cured" via medical intervention. Often born with their disability (as opposed to acquiring it later in life) these individuals resist characterizing themselves as suffering from a disease. From their vantage point, conventional "corrective" surgery would not remove a pathogen and restore them to a preexisting "whole" state but would instead alter what they perceive as their natural condition.¹¹ Often comparing themselves to left-hand dominant persons whose refusal to shed their physical variation served to transform previous beliefs that left-handed persons must conform to right-hand dominant norms, these individuals hope to reshape cultural attitudes toward their difference.¹² By gaining access to the workplace and other realms of

¹¹ See *Experiences of Deviance, Chronic Illness, and Disability*, in THE SOCIAL MEDICINE READER 75, 76 (Gail E. Henderson et al. eds., 1997) ("[A] study of 88 seriously physically restricted persons posed the question, 'If you were given one wish, would you wish that you were no longer disabled?' Only half said they would wish to remove their disability.") (citation omitted); JOSEPH P. SHAPIRO, NO PITY: PEOPLE WITH DISABILITIES FORGING A NEW CIVIL RIGHTS MOVEMENT 14 (1993) (quoting a wheelchair user as stating that she would not take "a magic pill" that would allow her to walk again and that asking her to do so is "the same thing as asking a black person would he change the color of his skin"); Nancy Weinberg, *Physically Disabled People Assess the Quality of Their Lives*, 45 REHABILITATION LITERATURE 12, 13 (1984) (finding that many people with disabilities indicate that they would refuse a risk-free surgery that would completely eliminate their disabilities, because they "fear that they would no longer be the same person"); Andrew Solomon, *Defiantly Deaf*, N.Y. TIMES MAG., Aug. 28, 1994, at 65 ("From the Deaf point of view, the notion that implants are beneficial 'is both inappropriate and offensive—as if doctors and newspapers joyously announced advances in genetic engineering that might someday make it possible to turn black skin white.'"); Marie Arana-Ward, *As Technology Advances, a Bitter Debate Divides the Deaf*, WASH. POST, May 11, 1997, at A1 ("'Let me put it this way,' [Judith Coryell, head of the deaf education program at Western Maryland College has explained]. 'Say you were black. Do you think you'd be considering surgery to make yourself white?'"); see also BERNARD BRAGG, LESSONS IN LAUGHTER: THE AUTOBIOGRAPHY OF A DEAF ACTOR 4 (Eugene Bergman trans., 1989) ("I thought deafness was a way of life and never linked it with sickness, defectiveness, or a handicapped condition. I thought, and I still do, that my deafness is just part of who I am.").

¹² See, e.g., Joe Griffith, *Disability Studies Chairman Chosen*, INDEPENDENT COLLEGIAN, Apr. 14, 2008, available at <http://media.www.independentcollegian.com/media/storage/paper678/news/2008/04/14/News/Disability.Studies.Chairman.Chosen-3322922.shtml> ("The medical field tends to view physical disabilities as a negative condition needing to be fixed, Wilkins said. 'In our world, we believe the disability is part of us,' he said. 'We're fine how we are.'") (quoting Dan Wilkins, manager of public relations for the Ability Center of Greater Toledo)); Ruth Colker, *Anti-Subordination Above All: A Disability Perspective*, 82 NOTRE DAME L. REV.

public life, they hope to gradually convince others that their physical differences might be accepted rather than erased.

This article argues that reading the ADA's nondiscrimination mandate to cover persons like Sarah who decline "corrective" surgery is consistent with both the ADA's core purpose and its text. Focusing on the ADA's purpose and its relationship to Title VII of the Civil Rights Act of 1964, section I argues that the ADA's overarching aim to reshape cultural responses to disability suggests that individuals need not acquiesce to all available medical efforts to eliminate their disability before they may challenge the negative social responses they experience. Instead, the ADA appears to give individuals, such as Sarah, the opportunity to argue that their physical differences should be accepted rather than masked or erased. Section II demonstrates that, textually, the ADA's coverage provisions include persons like Sarah who decline "corrective" surgery. It further suggests that the Supreme Court's *Sutton v. United Air Lines* decision,¹³ which contributed to many courts' conclusions that the ADA requires individuals to undergo corrective surgery, in fact discourages courts from excluding persons from the ADA's protected class based on the hypothetical benefits of forgone medical technology.

I. "CORRECTIVE" SURGERY AND THE SOCIAL MODEL OF DISABILITY

A. *The ADA's Social Model of Disability*

Title I of the ADA is patterned on Title VII of the Civil Rights Act of 1964, which prohibits employment discrimination on the basis of race,

1415, 1471 (2007) (noting that members of the "Deaf Culture" movement have "resisted the cochlear implant movement, arguing that deafness d[oes] not necessarily have to be 'cured'"); Amy Harmon, *How About Not 'Curing' Us, Some Autistics Are Pleading*, N.Y. TIMES, Dec. 20, 2004, at A1 ("'We don't have a disease,' said Jack, echoing the opinion of the other 15 boys at the experimental [school for autistic teenagers]. 'So we can't be 'cured.' This is just the way we are.'").

Left-handed individuals currently make up approximately twelve percent of the population in Western societies because parents, educators and other persons who influence children have become more permissive in allowing left-handed children to remain left-handed. By contrast, in countries that continue to view left-handedness as a problem, the incidence of left-handedness is less than five percent. *Korea Still Rough Place for the Left-Handed*, DIGITAL CHOSUN, Oct. 22, 2004, <http://english.chosun.com/w21data/html/news/200410/200410220027.html>; see also MARTIN GARDNER, *THE AMBIDEXTROUS UNIVERSE: LEFT, RIGHT, AND THE FALL OF PARITY* 77 (1964) ("Many authorities estimate that about 25 per cent are born left-handed . . .").

¹³ 527 U.S. 471 (1999).

sex, color, religion, and national origin.¹⁴ In the decade following Title VII's enactment, civil rights advocates attempted to amend Title VII to add "disability" to Title VII's protected categories.¹⁵ Although they ultimately achieved their goal to prohibit employment discrimination based on disability three decades after Title VII's passage in Title I of the ADA, Title I's provisions substantially parallel Title VII.¹⁶

Like Title VII, Title I prohibits intentional discrimination against members of its protected class as well as facially neutral policies that persist "through inertia or insensitivity" to exclude protected individuals.¹⁷ In this manner, Title I echoes the conclusion embodied in Title VII that social

¹⁴ 42 U.S.C. § 2000e-2 (2000); see Michael Ashley Stein & Michael E. Waterstone, *Disability, Disparate Impact, and Class Actions*, 56 DUKE L.J. 861, 921 (2006) ("Congress's impetus for passing Title VII (and then amending it in 1991) was strikingly similar to that underlying enactment of the ADA's employment provisions. In both cases, Congress recognized the need to eliminate barriers that historically had excluded groups from the workplace.").

¹⁵ See H.R. 14033, 92d Cong. (1972) (discussing an attempt in 1972 to add "mental or physical handicap" to the list of protected classes under Title VII of the Civil Rights Act of 1964); S. REP. NO. 96-316, at 1 (1979) (discussing a similar attempt in 1979).

¹⁶ See H.R. REP. NO. 101-485, at 22-24; Ruth Colker, *The ADA's Journey Through Congress*, 39 WAKE FOREST L. REV. 1, 46 (2004) (noting that "the ADA borrows Title VII's enforcement scheme"); Elizabeth A. Pendo, *Disability, Doctors and Dollars: Distinguishing the Three Faces of Reasonable Accommodation*, 35 U.C. DAVIS L. REV. 1175, 1178 (2002) ("Structurally and substantively, the ADA is based on Title VII of the Civil Rights Act of 1964 . . ."). The senators who introduced the ADA in 1989 expressly invoked the memory of the Civil Rights Act, describing persons with disabilities as a "minority" comparable to African-Americans and championing the ADA as designed to help "end this American apartheid." 101 CONG. REC. 8514 (1989) (remarks of Sen. Kennedy); see also, e.g., 101 CONG. REC. 8507-07 (1989) (remarks of Sen. Kennedy and Sen. Harkin).

¹⁷ *Finnegan v. Trans World Airlines, Inc.*, 967 F.2d 1161, 1164 (7th Cir. 1992). Disparate treatment cases involve situations in which an employer singles out a plaintiff for disadvantage because of her protected class status. *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 796 (1973). Disparate impact cases involve situations in which the employer imposes a neutral rule that screens out members of a protected class without sufficient business justification. See, e.g., *Griggs v. Duke Power Co.*, 401 U.S. 424, 427-28 (1971); see also *Raytheon Co. v. Hernandez*, 540 U.S. 44, 53 (2003) (noting that the ADA encompasses both types of cases).

Although some ADA scholarship characterizes the ADA's reasonable accommodation provision as dramatically different from Title VII's nondiscrimination provisions, recent scholarship has persuasively demonstrated that it parallels Title VII's requirement that employers eliminate barriers that disparately impact members of the groups Title VII protects. See Michael Ashley Stein, *Same Struggle, Different Difference: ADA Accommodations as Antidiscrimination*, 153 U. PA. L. REV. 579, 673 (2004) ("ADA-mandated accommodations are consistent with other antidiscrimination measures because each remedies artificial exclusion from employment opportunity by questioning the necessity of established workplace norms.").

factors contribute to the exclusion and subordination of certain groups and that, accordingly, social remedies can gradually remove the disadvantages such groups experience.

As the ADA's relationship to Title VII suggests, the ADA acknowledges that many of the disadvantages associated with disability do not proceed inevitably from an individual's biology but instead derive from social exclusion and subordination. In its statutory findings provision, the ADA outlines the need for a remedy for disability discrimination in terms comparable to the rationales for Title VII's remedies for race and sex discrimination. It notes that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."¹⁸ It further declares that individuals with disabilities "have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society."¹⁹ The ADA further notes the need to remedy "the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities."²⁰

In this way, the ADA reflects what sociologists have termed a "social model" of disability, which suggests "a switch away from focusing on the physical limitations of particular individuals to the way the physical and social environments impose limitations upon certain groups or categories of people."²¹ The social model directly rejects pre-ADA "medical model" thinking about disability, which regarded the disadvantages an individual with a disability experiences as flowing directly and inevitably from her aberrant biology.²²

Indiana Commissioner of Veteran's Affairs Gary May's comments at a Congressional hearing on the ADA reflect the social model's primary

¹⁸ 42 U.S.C. § 12101(a)(2) (2000).

¹⁹ *Id.* § 12101(a)(7).

²⁰ *Id.* § 12101(a)(5).

²¹ MICHAEL OLIVER, *SOCIAL WORK WITH DISABLED PEOPLE* 23 (1983); *see also* CLAIRE H. LIACHOWITZ, *DISABILITY AS A SOCIAL CONSTRUCT: LEGISLATIVE ROOTS* 11 (1988);

MICHAEL OLIVER, *THE POLITICS OF DISABLEMENT: A SOCIOLOGICAL APPROACH* 10 (1990).

²² *See* MARY JOHNSON, *MAKE THEM GO AWAY: CLINT EASTWOOD, CHRISTOPHER REEVE & THE CASE AGAINST DISABILITY RIGHTS* 237 (2003) (noting that within a medical model of disability, disability is "a personal, medical problem, requiring but an individualized medical solution; that people who have disabilities face no 'group' problem caused by society or that social policy should be used to ameliorate").

insights:

The general thrust and motivation for adaptive behavior by persons with disabilities has been from the “disability as liability” perspective. From this perspective, the existence of a disability is a totally negative phenomenon which must be conquered. This perspective does not fully embrace the concept of individual differences and pushes for standardization and homogenization in a society which operates from the same premise. This process is commonly understood as fitting the square peg into the round hole. The intractability of the round hole is accepted as a given.²³

As May’s comments suggest, many advocates for the ADA believed that disability policy prior to the ADA had overemphasized physical limitations and accordingly ignored the ways in which culturally contingent factors serve to constrict the opportunities available to persons with disabilities.²⁴ While disability policy prior to the ADA focused predominantly on “curing” persons with disabilities or otherwise adjusting them to fit existing cultural conceptions of normality,²⁵ the social model of disability embodied in the ADA focuses on adjustments to the cultural environment that the individual with a disability inhabits.

B. The Social Model and “Corrective” Surgery

The social model’s placement of responsibility for the disadvantages associated with disability on cultural factors, rather than solely on unmediated biology, suggests a perspective on medical treatment that differs from the pre-ADA assumption that persons with disabilities cannot reject medical efforts to eliminate or mask their disability. The social model emphasizes the manner in which the disadvantages associated with disability are largely cultural—and thus culturally contingent. Accordingly,

²³ *Americans with Disabilities Act of 1989: Hearing on H.R. 2273 Before the H. Comm. on Education and Labor*, 101st Cong. 79 (1988) (statement of Gary May, Commissioner, Indiana Department of Veterans’ Affairs).

²⁴ See Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 654 (1999).

²⁵ Samuel R. Bagenstos, *Subordination, Stigma, and “Disability,”* 86 VA. L. REV. 397, 427 (2000) (noting that pre-ADA policy “treat[ed] disability as an inherent personal characteristic that should ideally be fixed, rather than as a characteristic that draws its meaning from social context”); Harlan Hahn, *The Potential Impact of Disability Studies on Political Science (as Well as Vice-Versa)*, 21 POL’Y STUD. J. 740, 741 (1993) (noting that social policy regarding disability has historically focused predominantly on the need for “medical repair”).

it suggests that persons with disabilities need not acquiesce to all available medical efforts to eliminate their disability before they may challenge the negative social responses and unnecessary barriers they experience.

As philosopher Anita Silvers suggests, “[b]y hypothesizing what social arrangements would be in place were persons with disabilities dominant rather than suppressed, it becomes evident that systematic exclusion of the disabled is a consequence not of their natural inferiority but of their minority social status.”²⁶ For example, anthropological research has usefully illustrated the ways in which some of the disadvantages related to deafness are culturally contingent. Nora Groce studied Martha’s Vineyard in the eighteenth and early nineteenth centuries, a period in which approximately 1 in 155 islanders was deaf—as compared to 1 in 5728 in the mainland population.²⁷ Within this community, Groce found that deaf people were “completely integrated into community life, enjoying the same types of occupations, income levels and relationships as hearing people”²⁸ because all the islanders—including those with no hearing impairment and those with no deaf relatives—spoke an indigenous sign language.²⁹ Groce notes that “[p]erhaps the best description of the status of deaf individuals on the Vineyard was given to me by an island woman in her eighties, when I asked about those who were handicapped by deafness when she was a girl. ‘Oh,’ she said emphatically, ‘those people weren’t handicapped. They were just deaf.’”³⁰

These observations suggest that many of the disadvantages associated with deafness result not directly from the physical state of deafness but from stigmatization, isolation, and hearing persons’ lack of familiarity with sign language. When these cultural responses to deafness are not present, both deaf and hearing individuals regard deafness not as a disability but as a relatively insignificant physical trait. Disability studies scholars have documented similar attitudes toward deafness in schools where teachers instruct deaf and hearing children together in both English

²⁶ Anita Silvers, *Reconciling Equality to Difference: Caring (F)or Justice for People with Disabilities*, HYPATIA, Winter 1995, at 30, 48.

²⁷ NORA ELLEN GROCE, EVERYONE HERE SPOKE SIGN LANGUAGE: HEREDITARY DEAFNESS ON MARTHA’S VINEYARD 3 (1985).

²⁸ *Id.* at 80–85 (illustrating that, by using tax, census, bank and other records for deaf and non-deaf persons, deaf individuals experienced no economic disadvantages vis-à-vis hearing islanders and noting that mainland deaf persons during the same time period, by contrast, did experience significant economic disadvantage).

²⁹ *See id.* at 63 (“Hearing members of the community were so accustomed to using signs that the language found its way into discussions even when no deaf people were present.”).

³⁰ *Id.* at 5; *see also id.* at 110 (concluding that the deaf individuals on Martha’s Vineyard “were *not* handicapped, because no one perceived their deafness as a handicap”).

and American Sign Language.³¹ Under these cultural conditions, the disadvantages normally associated with deafness significantly diminish.

By revealing that many of the disadvantages experienced by persons with disabilities derive from culturally contingent factors rather than unmediated biology, the social model of disability suggests that the value of many medical treatments designed to address disability can be largely extrinsic.³² Many kinds of disabilities, such as deafness, “do not *per se* detract from a person’s health,”³³ and bear no indicia of disease except to the extent that nondisabled persons erroneously use the language of disease to describe the disadvantages that persons with disabilities experience. Close examination reveals that the disadvantages persons with disabilities experience often are not physical pain and weakness, but instead stigmatization, isolation, and difficulty navigating physical environments designed solely for persons without disabilities. If such culturally contingent factors were not present, many conventional medical treatments for disability might appear less necessary, just as a cure for deafness appeared unnecessary on Martha’s Vineyard in the eighteenth and early

³¹ See, e.g., SIMI LINTON, CLAIMING DISABILITY: KNOWLEDGE AND IDENTITY 61 (1998).

³² Roz Rosen, a past president of the National Association of the Deaf, has defended Deaf individuals’ decisions to reject cochlear implants by suggesting that since “[h]earing is not a life or death matter and consequently not worth the medical, moral, and ethical risk of altering a [person].” Roz Rosen, *President Rosen on Cochlear Implants*, NAD BROADCASTER, Dec. 1992, at 6. See also Position Statement, National Association of the Deaf, Cochlear Implants (Oct. 6, 2000), <http://www.nad.org/ciposition> (“Many within the medical profession continue to view deafness essentially as a disability and an abnormality and believe that deaf and hard of hearing individuals need to be ‘fixed’ by cochlear implants. This pathological view must be challenged and corrected by greater exposure to and interaction with well-adjusted and successful deaf and hard of hearing individuals.”); cf. HANS S. REINDERS, THE FUTURE OF THE DISABLED IN LIBERAL SOCIETY: AN ETHICAL ANALYSIS 45–46 (2000) (“Preventing the birth of a disabled child because its life will be devalued as abnormal is surely morally different from preventing the birth of a disabled child that will suffer a serious illness. . . . Even if in both cases their lives may be burdened by distress to similar degrees, their distress is very different in kind. . . . Given the fact that illness is necessarily a pathology, the appropriate response is medical care. But in cases of limited capabilities, the problem resulting need not be stated in medical terms at all. Limited capabilities are a source of human suffering depending on the social and cultural environment. In these cases, of which fragile X syndrome is an example, people suffer from a disabling condition, not because of illness but because of how this condition is socially evaluated. . . . If the cause of the suffering is society rather than nature, the more appropriate response would be political rather than medical.”).

³³ Ron Amundson, *Disability, Handicap, and the Environment*, 23 J. OF SOC. PHIL. 105, 106 (1992); see also *id.* (describing disability as “a very different category from illness”); see also, e.g., Andrew Solomon, *The Autism Rights Movement*, N.Y. MAG., June 2, 2008, at 32 (discussing the views of activists who “argue that autism is not an illness but an alternative way of being”).

nineteenth centuries.³⁴

This point is most clear in situations where surgery would have absolutely no impact on the person's functioning independent of alleviating negative social responses from others. For example, disability activists have widely criticized parents of children with Down syndrome who have hired plastic surgeons to reshape their children's facial features. Such surgery, of course, has no effect on the child's mental or physical capabilities.³⁵ The sole justification for the surgery is to ameliorate the social stigma and isolation the child may experience due to other persons' reactions to his appearance.³⁶ The perceived need for such surgery derives

³⁴ The widespread tendency to conflate illness and disability is understandable in light of the historical reality that the medical profession has had predominant responsibility for defining and describing disability. In order to receive disability compensation, such as Social Security Disability Insurance benefits, an individual must have documentation from a physician. See Samuel R. Bagenstos, *Comparative Disability Employment Law From an American Perspective*, 24 COMP. LAB. L. & POL'Y J. 649, 657 (2003) (explaining that SSDI/SSI claimants "must adduce the testimony of medical professionals in support of their claims of disability"). Similarly, many courts interpret the ADA to require plaintiffs to procure medical opinions regarding their disability even when their disability, such as mental retardation, does not require—or respond to—medical treatment. See Deirdre M. Smith, *Who Says You're Disabled? The Role of Medical Evidence in the ADA Definition of Disability*, 82 TUL. L. REV. 1, 20 ("[T]he dominant trend in the decisions is to assign a central and indispensable role to medical professionals in establishing disability for purposes of the ADA."). As humanities scholarship aptly demonstrates, this tendency to conflate disability with disease is not limited to law but in fact permeates most, if not all, discussions of disability. See, e.g., Bernhard Helander, *Disability as Incurable Illness: Health, Process, and Personhood in Southern Somalia*, in DISABILITY AND CULTURE 73, 73 (Benedicte Ingstad & Susan Reynolds Whyte eds., 1995) ("In much of contemporary anthropological work on the disabled there is a difficulty in defining and separating disability from disease."); Paul K. Longmore, *Elizabeth Bouvia, Assisted Suicide and Social Prejudice*, 3 ISSUES IN L. & MED. 141, 152 (1987) ("In the comedy classic 'Annie Hall,' Woody Allen has his principal male character say: 'I feel that life is divided up into the horrible and the miserable. Those are the two categories. . . . The horrible would be like, I don't know, terminal cases, you know, and blind people, cripples. I don't know how they get through life. It's amazing to me. You know. The miserable is everyone else. So when you go through life, you should be thankful that you're miserable. . . .' Allen's character expresses two common prejudices: he lumps disabled people with those who are terminally ill, and he sees an enormous gulf separating them from 'everyone else,' much like the chasm between 'the great neuropathic family' and the rest of humanity.").

³⁵ Crossley, *supra* note 24, at 663 (noting that "some plastic surgeons justify performing radical facial surgery on children with Down's syndrome to correct facial anomalies—even though such surgery has no effect on mental functions—simply on the grounds that emotional and behavioral responses to the children will improve following the surgery" (citing Jonathan Sinclair Carey, *The Quasimodo Complex: Deformity Reconsidered*, in THE TYRANNY OF THE NORMAL: AN ANTHOLOGY 27, 45 (Carol Donley & Sheryl Buckley eds., 1996))).

³⁶ *Id.*

solely from negative cultural responses, a problem external to the child. In this manner, such surgeries arguably parallel attempts to lighten the skin pigmentation of children born into cultures that stigmatize persons with dark skin.

While medical responses to other disabilities—such as cochlear implant surgery to address deafness—can actually change a person’s physical capabilities, the availability of such medical procedures may also serve to downplay the possibility of changing the cultural factors that contribute to the disadvantages the individual may experience. Operating from this perspective, Robert Carver has compared efforts to shape his deaf daughter into the mold of a hearing person to the ancient Chinese practice of binding young girls’ feet.³⁷ Suggesting that medical efforts to reduce disability forcibly twist a person’s natural state for the purpose of conforming them to cultural norms imposed by a dominant group, he explains that:

At the speech and hearing clinic, I was trained to bind the mind of my daughter. Like the twisting of feet into lotus hooks, I was encouraged to force her deaf mind into a hearing shape. I must withhold recognition of her most eloquent gestures until she makes a sound, any sound. I must force her to wear hearing aids no matter how she struggles against them. The shape of a hearing mind is so much more attractive.³⁸

As this perspective suggests, technological adjustments to an individual that will enable her body to better fit within existing able-bodied culture often serve to validate the assumption that the “problem” of disability lies solely within the individual. Medical procedures to “correct” disability mask the reality that much of the disadvantage associated with disability is attributable to a socially-constructed environment that unnecessarily disadvantages physically-variant individuals.

In sum, the ADA’s core objective of reforming the social forces that constrict the opportunities available to persons with disabilities suggests that corrective surgery should not be a precondition to membership in the ADA’s protected class. The ADA’s premise that the disadvantages persons with disabilities experience are largely cultural—and thus culturally contingent—counters the assumption that the ADA prevents persons with disabilities from rejecting medical efforts to “normalize” their physiology.

³⁷ Fiona Kumari Campbell, *Legislating Disability: Negative Ontologies and the Government of Legal Identities*, in FOUCAULT AND THE GOVERNMENT OF DISABILITY 108, 119 (Shelley Tremain ed., 2005) (quoting Robert Carver).

³⁸ *Id.*

II. “CORRECTIVE” SURGERY AND CURRENT CASELAW

A. *The ADA’s General Coverage Provisions*

Reading the ADA to permit persons to argue that their physical difference should be accepted rather than erased not only fits with the ADA’s grounding in a social model of disability, it also fits with the ADA’s text, which appears to include persons who decline corrective surgery. The following discussion of the ADA focuses on the ADA’s original text. Where relevant, the text and footnotes note changes to the ADA’s text made by the ADA Amendments Act, which goes into effect in January 2009.

Current doctrine on the question of whether persons who decline “corrective” surgery may access the ADA focuses on the interpretation of the ADA’s coverage provisions.³⁹ The ADA’s coverage provisions indicate that in order to obtain relief under the ADA, a plaintiff must first demonstrate that she is a “qualified individual with a disability.”⁴⁰ The ADA defines “disability” as “a physical or mental impairment that substantially limits one or more of the major life activities of the individual”⁴¹ “such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.”⁴² The “substantially limit[ed]” standard requires a plaintiff to show that she is “[s]ignificantly restricted as to the condition, manner or duration under which [she] can perform a particular major life activity as compared [to] . . . the average person in the general population.”⁴³

³⁹ Unlike Title VII, under which the protected classes—race, sex, color, religion, and national origin—encompass everyone, 42 U.S.C. § 2000e to 2000e-17 (2000), the ADA has a limited protected class that includes only a segment of the U.S. population. *See* 42 U.S.C. § 12102(2) (2000).

⁴⁰ 42 U.S.C. § 12102(2) (2000).

⁴¹ 42 U.S.C. § 12102(2) (2000). Title I also provides alternate definitions of disability that are beyond the scope of this article. An individual may meet these alternate definitions if she has “a record of such an impairment” that substantially limits one or more of her major life activities or is “being regarded as having such an impairment.” 42 U.S.C. § 12102(2)(B)&(C) (2000).

⁴² 29 C.F.R. § 1630.2(i) (2008) (“Major Life Activities means functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.”).

⁴³ 29 C.F.R. § 1630.2(j)(1)(ii) (2008); *Toyota Motor Mfg., Ky., Inc. v. Williams*, 534 U.S. 184, 197 (2002). The ADA Amendments Act expressly rejects the Supreme Court’s interpretation of “substantially limits” in *Toyota*. It provides that “the standard created by the Supreme Court in the case of *Toyota* for ‘substantially limits,’ and applied by lower courts in numerous decisions, has created an inappropriately high level of limitation necessary to obtain coverage under the ADA.” ADA Amendments Act § (2)(b)(5).

Based on this statutory definition, many persons who decline corrective surgery would appear to fall within the class of persons entitled to the ADA's protection. For example, Sarah appears to be an individual with a disability within the meaning of the statute. Compared to the average member of the general population, Sarah is significantly restricted as to the condition and manner under which she can hear, an activity which the Supreme Court has acknowledged as a major life activity within the meaning of the statute.⁴⁴ Accordingly, if Sarah is qualified for the job she desires, she appears to fall within the ADA's protected class.

The conclusion some courts have espoused that a plaintiff's "refusal to seek the recommended and available treatment precludes [her] from being a 'qualified individual with a disability'"⁴⁵ disregards the ADA's definition of the term "qualified." The ADA does not define "qualified" in terms of the individual's use of available medical technology. Instead, it defines "qualified" to mean that the individual "can perform the essential functions of the employment position" she holds or desires.⁴⁶ Regulations promulgated by the Equal Employment Opportunity Commission further provide that the term "qualified" means that the individual satisfies the requisite skill, experience, education and other job-related requirements of the employment position.⁴⁷ In our hypothetical, Sarah has chosen a job that she can perform without disability-related accommodations so she is "qualified" within the meaning of the ADA. The fact that Sarah might have different capabilities if she undergoes cochlear implant surgery appears irrelevant to her status as a member of the ADA's protected class.

B. Unsettling the Sutton v. United Air Lines Framework

⁴⁴ *Toyota Motor Mfg.*, 534 U.S. at 197 (acknowledging that the category of "major life activities" within the ADA includes hearing). The ADA Amendments Act, which adds an express list of sample "major life activities to the ADA's text, lists hearing as a major life activity. ADA Amendments Act § 3(3).

⁴⁵ *Roberts v. County of Fairfax, Va.*, 937 F. Supp. 541, 548 (E.D. Va. 1996) (emphasis added); *see also Hewitt v. Alcan Aluminum Corp.*, 185 F. Supp. 2d 183, 189 (N.D.N.Y. 2001) ("A plaintiff who does not avail himself of corrective medication is not a qualified individual under the ADA."); *Tangires v. Johns Hopkins Hosp.*, 79 F. Supp. 2d 587, 596 (D. Md. 2000) ("A plaintiff who does not avail herself of proper treatment is not a 'qualified individual' under the ADA."); *cf. Pangalos v. Prudential Ins. Co. of Am.*, No. 96-0167, 1996 WL 612469, at *3 (E.D. Pa. Oct. 15, 1996) (suggesting that a person would not receive the ADA's protection if "the disabling condition he allege[d] could readily be remedied surgically").

⁴⁶ 42 U.S.C. § 12111(8) (2000).

⁴⁷ 29 C.F.R. § 1630.2(m) (2008).

The Supreme Court's decision in *Sutton v. United Air Lines*⁴⁸ currently underpins many judicial conclusions that the ADA's protected class excludes persons like Sarah who have declined to undergo available "corrective" surgery.⁴⁹ In *Sutton*, the Supreme Court addressed a different, related question: the effect of an individual's voluntary use of mitigating measures on her right to access the ADA. The *Sutton* Court concluded that when an individual employs mitigating measures, such as hearing aids, to bring an otherwise "substantially limit[ing]" physical or mental impairment below the statutory "substantially limit[ing]" level, the individual falls outside the ADA's protected class.⁵⁰ Accordingly, the *Sutton* court held that the ADA excludes persons who reduce the effects of their disability with medical technology such as hearing aids or epilepsy medication.⁵¹

The *Sutton* Court rested its holding on the rationale that "[b]ecause the phrase 'substantially limits' appears in the Act in the present indicative verb form, . . . the language is properly read as requiring that a person be presently—not potentially or hypothetically—substantially limited" in order to fall within the ADA's protected class.⁵² The Court reasoned that speculation "based on general information about how an uncorrected impairment usually affects individuals, rather than on the individual's actual condition," would "run[] directly counter to the individualized inquiry mandated by the ADA."⁵³

⁴⁸ *Sutton v. United Air Lines, Inc.*, 527 U.S. 471 (1999).

⁴⁹ See *infra* notes 55–57.

⁵⁰ *Sutton*, 527 U.S. at 481–82.

⁵¹ See, e.g., *EEOC v. Sara Lee Corp.*, 237 F.3d 349, 350 (4th Cir. 2001) (holding that a person with epilepsy did not fall within the ADA's protected class because her medication reduced her symptoms below the substantially limiting level); *Chenoweth v. Hillsborough County*, 250 F.3d 1328, 1329 (11th Cir. 2001) (finding the same); see also Bradley A. Areheart, *When Disability Isn't "Just Right": The Entrenchment of the Medical Model of Disability and the Goldilocks Dilemma*, 83 *IND. L.J.* 181, 219 (2008) ("The scope of *Sutton* cannot be ignored. Its ruling excludes a vast number of potential plaintiffs from coverage under the ADA.").

⁵² *Sutton*, 527 U.S. at 482.

⁵³ *Id.* at 483. The Court further noted the ADA preamble's estimate that "43 million" Americans have conditions the ADA recognizes as disabilities came from a census that, based on a functional approach to disability, excluded persons who had effectively ameliorated their condition with medical technology. *Id.* at 485–86. See also 42 U.S.C. § 12101(a)(1) (2000) ("[S]ome 43,000,000 Americans have one or more physical or mental disabilities . . ."); *Sutton*, 527 U.S. at 486–87 (reasoning that the "43 million figure reflects [Congressional] understanding that those whose impairments are largely corrected by medication or other devices are not 'disabled' within the meaning of the ADA. . . . Had Congress intended to include all persons with corrected physical limitations among those covered by the Act, it undoubtedly would have cited a much higher number of disabled persons in the findings"); *id.* at 485–86 (noting that the report that generated the 43 million

The *Sutton* court's conclusion that an individual's decision to use mitigating measures could preclude an individual's membership in the ADA's protected class encouraged many courts to conclude that an individual's decision to *decline* corrective surgery also precludes her membership in the ADA's protected class.⁵⁴ Courts used *Sutton* to reason that the ADA's protected class excludes not only persons who use mitigating measures to bring themselves below the statutory "substantially limit[ed]" level but also persons who *could* use such measures.⁵⁵ In other words, they determined, based on *Sutton*, that the availability of medical technology determines the scope of the ADA's protected class. For example, the District Court of the Southern District of New York reasoned, in light of *Sutton*, that a plaintiff "cannot be said to [be] substantially impaired if she neglect[s] to avail herself of . . . corrective measures."⁵⁶ Similarly, the District Court of the Southern District of Florida concluded that when a plaintiff's "condition is treatable and can be corrected . . . [the p]laintiff cannot demonstrate that he is 'substantially limited in a major life activity.'"⁵⁷ In effect, these courts concluded that when medical technology could remove a person's currently experienced substantial limitation, *Sutton* excludes the person from the ADA's protected class, regardless of whether the person has actually adopted the medical technology.

The ADA Amendments Act undermines this rationale for **excluding the ADA's protections to persons** who decline mitigating measures for their disabilities from the ADA's protected class. Expressly rejecting the *Sutton* Court's holding, the amendments bring most persons who have effectively mitigated their disability—such as persons who use hearing aids or epilepsy

figure "took an explicitly functional approach to evaluating disabilities. . . . It measured . . . persons with a 'functional limitation' on performing certain basic activities when using, as the questionnaire put it, 'special aids'"

⁵⁴ A few courts had reached this conclusion prior to the *Sutton* decision. *See, e.g.*, *Bowers v. Multimedia Cablevision, Inc.*, No. CIV.A. 96-1298-JTM, 1998 WL 856074, at *4 (D. Kan. Nov. 3, 1998); *Roberts v. County of Fairfax, Va.*, 937 F. Supp. 541, 548 (E.D. Va. 1996); *Pangalos v. Prudential Ins. Co. of Am.*, No. 96-0167, 1996 WL 612469, at *4 (E.D. Pa. Oct. 15, 1996); *Franklin v. U.S. Postal Serv.*, 687 F.Supp. 1214, 1218 (S.D. Ohio 1988).

⁵⁵ *See, e.g.*, *Hooper v. Saint Rose Parish*, 205 F. Supp. 2d 926, 929 (N.D. Ill. 2002) ("Where a person's impairment can be treated and symptoms alleviated by mitigating factors such as medication or treatments, such medications or treatments must be taken into account in determining disability." (citing *Sutton*, 527 U.S. at 482–83)); *Spradley v. Custom Campers, Inc.*, 68 F. Supp. 2d 1225, 1232–33 (D. Kan. 1999) (expanding the *Sutton* opinion's actual holding to assert that "[t]he Supreme Court has recently held that if a disorder can be controlled by medication or other corrective measures, it does not substantially limit a major life activity").

⁵⁶ *Johnson v. Maynard*, No. 01 Civ. 7393(AKH), 2003 WL 548754, at *4 (S.D.N.Y. Feb. 25, 2003).

⁵⁷ *Mont-Ros v. City of W. Miami*, 111 F. Supp. 2d 1338, 1356–57 (S.D. Fla. 2000).

medication—into the ADA’s protected class.⁵⁸ Although the amendments do not appear to contemplate whether persons who *decline* mitigating measures fall within the ADA’s protected class, the amendments’ express rejection of *Sutton* significantly unsettles the *Sutton*-based rationale for excluding nonmitigators. By making *used* medical technology that removes an individual’s substantial limitation no longer relevant to her membership in the ADA’s protected class, the amendments appear to make the availability of *unused* medical technology irrelevant as well.

Furthermore, even if courts are unwilling to read the ADA Amendments Act to expressly bring nonmitigators like Sarah into the ADA’s protected class, courts need not necessarily read *Sutton* itself to take them outside the class. Unlike Justice Ginsburg’s concurring opinion in *Sutton* which occasionally used the term “correctable disabilities” to describe the category of conditions that the *Sutton* Court deemed to fall outside of the ADA’s scope,⁵⁹ the *Sutton* majority opinion eschewed a dichotomy between “correctable” and “uncorrectable” conditions.⁶⁰ The

⁵⁸ In their current form, the amendments provide that “[t]he determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures” ADA Amendments Act of 2008, H.R. 3195, 110th Cong. § 3(5)(D)(i) (2008); *see also id.* § 2(b)(2) (noting that the Act “reject[s] the requirement enunciated by the Supreme Court in *Sutton* . . . that whether an impairment substantially limits a major life activity is to be determined with reference to the ameliorative effects of mitigating measures”). The amendments would also undermine *Sutton* by permitting persons not seeking a reasonable accommodation to establish membership in the ADA’s protected class without demonstrating a substantial limitation of a major life activity. *See id.* § 3(4)(A).

⁵⁹ *See, e.g., Sutton*, 527 U.S. at 494 (Ginsburg, J., concurring) (“I agree that 42 U.S.C. § 12102(2)(A) does not reach the legions of people with correctable disabilities.”); *see also Sutton*, 527 U.S. at 502–03 (Stevens, J., dissenting) (concluding that “[t]he Act generally protects individuals who have ‘correctable’ substantially limiting impairments from unjustified employment discrimination on the basis of those impairments”).

⁶⁰ The Court uses the language “could correct” only once—in its recitation of the district court’s opinion. *See id.* at 471 (“The [district] court held that petitioners were not actually disabled under subsection (A) of the disability definition because they could fully correct their visual impairments.”). In the rest of the opinion, the majority’s language indicates that its framework for determining membership in the protected class focuses on the person’s actual state rather than on the availability of mitigating measures. *See, e.g., id.* at 482 (“[I]f a person *is taking* [not “could take”] measures to correct for, or mitigate, a physical or mental impairment, the effects of those measures—both positive and negative—must be taken into account when judging whether that person is ‘substantially limited’ in a major life activity and thus ‘disabled’ under the Act.”) (emphasis added); *id.* at 482 (“A ‘disability’ exists only where an impairment ‘substantially limits’ a major life activity, not where it ‘might,’ ‘could,’ or ‘would’ be substantially limiting if mitigating measures were not taken [not “were not available”].”); *id.* at 486 (“[T]hose whose impairments *are largely corrected by medication or other devices* [not “correctable”] are not ‘disabled’ within the meaning of the ADA.”) (emphasis added); *id.* at 487 (“Had Congress intended to include

Sutton majority emphasized that both “[t]he use *or nonuse* of a corrective device does not determine whether an individual” falls within the ADA’s protected class; instead, that determination hinges on “whether the limitations an individual with an impairment *actually* faces are in fact substantially limiting.”⁶¹

all persons with *corrected* [not “correctable”] physical limitations among those covered by the Act, it undoubtedly would have cited a much higher number of disabled persons in the findings. That it did not is evidence that the ADA’s coverage is restricted to only those whose impairments are not *mitigated* [not “able to be mitigated”] by corrective measures.”) (emphasis added); *id.* at 488 (“[O]ne has a disability under subsection (A) if, notwithstanding *the use of a corrective device* [not “the availability of a corrective device”], that individual is substantially limited in a major life activity.”) (emphasis added); *id.* at 486 (“[T]he 43 million figure reflects an understanding that those whose impairments are largely *corrected* by medication or other devices [not “correctable”] are not ‘disabled’ within the meaning of the ADA.”) (emphasis added).

⁶¹ *Id.* at 488 (first emphasis added). Even Justice Stevens, who used the term “correctable disabilities,” acknowledged that the majority’s framework hinged on the *use* of mitigating measures. *See id.* at 499 (Stevens, J., dissenting) (describing the Court as reaching the “counterintuitive conclusion that the ADA’s safeguards vanish when individuals make themselves more employable by ascertaining ways to overcome their physical or mental limitations”). Additionally, the Court’s heavy emphasis on the statutory estimate that 43 million Americans fall within the ADA’s protected class suggests that the ADA covers persons who decline mitigating measures. In its discussion of the reports that gave rise to the statutory estimate of 43 million, the Court indicates that the report excluded not all persons who *could* use medical technology to ameliorate their disability, but only persons who actually used such technology. *See id.* at 485–86 (noting that the report that generated the 43 million figure “measured . . . persons with a ‘functional limitation’ on performing certain basic activities when using, as the questionnaire put it, ‘special aids’ such as glasses or hearing aids, *if the person usually used such aids*”) (emphasis added); *see also* Capizzi v. County of Placer, 135 F. Supp. 2d 1105, 1113 (E.D. Cal. 2001) (“The conclusion that a failure to mitigate does not defeat the cause of action is supported by *Sutton*. There the Court observed that in the ADA ‘the phrase “substantially limits” appears . . . in the present indicative verb form, . . . [indicating that] the language is properly read as requiring that a person be presently—not potentially or hypothetically—substantially limited in order to demonstrate a disability.’ It should follow from the fact that the question of disability addresses plaintiff’s current condition, that the fact that a particular procedure would mitigate the condition cannot prevent a finding that the plaintiff is presently disabled.”) (citation omitted); *Finical v. Collections Unlimited, Inc.*, 65 F. Supp. 2d 1032, 1038 (D. Ariz. 1999) (reasoning, based on *Sutton*, that courts should assess the “limitations an individual presently faces”); *see also* Instructions for Field Offices: Analyzing ADA Charges After Supreme Court Decisions Addressing “Disability” and “Qualified,” EEOC, July 22, 1999, <http://www.eeoc.gov/policy/docs/field-ada.html> (reprinted in Agency Guidance in Binder 2A) (“The [*Sutton*] Court also emphasized that the disability determination must be based on a person’s actual condition at the time of the alleged discrimination. Therefore, if a [plaintiff] did not use a mitigating measure at that time, an Investigator must determine whether s/he was substantially limited in a major life activity based solely on his/her actual condition. For the purpose of determining whether a [plaintiff] meets the definition of ‘disability,’ speculation regarding whether the person would have been substantially limited if s/he used a mitigating measure is irrelevant.”).

Furthermore, the *Sutton* Court’s warning that it would violate “both the letter and the spirit of the ADA” to judge membership in the protected class based on an individual’s hypothetical state⁶² would seem to doubly apply to speculation about the effect an unadopted medical procedure might have on an individual. While estimating the difficulties a person who currently employs medical technology would experience without that technology would often be aided by records of the individual’s prior condition, predicting the effect of unadopted technology on an individual will nearly always require reliance on generalizations and statistical data, precisely the type of analysis that *Sutton* forbids.⁶³ Accordingly, while the *Sutton* decision has led many courts to read the ADA to exclude persons who decline medical technology that might remove the substantial limitation they currently experience, *Sutton*’s reasoning suggests the opposite conclusion. It suggests that an individual currently experiencing a substantial limitation of a major life activity should fall within the ADA’s protected class even if an unused medical procedure might remove that substantial limitation.⁶⁴

C. Beyond the General Coverage Provisions

⁶² *Sutton*, 527 U.S. at 483, 484; see also *id.* at 482 (“A ‘disability’ exists only where an impairment ‘substantially limits’ a major life activity, not where it ‘might,’ ‘could,’ or ‘would’ be substantially limiting if mitigating measures were not taken.”).

⁶³ The effectiveness of cochlear implant surgery, for example, varies widely from individual to individual and is difficult to precisely predict. David B. Pisoni, *Individual Differences in Effectiveness of Cochlear Implants*, 106 J. ACOUSTICAL SOC’Y OF AM. 2212 (1999) (explaining research demonstrating that “the effectiveness of cochlear implants varies widely” and that it is difficult to predict, in advance, the degree to which an implant will enable an individual to perceive speech).

⁶⁴ 42 U.S.C. § 12102(2)(A) (2000). See *Nawrot v. CPC Int’l*, 277 F.3d 896, 904 (7th Cir. 2002) (“[*Sutton*] is not . . . license for courts to meander in ‘would, could, or should-have’ land. We consider only the measures actually taken and consequences that actually follow. . . . Those who discriminate take their victims as they find them.”); *Jamison v. Dow Chemical Co.*, 354 F. Supp. 2d 715, 728 (E.D. Mich. 2004) (“The use or nonuse of a corrective device does not determine whether an individual is disabled; that determination depends on whether the limitations an individual with an impairment actually faces are in fact substantial limiting.” (citing *Sutton*, 527 U.S. at 488)); *Williams v. Thresholds, Inc.*, No. 02 C 9101, 2003 WL 22232835, at *5 (N.D. Ill. Sept. 22, 2003) (“The *Sutton* court explicitly stated that courts should not engage in counter-factual hypothesizing, guessing whether a course of treatment would have alleviated a plaintiff’s disability.”); *Bertinetti v. Joy Mining Machinery*, 231 F. Supp. 2d 828, 833–34 (S.D. Ill. 2002) (“*Sutton* . . . does not give courts a license to ‘meander in “would, could, or should-have” land.’ Courts should only consider mitigating steps actually taken and the consequences that actually followed. Accordingly, this court will not speculate about what Bertinetti’s condition would be if he had taken additional steps to improve his condition.” (citation omitted)).

Other provisions in the ADA's text support this reading of the ADA's general coverage provisions. For example, the ADA's express exclusion of nonmitigators with a particular type of disability from its protected class discredits the inference that the ADA generally excludes persons who decline conventional treatment for their disability. Section 12114 provides that drug addiction may qualify an individual for disability discrimination protection only when the individual is engaged in conventional efforts to eliminate the disability.⁶⁵ Congress added this provision to the Act after receiving advice from the Attorney General that the Act would otherwise prohibit employers from taking adverse employment actions on the basis of current illegal drug use against persons whose addiction substantially limited one or more of their major life activities.⁶⁶ The fact that the Attorney General and Congress believed that the ADA needed an amendment explicitly requiring persons addicted to illegal drugs to mitigate their disability suggests that they believed the ADA's protected class generally included persons who decline conventional treatment. The few members of Congress who characterized the "drug addiction" amendment as unnecessary based this characterization on the belief that courts would read the recently-enacted Drug Free Workplace Act to trump the ADA, not because they believed the ADA already excluded nonmitigators from its protected class.⁶⁷

Furthermore, another frequently-overlooked provision of the ADA provides support for the view that individuals with disabilities may reject unwanted medical procedures without forgoing the ADA's protection from

⁶⁵ 42 U.S.C. § 12114(b)(2) (2000) (providing that addiction to illegal drugs may qualify a person for membership in the ADA's protected class only if the person is "participating in a supervised rehabilitation program and . . . no longer engaging [in illegal drug] use"). Members of Congress regarded drug addiction as inherently negative and deserving of protection only if the person is taking all reasonable means to eliminate it. *See The Americans with Disabilities Act of 1989: Joint Hearing on H.R. 2273, Before the Subcomm. on Select Education and Employment Opportunities of the H. Comm. on Education and Labor*, 101st Cong. 40 (1989) ("[D]rug and alcohol addicts should not be placed into the same categories as those with physical and mental impairments . . .") (statement of Rep. Steve Bartlett, Member, H. Subcomm. on Select Education of the Comm. on Education and Labor); cf. Tim Edwards, *Constitutional Limits on an Employer's Right to Dictate the Terms of an Addict's Recovery Under the ADA: Some Sobering Concerns*, 44 WAYNE L. REV. 1679, 1700 (1999) (reading this provision as "evin[ing] a political commitment to conventional treatment as a condition to coverage, and employment, under the ADA" of persons addicted to illegal drugs).

⁶⁶ *Staff of H. Comm. on Education and Labor*, 101st Cong., *Legislative History of Public Law 101-336* (Comm. Print. 1990) (describing the Attorney General's opinion that, without an amendment to exclude current illegal drug users from the statute's scope, the statute's disability definition would include persons substantially limited by addiction to illegal drugs).

⁶⁷ *See* 135 CONG. REC. S10777 (1989).

disability discrimination. Section 12201(d), which Congress added by amendment prior to the ADA's initial passage, provides that "[n]othing in this [Act] shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit which such individual chooses not to accept."⁶⁸ Although the legislative history of this provision suggests that the sponsors of the amendment likely envisioned it as predominantly addressing unnecessary employer- (or public entity-) provided accommodations,⁶⁹ the inclusion of this provision lends support to the view that when an individual is able to perform a job without disability-related accommodations, the ADA permits her to reject aids she does not need, including medical technology such as cochlear implants.

In sum, the ADA's text appears to permit individuals who decline "corrective" surgery to challenge disability discrimination. Its coverage provisions textually include persons who decline "corrective" surgery. The Supreme Court's *Sutton v. United Air Lines* decision, which contributed to many courts' conclusions that the ADA requires individuals to undergo corrective surgery, in fact prevents courts from excluding persons from the ADA's protected class based on the hypothetical benefits of unadopted medical technology. Accordingly, courts should hold that the ADA's protected class includes persons, like Sarah, who decline corrective surgery.

CONCLUSION

In keeping with the ADA's focus on changing social responses to disability, courts should read the ADA to prioritize the modification of culturally contingent social and environmental barriers over the masking or eradication of disability. Courts should not regard the mere possibility that medical technology could reduce or mask an individual's physical difference as obliging her to employ such technology. Instead, they should read the ADA require employers to reshape the workplace to remove unnecessary barriers rather than to require persons with disabilities to

⁶⁸ 42 U.S.C. § 12201(d) (2000); see H.R. REP. NO. 101-485, at 71-72 (1990) ("The Committee added this section to clarify that nothing in the ADA is intended to permit discriminatory treatment on the basis of disability, even when such treatment is rendered under the guise of providing an accommodation, service, aid or benefit to the individual with disability.").

⁶⁹ Letter from American Foundation for the Blind, Scott Marshall, Director, Governmental Relations Department, H.R. 2273, 513 (1989) ("The last sentence of this new subsection addresses the 'unnecessary accommodation' issue. A blind or otherwise disabled person must be guaranteed the right to choose to accept or reject proffered accommodations, benefits, etc. It is not uncommon, for example, for a transportation provider to require a blind person to use a wheelchair in situations where the blind individual prefers to use a sighted guide or prefers no assistance at all.").

reshape themselves to fit existing norms. In this manner, the ADA will better fit with the goals of the disability rights movement, which in the tradition of many other groups previously excluded from public life, proudly insists that “[w]e will not change to fit the mold. . . . Instead, we will destroy the mold and change the world to make sure there is room for everyone.”⁷⁰

⁷⁰ Douglas Martin, *Disability Culture: Eager to Bite the Hands that Would Feed Them*, N.Y. TIMES, June 1, 1997, § 4.