

Chapter 2

An Essay on Modeling: The Social Model of Disability

Anita Silvers

2.1 Introduction

From its first exposition almost half a century ago, the social model of disability has been aimed at altering both theory and practice, bringing about profound changes in people's understanding of disability, and in the daily lives of disabled people as well. The social model's foil, and on some accounts its antithesis, is the medical model of disability. Both models treat disability as a locus of difficulties. While the medical model takes disability to be a problem requiring medical intervention—and as both the prerogative and the responsibility of medical professionals to fix—the social model understands disability as a political problem calling for corrective action by citizen activists who alter other people's attitudes and reform the practices of the state. These two conceptualizations of disability have been treated as competitors, as if one must prevail over and eradicate the other in thinking about who disabled people are and what should be said and done in regard to them.

Not long ago, the social model enjoyed almost unwavering allegiance from both disability activists and disability studies scholars. Now, however, fault lines in the disability community's fealty to the social model have appeared. Some disability studies scholars have launched criticisms of the social model, or more precisely, of claims they believe to be constitutive elements or entailments of the social model. These criticisms are advanced as being in the interest of revising disability theory to more accurately reflect disabled people's experiences, priorities, and needs.

The social model stands accused in some quarters of misrepresenting disabled people by abridging who they are, or of even more malignant distortions such as promoting values that exclude people with certain kinds of physical or cognitive limitations. These complaints are connected, in that the former criticizes the social model for suppressing rather than showcasing disabled people's differences, especially dysfunctional ones, while the latter objects to advancing an ideal of independence that some disabled people's dysfunctions make unrealizable for them.

A. Silvers (✉)

Department of Philosophy, San Francisco State University, San Francisco, California, USA
e-mail: asilvers@sfsu.edu

Pursued within disability studies scholarship, these charges echo concerns adherents of the medical model bring, namely, that to ignore experiences of being weak, enervated, in pain and vulnerable in modeling disability is deceptive because these are the most salient experiences in most, or at least in many, disabled people's lives. Of course, almost all people, regardless of whether they are disabled, have occasion to learn how such experiences feel. Yet some or all of these feelings chronically pervade the lives of at least some people with disabilities to a degree so marked and therefore so different as to distinguish their embodied lives, discerned at both the sentient and social levels.

These distinctive marks come to inscribe or inflect (some) disabled individuals' embodied subjectivity. Within disability studies, critics of the social model argue that obtrusive experiences of this sort, that seem to reflect minds or bodies (or both) while inflecting individuals' awareness or consciousness of their minds or bodies (or both), shape virtually every disabled person's awareness. Different disabled people respond in different ways, of course, but such characterizations of disabled embodiment are taken by many disability studies scholars (and by medical-model-influenced scholarship as well) as indispensable to understanding disability.

For example, bioethicist Jackie Leach Scully insists that "the strong social model is just not that interested in the subjective experience of the impaired body, or its psychoemotional aspects, or the processes through which disability is constructed by cultural representations and language." (Scully, 2008, p. 27) Scully adds, "The marginalization of disabled people cannot be effectively tackled, either theoretically or politically, if the subjective experience of impairment is left out" (Scully, 2008, p. 29). Scully and other critics (for example, Crow, 1996, p. 210) fear that the social model acquiesces to the traditional Cartesian split between mind and body, artificially splits the personal and the political apart, and fails to acknowledge that embodied perception and cognition distances disabled people's experiences from those of people who do not have anomalous bodies (Scully, 2008, pp. 28–29). Nevertheless, this line of criticism does not discount the social dimension of disability, and, despite returning focus to some of the matters that for the medical model are the essence of disability, need not adopt the values that motivate the medical model.

Parenthetically, by "strong social model," Scully explicitly has in mind the British "historical materialist" version of the social model (Scully, 2008, p. 28). In the US the social model also is invoked in the pursuit of political and legal liberation to argue for the social contingency of limitations that have been assumed in some quarters to characterize disability, but, *contra* Scully's account (Scully, 2008, p. 28) is decidedly concerned about the attitudinal and discursive manifestations of bias that energize and embed barriers (Silvers, 1998; Silvers & Stein, 2002; and see Areheart, 2008, for a recent example). This is not to say that the US version focuses on individual subjective states, any more than does its British forebear.

Ironically, at the same time (some) disability studies scholars are distancing themselves from the social model, medical professionals are drawing closer to it. An illustration is found in a recent Institute of Medicine (IOM) report. IOM followed up its 1991 and 1997 reports that designated disability as a pressing problem for

public health by publishing a third report, in 2007, on *The Future of Disability in America*. Not unexpectedly, the IOM report is suffused with ideas and values associated with the medical model. For example, extolling the effectiveness of medical technology to prevent or remedy disability, the report applauds the reduction of activity-limiting biological dysfunction in older adults over the last two decades but warns that increases in physical inactivity, diabetes and obesity in the same time frame place younger and middle-aged adults at growing risk of disability.

Of course, such sentiments lie uneasily, to say the least, with the social model's commitment to altering social arrangements to make them more welcoming to biologically anomalous people, and the social model's opposition to altering biological individuals to prevent or fix their anomalies. Nevertheless, by no means is *The Future of Disability in America* an exercise in application of the medical model, for IOM announced the report's findings with words that appear to embrace the social model:

Since IOM's previous reports in 1991 and 1997 that highlighted disability as a pressing public health issue, there has been growing recognition that disability is not inherent in individuals, but rather is the result of interactions between people and their physical and social environments. Many aspects of the environment contribute to limitations associated with disability—for example, inaccessible transportation systems and workplaces, restrictive health insurance policies, and telecommunications and computer technologies that do not consider people with vision, hearing, or other disabilities (Press release; see National Academies, 2007).

A further endorsement of the social model is added by Alan M. Jette, Ph.D., P.T., M.P.H., chair of the IOM's committee that produced the 2007 report: "Increasingly, scientific evidence reveals that disability results, in large part, from actions society and individuals take" (quoted in press release; see National Academies, 2007).

Which model of disability—medical or social—should shape thinking about disability's future in America? IOM's committee apparently saw no need to choose, an approach that may strike theoreticians immured in the debate between the models as question begging, while greeted by people to whom the debate has seemed peripheral as inspired. The discussion that follows here aims to illuminate the nature and purpose of creating models of disability, in order to see how the medical and social models of disability stand in relation to each other and whether there can be theoretical frameworks in which they coexist.

2.2 Models of Disability

Jette's mediating invocation of scientific confirmation as the basis for adopting the social model misunderstands what models are. Resolving the presumed conflict between the medical and social models is especially contentious because there is not nor can there be such a thing as a social model of disability. This concession does not gain much ground toward resolving whatever is in contention between the two accounts, however, for by the same token there can be no medical model of disability. Neither the ostensible medical model nor the so-called social model

actually models disability, nor could any other set of claims of a similar nature do so. Indeed, what an empirical representation of disability would be like is highly unclear.

A model is a standard, example, image, simplified representation, style, design, or pattern, often executed in miniature so that its components all are easy to discern. Neither the medical nor the social model presents a replica or representation of disability. Sometimes appeals to models of disability are meant to invoke a standard or paradigm for categorizing people as disabled for a particular purpose, such as to determine eligibility for social insurance scheme benefits or statutory protection against disability discrimination, or to determine ineligibility for social roles such as employment or responsibilities such as parenting. But if not intended to play such a gate-keeping function, what are the nature and the import of the claims that constitute the supposed models of disability and that now are widely believed to be in contention with each other?

Even if the sets of claims labeled as models of disability do not exemplify or otherwise represent disability as one would expect an illuminating model to do, they may serve other purposes for which we often turn to models. They can, for one thing, help determine what and consequently when disability is. That is, they can delineate a paradigm to which people can appeal in deciding who is disabled. They can, for another thing, help to explain why disability is. That is, having settled on an account of what disability is, these theories can contribute an account of how people come to be disabled.

Models of disability thus may be called upon to facilitate two different purposes, sometimes singularly but sometimes both at once. First, a model of disability may be used to characterize disability identity and sometimes also to determine who is eligible to assume this identity. Competing models of disability may propose quite different properties as the qualifying ones. For example, the medical and social models portray disability in very different ways, the former in terms of biological defect and the latter in terms of social victimization.

Second, a model of disability may be used to explain why individuals are disabled (or, more explicitly, why they have the limitations associated with disability). Competing models may propose quite different causal accounts, together with quite different proposals about how to intervene in the causal process. The medical and social models explain disability in different ways and call for different courses of action to address it. On the medical model, freeing individuals from biological dysfunction is the recommended approach to alleviate suffering from disability, while the social model proposes that freeing disabled people from stigmatization and exclusion offers the most effective relief from suffering.

Identifying the properties that make an individual one of the relevant kind is different from explaining how the individual came to have those properties. It follows that the plausibility and power of competing models of disability may diverge depending on whether their classificatory or their explanatory effectiveness is being assessed. Whether the “what” purpose or the “why” purpose of conceptualizing disability is more significant becomes crucial when we want to judge the social model and decide whether it is superior or inferior to the medical model. Weighing

the relative importance of the classificatory and explanatory roles requires a clearer notion of the circumstances in which people invoke the concept of disability

Identifying and disentangling from one another whatever discursive roles the social model of disability is used to play provides a better fix on what the social model of disability actually is, and thereby on the criteria by which to judge its adequacy. What the collection of claims that has become known as the social model of disability is supposed to do, and how well it satisfies the purpose(s) the social model is called on to achieve, will illuminate the relationship of the social model to the medical model (and to other so-called models of disability such as the moral model, the functional limitation model, and the minority model). The relative importance of the different roles, and how well the competing candidates can fulfill each of them, may cast light on which model should prevail.

2.3 The Concept of Disability: Classification

The idea that individuals with physical, sensory or cognitive impairments all together form a class of “the disabled” is a twentieth century invention. For in earlier times, classification was in terms of physical, sensory or cognitive condition. Persons were described as crippled or deaf or blind or mad or feebleminded, but only during the first part of the century was the term “disabled” introduced to characterize and collectivize them.

Disability as a concept originates in the context of the law, where it usually signifies a statutory incapacity or lack of legal qualification to do something. Someone with a legal disability suffers from an atypical or unusual or remarkable limitation that is legally imposed on her social participation, or at least is explicitly endorsed by the law. For example, prior to universal suffrage women had a disability in respect to exercising the franchise compared to men: they quite simply could not do so. Often, but by no means always, the legal limitations that constitute statutory disabilities are imposed because of supposed physical or mental inadequacies. Nineteenth century women were disabled in most places from voting, owning or managing their own property, and exercising custody over their own children because they were stereotyped as mentally feeble and physically frail. Analogously, during more than half of the twentieth century in the U.S., deaf people and blind people were prohibited from holding civil service jobs because they were stereotyped as inferior workers.

In contemporary Western culture, to be disabled is to be disadvantaged regardless of how much success one achieves individually. This is the generic implication of applying the term “disability” and its cognates and translations to label the group of biologically anomalous people whom we think of as being disabled. The idea of “disability” now is associated with physical or mental differences that compromise people’s liberty to achieve typical levels of success in one or more areas of social participation, whether the relevant activities are learning, communicating, mobilizing, communicating, being employed or some other important productive activity. The key phenomenon that informs this idea is the experience of disabled people’s being more limited than other people in one or more seemingly important respects.

Models of disability are invoked to identify the relevant kinds of limitations and to explain why these limitations occur.

Today, being physically, perceptually or cognitively impaired is categorically identified with disability, so much so that persons in very different conditions, with very different degrees of personal physical, sensory or cognitive limitation, and with quite disparate levels of socially significant achievement, are all referred to as “disabled.” Some social model adherents have wanted to draw a sharp line between impairment and disability, thinking of impairment as natural, because biological, fact, in contrast to disability, an artificial social classification. There is nothing about social model theory, however, that entails or otherwise calls for this dichotomization.

Indeed, impairment itself has no fixed standard. What counts as being physically, perceptually or cognitively impaired is relative to the powers and limitations that are taken to be typical either of the species or of those members of the species who belong to a particular society or a prominent social group. What counts as being physically, perceptually or cognitively disabled is relative to how unusual a limitation is presumed to be. Being unable to fly is a species-typical human limitation that no one supposes to be a disability, although an eagle with such a limitation would be considered to be impaired.

2.4 The Concept of Disability: Limitation

Contemporaries’ descriptions of seventeenth and eighteenth century people do not apply our categories of impairment and disability, although they do sometimes refer in detail to biological peculiarities or ill health. Perhaps because they were so much more common, expected and accepted then than they are today, illnesses, injuries, and syndromes (and their sequelae) that now place people in the disability group used not to render individuals socially unfit or invisible, that is, excluded on the basis of their biological anomalies. Biological conditions that since the nineteenth century have been subjected to therapeutic intervention or eugenic control were in earlier times accepted as common features of ordinary life, rather than as exceptional limitations.

The example of Samuel Johnson, who was the subject of replete writing by his friends, is a well-known illustration. Dr. Johnson was blind in one eye, had limited vision in the other, was deaf in one ear, was badly pock-marked, picked compulsively at his skin, suffered from spasticity or palsy and later in life from severe arthritis, and seems sometimes to have been so depressed as to remain bedridden (Boswell, 1934–1950, I: 485; Bate, 1978, *passim*; Thrall, 1984, p. 5). Nevertheless, as literary scholar Lennard Davis observes, “his contemporaries refer to his disabilities only in a casual and literary manner—tending to see him as a brilliant man who had some oddities rather than a seriously disabled person” (Davis, 2002, p. 49, and pp. 47–66, *passim*).

The initial expansion of the usage of the term “disability” to refer to physical, sensory and mental limitations appeared to move it from the political to the biological realm. What prompted the move was need for a terminology to refer to

groups of individuals who, despite very different kinds of limitations, had been made eligible by statute for various kinds of benefits, such as compensation because their limitations resulted from injury during military service or supplementary income because their limitations predicted or justified their exclusion from the workplace. This extended application of the term afforded physicians considerable involvement in a gate-keeping role, delineating eligibility criteria for public and private disability insurance and social welfare schemes (Bickenbach, 1993, pp. 75–76). Because such benefits compensate for work limitations, not for being ill or injured *per se*, physicians have been tasked not only with diagnosing medical conditions but also with interpreting how limiting such conditions will be in workplace situations, despite their lack of expertise about all the ways to accomplish different kinds of work.

Yet both the amount of litigation over who actually is disabled, and the rapid growth of U.S. disability rolls (and those of many other Western nations) during the 1980s (when many kinds of diminished or inappropriate performances were medicalized), suggest the indeterminateness of biological evidence of disability. Compromised competence resulting from a biological anomaly—not the biological anomaly *per se*—is supposed to occasion the attribution of disability. And correlations between medically designated pathologies and limitations in competence are by no means reliable or firm (Stone, 1984, pp. 116–117, 128). These considerations suggest why it is problematic to identify biological anomalies as disabilities.

Further, the influence of environment on achievement, and therefore on impediments to achievement, is well-known. The ability of blind and visually impaired individuals to access inscribed information is a striking illustration of how environment affects functional limitation. When DOS was the predominant computer operating system, many blind and visually impaired people, using devices for reading the screen text aloud, embarked on careers that depended on the use of computer applications. Computers opened new avenues of productivity for people who previously could not access inscribed information absent specialized translations of the material and their own skill in reading Braille. But when the Windows program was marketed so aggressively that it eventually superseded DOS, Microsoft, claiming that business necessity demanded secrecy, refused to provide the computer codes for Windows to the specialized companies that developed voice output software. More and more applications ran only under Windows, and consequently blind and visually impaired individuals found themselves unable to perform the computer tasks essential to their jobs.

The environment thus affects the extent to which unusually limited vision functionally reduces access to acquiring and conveying important information. Small changes in common practice can have widespread and rapid effects. This writer first used the example of the limiting impact of Microsoft's domination of the software market on blind and visually impaired people in a book published slightly more than a decade ago (Silvers, 1998, pp. 107–110). The prognosis at that time threatened an outcome for blind and visually impaired people similar to what the telephone had imposed on deaf and hearing impaired people a century earlier. Despite having been invented during a project to improve communication access for deaf people, the

introduction of the telephone proved disastrous because individuals who could not use it became extraordinarily limited in regard to functional communication in the workplace.

Fortunately, the Windows story has had a diametrically different conclusion. A political environment beginning to be reshaped by the social model of disability exhibited heightened commitment to equal opportunity for disabled people. Consequently, the organized campaigns of disability activists to make Windows-based programs accessible eventually elicited positive response when proprietary codes were made available to designers of adaptive software. Today blind and visually impaired people (and learning disabled people as well) can use technology that reads visually displayed texts out loud to access much of the information that is transmitted in electronic form. Indeed, we are moving toward a time when it is more accurate to talk about people being hard copy disabled rather than text disabled, a less disadvantageous limitation.

There are more reasons to believe that people's medical conditions underdetermine their functional limitations. To illustrate, individuals with identical prelingual hearing losses vary markedly in their ability to understand (usually by lip-reading), and be understood, through speaking. In the same vein, individuals with apparently identical muscular or nerve impairments differ in whether they can grasp, lift, stand, walk. There is a vast range of print-intensive occupations in which some people with dyslexia succeed while others with the same diagnosis fail, and this was equally the case prior to the medicalization and treatment of learning disabilities. These examples suggest that the limitations of or constraints on acting freely that disability is presumed to impose call for more expansive or more nuanced explanation than medical diagnoses of biological conditions usually provide. The superficiality of the biological account of why disability impinges on people's liberty suggests that this kind of model will not prompt the most propitious strategies for making their lives better.

Modeling disability in biological terms appears unable to account sufficiently for differences in the freedom of disabled and nondisabled people but especially for the reasons why the opportunities accessible to the former group usually are so limited. All models of disability seek to elucidate why individuals categorized as disabled are, in one or another way, unusually limited, and also, by explaining the reason(s) for these limitations, to show how individuals categorized as disabled can be less limited. But the explanatory power of the biological model is confounded by a multitude of cases in which the markedly different levels of achievement (and different degrees of suffering, as well) of individuals with identical biological conditions appear attributable to differences in how the individuals are socially situated.

2.5 Limitation and Political Action

The medical model elucidates disabled people's limitations in terms of biological pathology. This explanation makes medical intervention the route through which to address disabled people's limitations. If medicine can make them like other

people—that is, cure them—the physical and intellectual barriers they encounter and that limit them will be no greater than what keeps the majority of people from being fully free.

The medical model treats the built and arranged environment as an invariable to which humans have no choice but to adjust. But it clearly is human to manipulate and alter our environment. We, through our social processes, fashion the built environment, which can be hostile or welcoming depending on how inclusively thoughtful public standards are. We, or at least the preeminent ones among us, also influence the organization of the dominant cooperative scheme which structures communication, citizenship, reciprocal contributions through work and civic duties, allocation of resources, and the other transactional processes of our social environment.

While the medical model presumes that disabilities are, fundamentally, deficits of natural assets rather than of social assets, the social model presumes exactly the opposite. And if disability is due to the disadvantageous arrangement of social assets that should be equitably accessible to everyone alike, social reform is at least as appropriate a vehicle as personal restoration for remedying the disadvantage disability brings. This was the message that, half a century ago during the era in which great improvement was gained in civil rights, began to be circulated by disabled people themselves, especially those who wrote about disability.

In 1966, Paul Hunt published an essay called “A Critical Condition” in a volume called *Stigma: The Experience of Disability*. (U.S. sociologist Erving Goffman’s *Stigma: Notes on the Management of Spoiled Identity*, which made some of the same points but in a more abstract way, had been published three years earlier.) The thesis of this essay is widely accepted as the precursor of the social model. Hunt, a Briton with muscular dystrophy, had resided in institutions since beginning to use a wheelchair at age thirteen. His essay articulated what was then a radical view, namely, that what most limited people with disabilities was their segregation and the resulting social isolation.

Hunt attributed their social disadvantage not to their biological conditions preventing them from executing valuable social roles, but instead to their being the victims of socially embedded caricaturing that dismissed them as unfortunate, useless, different, oppressed, and sick. In other words, he analyzed their disadvantage as being of the same kind as that imposed on the victims of race-based and sex-based discrimination. Goffman was mainly interested in describing the psychological and sociological compliance in which disabled people engaged to survive in society despite such prejudice. Hunt, on the other hand, crafted a compelling, nuanced call for disabled people themselves to hold a moral mirror up to the nondisabled majority as a step toward liberating themselves from that same oppression.

A decade later, the British Union of the Physically Impaired Against Segregation developed an account of disability derived from Hunt’s theme. In 1978 UPIAS proclaimed disability to be the disadvantage or restriction of activity caused by a contemporary social organization which takes little or no account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities (UPIAS, 1978; Finkelstein, 1980; see also Barton, 1989

and Bynoe, Oliver, and Barnes, 1991). As its name suggests, UPIAS members saw their situation as an analogue to that of people of color such as black Africans suffering apartheid in South Africa. At that time, in the United Kingdom, the United States, and elsewhere, disabled people were often kept in charitable or state-run institutions regardless of their age, denied basic freedom to travel, to acquire a public education, and to pursue other opportunities their fellow citizens enjoyed.

In 1983 a research perspective was added when sociologist Mike Oliver, also an individual with a disability, labeled the ideas that lay behind the UPIAS definition as the social model of disability (Oliver, 1983). The social model removed individuals with disabilities from the role of dependent patient and recast them as independent citizens with rights which, when acknowledged, should eliminate the social disadvantages that are attendant upon their being a minority. From a health care ethics perspective, this transformation lines up with the evolution from paternalistic decision-making by professionals for patients to autonomous decision-making by patients themselves that prevailed during the same decades at the end of the twentieth century. Understanding that the burdens of exclusion and discrimination they bear arise from the defects of a biased environment rather than from personal deficits prompts both personal and political progress for people with disabilities.

The limitations associated with disability often are imposed or exacerbated by alterable cultural artifacts and arrangements. The social model uses this insight to trace the source of disabled people's disadvantage to a hostile environment and treats the dysfunction attendant on impairment as in great part artificial and remediable, rather than thoroughly natural and immutable. Thus the social model transforms the notion of handicapping condition from a state of a minority of people that disadvantages them in society to a state of society that disadvantages a minority of people. Their environment is inimical to them because in respect to almost all social venues and institutions, people with disabilities are neither numerous nor noticeable.

There are several compelling reasons why the social model is embraced by disabled people, and especially by disability activists and disability studies scholars. For one thing, the social model accords with disabled people's own experiences of the different effects of accessible and inaccessible environments on their lives. Whether they can execute the activities needed for daily life with the nonchalance other people enjoy, or whether even the most ordinary endeavors require a struggle to achieve, often is a matter of whether the organized environment acknowledges or ignores their existence.

From the standpoint of persons mobilizing in wheelchairs, for example, disablement is predominantly experienced not as the absence of walking but as the absence of access to bathrooms, theaters, transportation, the workplace, medical services and educational programs—all those opportunities citizens who can walk are at liberty to use. If the majority of people, instead of just a few, wheeled rather than walked, graceful spiral ramps instead of jarringly angular staircases would connect lower to upper floors of buildings. The wheelchair-using person who, in the course of a day of fulfilling responsibilities, must absorb the disruption of dealing with an insurmountable flight of stairs or an uncut curb, finds daily life to have a completely

different texture in an environment where s/he can concentrate on ordinary work or play as other people do free of fear of encountering mobility barriers.

Were the existence of vision-impaired individuals afforded greater regard, information would not be conveyed in a format accessible only to the sighted. Tactile and aural modes of recording and conveying information would be used as frequently as printed texts. Today, electronically-inscribed information usually can be fashioned for speech as well as text output—that is, made to be heard as well as seen. In the past decade, to take just one illustration, dedicated political work by the blind and visually impaired communities has persuaded banks across the U.S. to install talking ATM machines. The social model accords with such experiences of the difference between respectfully and negligently organized environments and their impact on how freely the minority of disabled people can participate in the activities of daily life.

Suppose most people were deaf. Closed-captioning would always have been open and would have been the standard for television manufacture in the U.S. long before July 1, 1993. The 1990 Television Decoder Circuitry Act established the principle that for-profit makers of components required for public broadcasting have a responsibility to include deaf and hard-of-hearing citizens in the market segment they serve. In this case also, political work aimed at securing organizational recognition vastly increased the liberty of deaf and hard of hearing people to access important components of the social environment.

Parenthetically, in a footnote to an essay entitled “What Good Is the Social Model of Disability?” legal scholar Adam Samaha takes this line of argument (Samaha, 2007), which I have called “historical counterfactualizing” (Silvers, 1998, pp. 74–75), to be a political argument, requiring justification for the claim that the interests of disabled people who form a majority would or should prevail. Disabled people could be more numerous than other kinds of people and yet be incapable or undeserving of having their needs take priority. But historical counterfactualization is a thought experiment, not a political argument. Imagining most people to be situated as people in wheelchairs are—i.e., unable to access buildings that must be entered by stairs—it is easy to see that designing entrances with stairs would be pointless, as the resulting buildings would remain mostly empty. Historical counterfactualizing simply tests various exclusionary social arrangements to see whether something more than convenience for the majority accounts for those arrangements.

People with schizophrenia now are thought to be individuals with physiological impairments “that make them especially vulnerable to emotional stress... often from dealing with other people (which) can . . . spiral down into psychosis” (Grady, 1998, p. B17). Were the concern to maintain such individuals’ productivity paramount, we would promote practices to reduce anxiety in interpersonal transactions instead of accepting—indeed, even admiring—the behavior of those who place stress on others while avoiding it themselves. Promoting supportive ways of relating to each other would acknowledge this dimension of neurological difference among people and make cooperative activities more accessible to more people by freeing those impeded by their reactions to adversarial practices to participate.

In sum, by explaining disabled people's limitations in terms of conditions that are subject to political action, the social model has empowered disabled people to achieve more freedom of social participation. A powerful reason for embracing it, therefore, is the proof provided by the improvements political action informed by the social model have made in shrinking the limitations disabled people experience in their lives. And as far as this reason goes, any incompatibility between the social and medical models is merely contingent and strategic. For neither model denies that both biological and social conditions contribute to disablement.

The decision about whether it is preferable to attempt to adjust environments to individuals' differences, or instead to alter the individuals so they more closely approximate the typical person for whom constructed environments usually are made, is to some extent a practical one. But it also is a matter of who is valued, which leads back to the question of what disability is. The social model explicitly explains why people with certain biological conditions may have less liberty than others, and the explanation is confirmed by disability activists' success in gaining liberty by pursuing political action to remove barriers in the architectural and technological environment. But simply understanding that inaccessible environments keep disabled people far away, or locked away, prompts no political reform unless value is placed on promoting social and economic inclusiveness.

2.6 Limitation and Disability Identity

Does the social model also adequately identify what disability is in terms that both those who are disabled and those who are not can embrace?

The social model ushers in an account of what disability is that is at odds with basic conceptions of medical ideology. Physical, perceptual and mental anomalies are not treated as flaws but instead as neutral human variations. The social model strengthens disabled people's positive sense of their own identities by refusing to measure them on scales calibrated to the typical human. On a standard constructed to make such normality the measure of man (and of woman), as the medical model does, disability inevitably falls short and therefore falls into the realm of the pathological (in contrast to being normal) or aberrant or "special" (in contrast to being ordinary).

In contrast, the social model aspires to employ a neutral concept of disability (Silvers, 2003). The anomalies that count as pathological on the medical model are portrayed by the social model in neutral terms as human variations. Such variations sometimes mean that the individual can function, but in a different mode. Thus, people who cannot walk mobilize on wheels, people who cannot hear use their hands to talk, and people who hear voices when there is no other person there have various strategies, as well as pharmaceuticals, for not responding to the voices.

Whether such alternative modes of functioning are available, and whether they succeed, depends on whether the environment fits the individual's adaptive abilities. Sometimes only tolerance of a different way of doing things is needed. For

example, including a skilled lip reader in a spoken conversation often calls for no more than other participants' courteously facing the hearing impaired individual when they speak and making sure that hand gestures or shadows do not obscure the view of their lips. Sometimes the alternative mode of functioning requires the products of highly technological environments. For example, people with missing limbs will mobilize and manipulate successfully in an environment that can supply bionic prosthetics, and people with hearing loss will understand broadcast communications successfully in an environment where captioning devices are in common use. But sometimes the alternative mode finds more welcome in a non-technological society. For example, mild mental retardation that is dysfunctional in a highly technological society often is not even noticed in a subsistence farming community. And the person who lip reads instead of hearing clearly will communicate more successfully in a business environment like that which existed before the invention of the telephone, as well as that which now exists after the invention of email, than when commercial communication was conducted mainly by phone. Sometimes what is most important is acknowledgement of a disabled person's potential functionality. For example, 40 years ago no one with Down Syndrome could read or drive because the mistaken belief that they could not do so meant that no one bothered to teach them how, but now many such individuals do so, following upon legal mandates that they be provided with an equitable public education.

Sometimes, of course, biological anomaly results in inescapable dysfunction, either because the individual has no alternative mode of functioning or because the environment is not accepting of one. This being so, does the social model's strategy of distancing disability from dysfunction suppress what is most salient about disability in these cases, namely, that it is regrettable, or a harm? Common sense may prompt us to deny that disability can be a neutral idea, for it seems obviously preferable not to be disabled. Consequently, it is tempting to dismiss social model advocates as being in denial.

Of course, we cannot infer from our sense of one condition's being less preferable than some others that it also is inherently bad. We often prefer someone else's condition to our own—someone richer, smarter, handsomer, or more generous than ourselves—without condemning our own state as bad. Indeed, being dissatisfied with ourselves just because there are others who seem to us more fortunate is a recipe for unhappiness. So the fact that not being disabled may be preferable to being disabled does not entail that the state of being disabled is bad.

The social model counsels the acceptance of disability as being a natural state of some people, just as having a squarish shaped face, being five and a half feet tall, and remembering in pictures rather than in words are natural states of some people. Medical technology can be applied to alter each of these, but the cost, risk, and probability of failure in each case are disincentives to doing so. Even if disability is itself a neutral concept, however, any analysis of disability identity should address the relationship between disability and health.

Susan Wendell (2001) considers the ways in which people she calls the unhealthy disabled are different from the healthy disabled (Wendell, 2001, p. 19). The latter have relatively stable limitations, while fluctuations of limitation for those in the

former category mean that their disabilities are not as easily understood. Sometimes they must endure other people's suspicion that they are not really disabled (Wendell, 2001, p. 21).

Like disability, illness should be a neutral category, according to Wendell. Illness is not evil in itself, but it causes suffering, which is evil (Wendell, 2001, p. 30). Some of the suffering that accompanies illness might be alleviated by improving social justice, but not all. Whereas healthy disabled people seek freedom from being confined to the "sick role," unhealthy disabled people may desire another kind of liberty, the freedom to dwell on their illnesses.

The feminist disability activist Jenny Morris describes what stands in the way of such freedom: "It is difficult. . . and dangerous because, to articulate any negative feelings about our experience of our bodies may be to play into the hands of those who feel that our lives are not worth living. We share a lot with other civil rights movements, but our form of oppression has a unique characteristic: it is not inherently distressing to be Black or a woman or gay, while it may be to experience an impairment. . . . But to deny the distressing nature of the body's experience of arthritis or epilepsy, for example, would be foolish" (Morris, 2001, p. 9; see also Morris, 1991, *passim*).

In Morris's experience, acknowledgement that one's health state is incurably defective is imprudent to express: "Sensory impairment, motor impairment, intellectual impairments are seen as things to be avoided at all costs. In the face of this prejudice it is very important to assert that anatomy is not destiny and that it is instead the disabling barriers 'out there' which determine the quality of our lives. . . . Indeed, I worry myself that if we do start talking about the negative aspects of living with impairment and illness, non-disabled people will turn around and say, 'there you are then, we always knew that your lives weren't worth living'" (Morris, 2001, p. 10).

"As long as non-disabled people retain the power to represent our reality," Morris says, "impairment will always mean at best a cause for treatment and cure, at worst a life not worth living. . . . It is this approach which leads to segregation and exclusion—and ultimately to the assumption that our lives are not worth living and that we would be better off dead, or not being born in the first place" (Morris, 2001, p. 3).

A somewhat less dramatic, but no less telling, argument along the same line may be found in analyses of how individuals with disabilities have been treated by U.S. courts in regard to the protection from employment discrimination promised by Title I of the Americans with Disabilities Act (ADA). Courts have tended to suppose that individuals who have been able to work successfully despite a biological or psychological impairment are insufficiently disabled to merit protection under the ADA, even when an employer's refusal to accommodate (for instance, to permit the employee continued access to an indoor parking lot with an elevator) prevents the individual from continuing in the job. On the other hand, courts (sometimes the same court) also have tended to hold that individuals who have not worked successfully where employers refuse accommodation are too disabled to be qualified for the job (Silvers, 1998; Pendo, 2002; Rovner, 2004; Areheart, 2008).

One conceptual response to these often repeated concerns has been to try to drive a theoretical wedge between impairments and people with impairments. The claim is that to abhor impairment is not to abhor people whose bodies or minds are impaired. But this strategy is far from reassuring, for impairments do not have abstract or disembodied existence, and negativity about an illness (or even a potential illness) easily transfers to negativity about people with that illness. For instance, in *Chevron USA, Inc. v. Echazabal* (2002) [00-1406], the U.S. Supreme Court ruled that an oil refinery could put an individual who long had tested positive for Hepatitis C out of work based on his potential for illness, even though he had been in the job and working successfully for over a quarter century without being symptomatic of either hepatitis or liver toxicity and with no unusual absences or other burdens placed on his employers or fellow workers (Silvers, 2005, 2007).

2.7 Can the Social and Medical Models Meet? Shake Hands? Connect?

Modeling disability in the ways both the medical and social models do mixes classificatory and explanatory discourse. This observation suggests where the models can be compatible, and also where they cannot. As we shall see, it is where explanation feeds action, and especially where explanatory theory translates into policy, that decisions granting exclusivity to one or another model have been, and perhaps must, be made.

Different systems of classification may focus on different features of their subjects, with the same individual being described in thoroughly different ways. Thus, for example, the same person may be accurately characterized as being both (socially) productive and (biologically) pathological. There is no logical conflict between these classifications, for we can conceive of people being socially productive despite being biologically ill or impaired, just as healthy but nonproductive people are conceivable. Nevertheless, challenging empirical disconnects and contentiousness between properties from different classificatory schemes may emerge or be fashioned. These sometimes occasion and sometimes even necessitate our making choices about which way(s) of classifying subjects to adopt.

Statistically, the correlation between the property of being socially productive and the property of being biologically anomalous may be weaker than holds for the productivity of biologically species-typical people, for example. That is to say, as a group, counting in all types of anomalies from the innocuous to the devastating, biologically anomalous people may be less productive along one, some, or all dimensions of productivity valued by a society than species-typical people are. When over-general and under-determined claims of this sort capture the public consciousness, policy tends to be adopted to drive the pathological and the productive further apart (than they actually are or need be), as for example, when the U.S. government adopted regulations that categorically excluded deaf and blind people from civil service jobs. Such background facts propel choices between modes of classification.

Historically, the contextual factors mentioned combined to place a premium on sorting people into or out of the workforce. Their salience promoted thinking about people solely or predominantly in terms of being normal or pathological. Classifying individuals in this way was a handy surrogate for designating them as “employable” or “nonemployable.” Thus, because the social importance of work identities was so strong, the biological distinction between normal and pathological became a fundamental term in thinking about people in general.

And because the benefits of having a vigorous work identity were so conspicuous, explanations of how individuals came to fall into the pathological category issued in actions aimed at qualifying them for reclassification into the normal category, namely, at promoting programs for action aimed at reconfiguring individuals through the usual interventions into human biology—that is, at medical treatment through pharmaceuticals, prosthetics, surgery and rehabilitation. The medical model therefore is no representation of disability. Rather, it is a program for altering the numbers of people represented in the different categories of a classification scheme linked to the value of work.

To the extent that values other than work capability—for instance, liberty or security or happiness—evolve in preeminence, other systems of classification, together with programs enabling individuals to move from one category to another within them, will emerge. Liberty was the value that, at least initially, inspired the development of the social model, with its fundamental classification of people as institutionalized and therefore lacking liberty, or as living in the community and thereby free. In line with the analysis of the medical model advanced in the preceding paragraph, the social model thus can be understood as a program for altering the numbers of people in the different categories of a classification scheme linked to the value of liberty. Parenthetically, there is no more powerful example of a liberty driven disability program than the arguments for shifting the representation of disabled people from some legal categories to others advanced in the classic disability rights article by Jacobus tenBroek, “The Right to Live in the World: The Disabled in the Law of Torts” (tenBroek, 1966).

In a pluralistic society, we should expect that different models of disability will be appropriate to realize different values, and that these will be as compatible, or as antithetical, as the values they serve. Contentiousness between models generally can be traced to tension between values—for example, to the tenuous balance between security and liberty that must be maintained when a classification scheme incorporating categories of dependence and independence is invoked in modeling disability, as (for example) in some feminist care theory approaches to disability. As these are contests among values, we cannot expect science to confirm or disconfirm any model of disability, although weighing empirical evidence and attending to experience undoubtedly are important in considering the adequacy of any such model. Evidence and experience clearly contribute, along with values, to the process of setting a familiar model off to the side so as to think of disability in terms previously not conceived or supposed to be inconceivable. For a pluralistic society, many models of disability are better than one.

A caveat is called for here, however, for the corollary of the principle just articulated is not that any model will do, nor will any argument for appealing to or rejecting a model do. To illustrate, the importance of health care for the population as a whole has been offered as a reason for maintaining the medical model of disability against the social model. For the social model is feared to divert funding away from the health care system—for if disability is a property of environments rather than of people populating those environments, then resources directed at these people's health will be irrelevant to disability. If, as the social model suggests, people with biological anomalies, even with dysfunctional ones, can accept these and flourish, if only their environment can be made more welcoming, the calculation of benefit to risk in medical interventions to prevent or repair biological deficits may change, with a concomitant diversion of resources away from healthcare, and especially away from programs preventative of disability.

While there may be some merit to this worry from the general population's point of view, models of disability should not be adopted to further the interests of nondisabled people alone, or even predominantly. A basic question to answer before relying on any classificatory or explanatory scheme is about what interests the particular way of thinking serves. In their ways, and in their times, both the medical and the social models of disability have been welcomed as progressive. Each now may create more concerns than benefits because the interests they have come to serve have grown murky, or at least unclear.

The welcome news after half a century is that the social model's entrenchment may be approaching the medical model's—especially if the medical community is beginning to come on board, thereby achieving a practical balance between adjusting diverse people and uniform environments to one another. The challenging news is that the philosophical struggle to align the fundamental values of which these two models are expressions is nowhere near as close to achieving accommodation or resolution. The most exciting news, however, is that people with disabilities appear to become less and less marginalized when philosophical investigation of these values in the context of medical ethics and health care justice take place. Pursuing such theoretical exploration rigorously but not dismissively helps purge both medical and political understandings of disability of long ignored flaws caused by biased ideas and oversimplified or simply false claims of facts.

References

- Areheart, B. (2008). When disability isn't "just right": The entrenchment of the medical model and the Goldilocks dilemma. *Indiana Law Journal*, 83, 181–232.
- Barton, L. (1989). *Disability and dependence*. Lewes: Faimer Press.
- Bate, W. J. (1978). *Samuel Johnson*. New York: Harcourt Brace Jovanovich.
- Bickenbach, J. (1993). *Physical disability and social policy*. Toronto: University of Toronto Press.
- Boswell, J. (1934–1950). *Life of Samuel Johnson* (G. B. Hill, Eds.; Rev. L. F. Powell). Oxford: Clarendon Press.
- Bynoe, I., Oliver, M., & Barnes, C. (Eds.). (1991). *Equal rights and disabled people: The case for a new law*. London: Institute of Public Policy Research.

- Chevron USA, Inc. v. Echazabal. (2002). U.S. Supreme Court 00-1406.
- Crow, L. (1996). Including all of our lives: Renewing the social model of disability. In J. Morris (Ed.), *Encounters with strangers: Feminism and disability* (pp. 206–222). London: Women's Press.
- Davis, L. (2002). *Bending over backwards: Disability, dismodernism & other difficult positions*. New York: NYU Press.
- Finkelstein, V. (1980). *Attitudes and disabled people*. Geneva: World Health Organisation.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York: Simon & Schuster, Inc.
- Grady, D. (1998). Studies of schizophrenia indicate psychotherapy. *NY Times* (Tuesday, January 20, B17).
- Hunt, P. (Ed.). (1966). *Stigma: The experience of disability*. London: Geoffrey Chapman.
- Morris, J. (1991). *Pride against prejudice: Transforming attitudes to disability*. London: The Women's Press.
- Morris, J. (2001). Impairment and disability: constructing an ethics of care that promotes human rights. *Hypatia*, 16(4), 1–16.
- National Academies. (2007). *Outdated policies are impediment for Americans with disabilities; Report recommends ways to remove barriers to care, assistive services*. Available at <http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=04242007>
- Oliver, M. (1983). *Social work with disabled people*. London: Macmillan.
- Pendo, E. (2002). Disability, doctors and dollars: Distinguishing the three faces of reasonable accommodations. *Disability, Doctors and Dollars*, 35 U.C. Davis L. Rev. 1175, 1191.
- Rovner, L. L. (2004). Disability, equality and identity. *Disability, Equality, and Identity*, 55 ALA. L. Rev. 1043.
- Samaha, A. (2007). *What good is the social model of disability?* 74 U CHI. L. Rev. 1251, 1257. Working Paper 166, Public Law and Legal Theory Working Papers, University of Chicago Law School. Available at http://lawreview.uchicago.edu/issues/archive/v74/74_4/Samaha.pdf
- Scully, J. L. (2008). *Disability bioethics: Moral bodies, moral difference*. Lanham, Maryland: Rowman and Littlefield.
- Silvers, A. (1998). Formal justice. In A. Silvers, D. Wasserman, & M. Mahowald (Eds.), *Disability, difference, discrimination: Perspectives on justice in bioethics and public policy* (pp. 13–145). Lanham, Maryland: Rowman and Littlefield.
- Silvers, A. (2003). On the possibility and desirability of constructing a neutral conception of disability. *Theoretical Medicine and Bioethics*, 25(6), 471–487.
- Silvers, A. (2005, Winter). Protection or privilege? Reasonable accommodation, reverse discrimination, and the fair costs of repairing recognition for disabled people in the workforce. *The Journal of Gender, Race and Justice: A Journal of the University of Iowa College of Law*, 34, 561–594.
- Silvers, A. (2007). Predictive genetic testing: Congruence of disability insurers' interests with the public interest. *Journal of Law, Medicine and Ethics*, 35(2), 52–58.
- Silvers, A., & Stein, M. (2002). *Disability, equal protection, and the Supreme Court: Standing at the crossroads of progressive and retrogressive logic in constitutional classification*, 35 U. Mich. J.L. Reform 81.
- tenBroek, J. (1966). The right to live in the world: The disabled in the law of torts. *California Law Review*, 54 CAL. L. Rev. 841, 858).
- Stone, D. (1984). *The disabled state*. Philadelphia: Temple University Press.
- Thrale, H. (1984). *Dr. Johnson by Mrs. Thrale: The "Anecdotes" Mrs. Piozzi in their original form* (R. Ingrams, Ed.). London: Chatto and Windus.
- Union of the Physically Impaired Against Segregation (UPIAS) and the Disability Alliance. (1978). *Fundamental principles of disability*. Available at <http://www.leeds.ac.uk/disability-studies/archivuek/UPIAS/fundamental%20principles.pdf>
- Wendell, S. (2001). Unhealthy disabled: Treating chronic illnesses as disabilities. *Hypatia*, 16(4), 17–33.