



## **Proving Diabetes is a Disability Under the New Americans with Disabilities Act: A Guide for Lawyers**

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### **Introduction**

The question of who has a disability for purposes of the Americans with Disabilities Act (“ADA”) and is thus protected by the ADA’s anti-discrimination provisions has been the subject of frequent litigation since the Act’s passage in 1990. The Americans with Disabilities Act Amendments Act of 2008 (“ADAAA”), Pub. L. No. 110-325, however, mark a sea change in how courts are to answer this question, particularly as it relates to individuals with diabetes and other chronic conditions. The new law provides numerous ways for people with diabetes to establish coverage under the ADA. The purpose of this paper is to guide attorneys through the developing law in this area and to present strategies for establishing that individuals with diabetes, whatever its classification or symptoms, have a disability within the meaning of the ADA.

When originally passed, the ADA was hailed as sweeping civil rights legislation that would protect individuals with all types of disabilities from the discrimination many of them had regularly faced. But in the ensuing two decades, courts too often denied protection to individuals with many kinds of serious medical conditions because of an overly strict interpretation of what constitutes a disability under the Act. Many plaintiffs with worthy claims were thrown out of court before there was any consideration of the merits of their allegations of discrimination, and even those who overcome this hurdle were forced to devote significant resources to the threshold issue of proving they had a disability.

Nowhere was the problem caused by the judicial interpretation of disability more apparent than in the case of people with diabetes. Particularly after the Supreme Court handed down the “Sutton trilogy” of cases in 1999,<sup>1</sup> the question of whether diabetes was a disability under the ADA was frequently litigated, with mixed results. Compare *Lawson v. CSX Transp., Inc.*, 245 F.3d 916 (7th Cir. 2001), *Fraser v. Goodale*, 342 F. 3d 1032 (9<sup>th</sup> Cir. 2003); *Branham v. Snow*, 392 F. 3d 896 (7<sup>th</sup> Cir. 2004) (finding plaintiff’s diabetes to be a disability) with *Orr v. Wal-Mart*

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<sup>1</sup> *Sutton v. United Air Lines, Inc.*, 527 U.S. 471 (1999); *Murphy v. United Parcel Service*, 527 U.S. 516 (1999); and *Albertson’s Inc. v. Kirkingburg*, 527 U.S. 555 (1999).

*Stores*, 297 F. 3d 720 (8<sup>th</sup> Cir. 2002); *Cash v. Smith*, 231 F.3d 1301 (11<sup>th</sup> Cir. 2000); *Brady v. Potter*, 273 Fed. Appx. 498 (6<sup>th</sup> Cir. 2008) (finding no coverage for an individual with diabetes).

The ADAAA was passed to counter these narrow judicial constructions and to restore the ADA to its original scope of coverage. As discussed more fully below, the ADAAA makes a number of changes to the coverage provisions of the ADA. The most significant changes are:

- Stating that the coverage provisions are to be construed broadly, and explicitly rejecting Supreme Court interpretations setting a demanding standard;
- Requiring that the ameliorative effects of mitigating measures such as medication not be considered when determining the presence of a disability;
- Expanding the list of major life activities, and including major bodily functions as a major life activity;
- Requiring that conditions that are episodic or in remission be evaluated in their active state; and
- Expanding the “regarded as” category of disability so that a condition need not limit a major life activity to be the basis for a regarded as claim.

The ADAAA also amends the definition of disability governing claims under the anti-discrimination provisions of the Rehabilitation Act, 29 U.S.C. § 791 *et seq.*, which applies to the federal government and entities receiving federal financial assistance. The Rehabilitation Act now takes its definition of disability directly from the (amended) ADA. *See* 29 U.S.C. §§ 705(9)(B), 705(20)(B). While the rest of this document discusses claims under the ADA, the same standards related to the definition of disability apply under the Rehabilitation Act.

The changes made by the ADAAA took effect on January 1, 2009, and the new standards apply to conduct on or after that date. But cases arising before 2009 may continue to be governed by the old judicial interpretations of the ADA.<sup>2</sup> As noted above, a number of courts did find diabetes to be a disability under the “old” ADA, though far more care and evidence is required to make the needed factual showing. For more information on proving disability under these standards, see “Background Materials on Diabetes and Functional Limitations For Lawyers Handling Diabetes Discrimination Cases”, available at <http://www.diabetes.org/uedocuments/ad-background-materials-for-lawyers.pdf>.

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<sup>2</sup> Several courts have concluded, at least in dicta, that the ADAAA does not apply retroactively to conduct occurring before January 1, 2009. *See Kiesewetter v. Caterpillar, Inc.*, 2008 U.S. App. Lexis 21481 (7<sup>th</sup> Cir. 2008); *Parker v. ASRC Omega Natchiq*, 2008 U.S. Dist. Lexis 9682 (W. D. La. 2008) (rejecting argument that amendments should apply to conduct occurring prior to 2009); *see also Rivers v. Roadway Express*, 511 U.S. 298 (1994) (absent a clear expression by Congress, statutes modifying substantive rights will not be read to apply retroactively, even where the statute overturns a prior court decision which Congress believes was wrongly decided). However, the 6<sup>th</sup> Circuit recently held that the ADAAA applies to cases pending after its effective date which seek prospective relief. *Jenkins v. Nat’l. Bd. of Medical Examiners*, 2009 U.S. App. Lexis 2660 (6<sup>th</sup> Cir. 2009). Also, a court recently held that the ADAAA can be used as interpretive guidance in construing the original ADA, at least as to issues not previously decided by binding precedent. *Menchaca v. Maricopa Comm. Coll. Dist.*, 2009 U.S. Dist. Lexis 5510 (D. Ariz. 2009); *see also Rohr v. Salt River Project Agric. Improvement and Power Dist.*, 2009 U.S. App. Lexis 2856 (9<sup>th</sup> Cir. 2009) (ADAAA can inform court’s interpretation of issues under the prior version of the ADA).

It is essential to keep in mind that the ADAAA does not explicitly make diabetes, or any other condition, an automatic disability; a factual showing that an individual's diabetes substantially limits a major life activity is still required to prove actual disability. The ADAAA does, however, provide several new avenues to establish coverage that, used separately or in combination, can be used to establish that diabetes is covered by the ADA. Courts are already recognizing the impact of the ADAAA on diabetes cases. The 9<sup>th</sup> Circuit recently became the first court to extensively discuss the application of the ADAAA to people with diabetes and, as will be discussed further below, the court noted several ways in which the new act makes it much easier for people with diabetes to prove coverage. *Rohr v. Salt River Project Agricultural Improvement and Power District*, 2009 U.S. App. Lexis 2856 (9<sup>th</sup> Cir. 2009). Indeed, if one thing is clear from the legislative record, it is that diabetes is one of the conditions that Congress intends to be covered by the ADA, and the ADAAA provides a clear path to this coverage.

### **The Science and Medicine of Diabetes and its Management**

It is not enough, even under the new law, to rely on an individual's diagnosis of diabetes alone to prove disability; evidence must be introduced of the effect of diabetes on the individual. Therefore, in order to effectively prove disability (under either the old or new ADA), attorneys need a solid understanding of the science and medicine of diabetes so that the appropriate evidence can be gathered and presented to the court.<sup>3</sup>

#### Effect of diabetes on the endocrine system

Diabetes is a disorder of the endocrine system which affects nearly 24 million Americans<sup>4</sup> and is characterized by high blood glucose (sugar) levels resulting from defects in insulin secretion, insulin action or both.<sup>5</sup> The endocrine system is a series of glands that produce and secrete hormones, which are released into the bloodstream and regulate many of the body's functions. The pancreas, one of the major glands of the endocrine system, is an organ responsible for making (in specialized cells called beta cells) and secreting insulin, a hormone that is used to regulate the level of glucose in the blood. In diabetes, the pancreas has trouble producing sufficient insulin, limiting the body's ability to regulate glucose and convert it into energy.

Insulin has two major roles in regulating sugar metabolism in the body. When one is fasting, the liver must produce glucose (sugar) to meet the needs of the brain and other organs that depend upon glucose for energy. Small amounts of insulin released by the pancreas's islet cells regulate the amount of glucose the liver produces, keeping the blood glucose levels in a narrow range. After eating, the digestive system, including the liver, changes sugars, starches, and other foods into glucose. The blood then carries this glucose to cells throughout the body. There, with the help of insulin, glucose enters the cells and is changed into quick energy for the cells to use or

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<sup>3</sup> For a more detailed discussion of diabetes and its treatment attorneys should consult the resources listed in the bibliography at the end of this paper.

<sup>4</sup> Centers for Disease Control and Prevention: *National Diabetes Fact Sheet: General Information and National Estimates on Diabetes in the U.S., 2007*. Atlanta, GA, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.

<sup>5</sup> Insulin resistance, common among people with diabetes, is also a disorder of the endocrine function.

store for future needs. This process of turning food into energy is crucial, because the body depends on this energy for every action, from pumping blood and thinking to running and jumping. Even in people without diabetes, blood glucose levels go up and down throughout the day in response to food and the needs of the body. However, in the person without diabetes, this is a finely tuned system that keeps blood glucose levels within the normal, healthy range.

In diabetes, something goes wrong with this process of turning food into energy. The liver is unleashed from the control that insulin exerts and produces large amounts of excess glucose, well beyond the body's needs. After eating, food is changed into glucose readily enough, but insulin is not present or cannot be used properly, resulting in even higher levels of glucose accumulating in blood and tissues.

There are three main types of diabetes: type 1 diabetes, type 2 diabetes, and gestational diabetes.<sup>6</sup> In type 1 diabetes, the pancreas stops making insulin or makes only a tiny amount. Type 1 develops when the body's immune system destroys beta cells in the pancreas, the only cells in the body that make insulin. Thus, the body is no longer able to produce significant amounts of insulin, and a person with type 1 diabetes must receive insulin from an outside source (typically through injections or use of an insulin pump) in order to survive.

In type 2 diabetes, the body retains the ability to make insulin, but cannot make enough to meet its needs. It is generally believed that in people with type 2 diabetes the body's cells cannot recognize insulin or use it as effectively as in people without diabetes (a condition known as insulin resistance). This causes the body to need more insulin to process the same amount of glucose. While the pancreas may be able to produce some additional insulin for a while (thus minimizing the harmful effects of the disease), generally over time the pancreas's ability to produce insulin decreases and causes blood glucose levels to rise. Some people with type 2 (particularly in the early stages of the disease) can control their diabetes through diet and exercise.<sup>7</sup> Others must take various types of medications, while still others use insulin much as those with type 1 do.

Gestational diabetes develops during pregnancy (usually during the second or third trimesters) as a result of the body's inability to produce sufficient insulin to respond to insulin resistance, which is a natural part of pregnancy. It is treated much like type 2; treatment can begin with diet and exercise but can include insulin if necessary (oral medications are not used because of concern about risk of harm to the baby). After pregnancy, gestational diabetes generally disappears, although women who have had it are more likely to develop type 2 diabetes later in life.

When insulin is absent or ineffective, the excess glucose in the bloodstream cannot be used by the cells to make energy. Instead, glucose collects in the blood, leading to the high glucose

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<sup>6</sup> Type 1 diabetes is sometimes still referred to as "juvenile diabetes" or "insulin-dependent diabetes", while type 2 diabetes is sometimes referred to as "adult-onset diabetes" or "non-insulin dependent diabetes". However, these alternative terms are no longer favored by the diabetes health care community and should be avoided because they are ambiguous.

<sup>7</sup> All people with diabetes utilize diet and exercise as a part of the treatment regimen, but for some people with type 2 diabetes it is the only way they manage their condition.

levels or “hyperglycemia” that is the defining characteristic of untreated diabetes.<sup>8</sup> The symptoms of hyperglycemia can include frequent urination, thirst, headache, weight loss, fatigue, and blurry vision. With prolonged hyperglycemia and inadequate insulin action, the person may develop *diabetic ketoacidosis*, or *hyperosmolar hyperglycemic syndrome* as discussed below. In addition to these short term consequences of acute hyperglycemia, high blood glucose levels cause a number of very serious long-term complications. Some of the more important long term complications include:<sup>9</sup>

- *Retinopathy*: diabetic retinopathy causes 12,000 to 24,000 new cases of blindness each year, making diabetes the leading cause of new cases of blindness in adults 20-74 years of age;
- *Kidney disease*: diabetes is the leading cause of kidney failure, accounting for 44% of new cases in 2005;
- *Neuropathy*: about 60% to 70% of people with diabetes have mild to severe forms of nerve damage, which can cause a number of symptoms, including numbness in extremities, difficulty standing and walking, and slowed digestion of food in the stomach;
- *Cardiovascular disease*: heart disease is the leading cause of diabetes-related deaths, and adults with diabetes are 2 to 4 times more likely to die of heart disease than adults not affected by diabetes;
- *Cerebrovascular disease*: the risk of death from stroke is 2.8 times higher among people with diabetes;
- *Hypertension*: about 73% of adults with diabetes have high blood pressure; and
- *Amputations*: more than 60% of nontraumatic lower-limb amputations occur in people with diabetes, and the rate of amputation for people with diabetes is 10 times higher than for people without diabetes.<sup>10</sup>

In addition, people with diabetes are at risk for complicated pregnancy,<sup>11</sup> and are susceptible to infections and other illnesses.<sup>12</sup> Diabetes also increases the risk of prolonged illness and death from other illnesses, including pneumonia, heart attack, and stroke.

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<sup>8</sup> Hyperglycemia can occur in people whose diabetes is being treated with insulin or other means (as discussed below) and may also be caused by illness, infection or stress.

<sup>9</sup> Centers for Disease Control and Prevention: *National Diabetes Fact Sheet: General Information and National Estimates on Diabetes in the U.S., 2007*. Atlanta, GA, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.

<sup>10</sup> Amputations in people with diabetes are usually the result of two factors. First, individuals with neuropathy frequently lack the normal protective sensation to discern injury to the feet. Over time, this can lead to callous formation and abnormal distribution of weight to the feet which puts the person at risk for skin breakdown. That, in turn, can lead to ulcers and infection. The second factor is coinciding peripheral vascular disease, which limits blood flow to the feet and can produce wounds that may not heal even in response to antibiotics and normal care.

<sup>11</sup> Reproductive complications include impotence for men and conditions that make pregnancy complicated for women. Poorly controlled diabetes before conception and during the first trimester of pregnancy can cause major birth defects, and poorly controlled diabetes during the second and third trimesters can result in excessively large babies, which pose a risk to the mother and the child.

<sup>12</sup> People with diabetes are also susceptible to other illnesses and, once they acquire these illnesses, often have worse prognoses.

## Diabetes management

The goal of diabetes management is to try to balance the blood glucose level within a safe range, minimizing very low and very high glucose levels. As noted above, type 1 diabetes must be treated with insulin, while type 2 can be treated with insulin, other medications, or diet and exercise.

Proper diabetes treatment depends on knowing and responding to the current blood glucose level. Checking blood glucose involves pricking the skin with a lancet at the fingertip, forearm, or other test site to obtain a drop of blood and placing the drop on a special test strip that is inserted in a glucose meter. The frequency of blood glucose checks can vary from person to person, and checks may be done both at scheduled times (such as before meals) and unscheduled times (such as when a person senses their blood glucose levels are too high or too low).

Insulin can be self-administered through injections or by wearing an insulin pump. There are four broad types of insulin (rapid-acting, short-acting, intermediate-acting, and long-acting) classified based on how soon the insulin starts working (onset), when it works the hardest (peak time), and how long it lasts in the body (duration). Short or rapid-acting insulins are generally given before meals or in an insulin pump. Intermediate and long-acting insulins are used to provide between-meal low levels of insulin necessary to control the liver's production of glucose. Pre-mixed insulin combinations combine short or rapid with intermediate insulins. Pre-mixed insulin is generally given once or twice a day. Today it is common to take a long-acting insulin to cover the body's needs over the course of the day and to take a rapid-acting insulin just before or after meals to cover food consumed. Individuals who use an insulin pump receive insulin in small, steady doses throughout the day and can give themselves extra insulin to cover food intake by pushing a series of buttons on the pump.

In addition, when people are diagnosed with type 2 diabetes they often treat the disease with oral medications taken once or twice a day. Commonly used oral medications for diabetes fall into two major groups: drugs that increase insulin levels and those that enhance insulin's actions. Medications that increase insulin levels are the *sulfonylureas* and the *glinides*. Those that increase insulin's actions are the *biguanides* and *glitazones*. A new class of oral agents for diabetes, the *gliptins*, have a combination of both effects.<sup>13</sup> The following chart includes the generic and brand names for oral diabetes medications on the market in 2009:

Medication Class	Generic Name	Brand Name
Sulfonylurea (all generic)	Glyburide Glipizide Glimepiride	Diabeta/Micronase Glucotrol Amaryl
Biguanide (generic)	Metformin	Glucophage
Glinide	Nateglinide	Starlix

<sup>13</sup> For more information about oral diabetes medications, see American Diabetes Association: *American Diabetes Association Complete Guide to Diabetes* at 39-46. 4<sup>th</sup> ed. Alexandria, VA, American Diabetes Association, 2005.

	Repaglinide	Prandin
Gliptin	Sitagliptin Saxagliptin	Januvia Onglyza
Glitazone	Rosiglitazone Pioglitazone	Amaryl Actos
Multiple combinations of two medications – both branded and generic		

Over time, the disease progresses and most people must increase the amount of medication, and change to insulin or a combination of insulin and oral medications to manage blood glucose levels. However, insulin and medication regimens vary from person to person based on a number of factors.

Treatments such as insulin and oral medications do not cure diabetes, and in fact, some medications can lower blood glucose levels too much, leading to a dangerous condition known as hypoglycemia (low blood glucose levels). All types of insulin and certain classes of oral medications (sulfonylureas) can cause hypoglycemia – insulin because it lowers the body’s blood glucose level, and sulfonylureas because they stimulate the pancreas to produce and release more insulin. Other oral medications, unless taken in conjunction with sulfonylureas, do not cause hypoglycemia because they do not act to increase insulin levels. Hypoglycemia symptoms include anxiety, hunger, tremors, palpitations and sweating, confusion, drowsiness, mood changes, unresponsiveness, unconsciousness, convulsions, and, if untreated, death.

Hazardous short term side effects associated with low blood glucose levels occur more quickly and more frequently than do the short term effects of high blood glucose levels. In addition, people with diabetes, no matter how carefully the disease is managed, will still experience some high blood glucose levels. Even with the best treatment regimen, a person with diabetes cannot obtain glucose control that is comparable to – or as effective as – what the body does naturally in the person without diabetes, because the normally functioning pancreatic endocrine system releases small amounts of insulin directly into the liver in minute-to-minute response to the body’s needs.

### Untreated diabetes

Diabetes is treated in a variety of ways depending upon the individual’s situation. Because insulin is necessary to life, all people with type 1 diabetes must receive insulin every day through injections or an insulin pump. A person with type 1 diabetes would deteriorate rapidly and die within a matter of days if not given insulin artificially. People with type 2 diabetes may be able to treat the condition with changes to their diet and exercise, or may require insulin and/or various oral medications to control high blood glucose levels. Without the use of mitigating measures such as insulin or oral medications, individuals with diabetes will experience the complications of hyperglycemia discussed above, possibly including death.

A person with type 1 diabetes who does not have insulin will quickly become very ill. Within a matter of hours, glucose will build up in the blood, accompanied by fat breakdown toxins called “ketoacids.” Elevated blood glucose levels will cause increased urination and result in

dehydration. The person will become fatigued, and, as ketoacids increase, will experience loss of appetite, followed by nausea and vomiting. This condition is called “diabetic ketoacidosis” (DKA).<sup>14</sup> DKA can progress from nausea and vomiting to coma, shock, and death if left untreated.

A person with type 2 diabetes who requires insulin or oral medications may also experience severe hyperglycemia if he or she does not have medication. People with type 2 diabetes usually have a reserve of native insulin, but, in most cases, depend upon medication to maintain adequate control of their blood glucose levels. Without medication (oral agents or insulin), they will lose glucose control quickly. The little insulin they do produce will be less effective if medications to reduce insulin resistance are removed, causing glucose levels to rise.<sup>15</sup> A person with type 2 diabetes who manages the disease through diet and exercise also suffers consequences if the diet and exercise are stopped or are ineffective. The person’s blood glucose will rise to a level requiring medication to be brought back into a safe range.

The high blood glucose levels that mark untreated type 2 diabetes are often present before a person is diagnosed with diabetes, and can be as high as 600-1,000 mg/dl<sup>16</sup> (five to ten times the normal blood glucose level, which is between 70 and 140 mg/dl) As a result of the high blood glucose levels, the person will exhibit excessive thirst and frequent urination because of the overflow of glucose into the urine. Left untreated, this increased urination will lead to severe dehydration. Although DKA is extremely rare in people with type 2 diabetes, they are susceptible to extreme dehydration, leading to another life-threatening condition called hyperosmolar hyperglycemic syndrome (HHS). HHS develops over days or weeks, but can lead to confusion, hypotension (low blood pressure), shock, and eventually, to coma and death. HHS may be fatal in as many as 50% of those who develop it.

If a person with diabetes does not receive necessary medication, he or she is likely to suffer consequences as described above. This is because many of the complications of diabetes are caused by having too much glucose in the blood, and excess glucose damages the small blood vessels that carry blood throughout the body. Blood can’t get where it needs to be, and causes problems with circulation that lead to retinopathy and nephropathy (kidney damage). Too much glucose also speeds up the normal hardening of the arteries (atherosclerosis), decreasing blood flow to the heart and to the brain, causing heart attack and stroke. Likewise, too much glucose damages nerve cells and affects the electrical messages that nerve cells send throughout the body, especially to the feet. Because diabetes is a relentlessly progressive disease, the consequences of unmitigated diabetes will change over time and the rate at which these complications develop in a person with untreated diabetes will vary.

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<sup>14</sup> DKA can also develop in people with type 1 diabetes who are sick. The stress of illness on the body results in increased sugar output by the liver and increased fat breakdown, causing elevated blood levels of both sugar and ketoacids.

<sup>15</sup> People with type 2 diabetes are not truly insulin deficient and, thus, will not usually have the same dire and rapid deterioration as will the person with type 1 diabetes if medication is removed. However, they are at risk for serious adverse effects of high blood glucose, as described above.

<sup>16</sup> American Diabetes Association: *American Diabetes Association Complete Guide to Diabetes* at 177-78. 4<sup>th</sup> ed. Alexandria, VA, American Diabetes Association, 2005. Normal blood glucose levels are usually in the range of 80-120 mg/dl.

## Statutory Framework for Establishing Coverage

There are three ways to prove that someone has a disability under the ADA, as set forth in 42 U.S.C. § 12102(1): “The term disability means, with respect to an individual—

- (A) a physical or mental impairment that substantially limits one or more major life activities of such individual;
- (B) a record of such an impairment; or
- (C) being regarded as having such an impairment (as described in paragraph (3))”.

The concept of a substantial limitation on a major life activity is central to whether an individual has an actual disability or a record of a disability, and the new law has not changed this terminology.<sup>17</sup> This inquiry can be broken down into three steps:

- (1) Does the individual have a physical or mental impairment?
- (2) Does that impairment limit a major life activity? and
- (3) Is that limitation substantial?

The first two questions are rarely controversial in cases involving diabetes. Numerous courts have acknowledged that diabetes is a physical impairment.<sup>18</sup> *See, e.g., Gonzales v. City of New Braunfels*, 176 F.3d 834, 837 (5<sup>th</sup> Cir. 1999) (describing diabetes as a “serious impairment”); *Fraser, supra*, 342 F.3d at 1038; *Lawson, supra*, 245 F.3d at 923.<sup>19</sup> Also, plaintiffs have had little trouble showing that diabetes impacts major life activities. Plaintiffs have had the most success in arguing that their diabetes substantially limits the activities of eating and caring for oneself, which courts have long recognized as major life activities. (The ADAAA codifies the acceptance of these activities and others by courts by defining major life activities as “includ[ing], but ... not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading,

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<sup>17</sup> However, as will be discussed further below, the concept of substantial limitation no longer applies where the plaintiff claims that he or she was “regarded as” disabled under section 12102(1)(C). Where such a claim can be pursued, the plaintiff need only prove the existence of a physical or mental impairment.

<sup>18</sup> The EEOC regulations developed under the prior version of the ADA define a physical or mental impairment, in part, as “[a]ny physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine”. 29 C.F.R. § 1630.2(h).

<sup>19</sup> Numerous other courts have assumed that diabetes is an impairment under the ADA with little or no discussion. *Collado v. UPS*, 419 F.3d 1143, 1155 (11<sup>th</sup> Cir. 2005); *Thunderbull v. Barnhart*, 85 Fed. Appx. 67, 68 (10<sup>th</sup> Cir. 2003); *Cash v. Smith, supra*, 231 F.3d at 1305; *Matczak v. Frankford Candy & Chocolate Co.*, 136 F.3d 933, 937 (3d Cir. 1997). Similarly, the Sixth Circuit found that type 1 diabetes is an impairment under the Rehabilitation Act without discussion. *Brady v. Potter*, 273 Fed. Appx. 498, 502-03 (6<sup>th</sup> Cir. 2008). In fact, there are no cases holding to the contrary.

concentrating, thinking, communicating, and working” (42 U.S.C. § 12102(2)(A)), as well as major bodily functions, discussed below.<sup>20</sup>

Most of the litigation about the definition of disability prior to the passage of the ADAAA centered around the question of whether the limitations caused by an impairment are substantial. Many courts had narrowly construed this term to set a high standard of eligibility, taking their lead from the *Sutton* trilogy and from *Toyota Motor Manufacturing v. Williams*, 534 U.S. 184 (2002) (holding that the term “substantially limited” must be interpreted strictly to create a demanding standard for eligibility, and that a limitation must be “severe” in order to meet that test). However, the ADAAA and its legislative history make clear that Congress has rejected this heightened legal standard.

### Legislative History and Congressional Intent

The Congressional record of the ADAAA’s passage is filled with references to problems caused by narrow court interpretations of the definition of disability under the ADA for people with diabetes.<sup>21</sup> See Senate Managers’ Statement, 154 Cong. Rec. S8840-S8841 (Sept. 16, 2008) (“[W]e are faced with a situation in which physical or mental impairments that would previously have been found to constitute disabilities are not considered disabilities under the Supreme Court’s narrower standard. These can include individuals with impairments such as ... diabetes .... The resulting court decisions contribute to a legal environment in which individuals must demonstrate an inappropriately high degree of functional limitation in order to be protected from discrimination under the ADA.”) Congress made clear that in passing the ADA in 1990 it intended diabetes to be covered as a disability, and the ADAAA is meant to restore this original intent. See H. Comm. on the Judiciary, ADA Amendments Act of 2008, H. Rep. No. 110-730 pt. 2, at 7 (June 23, 2008) (“In enacting the ADA, Congress issued extensive reports expressing its intent and expectation that the definition it adopted from the Rehabilitation Act would continue to be interpreted broadly. ... Likewise, persons with impairments, such as epilepsy or diabetes, which substantially limit a major life activity are covered under the first prong of the definition of disability, even if the effects of the impairment are controlled by medication.”) Finally, Congress made clear its intent that individuals with impairments like diabetes should be considered disabled under the standards set by the ADAAA. See H. Comm. on Education and Labor, ADA Amendments Act of 2008, H. Rep. No. 110-730 pt. 1, at 15-16 (June 23, 2008) (describing *Orr, supra*, as an example of a case “that likely would be decided differently with regard to the threshold question of whether one qualifies as disabled”).

The ADA now states that “[t]he definition of disability in this Act shall be construed in favor of broad coverage of individuals under this Act, to the maximum extent permitted by the terms of this Act.” 42 U.S.C. § 12102(4)(A). The ADA also is to be interpreted consistent with the findings and purposes of the ADAAA, including its expression of Congressional belief that

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<sup>20</sup> Previously, major life activities were not defined or listed in the statute, but a non-exhaustive list was provided in the EEOC’s regulations implementing the ADA. 29 C.F.R. § 1630.2(i). These regulations did not include eating as a major life activity. Nonetheless, numerous courts had recognized eating as such. See *Lawson, supra*, 245 F. 3d at 923; *Waldrip v. General Electric Co.*, 325 F. 3d 652, 655 (5<sup>th</sup> Cir. 2003); *Weber v. Strippit, Inc.*, 186 F. 3d 907, 914 (8<sup>th</sup> Cir. 1999); *Erjavac v. Holy Family Health Plus*, 13 F. Supp. 2d 737, 746-47 (N.D. Ill. 1998).

<sup>21</sup> Georgetown University Law Center’s ArchiveADA provides convenient access to the general legislative history of the ADAAA, including the documents cited here, at <http://www.law.georgetown.edu/archiveada/>

Supreme Court decisions have “created an inappropriately high level of limitation necessary to obtain coverage under the ADA,” that “the primary object of attention in cases brought under the ADA should be whether entities covered under the ADA have complied with their obligations”, and “the question of whether an individual’s impairment is a disability under the ADA should not demand extensive analysis.’ 42 U.S.C. § 12102(4)(B); ADAAA § 2(b)(5).

Congress explicitly rejected the demanding standard set by the Supreme Court in *Toyota, supra*, along with its narrow definition of “substantial limitation”.<sup>22</sup> Congress also rejected the current definition of “substantial limitation” contained in EEOC regulations as setting too high a standard.<sup>23</sup> Yet Congress did not further describe the new standard, something that is likely to be explained in new regulations by the EEOC.<sup>24</sup>

### **Proving Diabetes is a Substantial Limitation**

While the precise scope of the substantial limitation requirement can be debated, it is clear that coverage is to be much broader under the new ADA, and doubts are to be construed in favor of coverage. These general principles are very helpful for people with diabetes. However, it is not necessary to rely solely on general principles; the ADAAA makes a number of specific changes to the law that establish coverage for people with diabetes. Given these changes and the Congressional intent behind them, attorneys should seek, where possible, to resolve this issue through a stipulation or an admission in discovery that their client is disabled. If the issue does need to be litigated, attorneys should keep in mind that any one of the strategies discussed below is sufficient to establish coverage under the ADA, although it may be advisable to pursue multiple strategies in a given case, at least until the law is well-established.

#### No Consideration of Mitigating Measures

One of the most important provisions of the ADAAA reverses the Supreme Court’s holding in the *Sutton* trilogy and makes clear that, in determining whether an individual is covered by the ADA, employers and courts may not consider that individual’s use of “mitigating measures” such as medication to control the condition. The law states:

The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures such as--

(I) medication, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies;

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<sup>22</sup> ADAAA § 2(a)(7)

<sup>23</sup> ADAAA § 2(a)(8)

<sup>24</sup> The EEOC has been given explicit authority to issue regulations related to the definition of disability, and Congress has stated its expectation that these new regulations would revise the definition of a substantial limitation to be consistent with the ADAAA. 42 U.S.C. § 12206; ADAAA § 2(b)(6). These regulations are currently being developed.

- (II) use of assistive technology;
- (III) reasonable accommodations or auxiliary aids or services; or
- (IV) learned behavioral or adaptive neurological modifications.

42 U.S.C. § 12102(4)(E)(i). For individuals with diabetes, this means that the beneficial effects of insulin and oral medications in treating the disease may not be considered in determining the existence of a disability. Instead, the focus must be on the condition as it exists in its unmedicated state. *See Rohr, supra*, at \*27 (“Impairments are to be evaluated in their *unmitigated* state, so that, for example, diabetes will be assessed in terms of its limitations on major life activities when the diabetic does *not* take insulin injections or medicine and does not require behavioral adaptations such as a strict diet”) (emphasis in original). Likewise, the effects of any complications the individual experiences due to diabetes, such as vision loss or neuropathy, must be considered without regard to any medication or treatment employed, as well as any devices or technology the individual uses such as a prosthesis or screen reader software.<sup>25</sup>

The *Sutton* Court itself makes the case that diabetes must be considered a disability when mitigating measures are not considered, in a quote that should be widely used in cases following the ADAAA. The Court stated:

[U]nder this view [i.e., without regard to mitigating measures], courts would almost certainly find all diabetics to be disabled, because if they failed to monitor their blood sugar levels and administer insulin, they would almost certainly be substantially limited in one or more major life activities. A diabetic whose illness does not impair his or her daily activities would therefore be considered disabled simply because he or she has diabetes.

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

Since diabetes can vary in cause, treatment and severity, it is important to understand the type of diabetes an individual has and to tailor the argument accordingly by focusing the attention of the court on the consequences that will result if he or she forgoes prescribed individualized treatment. Most people with diabetes will fall into one of four broad categories:

- **Type 1 diabetes:** The diagnosis of type 1 diabetes, by definition, means that the body is unable to produce insulin because the cells that produce it naturally have been destroyed. Insulin is necessary for survival as it is the only means for transport of glucose into the cells to be used as a source of energy.. As described above, within a few hours a person

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<sup>25</sup> There are several special provisions relating to eyeglasses and other vision aids. The effects of ordinary eyeglasses or contact lenses (defined by the act as those that fully correct the visual problem) may be considered in making the disability determination, but other low vision aids may not. 42 U.S.C. § 12102(4)(E)(ii), (iii). Moreover, qualification standards based on uncorrected vision must be job-related and consistent with business necessity (thus extending some protection to those who are not disabled because they use ordinary eyeglasses or contact lenses). 42 U.S.C. § 12113(c).

who receives no insulin will experience moderate to severe hyperglycemia, which causes blurry vision, headaches, nausea, fatigue, hunger and thirst. Diabetic ketoacidosis (DKA) will soon follow, as discussed above, and in a matter of days death will result if insulin is not provided. Thus, type 1 diabetes in its unmitigated state causes death, which substantially limits all major life activities. Even before death occurs, untreated type 1 diabetes will cause substantial limitations in thinking, concentrating, eating and caring for oneself (due to hunger, fatigue, and then shock and coma), seeing (due to blurred vision), and breathing (due to pneumonia) because of untreated diabetes and DKA. Many people experience severe hyperglycemia and DKA when they are first diagnosed with type 1; introducing evidence of the symptoms the individual experienced when diagnosed can be useful to show what would occur without treatment. With proper medical testimony, it will not be difficult to prove that type 1 diabetes is a disability.

- **Type 2 diabetes treated with insulin alone or insulin and oral medications:** People who use insulin to treat type 2 diabetes do not face the same immediate risks as those who have type 1 diabetes, because their bodies still produce some insulin and their blood glucose levels will not rise as quickly. However, the constant hyperglycemia that would result if individuals with type 2 diabetes did not receive insulin when needed will cause substantial limitations in thinking, concentrating, breathing, seeing, eating and caring for oneself, as described above for type 1. Also, prolonged hyperglycemia over time causes severe complications that are substantially limiting. For example, retinopathy causes limitations in seeing, neuropathy causes limitations in walking and standing, and kidney disease can lead to kidney failure, which limits the ability to care for oneself. In addition, prolonged hyperglycemia can cause a life threatening condition known as HHS, described above, which causes limitations similar to those for DKA in type 1. Attorneys should investigate whether their clients were experiencing any of these symptoms when diagnosed with diabetes or when first placed on insulin therapy (which is often begun when treatment with diet, exercise or medications is not working) because, while it should not be required, such a history can provide additional evidence of what complications would result without treatment.
- **Type 2 diabetes treated with oral medications:** As with people who use insulin to treat type 2 diabetes, those who use oral medications face serious health consequences without those medications. Where oral medications are prescribed they are needed to keep blood glucose levels in the target range; without them, blood glucose levels will run too high, resulting in the complications and limitations described above. However, it is worth noting that oral medications are often used as treatment prior to insulin and earlier in the progression of the disease and its complications, which may make it somewhat more difficult for a court to recognize that untreated diabetes does cause long-term complications.
- **Type 2 diabetes treated solely with diet and exercise:** Some people with type 2 diabetes, particularly in the early stages of the disease, are able to control their diabetes through diet and exercise. A threshold question in this situation is whether the effects of diet and exercise may be considered by the court in deciding whether a disability is present. Diet and exercise are not specifically listed by the statute as “mitigating

measures”, but the Ninth Circuit recently indicated that they should be considered as such. *See Rohr, supra*, at \*27 (diabetes must be “assessed in terms of its limitations on major life activities when the diabetic ... does not require behavioral adaptations such as a strict diet.”) Moreover, in numerous cases prior to the passage of the ADAAA, courts indicated that diet and exercise could be considered mitigating measures.<sup>26</sup> Even so, such a claim could raise challenging problems of proof. For example, it could be difficult to assess a person with diabetes in an unmitigated state, since that would require determining how much they “would have” eaten or exercised and determining the effect of a typical diet or exercise regimen on diabetes. It may be easier in these cases to demonstrate a substantial limitation in endocrine function or to prove that the individual was regarded as disabled (see further discussion below).

- **Gestational Diabetes:** Gestational diabetes is treated much like type 2 diabetes, so its potential limitations will be similar to those described above for type 2 treated with insulin or diet/exercise. However, since gestational diabetes is normally temporary (ending when the pregnancy does) defendants may claim that it cannot be substantially limiting. While court prior to the ADAAA frequently held that temporary disabilities could not be considered disabilities, the broadening of the interpretation of the disability definition mandated by the ADAAA should make courts more likely to accept this kind of claim.

A useful guide to how courts will address diabetes as a disability in the ADAAA’s post-*Sutton* era can be found in cases brought under the ADA prior to the *Sutton* trilogy when most federal appellate courts had ruled that mitigating measures could not be considered in determining whether an individual had a disability and a number of courts found that diabetes qualified as a disability on this basis. For example, in *Baert v. Euclid Beverage*, 149 F.3d 626, 630 (7th Cir. 1998), the court indicated that it does not matter which major life activity a person who uses insulin alleges to be limited, because “an insulin-dependent diabetic, who would likely lapse into a coma and die without insulin, would be ‘substantially limited’ in all life activities, indeed would be deprived of life itself.” To further emphasize this point, the court pointed out that although the plaintiff claimed that “diabetes affects his ability to work,” he “could just as easily have focused on any other life activity.” *Id.* The court approvingly noted that the plaintiff supported his claim by providing evidence that he had to be hospitalized when he was initially diagnosed, and noted that the “hospitalization corroborates his dependence on insulin and speaks to the severity of the consequences of failing to take it.” *Id.* Also, in *Erjavac v. Holy Family Health Plus*, 13 F. Supp. 2d 737, 746 (N.D. Ill. 1998), the court stated that “it is generally understood that an insulin-dependent diabetic would be likely to suffer a coma or worse if unable to administer insulin as needed.” *Id.* (quoting *Schluter v. Industrial Coils, Inc.*, 928 F. Supp. 1437, 1444 (W.D. Wis. 1996)). Thus, the court found that “untreated diabetes is substantially life-limiting” and therefore “insulin-dependent diabetes is a disability under the ADA.” *Id.*

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<sup>26</sup> See, e.g., *Orr, supra*, 297 F.3d at 724 (8th Cir. 2002) (diet); *Burrell v. Cummins Great Plains, Inc.*, 324 F. Supp. 2d 1000 (S.D. Iowa 2004) (diet); *Millage v. City of Sioux City*, 258 F. Supp. 2d 976, 991 (N.D. Iowa 2003) (diet); and *Carruth v. Continental General Tire*, 2001 U.S. Dist. Lexis 22368, at \*6 (S.D. Ill. 2001) (monitoring diet and exercise). See also *Droutman v. N.Y. Blood Center, Inc.*, 2005 U.S. Dist. Lexis 42951, at \*19 (E.D. N.Y. July 27, 2005) (breathing exercises for asthma); *Jones v. Family Health Center, Inc.*, 323 F. Supp. 2d 681, 688 (D. S.C. 2003) (diet for a variety of impairments); and *Testerman v. Chrysler Corp.*, 1997 U.S. Dist. Lexis 21392, at \*36 (D. Del. Dec. 30, 1997) (exercise and nutrition).

In *Pate v. Baker Tanks Gulf South, Inc.*, 34 F. Supp. 2d 411, 415 (W.D. La. 1999), a district court found a person with “moderately severe” type 2 diabetes met the definition of disability because, without medication, her “blood sugar level would be extremely high, and would result in bilateral kidney failure, heart and hearing problems, and loss of a limb(s).” In *Pate*, the plaintiff used insulin, but the risk of high blood glucose and its attendant complications from untreated diabetes could support a finding of disability for someone who used oral medication, as well.

### *The Need for Medical Evidence*

It is very important when asking the court to assess an individual’s diabetes in its unmitigated state to present adequate evidence of the impact and results of untreated diabetes. Plaintiffs who attempt to rely on the diagnosis of diabetes alone have routinely lost, and will likely continue to do so since the underlying legal standard (establishing substantial limitation in a major life activity) has not changed. Adequate proof will, in most cases, include medical testimony, either from the individual’s treating physician or from a properly qualified expert. While a person with diabetes can testify about the disease’s actual day to day effects,<sup>27</sup> it is much more difficult for someone without medical training to competently testify about what the disease would be like without insulin or oral medications. *See, e.g., Erjavac*, supra, 13 F. Supp. 2d at 746 (court held that plaintiff could not rely upon common knowledge about diabetes to establish disability, but that plaintiff in this case gave the requisite information by presenting “the expert testimony of her physician, who described in detail the substantial limitations of Erjavac's diabetes in both its treated and untreated states.”)

Defendants may try to challenge some claims of disability based on the effects of a disease in its untreated state as overly speculative, particularly if the effects vary over time or among individuals. For example, complications of diabetes such as neuropathy and retinopathy can take years or decades to develop, even if the disease is not properly treated, and not all individuals develop all complications. Case law suggests that an individual’s claim of disability is to be evaluated at the time the alleged discrimination occurred, not at some later time, *see, e.g., Scheerer v. Potter*, 443 F. 3d 916 (7<sup>th</sup> Cir. 2006) (evidence of plaintiff’s subsequent toe amputation was irrelevant because it happened months after the alleged discrimination occurred). It is conceivable that a court might require evidence that the complications were likely to have occurred, absent treatment, by the time of the alleged employment discrimination. This could create challenges for individuals recently diagnosed with type 2, because they may not have had the disease long enough for complications to be likely. Plaintiffs faced with this situation may want to point to evidence of the complications or health problems that led to their diagnosis of diabetes (as these would have likely only gotten worse in the absence of treatment). Moreover, the strongest point to be made in response to such an assertion by the defendant may be that such an analysis is rooted in the now-overturned *Sutton* decision and its rationale for why mitigating measures must be considered, (that is, that otherwise courts would be required to speculate)—a rationale that is no longer applicable.

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<sup>27</sup> For example, one court held that medical evidence was not necessary to withstand summary judgment because “the lack of supporting medical evidence here would not prevent a jury, if necessary, from tying eating limitations to Plaintiff's diabetes. The connection, in the court's view, is generally understood by lay people.” *Miller v. Verizon Communications*, 2007 U.S. Dist. Lexis 12265 (D. Mass. 2007).

### *Negative Effects of Mitigating Measures*

It is important to note that the ADA only forbids considering the ameliorative effects of mitigating measures. 42 U.S.C. § 12102(E)(i). Therefore, any side effects or harm caused by the mitigating measures may still be considered. For people with diabetes, this is important because the use of insulin (and, to a lesser degree, certain oral medications) carries risks of its own. Too much insulin can cause hypoglycemia, which can limit abilities such as thinking, concentrating, and caring for oneself and can be life threatening when severe. Because of the risk of hypoglycemia, diabetes treatment regimens involve walking a tightrope—too little insulin leads to hyperglycemia and long term complications, while too much insulin can lead to the severe short term consequences of hypoglycemia. Because of this, and because of the scientifically demonstrated benefits of tighter blood glucose control, treatment regimens often require numerous daily blood glucose tests and insulin injections. Individuals with diabetes must carefully balance insulin, food intake and physical activity, and are not free to eat whenever and whatever they choose. The diabetes treatment regimen itself therefore can substantially limit the major life activities of eating and caring for oneself, among others. In cases decided under the *Sutton* framework, this was often the focus of the disability inquiry. *See, e.g., Branham, supra*, 392 F. 3d at 903 (individual with type 1 diabetes survived summary judgment on issue of disability because his need for frequent blood glucose checks and to balance food intake, exercise and insulin substantially limited his ability to eat); *Fraser, supra*, 342 F. 3d at 1042 (burdens of the treatment regimen of an individual with type 1 diabetes substantially limited her ability to eat); *Nawrot v. CPC International*, 277 F.3d 896, 905 (7th Cir. 2002) (the need to carefully manage diabetes in order to avoid hypoglycemia substantially limited an individual's ability to care for himself). While often successful in the past, this line of argument also carries risks, because pre-ADAAA courts usually required putting forward evidence of problems the individual has experienced due to his/her diabetes and its treatment regimen (such as recurrent hypoglycemia), which may play into an employer's argument that an individual is not otherwise qualified for a job or poses a direct threat. The ADAAA has greatly reduced the need to rely on such risky evidence by shifting the focus of the disability inquiry from what the individual does or does not do to manage the condition to the condition's underlying effects. Nonetheless, in appropriate cases, attorneys may want to consider introducing evidence of the limiting effects of mitigating measures such as insulin.

#### The New Major Life Activity of Endocrine Function

As discussed earlier, diabetes can substantially limit a number of major life activities, particularly when the unmitigated effects of the disease are considered. In the past, major life activities were often seen as limited to external physical activities (such as walking or standing) or mental processes with clear external effects (such as thinking or concentrating). However, the ADAAA introduces a new category of major life activity relating to the body's internal processes. 42 U.S.C. § 12102(2)(B) provides:

[A] major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel,

bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

This new provision means that plaintiffs can now prove disability by showing that diabetes has caused a substantial limitation in the operation of their endocrine system (instead of or in addition to proving disability using the other major life activities previously discussed in this article). The purpose of the endocrine system, as described above, is to produce and secrete needed hormones so they can be distributed throughout the body. Diabetes renders the body unable to produce adequate supplies of insulin, a critical hormone produced by the endocrine system. It can also cause cells to be resistant to recognizing and using insulin (insulin resistance), requiring the endocrine system to produce more insulin to do the same work and putting strains on the system that over time will damage its ability to function and produce insulin. Because diabetes, by definition, impairs the functioning of the endocrine system in significant ways, it should not be difficult to prove that the disease causes substantial limitation in endocrine function, with proper medical evidence.<sup>28</sup> In addition, complications of diabetes may affect other bodily functions, including the circulatory and digestive systems. *See, e.g., Rohr, supra*, at \*16 (diabetes affects the digestive, hemic and endocrine systems). Lawyers handling diabetes discrimination cases under the ADAAA should consult with the Association for assistance compiling medical evidence and expert testimony.

There is as yet no case law applying this expanded concept of major life activities to diabetes. However, even prior to the passage of the ADAAA courts had begun to recognize disabilities based on internal bodily processes. For example, several courts found evidence that an individual was suffering from kidney disease or end-stage renal failure sufficient to establish a claim of disability. Describing the major life activity at issue there as “eliminating waste,” the courts found evidence of the disease and its effects on the kidneys sufficient to demonstrate a substantial limitation. *Fiscus v. Wal-Mart Stores*, 385 F. 3d 378, 385 (3d Cir. 2004); *Heiko v. Columbo Savings Bank, F.S.B.*, 434 F. 3d 249, 257-258 (4<sup>th</sup> Cir. 2006). It remains to be seen what standards courts will apply to determine when a bodily system is substantially limited, but diabetes seems a perfect fit with the Congressional intent behind the bodily function provisions.

Such an argument may, in some cases, offer advantages over an approach focusing on the unmitigated effects of diabetes. First, it requires only proof of the disease itself as it currently exists, not its likely effects in the event it was not treated. Second, the plaintiff need not present any evidence of the external effects of the disease, such as the possibility of severe hyperglycemia or hypoglycemia. This may be desirable in cases where the employer argues that the employee is a safety risk or a direct threat, as extensive evidence about the harmful effects of diabetes on consciousness and cognitive functioning, even if only hypothetical, may undermine the employee’s case. Focusing on endocrine functioning should be particularly useful for individuals with type 2 diabetes using fewer medications, for whom the immediate effects of ceasing treatment are not as obvious.

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<sup>28</sup> Diabetes also limits cell function because it deprives cells of the energy they derive from glucose.

## Effects of Episodic Conditions

Another provision added by the ADAAA concerns the treatment of conditions whose effects are episodic or in remission. The act provides: “An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.” 42 U.S.C. § 12102(4)(D). This provision may be useful as an additional argument as to why individuals with diabetes have a disability. Diabetes can cause fluctuations in blood glucose levels, resulting in episodes of hyperglycemia and, for those taking insulin or certain oral medications, hypoglycemia. As noted above, both hyperglycemia and hypoglycemia cause severe symptoms that can substantially limit major life activities. For example, even mild to moderate hypoglycemia may cause blurred vision, inability to concentrate, disorientation and confusion, thus substantially limiting the ability to see, think, concentrate, and care for oneself. More severe hypoglycemia can leave the person unable to swallow food or care for himself/herself, requiring assistance by others (limiting the ability to eat, concentrate and care for oneself), and even cause coma or death.

Even before the passage of the ADAAA, some courts had held that individuals could show a substantial limitation in major life activities such as thinking, communicating, and working where the plaintiff had experienced recurring hypoglycemia or hyperglycemia. *See Nawrot, supra*, 277 F. 3d at 905 (finding plaintiff substantially limited in thinking and caring for himself based in part on his lack of success in maintaining blood glucose levels within target ranges, despite his treatment efforts); *EEOC v. Wal-Mart Stores, Inc.*, 2001 U.S. Dist. Lexis 23027 (W.D.N.Y. 2001) (evidence of incapacitating hypoglycemia on the job sufficient to raise genuine issue of fact); *McCusker v. Lakeview Rehab. Ctr.*, 2003 U.S. Dist. Lexis 16340 (D. N.H. 2003); *c.f. EEOC v. Sears, Roebuck & Co.*, 233 F.3d 432, 438 (7th Cir. 2000), *subsequent opinion at* 417 F. 3d 789 (7<sup>th</sup> Cir. 2005) (episodic nature of limitations in ability to walk due to diabetic neuropathy did not necessitate summary judgment). Other cases rejecting disability claims because the effects were only episodic are no longer good law.<sup>29</sup>

While the effect of episodic hypoglycemia and hyperglycemia is no longer a central focus of the inquiry because of the other changes made by the ADAAA, evidence of the way these conditions affect a person with diabetes when they are active may be useful in certain cases. While it is possible that a person might not actually need to experience these episodic conditions in their active state, it may be easier to argue for coverage based on the effects of hypoglycemia or hyperglycemia where there is a documented history of these conditions.

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<sup>29</sup> *See, e.g., Fraser, supra*, 342 F. 3d at 1043 (rejecting argument that plaintiff was substantially limited in caring for herself because of her episodes of hypoglycemia and hyperglycemia, even though the court had already found her to be substantially limited in the major life activity of eating because of her treatment regimen); *Orr v. Wal-Mart Stores*, 297 F. 3d 720, 724 (8<sup>th</sup> Cir. 2002); *Espinal v. Northwest Airlines Inc.*, 1999 U.S. App. LEXIS 8250 (9th Cir. 1999) (holding not disabled because plaintiff was only suffering from the short-term effects of a new diabetes diagnosis); *Davis v. Ozarks Electric Cooperative*, 2006 U.S. Dist. Lexis 21835 (W.D. Ark. 2006) (holding recently diagnosed plaintiff did not have an actual disability because limitations only expected to last until she got her diabetes under control)

## “Record of” and “Regarded as” Claims

Even if an individual does not have an actual disability, the ADA provides two other avenues for coming within the act’s protections. The definition of disability under the ADA includes individuals who have a record of an impairment that substantially limits a major life activity or who are regarded as having such an impairment. 42 U.S.C. §§ 12102(1)(B), (C).

“Record of” claims have not been litigated frequently, but medical records of diabetes diagnosis or treatment, as well as other records (such as government disability benefits) should be sufficient to establish a “record of” claim if they also reflect substantial limitations on major life activities, as discussed above. *See, e.g., Lawson, supra*, at 926-30 (finding that the fact that plaintiff received Social Security disability benefits for a dozen years raises a jury question as to whether he has a “record of” a disability). Because diabetes is generally not curable and is an actual disability, it is hard to anticipate a situation when a plaintiff should rely solely on a “record of” claim.

The ADAAA significantly expanded the availability of “regarded as” claims. According to the amended ADA, “An individual meets the requirement of ‘being regarded as having such an impairment’ if the individual establishes that he or she has been subjected to an action prohibited under this Act because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.” 42 U.S.C. § 12102(3)(A). An impairment therefore need not be substantially limiting in order to be the basis for a “regarded as” claim. Previously, the “regarded as” inquiry focused on what the employer thought about the plaintiff’s condition, and was of limited usefulness to plaintiffs without detailed evidence of the opinions of the employer about plaintiff’s specific limitations. Now, however, the inquiry is limited to the existence of an impairment and whether the employer took a prohibited action on the basis of that impairment. As noted above, there can be no dispute that diabetes is a physical impairment.<sup>30</sup> Thus, all individuals with diabetes should be able to prevail in a regarded-as claim if their employer took a prohibited action based on their diabetes.

There is a tradeoff, however. The ADA now makes clear that an individual with only a regarded-as disability, who does not establish an actual disability, has no right to reasonable accommodations (an issue on which the circuits were previously split). 42 U.S.C. § 12201(h). Such an individual may only assert a claim that he or she experienced an adverse employment action (such as failure to hire or firing) because of a disability. Individuals who require reasonable accommodations must prove that they have an actual disability.

“Regarded as” claims should be included whenever an individual with diabetes does not need any accommodations and will be particularly useful for individuals who don’t use medications or have any long-term complications (for example, an individual who manages his diabetes without

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<sup>30</sup> Physical and mental impairments under this section do not include those that are “transitory and minor” (transitory is defined as having an actual or expected duration of six months or less). 42 U.S.C. § 12102(3)(B). As diabetes is neither curable nor minor, this provision does not stand in the way of a regarded as claim by an individual with diabetes. Even gestational diabetes, which will often be “transitory” under this definition, can hardly be considered minor, given the significant risks to the health of mother and baby posed by hyperglycemia during pregnancy.

medication but is nonetheless fired because of fears about experiencing hypoglycemia or because of a desire to lower health care costs by ridding the workforce of those with chronic diseases). In these cases, there is no need to inquire into the severity or effects of the individual's diabetes. So long as discrimination occurred, he or she was regarded as disabled. In such cases, it is hard to imagine what sorts of accommodations might be needed. However, as noted above, there are a number of ways to easily establish actual disability, so care should be taken to be certain no reasonable accommodations are needed before foregoing the benefits of actual disability status.

## **Conclusion**

The intent and promise of the ADAAA is to turn the question of eligibility under the ADA from the most frequently debated and litigated legal issue to a threshold question of minor importance that will not serve as a barrier to people with chronic diseases and medical conditions such as diabetes. As described above, it accomplishes this goal through several provisions designed to overturn narrow interpretations used by the courts and providing new ways to establish coverage. Advocates should thus feel confident that they can establish coverage for people with diabetes under the ADA. However, along with that confidence should come the obvious caution that a winnable case can be easily lost without the right evidence. Here, it is important to keep in mind that getting over the coverage threshold still requires more than a mere diagnosis of diabetes. At least until case law is developed under the ADAAA, proper medical testimony from the individual's treating physician and/or an expert should be used to demonstrate the effects of and limitations caused by the disease (or those that would be caused but for the mitigating measures). Attorneys bringing early cases under the new standards should be especially careful to provide adequate proof and clear argument to help courts understand the new legal landscape as it relates to the science and treatment of diabetes.

The American Diabetes Association stands ready to assist attorneys bringing these pioneering cases. The Association provides extensive resources on this and other aspects of diabetes discrimination litigation on its website at <http://www.diabetes.org/advocacy-and-legalresources/attorneymaterials.jsp> This site includes case lists, articles like this one discussing relevant legal issues, and pleadings and other materials from key cases that have successfully addressed these issues. The Association also provides assistance to attorneys bringing diabetes discrimination cases, including assistance in shaping arguments and drafting briefs. Lawyers with questions about a specific case are encouraged to contact Brian Dimmick at [bdimmick@diabetes.org](mailto:bdimmick@diabetes.org).

## Resources on Diabetes

### Website and Pamphlets

The American Diabetes Association (Association) has a great deal of information about diabetes, its complications and its treatment on its web site, <http://www.diabetes.org>. In the “All About Diabetes” section are pages on numerous topics that can be useful as background for attorneys who have clients with diabetes. In addition, pamphlets describing diabetes and its treatment and care can be obtained by calling 1-800-DIABETES.

In addition, the Association’s website has extensive information for lawyers litigating diabetes discrimination cases under the ADA. Of particular interest are a comprehensive case list of diabetes cases (including pre-*Sutton* decisions considering diabetes in its unmitigated state) and briefs and other litigation materials from numerous cases. These resources can be accessed at <http://www.diabetes.org/attorneymaterials>.

### American Diabetes Association’s Clinical Practice Recommendations

The Association’s Clinical Practice Recommendations are the most authoritative and widely-followed guidelines for the treatment of diabetes. They represent the official opinion of the Association as denoted by formal review and approval by the Professional Practice Committee and the Executive Committee of the Board of Directors. They are published each January as a supplement to *Diabetes Care*, the Association’s peer-reviewed journal for diabetes health care professionals. The Introduction to these Recommendations further explains their origins. The current Clinical Practice Recommendations can be found online at: [http://care.diabetesjournals.org/content/vol32/Supplement\\_1/](http://care.diabetesjournals.org/content/vol32/Supplement_1/).

Some of the more broadly applicable Recommendations that address the functional limitations issues are: Standards of Medical Care for Patients with Diabetes Mellitus; Diabetes and Employment; and Diagnosis and Classification of Diabetes Mellitus.

### Books

Numerous Association books provide more detailed explanations of the issues discussed above. *The American Diabetes Association Complete Guide to Diabetes* (4<sup>th</sup> ed., 2005) is intended for a lay audience. *Medical Management of Type 1 Diabetes* (5<sup>th</sup> ed. 2008), *Medical Management of Type 2 Diabetes* (6<sup>th</sup> ed. 2008), and *Therapy for Diabetes Mellitus and Related Disorders* (4<sup>th</sup> ed. 2004) are geared toward a health care professional audience. These books can be obtained by calling 1-800-DIABETES or through the Association’s website at <http://store.diabetes.org/>.