

FRAMING DISABILITY

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Mainstream attitudes toward disability lag behind U.S. law. This tension between attitudes and law reflects a wider gap between the ideas about disability pervasive in mainstream society—what this Article calls the “outside” view—and the ideas about disability common within the disability community—what this Article calls the “inside” view. The outside perspective tends to misunderstand and mischaracterize aspects of the experience, theory, and law of disability.

The law can help to close this gap in attitudes by changing the conditions in which attitudes are formed or reinforced. Thus, this Article proposes using framing rules to target the moments when non-disabled people make decisions that implicate their future relationship to disability. Framing rules prescribe the frame applied to particular decision moments, by specifying the information and context that accompany the decision. The current messages surrounding disability decision moments tend to be misleading and negative, rooted in the outside view of disability. The proposed framing rules would instead provide insights from the inside view to people who have a reason to think about disability.

This Article examines several decision points to which the inside framing perspective could be applied, including prenatal testing, driver’s licensing, and disability insurance. Each of these areas is an example of a broader domain—thinking about the kind of children we want, injury prevention campaigns, and contingency planning—in which disability is frequently presented in negative terms. Reframing

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these disability-relevant moments from an inside perspective should help bring society closer to understanding how accessibility and inclusion provide a form of social insurance not just for some, but for us all.

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I. INTRODUCTION: BEHIND THE LAW

Our capacity to really talk about [disability] and think about it—my own impression is we're not very good at that relative to lots of other kinds of diversity issues we speak of. So, I would say that it strikes me that . . . the law has been much more aggressive about this than has our own values.¹

There is a tension in this country between disability antidiscrimination law and mainstream discourse about disability. It is as if we are students in a high school who begin the day in civics class, where we learn about the civil rights struggles in this country's history and study the groups who have successfully lobbied for antidiscrimination protections. We learn that the groups legally protected against discrimination include disability. We read about famous disabled Americans, such as Franklin Delano Roosevelt, and learn that people with disabilities can achieve great things in the United States, despite the discrimination they sometimes face. Then we go down the hall to health class, where we are told to stay healthy and avoid disability: eat a balanced diet, exercise, use condoms, take vitamins, do not drink and drive, and so forth. These are the messages that we hear from, on the one hand, law and, on the other, culture.

It should not surprise us that, as the epigraph suggests, attitudes toward disability trail behind the law. Antidiscrimination law and societal attitudes toward disability could not easily coincide if our collective conversation about disability includes, on the one hand, ideas about respecting the rights and capacities of people with disabilities and, on the other hand, extensive warnings about the many ways we must behave in order to avoid becoming disabled. While it may be possible to reconcile these competing messages of respect and prevention—and some scholars have made strides in this direction²—in mainstream discourse these messages currently exist in an uneasy relation to each other.

1. Lee C. Bollinger, President, Columbia University, Conference on Diversity in Higher Education, sponsored by Rutgers University and the Center for Institutional and Social Change at Columbia Law School (Dec. 3, 2008) (transcript on file with the *University of Illinois Law Review*). The context of Bollinger's remarks was as follows: This conference participant had asked his panel, after there had been no mention of disability in ninety minutes of presentations on diversity, "where you think disability fits in the conversation about diversity in higher education, and particularly in . . . this time of fiscal challenges, if you think disability can contribute anything positive to the work of diversity in higher education?" *Id.* (quoting Elizabeth Emens). Bollinger answered that disability "certainly can" contribute something positive to higher education, saying that he has seen the evidence in his own teaching. *Id.* Then he offered the view stated in the epigraph.

2. See, for example, David Wasserman, *Is Disability Discrimination Different? Reasonable Accommodation, Injury Prevention*, in *PHILOSOPHICAL FOUNDATIONS OF ANTI-DISCRIMINATION LAW* (Deborah Hellman & Sophia Moreau eds., forthcoming 2013); Adrienne Asch & David Wasserman, *Making Embryos Healthy or Making Healthy Embryos: How Much of a Difference Between Prenatal Treatment and Selection?*, in *THE "HEALTHY" EMBRYO: SOCIAL, BIOMEDICAL, LEGAL AND PHILOSOPHICAL PERSPECTIVES 201* (Jeff Nisker et al. eds., 2010).

Indeed, this tension reflects a wider gap between what I call the “inside” and the “outside” views of disability.³ To speak of an inside and an outside to disability is to generalize in ways that are necessarily imperfect, but these imperfect generalizations nonetheless capture something useful about our thinking about disability. Those on the inside and the outside of disability often look differently at the experience, the theory, and the law of disability. From the outside, disability commonly looks like an unhappy place created by an individual medical problem for which the law sometimes provides special benefits to that individual. From the inside, disability often looks like a mundane feature of a no-less-happy life, rendered inconvenient or disabling largely by interactions with the surrounding environment, which legal accommodations alter in ways that sometimes provide benefits to many.

The tension between law and attitudes—and the underlying gap between the inside and outside views of disability—has serious consequences for the law in action. Numerous commentators have observed that courts have narrowed the scope of the Americans with Disabilities Act (ADA) in the twenty years since its enactment.⁴ The recent ADA Amendments Act (ADAAA) attempts to correct this doctrinal drift.⁵ The ADAAA explicitly rejects prior court interpretations of the ADA, including, for instance, the “demanding standard” the Supreme Court has applied when determining who counts as disabled under the ADA.⁶ It remains to be seen whether courts will now implement the ADA more broadly, or whether they will find new ways to narrow its scope.⁷

3. Cf. Russell K. Robinson, *Perceptual Segregation*, 108 COLUM. L. REV. 1093 (2008) (using the terms “insider” and “outsider” to refer to the advantaged and disadvantaged groups, respectively, in an article arguing that those subordinated on the basis of race and sex view discrimination differently than those in the superordinate position). Although Robinson and I use these terms differently, our projects share the aim of demonstrating differences in perspective across lines of subordination. Like Robinson, I do not claim a single essential experience associated with any identity category. Indeed, I choose the terms “inside” and “outside”—rather than “insider” and “outsider”—because I am talking about ways of *looking at* disability, rather than the direct experience of disability. Although experience with disability is correlated with an inside perspective, being disabled is neither necessary nor sufficient for an inside perspective in my account. Even my discussion of happiness and the disability paradox, *see infra* Part II.A.1, which looks at the experience of disability, is about the ways people understand the happiness or unhappiness of disability.

4. See, e.g., Cheryl L. Anderson, “*Deserving Disabilities*”: *Why the Definition of Disability Under the Americans with Disabilities Act Should Be Revised to Eliminate the Substantial Limitation Requirement*, 65 MO. L. REV. 83, 91–109 (2000); Samuel R. Bagenstos, *Subordination, Stigma, and “Disability,”* 86 VA. L. REV. 397, 466–73 (2000); Chai R. Feldblum, *Definition of Disability Under Federal Anti-Discrimination Law: What Happened? Why? And What Can We Do About It?*, 21 BERKELEY J. EMP. & LAB. L. 91, 91–94 (2000). On the particularly poor outcomes for disability plaintiffs in federal courts, see Ruth Colker, *The Americans with Disabilities Act: A Windfall for Defendants*, 34 HARV. C.R.-C.L. L. REV. 99, 99–100 (1999); Ruth Colker, *Winning and Losing Under the Americans with Disabilities Act*, 62 OHIO ST. L.J. 239, 248–49 (2001).

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

6. *Id.* (findings and purposes); *Toyota Motor Mfg., Ky., Inc. v. Williams*, 534 U.S. 184, 197 (2002).

7. See, e.g., Dale Larson, Comment, *Unconsciously Regarded As Disabled: Implicit Bias and the Regarded-As Prong of the Americans with Disabilities Act*, 56 UCLA L. REV. 451, 485–86 (2008); Elizabeth F. Emens, *Disabling Attitudes: U.S. Disability Law and the ADA Amendments Act*, 60 Amer. J.

The law will not be interpreted or implemented effectively until attitudes toward disability change.⁸ Though law is rarely the first step in social change, law can play a role in influencing attitudes by changing conditions so that attitudes change in response. But the law will continue to falter in the hands of courts, employers, and public opinion unless attitudes shift.⁹

How, then, can attitudes toward disability change? The ADA, like other antidiscrimination laws, is premised in part on the idea that “contact” between disabled and nondisabled people, under certain conditions, causes nondisabled people to like and respect disabled people more.¹⁰ These integrative efforts are important and should continue, but thus far they have not succeeded in solving the problem of disability discrimination.¹¹ There is therefore a need to be creative about devising additional strategies. This Article proposes one novel way to help attitudes toward disability catch up with the law: using *framing rules* to target the moments when nondisabled people make decisions that implicate their future relationship to disability.¹²

Compar. L. 205, 207-09 (2012). The fate of the ADAAA is unclear at this point because courts have interpreted it not to apply retroactively. See, e.g., *Becerril v. Pima Cnty. Assessor's Office*, 587 F.3d 1162, 1164 (9th Cir. 2009); *Lytes v. DC Water & Sewer Auth.*, 572 F.3d 936, 938 (D.C. Cir. 2009); *Milholland v. Sumner Cnty. Bd. of Educ.*, 569 F.3d 562, 565 (6th Cir. 2009). But the early cases suggest that courts are responding to Congress's mandate for a broader definition of disability. See, e.g., *Hoffman v. Carefirst of Fort Wayne, Inc.*, 737 F. Supp. 2d 976 (2010); *Horgan v. Simmons*, 704 F. Supp. 2d 814 (2010).

8. This Article takes as its starting point that antidiscrimination protections and accessibility for disability are worthwhile endeavors. For discussion of these prior questions, see generally SIM LINTON, *CLAIMING DISABILITY: KNOWLEDGE AND IDENTITY* (1998); ANITA SILVERS ET AL., *DISABILITY, DIFFERENCE, DISCRIMINATION: PERSPECTIVES ON JUSTICE IN BIOETHICS AND PUBLIC POLICY* (1998); Samuel R. Bagenstos, “*Rational Discrimination, Accommodation, and the Politics of (Disability) Civil Rights*,” 89 VA. L. REV. 825 (2003); Michael Ashley Stein, *Same Struggle, Different Difference: ADA Accommodations As Antidiscrimination*, 153 U. PA. L. REV. 579 (2004).

9. See, e.g., Michael Selmi, *Interpreting the Americans with Disabilities Act: Why the Supreme Court Rewrote the Statute, and Why Congress Did Not Care*, 76 GEO. WASH. L. REV. 522, 571–75 (2008).

10. See, e.g., Mark C. Weber, *Home and Community-Based Services, Olmstead, and Positive Rights: A Preliminary Discussion*, 39 WAKE FOREST L. REV. 269, 278–80 (2004) (describing integration as the central “promise” of the ADA); see also *infra* note 127 (citing sources on contact); cf. Jacobus tenBroek, *The Right To Live in the World: The Disabled in the Law of Torts*, 54 CALIF. L. REV. 841, 843–47 (1966) (claiming that integration should be the goal of policy making in this area). For the view that integration is a secondary goal after antisubordination, see Ruth Colker, *Anti-Subordination Above All: A Disability Perspective*, 82 NOTRE DAME L. REV. 1415 (2007).

11. See, e.g., SAMUEL R. BAGENSTOS, *LAW AND THE CONTRADICTIONS OF THE DISABILITY RIGHTS MOVEMENT* (2009); *BACKLASH AGAINST THE ADA: REINTERPRETING DISABILITY RIGHTS* (Linda Hamilton Krieger ed., 2003).

12. Note that “nondisabled people” is a complicated phrase, since many people have some kind of disability, often hidden or unacknowledged, and having one disability does not mean a person is well informed or lacking in prejudice as to any other disability. See *infra* Part II.B.3. But I use “nondisabled” rather than “able-bodied,” for instance, because “nondisabled” puts disability at the definitional center and draws the line based on those who are identifiably disabled and those who are not—and because it assumes a backdrop of mental as well as physical disabilities. In addition, in writing about disability, I alternate between the term “people with disabilities”—employing the “people first” language popular in the United States—and the term “disabled people”—using the formulation

The law frames the decisions we make in many situations, requiring us to consider certain alternatives or information as we make our choices.¹³ Framing rules prescribe the frame applied to particular decision moments, by specifying the information and context that accompany the decision.¹⁴

This Article proposes designing framing rules for moments in which individuals make decisions that affect whether, or under what conditions, they or their children might be disabled in the future. Disability is unusual in the extent to which those outside the category could fall into the category at any time.¹⁵ Because anyone can become disabled, nondisabled people face decisions that implicate the future possibility of disability, moments when they have reason to think about disability arising in their lives. The current messages about disability surrounding these moments tend to be misleading and negative, rooted in the outside view of disability. This Article explores ways that we might use these moments of attention to disability to encourage attitudes toward disability that draw on the inside view.¹⁶ Often these decision moments are already regulated, by law or professional rules, so the suggestion is not necessarily to create new spheres of regulation, but rather to consider attitudes toward disability in the ongoing regulatory framing of these moments.

The claim here is not that the inside perspective on disability is the right or true one. For example, in some areas both disabled and nondisabled people make mistaken predictions about the experience of a given disability.¹⁷ But people with disabilities are likely to have relevant knowledge and perspective on disability. Moreover, the outside perspective so dominates the mainstream discourse that integrating the inside perspective should help to shift mainstream views on disability in a more realistic, as well as more positive, direction.

The Article comes in six parts. Following this Introduction, Part II describes the gap in attitudes between inside and outside views of disability in three areas: the relative happiness of people with disabilities (experience), the nature of discrimination and disability (theory), and the question of who benefits from disability law (law). Part III explains the idea of framing rules and proposes using this tool for disability-salient

deemed more consistent with the social model in British disability circles. On the social model, see *infra* Part II.B.2.

13. On the broader literature applying decision science to law, see *infra* notes 130–38 and accompanying text.

14. See Elizabeth F. Emens, *Changing Name Changing: Framing Rules and the Future of Marital Names*, 74 U. CHI. L. REV. 761, 840 (2007).

15. Jane West, *The Social and Policy Context of the Act*, 69 MILBANK Q. (SUPPLEMENTS 1/2) 3, 10 (1991). The risk of falling into a category does not necessarily make people more sympathetic to those who inhabit that category. See *infra* Part II.B.3.

16. The scope of this project is limited to physical and cognitive disabilities because psychosocial disabilities involve overlapping but also distinct considerations that merit independent treatment. See *infra* note 21 and accompanying text.

17. See *infra* note 39. In addition, disabilities vary widely, and people's perspectives on disability change over time, so there could never be one true inside view. Cf. *supra* note 3.

moments. Part IV applies this proposal to four different areas: prenatal testing, driver's licensing, warning labels, and disability insurance. These examples represent several broader domains—that is, thinking about the kind of children we want, injury prevention campaigns, and contingency planning—in which disability is often discussed in negative terms. The Article proposes that we reframe these decision moments and the messages that surround them, utilizing the perspective that comes from meaningful integration of people with disabilities. Finally, Part V addresses several objections to this proposal, and Part VI concludes.

II. THE DISABILITY PERSPECTIVES GAP

The biggest obstacle for disability law continues to be attitudes toward disability—attitudes of discomfort (“Ick!”), existential anxiety (“Could that happen to *me*?”), costliness (“Hiring or accommodating this person will be *expensive!*”), and triviality (“Not many disabled people will really come to my restaurant, store, or workplace, so why should I make these changes?”). More broadly, anecdotal and empirical accounts demonstrate a striking gap between the ideas about disability pervasive in mainstream society—what I call the “outside” view—and the ideas about disability common in the disability community—what I call the “inside” view.¹⁸ This Part draws on empirical, cultural, and legal sources to illustrate the gap between the inside and outside views of disability in experience, theory, and law.

A. *Happiness: The Experience of Disability*

It's not that I'm ugly. It's more that most people don't know how to look at me. The sight of me is routinely discombobulating. The power wheelchair is enough to inspire gawking, but that's the least of it. Much more impressive is the impact on my body of more than four decades of a muscle-wasting disease. . . . Strangers on the street are moved to comment:

I admire you for being out; most people would give up. . . .

If I had to live like you, I think I'd kill myself.

I used to try to explain that in fact I enjoy my life, that it's a great sensual pleasure to zoom by power chair on these delicious muggy streets, that I have no more reason to kill myself than most

18. There is not, of course, one monolithic disability community (or one mainstream view), but various sources document this gap between the views common to each context. As noted earlier, my conception of “inside” and “outside”—also not intended to be monolithic or essential—draws support from Russell Robinson's overlapping (though different) use of similar terms in writing about divergent perspectives across the lines of race and sex. See Robinson, *supra* note 3. A parallel gap occurs across the line of disability, as this Part elaborates.

people. *But it gets tedious . . . provid[ing] disability awareness training to the likes of them . . .*

Are we “worse off”? I don’t think so. Not in any meaningful sense. There are too many variables. For those of us with congenital conditions, disability shapes all we are. Those disabled later in life adapt. We take constraints that no one would choose and build rich and satisfying lives within them. We enjoy pleasures other people enjoy, and pleasures peculiarly our own. We have something the world needs.¹⁹

These lines from Harriet McBryde-Johnson capture something of the contrast between inside and outside views of happiness for disabled people. McBryde-Johnson’s richly human account is echoed by a set of empirical findings in the study of hedonics: Outside views of disability typically predict that significant disabilities would lead to substantial unhappiness; by contrast, people with a range of disabilities frequently report similar levels of happiness to people without the disabilities.²⁰ This Section sketches the contrast between the inside and outside views of life with a disability, drawing first on empirical literature and then on cultural texts. My discussion considers only physical and cognitive disabilities, not psychosocial disabilities, which are differently situated in many ways.²¹

Before beginning, note that the empirical work on happiness has been criticized both as a philosophical matter—for offering an incomplete or impoverished view of human flourishing—and as a practical matter—for offering insufficient or misleading bases for legal or social policies.²² This Article does not delve into these debates, because these critiques, while interesting and provocative, do not affect my use of this literature. The argument here is simply that people without a disability tend to underestimate the happiness levels of people with a disability—which is a basic finding of this body of work²³ and also a theme of narrative writing about disability²⁴—and that this perceptual gap matters because mistaken assumptions about unhappiness can lead to pity and so-

19. Harriet McBryde Johnson, *Unspeakable Conversations*, N.Y. TIMES MAG., Feb. 16, 2003, at 50 (italics added).

20. See *infra* Part II.A.1. The question of adaptation raises challenging questions for utilitarian accounts of justice, which are interesting though not directly implicated by the analysis here. See, e.g., JON ELSTER, *SOUR GRAPES: STUDIES IN THE SUBVERSION OF RATIONALITY* pt. 3 (1985).

21. For instance, the hedonics literature tells a different story about psychosocial disabilities, as discussed later. See *infra* note 33.

22. See, e.g., Martha Nussbaum, *Who Is the Happy Warrior? Philosophy Poses Questions to Psychology*, 37 J. LEGAL STUD. S81 (2008); Matthew Adler & Eric A. Posner, *Happiness Research and Cost-Benefit Analysis*, 37 J. LEGAL STUD. S253 (2008); Sean Hannon Williams, *Self-Altering Injury: The Hidden Harms of Hedonic Adaptation*, 96 CORNELL L. REV. 535 (2011).

23. See *infra* Part II.A.1.

24. See, e.g., Johnson, *supra* note 19; Kent, *infra* note 301; *supra* text accompanying note 19; *cf. infra* text accompanying note 26.

cial distance.²⁵ For this reason, the rest of the Article proposes framing rules that bring the inside view of disability experience—as reflected in the hedonics literature and in narrative and other cultural sources—more into public view.

1. *The Disability Paradox*

Psychologist Daniel Gilbert begins a chapter of his book, *Stumbling on Happiness*, by introducing the twins Lori and Reba Schappel, who are “very different people”:

Reba is a somewhat shy teetotaler who has recorded an award-winning album of country music. Lori, who is outgoing, wisecracking, and rather fond of strawberry daiquiris, works in a hospital and wants someday to marry and have children. They occasionally argue, as sisters do, but most of the time they get on well, complimenting each other, teasing each other, and finishing each other’s sentences. In fact, there are just two unusual things about Lori and Reba. The first is that they share a blood supply, part of a skull, and some brain tissue, having been joined at the forehead since birth. . . . The second unusual thing about Lori and Reba is that they are happy—not merely resigned or contented, but joyful, playful, and optimistic.²⁶

Gilbert uses the Schappels to initiate a series of questions about how we evaluate another person’s happiness. He asks the reader how she would feel if she were a conjoined twin like Lori or Reba. He presumes the answer, teasing the reader, “If you said, ‘Joyful, playful, and optimistic,’ then you are not playing the game and I am going to give you another chance.”²⁷ He says that the “honest answer” to the question is “[d]espondent, desperate, and depressed,” and that this “is why the conventional medical wisdom has it that conjoined twins should be separated at birth, even at the risk of killing one or both.”²⁸

Gilbert can so confidently assume the reader’s answer because a substantial literature documents the gap between the self-reported happiness levels of people with a range of physical disabilities and the anticipated (un)happiness levels that nondisabled people imagine those disabilities would inspire.²⁹ This gap is referred to as the *disability paradox*.³⁰

25. Cf., e.g., Ron Amundson, *Quality of Life, Disability, and Hedonic Psychology*, 40 J. THEORY SOC. BEHAV. 374, 377 (2010) (observing that “the stereotyped unhappiness of the disabled person involves a kind of misery so abject that [societal] improvements . . . are made to seem pointless”).

26. DANIEL GILBERT, *STUMBLING ON HAPPINESS* 29 (2006) (citing NANCY L. SEGAL, *ENTWINED LIVES: TWINS AND WHAT THEY TELL US ABOUT HUMAN BEHAVIOR* (1999)).

27. *Id.* at 27.

28. *Id.* at 28.

29. For thoughtful discussion of the difficulties in assessing happiness and well-being, see, for example, David Wasserman, *Philosophical Issues in the Definition and Social Response to Disability*, in *HANDBOOK OF DISABILITY STUDIES* 219, 229–34 (Gary L. Albrecht et al. eds., 2001); Nussbaum, *supra* note 22, *passim*.

An early study found that lottery winners were not much happier than people with accident-induced paraplegia.³¹ This unexpected finding spurred a series of studies showing that nondisabled people rate life with various disabilities—such as conditions requiring dialysis or colostomies—as far less happy than the individuals with those disabilities report their own lives to be, whether measured in global quality of life assessments or moment-to-moment emotional states.³² These studies largely support the conclusion that, after an initial adjustment period, people with many physical disabilities tend to return to something near to their pre-disability state of happiness.³³

What causes the disability paradox? One part of the gap in perception seems to result from *focusing illusions*, whereby people—when thinking about a particular change of life, such as a new disability—tend to focus disproportionately on the parts of life that will be affected by the disability.³⁴ As Peter Ubel and his colleagues put it, people imagining a

30. See Peter A. Ubel et al., *Misimagining the Unimaginable: The Disability Paradox and Health Care Decision Making*, 24 HEALTH PSYCHOL. (SUPPLEMENT) S57, S57 (2005).

31. Philip Brickman et al., *Lottery Winners and Accident Victims: Is Happiness Relative?*, 36 J. PERSONALITY & SOC. PSYCHOL. 917 (1978).

32. See, e.g., Norman F. Boyd et al., *Whose Utilities for Decision Analysis?*, 10 MED. DECISION MAKING 58 (1990) (finding that patients who received colostomies generally assigned significantly higher utilities to colostomies than did patients who did not receive the procedure); Jason Riis et al., *Ignorance of Hedonic Adaptation to Hemodialysis: A Study Using Ecological Momentary Assessment*, 134 J. EXPERIMENTAL PSYCHOL.: GEN. 3 (2005) (finding, through online mood assessment tools, that dialysis patients experience positive moods in most of their waking hours, whereas healthy people assumed that dialysis patients would experience unpleasant moods during most of their waking hours); David L. Sackett & George W. Torrance, *The Utility of Different Health States As Perceived by the General Public*, 31 J. CHRONIC DISEASES 697 (1978) (finding that public estimates of health-related quality of life for dialysis patients are far lower than the self-estimates of dialysis patients); see also Samuel R. Bagenstos & Margo Schlanger, *Hedonic Damages, Hedonic Adaptation, and Disability*, 60 VAND. L. REV. 745 (2007) (reviewing the hedonic-adaptation literature in the context of an article arguing against hedonic damages in tort suits). For critiques of Bagenstos and Schlanger's application of the hedonics literature to tort damages, see Anne Bloom with Paul Steven Miller, *Blindsight: How We See Disabilities in Tort Litigation*, 86 WASH. L. REV. 709 (2011) (agreeing with many of Bagenstos and Schlanger's points about disability and happiness, but disagreeing with their conclusion that hedonic damages should be eliminated), and Williams, *supra* note 22, at 557 & passim (critiquing Bagenstos & Schlanger's argument against hedonic damages, inter alia, and arguing for hedonic damages on the basis that disability can be a nonconsensual injury to a person's self in the sense of her "ideas, goals, and preferences").

33. See, e.g., Bagenstos & Schlanger, *supra* note 32, at 760–69 (citing sources). But cf. Andrew J. Oswald & Nattavudh Powdthavee, *Does Happiness Adapt? A Longitudinal Study of Disability with Implications for Economists and Judges*, 92 J. PUB. ECON. 1061, 1072 (2008) (estimating the degree of hedonic adaptation after disability to be approximately 30% to 50%). Some work cites the following as exceptions to the disability paradox: some psychiatric impairments and conditions involving chronic pain, see Cass R. Sunstein, *Illusory Losses*, 37(2) J. LEGAL STUD. S157, S167 (2008), and progressive or degenerative conditions such as multiple sclerosis, see Shane Frederick & George Loewenstein, *Hedonic Adaptation*, in WELL-BEING: THE FOUNDATIONS OF HEDONIC PSYCHOLOGY 302, 312 (Daniel Kahneman et al. eds., 1999). As to chronic pain conditions, even pain can be separated into sensory and affective components, with reductions in the affective component while the sensory component stays the same or increases. *Id.* at 311. As to progressive or degenerative conditions, it is hard to say whether adaptation truly does not occur or if the rate of change of the condition is greater than the rate of adaptation. *Id.* at 312.

34. Cf., e.g., Peter A. Ubel et al., *Disability and Sunshine: Can Hedonic Predictions Be Improved by Drawing Attention to Focusing Illusions or Emotional Adaptation?*, 11 J. EXPERIMENTAL

colostomy “think about being unable to go outside in a bathing suit”; “[t]hey do not consider the hundreds of routine daily activities that will be unaffected by their colostomy—things like watching TV shows, enjoying good conversations, savoring tasty meals, and the like. They may even overlook the fact that they haven’t worn a bathing suit in public in years.”³⁵ The gap also results from people’s failure to appreciate the forms of *adaptation* disability would inspire.³⁶ The importance of adaptation is a central reason why simulation exercises, sometimes included as part of “Disability Awareness” days, can create as much misunderstanding as real empathy.³⁷ Getting into a wheelchair, or wearing a blindfold, for one hour or one day is likely to lead a person to assume that living with a relevant disability is much harder than it is; in such a short time, the person has no chance to develop the skills, strategies, and understanding that would characterize a more sustained transition. Research suggests that the disability paradox is difficult to overcome; cueing subjects to consider adaptation works better than encouraging them to escape their focusing illusions, but neither works very well.³⁸ In sum, research into the disability paradox supports the conclusion that the phenomenon is robust and that the gap between predictions of quality of life with disability and self-reports at least in part “results because healthy people mispredict the emotional impact of chronic illness and disability.”³⁹

PSYCHOL.: APPLIED 111 (2005) (discussing adaptation and focusing illusions as components of the disability paradox). Other possible explanations for the disability paradox include contrast effects (wherein a person who faces significant difficulties is less bothered by smaller difficulties) and incomplete health state descriptions (in the relevant studies). See Peter A. Ubel et al., *Whose Quality of Life? A Commentary Exploring Discrepancies Between Health State Evaluations of Patients and the General Public*, 12 QUALITY LIFE RES. 599, 601, 603–04 (2003).

35. Ubel et al., *supra* note 30, at S61. In a similar vein, Adrienne Asch and David Wasserman discuss the ways that prospective parents imagine a child with a disability only in terms of the disability, neglecting the fact that the disability would be one feature of a much more complex individual. See, e.g., Adrienne Asch & David Wasserman, *Where Is the Sin in Synecdoche?: Prenatal Testing and the Parent-Child Relationship*, in QUALITY OF LIFE AND HUMAN DIFFERENCE: GENETIC TESTING, HEALTH CARE, AND DISABILITY 172 (David Wasserman et al. eds., 2005); Adrienne Asch, *Why I Haven’t Changed My Mind About Prenatal Diagnosis: Reflections and Refinements*, in PRENATAL TESTING AND DISABILITY RIGHTS 234, 235–36, 247–55 (Erik Parens & Adrienne Asch eds., 2000).

36. See Ubel et al., *supra* note 30, at S61.

37. See, e.g., Sally French, *Simulation Exercises in Disability Awareness Training: A Critique*, 7 DISABILITY, HANDICAP & SOC’Y 257 (1992).

38. See Ubel et al., *supra* note 30, at S61–S62 (finding that asking people to reflect on adaptation helps to increase, i.e., correct, their estimates of quality of life with a hypothetical disability, but only partially, and finding that efforts to help people overcome focusing illusions have not been successful in reducing the disability paradox).

39. Ubel et al., *supra* note 30, at S58. As mentioned in the Introduction, see *supra* note 17, people with disabilities also show a tendency to mispredict their happiness levels in relation to disability. See, e.g., Peter A. Ubel & George Loewenstein, *Pain and Suffering Awards: They Shouldn’t Be (Just) About Pain and Suffering*, 37 J. LEGAL STUD. S195, S203 (2008) (“[M]ispredictions are not limited to healthy persons but can also be seen in patients[] who have experienced both health and sickness. In a number of studies, we not only asked healthy people how happy they would be if they were sick but also asked people with illness or disabilities to estimate how happy they would be if they were healthy. Invariably, we found that patients believe they would be substantially happier if they were healthy—

2. *Family Well-Being*

Families of children with physical and cognitive disabilities may also be happier than outsiders would expect, although the data are much less clear.⁴⁰ In contrast to the disability paradox literature, which focuses on individuals, the studies of family experience are not focused directly on inside and outside views of happiness, but emphasize related factors like quality of life and depression. Family responses to a child with a disability vary widely, with some studies reporting more negative consequences and some reporting more positive ones.⁴¹ Mediating influences include factors unrelated to the disability such as income levels,⁴² services and social supports,⁴³ and parental cognitions,⁴⁴ as well as disability-related factors such as the type of disabilities involved.⁴⁵ For instance, some researchers have found a “Down syndrome advantage,” whereby parents of children with Down syndrome fare better than other families.⁴⁶ This literature typically compares Down syndrome with other disabilities, although one study finds a lower divorce rate for parents of children with Down syndrome, as compared both to parents of children with “other birth defects” and to parents of children with “no identified disability.”⁴⁷

indeed, they typically predict an increase in happiness equal to the decrease in happiness predicted by healthy people if they were sick.” (citations omitted)).

40. See, e.g., Philip M. Ferguson et al., *The Experience of Disability in Families: A Synthesis of Research and Parent Narratives*, in *PRENATAL TESTING AND DISABILITY RIGHTS*, *supra* note 35, at 72, 74 (describing this research as “bewilderingly multidisciplinary and difficult to follow”).

41. Compare, e.g., Roy I. Brown et al., *Family Quality of Life When There Is a Child with a Developmental Disability*, 3 *J. POL’Y & PRAC. INTELL. DISABILITIES* 238 (2006), and Nancy E. Reichman et al., *Impact of Child Disability on the Family*, 12 *MATERNAL & CHILD HEALTH J.* 679, 680 (2008) (reporting more negative consequences), with Sylvia Rodger & Leigh Tooth, *Adult Siblings’ Perceptions of Family Life and Loss: A Pilot Case Study*, 16 *J. DEVELOPMENTAL & PHYSICAL DISABILITIES* 53 (2004), and Tim Stainton & Hilde Besser, *The Positive Impact of Children with an Intellectual Disability on the Family*, 23 *J. INTELL. & DEVELOPMENTAL DISABILITY* 57 (1998) (reporting more positive consequences).

42. See, e.g., Eric Emerson et al., *Levels of Psychological Distress Experienced by Family Carers of Children and Adolescents with Intellectual Disabilities in an Urban Conurbation*, 17 *J. APPLIED RES. INTELL. DISABILITIES* 77 (2004).

43. See, e.g., Richard Hassall et al., *Parenting Stress in Mothers of Children with an Intellectual Disability: The Effects of Parental Cognitions in Relation to Child Characteristics and Family Support*, 49 *J. INTELL. DISABILITY RES.* 405 (2005).

44. See, e.g., Brown et al., *supra* note 41, at 244–45 (reporting that “spiritual and cultural aspects of life may contribute more to overall family quality of life” than type or severity of disability); Hassall et al., *supra* note 43, at 413–16 (reporting that maternal cognitions matter to well-being).

45. See, e.g., Robert M. Hodapp et al., *Less Stress, More Rewarding: Parenting Children with Down Syndrome*, 1 *PARENTING: SCI. & PRAC.* 317 (2001).

46. See, e.g., *id.* at 325–26. Some work finds that this effect disappears when factors such as parental socioeconomic status are held constant. Compare, e.g., Zolinda Stoneman, *Examining the Down Syndrome Advantage: Mothers and Fathers of Young Children with Disabilities*, 51 *J. INTELL. DISABILITY RES.* 1006 (2007) (reporting that the Down syndrome advantage disappears when variances attributable to income are removed), with Anna J. Esbensen & Marsha Mailick Seltzer, *Accounting for the “Down Syndrome Advantage,”* 116 *AM. J. INTELL. & DEVELOPMENTAL DISABILITIES* 3 (2011) (reporting that social support contributed very little to the psychological well-being of mothers of children with Down syndrome).

47. Richard C. Urbano & Robert M. Hodapp, *Divorce in Families of Children with Down Syndrome: A Population-Based Study*, 112 *AM. J. MENTAL RETARDATION* 261, 261 (2007).

On the other hand, some research suggests that parents of a child with a significant disability are less likely to have subsequent children.⁴⁸ More generally, one recent literature review concludes that, in the aggregate, families with children with a range of disabilities exhibit patterns of overall well-being and adjustment similar to families without children with disabilities.⁴⁹

Social practices may help to illuminate the outside and inside views of the family experience of disability. The outside view of family happiness may in part be reflected in the extensive testing parents undergo to avoid the possibility of having a child with a disability such as Down syndrome, as well as in the substantial rates of abortion associated with a prenatal diagnosis of Down syndrome.⁵⁰ The point is underscored by the fact that this testing is thought to entail a nonnegligible risk of miscarriage—for instance, for the common practice of amniocentesis, the average miscarriage rates are widely cited as approximately one in three hundred.⁵¹ By contrast, parents who already have a child with a disability who get pregnant again are less likely to undertake prenatal testing, a decision that may suggest, among other things, a different view of family happiness from the inside.⁵² On the other hand, as noted above, parents who already have a child with a disability are less likely to have a second child, suggesting complexity and variety of experience.⁵³

Some prospective parents might assume that family life with a disabled child is unhappy based on outdated information. Accessibility has begun to make disability less isolating than it once was, for parents and children.⁵⁴ Although enforcement of the nation's disability laws has fallen short of the law's requirements,⁵⁵ times have changed since the periods of widespread institutionalization.⁵⁶ Together with developments in health care and physical therapy, these changes have increased not just quality of life but life expectancy. For instance, the life expectancy for people with Down syndrome roughly doubled at the end of the twentieth century, from twenty-five years in 1983 to forty-nine years in 1997.⁵⁷

48. Susan E. Kelly, *Choosing Not to Choose: Reproductive Responses of Parents of Children with Genetic Conditions or Impairments*, 31 SOC. HEALTH & ILLNESS 81 (2009).

49. See Ferguson et al., *supra* note 40, at 85.

50. See *infra* Part IV.A.

51. For a discussion of this figure and the latest data, see *infra* note 158 and accompanying text.

52. See, e.g., Kelly, *supra* note 48. For discussion of some of the reasons that parents may choose not to engage in prenatal testing, other than the risk of miscarriage for some tests, see *infra* note 160.

53. See *supra* note 48 and accompanying text.

54. See, e.g., Rachel Adams, *The Ethics of Choice, Revisited 3–4* (Nov. 3, 2009), available at <https://sites.google.com/site/narrativegenetics/Home/the-ethics-of-choice>.

55. See, e.g., *supra* notes 4–7 and accompanying text (describing the courts' restrictive interpretations of the ADA and Congress's recent legislation to restore the intent); see also NAT'L COUNCIL ON DISABILITY, *Individuals with Disabilities Education Act Reauthorization: Where Do We Really Stand?* 3, 22 (2002) ("There is clear agreement that significant weaknesses are present in the current systems of monitoring and enforcement [of the Individuals with Disabilities in Education Act].").

56. See, e.g., *Olmstead v. L.C.*, 527 U.S. 581 (1999).

57. Hajo I.J. Wildschut et al., *Screening in Women's Health, with Emphasis on Fetal Down's Syndrome, Breast Cancer and Osteoporosis*, 12 HUM. REPROD. UPDATE 499, 501 (2006). The National

3. *Athletics and Vitality*

One realm in which the changes in quality of life have been dramatic is athletics.⁵⁸ Athletic events for people with disabilities now include not only opportunities for participation, but highly competitive arenas. For instance, the Special Olympics has become a well-known organization for people with intellectual disabilities to participate at all levels of athletic ability; by contrast, the Paralympics requires athletes—with specified physical or mental disabilities—to meet certain qualifying standards to compete for medals.⁵⁹ The fact that many people still confuse the Special Olympics and the Paralympics is a sign of how little awareness there is of the fierce competition that disabled athletes face in the latter context.⁶⁰

The documentary film *Murderball* portrays the competitive culture of wheelchair rugby, as the film tracks the progress of the U.S. team to the finals of the 2004 Paralympic Games.⁶¹ Self-consciously depicting the macho culture of the guys who play “quad rugby” (and the adoration of the girls who desire them), *Murderball* captures the sexiness of this brash contact sport.⁶² Literary critic Rosemarie Garland-Thompson rightly

Association for Down Syndrome says the average life expectancy is fifty-five years but does not provide a source for this statistic. *Facts About Down Syndrome*, NAT'L ASS'N FOR DOWN SYNDROME, http://www.nads.org/pages_new/facts.html (last visited Aug. 20, 2012). Researchers at the Mayo Clinic continue to cite the 1997 statistic given in the text, suggesting that more recent data may not be available. David S. Majdalany et al., *Adults with Down Syndrome: Safety and Long-Term Outcome of Cardiac Operation*, 5 CONGENITAL HEART DISEASE 38, 38 (2010).

58. See, e.g., SPORT FOR DEV. & PEACE INT'L WORKING GRP., HARNESING THE POWER OF SPORT FOR DEVELOPMENT AND PEACE: RECOMMENDATIONS TO GOVERNMENTS 171–72 (2008), <http://www.un.org/wcm/webdav/site/sport/shared/sport/pdfs/SDP%20IWG/Final%20SDP%20IWG%20Report.pdf>; Michael Ashley Stein & Janet E. Lord, *Future Prospects for the United Nations Convention on the Rights of Persons with Disabilities*, in THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES: EUROPEAN AND SCANDINAVIAN PERSPECTIVES 17, 29 (Oddný Mjöll Arnardóttir & Gerard Quinn eds., 2009).

59. See, e.g., *Special Olympics and Paralympics: What's the Difference?*, SPECIAL OLYMPICS (Mar. 16, 2010), <http://media.specialolympics.org/soi/files/press-kit/What's%20the%20difference%20SO%20and%20Paralympics.pdf>.

60. See, e.g., Teddy Katz, *Paralympics Are Not Special Olympics*, CBC DIGITAL ARCHIVES, <http://www.cbc.ca/archives/categories/sports/olympics/playing-to-win-canada-at-the-paralympics/paralympics-are-not-special-olympics.html> (last updated Aug. 13, 2012).

61. MURDERBALL (THINKFilm 2005). For a summary of the film and an explanation of the sport, see Stephen Holden, *These Gladiators on Wheels Are Not Playing for a Hug*, N.Y. TIMES, July 8, 2005, at E8 (“A synthesis of basketball, hockey and rugby, it is played by quadriplegic men . . . outfitted like warriors but without helmets [and] strapped into armored, custom-made wheelchairs that collide in a kind of human demolition derby as the teams compete to carry a ball into the end zone. . . . Wheelchair rugby players are assigned rankings, from .5 to 3.5, depending on their degree of upper-body mobility. A team’s total score cannot exceed 8. The more mobile players handle the ball; the rest play defense.”).

62. Women are officially allowed to play quad rugby, but no female athlete had been named to the U.S. national team before 2009, when Kerri Morgan was the first. See *Frequently Asked Questions About Murderball*, U.S. QUAD RUGBY ASS'N, <http://quadrugby.com/murderball/faqs.html> (last visited Aug. 20, 2012); Ralph Raymond, *2009 U.S. Men's (and 1st Woman!) Quad Rugby Team Announced*, ROLLINGPIX (Dec. 20, 2008, 9:53 AM), <http://rollingpix.blogspot.com/2008/12/2009-us-mens-and-1st-women-quad-rugby.html>. The film depicts only male players, with one exception. In the final scene, a

notes that “the conventional ‘what-happened-to-you?’ narrative mandate of disability stories” is “admirably restrained” in the film.⁶³ The drama of the film comes largely from the fierce rivalry between the Canadian and U.S. teams, on and off the court, not from the origins of the disabilities that brought the players to their wheelchairs.⁶⁴

From an inside perspective, not all representations of disability and sports are salutary. Disability scholars have illuminated the ways that sports discussions can open the door to problematic narratives of “overcoming” disability.⁶⁵ Such narratives emphasize how a person has succeeded by overcoming or escaping her disability—for example, the frequent comment about *Murderball* star Mark Zupan that “he plays quad rugby with ‘so much intensity’ that people ‘forget’ he is disabled.”⁶⁶ As Zupan has observed, this is like saying, “Denzel Washington is such a good actor that you forget he’s black.”⁶⁷ Alongside stereotypes of overcoming, however, sports contexts also offer powerful opportunities for narratives of disability as an integral part of an active or successful life. Consider these words from the track star and model Aimee Mullins, who is a below-the-knee amputee:

[P]eople have continually wanted to talk to me about overcoming adversity and . . . this phrase never sat right with me. . . . Implicit in this phrase of overcoming adversity is the idea that success or happiness is about emerging on the other side of a challenging experience unscathed or unmarked by the experience . . . but in fact we are changed, we are marked, of course, by a challenge, whether physically, emotionally, or both, and I’m going to suggest that this is a good thing. . . . [T]he idea I want to put out there is not so much overcoming adversity as it is opening ourselves up to it, embracing it, grappling with it . . . maybe even dancing with it.⁶⁸

woman tries out a quad-rugby wheelchair at an introductory session for disabled service members. See MURDERBALL, *supra* note 61.

63. Rosemarie Garland-Thompson, *Shape Structures Story: Fresh and Feisty Stories About Disability*, 15 NARRATIVE 113, 115 (2007).

64. The hypermasculinity of the film and its star, Mark Zupan, have provided fodder for critical examination, and one scholar has characterized Zupan’s “complex embodiment” as involving both an effort to “pass” as nondisabled, in some ways, and an embrace of his identity as “a quad,” in others. See Michael A. Rembis, *Athlete First: A Note on Passing, Disability, and Sport*, 1, 13–14, in *BLURRING THE LINES: DISABILITY, RACE, GENDER AND PASSING IN MODERN AMERICA* (Daniel Wilson & Jeff Brune eds., forthcoming 2013); see also Garland-Thompson, *supra* note 63, at 115–16.

65. See, e.g., Rembis, *supra* note 64, at 4 & passim; Beth A. Haller & Sue Ralph, *Are Disability Images in Advertising Becoming Bold and Daring?: An Analysis of Prominent Themes in US and UK Campaigns*, 26 DISABILITY STUD. Q. (Summer 2006).

66. Rembis, *supra* note 64, at 15 (quoting MARK ZUPAN & TIM SWANSON, *GIMP* 7 (2006)). For a rich discussion of these and other passages from Zupan and from Aimee Mullins, see generally Rembis, *supra* note 64, at 13–22.

67. Rembis, *supra* note 64, at 15 (quoting ZUPAN & SWANSON, *supra* note 66, at 7).

68. Rembis, *supra* note 64, at 20 (quoting Aimee Mullins, *The Opportunity of Adversity*, Lecture given at TEDMED, San Diego, CA (Oct. 2009), <http://www.youtube.com/watch?v=dTwXeZ4GkzI&feature=channel> (last viewed Sept. 7, 2012)).

Or in Zupan's pithy, crasser words, "I can be disabled and still play really fucking hard."⁶⁹

The film *Murderball*—with its fierce and vibrant portrayal of disability—stands in stark contrast to the Oscar-winning *Million Dollar Baby*, in which the athletic excitement and activity abruptly cease when the heroine (played by Hilary Swank) becomes quadriplegic.⁷⁰ The drama in the latter film then becomes about whether Clint Eastwood's character should help the former boxer die. Disability advocates argued that *Million Dollar Baby* presented life as a disabled person as not worth living.⁷¹ Critics of this view replied that *boxing* was the character's life, and so she wanted to die because she could not box, not because she was disabled.⁷² Boxing was indeed vital to the character. But it is hard to imagine the same story winning Academy Awards (including Best Picture, as well as Best Director for Clint Eastwood⁷³) if Swank's character was simply disqualified from all future boxing competitions, or even injured in a way that affected only competitive sports, and Clint Eastwood was nonetheless depicted as making the tragically humane choice of helping her die. The film's narrative arc depends on an underlying feeling that quadriplegia is a grim, passive, lifeless state. This feeling is conveyed through the dark and dreary nursing home scenes, in which no other disabled characters are present to give any sense of where rehabilitation might lead, and in which apparently inadequate care led to extreme pressure sores requiring the amputation of her leg.⁷⁴ This is remarkably poor care—as one critic mused, "Why is Maggie in a nursing home rather than receiving effective rehabilitation?"⁷⁵—particularly for someone luxuriously funded by the boxing federation.⁷⁶

The narrative arc of *Million Dollar Baby*, relying on the grim lifelessness of paraplegia, was apparently well-received by much of the audience that helped the film gross \$100.5 million domestically and win four

69. Rembis, *supra* note 64, at 15 (quoting ZUPAN & SWANSON, *supra* note 66, at 7).

70. *MILLION DOLLAR BABY* (Warner Bros. Pictures 2004).

71. See, e.g., *Million Dollar Baby Built on Prejudice About People with Disabilities*, DISABILITY RTS. EDUC. & DEF. FUND (Feb. 2005), <http://www.dredf.org/archives/mdb.shtml>.

72. See, e.g., John Caskey, *Million Dollar Baby in Review*, DISABILITY STUD. Q. (Summer 2005), <http://www.dsqsds.org/article/view/590/767>.

73. See *The 77th Academy Awards (2005) Nominees and Winners*, THE ACAD. OF MOTION PICTURE ARTS & SCI., <http://www.oscars.org/awards/academyawards/legacy/ceremony/77th-winners.html> (last visited Aug. 20, 2012).

74. *MILLION DOLLAR BABY*, *supra* note 70.

75. *Million Dollar Baby Built on Prejudice About People with Disabilities*, *supra* note 71.

76. Critics aware of recent disability rights history were not entirely surprised that Eastwood's portrayal was poorly informed about appropriate conditions for rehabilitation, however, since Eastwood had made headlines in 2000 by attacking the ADA in response to a lawsuit against his Mission Ranch Hotel in Carmel, California. See, e.g., MARY JOHNSON, MAKE THEM GO AWAY: CLINT EASTWOOD, CHRISTOPHER REEVE & THE CASE AGAINST DISABILITY RIGHTS 1–2 (2003); Mary Johnson, *Killing Us Kindly*, RAGGED EDGE ONLINE (Jan. 19, 2005), <http://www.raggededgemagazine.com/mediacircus/killingkindly.html>.

Academy Awards.⁷⁷ *Murderball*, which grossed just over \$1.5 million⁷⁸ and ceded the following year's Oscar for Best Documentary to *March of the Penguins*,⁷⁹ belies the assumptions that drive its more popular predecessor. The disability paradox helps to explain the gap between these two views.

B. Disability Discrimination: Attitudes and Models

It is not news that there is widespread disability discrimination.⁸⁰ The focus of this Section, however, is on gaps between inside and outside views of what constitutes discrimination.

1. What Counts As a Positive or Negative Attitude?

Anecdotal and empirical accounts document that disabled and non-disabled people disagree about how to interpret their interactions. As Adrienne Asch explains, "Much personal narrative and social science writing about the experience of having a disability includes stories of indignities at the hands of strangers, neighbors, co-workers, friends, and family—and then having to be told that your interpretation is always wrong."⁸¹ In one article, Asch offers some personal instances of insult and interpretive disconnect:

Some examples of events that occurred during a two-week period while this essay was my main intellectual focus, and therefore causing me to be especially aware of the impact of routine events: I was asked by an examining physician whether, because I was blind, I needed her assistant to "come in and help you get dressed"; I was told by a bus driver and several passengers that I must sit down, even though several other bus passengers were already standing on the crowded bus; I was pushed to the front of a line of customers at a bank, although blindness does not have any relationship to the

77. See *The 15 Lowest-Grossing Oscar Winners: 8. Million Dollar Baby (2004)*, CNBC, http://www.cnb.com/id/41762460/The_15_Lowest_Grossing_Oscar_Winners?slide=9 (last visited Aug. 20, 2012); *The 77th Academy Awards (2005) Nominees and Winners*, *supra* note 73. It is interesting that *Million Dollar Baby* is one of the fifteen lowest grossing Oscar winners, which the authors of a profile on that topic consider as possibly due to the negative press from disability rights groups. *The 15 Lowest-Grossing Oscar Winners: 8. Million Dollar Baby (2004)*, *supra*.

78. See *Murderball*, BOX OFFICE MOJO, <http://boxofficemojo.com/movies/?id=murderball.htm> (last visited Aug. 20, 2012) (the gross total given in the text is domestic; foreign gross included another \$219,057).

79. See *The 78th Academy Awards (2006) Nominees and Winners*, THE ACAD. OF MOTION PICTURE ARTS & SCI., <http://www.oscars.org/awards/academyawards/legacy/ceremony/78th-winners.html> (last visited Aug. 20, 2012).

80. See, e.g., ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (findings); Robert Kleck, *Emotional Arousal in Interactions with Stigmatized Persons*, 19 PSYCHOL. REP. 1226 (1966); *Fact Sheet 1: Employment of Persons with Disabilities*, UNITED NATIONS ENABLE (Nov. 2007), <http://www.un.org/disabilities/documents/toolaction/employmentfs.pdf>.

81. Adrienne Asch, *Critical Race Theory, Feminism, and Disability: Reflections on Social Justice and Personal Identity*, 62 OHIO ST. L.J. 391, 395 (2001) (footnote omitted).

ability to stand and wait one's turn in a bank line; I was spoken about rather than spoken to—"put her here" was said to a friend of mine as we walked into a crowded room to join a meeting; a friend was described by others not as my friend, but as my "assistant" and my "guide"; a friend of more than twenty years explained to me that my distress, irritation, and frustration were unreasonable responses to people who were "trying to do the right thing."⁸²

The problem of discrimination is not just a matter of nondisabled people not trying hard enough to behave appropriately. For example, Elaine Makas has shown that nondisabled subjects exhibited less-positive attitudes toward disability when they were trying to impress a disabled person.⁸³ Makas asked nondisabled students to agree or disagree with a series of statements about disability, first truthfully, and then under "fake-well" instructions. Under the "fake-well" conditions, students were told that they should answer "in a way that they felt reflected 'the most positive attitudes toward persons with disabilities,'" as if they were "really try[ing] to impress" someone who was giving out a \$10,000 prize for the "student who had the most positive attitudes toward disabled people."⁸⁴ Makas found that on a substantial number of items the students in the "fake-well" condition showed *less favorable* attitudes than in the truthful condition, under the disabled respondents' view of positive attitudes toward disability.⁸⁵ In other words, when the nondisabled subjects tried to display what they thought were more positive attitudes to disability, they displayed less positive attitudes, viewed from an inside perspective.

These gaps in perspective on what counts as discrimination—or even as appropriate or considerate behavior—are akin to what Russell Robinson has called "perceptual segregation" in the contexts of race and sex.⁸⁶ Robinson defines perceptual segregation as the idea that "[b]lack and whites, on average, tend to view allegations of racial discrimination through substantially different perceptual frameworks."⁸⁷ With regard to

82. *Id.* at 395–96 n.21. Many of the plays in Theater Breaking Through Barriers' *Some of Our Parts* address this theme, particularly Bekah Brunstetter's *Gorgeous* and Samuel D. Hunter's *Welcome to Walmart*.

83. Elaine Makas, *Positive Attitudes Toward Disabled People: Disabled and Nondisabled Persons' Perspectives*, 44 J. SOC. ISSUES 49 (1988).

84. *Id.* at 54.

85. *Id.* (finding that student attitudes were more negative on twenty out of one hundred items in the "fake-well" condition, and eleven of these items were statistically significant). The items on which "fake-well" conditions produced a perverse result generally fell into two categories: what Makas termed the "Give the Disabled Person a Break" cluster (for instance, agreeing with the statement, "Generally, it's a good idea not to try to win a game when competing with a physically disabled person") and what Makas called the "Disabled Saint" cluster (for instance, agreeing with the statement "Disabled people should be considered courageous for having overcome their disabilities"). *Id.* at 55. Makas included in the study another group of nondisabled subjects—who were specifically chosen by disabled people for having "extremely positive attitudes toward people with disabilities"—and they answered the questions in ways much more similar to the disabled respondents. *Id.* at 53–56.

86. Robinson, *supra* note 3.

87. *Id.* at 1106. Robinson also applies the theory, secondarily, to the context of sexual harassment. *Id.* at 1113–17.

disability discrimination, the perceptual gap goes to the heart of what we understand “disability” to mean, as the next Subsection discusses.

2. *Explaining Discrimination*

A core insight of disability studies is the idea that disability can be understood in either of two ways: using a *medical model* or a *social model*.⁸⁸ The medical model is the idea, common to mainstream portrayals, that disability is an individual medical problem. By contrast, the social model understands disability to inhere in the interaction between an individual’s impairment and the surrounding social context. Simi Linton, who uses a wheelchair, nicely captures this distinction when she asks her students, “If I want to go to vote or use the library, and these places are inaccessible, do I need a doctor or a lawyer?”⁸⁹ The social model does not necessarily reject the idea of biological impairment—in the sense of variations from a value-neutral idea of species-typical or normal functioning—but thinking through the frame of the social model makes it much harder to see limitations caused by those variations as inherent.⁹⁰ Even if one accepts some impairments as inherently undesirable, the social model shifts the focus from whatever physical or mental variation an individual might bear, to the ways that the environment renders that variation disabling.

Once one sees disability using a social model, then one may also see that disability discrimination includes a wider range of attitudes and environmental features than an individual medical model suggests.⁹¹ This is because the social model denaturalizes the current environment.⁹² Common features of our homes and offices begin to look less like essential components and more like accommodations to the majority: chairs are provided for people who walk (rather than travel in their own chairs), and lights are required only by people who see (but not by those who do not).⁹³ From this perspective, particular accommodations for

88. See, e.g., Bagenstos, *supra* note 4, at 426–31; see also MICHAEL OLIVER, UNDERSTANDING DISABILITY: FROM THEORY TO PRACTICE ch. 3 (1996). For a discussion of different versions of the social model, and for critiques of its boldest version, see, for example, TOM SHAKESPEARE, DISABILITY RIGHTS AND WRONGS (2006).

89. SIMI LINTON, MY BODY POLITIC: A MEMOIR 120 (2006).

90. See Wasserman, *supra* note 29, at 222–29.

91. For an explanation of why no normative conclusions necessarily result from the social model, in the absence of some other normative theory (such as utilitarianism), see Adam M. Samaha, *What Good Is the Social Model of Disability?*, 74 U. CHI. L. REV. 1251 (2007).

92. Cf. SUSAN WENDELL, THE REJECTED BODY: FEMINIST PHILOSOPHICAL REFLECTIONS ON DISABILITY 39 (1996) (observing that “[m]uch of the public world is . . . structured as though everyone were physically strong, as though all bodies were shaped the same, as though everyone could walk, hear, and see well, as though everyone could work and play at a pace that is not compatible with any kind of illness or pain, as though no one were ever dizzy or incontinent or simply needed to sit or lie down”).

93. See Asch, *supra* note 81, at 402 (citing Susan Daniels, Address at the Conference of the Association for Higher Education and Disability (July 14, 1999)).

people with disabilities start to look less like “special rights” than variations in the accommodations provided to everyone.

3. *Recognizing Disability*

One key difference in perspective centers on the prevalence and meaning of disability.⁹⁴ From an inside perspective, disability is a pervasive feature of life, something most everyone will experience if they are lucky enough to live that long.⁹⁵ Outside perspectives on disability tend to hold disability at arm’s length, to try to create distance from it, both physically and psychologically. Harlan Hahn has aptly termed this the “existential anxiety” that drives disability discrimination.⁹⁶ Hahn defines existential anxiety as “the perceived threat that a disability could interfere with functional capacities deemed necessary to the pursuit of a satisfactory life,” a feeling resulting from “a sense of personal identification with the position of a disabled person.”⁹⁷

Disability is unusual, if not unique, among the groups protected by antidiscrimination law in that anyone could fall into the category at any time.⁹⁸ This, we might think, would create empathy for those in the group. Hahn’s account of existential anxiety shows why the opposite

94. Again, like Russell Robinson, I use the language of inside and outside (though differently than Robinson does), while rejecting any claim of an essence to either category. See Robinson, *supra* note 3.

95. See, e.g., U.S. DEP’T OF HEALTH & HUMAN SERVICES, *The Surgeon General’s Call to Action to Improve the Health and Wellness of Persons with Disabilities: What it Means to You*, 1 (2005), <http://www.surgeongeneral.gov/library/calls/disabilities/calltoaction.pdf> (“The chance of having a disability goes up with age . . . to almost 75% for people 80 or older.”). Relatedly, the most common disabilities are not the most obvious ones like paraplegia or blindness, but less obvious conditions like arthritis, hypertension, and back problems, for which the bearers do not typically claim a disability identity. See, e.g., Centers for Disease Control & Prevention, *Prevalence and Most Common Causes of Disability Among Adults—United States, 2005*, (May 1, 2009), <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5816a2.htm> (reporting the three most common disabilities in the U.S. as arthritis or rheumatism, back or spine problems, and heart trouble); see also Aimee Burke Valeras, “*We Don’t Have a Box*”: *Understanding Hidden Disability Identity Utilizing Narrative Research Methodology*, *DISABILITY STUD. Q.* (2010), <http://www.dsqsds.org/article/view/1267/1297>. (Relatedly, people with many of these common impairments often hold more of an outside than inside view of disability.) Definitions of disability are contested. See, e.g., Bagenstos, *supra* note 4; Feldblum, *supra* note 4. But if we take the ADA’s definition—“a physical or mental impairment that substantially limits one or more of the major life activities of such individual . . . a record of such an impairment . . . or being regarded as having such an impairment” (even if not substantially limiting)—then so long as the impairments listed above are somewhat limiting, they arguably fit under the ADA’s definition, now that the ADAAA lowered the Court’s “demanding standard” for who counts as having a “disability” under the ADA. Americans with Disabilities Act of 1990, 42 U.S.C. § 12102(2) (2006); see *supra* note 5 and accompanying text.

96. Harlan Hahn, *The Politics of Physical Differences: Disability and Discrimination*, 44 *J. SOC. ISSUES* 39 (1988).

97. *Id.* at 43.

98. Disability is not unique, however, in being mutable. People advance into old age, for instance, and even sex and race are changeable to various degrees, depending on one’s definitions of these categories. On these kinds of mutability, see, for example, Elizabeth F. Emens, *Against Nature*, in *NOMOS LII: EVOLUTION AND MORALITY* (James E. Fleming & Sanford Levinson eds., forthcoming Sept. 2012). What is distinct about disability is that anyone can fall into the category, unexpectedly, at any time. See, e.g., West, *supra* note 15.

may instead occur. Precisely because anyone could end up in the category at any time, outsiders may distance themselves from those in the group, and from any feeling of identification with their interests. Existential anxiety therefore may lead to greater resistance to groups that represent this threatening possibility.⁹⁹

From an inside perspective, disability is common, familiar, and a feature of life like anything else: sometimes a nuisance, sometimes salutary, but rarely the focus of attention.¹⁰⁰ This is consistent with the empirical work on the disability paradox, discussed earlier, which shows that disability becomes relatively unimportant in many people's happiness levels after a period of adjustment, despite the perception from the outside that the disability would create great unhappiness.¹⁰¹

Once disability looks like something that will affect everyone, typically in more mundane than tragic ways, disability accommodation begins to look like a social insurance policy for everyone.¹⁰² If nondisabled people are understood as temporarily able-bodied, then accommodations are not special rights for a few, but are instead approaches to our common environment that aim to benefit us all. The failure to provide those accommodations—through, for instance, “selective sympathy and indifference”¹⁰³—looks like discrimination.¹⁰⁴

C. *The Law: Who Benefits?*

Disability law offers opportunities to benefit not just *anyone* but *everyone*, because disabilities provide lenses through which we may identify improvements to a non-ideal environment.

1. *Outside Oversight*

Disability accommodations under the ADA are generally understood to benefit the individual with a disability who requests the accommodation, and to impose costs on the employer or other entity charged

99. By way of comparison, one might think here, for instance, of bisexuality, which may be more threatening to heterosexuals than homosexuality because it is easier to fall into. See Kenji Yoshino, *The Epistemic Contract of Bisexual Erasure*, 52 STAN. L. REV. 353, 402–04 (2000).

100. Cf. Asch & Wasserman, *supra* note 35.

101. See *supra* Part II.A.1.

102. By this, I do not, however, mean a scheme that compensates for disability at an individual level. Cf., e.g., Ronald Dworkin, *What Is Equality? Part 2: Equality of Resources*, 10 PHIL. & PUB. AFF. 283, 296–98 (1981) (discussing disability insurance in the context of a hypothetical auction, which measures how much disability insurance coverage the average member of the community would purchase if each member had the same risk of developing disabilities); David Wasserman, *Distributive Justice*, in DISABILITY, DIFFERENCE, DISCRIMINATION: PERSPECTIVES ON JUSTICE IN BIOETHICS AND PUBLIC POLICY, *supra* note 8, at 147, 165–72 (critiquing Dworkin's disability insurance scheme). I mean instead that a society that attempts to minimize the disadvantage created by impairment benefits not only people with disabilities now but those who may someday become disabled.

103. See, e.g., Bagenstos, *supra* note 8, at 853–54 (explaining the concept).

104. Cf. *id. passim*; Christine Jolls, *Antidiscrimination and Accommodation*, 115 HARV. L. REV. 642 (2001); Stein, *supra* note 8.

with providing the accommodation. In addition, some ADA employment-discrimination cases recognize the potential costs to third parties—coworkers, customers, bystanders—who might incur some externalities due to the accommodation provided to the disabled individual.¹⁰⁵ Nowhere, however, does the case law recognize that accommodations might actually provide *benefits* to third parties.¹⁰⁶ The potential benefits include everything from ergonomic office equipment designed or purchased for people with disabilities, to classroom aides that improve the student-teacher ratio, to closed captioning that allows for silent television in athletic clubs and airports, to name a few examples.¹⁰⁷

2. *Obvious to Some*

By contrast to this oversight in the ADA case law, the third-party benefits of accommodation are glaringly obvious under the inside view of disability.¹⁰⁸ At times, disabled people even express frustration at the prospect of any *more* discussion of these broader benefits: “How often . . . are the proliferation of curb cuts, ramped entrances, and widened doorways hailed as a benefit for people who push shopping carts, or for parents wheeling baby strollers!”¹⁰⁹ And yet these benefits have been completely unseen by the courts—and many commentators—who interpret the ADA’s accommodation requirement.¹¹⁰

3. *Currency for All*

A recent example of this oversight by courts is the D.C. Circuit’s 2008 decision declaring U.S. currency to violate the Rehabilitation Act, the corollary act to the ADA for federal agencies and programs.¹¹¹ The American Council of the Blind brought suit against the U.S. Treasury arguing that the currency “denies meaningful access” to blind people, because the combination of uniform shape, color, size, and texture prevents blind people from distinguishing denominations of bills without third-party assistance.¹¹² The district court ordered the Treasury to redesign the money, or otherwise create and provide effective reading machines

105. See, e.g., *US Airways, Inc. v. Barnett*, 535 U.S. 391, 402–06 (2002).

106. See Elizabeth F. Emens, *Integrating Accommodation*, 156 U. PA. L. REV. 839, 842, 867–76 (2008).

107. For more examples, see *id. passim*.

108. See, e.g., Ron Amundson, *Disability, Handicap, and the Environment*, 23 J. SOC. PHIL. 105, 116 (1992).

109. Asch, *supra* note 81, at 401.

110. See Emens, *supra* note 106. A recent exception to this trend is the EEOC’s regulations interpreting the ADA Amendments Act of 2008, which acknowledge the possibility of third-party benefits of accommodations. See 76 Fed. Reg. 16,997–98 (Mar. 25, 2011) (citing Emens, *supra* note 106).

111. *Am. Council of the Blind v. Paulson*, 525 F.3d 1256 (D.C. Cir. 2008).

112. *Id.* at 1259–61.

(which would require a technological breakthrough¹¹³), and the D.C. Circuit agreed.¹¹⁴ The decisions paid substantial attention to the possible third-party costs of a change to the currency: Vending machine owners, for instance, would have to bear the costs of altering their machines.¹¹⁵ This attention to burdens on third-party vendors appeared in spite of any challenge to the \$1 bill.

Amidst extensive discussion of third-party costs, the D.C. Circuit made no mention of the possible third-party benefits of altering the U.S. currency to vary the appearance of monetary denominations. The United States is alone in the world in printing currency that is uniform in size, shape, color, and texture.¹¹⁶ Although the uniquely uniform U.S. denominations create difficulty for foreign visitors as well as blind people,¹¹⁷ the court attended only to the third-party costs. This oversight appeared in a controversial ruling that could easily have benefitted from further evidence that the costs did not outweigh the benefits of such a bold order of relief.¹¹⁸

D. *Inside Insights*

This Section extracts a series of discrete ideas from the previous discussion to provide a summary of the kind of material that framing rules in the context of disabilities should address. These generalizations are of course overbroad and subject to debate and refinement, but the aim is to sketch some broad-brush ideas that might nonetheless be useful in laying the groundwork for trying, in the rest of the Article, to design strategies for bringing the outside view closer to the inside view. As noted earlier, the discussion here is limited to physical and cognitive disabilities.¹¹⁹

113. The current readers are expensive and have trouble identifying \$20 bills, and thus the courts determined them to be inadequate. *Id.* at 1263.

114. *Id.* at 1274; *Am. Council of the Blind v. Paulson*, 581 F. Supp. 2d 1 (D.D.C. 2008).

115. 525 F.3d at 1272–73.

116. See Nat'l Materials Advisory Board, *Currency Features for Visually Impaired People*, NAT'L ACADEMIES PRESS, 106–12 (1995), http://www.nap.edu/openbook.php?record_id=4828&page=R1.

117. See, e.g., ShinyJess, *The App that Reads Money for the Blind (and Tourists)*, TECH DIGEST (Mar. 11, 2011), http://www.techdigest.tv/2011/03/the_app_that_re.html.

118. Indeed, some of the controversy stemmed from opposition by the other major blind organization in the country, National Federation of the Blind, whose president expressed concern that the lawsuit would make blind people look helpless and financially vulnerable: “Blind people transact business with paper money every day. This ruling puts a roadblock in the way of solving the real problem, which is the seventy percent unemployment rate among working-age blind Americans that severely limits our access to cash.” *National Federation of the Blind Comments on Federal Court Ruling on U.S. Currency: Views Effort As Dangerously Misguided*, FREE LIBR. BY FARLEX (Nov. 29, 2006), http://www.thefreelibrary.com/_/print/PrintArticle.aspx?id=155151019 (quoting Dr. Marc Maurer, President of the National Federation of the Blind). Recognizing that blind people are not uniquely disadvantaged here—because people who did not grow up with these uniquely uniform bills also find them challenging—might help address these concerns.

119. For explanation, see *supra* notes 21 and 33.

- (1) Disability happens to many people, indeed, most people, if they are lucky enough to live that long.¹²⁰ (Age and disability potentially create interest convergence; accessibility is a form of social insurance for everyone.¹²¹)
- (2) The fact that disability could happen to anyone does not, however, mean that nondisabled people will relate to disabled people, or disability rights, with empathy; it may instead lead to “existential anxiety” and a resistance to thinking about disability or people with disabilities.¹²²
- (3) Disability need not be as frightening as it sounds to many outsiders. Quality of life with a disability is typically much better than nondisabled people predict it would be.¹²³ For example, after an initial adjustment period, people who become paraplegic tend to return to something near to their pre-disability state of happiness.¹²⁴ And while there is much variability across families, some work suggests that in the aggregate families with children with physical and intellectual disabilities exhibit patterns of overall well-being and adjustment similar to families without children with disabilities.¹²⁵
- (4) Life with a disability is a life in which disability is one, often small, piece. When imagining disability, nondisabled people often focus so much on the disability that they do not appreciate the ways that adaptation makes disability a part of life like anything else.¹²⁶
- (5) Life with a disability can be active and athletic. For example, people with disabilities can and do participate in competitive and recreational sports, both in standard sports settings and in disability-specific sports and competitions.¹²⁷
- (6) Accessibility has begun to make disability more livable and much less isolating than it once was (for instance, in periods of widespread institutionalization). Together with developments in health care and physical therapy, these changes have increased not just quality of life but life expectancy for some disabilities, such as Down syndrome.¹²⁸

120. See *supra* Part II.B.3.

121. See *supra* note 102. The fact that age and disability could involve a convergence of interests does not mean that advocates on each side will be allies. See *infra* note 122 and accompanying text.

122. See, e.g., Hahn, *supra* note 96; *supra* Part II.B.3.

123. See *supra* Part II.A.1.

124. See *supra* notes 31–33 and accompanying text.

125. See *supra* notes 40–47 and accompanying text.

126. See *supra* notes 34–39 and accompanying text.

127. See *supra* notes 58–60 and accompanying text.

128. See *supra* notes 54–57 and accompanying text.

- (7) Much of what makes disability disabling is the way that the environment is structured.¹²⁹ Think, for example, about the ways that opportunities are limited for nondisabled people who go places with a disabled person; for those (nondisabled) people, accessibility determines what restaurants, theaters, or homes they can enter, although no medical condition limits them.¹³⁰
- (8) Changing the environment to accommodate disability may not be granting “special rights,” but may just involve broadening the kinds of accommodations provided in order to include those people neglected by typical design principles.¹³¹
- (9) Adaptations and accommodations for disability can benefit more than just the disabled person who needs them.¹³² These innovations can benefit other disabled people, as well as nondisabled people.

Any given framing rule would target only one or a few of these ideas, and I make some observations about these particulars in what follows. This list should nonetheless give a sense of the kinds of attitudes that it could be useful to encourage. The rest of the Article focuses less on these questions of content and more on generating proposals for transmission of these ideas.

III. FRAMING RULES

Various strategies are available for shaping attitudes toward disability. “Contact” through integration—in schools,¹³³ workplaces,¹³⁴ public accommodations,¹³⁵ civic activities,¹³⁶ and other settings¹³⁷—probably offers the most promise for changing nondisabled people’s beliefs about the capacities of people with disabilities.¹³⁸ Contact (with particular fea-

129. See *supra* Part II.B.2.

130. See, e.g., Elizabeth F. Emens, *Intimate Discrimination: The State’s Role in the Accidents of Sex and Love*, 122 HARV. L. REV. 1307, 1366–79 (2009).

131. See *supra* Part II.B.2.

132. See *supra* Part II.C.

133. See, e.g., Individuals with Disabilities Education Act, 20 U.S.C. §§ 1400–1482 (2006).

134. See, e.g., Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101–12117 (2006).

135. See, e.g., 42 U.S.C. §§ 12181–12189.

136. See, e.g., 42 U.S.C. § 2000a-6; *Tennessee v. Lane*, 541 U.S. 509 (2004).

137. See, e.g., *Olmstead v. L.C.*, 527 U.S. 581 (1999) (community integration).

138. See, e.g., Patrick W. Corrigan & David L. Penn, *Lessons from Social Psychology on Discrediting Psychiatric Stigma*, 54 AM. PSYCHOLOGIST 765, 772–73 (1999); Donna M. Desforges et al., *Effects of Structured Cooperative Contact on Changing Negative Attitudes Toward Stigmatized Social Groups*, 60 J. PERSONALITY & SOC. PSYCHOL. 531 (1991); Monika E. Kolodziej & Blair T. Johnson, *Interpersonal Contact and Acceptance of Persons with Psychiatric Disorders: A Research Synthesis*, 64 J. CONSULTING & CLINICAL PSYCHOL. 1387 (1996); Makas, *supra* note 83; Dianna L. Stone & Adrienne Colella, *A Model of Factors Affecting the Treatment of Disabled Individuals in Organizations*, 21 ACAD. MGMT. REV. 352 (1996). For a recent large-scale demonstration of the benefits of contact across studies and categories, see Thomas F. Pettigrew & Linda R. Tropp, *A Meta-Analytic Test of Intergroup Contact Theory*, 90 J. PERSONALITY & SOC. PSYCHOL. 751 (2006). The original idea for the

tures) has the strongest empirical support as a means of changing minds and hearts across identity categories, including disability.¹³⁹ Any number of additional mechanisms might supplement the work of contact, ranging from popular media to high art to famous spokespeople to educational programming in schools. Broad public education initiatives could also be considered: for example, messages pasted on the sides of buses or television public service announcements. This Part identifies a further, novel strategy for conveying messages about disability.

At various junctures in life, nondisabled people have reason to think about disability. Because anyone could become disabled at any time,¹⁴⁰ nondisabled people make many decisions that implicate their (possible) future relation to disability. These decisions are sometimes routine and repeated, such as whether to smoke or take medication with a small risk of disabling side effects, and sometimes unusual or infrequent, such as whether to go skydiving or engage in prenatal testing.

Whatever the scale, such moments give nondisabled people a reason to think about disability. And they are often moments when disability is framed—directly or indirectly—in uninformed and negative ways. This Article suggests that we should target these moments with better information about disability drawn from the inside perspective.

A. *Introducing Framing Rules*

Extensive work in decision science demonstrates that context shapes people's decisions.¹⁴¹ Legal scholars have drawn on this literature to develop tools for shaping decision making through a variety of regulatory forms. Much of this work has focused on designing *default rules*, that is, on deciding what default the state should supply when parties do not affirmatively choose something else.¹⁴² In addition, *menus* concern

contact hypothesis is generally attributed to Gordon Allport. See GORDON W. ALLPORT, *THE NATURE OF PREJUDICE* (1954).

139. On the particular conditions that lend themselves to effective contact, see, for example, Bagenstos, *supra* note 8, at 843–44 & n.55; Cynthia L. Estlund, *Working Together: The Workplace, Civil Society, and the Law*, 89 *GEO. L.J.* 1, 23–24 (2000); Jerry Kang & Mahzarin R. Banaji, *Fair Measures: A Behavioral Realist Revision of "Affirmative Action,"* 94 *CALIF. L. REV.* 1063, 1101–02 (2006); see also Linda Hamilton Krieger, *Civil Rights Perestroika: Intergroup Relations After Affirmative Action*, 86 *CALIF. L. REV.* 1251, 1331 (1998).

140. See *supra* Part II.B.3.

141. See, e.g., RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008); Ian Ayres, *Menus Matter*, 73 *U. CHI. L. REV.* 3 (2006); Colin Camerer et al., *Regulation for Conservatives: Behavioral Economics and the Case for "Asymmetric Paternalism,"* 151 *U. PA. L. REV.* 1211 (2003); Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 *U. CHI. L. REV.* 1159 (2003) [hereinafter Sunstein & Thaler, *Libertarian Paternalism*].

142. See, e.g., Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 *YALE L.J.* 87, 87–92 (1989); Charles J. Goetz & Robert E. Scott, *The Mitigation Principle: Toward a General Theory of Contractual Obligation*, 69 *VA. L. REV.* 967, 971 (1983).

what range of options parties are given, and *altering rules* determine the steps that parties need to take to contract around a default.¹⁴³

Most pertinent to this Article is the category called *framing rules*,¹⁴⁴ which are rules about the information, context, and wording that frame a decision, as well as the timing of the frame.¹⁴⁵ Examples of framing rules include *Miranda* warnings, Surgeon General's warnings, and laws requiring county clerks to inform prospective spouses of their legal options for married surnames.¹⁴⁶ Framing rules are most relevant in contexts in which misinformation or norms are likely to influence decision makers or those who advise them.¹⁴⁷

This Article draws on the idea of framing rules, but with a twist. The aim here is not to influence the particular decision the individual is making. Rather, the aim is to influence the person's thinking about disability in, around, and after that decision.

Framing rules come in three forms: interrogatory frames, embedded frames, and informational frames.¹⁴⁸ Interrogatory frames concern how a question is asked, embedded frames concern the context of a question, and informational frames concern the information provided to accompany a question.¹⁴⁹ Interrogatory and embedded frames might be worth considering in some areas, in terms of whether the wording, tone, or context of a question conveys an assumption about disability. But in general, informational frames are most important for this discussion, because they concern the explicit messages and data provided to decision makers.

B. *The Advantages of Targeting Decision Moments*

In a sense, using framing rules to shape attitudes toward disability is similar to a broad-based public education campaign, except that it targets particular moments when people are primed to think about the problem at hand. To see the distinction, think of the difference between anti-smoking ads posted in subway cars or buses, on the one hand, and Surgeon General's warnings covering cigarette packs, on the other. Both aim to shape people's thinking and decisions about smoking. Unlike the anti-smoking bus ads, however, the rule that Surgeon General's warnings should appear on cigarette packs is a framing rule, because it frames the particular decision whether to smoke that pack. The focus of this Article is not on shaping the particular decision framed by the rule. But the

143. See Ayres, *supra* note 141.

144. Emens, *supra* note 14.

145. See *id.* at 839–54.

146. *Id.* at 853–54; see also, e.g., N.Y. DOM. REL. LAW § 15(1)(b) (McKinney 2010). Other examples include the unconscionability doctrine, as well as vaccination disclosure laws.

147. See, e.g., Emens, *supra* note 14, at 841.

148. See *id.* at 843–51.

149. See *id.*

framing rule about Surgeon General's warnings is nonetheless similar to the framing rules I discuss here, because the Surgeon General's warning also aims to change thinking more generally. That is, like the cases I discuss in this Article, the Surgeon General's message aims to shape the smoker's overall thinking about smoking by targeting a moment when a smoker is particularly likely to be thinking about smoking and to see the message.

There are several advantages to framing decision moments, even though the aim is not to influence those decisions.¹⁵⁰ First, people who are already thinking about disability, or have reason to do so, may be more likely to pay attention to new information and ideas about disability. Second, framing these moments can help offset the negative messages about disability frequently present in these moments, either formally (from doctors or regulators, for instance) or informally (from friends or media sources). Third, targeting these moments may be relatively efficient, because regulatory channels may already exist, so transmitting new information to individuals in these moments need not require new informational mechanisms. In addition, from the individual's perspective, receiving this information in the context of a decision that already involves some attention to disability may be more helpful than costly; that is, framing may deliver information to people who are more likely to welcome it, rather than imposing this information on everyone.

The next Part provides several concrete examples of how framing rules could help change attitudes toward disability.

IV. FRAMING DISABILITY

Framing rules could be used to target attitudes toward disability in a wide range of contexts. This Part focuses on three types of disability-conscious moments, with attention to particular examples of each: awaiting test results (focusing on prenatal testing), preventing injuries and illnesses (focusing on driver's education and tobacco labeling), and planning for contingencies (focusing on disability insurance).

A. Awaiting Results: Prenatal Testing

A colleague in the humanities recently described the birth of her second child with these words:

After an uneventful pregnancy, I gave birth to a boy. Just minutes after he was born, doctors told us that he had defied the odds: our baby had Down syndrome. . . . On hearing the news of Henry's

150. Nonetheless, framing decision moments does risk influencing the decision. On this objection to the Article's use of framing rules, see *infra* Part V.A.

birth, more than one person responded by asking how this could have happened. “Didn’t you get tested?” they said incredulously.¹⁵¹

The question others asked after her son’s birth is telling about outside attitudes toward disability: *Didn’t you get tested?* The question seems to assume at least two things. First, that prenatal screening for disability is an expected occurrence, at least in her situation—a woman over thirty-five.¹⁵² And second, that if a woman knew when she was pregnant that her baby would be born with Down syndrome, she would have aborted.¹⁵³

Much writing on the ethics of prenatal testing focuses on questions such as how much prenatal testing should be available, how prospective parents should make ethical choices in the face of prenatal diagnoses of disability,¹⁵⁴ and how health-care professionals should advise prospective parents in these situations.¹⁵⁵ These are difficult and interesting questions, but my focus here is different.

My focus is not on the choices that prospective parents make when confronting so-called positive diagnoses of disability. Indeed, my focus is not on the prospective parents who receive these diagnoses at all. Rath-

151. Adams, *supra* note 54, at 2, 6.

152. Adams gives further details in the lines leading up to those quoted in the epigraph:

My husband and I . . . decided to forgo an amniocentesis even though I was 38, already well across the threshold of what doctors call “advanced maternal age.” Although amniocentesis is now routinely prescribed for any woman over 35, our obstetrician was unorthodox in presenting us with genuine choices about the prenatal testing we would undertake. I had already had a combination of ultrasound and blood work called the “fully integrated screen,” which predicted that we had less than a one in two thousand chance of having a baby with Down syndrome. . . . In making our decision, our doctor advised us to consider the results of the tests we had already taken, as well as the risk of miscarriage carried by the amnio, which was about 1 in 300. After carefully weighing our options, we declined further testing. We very much wanted this baby, the tests suggested that it was very likely to be healthy, and we didn’t want to risk losing it. Besides, we reasoned, given all of the things that could go wrong with a child, Down syndrome wasn’t even near the top of our list.

Id. at 1–2.

153. The question also assumes that the testing is accurate enough that it would have turned up a positive result in this case. Because the accuracy of invasive screening, particularly amniocentesis, has been greater than for non-invasive screening (though this may be changing, *see infra* note 158 and accompanying text), I therefore read the question to assume that everyone in Adams situation would have undergone *invasive* testing, most likely an amniocentesis. Chronic villus sampling (CVS) is another highly accurate form of invasive testing, *see* Naomi Nakata et al., *Trends in Prenatal Screening and Diagnostic Testing Among Women Referred for Advanced Maternal Age*, 30 *PRENATAL DIAGNOSIS* 198 (2010), but it is still not as common or as well-known as amniocentesis, so I tend to refer in the text to the latter.

154. Note that prenatal decisions—whether about testing or about abortion—sometimes involve only the pregnant woman as decider and sometimes involve multiple decision makers (typically her and her spouse or partner). I try to recognize both the pregnant woman’s authority in this regard, as a medical and constitutional matter, as well as the practical role often played by a partner or spouse, by varying the language in this Article between “prospective parents” and “pregnant woman.” (Surrogacy arrangements raise a host of further questions in this regard, which are beyond the scope of this Article.)

155. *See, e.g.*, *PRENATAL TESTING AND DISABILITY RIGHTS*, *supra* note 35; Darrin P. Dixon, *Informed Consent or Institutionalized Eugenics? How the Medical Profession Encourages Abortion of Fetuses with Down Syndrome*, 24 *ISSUES L. & MED.* 3 (2008); Sonia Mateu Suter, *The Routinization of Prenatal Testing*, 28 *AM. J.L. & MED.* 233 (2002).

er, my interest here is in everyone else: prospective parents who do not receive a positive diagnosis, the “everyone else” who might ask that question of Adams: *Didn't you get tested?* What might be done to contextualize their incredulity, to lighten their judgment of her situation, in order to make such a question less common?

1. *Testing in Context*

In 2007, the American College of Obstetricians and Gynecologists (ACOG) began to recommend that doctors offer invasive prenatal genetic testing to all pregnant women.¹⁵⁶ Prior to that, the recommendation was for such testing only for “high-risk pregnancies,” including those in which the pregnant woman is at least thirty-five years old.¹⁵⁷

The push for prenatal testing is particularly notable given the invasiveness of procedures such as amniocentesis and the common wisdom that its risk of miscarriage is as high as one in three hundred (though recent data suggest the risk may be much lower).¹⁵⁸ Indeed, for many pregnant women, the perceived risk of miscarriage from the amniocentesis may be greater than the risk of Down syndrome in the fetus.¹⁵⁹ The calculation is complicated by numerous factors, including other genetic conditions that may show up in an amniocentesis, some conditions that cannot be screened for, and the varying rates of miscarriage across doctors and regions.¹⁶⁰ But at some level, the message from the doctors urging amniocentesis for women who have already done the noninvasive screening that puts their fetus's chances of Down syndrome at far less than one in three hundred (which Adams tells us was true for her¹⁶¹)—

156. American College of Obstetricians & Gynecologists (ACOG), *Invasive Prenatal Testing for Aneuploidy*, 110 *OBSTETRICS & GYNECOLOGY* 1459, 1462 (2007).

157. *Id.*; ACOG, *Prenatal Diagnosis of Fetal Chromosomal Abnormalities*, 97 *OBSTETRICS & GYNECOLOGY* supp. 1–12 (2001).

158. Estimates for the rate of miscarriage from amniocentesis vary; the number 1 in 300 is frequently cited as an average, sometimes with an acknowledgement that the risk is lower for some doctors and regions with high numbers of the procedure. See, e.g., Julie Chevalier Sapp et al., *Ambivalence Toward Undergoing Invasive Prenatal Testing: An Exploration of Its Origins*, 30 *PRENATAL DIAGNOSIS* 77, 77 (2010) (citing studies for the one in two hundred to one in three hundred statistic); Amer. Pregnancy Ass'n, *Amniocentesis*, <http://www.americanpregnancy.org/prenataltesting/amniocentesis.html> (last updated Apr. 2006) (“The risk of miscarriage ranges from 1 in 400 to 1 in 200. In facilities where amniocentesis is performed regularly, the rates are closer to 1 in 400.”); Mayo Clinic Staff, *Amniocentesis: Risks*, <http://www.mayoclinic.com/health/amniocentesis/MY00155/DSECTION=risks> (May 15, 2010) (“Second-trimester amniocentesis carries a slight risk of miscarriage—between 1 in 300 and 1 in 500. Research suggests that the risk of miscarriage is higher for amniocentesis done before 15 weeks of pregnancy.”); see also *supra* note 152. More recent research on amniocentesis indicates that miscarriage rates may be far lower than the commonly cited figure. Keith A. Edelman et al., *Pregnancy Loss Rates After Midtrimester Amniocentesis*, 108 *OBSTETRICS & GYNECOLOGY* 1067, 1072 (2006) (citing a figure of 1 in 1600). Because many individuals and organizations assume miscarriage rates of approximately 1 in 300, however, the message about disability in the usual case remains the same.

159. See, e.g., *supra* note 152.

160. See *supra* note 158.

161. See *supra* note 152.

when the doctor believes that the risk from the amniocentesis is one in three hundred—is that having a disabled child is worse than not having a child.¹⁶²

In general, doctors frequently help patients understand relevant risks and probabilities and suggest procedures that they, as medical professionals, think are advisable.¹⁶³ Patients often want doctors' opinions to play a role in their decisions whether to undergo procedures, because of doctors' knowledge and experience.¹⁶⁴ But doctors' views sometimes bear a more complicated relation to patient decision making, and there are a number of problems with the current approach to giving prospective parents advice about testing.

First, the decision to undergo invasive prenatal testing implicates more than just medical considerations. Whether to assume the risk of miscarriage in order to undergo prenatal testing is a decision that involves values as well as probabilities. And doctors may not adequately understand their patients' preferences and aims.¹⁶⁵

Second, doctors and genetic counselors often decline to mention abortion to pregnant women deciding whether to undergo prenatal testing, and women sometimes think prenatal screening is for the health of the fetus, without realizing that in utero treatment is generally not yet available and so the only "treatment" option is typically abortion.¹⁶⁶

Third, even if one assumed that disability is highly undesirable, the common practice of urging amniocentesis for women over thirty-five might be misguided. One recent analysis suggests that factoring in the chance of becoming pregnant another time changes the calculus and suggests that amniocentesis may make more sense for the woman at younger, rather than older, ages, at least from her individual perspective.¹⁶⁷

162. For a discussion of this point in light of the latest research on miscarriage rates from amniocentesis, see *supra* note 158.

163. See, e.g., Cathy J. Jones, *Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379, 400–02 (1990); see also Adrian Edwards et al., *Presenting Risk Information: A Review of the Effects of "Framing" and Other Manipulations on Patient Outcomes*, 6 J. HEALTH COMM.: INT'L PERSP. 61 (2001); Isaac M. Lipkus, *Numeric, Verbal, and Visual Formats of Conveying Health Risks: Suggested Best Practices and Future Recommendations*, 27 MED. DECISION MAKING 696, 709 (2007).

164. See, e.g., Benjamin Moulton & Jaime S. King, *Aligning Ethics with Medical Decision-Making: The Quest for Informed Patient Choice*, 38 J.L. MED. & ETHICS 85, 89 (2010).

165. Cf. *id.* at 85 ("Recent studies have found that most physicians still undervalue disclosure and underestimate the variability in patient preferences.").

166. See Dov Fox & Christopher L. Griffin, Jr., *Disability-Selective Abortion and the Americans with Disabilities Act*, 2009 UTAH L. REV. 845, 851. Cf., e.g., Jan M. Hodgson et al., "Testing Times, Challenging Choices": *An Australian Study of Prenatal Genetic Counseling*, 19 J. GENETIC COUNSELING 22, 34 (2010) ("Genetic counselors spent a significantly larger proportion of time clarifying information about the screening tests and addressing procedural aspects of the diagnostic testing procedures than they did giving information about the conditions that such tests may diagnose or the options that would be available following a diagnosis of fetal anomaly."). I say "generally" because there are instances in which early information about some disabilities can help lead to treatment possibilities. See *infra* note 174 and accompanying text.

167. Eduardo Fajnzylber et al., *An Economic Model of Amniocentesis Choice* (Nat'l Bureau of Econ. Research, Working Paper No. 16306, 2010), available at <http://papers.nber.org/papers/w16306>.

That is, for older women, their risk for Down syndrome is greater, but so is their risk of not becoming pregnant again. So it might make sense to advise women differently so long as amniocentesis is the state of the art¹⁶⁸—because the risks of the procedure might outweigh, for more women than commonly assumed, the risks of an unexpected disability at birth.¹⁶⁹

Even if true, however, this conclusion may not be terribly important in the near future. Noninvasive testing is becoming more accurate and soon may replace invasive testing for an increasing number of conditions.¹⁷⁰ Scholars have expressed the concern that, if noninvasive testing becomes the norm, even fewer doctors will obtain truly informed consent to testing.¹⁷¹ Some women may not want even noninvasive, risk-free testing, for conditions for which the only medical solution is abortion, if they already know that they would continue the pregnancy.¹⁷² On the other hand, some women who would continue the pregnancy will welcome this risk-free testing because they want to test for informational purposes or to prepare emotionally or practically for a disabled child.¹⁷³ In addition, for a growing number of conditions, early information may allow for treatments that are unavailable or costlier later on.¹⁷⁴ Moreover, of course, some women will be glad for risk-free testing to help them decide whether to continue the pregnancy, as they would also be inclined to accept the risks currently involved in tests such as amniocentesis.¹⁷⁵ In any case, because testing is on the rise, for many more conditions and with

These authors use a rather high estimate of the rate of miscarriage from amniocentesis, *id.* at 2 (“The amniocentesis procedure results in a spontaneous miscarriage for 1 in 100 to 1 in 200 women . . .”), calling into question their conclusions in light of more recent research, *see supra* note 158.

168. Or CVS testing, which is also invasive. *See supra* note 153.

169. *But cf. supra* note 167. The current ACOG guidelines recommend that amniocentesis be available to all women, revising their past policy of recommending it only for women over thirty-five. *See supra* notes 156–57 and accompanying text.

170. *See, e.g.,* Nakata et al., *supra* note 153; Ainsley J. Newson, *Ethical Aspects Arising from Non-Invasive Fetal Diagnosis*, 13 *SEMINARS FETAL & NEONATAL MED.* 103 (2008); Ananda van den Heuvel et al., *Will the Introduction of Non-Invasive Prenatal Diagnostic Testing Erode Informed Choices? An Experimental Study of Health Care Professionals*, 78 *PATIENT EDUC. & COUNSELING* 24 (2010).

171. *See, e.g.,* van den Heuvel et al., *supra* note 170, at 28.

172. *See, e.g.,* Rayna Rapp, *Refusing Prenatal Diagnosis: The Uneven Meaning of Bioscience in a Multicultural World*, 23 *SCL., TECH., & HUM. VALUES* 45, 55, 58–59 (1998) (discussing reasons women refuse prenatal testing, other than the fear of miscarriage, including a belief that the tests are faulty or fail to detect enough conditions, concern about participating in research science, or religious beliefs); Kelly, *supra* note 48, at 92–94 (discussing reasons that mothers who already have children with disabilities are inclined to refuse testing in future pregnancies, including the tests’ lack of definitive conclusions, not wanting to face a dilemma about termination, or a sense of having gained “joy and improvement” from the first, affected child).

173. *See, e.g.,* BARBARA KATZ ROTHMAN, *THE TENTATIVE PREGNANCY: HOW AMNIOCENTESIS CHANGES THE EXPERIENCE OF PREGNANCY* 251 (1993) (discussing, and questioning the utility of, this reason for undergoing amniocentesis).

174. *See, e.g.,* Fox & Griffin, *supra* note 166, at 851 n.33 (citing Norman M. Ford, *Ethical Aspects of Prenatal Screening and Diagnosis*, in *GENETICS AND ETHICS: AN INTERDISCIPLINARY STUDY* 197, 198–200) (Gerard Magill ed., 2004) (providing examples of such conditions).

175. For a discussion, see Mary Ann Bailly, *Why I Had Amniocentesis*, in *PRENATAL TESTING AND DISABILITY RIGHTS*, *supra* note 35, at 64.

fewer risks,¹⁷⁶ this is an important period to think about what messages expectant parents receive about disability around the testing process. This brings us to an intriguing framing rule that was dropped from recently enacted federal legislation.

2. *A Legislative Prompt*

In 2008, the federal Prenatally and Postnatally Diagnosed Conditions Awareness Act (the Act) became law.¹⁷⁷ The Act aims to help provide prospective parents who receive a positive prenatal (or postnatal) diagnosis of Down syndrome or other conditions with “up-to-date information on the range of outcomes for individuals living with the diagnosed condition, including physical, developmental, educational, and psychosocial outcomes.”¹⁷⁸ The Act encourages the collection and dissemination of evidence-based information to support and assist parents receiving diagnoses of disability.¹⁷⁹

The final version contains no funding allocation and no mandates. But a version of the bill introduced in 2007 by Senator Sam Brownback would have required doctors to provide prospective parents receiving a diagnosis of Down syndrome and related conditions with certain information about families living with the disability.¹⁸⁰ This informational frame would have targeted those facing a decision whether to abort, with the apparent aim of helping them make more informed decisions about living with these disabilities.¹⁸¹ From the disability rights perspective, additional information could help dispel misconceptions about living with these disabilities and help prospective parents contextualize medical information, which tends to focus exclusively on the particular problems associated with a disability.¹⁸² A focus on decisions to abort was under-

176. See *supra* note 156 and accompanying text.

177. Prenatally and Postnatally Diagnosed Conditions Awareness Act, Pub. L. No. 110-374, 122 Stat. 4051 (2008) (to be codified at 42 U.S.C. § 280g-8).

178. *Id.* § 2.

179. *Id.*

180. Here is the introduced version:

(d) PROVISION OF INFORMATION BY PROVIDERS—Upon receipt of a positive test result from a prenatal or postnatal test for Down syndrome or other prenatally or postnatally diagnosed conditions performed on a patient, the health care provider involved (or his or her designee) shall provide the patient with the following:

[(1) Up-to-date, scientific, written information concerning the life expectancy, clinical course, and intellectual and functional development and treatment options for a fetus diagnosed with or child born with Down syndrome or other prenatally or postnatally diagnosed conditions.

[(2) Referral to supportive services providers, including information hotlines specific to Down syndrome or other prenatally or postnatally diagnosed conditions, resource centers or clearinghouses, and other education and support programs as described in subsection (b)(2).

Prenatally and Postnatally Diagnosed Conditions Awareness Act, S. 1810, 110th Cong. § 3(d) (2007) (version introduced in Senate), <http://www.gpo.gov/fdsys/pkg/BILLS-110s1810is/pdf/BILLS-110s1810is.pdf>.

181. *Id.* It also covered parents of children up to one year old, *id.*, as did the enacted version, see *supra* note 177.

182. See, e.g., Ferguson et al., *supra* note 40, at 86.

scored by Senator Brownback's press release about the Act, which cites a very high estimate of the prevalence of abortion after a Down syndrome diagnosis.¹⁸³

3. *Designing an Earlier Frame for a Broader Audience*

It seems plausible to think that many people ask themselves "What kind of child could I parent?" while waiting for the results of prenatal testing.¹⁸⁴ Even if one wanted to affect abortion decisions through information, then, one might well want to provide this information earlier in the process than at the point of diagnosis.¹⁸⁵ But my interest here is not in the small number of people who receive a prenatal diagnosis of disability and the choices they make. (Indeed, the Act was supported by abortion opponents, as well as disability advocates, a political reality that urges caution about interventions in this area, as I discuss later.¹⁸⁶) Many more people undergo prenatal testing than receive a positive diagnosis. The Act therefore points us toward a crucial period when many people consider disability in relation to their own lives: the period of prenatal testing. If our interest is in broadly affecting attitudes, then we should design a framing rule that targets everyone who undergoes testing.¹⁸⁷

183. Brownback's press release claims that ninety percent of fetuses diagnosed with Down syndrome are aborted. Press Release, Office of Senator Sam Brownback, Brownback, Kennedy Reintroduce Pre-Natally and Post-Natally Diagnosed Conditions Awareness Act (July 18, 2007), available at <http://www.jfanow.org/jfanow/index.php?mode=P&id=3351>. Other sources suggest that it is very hard to make these estimates, and the extant estimates in the United States are far lower than ninety percent and also lower as compared to other countries. See, e.g., Armand Marie Leroi, *The Future of Neo-Eugenics*, 7 EMBO REP. 1184, 1184 (2006) ("These estimates are based on . . . an abortion rate of about 29% of fetuses diagnosed with Down syndrome in Atlanta, GA, and Hawaii—the only two US locations for which reliable data are available. Data from other regions are similar or even higher: 32% of Down syndrome fetuses were aborted in Western Australia; 75% in South Australia; 80% in Taiwan; and 85% in Paris, France.") (internal citations omitted); see also Caroline Mansfield et al., *Termination Rates After Prenatal Diagnosis of Down Syndrome, Spina Bifida, Anencephaly, and Turner and Klinefelter Syndromes: A Systematic Literature Review*, 19 PRENATAL DIAGNOSIS 808, 810 tbl.1 (1999) (reporting U.K. abortion rates of ninety-two percent following a prenatal diagnosis of Down syndrome).

184. On this question, see, for example, Asch & Wasserman, *supra* note 35.

185. For this point, as well as for a critique of the way that women are encouraged to undergo prenatal testing, see Adrienne Asch & David Wasserman, *Informed Consent and Prenatal Testing: The Kennedy-Brownback Act*, 11 VIRTUAL MENTOR 721, 723 (2009).

186. See *infra* Section V.A.1.

187. This seems particularly important, given the research suggesting that prospective parents who never receive a prenatal diagnosis of disability are especially unlikely to receive anything but negative information about disability. See Allison C. Carey, ON THE MARGINS OF CITIZENSHIP: INTELLECTUAL DISABILITY AND CIVIL RIGHTS IN TWENTIETH-CENTURY AMERICA 210 (2009) ("They typically do not provide positive information regarding a disability until an 'abnormality' is found, and then they *might* present a more balanced view."); Annette Patterson & Martha Satz, *Genetic Counseling and the Disabled: Feminism Examines the Stance of Those Who Stand at the Gate*, 17 HYPATIA, Summer 2002, at 118, 131 ("Genetic counseling sessions are structured to inform parents of the negative consequences of having a particular genetic condition and to make sure that they understand those consequences. . . . In these abbreviated educational sessions, counselors may discuss the pros and cons of having a genetic test such as amniocentesis, but rarely, if ever, discuss the positive aspects of having a particular condition or disease. In most cases, only detection of abnormality

An informational frame might help convey the “inside perspective” to a broad audience. For instance, prospective parents awaiting prenatal testing results could be given access to resources on living with a disability or with a disabled child, in terms of the experience of disability, or the changes in the laws and resources available to people with relevant disabilities. For example, they might be given up-to-date information on the life opportunities and life expectancy for various disabilities, such as for Down syndrome (the life expectancy of which has doubled in the last thirty years, as noted earlier).¹⁸⁸ They could receive contact information for supportive disability-oriented organizations. The current version of the Act requires the collection of information and resources that could facilitate this.¹⁸⁹

Such information could be conveyed in any number of ways. Prospective parents could speak directly with a doctor, nurse, or genetic counselor, although written informational materials would impinge less on these professionals’ time and also guarantee that the information was conveyed accurately and evenhandedly.¹⁹⁰ Informational video or audio recordings would combine the advantages of quality control with a format friendlier to those less inclined to read distributed materials, though recordings would be costlier to create and administer. Access to engaging movies and literature related to relevant disabilities, or the recent flourishing in disability arts,¹⁹¹ could provide a different sort of information. The frame should offer resources for connecting with and learning from families with children with relevant disabilities, as well as adults with those disabilities.¹⁹² In sum, a list of resources (available in various accessible formats)—combining contact information for relevant organizations, links to informational websites, and references to film, fiction, and artistic sources—looks most promising from the perspective of both cost and quality control.¹⁹³ Doctors or genetic counselors could distribute this list after tests are administered, along with the message that if people are worried about their results, they might find some of this material in-

prompts a more comprehensive discussion, which might include viewpoints from disabled individuals and the parents who raise them.”)

188. See *supra* note 57. Information could vary for the particular test or disability at issue, but testing often involves the prospect of detecting a wide range of disabilities (for instance, in an amniocentesis), at which point more general information would be appropriate.

189. See *supra* notes 177–79 and accompanying text.

190. For an example of work that encourages women to think about their own parenting values in relation to questions about whether to test and how to proceed after positive diagnoses, see Adrienne Asch et al., *Prenatal Testing*, in *OUR BODIES, OURSELVES: PREGNANCY AND BIRTH* 109 (2008).

191. See, e.g., DISTHIS! FILM SERIES, <http://www.disthis.org> (last visited Aug. 20, 2012); THE GIMP PROJECT, <http://www.thegimpproject.com/gimp> (last visited Aug. 20, 2012); see also *infra* note 229 (discussing *Invitation to Dance*).

192. For a lovely account of what information and connections could be offered (though, as is typical, with the focus on those who have already received a positive diagnosis), see MICHAEL BÉRUBÉ, *LIFE AS WE KNOW IT: A FATHER, A FAMILY, AND AN EXCEPTIONAL CHILD* 80–85 (1996).

193. For example, ACOG distributes informational pamphlets that many doctors keep in their waiting rooms, called things like “Menstruation;” this one could be called something like “While you’re waiting.”

formative and even reassuring. Part V addresses various objections that might be raised to using framing rules in this context, but it is worth noting here that targeting all people who have decided to test, and who are not (yet) facing any decision about abortion, should go some way toward easing concerns about influencing abortion decisions.¹⁹⁴

B. Preventing Injury and Illness: Driver's Education and Tobacco Labeling

Efforts to prevent injuries and disease present a difficult set of dilemmas. Injury prevention programs, such as driver's education, and warning labels, such as Surgeon General's warnings on cigarettes, encourage people to make choices that minimize their risks of certain harms. They often do so by highlighting the consequences of risky choices, and in the process they frequently offer stigmatizing images of disability. This Section considers how we might continue these worthy efforts while paying greater attention to the messages we are sending about disability in the process. The aim here is not to sacrifice these harm-prevention efforts, but to ask if these campaigns could remain as successful—or even, in some cases, be made more successful—if their design process incorporated an inside perspective on disability.

1. Driver's Licensing

The decision to apply for a driver's license—and subsequently to drive a car alone for the first time—meaningfully implicates a person's relationship to disability, because car accidents are the leading cause of mortality and serious injury for adolescents and young adults.¹⁹⁵ Thus, applicants for driver's licenses often receive warnings about disability.

194. The framing rule could, alternatively, target everyone who considers testing. On the positive side, this approach would have the advantage of reaching an even larger group. On the negative side, however, providing the information when parents are deciding whether to test raises concerns about influencing the testing decision. See *infra* Part V.A.1.

195. See, e.g., RICHARD P. COMPTON & PATRICIA ELLISON-POTTER, NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., *TEEN DRIVER CRASHES: A REPORT TO CONGRESS 1* (2008) ("Motor vehicle crashes are the leading cause of death for 15- to 20-year-olds. In 2006, 3,490 15- to 20-year-old drivers died and an additional 272,000 were injured in motor vehicle crashes. In 2006, 12.9 percent of all the drivers involved in fatal crashes were between 15 and 20 years old. In comparison, these young drivers represent 6.3 percent of all licensed drivers."); SOC'Y FOR ADOLESCENT HEALTH & MED., *Adolescents and Driving: A Position Paper of the Society for Adolescent Health and Medicine*, 47 J. ADOLESCENT HEALTH 212, 213 (2010) ("[M]otor vehicle crashes continue to be the leading cause of mortality and severe morbidity among adolescents and young adults."); see also Colin D. Mathers & Dejan Loncar, *Projections of Global Mortality and Burden of Disease from 2002 to 2030*, 3 PLOS MED. 2011, 2026 tbl.5 (2006) (reporting that driving accidents were the eighth leading cause of "disability-adjusted life years" (DALYs) worldwide in 2002). The rates are higher in the U.S. See, e.g., Matthew T. McKenna et al., *Assessing the Burden of Disease in the United States Using Disability-Adjusted Life Years*, 28 AM. J. PREVENTATIVE MED. 415, 418 tbls.3 & 4 (2005) (reporting that in 1996, car accidents were the second leading basis of disability among U.S. males, leading to 5.2 percent of DALYs, and the tenth leading basis of disability among women, leading to three percent of DALYs).

Driver's education programming in some jurisdictions includes gruesome films about the potential consequences of unsafe driving.¹⁹⁶

The language of public health campaigns targeting unsafe driving—especially drinking and driving—gives some indication of the ways disability is typically portrayed in injury prevention campaigns.¹⁹⁷ One ad, for example, shows a woman in a wheelchair at the base of a staircase, looking up at a door; the caption reads, “That ‘One for the road’ could change your road to the future. It only takes a second to ruin your life. Please don’t drink and drive.”¹⁹⁸ The message here is clear: Driving can “ruin your life” because a life with a disability is a ruined life.

The public health literature on accident prevention has engaged little with the insights of disability studies.¹⁹⁹ Injury prevention efforts may further stigmatize disabilities, even as these efforts aim to reduce public suffering by preventing injury and death.²⁰⁰ Such efforts may affect people who already have disabilities, whether directly or indirectly.²⁰¹ (Imagine being the person with a mobility impairment in the driver's education course that presents such messages.) Relatedly, and more importantly for this Article, such injury-prevention messages also affect people who are not currently disabled, reinforcing stigmatizing attitudes.

a. Pilot Studies

Introducing *positive* information about disability into driver's education seems counterintuitive. But incorporating more of an inside perspective on disability into driver's education—which is generally more positive, as well as more informed, than the outside perspective²⁰²—might be appealing to parents and others concerned with teen safety for several

196. See, e.g., HELL'S HIGHWAY: THE TRUE STORY OF HIGHWAY SAFETY FILMS (Kino International 2002); Stephanie Clifford, *Doubts About Scare Tactics on Drivers Who Text*, N.Y. TIMES, Sept. 1, 2009, at B1 (describing a gruesome Welsh educational video about texting while driving that went viral as “the stuff of American worst-case driver-education films” and presenting criticism of such tactics from U.S. experts); Jennifer Morse, *Should a School Use Graphic Violence to Teach Driving Safety?*, CIRCLE OF MOMS (Apr. 28, 2010), <http://www.circleofmoms.com/kids-aged-over-10yrs-old/should-a-school-use-graphic-violence-to-teach-driving-safty-529722#>.

197. See Caroline Wang, *Culture, Meaning and Disability: Injury Prevention Campaigns and the Production of Stigma*, 35 SOC. SCI. & MED. 1093 (1992) [hereinafter Wang, *Culture, Meaning and Disability*]; Caroline C. Wang, *Portraying Stigmatized Conditions: Disabling Images in Public Health*, 3 J. HEALTH COMM.: INT'L PERSP. 149 (1998) [hereinafter Wang, *Portraying Stigmatized Conditions*].

198. Wang, *Portraying Stigmatized Conditions*, *supra* note 197, at 153. I will say more about the stairs later. See *infra* notes 222–25.

199. A notable exception is the work of Caroline Wang. See *supra* note 197. One arena outside of injury prevention, but still within the broader domain of public health, in which activists have pushed for an attention to stigma is in the area of AIDS and HIV prevention. See, e.g., Sean Strub, *'It's Never Just HIV' Ad Campaign Oversimplifies the Issue*, HUFFINGTON POST (Jan. 4, 2011, 6:22 PM), http://www.huffingtonpost.com/sean-strub/its-never-just-hiv_b_804438.html (“We can and should tell young people that HIV is very bad and they don't want to get it, but we can do that without condemning or stigmatizing people who already have HIV.”).

200. See Wang, *Culture, Meaning and Disability*, *supra* note 197.

201. See Wang, *Portraying Stigmatized Conditions*, *supra* note 197, at 150–54.

202. See *supra* Part II; *supra* note 17 and accompanying text.

reasons. First, driver's education has been widely criticized as needing improvement.²⁰³ This is an area ripe for innovation. Second, while young drivers suffer the most injuries from automobiles,²⁰⁴ teenagers are also a particularly difficult group to influence on such matters. As a matter of both common sense and developmental psychology, trying to get teenagers to consider the possible consequences of their actions is very challenging.²⁰⁵ Third, and relatedly, teens might be more likely to pay attention to or to remember a message that is not entirely predictable. In other words, disability-affirmative material in driver's education might help influence teen attitudes toward the risks of driving as well as toward disability, precisely because anything other than negative messages about disability is counterintuitive in context.

Recent studies of driver's education programs in Toronto and Tel Aviv that included some encounters with disability provide indirect support for this idea. The Toronto study involved a program called "Think-First-PartyLater" for fifteen- to seventeen-year-olds.²⁰⁶ The program combined instruction from nurses on the risks of driving—in particular the link between driving and traumatic brain injury—with a visit to a trauma center, interactive discussions with police first responders, members of Mothers Against Drunk Driving, and trauma doctors and nurses, and, most significantly to the participants, the voice of another teenager injured in a car accident.²⁰⁷ Eight days later, the program showed positive effects both on knowledge about injury patterns and outcomes and on risk-perception scores, relative to controls (though with scores still lower than experts').²⁰⁸ Although the effects on knowledge diminished at thirty days, the effects on risk perception remained.²⁰⁹ At six months, a qualitative assessment showed that the subjects still remembered the experiential—as opposed to didactic—component of the program, and had some greater appreciation that injury can happen to teens.²¹⁰ Some subjects still made claims, however, about the relative invincibility of youth

203. See, e.g., COMPTON & ELLISON-POTTER, *supra* note 195; SOC'Y FOR ADOLESCENT HEALTH & MED., *supra* note 195; Allan F. Williams, *Contribution of the Components of Graduated Licensing to Crash Reductions*, 38 J. SAFETY RES. 177 (2007); Michelle Browning Coughlin, Note, *Proposing a Uniform National Graduated Driver License Law to Reduce Motor-Vehicle Fatalities Among Teenagers*, 46 U. LOUISVILLE L. REV. 495 (2008); Veli-Pekka Kallberg, *Supreme—European Best Practice in Road Safety*, VIA NORDICA 2008 (MAY 26, 2008), http://vianordica2008.vegagerdin.is/vetenskapligt_webb/Tisdag/Session5_sal5/Kallberg.pdf.

204. See *supra* note 195 and accompanying text.

205. See, e.g., ELIZABETH S. SCOTT & LAURENCE STEINBERG, *RETHINKING JUVENILE JUSTICE* 13–16 (2008) (citing sources).

206. Olivier JY Monneuse et al., *Attitudes About Injury Among High School Students*, 207 J. AM. C. SURGEONS 179, 179–80 (2008).

207. *Id.*

208. *Id.* at 181.

209. *Id.*

210. *Id.* at 182 tbl.1 (quoting a subject, as an example of the injured-peer portion having the "greatest impact," as saying the following: "The room was so quiet when she was talking . . . Everyone was just like—you can't be serious . . . you could tell by the look on everyone's face that we were all freaked out").

and the power of medical science to save young people in particular.²¹¹ The authors infer, however, from the subjects' responses that the interaction with the injured peer had "the greatest impact."²¹² It also seems notable, though unsurprising, that subjects reported having expected that the program would be a waste of time; the interactive component seems to have been what led to contrary conclusions among some subjects.²¹³

The Tel Aviv study also involved a multi-pronged intervention incorporating interaction with an injured peer.²¹⁴ The interesting finding from this study is that the intervention showed effects on the subjects from vocational high schools, but not on those from academic high schools.²¹⁵ The authors speculate that this is because the vocational-school teens start with less knowledge about road safety.²¹⁶ Perhaps this is true. But it also seems possible that students with a more academic education are more cynical about such education, and therefore require something more to engage them. Perhaps a less predictable presentation format—namely, one that incorporates surprising inside perspectives on disability alongside warnings about unsafe driving—would better reach these students.²¹⁷

b. Designing Provocative Programs

Disability-affirmative driver's education could draw on a range of possible tools. Disability-related arts, including film, could provide materials that would capture teens' attention more than didactic educational messaging. Driver's education sometimes involves attempting to scare teens by reciting statistics to them about the dangers of driving, or show-

211. *Id.* (quoting, for example, a subject as saying "doctors and nurses, and ambulances and hospitals . . . they make people better all the time . . . especially young people").

212. *Id.*

213. *See id.*

214. Tova Rosenbloom et al., *Effectiveness of Road Safety Workshop for Young Adults*, 47 SAFETY SCI. 608, 609 (2009) (describing an intervention combining the students' watching a video "documenting the lives of young people like themselves leading up to a road accident, and the ensuing recovery process," meeting and hearing the story of "a young person who has survived an accident," "ask[ing] questions and hold[ing] a discussion," sometimes hearing from a parent of a seriously disabled teen, and participating in a simulation exercise about disability, such as "controlling a wheelchair in a hospital or . . . attempting routine activities with one limb tied to their body"). Note, as discussed earlier, that such "simulation exercises" have been subjected to incisive critique from an inside perspective on disability. *See supra* note 37 and accompanying text.

215. Rosenbloom et al., *supra* note 214, at 611.

216. *Id.* at 612 ("It would appear that students from schools with relatively low achievement rankings come to the workshop with less outside knowledge regarding road safety. After participating in the workshop, their knowledge increases, their intentions change, and they become more willing to implement what they have learned. The outside knowledge and awareness of students from schools with higher achievement rankings do not lead to any change regarding intentions as a result of participation in the workshop.")

217. Though expectations will vary, the more surprising elements of the inside perspective might include, for example, the happiness of the twins that Daniel Gilbert describes, the brash sexiness of a film like *Murderball*, the way the world looks through the social model, or the third-party benefits of disability accommodations. *See supra* Part II (presenting these and other examples).

ing them images of crashes.²¹⁸ The literature on public health messaging is conflicted over the value of deploying fear in public health and related initiatives.²¹⁹ Presenting disability as a complex and livable phenomenon might engage teens in thinking about its reality, without triggering a pronounced cycle of fear and resistance.²²⁰

For instance, informing prospective drivers about some of the more interesting findings from the study of hedonics could engage their minds and also teach them something about disability and the diversity of human happiness.²²¹ Past injury prevention ads could also form the basis for thoughtful discussion of assumptions about disability. Recall the ad mentioned earlier about the woman in a wheelchair sitting at the base of the stairs, looking longingly towards a doorway at the top, with the caption suggesting that she “ruin[ed] [her] life” by drinking and driving.²²² As one commentator succinctly put it, “[t]he irony of this image is that the problem is *not* the wheelchair. The problem is the steps.”²²³ Apparently unbeknownst to the ad’s designer, the image of the person in a wheelchair thwarted by stairs is a classic way to illustrate the social model of disability.²²⁴ The social model points out that stairs can be readily replaced by ramps or elevators, and the apparent barrier to entry falls away. A discussion of such changes could also incorporate discussion of the frequently overlooked point—if the courts’ oversights are any indication of mainstream views—that these changes to the environment prompted by disability can have broader benefits.²²⁵

Moreover, a presentation that involved not only statistics or abstract discussion, but also nuanced films or personal narratives reflecting an inside perspective on disability, might have more of an impact on teens. The film *Murderball* about quad rugby, discussed earlier, includes some individual accounts of risky teenage behavior involving motor vehicles.²²⁶

218. See *supra* note 196.

219. See *infra* notes 235–39.

220. Cf., e.g., Adam Bourne, *The Role of Fear in HIV Prevention*, SIGMA RES. (Sept. 2010), <http://www.sigmaresearch.org.uk/files/MiC-briefing-1-Fear.pdf> (discussing “coping strategies” in response to fear, including avoidance, denial, counter-arguing, and othering, which do not “result in adoption of the desired behavior” urged by the campaign).

221. See *supra* Part II.A.1.

222. See *supra* text accompanying note 198.

223. Wang, *Portraying Stigmatized Conditions*, *supra* note 197, at 153.

224. See, e.g., *supra* note 89 and accompanying text (quoting Simi Linton).

225. See *supra* Part II.C.

226. MURDERBALL, *supra* note 61. In his autobiography, Mark Zupan, the well-known U.S. quad rugby player discussed earlier, describes his accident at age eighteen in these words, among others:

My life changed forever more than a decade ago, on October 14, 1993. I had been in college at Florida Atlantic University in Boca Raton for a handful of weeks, living with a good friend of mine named Chris Igoe. . . .

Even though I was only a freshman, I had earned a starting position on FAU’s Division I [soccer] squad. . . .

At FAU, we had a saying: “Win or lose, we booze.” So after we won an early evening game, the team headed to a local bar called Dirty Moe’s, famous for its nickel beers, dollar shots, and lax policy when it came to carding. . . . [Igoe] was with me at the bar that night, glass in hand, hitting on women. The place was packed with people who had been at the game, so I didn’t have to

This discussion of the impact of risk taking with cars appears in the context of a film more concerned, however, with the power, athleticism, camaraderie, and sex appeal of sports within the disability community.²²⁷ A film like this could be part of a more complicated frame for new driver's license applicants. *Murderball* presents a very macho and sports-oriented picture,²²⁸ which is of course part of what might appeal to some teens; however, others might respond better to a different kind of narrative, such as that of Simi Linton, who was injured in a car accident in her early twenties. Linton's story is powerfully rendered in her memoir *My Body Politic*, which is being made into a movie.²²⁹

Finally, the studies discussed above offer a tentative basis for thinking that some kind of human component, involving young adults injured in motor vehicle accidents, could be a meaningful feature of such programs—involving “contact” as well as narrative.²³⁰ In well-designed encounters, people with disabilities acquired through road accidents could serve as “powerful spokespersons” who have “survived months and years of acute care followed by rehabilitation” and “achieved independence,” in contrast to the stereotype of the “dependent and helpless” telethon participant.²³¹ It would be important to assess the impact of such programs along several dimensions. For the disabled speakers, the programs would need to be carefully designed and monitored to facilitate a positive experience.²³² If the direct interactions had problematic consequenc-

buy a drink all night. At one point in the evening, I had four drinks lined up in front of me—cocktails, beer, shots, whatever. I drank them all.

This is where things get a little hazy. I know I left the bar stumble drunk around midnight. I was probably feeling sick from all the alcohol or was worried that I was making a fool of myself in front of the ladies. It was drizzling outside. I was shithoused and just looking for a quiet place to pass out. Igoe's black Isuzu pickup was in the dark parking lot. Despite the rain, I climbed into the truck's bed, curled up in a ball, and fell asleep.

Fourteen hours later, firemen would fish my crippled body out of a shallow canal near the freeway. My temperature would be eighty-eight degrees and my heartbeat would have slowed to thirty beats per minute. I'd have both hypothermia and pneumonia from being in the cold water for so many hours. But that wouldn't even be the bad news. My neck would be broken and it wouldn't seem very likely that I would ever walk—let alone run—again.

ZUPAN & SWANSON, *supra* note 66, at 3–4.

227. See *supra* notes 61–63 and accompanying text.

228. See *supra* note 64.

229. LINTON, *supra* note 89; Metuffer Films, *Invitation to Dance*, <http://invitationtodancemovie.com/> (last visited Sept. 4, 2012).

230. On the potential benefits of contact across disability, see *supra* notes 133–39.

231. See Wang, *Culture, Meaning and Disability*, *supra* note 197, at 1101. On telethons, see, for example, JOSEPH P. SHAPIRO, *NO PITY: PEOPLE WITH DISABILITIES FORGING A NEW CIVIL RIGHTS MOVEMENT* 20–24 (1994).

232. One might worry that the presentation of disability in such programs would always inevitably be negative, since disability is being offered as the undesirable consequence of risky driving. This Article does not attempt to resolve the tension between prevention and empowerment perspectives on disability, as noted earlier. See *supra* note 2 and accompanying text. But it seems possible that a driver's education program could incorporate a happy portrayal of life with disability, while also suggesting that teens would want to avoid the physical and emotional pain that often accompany the transition to disability. Cf. Bloom & Miller, *supra* note 32, at 747–48 (arguing for hedonic damages “for lost pleasures during the period after injury and before adaptation,” while rejecting hedonic damages for

es for the disabled participants, then programs could introduce and evaluate pre-recorded interactions or messages instead.²³³ For the teen participants, the programs should be evaluated both for their attitudinal impact and their efficacy. The hypothesis proposed here is that if the programs thoughtfully incorporated the inside perspective on disability, especially its more surprising elements, then a wider audience of teens—including more skeptical minds—might be engaged by the educational exercise.²³⁴

2. *Product Warnings: Changing Labels*

Warning labels are everywhere, covering, among other things, household appliances, medications, and alcohol and tobacco products. These warnings tell us all the bad things that might happen to us if we use a particular item, and these “bad things” often include disabilities.²³⁵ Like prenatal testing and driver’s education, these warning labels frame decisions that implicate a person’s (possible) future relation to disability, and in a resoundingly negative way.

Warning labels of course reach people with disabilities, as well as those without. Like accident prevention programs, warning labels could be demoralizing for people who currently have the disability of which the label warns.²³⁶ (Imagine a warning label: “This product may cause someone to take on the features of YOU.”) But my focus is not labels’ direct effect on people who have the impairment now, but rather their effect on the attitudes of people who do not have the impairment. Such warnings generate or underscore a strictly negative and medicalizing message about the impairments at issue. This Subsection takes as its example the Surgeon General’s warnings on tobacco products.

a. *The Puzzle of Cigarette Warning Labels*

Recent legislation has cast a spotlight on these labels, which are regulated by federal law.²³⁷ The Family Smoking Prevention and Tobac-

future happiness, and citing sources on the pain and unhappiness during the transition period); *cf. also supra* Part II.A.1 (citing sources on the adjustment to disability).

233. Pre-recorded interviews or interactions might not have the same impact in terms of “contact,” but they could also be more carefully scripted to meet their diverse goals.

234. *See supra* note 217. Note that military enlistment might be another place to consider a disability-related framing rule, because veterans have relatively high rates of disability, and the military has a tradition of honor through disability. *Cf. Michael Waterstone, Returning Veterans and Disability Law*, 85 NOTRE DAME L. REV. 1081, 1096–97 (2010) (noting that due to military and medical advances, more soldiers are returning to the U.S. with disabilities from injuries that would have been deadly in previous wars).

235. The definition of disability is a matter of contention, *see, e.g.,* Bagenstos, *supra* note 4; Feldblum, *supra* note 4, and the line between disease and disability is also a contested matter which I bracket here, *see, e.g.,* Amundson, *supra* note 108, at 105.

236. *See supra* notes 199–201 and accompanying text.

237. *See* Federal Cigarette Labeling and Advertising Act, 15 U.S.C. §§ 1331–1341 (2006).

co Control Act²³⁸ requires, among other things, larger, more visible print, and a set of nine graphic images that tobacco companies must display on cigarette packs.²³⁹ In 2011, the Food and Drug Administration (FDA) issued implementing regulations and released the precise images that cigarette packs will bear.²⁴⁰ Tobacco companies promptly brought suit and, thus far, one circuit court has upheld and one circuit court has struck down the new warnings on First Amendment grounds.²⁴¹ Addressing an issue overlooked in these disputes, this Subsection proposes that future cigarette warnings be designed through a process that takes into account the attitudes they project toward disability.

Framing disability through cigarette warning labels is in some ways similar to framing disability through driver's education. Both cigarette warning labels and driver's education are public health projects trying to reduce health-care costs and fatalities through education. These are important goals, and so the aim here is not to derail these efforts, but to use the inside perspective on disability to look for ways to improve these efforts, in terms of both attitudes to disability and, ideally, efficacy.

Notably, the warning label context differs from driver's education in the size and scope of the messaging. Whereas driver's education is an involved educational program to provide advance preparation for (typically) teenagers who want to drive, cigarette labeling supplies only very brief messages to prospective smokers just at the moment when they are choosing whether to smoke a particular pack of cigarettes. Driver's education therefore offers a great deal more leeway for incorporating meaningful resources like film and literature, or exposure to people who have become disabled through relevant means, than do cigarette labels. Warning labels are, and must be, brief and to the point.²⁴² Nonetheless, these warning labels could be designed with an eye to how they frame disability. And doing so would help to shape a realm where the government currently speaks about disability to a large and diverse audience.²⁴³

238. Pub. L. No. 111-31, 123 Stat. 1776 (2009).

239. *Id.* § 4.

240. Required Warnings for Cigarette Packages and Advertisements, 76 Fed. Reg. 36,628, (June 22, 2011) (to be codified at 21 C.F.R. pt. 1141). To view the images, see *Cigarette Health Warnings*, U.S. FOOD & DRUG ADMIN., <http://www.fda.gov/TobaccoProducts/Labeling/Labeling/CigaretteWarningLabels/default.htm> (last updated Feb. 24, 2012).

241. *Compare* Disc. Tobacco City & Lottery, Inc. v. United States, 674 F.3d 509 (6th Cir. 2012) (upholding the warnings), *with* R.J. Reynolds Tobacco Co. v. Food & Drug Admin., No. 12-5063, 2012 WL 3632003 (D.C. Cir. Aug. 24, 2012) (striking down the warnings); *see also* Duff Wilson, *Tobacco Firms Sue to Block Marketing Law*, N.Y. TIMES, Sept. 1, 2009, at B1.

242. These labels do sometimes provide information on other resources, however—for instance, the toll-free numbers on the proposed cigarette warning labels. *See infra* note 263.

243. *See Adult Cigarette Smoking in the United States: Current Estimate*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm (last updated Mar. 14, 2012) (“An estimated 45.3 million people, or 19.3% of all adults . . . in the United States smoke cigarettes.”).

b. The Disabled-Listener Heuristic

The process of designing these warning labels should include a two-step inquiry related to the labels' messages about disability. The first step would assess the attitudes to disability conveyed by the proposed labels. Although simple, this step seems to be missing from the process of designing these warnings. The FDA's 150-page document implementing the new labeling law contains no discussion of the potential for stigma or other costs for people who are currently disabled.²⁴⁴ The only discussion of "stigma" concerns the tobacco companies, who charge that these new labels will force them to "stigmatize their own products" in violation of the First Amendment.²⁴⁵

At this first step, cigarette warning labels should be examined through what we might call the *disabled-listener heuristic*. The idea here is to examine any proposed label—and to consider new strategies for designing these labels—by asking the question, "How would this message feel to someone with the relevant disability?" The disability paradox literature suggests that we cannot trust our estimates of how it feels to have disabilities that we do not have.²⁴⁶ But that gap is not paramount here, because rather than trying to design the warning labels to make disabled people feel or not feel something, the disabled-listener heuristic uses an empathy exercise of imagining how this message might feel to someone with that disability, to scrutinize the label for the attitudes it projects to people who do not have the disability.²⁴⁷ Nonetheless, in light of Elaine Makas' work on attitudes discussed earlier,²⁴⁸ it would be important to involve people with disabilities, or nondisabled people very familiar with the inside perspective, in this inquiry.

A number of the images proposed by the FDA seem acceptable under the disabled-listener heuristic. Several images concern death, and dead people are (presumably) not around to be offended, so these are not a concern.²⁴⁹ Two involve harms to "your baby" or "your children,"

244. See Required Warnings for Cigarette Packages and Advertisements, 76 Fed. Reg. at 36,628.

245. *Id.* at 36,694, 36,696, 36,697; see also Brief of Plaintiffs-Appellants at 2, *Disc. Tobacco City & Lottery, Inc. v. United States*, Nos. 10-5234, 10-5235 (6th Cir. Sept. 28, 2010) ("[T]he Act contains . . . massively expanded warnings bombarding consumers with universally known information in order to stigmatize tobacco products."); *id.* at 42 ("Indeed, the [Canadian] survey confirms that the warnings are intended to stigmatize tobacco products rather than cure an information deficit, since 58% of respondents reported they were 'disgust[ed]' and 17–21% reported they 'tried to cover or hide,' or 'requested a specific package' to avoid, the warnings." (citation omitted)). Cf. *Disc. Tobacco City & Lottery, Inc.*, 674 F.3d at 526 ("The government argues that the purpose of the new warning label requirement 'is not to stigmatize the use of tobacco products on the industry's dime; it is to ensure that the health risk message is actually seen by consumers in the first instance.'" (citation omitted)).

246. See *supra* Part II.A.1.

247. For other hypothetical inquiries used to filter disability questions, see, for example, Anita Silvers, "Defective" Agents: Equality, Difference and the Tyranny of the Normal, 25 J. SOC. PHIL. 154, 168–69 (1994) (discussing her disabled majority inquiry).

248. See *supra* notes 83–85 and accompanying text.

249. The exception to this might be a person currently fighting cancer who finds these images demoralizing, but this does not seem a basis for ignoring the link between smoking and death in a public

and neither one is particularly sensational.²⁵⁰ It is difficult to see how these images would make a disabled person feel bad, though it might make the smoking pregnant mother feel bad, which, if effective in urging her not to smoke, seems sensible and not problematic from a disability perspective.

One image avoids disability altogether, and so would surely pass muster with the disabled listener: It shows a serious young bald man pulling back his button-down shirt to reveal a t-shirt that says, "I QUIT." Next to him is the message: "WARNING: Quitting smoking now greatly reduces serious risks to your health."²⁵¹ The image portrays his entire face, as well as much of his chest and his hands. He is a real person, fully present, and the audience is meant to relate to him, to want to congratulate him and join him. This image falls under the category of what is called "gain-framed" messaging, focusing on the benefits of the healthier behavior, which studies show is effective in influencing disease prevention behavior.²⁵²

Other images, however, fail when considered under the disabled-listener heuristic. One image portrays scabbed lips pulled back too far to reveal cracked black teeth, and thus portrays someone with oral cancer as scary and disgusting—drawing on the aesthetic anxiety that Harlan Hahn identifies in negative reactions to disability.²⁵³ Two images show disabling conditions in the context of partial or full facial views of people with the conditions. The first shows a man apparently smoking through the hole in his throat, from which smoke is pouring out, after a laryngectomy.²⁵⁴ His mouth is turned down in a pained and unhappy grimace. The other shows an overweight, bald man, whose face is almost entirely covered by an oxygen mask.²⁵⁵ He is leaning back so we can barely see his eyes, almost as if he is falling over backwards. Both of these images present the bearers of these conditions as very unhappy, with pained expressions in either their mouth or their eyes. Neither shows both mouth and eyes, since the images create distance from the figures by presenting their faces partially obstructed, in contrast to the "I QUIT" guy. These images are all "loss-framed," meaning that they focus on what a person has to lose from continuing the targeted behavior.²⁵⁶

The public health literature is conflicted over whether and when loss-framed messaging, as opposed to gain-framed messaging, is effec-

health campaign about smoking. I do use the perspective of someone with cancer who seeks warmer messaging to propose a novel message below. See *infra* text accompanying note 266.

250. See *Cigarette Health Warnings*, *supra* note 240.

251. See *id.*

252. See, e.g., Loraine Devos-Comby & Peter Salovey, *Applying Persuasion Strategies to Alter HIV-Relevant Thoughts and Behavior*, 6 REV. GEN. PSYCHOL. 287, 291–92 (2002).

253. *Cigarette Health Warnings*, *supra* note 240; *supra* notes 96–97 and accompanying text (discussing Hahn on aesthetic and existential anxiety).

254. *Cigarette Health Warnings*, *supra* note 240.

255. *Id.*

256. See, e.g., Devos-Comby & Salovey, *supra* note 252.

tive.²⁵⁷ In the context of HIV, for instance, while gain-framed messaging is apparently more effective at spurring prevention behavior, loss-framed messages may be more effective at prompting testing behavior.²⁵⁸ In the smoking context, the FDA posits that “negative emotional reactions” are correlated with the likelihood of reducing or quitting smoking.²⁵⁹ All nine images proposed by the FDA in this new campaign were tested and shown to have significant effects on viewers’ attitudes toward smoking,²⁶⁰ though more research is needed to establish that such labels have long-term effects on smoking behavior.²⁶¹ It is quite possible, however, that some of the loss-framed cigarette labels, even the most disability-negative ones, might be so effective that their benefits could outweigh a concern with attitudes toward disability.²⁶² This kind of balancing comes in at the second stage of the inquiry.

At step two, the insights of the disabled-listener heuristic must be factored into the broader calculus of the costs and benefits, and overall utility, of a particular message. The aim of the heuristic is to create a tool for asking the question of how this message might influence attitudes, by considering how it looks to someone with the disability. Under this analysis, the cancerous mouth and the two partial facial views of the distressed and unappealing sufferers would raise red flags, signaling the

257. See, e.g., Strub, *supra* note 199; cf. Andrew Caplin, *Fear As a Policy Instrument*, in TIME AND DECISION: ECONOMIC AND PSYCHOLOGICAL PERSPECTIVES ON INTERTEMPORAL CHOICE 441 (George Loewenstein et al. eds., 2003) (observing that, while fear has produced mixed results in public health campaigns, it can be used effectively in some circumstances); Devos-Comby & Salovey, *supra* note 252, at 289 (reporting on an Australian study in which “gay men exposed to the ‘grim reaper’ advertisement subsequently reduced safer sex behaviors” (citation omitted)); Rosenbloom et al., *supra* note 214, at 609 (noting studies showing some negative effects of fear-based appeals, as well as other studies indicating the effectiveness of fear); *supra* note 220 (discussing work on the defensive and avoidant coping mechanisms that fear may induce).

258. See, e.g., Devos-Comby & Salovey, *supra* note 252; Strub, *supra* note 199.

259. Required Warnings for Cigarette Packages and Advertisements, 76 Fed. Reg. 36,628, 36,635 (June 22, 2011) (to be codified at 21 C.F.R. pt. 1141).

260. *Id.* at 36,637 (reporting on the reactions of over 18,000 participants). For each image, the research evaluated emotional and cognitive salience, recall one week later, influence on beliefs, and effect on the behavioral intentions. *Id.* at 36,638.

261. See, e.g., R.J. Reynolds Tobacco Co. v. Food & Drug Admin., No. 12-5063, 2012 WL 3632003, at *2 (D.C. Cir. Aug. 24, 2012) (“FDA conceded the study did not permit it to reach ‘firm’ conclusions about the ‘long-term, real-world effects’ of the proposed warnings, but claimed the existing scientific literature ‘provides a substantial basis for our conclusion that the required warnings will effectively communicate the health risks of smoking, thereby encouraging smoking cessation and discouraging smoking initiation.’” (citation omitted)); *id.* (“Still other comments asserted that FDA’s research study failed to provide evidence that the proposed warnings would actually affect smoking rates, significantly affect consumers['] knowledge of the risks of smoking, or bring about actual behavior change. But FDA disagreed, again relying on the ‘substantial research’ showing the effectiveness of similar graphic health warnings in other countries.” (citations omitted)).

262. For an example of an article reaching this type of conclusion about obesity stigma, see Adam R. Pulver, Note, *An Imperfect Fit: Obesity, Public Health, and Disability Antidiscrimination Law*, 41 COLUM. J.L. & SOC. PROBS. 365 (2008). Notably, however, two of the most negative images inspired some comments that they were “too gross to be effective” or “offensive.” See Required Warnings for Cigarette Packages and Advertisements, 76 Fed. Reg. at 36,652–53.

need for close scrutiny of their effect on viewers.²⁶³ At this stage of the analysis, these images would need to be compared with other effective messages that passed the disabled-listener test, to see if the negative messages were uniquely contributing to the campaign's goals.²⁶⁴

Finally, in addition to screening messages, the disabled-listener heuristic can help us to design new labels, drawing on the inside insights outlined earlier.²⁶⁵ For instance, imagine a label that says, "Light up a life instead. Hug a friend with cancer."²⁶⁶ This approach might benefit from the element of surprise, when labels present messages so different from what an audience expects.²⁶⁷ Any new messages would require empirical study, to determine their effects on smoking attitudes and behavior.²⁶⁸ But the important point here is that that empirical study should also involve an examination of warning labels' effects on attitudes toward disability, and the resulting data on attitudes, as well as efficacy, should inform decisions about what labels are required.

C. Contingency Planning: Disability Insurance

A very different kind of disability decision moment comes with the decision whether to purchase disability insurance. Here, disability is front and center. It is typically in the name of the product: disability insurance.²⁶⁹ Individuals are asked, often by their employer's benefits en-

263. Note that all the new cigarette images also contain a telephone number that viewers can call for help with quitting. See *Cigarette Health Warnings*, *supra* note 240; see also *R.J. Reynolds Tobacco Co.*, 2012 WL 3632003, at *14 (Rogers, J., dissenting) (concluding that the new warning labels pass constitutional muster, but for the requirement that they bear the 1-800-QUIT-NOW number). This is part of the approach that pairs concerning or inspiring information with immediate access to help taking steps toward quitting. See *Required Warnings for Cigarette Packages and Advertisements*, 76 Fed. Reg. at 36,686–87. This link to other resources could also be used to provide more information about disability, or this kind of format could be used—on cigarette or other warning labels, such as for medication—to present the address of a website listing various resources for learning more about disability along the lines discussed here. See *supra* Part II.D.

264. The loss-framed images could also be important in combination with the gain-framed images, as some work suggests may be the case. See, e.g., *Devos-Comby & Salovey*, *supra* note 252, at 292. All of these considerations must be taken into account in evaluating an image, at this second step of the analysis.

265. See *supra* Part II.D.

266. I thank Timothy Gray for this particular slogan. Admittedly, some readers might interpret this language to mean that a person with cancer is living in darkness or isolation, and thus needs a pity hug; however, the accompanying image could do much to create a different impression, for instance, by presenting the people hugging in positions of equal stature, indistinguishable (in terms of who has cancer and who does not), and in a bright and warm setting.

267. See *Devos-Comby & Salovey*, *supra* note 252, at 293 (noting that "[m]essages that are framed in unexpected ways or that do not match participants' experiences or concerns can be more effective in that they can lead to greater scrutiny or deeper message processing" (citations omitted)).

268. See *supra* notes 246–48 and accompanying text (discussing a two-step framework for this sort of inquiry).

269. Some marketing efforts have, however, eschewed this label. For instance, in the late 1990s, Provident (now Unum) tried to increase sales by reframing disability insurance as "income protection," to move away from consumers' negative feelings about "disability." See Stuart Elliott, *Provident Hopes Using a Different Name for Disability Insurance Will Increase Its Sales*, N.Y. TIMES (Sept. 3, 1998).

rollment process, to think about their future possible relationship to disability. But this is a decision moment that in no way influences one's chances of having (or having a child with) a disability. Rather, it is a moment when people decide, if they develop a disability, what kind of life they will have. Specifically, they make a decision that determines their income stream if they become disabled.

Substantial numbers of workers face the decision whether to purchase disability insurance through various means. Many employees are offered disability insurance through their employer. A 2006 survey by the U.S. Department of Labor reported that “[s]hort- and long-term disability benefits were available to 39 and 30 percent of workers, respectively.”²⁷⁰ While the Department of Labor reports very high employee participation rates in disability insurance plans (where available),²⁷¹ other sources indicate that “when employees have to pay the entire premium”—which is the case for about “half of all long-term-disability offerings”—then “only about 40 percent generally sign up.”²⁷² Higher income workers, and those in larger private companies, are more likely to have the opportunity to purchase this insurance through their employer.²⁷³ Private plans are also available for individuals to purchase directly through a range of insurance companies, which market these plans through the internet, telephone and mail solicitations, and face-to-face interactions.²⁷⁴ The process of applying for a voluntary plan generally involves completing an application about medical and financial history and then a brief (fifteen- to thirty-minute) medical examination.²⁷⁵ A typical

270. U.S. DEP'T OF LABOR & U.S. BUREAU OF LABOR STATISTICS, *National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2006*, BUREAU LAB. STAT. 1 (Aug. 2006), <http://www.bls.gov/ncs/ebs/sp/ebsm0004.pdf>.

271. *Id.*; U.S. DEP'T OF LABOR & U.S. BUREAU OF LABOR STATISTICS, *National Compensation Survey: Employee Benefits in the United States, March 2010*, BUREAU LAB. STAT. tbl.17 [p. 237] (Sept. 2010), <http://www.bls.gov/ncs/ebs/benefits/2010/ebbl0046.pdf> (reporting that thirty-three percent of workers in private industry had access to long-term disability benefits in 2010 (up from thirty percent), and ninety-five percent of those workers participated in such a plan). Such high participation rates presumably reflect the fact that disability insurance plans covered by the DOL survey are “usually fully employer-paid.” DEP'T OF LABOR, *supra* note 270, at 2; DEP'T OF LABOR, *supra* note 271, tbl. 23 [p. 438].

272. Michelle Andrews, *Employers Shift Disability Insurance Costs to Workers and Trim Benefits*, WASHINGTON POST, Sept. 19, 2011.

273. U.S. DEP'T OF LABOR & U.S. BUREAU OF LABOR STATISTICS, *supra* note 270, at 2 (“Only 17 percent of those earning under \$15 had access to [long-term disability insurance], compared with 48 percent of those in the higher earnings category.”). Workers in private establishments who employed 100 employees or more enjoyed higher rates of access to disability benefits generally than their counterparts in small establishments. *Id.*

274. *See, e.g.*, Karen Terry, *Breaking the DI Sales Barrier*, LIMRA'S MARKETFACTS Q., no. 1, 2012 at 64, 65–67; *see also* Jinkook Lee, *A Key to Marketing Financial Services: The Right Mix of Products, Services, Channels and Customers*, 16 J. SERVICES MARKETING 238, 245 (2002) (finding that a plurality of the consumers surveyed preferred to purchase disability insurance through face-to-face transactions, though some were open to other methods).

275. For additional information about the process of applying for long-term disability insurance, *see generally* *Long-Term Disability Income Insurance: Financial Protection for You & Your Family*, CONSUMER FED'N AM. (Nov. 7, 2000), <http://www.consumerfed.org/pdfs/ltdbrochure.pdf>.

medical exam includes a physical examination, blood work, urine analysis, and an EKG.²⁷⁶

1. *The Traditional Frame*

The promotional literature that frames this decision has tended, perhaps unsurprisingly, to paint a rather bleak picture of life with disability. The Council for Disability Awareness, an insurance industry organization, warns, “Disability is already a widespread problem, and the threat is growing at an alarming rate.”²⁷⁷ These materials emphasize—and sometimes exaggerate²⁷⁸—the likelihood of becoming disabled during one’s working years²⁷⁹ and at any time.²⁸⁰

The basic message from the insurers is that “[b]ecoming disabled can have devastating financial implications by stripping you of your ability to make a living.”²⁸¹ But the advertising often goes further. One promotional video by MetLife, for instance, emphasizes how “a disability can have a serious impact on one’s quality of life,” affecting not only a person’s income (“a long-term disability can have a disastrous effect on a family’s standard of living”), but one’s mental health (“disabled individuals may suffer from depression due to their disability”), stress (for family members who take care of someone with a disability), and even marriage (“financial stress is often cited as the leading cause of divorce, and the financial impact of a disabled spouse can be overwhelming in a marriage”).²⁸²

Many industry publications also adopt and advocate a highly negative view of disability. For instance, one insurance agent, injured in a

276. *Frequently Asked Questions*, DOCTOR DISABILITY, <http://www.doctordisability.com/faqs/> (last visited Aug. 20, 2012); see also *Frequently Asked Questions About Disability Insurance*, 4-DISABILITY-INS.-QUOTES, <http://www.ezdisabilityquote.com/resources/faq/#medicalexam> (last visited Aug. 20, 2012).

277. *Chances of Disability*, COUNCIL FOR DISABILITY AWARENESS, http://www.disabilitycanhappen.org/chances_disability/causes.asp (last visited Aug. 20, 2012).

278. See Ron Lieber, *The Odds of a Disability Are Themselves Odd*, N.Y. TIMES (Feb. 5, 2010) <http://www.nytimes.com/2010/02/06/your-money/life-and-disability-insurance/06money.html>.

279. *Learn the Basics in a Fraction of the Time*, EDISABILITYQUOTES, <http://www.edisabilityquotes.com/learning-center/disability-university/learning-the-basics/> (last visited Aug. 20, 2012) (“Fact: Nearly 1 in 5 Americans will become disabled for 1 year or more before age 65.”).

280. *Id.* (“Fact: During the past 10 minutes, on average, 498 Americans have become disabled!”); see also *Disability Insurance Overview*, METLIFE, <http://www.metlife.com/individual/insurance/disability-insurance/index.html#basics> (last visited Aug. 20, 2012) (“You wake up one morning and things are different . . . What started off as a normal day at work, quickly turned into a bout of disability leaves.”); *The Basics of Long-Term Disability Insurance*, INSURE.COM (Jan. 29, 2010), <http://www.insure.com/articles/disabilityinsurance/long-term-disability.html> (“You may not realize the potential danger of becoming disabled. . . . [T]he average long-term disability (LTD) absence from work lasts 2.5 years, according to the Council for Disability Awareness (CDA). That’s a long time to survive without a steady income.”).

281. *The Basics of Long-Term Disability Insurance*, *supra* note 280.

282. *Safeguard Your Lifestyle and Financial Future with MetLife’s Disability Insurance*, METLIFE, <https://intramet.investmet.com/public/doclib/LifeMarketing/Flash/DisabilityConsumer/DCBP.html> (last visited Aug. 20, 2012).

slip-and-fall accident seven years into his career, uses these words to convey to other agents the importance of disability insurance: “[B]eing disabled wreaks havoc, but it’s much less destructive if your financial affairs are in order.”²⁸³ One insurance company executive urges advisors to sell disability insurance by linking it with life insurance, and refers to disability insurance as protection from “economic death.”²⁸⁴

2. *An Alternative Approach*

The inside view of disability suggests another way to look at this decision. If disability is not nearly so bad an experience as outsiders think, then why would insurance companies ever want to present this perspective? Because the inside view highlights the way one’s interaction with the environment determines how disabling a disability is.²⁸⁵ If disability is meaningfully shaped by the surrounding context, then disability insurance becomes even more important. Financial circumstances can make disability look very bad or very livable. And insights from the inside view could also make disability sound less scary, enabling people to move beyond fear and denial to face the real possibility that they could become disabled.

The insurance industry has shown some signs of appreciating that a more positive frame could be useful to sales efforts.²⁸⁶ For instance, in the 1990s, three big insurers that made up “about forty percent of the \$6 billion-a-year disability insurance market” launched ad campaigns featuring wheelchair athletes and other disabled people engaging in sports and outdoor activities.²⁸⁷ Insurers claimed these ads “do more than pound the drum of fear to attract those who do not have coverage,” but “instead show how helpful, efficient insurers can make a difference in one’s life.”²⁸⁸ In other words, the ads “succeed by stressing the posi-

283. Daniel C. Steenerson, *In the Blink of an Eye . . . Disability Happens*, HEALTH INS. UNDERWRITER, April 2011, at 12. The article emphasizes that the agent lost his ability to play basketball, “a great love in his life,” and offers these striking observations about disability from him: “Do you understand the difference between being handicapped and being disabled? . . . Handicapped people can work and disabled people cannot. You don’t usually see them because they’re at home in bed or in the hospital.” *Id.* at 14.

284. Dave Willis, *On Target with Your DI Sales*, ADVISOR TODAY, May 2010, at 42, 44.

285. See *supra* Part I.B.2.

286. See, e.g., Rosemarie Rossetti, *Selling Disability Income Insurance with Conviction*, LIFEHEALTHPRO (June 18, 2009), <http://www.lifehealthpro.com/2009/06/18/selling-disability-income-insurance-with-conviction> (drawing on her personal experience of being disabled in an accident and characterizing disability-insurance agents’ role as the “power of helping a person to take back their life and adjust to their disability”); Elliott, *supra* note 269 (observing, in conjunction with Unum’s attempt to reframe disability insurance as income protection, noted earlier, that the term disability was a “roadblock” because it “conjures up images of bodily injury and loss, which create feelings of fear, concern, and anxiety—and talking about insurance in that context gets you nowhere”).

287. See Matthew Lubanko, *Stressing Able in Disabled*, HARTFORD COURANT (Oct. 16, 1998) (describing campaigns by Hartford Life, Cigna, and Unum).

288. *Id.*

tive.”²⁸⁹ One of these companies, Hartford, later became the “first-ever corporate sponsor” of the U.S. Paralympics.²⁹⁰ Some scholars have critiqued the ways that ads involving disabled athletes can fall prey to stereotyped views of “overcoming” disability, a concept discussed earlier,²⁹¹ but this work also acknowledges that more realistic and positive portrayals of disability in advertising can help improve public attitudes.²⁹²

Perhaps these approaches could be enhanced, or complemented, with advertising that draws more strongly on the inside view. For example, photos in disability insurance advertising sometimes feature stairs or other insurmountable obstacles, shot from the perspective of a person who is excluded by them.²⁹³ These architectural images could be accompanied by text that emphasizes that many workers are unprepared to be disabled in a world designed for people without disabilities;²⁹⁴ they could use narrative text to show how disability insurance can enable a person to change her surroundings to continue living in her home and achieving her goals.²⁹⁵ Some work suggests that advertising text written in the second-person (“you”) perspective, in addition to photos shot from a first-person (“I”) perspective, can invite identification; in addition to enhancing sales if presented properly, this approach might help to educate consumers through empathetic exposure to a social-model perspective on disability.²⁹⁶ Moreover, from the perspective of industry interest, one analyst suggests that insurers may stand to gain directly if people with disabilities are empowered, because “[i]nspiring people to get up and about helps insurers retain the money they might otherwise pay out in claims.”²⁹⁷

289. *Id.*

290. Michelle Jeffers, *The Hartford Teams with U.S. Paralympics*, ADWEEK, Apr. 8, 2003, available at <http://www.adweek.com/news/advertising/hartford-teams-us-paralympics-63195>.

291. See *supra* text accompanying notes 65–69.

292. See, e.g., Haller & Ralph, *supra* note 65.

293. See, e.g., Joan Meyers-Levy & Laura A. Peracchio, *Moderators of the Impact of Self-Reference on Persuasion*, 22 J. CONSUMER RES. 408, 408 (1996).

294. Cf. Part I.B.2 (discussing the social model of disability).

295. Cf. Debra Lynn Stephens & Karyn Bergman, *The Americans with Disabilities Act: A Mandate for Marketers*, 14 J. PUB. POL'Y & MKTG. 164,167 (Spring 1995) (discussing the importance of an “empathetic stance” when depicting disability in advertisements, though in the context of an article about marketing to people with disabilities).

296. See, e.g., Meyers-Levy & Peracchio, *supra* note 293. This work finds that the effectiveness of these techniques for increasing “self-reference” by viewers is mediated by, *inter alia*, viewers’ motivation to consider the ad carefully, which can be encouraged by a “negative outcome” in the ad. See *id.* at 419. The authors also suggest, however, that there is a “threshold beyond which an ad that depicts a negative outcome evokes a fear-arousing response, which is likely to terminate processing.” *Id.* at 420. The prospect of disability may itself seem sufficiently negative to many viewers to meet this threshold, but this finding suggests the need for careful design and evaluation of ads in this vein, in terms of both effectiveness and messages about disability. On the social model, see *supra* Part I.B.2.

297. See Lubanko, *supra* note 287 (quoting an unnamed industry analyst). There’s a potentially darker side to this suggestion, as some insurers require claimants to comply with particular forms of rehabilitation, “or possibly lose benefits, if they refuse treatment.” *Id.* On some of the complexities of requiring mitigation of disability, see, for example, Jill Elaine Hasday, *Mitigation and the Americans with Disabilities Act*, 103 MICH. L. REV. 217 (2004).

The moment of deciding whether to purchase disability insurance is not as susceptible to regulatory influence as the other moments discussed so far. Outside the context of government employment, these are decision moments largely determined by private employers and insurance companies. So here the aim would be to persuade these entities that offering an inside view of disability could benefit them. Empirical work is necessary in this area. This Section has tried to suggest, however, that persuading consumers to move beyond fear and to recognize how context would shape their experience of disability could potentially help both to sell insurance and to improve attitudes to disability.

V. OBJECTIONS

Various objections might be raised to using framing rules to change attitudes toward disability. These range from concerns about influencing the practical decisions at issue, to imposing costs on the decision makers, to inspiring a backlash in attitudes toward disability, to having no effect at all. This Part briefly considers each type of objection.

A. *Affecting the Decision at Hand*

Though the aim here is not to shape decisions about prenatal testing, driving, smoking, or insuring, we might be concerned that disability-oriented framing rules would in fact affect these decisions. As noted earlier, research in decision science indicates that frames can have substantial effects on people's decisions.²⁹⁸ This is therefore a reasonable concern, but one that does not override the argument for framing rules in these contexts. Because the particulars of this objection vary for each context, this Section discusses each in turn.

1. *Prenatal Testing*

Framing rules that present the inside view of disability might affect some decisions whether to continue or terminate a pregnancy. Offering prospective parents information that prompts them to see disability differently—for instance, helping them see that life with a significant disability may be far happier than they would predict²⁹⁹—could make some parents decide that they want to continue a pregnancy that they would otherwise have ended. Justice Kennedy, dissenting in *Hill v. Colorado*, went so far as to say that “a leaflet” about abortion can make a “profound difference . . . in a woman’s decisionmaking process.”³⁰⁰ The pos-

298. See *supra* note 141 and accompanying text.

299. See *supra* Part II.A.1.

300. *Hill v. Colorado*, 530 U.S. 703, 789 (2000) (Kennedy, J., dissenting) (dissenting from the Court’s decision to uphold, in the face of a First Amendment challenge, a criminal statute prohibiting

sibility that framing rules might influence abortion decisions is a serious concern. Prenatal testing and selective abortion are highly emotional issues;³⁰¹ indeed, abortion for any reason is a deeply fraught personal and political matter.³⁰² Moreover, efforts by anti-abortion advocates to place obstacles in the path to abortion have included forms of framing rules, such as mandatory ultrasounds, which have been criticized as impermissibly burdening women's choices.³⁰³

But there is a difference between taking actions in the world that might have secondary effects on abortion decisions and taking actions to attempt to influence abortion decisions.³⁰⁴ Many social and legal actions might indirectly affect abortion decisions. For example, one recent article argues that the passage of the ADA increased the abortion rate for fetuses with Down syndrome through "indirect expressive effects."³⁰⁵ If the ADA could influence abortion rates—one way or another³⁰⁶—then providing information during prenatal testing could also affect these decisions. Few would argue that such secondary effects were a reason not to pass the ADA, however, and, likewise, the mere possibility of these effects does not overcome the need for disability framing rules. Indeed, the authors of the ADA study conclude that their results point to the need for public education efforts, as well as physician referrals of parents who receive a prenatal diagnosis to "resources such as local support groups, national disability organizations, and parents who have children with disabilities."³⁰⁷

a person from approaching another, without consent, within one hundred feet of a health care facility entrance, in order to pass out a leaflet, display a sign, or engage in oral protest or counseling).

301. Compare, e.g., Deborah Kent, *Somewhere a Mockingbird*, in PRENATAL TESTING AND DISABILITY RIGHTS, *supra* note 35, at 57, with Mary Ann Baily, *Why I Had Amniocentesis*, in PRENATAL TESTING AND DISABILITY RIGHTS, *supra* note 35, at 64.

302. Cf., e.g., Jeannie Suk, *The Trajectory of Trauma: Bodies and Minds of Abortion Discourse*, 110 COLUM. L. REV. 1193 (2010) (discussing the legal discourse of abortion trauma).

303. See, e.g., Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351 (2008).

304. To distinguish one particular kind of information provided in some jurisdictions with the obvious intent to discourage abortion, consider laws requiring doctors to provide names and addresses of adoption agencies. See Nadia N. Sawicki, *The Abortion Informed Consent Debate: More Light, Less Heat*, 21 CORNELL J.L. & PUB. POL'Y 1, 9 (2011). In the context at issue here, involving prenatal testing for disability, the issue seems somewhat different for several reasons. Most notably, in the disability context there is factual information that parents might not know they do not know, since nondisabled people hold mistaken assumptions about the average happiness of people with disabilities and their families. (And indeed many doctors may not even be up to date on the developmental outcomes for kids with Down syndrome, in terms of their life expectancy and their possibilities for learning, etc.) Thus, there is information that doctors are the ones best positioned to offer, which is potentially relevant to a decision to test, at the outset, or to abort or continue the pregnancy, once a diagnosis comes, but that patients are not in a position to know to ask for. This seems different from information about adoption agencies, which is the kind of information that someone interested in adoption could surely figure out they would need to ask for, even if they did not have it already.

305. See Fox & Griffin, *supra* note 166, at 859.

306. The authors of that study acknowledge that it is standard for this kind of research to undergo scrutiny to which their results had not yet been subjected. *Id.* at 892.

307. *Id.* at 893. The context is as follows: "We suggest that policymakers supplement the passage of certain civil rights laws with public education campaigns on behalf of the protected group in ques-

But any intervention in this area must be careful not to burden women's choices, nor to invite doctors or regulatory bodies to do so. The focus of my intervention and the method I propose are consistent with this concern. For the reasons discussed earlier, my focus is on *all* prospective parents who undergo testing, rather than on those who receive a diagnosis.³⁰⁸ My aim is to shape the reception of disability by those who might be inclined to ask parents of a child with a disability, *Didn't you get tested?*³⁰⁹ I therefore propose that framing rules target the moment when prospective parents await their test results, rather than the point of a positive diagnosis. This contrasts with the proposal of the Prenatally and Postnatally Diagnosed Conditions Awareness Act,³¹⁰ which singles out parents who receive a positive diagnosis of disability. In addition, my proposal is that written literature be made available to parents, offering lists and links to various information and resources, so that the tone and content can be carefully designed and executed.³¹¹ These features of the proposal should help to ease concerns about burdening abortion decisions.

2. *Driver's Licensing*

The possibility of affecting decisions about driving should also be taken seriously. Here the clear public-policy interest is in safe driving rather than autonomous decision making. Thus, in order to support disability framing rules in this context, we would have to believe that these rules would have either no effect or a positive effect on safe driving practices.

We might worry that presenting disability in a more positive light could lead teens to take road safety less seriously. Some people surely have "perverse" responses to presentation of risk, perhaps teens in particular.³¹² (Thinking about trying to educate motorcyclists about risk may call this perspective to mind.³¹³) A "sexy" presentation of disability might fuel this response.

tion. Where reproductive practices are affected, physicians should refer parents who receive an unexpected diagnosis to resources such as local support groups, national disability organizations, and parents who have children with disabilities." *Id.* This sounds similar to the framing rule proposed in this Article, except for their focus only on parents who receive a positive diagnosis.

308. See *supra* Part IV.A; see also *supra* note 194 (explaining the focus on those who test, rather than on all those deciding whether to test).

309. See *supra* text accompanying note 151.

310. See *supra* Part IV.A.2. The draft proposed it as a requirement; the enacted version encourages it.

311. See *supra* note 193 and accompanying text. As noted earlier, the material should of course be offered in various accessible formats.

312. See Toni M. Massaro, *The Meanings of Shame: Implications for Legal Reform*, 3 PSYCHOL., PUB. POL'Y, & L. 645 (1997) (discussing shaming penalties and teen responses); cf. J.G. BALLARD, CRASH (1973) (offering a narrative of lust in response to car crashes).

313. See, e.g., Allison Daniello et al., *Effectiveness of Motorcycle Training and Licensing*, TRANSP. RES. REC.: J. TRANSP. RES. BOARD, no. 2140, 2009, at 206, 212 (reporting that the data on motorcycle

On the other hand, driver's education is sorely in need of invigoration. Expert and anecdotal reports recount the failings of current approaches.³¹⁴ As discussed earlier, a driver's education program that incorporated surprising and stimulating material might capture the attention of challenging teen audiences.³¹⁵ Moreover, even a very positive portrayal of disability seems unlikely to eliminate someone's years of acculturation to negative views of disability.³¹⁶ Ultimately, such interventions require empirical study of their effects both on attitudes to disability and on risky driving beliefs and behavior. However, pilot programs involving interaction with teens disabled through automobile accidents provide a basis for supposing that initiatives of this sort could have a positive effect on safe driving.³¹⁷ Such programs might be more effective with a broader audience if they actively sought to present surprising elements of the inside perspective on disability.³¹⁸

3. *Warning Labels*

With warning labels, we might be concerned that frames that attempt to avoid stigmatizing people with the relevant disabilities would undermine the anti-smoking message. This possibility depends on the effectiveness of fear in changing people's behavior. As discussed earlier, loss-framed messaging, which plays on people's fear of negative consequences, may be effective in some contexts but also risks defensive reactions.³¹⁹ Gain-framed messaging appears effective in at least some contexts and features in one of the nine new FDA images for cigarette packets.³²⁰ The proposal here is that the FDA should consider in its calculus of the best approach to cigarette warning labels the problem of stigmatizing smoking-related disabilities. The agency might ultimately conclude that the negative messages are uniquely effective and thus should be used despite stigmatic consequences, though an attention to framing disability could, even then, help them choose among the negative messages.³²¹ Moreover, thinking through the lens of inside insights might help spur creative ideas for new messages, drawing on the element of surprise to capture users' attention, which further research would evaluate for their effectiveness.

training are mixed, with some studies showing that training decreases accidents, and other work showing it has no effect or even the reverse effect).

314. See *supra* note 203.

315. See *supra* Part IV.B.1.b.

316. This of course highlights the concern raised earlier that portrayals of disability in driver's education will always inevitably be negative. For discussion, see *supra* note 233.

317. See *supra* Part IV.B.1.a.

318. See *supra* note 217.

319. See *supra* notes 257–61.

320. See *supra* notes 251–52 and accompanying text.

321. Cf. Pulver, *supra* note 262 (balancing stigma against benefits in the context of obesity).

4. *Disability Insurance*

A concern about influencing the decision is perhaps least weighty with regard to long-term disability insurance. Insurers will change their advertising only if the inside perspective helps them to sell insurance—or perhaps if it has no effect on sales but generates positive publicity or goodwill. And if insurers deploy this perspective to increase sales, we need not worry that consumers will be misled by the new advertising, since the inside perspective better reflects the experience of disability.³²²

B. Imposing Costs on Decision Makers

We might also worry that, even if framing rules do not influence the decisions at hand, they will impose costs on decision makers. Providing people with information gives them one more thing to think about or to decide not to think about. The concern here is akin to that raised about “forced choosing” regimes; though forced choosing gives decision makers more control over decisions than mandatory or even default rules, these regimes also require people to endure at least the minimal costs of thinking about something they may not have wanted to think about.³²³

Such costs could be minimized by making the information optional. Of course, if many choose not to access the information, this would diminish the effect of the intervention. But making it optional to engage with the information does seem important in the prenatal testing context, for the reasons discussed earlier.³²⁴ In driver’s education, if the intervention has neutral or positive effects on highway safety, then that should render the administrative costs worthwhile. For warning labels, the intervention will involve minimal information automatically displayed, and possibly optional additional information,³²⁵ so the costs should be minor. For disability insurance, reading or listening to the information provided by an employer’s human resources department or private insurance company is generally optional already.

More than just consuming time, thinking about disability may be emotional for some people, particularly as they are about to embark on a significant activity like parenting, learning to drive, or quitting smoking. In the prenatal testing context, for example, informational frames about disability might increase patient anxiety during an already stressful time. A woman given this information while awaiting her prenatal testing results might worry that she is being provided with information about disability because the doctor thinks her fetus has a disability. For this reason,

322. See *supra* Part II.

323. See, e.g., Emens, *supra* note 14, at 837–38; Sunstein & Thaler, *Libertarian Paternalism*, *supra* note 141, at 1198–99.

324. See *supra* Part V.A.1. Note also that the costs on doctors or genetic counselors can be reduced by putting the information in written or recorded form, to be reused across patients.

325. See *supra* note 263.

any frame would need to make clear that information is provided to all patients who undergo testing.

A concern about emotional costs cuts the other way as well. Providing some more realistic information about life with disability could decrease anxiety. To realize that adjustment to disability, in oneself or one's children, often leads to unexpected levels of happiness and well-being should be reassuring to some.³²⁶

C. *Creating Backlash*

We might also worry that providing information about the inside view of disability will create a backlash against this view of disability. Larry Lessig warns of the possibility of an “Orwell effect” to legislation that runs counter to popular conventions.³²⁷ Thus, providing the kind of counter-intuitive or surprising information about disability proposed here might trigger this response. One scholar writing about the prenatal testing debate has offered a similar warning about the expressive critique of prenatal testing and selective abortion, arguing that if women are told that screening against disabled fetuses means they think disabled lives are not worth living, then some women may defensively conclude that they in fact think disabled lives are not worth living.³²⁸ Relatedly, we might worry that any discussion of disability in the driver's education context will inspire negative thinking about disability because of the context.³²⁹ In the anti-smoking context, the link between smoking and disability is already so strong and negative that it is hard to see it getting more negative, but if people perceive the framing disability efforts to undercut anti-smoking efforts, that could generate new hostility.

A concern about backlash is worth considering when designing any framing rule, but it should not negate the value of a well-designed framing rule. In contexts such as the injury prevention campaigns, the aim is not to undercut these efforts, but to have a neutral or positive effect on them through creative thinking inspired by the disabled-listener heuristic. Thus, a backlash should be avoidable through clear communication of this aim. More generally, the purpose of these rules is to provide some measure of counterbalancing information about life with a disability as part of people's thinking about a range of decisions that may implicate disability. By contrast to interventions that attempt to change people's

326. Cf. Hahn, *supra* note 96, at 43–44.

327. Lawrence Lessig, *The Regulation of Social Meaning*, 62 U. CHI. L. REV. 943, 1016–19 (1995). This is akin to what psychologists call “reactance.” See, e.g., SHARON S. BREHM & JACK W. BREHM, *PSYCHOLOGICAL REACTANCE: A THEORY OF FREEDOM AND CONTROL* 3–4 (1981) (“[T]he theory [of psychological reactance] holds that a threat to or loss of a freedom motivates the individual to restore that freedom.”).

328. See Mary Ann Baily, *Why I Had Amniocentesis*, in *PRENATAL TESTING AND DISABILITY RIGHTS*, *supra* note 35, at 70.

329. See *supra* notes 195–201.

decisions on important subjects, this relatively mild informational framing should create less resistance.

D. *Generating Ineffectual Noise*

Rather than creating problematic effects, disability framing rules might have no effect. Providing additional information to decision makers raises the specter of “warning clutter,” a concern elaborated in the products liability context.³³⁰ There, courts and commentators worry that too much information on labels will undermine consumers’ ability or willingness to take in the information provided.³³¹ Likewise, we might be concerned that framing decisions about prenatal testing, driver’s licensing, smoking, or insurance with information about the inside view of disability would present too much detail or new information to have any meaningful effect. Moreover, the stress or excitement of the relevant moments—particularly for prenatal testing and driver’s licensing—might make people especially resistant to new information.³³² Finally, even if the information were absorbed by some, the receptive audience might be predominantly an educated subset more inclined to pursue additional resources about prenatal testing or the health risks of their choices. (This last point is of course speculation, which might not prove true, but this Section assumes the possibility in order to address it.)

For some people, however, moments of heightened anxiety might make them unusually interested in disability, and therefore more inclined to follow up on resources provided to them. Information could be offered in multiple formats, including links to audio and film clips. Varied formats would appeal to a varied audience with different interests and orientations, as well as making the material accessible to people with diverse disabilities. In addition, as noted earlier, surprising material may get the attention of individuals who anticipate hearing only what they think they already know. Finally, even if disability frames reach only a subset of the population—and that subset is on average more educated—that would be a significant intervention. Given the unfortunate degree of class continuity in this country,³³³ the better-educated consumers of prenatal testing, driver’s education, warning labels, and disability insurance are more likely to become the country’s judges and other lawmakers (and to some extent employers) who are shaping interpretations of disa-

330. See, e.g., Gary T. Schwartz, *The Beginning and Possible End of the Rise of Modern American Tort Law*, 26 GA. L. REV. 601, 688 (1992).

331. See, e.g., *Hood v. Ryobi Am. Corp.*, 181 F.3d 608, 611 (4th Cir. 1999); W. Kip Viscusi, *Individual Rationality, Hazard Warnings, and the Foundations of Tort Law*, 48 RUTGERS L. REV. 625 (1996); James A. Henderson, Jr. & Aaron D. Twerski, *Doctrinal Collapse in Products Liability: The Empty Shell of Failure to Warn*, 65 N.Y.U. L. REV. 265, 300 (1990).

332. Cf. George Loewenstein, *Emotions in Economic Theory and Economic Behavior*, 90 AM. ECON. REV. 426, 430 (2000) (discussing the effects of “hot” visceral states on decision making).

333. See, e.g., Tom Hertz, *Understanding Mobility in America*, CENTER FOR AM. PROGRESS 3, 10 (Apr. 26, 2006), http://www.americanprogress.org/issues/2006/04/Hertz_MobilityAnalysis.pdf.

bility law. Even reaching this subset of the population with a better understanding of disability could be useful at a time when law and attitudes are out of step.³³⁴

VI. CONCLUSION

This is an auspicious moment to focus on societal attitudes toward disability and the ways the state might influence them. President Obama has signed the U.N. Convention on the Rights of Persons with Disabilities (CRPD), the first human rights convention adopted by the United Nations in the twenty-first century.³³⁵ The CRPD contains an “[a]wareness-raising” article requiring states parties to “adopt immediate, effective and appropriate measures” to “raise awareness,” “combat stereotypes,” and “promote awareness of the capabilities and contributions of persons with disabilities.”³³⁶ The Convention offers some broad-brush ideas of what that might involve, such as creating “public awareness campaigns,” fostering respect in education, and “[p]romoting awareness-training programmes.”³³⁷ Nothing in the Convention, however, gives any real guidance for meaningful or effective ways to change attitudes toward disability.

This Article has examined current attitudes toward disability in order to design a set of targeted interventions to improve them. A significant gap separates “inside” and “outside” perspectives on the experience, theory, and law of disability. We should address this gap by targeting moments in which nondisabled people make decisions that implicate their future relationship to disability. Applying framing rules to these moments could provide people who have a reason to think about disability with insights from the inside of disability thinking. The examples examined here—prenatal testing, driver’s licensing, warning labels, and disability insurance—provide a starting point for the project of identifying these disability-relevant decision points. Reframing these moments through the inside perspective on disability should help to bring everyone closer to understanding how accessibility and inclusion provide a form of social insurance for us all.

334. See *supra* text accompanying note 1.

335. See *Convention and Optional Protocol Signatures and Ratifications*, UNITED NATIONS ENABLE, <http://www.un.org/disabilities/countries.asp?id=166> (last visited Aug. 20, 2012).

336. See *Convention on the Rights of Persons with Disabilities*, UNITED NATIONS ENABLE (Dec. 6, 2006), <http://www.un.org/disabilities/convention/conventionfull.shtml>.

337. *Id.*

