

Background Materials on Diabetes and Functional Limitations For Lawyers Handling Diabetes Discrimination Cases

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The purpose of this article is to provide background information for lawyers representing clients with diabetes who are facing challenges regarding whether the client qualifies as someone who has a disability, has a record of a disability, or is regarded as having a disability under the Americans with Disabilities Act (ADA) or the Rehabilitation Act of 1973 (as those statutes were interpreted prior to 2009). The discussion in this document is also applicable to state laws with the same standards for coverage. Specifically, this article addresses how diabetes may substantially limit major life activities by providing basic background about diabetes, providing resources to learn more about diabetes, and discussing strategies for establishing coverage in diabetes discrimination cases.

Important Note: On September 25, 2008, the ADA Amendments Act of 2008 was signed into law. This statute, which becomes effective on January 1, 2009, dramatically changes how the determination of who has a disability under the Americans with Disabilities Act and the Rehabilitation Act is made. For example, under the new law mitigating measures may not be considered in determining whether an individual has a disability and coverage may be established based on a substantial limitation of a major body system such as the endocrine system. It is critical that attorneys representing clients who have faced discrimination on or after January 1, 2009 be aware of the new law. For more information, see <http://www.diabetes.org/advocacy-and-legalresources/discrimination/employment/americans-with-disabilities-act-amendments-act.jsp>. However, it is also important to remember that the coverage standards discussed in this document will apply to all claims based on conduct occurring prior to 2009, regardless of when the charge of discrimination or the lawsuit is filed.¹

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¹ Case law thus far states that the new law does not apply retroactively. See *Kiesewetter v. Caterpillar, Inc.*, 2008 U.S. App. Lexis 21481 (7th 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); *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 is “restorative” in that it overturns a prior court decision which Congress believes was wrongly decided).

Introduction to Diabetes

In dealing with the issue of whether diabetes – as it affects your client – constitutes a disability, it is useful to begin with a summary of diabetes. The following is a simplified explanation of the disease intended to put the rest of the literature on diabetes into context.

Explanation of the Disease

Diabetes is an incurable disease that affects the way the body uses food. It causes glucose levels in the blood to be too high.

Normally, during digestion, the body changes sugars, starches, and other foods into a form of sugar called glucose. The blood then carries this glucose to cells throughout the body. There, with the help of insulin (a hormone), glucose enters the cells and is changed into quick energy for the cells to use or store for future needs. (Insulin is made in the beta cells of the pancreas, a small organ behind the stomach.) This process of turning food into energy is crucial, because the body depends upon 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 the normal process of turning food into energy. Food is changed into glucose readily enough, but insulin is not present or cannot be used properly. There are three main types of diabetes²: type 1 diabetes, type 2 diabetes, and gestational diabetes.³ 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. In type 2 diabetes, the body makes some insulin, but either makes too little, or has trouble using the insulin, or both. Gestational diabetes is a form of glucose intolerance that is diagnosed in some women during pregnancy. 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 glucose in the bloodstream cannot be used by the cells to make energy. Instead, glucose collects in the blood, leading to the high glucose levels or “hyperglycemia” that is the defining characteristic of untreated diabetes.

² There are other forms of diabetes that do not fit readily into these three types, but they are much less common and are not the focus of this article.

³ 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.

Diabetes is treated in a variety of ways depending upon the individual's situation. Since insulin is necessary to life, all people with type 1 diabetes must receive insulin every day through injections, an insulin pump, or another external source. A person with type 1 diabetes would 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.

These treatments, however, *do not cure diabetes*. In fact, use of insulin and some oral medications can cause too much sugar to cross the cell membranes. This results in abnormally low blood glucose levels or "hypoglycemia" that causes very serious medical problems, as discussed below. Treatment also *does not correct diabetes* in that people with diabetes, no matter how carefully the disease is managed, will still experience some high blood glucose levels and – for people taking insulin and some oral medications – will also experience some low blood glucose levels. This does not mean that all people with insulin-treated diabetes will experience the most extreme symptoms, such as passing out from low blood glucose levels. It does mean that all such people must use constant vigilance to avoid low blood glucose levels. The bottom line is that, even with the best treatment regimen, a person with diabetes cannot obtain glucose control that is comparable to – or as good as – what the body does naturally in the person without diabetes. Rather, treatment for diabetes focuses on trying to keep blood glucose levels as close as possible to the normal range in order to avoid a broad range of immediate and long-term medical problems.

Functional Limitations

The functional limitations for people with diabetes result from four basic causes: (1) the short term effects of high blood glucose levels (hyperglycemia); (2) the immediate consequences of low blood glucose levels (hypoglycemia); (3) the long term complications caused by hyperglycemia; and (4) the myriad of difficulties that are caused by trying to keep blood glucose levels balanced at a healthy level.

(1) Hyperglycemia — short term

The symptoms of hyperglycemia include hunger, thirst, headache, blurry vision, frequent urination, itchy and dry skin, and – the most serious possible short term consequence – diabetic ketoacidosis, which can cause breathing difficulties, dangerous electrolyte imbalance, coma, shock, and even death.

(2) Hypoglycemia

The symptoms of hypoglycemia (caused by insulin and/or certain oral medications) include tremors, palpitations and sweating, confusion, drowsiness, mood changes, unresponsiveness, unconsciousness, convulsions, and 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.

(3) Hyperglycemia — long term

Given the dangers of hypoglycemia, it might seem to make sense to take every possible measure to avoid low blood glucose levels, even if it meant running higher than normal blood glucose levels. The problem is that, in addition to the short-term consequences of acute hyperglycemia discussed above, high blood glucose levels cause a number of very serious long-term complications. These include (but are not limited to) eye disease (including blindness), kidney disease (including kidney failure), nerve damage (including limitations on the ability to sit, stand, walk, feel pain, and digest food, as well as problems caused by incontinence and diarrhea), blood vessel disease (including heart attack, stroke and leg/foot amputations), difficulty with reproduction (impotence for men, conditions that make pregnancy complicated for women), and susceptibility to dangerous infections. Diabetes is the number one cause of blindness, kidney disease, and amputations, as well as a significant contributor to heart disease and stroke. The life expectancy of a person with diabetes is shortened by up to fifteen years.

(4) Activities Used To Control Blood Glucose Levels

Since untreated diabetes will cause dangerous high blood glucose levels whereas diabetes treated with too much insulin (or some oral medications) can result in dangerous low blood glucose levels, the goal of treatment is to try to balance the blood glucose level within a safe range. The result for people with diabetes is a very delicate, and very crucial, balancing act. This is a complex process, *some* of the components of which are described below.

People with diabetes monitor their blood glucose levels through awareness of body signals, and self-administration of blood glucose checks. (An exception is that some children and some people with other disabilities need assistance in these tasks.) 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.

Some people with diabetes are better able to recognize the symptoms of high and low blood glucose levels than are others. Blood glucose checks are done a number of times each day, with the frequency depending on many factors. Blood glucose monitoring gives the person with diabetes information that allows him or her to make immediate necessary adjustments in medication, nutrition, and activity levels – as well as providing vital information to his or her health care team. In addition, urine or blood tests are used when especially high blood glucose levels are found (as well as in certain other situations) to check for ketones. Ketones are a dangerous byproduct of the liver breaking

down fat in order to supply the cells with needed energy.⁴ Careful records must be kept of all monitoring results.

For some people with diabetes, insulin is required. Insulin can be self-administered through injections or through constantly wearing an insulin pump. Insulin administration does not consist of a single shot a day or a set regimen of shots that a person with diabetes can follow year in and year out. Rather, it is a dynamic process that is adjusted either throughout a given day or at least periodically depending upon the level of glucose control that is sought. There are many types of insulin that differ in how they are made, how they work in the body, and price. These insulins are divided into four broad types 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). The impact of insulin is affected by when it is taken and where it is injected. In addition, each person responds to insulin in his or her own way.

People with diabetes must consider the impact on the disease of everything they eat, how much they eat, and when they eat it – or don't eat it. Both food and lack of food can cause severe short and/or long-term medical problems for people with diabetes. In addition, different foods and combinations of foods affect blood glucose levels in different ways.

People with diabetes must also take into account the many other factors that affect blood glucose levels such as the timing, type, and duration of exercise; illness; stress; and the phases of a woman's menstrual cycle. People react differently to all of these factors.

In addition, people with diabetes need to use vigilance in their attempt to control the complications of diabetes. This requires self-assessment of body signals as well as preventative action. As an example, see <http://www.diabetes.org/type-2-diabetes/foot-care.jsp> which lists the many aspects of preventative foot care.

People with diabetes work to understand the effect of all these factors on their bodies and – depending upon the treatment regimen established for that individual – make adjustments throughout the day in the administration of insulin (type, time, and dosage), food (type, time, and amount), and activity. The complexity of the changes made on a daily basis depends upon what level of glucose control the patient and his or her health care providers are attempting to achieve. Those seeking tight control (necessary in order to lessen the possibility of the long-term consequences of high blood glucose levels) are generally required to test their blood glucose levels more often and make more adjustments throughout the day than do those whose medical condition prevents them from attempting to obtain tight control.

Materials on Diabetes

⁴ Although glucose levels in the urine can also be measured with lab tests, urine glucose test results do not correlate well with blood glucose levels and are not a good indicator of diabetes management.

There is a vast amount of literature on diabetes, ranging from pamphlets geared toward lay audiences to highly sophisticated scientific analyses. The documents described below are intended to be a sample of the information available and to reflect the broad array of possible materials. The introductory materials, written for people with diabetes, their families, and the public, are useful to familiarize investigators and lawyers with the basics of diabetes. The more technical information would be needed further on in the litigation process as well as to truly understand the complexity of dealing with 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.

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/.

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* is intended for a lay audience. *Medical Management of Type 1 Diabetes*, *Medical Management of Type 2 Diabetes*, and *Therapy for Diabetes Mellitus and Related Disorders* are geared toward a health care professional audience. In addition to providing a more detailed explanation of various issues related to diabetes, these books show the true complexity of diabetes management. For example, page 72 of *Medical Management of Type 1 Diabetes* contains a detailed discussion of insulin adjustments to compensate for exercise. These books can be obtained by calling 1-800-DIABETES or through the Association’s website at <http://store.diabetes.org/>.

Major Life Activities in Diabetes Disability Cases Post-*Sutton*

Establishing that a person with diabetes has a disability within the meaning of the anti-disability discrimination laws requires knowledge of the relevant law as well as an effective strategy for creating a record, through expert medical and other testimony, that will show the limitations caused by plaintiff's diabetes. This article discusses both points, and the American Diabetes Association makes additional resources available to attorneys litigating these cases. Of particular importance are the resources available in the Association's online materials bank for attorneys, available at <http://www.diabetes.org/attorneymaterials>. 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. Contact information for the Association's Legal Advocacy staff can be found at the end of this article.

The American Diabetes Association has compiled a list of 128 federal and state diabetes employment discrimination decisions dealing with the definition of disability in light of the Supreme Court's *Sutton* trilogy, which required that the presence of a disability be assessed in light of the mitigating measures that a person use.⁵ One basic theme emerges from a review of this case law: plaintiffs who prevail usually include in their evidence a detailed explanation of how diabetes affects the individual plaintiff supported by expertise from the plaintiff's treating physician and, better yet, additional testimony from an outside endocrinologist or other experts in diabetes. In the cases decided favorably to plaintiffs, the courts had a better understanding of how diabetes works; in many of the others, the courts seemed not to understand diabetes. In some unfavorable cases plaintiff had failed to even allege specific major life activities or provide any explanation of how those life activities were affected by diabetes. In the cases decided unfavorably to people with diabetes, the courts also often seemed to forget the heavy burden on the moving party at the motion to dismiss and summary judgment stages.

Diabetes and its complications can substantially limit a wide variety of major life activities. The relevance of various major life activities will depend on the individual circumstances, including the type of diabetes, the level of control being sought, and the complications that the person has experienced.

⁵ *Sutton v. United Air Lines, Inc.*, 527 U.S. 471 (1999); *Murphy v. United Parcel Service*, 572 U.S. 516 (1999); and *Albertson's Inc. v. Kirkingberg*, 527 U.S. 555 (1999). These cases are included within a broader list of employment cases dealing with discrimination on the basis of diabetes that can be found at <http://www.diabetes.org/advocacy-and-legalresources/attorneymaterials/training-employment.jsp>.

The efforts needed to constantly try to keep blood glucose levels within a safe range can themselves constitute a substantial limitation on the major life activities of caring for oneself and eating. Lawyers, assisted by testimony from their clients and medical experts, must explain the multifaceted details of diabetes management, helping the court to understand that people with diabetes who take insulin – and some oral medications – must walk on a life-sustaining tightrope, with the serious risks of low blood glucose levels on one side of the tightrope, and the serious risks of high blood glucose levels on the other.

An excellent analysis of how this balancing affects the major life activity of eating is found in *Lawson v. CSX Transp., Inc.*, 245 F.3d 916 (7th Cir. 2001). *Lawson* spells out in detail how plaintiff must carefully monitor his blood glucose level, insulin dosages, and eating habits. Aptly, the court distinguishes this case from *Sutton*, noting that plaintiff's control and maintenance of his diabetes involves much more effort than simply putting on a pair of corrective lenses. "Lawson cannot simply eat when and where he wants to, or exert himself without concern for the effect the exertion will have on his glucose levels . . . [Instead, he] must always concern himself with the availability of food, the timing of when he eats, and the type and quantity of food he eats." *Id.* at 924. The court goes on to explain that "[t]he evidence shows that, every day of his life, Mr. Lawson must deal with the concern that the insulin he injects to treat his illness will itself bring about debilitating symptoms that can only be ameliorated by immediately eating certain foods." *Id.* at 925-26. This focus on the 24 hour a day/7 day a week needs of diabetes management, and its impact on the most basic of life activities, would enable a case like Lawson's to withstand scrutiny under the Supreme Court's decision in *Toyota Motor Mfg, Ky., Inc. v. Williams*, 534 U.S. 184 (2002) (requiring – in the context of the major life activity of performing manual tasks – that the limitation to be on activities that are of central importance to most people's lives), discussed below.

In *Branham v. Snow*, 392 F. 3d 896 (7th Cir. 2004), the Seventh Circuit reaffirmed *Lawson* stating:

For Mr. Branham, these negative side effects [of diabetes treatment] are many. He is significantly restricted as to the manner in which he can eat as compared to the average person in the general population. His dietary intake is dictated by his diabetes, and must respond, with significant precision, to the blood sugar readings he takes four times a day. Depending upon the level of his blood sugar, Mr. Branham may have to eat immediately, may have to wait to eat, or may have to eat certain types of food. Even after the mitigating measures of his treatment regimen, he is never free to eat whatever he pleases because he risks both mild and severe bodily reactions if he disregards his blood sugar readings. He must adjust his diet to compensate for any greater exertion, stress, or illness that he experiences.

We must conclude that, on the record before us, a trier of fact rationally could determine that Mr. Branham's diabetes and the treatment regimen that he must follow substantially limit him in the major life activity of eating.

Id. at 903-904. The court had previously discussed record evidence showing that Branham checked his blood glucose levels four to five times a day and relied on the results of these checks to determine what and how much to eat. It also noted that Branham experienced mild hypoglycemia regularly (about once every three weeks) and had to keep additional insulin and a carbohydrate source with him at all times to treat hyperglycemia or hypoglycemia. *Id.* at 899.

The true significance of the *Branham* decision is that the plaintiff, who was seeking to be an IRS law enforcement officer, was in excellent control of his diabetes, had never had a severe hypoglycemic or hyperglycemic reaction, and had experienced no long-term complications. Nonetheless, the court recognized that he could meet the definition of disability based on the burdens imposed by his treatment regimen. *Id.* at 903. *Branham* refutes the argument often made by defendants that an individual who experiences no severe short or long-term complications from his diabetes cannot have a disability. *See also Davenport v. Idaho Dept. of Envtl. Qualify*, 469 F. Supp. 2d 861 (D. Idaho 2006) (although plaintiff had never experienced severe hypoglycemia, he was required to carefully monitor his food intake, insulin doses and physical activity, and was not free to eat whatever and whenever he wished).⁶

The Ninth Circuit has also addressed the limitations that diabetes can impose on the major life activity of eating in *Fraser v. Goodale*, 342 F. 3d 1032 (9th Cir. 2003). The court drew a distinction between a diabetes treatment regimen and the dietary restrictions that many people face in order to lose weight or attain other health benefits, stated:

Fraser's diabetes regimen is perpetual, severely restrictive, and highly demanding. Fraser must test her sugar several times daily, each test is painful, and takes close to five minutes to complete. She must vigilantly monitor what and how much she eats. She must time her daily shots and meals so carefully that it is not safe for her to live alone She must always have certain foods available in case her blood sugar drops or skyrockets. She must always be able to take time to eat or give herself injections to balance her blood sugar levels. She cannot put a morsel of food in her mouth without carefully assessing whether it will tip her blood sugars out of balance. She cannot skip or postpone a snack or meal without cautiously studying her insulin and glucagon levels. She must constantly, faithfully, and

⁶ Care should be taken to distinguish the eating restrictions faced by people with diabetes from those used by many people in the general population to lose weight or achieve a healthier lifestyle. Where courts view plaintiff's eating restrictions as more akin to going on a diet, courts are likely to grant summary judgment to defendants. *Compare Scheerer v. Potter*, 443 F. 3d 916 (7th Cir. 2006) (court rejected plaintiff's argument that his eating restrictions were substantially limiting because they were only focused on losing weight) *with Davenport*, *supra* (distinguishing *Scheerer* because, unlike *Scheerer*, plaintiff's limitations on his ability to eat were due to the need to control blood glucose levels, not merely to a general need to lose weight). *See also Vasquez v. Laredo Transit Mgmt.*, 2007 U.S. Dist. Lexis 60216 (S. D. Tex. 2007) (evidence that plaintiff needed to avoid certain foods because of his diabetes was insufficient to prove disability because common dietary restrictions are not enough to show a substantial limitation in eating); *Husinga v. Federal Mogul Ignition Co.*, 519 F. Supp. 2d 929 (S. D. Iowa 2007) (need to limit caloric intake and consumption of sugar and carbohydrates is analogous to dietary restrictions shared by large segments of the population).

precisely monitor her eating, exercise, blood sugar, and other health factors, and even this is no guarantee of success. . . .

Unlike a person with ordinary dietary restrictions, Fraser must monitor much more than what and how much she eats. Unlike a person with ordinary dietary restrictions, she does not enjoy a forgiving margin of error. While the typical person on a heart-healthy diet will not find himself in the emergency room if he eats too much at a meal or forgets his medication for a few hours, Fraser does not enjoy this luxury.

Id. at 1041. *See also DuBerry v. District of Columbia*, 2008 U.S. Dist. Lexis 86151 (D. D.C. 2008) (plaintiff could show he was substantially limited in eating because of his need for a strict eating and blood glucose monitoring schedule to prevent diabetes complications); *Robbins v. WXIX Raycom Media Inc.*, 2008 U.S. Dist. Lexis 17028 (S. D. Ohio 2008) (plaintiff with type 2 diabetes did not need to show that she used insulin or had past incidents of hypoglycemia in order to be disabled; she survived summary judgment by showing her need to eat at regular times, inability to skip meals, and need to frequently monitor her blood glucose levels); *Downs v. AOL Time Warner, Inc.*, 2006 U.S. Dist. Lexis 4848 (S.D. Ohio 2006) (plaintiff who has type 2 diabetes treated with oral medications but not insulin survived summary judgment on whether he was substantially limited in eating based on evidence that he needed to eat at specified times to manage his blood glucose levels).

Similar arguments can be used to demonstrate a substantial limitation in the major life activity of caring for oneself. In essence, eating is just one aspect of self-care, and the burdens of maintaining a diabetes treatment regimen limit the ability to care for oneself as well. That is, diabetes not only limits what Lawson, Branham, Fraser and others can eat, or not eat, and when, but also restricts what activities they can or cannot engage in, when and how they test blood glucose levels and take medication, and how they must react to factors such as stress and illness. The Seventh Circuit recognized as much in *Nawrot v. CPC Int'l.*, 277 F.3d 896 (7th Cir. 2002), finding Nawrot to be substantially limited in the ability to care for himself. *See also Amick v. Visiting Nurse & Hospice Home*, 2006 U.S. Dist. Lexis 76326 (N. D. Ind. 2006) (plaintiff nurse who had experienced hypoglycemia on the job had created a fact issue as to whether she was substantially limited in thinking and caring for herself because of her treatment regimen and the possibility of serious hypoglycemia even when she followed that regimen).

Other major life activities may be substantially limited by the effects of the short-term complications of diabetes (hypoglycemia and hyperglycemia), including thinking, communicating, and working where the plaintiff has experienced recurring hypoglycemia or hyperglycemia. *See Nawrot, supra* (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); *Rebhan v. Atoll Holdings Inc.*, 2001 Cal. App. LEXIS 1219 (Cal. Ct. App. 2001). The standard objection to this argument is that such incapacitation is episodic and generally occurs relatively infrequently. Plaintiffs have had mixed success in countering such arguments. For cases

where plaintiffs have succeeded with these arguments, *see Equal Employment Opportunity Commission and Landers 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); *cf Equal Employment Opportunity Comm'n and Keane v. Sears, Roebuck & Co.*, 233 F.3d 432 (7th Cir. 2000), *subsequent opinion* at 417 F. 3d 789 (7th Cir. 2005) (episodic nature of limitations in ability to walk due to diabetic neuropathy did not necessitate summary judgment). *But see, e.g., Fraser*, *supra*, 342 F. 3d at 1043 (rejecting argument that plaintiff was substantially limited because of her inability to care for herself during 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 (8th Cir. 2002).

In addition to the limitations imposed by attempting – or failing – to keep blood glucose levels within a safe range, there are substantial limitations imposed by the long-term complications of diabetes. These include limitation in walking, standing, sitting, or lifting as a result of diabetic neuropathy, infection, amputation, or heart disease, *see Equal Employment Opportunity Comm'n and Keane v. Sears, Roebuck & Co.*, 417 F. 3d 789 (7th Cir. 2005); *Smith v. District of Columbia*, 271 F. Supp. 2d 165 (D. D.C. 2003), *Bugg-Barber v. Randstad*, 271 F.Supp.2d 120 (D. D.C. 2003), *Heimback v. Lehigh Valley Plastics, Inc.*, 2000 U.S. Dist. LEXIS 55 (E.D. Pa. 2000); *Medlock v. St. Charles*, 89 F. Supp. 2d. 1079 (E.D. Mo. 2000); *Needle v. Alling & Cory, Inc.*, 88 F. Supp. 2d. 100 (W.D.N.Y. 2000); seeing as a result of diabetic neuropathy; or limitations caused by kidney disease or the need for dialysis, *see Price v. Washington Hospital Center*, 321 F. Supp. 2d 38 (D. D.C. 2004) (finding plaintiff disabled in part because of need for regular dialysis without specifying which major life activity was limited).

One more major life activity that may be worth considering is the activity of metabolizing food. To date, no court has recognized this as a major life activity in a diabetes case. However, several courts have held (in cases not involving diabetes) that the ability to cleanse and eliminate body waste, which like metabolizing food is an internal body process, is a major life activity and can be substantially limited by kidney disease. *See Fiscus v. Wal-Mart Stores*, 385 F. 3d 378 (3d Cir. 2004); *Heiko v. Columbo Savings Bank, F.S.B.*, 434 F. 3d 249 (4th Cir. 2006); *see also Dillbeck v. Whirlpool Corp.*, 2008 U.S. Dist. Lexis 61999 (S. D. Ind. 2008) (noting that eliminating waste is a major life activity because, without the ability to cleanse toxins from the blood, death would result). Several courts have also recognized that pumping and circulating blood is a major life activity. *See Motsay v. Pa. Am. Water Co./RWE Group*, 2008 U.S. Dist. Lexis 9934 (M. D. Pa. 2008); *Snyder v. Norfolk Southern Railway*, 463 F. Supp. 2d 528 (E. D. Pa. 2006). In doing so, courts have rejected the argument that an activity that is not externally visible or volitional cannot be a major life activity under the Americans with Disabilities Act. *Fiscus, supra*, 385 F. 3d. at 383.⁷ A strong argument could be made that

⁷ *See also Timothy v. CBOCS West, Inc.*, 2005 U.S. Dist. Lexis 9503 (N.D. Ill. 2005) (following *Fiscus* in holding that waste processing was a major life activity and that plaintiff with Crohn's disease was substantially limited in this activity). *But see Talbot v. Acme Paper & Supply Co.*, 2005 U.S. Dist. Lexis

metabolizing food is just as central to human life as is eliminating waste, and clearly people with diabetes are substantially limited in performing this activity, as it is in the very nature of diabetes.⁸ In addition, breathing, which is in effect metabolizing air, is a well-recognized major life activity. Nonetheless, this legal theory remains unproven and advocates are strongly advised to plead other major life activities (such as eating) that have been more readily recognized in addition to or instead of metabolizing food.

Critical to succeeding in establishing coverage for people with diabetes is presenting adequate evidence of the limitations caused by diabetes. Plaintiffs who attempt to rely on the diagnosis of diabetes alone (even when basing their arguments on the favorable cases cited above) routinely lose. Specific, individualized allegations regarding the substantial limitations caused by the person's diabetes, supported by competent and effective medical testimony, is crucial, and the lack of such evidence can doom a plaintiff's claim. *See, e.g., Collado v. UPS.*, 419 F. 3d 1143 (11th Cir. 2005) (summary judgment granted where plaintiff attempted to rely on his own testimony about his diabetes and offered no medical testimony).⁹ As the Seventh Circuit noted in *Branham*, the favorable cases discussed in this article do not automatically clear the way for all plaintiffs with diabetes:

Thus, we emphasize that, even though this court has determined on two separate occasions that a person with Type I diabetes can be substantially limited with respect to one or more major life activities, see [*Nawrot, Lawson*], neither of those cases dictates the outcome here. To hold otherwise would be to contravene the Supreme Court's determination that "both the letter and the spirit" of the Americans with Disabilities Act require an individualized assessment of each plaintiff's "actual condition," rather than a "determination based on general information about how an uncorrected impairment usually affects individuals."

See Branham, 392 F. 3d at 903 (citing *Sutton*, 527 U.S. at 483).

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18537 (D. Md. 2005) (expressing reservations that waste processing or kidney function could be major life activities despite *Fiscus* holding, but holding that plaintiff was disabled because of the limitations on caring for oneself caused by the need for dialysis); *Furnish v. SVI Sys.*, 270 F. 3d 445, 449 (7th Cir. 2001)..

⁸ One court in a diabetes case held that the plaintiff had raised an issue of fact as to whether he was substantially limited in eating, thinking and secreting insulin, based on the demands of his treatment regimen. *Herman v. Kraevner of Philadelphia Shipyard, Inc.*, 461 F. Supp. 2d 332 (E. D. Pa. 2006). While apparently accepting the idea that secreting insulin was a major life activity, the court did so with little legal analysis and without distinguishing it from the other two major life activities put forward by plaintiff, perhaps because defendant did not specifically question its propriety as a major life activity.

⁹ While medical testimony is always beneficial and very often necessary to survive summary judgment, one court recently held that it is not necessary to show that plaintiff is substantially limited in eating 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).

Defendants often argue that the Supreme Court's decision in *Toyota Motor Mfg, Ky., Inc. v. Williams*, 534 U.S. 184 (2002) has "raised the bar" that plaintiffs must meet in surviving summary judgment on the issue of whether their impairment is substantially limiting. While *Toyota* is certainly an adverse decision for disability-rights activists and many courts have applied a higher standard as a result of it, it bears noting that this argument, which generally asserts that plaintiffs must now prove that their limitations are "severe" rather than "substantial", was decisively rejected in a Seventh Circuit case involving diabetes. *Equal Employment Opportunity Comm'n and Keane v. Sears, Roebuck & Co.*, 417 F. 3d 789 (7th Cir. 2005). The court held that *Toyota* had not in fact altered the statutorily mandated inquiry into disability, nor did it require plaintiffs to meet a higher standard than had been in effect previously. Further, the court noted that much of the Supreme Court's holding, particularly its admonition to focus on activities central to most people's daily lives, have much less force outside the major life activity of performing manual tasks, which is the activity at issue in *Toyota*.

The Trap of the "Can Do" Spirit

One ironic pitfall to watch out for is that many people with diabetes – and their health care teams – have adopted a "can do" attitude to help manage diabetes. While very useful from a treatment perspective, minimizing the impact of diabetes can deal the death knell in disability discrimination litigation. The First Circuit's opinion in *Gillen v. Fallon Ambulance Service, Inc.* 283 F.3d 11 (1st Cir. 2002), involving a plaintiff who since birth has had a left arm that ends just below the elbow, should be useful in diabetes cases where the plaintiff's avowed self-assessment harms his or her chances of meeting the definition of disability. The court in *Gillen* aptly described the proper view of a plaintiff's self assessment:

In concluding that the appellant had no substantial limitation on her ability to lift, the district court relied upon two items. The first of these was the appellant's optimistic self-assessment of her capabilities. This consideration deserves little weight. Although the appellant took an upbeat view of her prowess (when [defendant's] counsel asked, during her deposition, if there was anything that she would like to do that she had not been able to do because of her missing hand, she replied "no"), that was more a testament to her determination than to her condition. She did not dwell on the restrictions on lifting that she had to overcome in order to achieve her objectives – and those restrictions comprise the focal point of this prong of the [Americans with Disabilities Act] inquiry. The key question is not whether a handicapped person accomplishes her goals, but whether she encounters significant handicap-related obstacles in doing so. For summary judgment purposes, we must resolve this question in the appellant's favor.

Id. at 17-18. In a similar case involving an individual with cerebral palsy, the Third Circuit held:

The District Court's focus on what Emory has managed to achieve misses the mark. While evidence of tasks he has mastered might seem to serve as a natural counterpoint when evaluating disability, the paramount inquiry remains – does Emory “have an impairment that prevents or severely restricts [him] from doing activities that are of central importance to most people's daily lives”? *Toyota*, 534 U.S. at 197. If so, then he is substantially limited in the performance of manual tasks and has established disability under the [Americans with Disabilities Act].

...

The crux of the inquiry lies in comparing the way in which Emory is able to perform activities, if at all, with the way in which an average member of the general population performs the same activities. . . . What a plaintiff confronts, not overcomes, is the measure of substantial limitation under the [Americans with Disabilities Act].

Here too, AstraZeneca has offered evidence of Emory's force of will, perseverance, and some learned accommodations; however, the fact that Emory has been able to become a productive member of society by having a family, working, and serving his community does not negate the significant disability-related obstacles he has overcome to achieve

Emory v. AstraZeneca Pharmaceuticals, 401 F. 3d 174, 181 (3d Cir. 2005); see also *Robertson v. Las Animas County Sheriff's Dept.*, 500 F. 3d 1185, 1194 (10th Cir. 2007) (“the fact that Mr. Robertson is not bothered by his impairment or that he does not consider himself to be substantially limited by it does not enter into the calculus”); *Weisberg v. Riverside Twp. Bd. of Educ.*, 180 Fed. Appx. 357, 364 n. 3 (3d Cir. 2006). It is tempting to think that, where a plaintiff's achievements in overcoming diabetes are clear, the only possible way to win a diabetes discrimination case is to argue that the plaintiff was “regarded as” disabled. However, care should be taken before rejecting the idea of an actual disability claim. As the cases cited in this section show, achievement is no automatic bar to establishing actual disability. *Branham*, discussed earlier, where an individual who had great success in managing his diabetes survived summary judgment on whether he had an actual disability, is also instructive in this context. And, as discussed in the next section, putting all one's eggs in the “regarded as” basket carries risks of its own.

“Record of” And “Regarded as” Claims

Many diabetes cases involving the definition of disability concern allegations of actual disability, as opposed to having a record of a disability or being regarded as having a disability. However, these alternative means of establishing coverage under anti-disability discrimination laws should also be considered and, when doing so, lawyers will also need a working knowledge of the science of diabetes and diabetes management in order to prevail.

A lengthy discussion of record of disability is found in *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).

Numerous plaintiffs have sought to rely on the “regarded as” prong. This is not surprising, since discrimination against people with diabetes is often the result of misperceptions or ignorance about the disease. However, surviving a summary judgment motion on a “regarded as” claim can be trickier than it may at first appear. Employers frequently argue that they simply made an employment decision about an individual’s qualifications for one particular job, and entertained no perceptions about an individual’s limitations other than that he or she could not do that particular job. Because courts have held that the inability to do a particular job is not a substantial limitation on the major life activity of working or any other major life activity, this argument can be fatal to a “regarded as” claim if not carefully countered. See *Branham, supra*, at 904 (no evidence defendant regarded plaintiff as anything other than unsuited for one particular job); *Equal Employment Opportunity Commission v. J.B. Hunt Transp.*, 321 F.3d 69 (2d Cir. 2003) (defendant regarded plaintiff as only limited in the ability to drive large vehicles).

This prong offers the most promise when plaintiff’s counsel uses discovery to break down what it is defendant is claiming plaintiff can or cannot do. Where defendant claims that the plaintiff is not qualified for a given position, the reasons for that decision need to be probed carefully. Often the defendant’s reasoning has little to do with the specific job requirements of the position in question, but instead is based on (often incorrect) assumptions about how the individual’s diabetes affects that person’s ability to work in general or his or her daily life. Thus, the defendant’s stated reasons for a decision should not be taken at face value; rather, counsel should carefully explore in discovery the thinking and assumptions underlying these reasons. Particularly useful are statements, by defendant’s employees or doctors with whom it contracts, that plaintiff is unfit to do many tasks or is prone to have unexpected and severe diabetes complications at any time. Such admissions can show that a plaintiff is regarded as substantially limited in working, caring for oneself, thinking, or other major life activities. Indeed, where an employer regards an individual as prone to severe hypoglycemia or hyperglycemia at any time and without warning (often manifested through general statements about fear of a person with diabetes passing out or becoming confused on the job), the argument could be made that employer, at a minimum, regards the individual as unable to perform any jobs requiring continued alertness or concentration (a large number of jobs indeed).

Rodriguez v. ConAgra Grocery Products, 436 F. 3d 468 (5th Cir. 2006), provides a good example of how this can be done. Plaintiff in that case was actually able to get summary judgment for himself (not just survive defendant’s summary judgment motion) by pointing to statements made by defendant and its doctor in depositions. Both ConAgra’s Human Resources manager and the doctor it hired to conduct medical exams demonstrated ignorance about diabetes. The doctor said that plaintiff’s “uncontrolled” diabetes “made him unfit to perform any manual labor job. In the doctor's own words, ‘Outside of a padded room where he could even then fall and break his neck from dizziness or fainting, I don't know that there would be a safe environment that we could

construct.” Id. at 477. The Human Resources manager said she assumed that anyone with diabetes who was not taking their medications was out of control and a safety risk. Faced with that evidence, the court found it easy to determine that the plaintiff was regarded as substantially limited in working. Another example is *Davis v. Ozarks Electric Cooperative*, 2006 U.S. Dist. Lexis 21835 (W. D. Ark. 2006), where the court found plaintiff had raised an issue of fact as to whether defendant regarded her as having a disability because the individuals who made the decision to terminate her believed that “because plaintiff had diabetes, she was ‘out of control,’ she might pass out at any time, or that ‘I don't know what all’ could happen.” See also *Malone v. Greenville County*, 2008 U.S. Dist. Lexis 86520 (D. S.C. 2008) (plaintiff can prove he was regarded as disabled based on defendant’s belief that his diabetes could cause disabling seizures); *Johnston v. Mid-Michigan Medical Center*, 2008 U.S. Dist. Lexis 1125 (E. D. Mich. 2008) (regarded as claim survived based on evidence that plaintiff’s manager repeatedly expressed concerns about plaintiff’s diabetes and its impact on his performance and tended to ascribe all performance issues to diabetes without any proof); *EEOC v. Northwest Airlines, Inc.* 246 F. Supp. 2d 916 (W.D. Tenn. 2002) (plaintiff was regarded as substantially limited in working where defendant's doctor stated that his diabetes prevented him from operating heavy equipment and working at unprotected heights, and such restrictions would disqualify him from a broad class of jobs).

Another potential problem with relying on these alternative prongs is that there is a split among the circuits as to whether someone who does not have an actual disability is entitled to reasonable accommodations.¹⁰ Thus, in these circuits, if accommodation is needed actual disability must be established. It is recommended that attorneys not rely solely on a “regarded as” or “record of” claims unless absolutely necessary, and that claims of actual disability (as described earlier) also be asserted.

For further information, visit the American Diabetes Association website at www.diabetes.org or call 1-800-DIABETES. Lawyers with questions about a specific case may contact Brian Dimmick at bdimmick@diabetes.org.

¹⁰ Compare *Williams v. Phila. Hous. Auth. Police Dep't*, 380 F.3d 751, 772-76 (3d Cir. 2004); *D'Angelo v. ConAgra Foods*, 422 F. 3d 1220 (11th Cir. 2005); *Kelly v. Metallics West, Inc.*, 410 F. 3d 670 (10th Cir. 2005) (holding that reasonable accommodation requirement applies to plaintiffs who are regarded as disabled) with *Kaplan v. N. Las Vegas*, 323 F.3d 1226, 1233 (9th Cir. 2003); *Weber v. Strippit, Inc.*, 186 F.3d 907, 916-17 (8th Cir. 1999); *Workman v. Frito Lay, Inc.*, 165 F.3d 460, 467 (6th Cir. 1999); *Newberry v. E. Tex. State Univ.*, 161 F.3d 276, 280 (5th Cir. 1998) (holding that plaintiffs regarded as disabled are not entitled to accommodations). Cf. *Katz v. City Metal Co.*, 87 F.3d 26, 32-34 (1st Cir. 1996) (assuming without deciding that regarded as plaintiffs are entitled to accommodations).

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Bibliography

American Diabetes Association. *American Diabetes Association Complete Guide to Diabetes*. 4th ed. American Diabetes Association, Inc., 2005.

American Diabetes Association. *Medical Management of Type 1 Diabetes*. 5th ed. American Diabetes Association, Inc., 2008.

American Diabetes Association. *Medical Management of Type 2 Diabetes*. 6th ed. American Diabetes Association, Inc., 2008.

American Diabetes Association. *Therapy for Diabetes Mellitus and related Disorders*. 4th ed. American Diabetes Association, Inc., 2004.