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IMPAIRMENT AND DISABILITY: CONCEPTS AND MODELS

Abstract

The paper briefly examines some of the major issues in defining disability, through the differences between impairment and disability (biological origins of dysfunction and social circumstances of limitation), the different approaches to disability (various treatments of disability depending on context, the scope of the treatment of disability, etc.), and the main models of disability (the medical model and the social model, some variations of the social model, such as the minority group model and human variation model, etc). The basic characteristics and implications of the medical and of the social model of disability are shown, along with several other problems of understanding, accommodating, and discussing disability.

Key words: disability, social model, medical model, impairment, variation

Framing disability

Disability may be defined as a lack of function, or a biological dysfunction, or an impairment that may be physical, developmental, cognitive, intellectual, mental, psychological, sensory, or combined, and as a societal disadvantage connected to (or arising from) the biological impairment(s). In this text some concepts about disability will be briefly outlined, and the question of the different models of disability will be tackled mostly through the differences between the medical and the social model.

According to the so-called medical model of disability, the lack of function (or dysfunction) is caused by some health impairment; according to the so-called social model of disability, the lack of function is caused by the social environment of the person with impairment(s). It seems common to view the medical model (with the belief that disability is caused by physical impairments), and the social model (with the belief that disability is caused by and exteriorised in social circumstances), as in a relation of exclusive disjunction. Of course, an integrative (but not necessarily neutral) position would allow for disability to be caused

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by both biological and societal causes, and could also include some other factors. According to the medical model, disability is a problem typical for (and limited to) the disabled person, and according to the social model, disability is not merely a physical issue pertaining to the individual who has that issue, for it is society that makes the individual disabled. In very simplified terms, while the medical model, through the efforts of medicine, biotechnology etc. aims to improve the condition and well-being of the disabled person, but is not concerned with much beyond these aspects, the social model highlights the ways in which society disadvantages persons with disabilities, and works on ways to reduce and even eliminate disabling obstacles. The biomedical perception of disability, as part of the medical model, links disability to the physical body (or the mind and the body) of the disabled individual, which reduces that individual's quality of life, and aims to medically intervene in order to correct or diminish the (effects of the) disability, it focuses on the medical management or cure of the disability (or illness), by striving to increase, expand and improve the functionality and quality of life of the disabled person. The social model of disability has started as a response to the dominant medical model, and identifies society as a main factor in disabling people with impairments, though negligence, systemic barriers, various negative attitudes and obstacles, exclusion and stigmatisation of disabled persons. The physical variations (developmental, cognitive, intellectual, sensory, etc.) which are considered impairments, would not constitute disability on their own, they only lead to disability within society that underachieves in accommodating people with disabilities.²³⁶

Disability is an umbrella term, covering impairments (problems in body function or structure), activity limitations (difficulties and obstacles experienced by an individual while attempting to execute some action/task), participation restrictions (problems encountered during the involvement in life situations), and various combinations of these categories. Disability is not just a health problem, according to the World Health Organisation (WHO), but a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which that person lives (WHO, n. d.).

Disability is a contested concept, whose meanings (and approaches to whom) vary in different communities (Linton, 1998) and disciplines. The *International*

²³⁶ As basic as this illustration seems – if a person is in a wheelchair, and cannot climb the stairs at the entrance of a building because of the physical handicap, the medical model would point out that they cannot climb stairs because of the medical condition (due to *X* reasons, and manageable with *X* means), and the use of a wheelchair, and the social model will focus not on the physical lack of function, but on the fact that the building is inaccessible, which should be remedied by constructing other ways to enter it, fit to accommodate the needs of disabled individuals unable to climb stairs.

Classification of Functioning, Disability and Health (ICF), is WHO's framework for measuring health and disability on individual and population levels. This framework has been developed through a collaborative international approach towards a generic instrument for assessing health status and disability across various settings, different cultures and contexts. Within it, disability is defined as a condition or function judged to be significantly impaired, relative to the usual standard of an individual or group. Therefore, the term may refer to individual functioning, including physical, sensory, cognitive or intellectual impairment, mental illness, and various types of chronic disease.²³⁷ Disability is a universal human condition (Zola, 1989) which means that there is a probability that anyone might acquire familiar disabilities in the course of a lifetime, or at least that the specific physical and mental characteristics (variations) in humans might, at some point, be a source of vulnerability in certain contexts; it is a shared human identity (Davis, 2002, Ch. 1), in the sense that disadvantages and impediments are possible for anyone in a certain setting.

Disability is a multidimensional experience for the person involved, and the ICF recognises three dimensions: body structure and function (and impairment thereof), activity (and activity restrictions), and participation (and participation restrictions). People with disability experience "restrictions of activity", as obstacles affecting what people can do (like the inability to go places, participate in activities, partake in the world of discourse etc.), and suffer the psycho-emotional dimensions of who they can be (these are often in a reciprocal causal relation – what a person can do affects who they can be; who they are influences the range of things they can do etc.).

As a concept, or a term referring to the shared experience by a specific class of people, *disability* is a fairly recent construct (if it is suitable to call it so). Before the beginning of the last century, *disability* stood for *inability*, or to denote exertion of legal limitation on rights and powers. The previous classification of disability was in terms of physical, sensory or cognitive conditions, and got replaced by the idea that people with such conditions and impairments all form the category of the disabled. The fairly recent occurrence of acknowledgment and, therefore, the emergence of different approaches to disability might account for the lack of much philosophical interest into the field and meaning of disability, and of philosophical interpretations offered to a more interdisciplinary study of impairment and disability. The facts we now consider constituents of impairment

²³⁷ The relationship between disability and illness is problematic, as there are people disabled by means of chronic illnesses, many people with disabilities not caused by illness have chronic health problems as results of their disabilities, and there are many other permutations of these problems as well - for an account on modern movements for the rights of people with disabilities against the identification of disability with illness see Wendell 2001.

and disability were in ways present in philosophical discussions throughout the ages, as both biological traits and instances of unjust exclusion or downright cruelty towards people with disabilities²³⁸ were matter-of-factly conspicuous in life, and surely impossible to completely overlook. Problems of impairment and disease, however, along with (un/just) suffering and its implications were often mentioned in discussions of evil, retribution, theodicy, divine justice etc. As a topic for philosophical research, disability is in some ways similar to race or sex, in that it applies to a classification of people on the basis of perceived or supposed attributes, also concerning questions whether the classification is founded (more) on biological traits or social constructs. Disability decreases the overall content of well-being in a person affected, though, not only because of the exclusion and stigma, but due to the physical, mental and emotional inconveniences (including pain and suffering) it causes, and in this sense it is not like race or sex, as it necessarily affects the well-being of a person, even if in a perfect societal setting of inclusion, accommodation and equality.

The term *disability* covers a vast range of conditions and illnesses, and each of these includes various types, forms, and manifestations: congenital or adventitious losses of limbs, senses, and bodily functions; progressive neurological conditions like multiple sclerosis; chronic diseases like haemophilia or asthma; conditions of decreased cognitive capacities, like dyslexia; as well as psychiatric disorders. The lack of similarity between all these various states and conditions²³⁹ may also raise questions about the justifiability of the common concept, or umbrella-approach, to the point of doubting whether the concept of disability is a

²³⁸ The violence, abuse and cruelty that people with disabilities suffer are not the subject of this paper, as they are a separate enormous concern. For the abuse of people with disabilities see “Abuse of women with disabilities”; “The Unacknowledged Crisis of Violence against Disabled People.”; and especially the vast meta-analyses Hughes, K. at al. April 2012, and Jones, L., at al. 2012.

²³⁹ It can be argued that “... there is at least as much variation among ‘disabled’ people with respect to their experiences and bodily states as there is among people who lack disabilities” (Wasserman, Asch, Blustein, and Putnam, 2016). However, the fact that there is such variation within both groups does not mean that there is no difference between the two. Being able-bodied with x-types of experiences is different from being able-bodied with y-types of experiences; and being disabled with p-types of experiences is different from being disabled with q-types of experiences, and yet the common denominator remains the able-bodiedness, or disability, respectively. The experience of multiple sclerosis, for example, differs vastly from the experience of a congenital lack of a limb, but both share certain traits that do not pertain to the life-experience of persons unaffected by these conditions. Being late with this paper due to symptoms of multiple sclerosis is unlike being late because of symptoms of schizophrenia, for example, but it is more extensively, and on significantly more levels unlike being late because of other engagements and/or procrastination unrelated to forms and symptoms of disability and illness.

fruitful area for philosophical work.²⁴⁰ If this problem of observed lack of similarity cannot be overcome by a suitable baseline for a minimum definition of disability (not an all-encompassing blob-concept or a cluster of only vaguely related biological facts, social implications and life experiences, although this, too, should be an adequate inspiration for philosophical work), thus hindering any productive philosophical research, the concepts, issues, implications and even existential questions of disability remain to be tackled by sociology, medicine, social work, art, and other human endeavours.²⁴¹ On another note, the versatile nature of different disabilities, the varying experiences of disability, and the nature of questions surrounding it, make it a great area for pluriperspective and multidisciplinary research, and therefore, a great topic of bioethics. However, since disability has not been in the focus of bioethics for a considerable time, there is vast

²⁴⁰ Wasserman, Asch, Blustein, and Putnam (2016), reference Beaudry (2016), at first glance as if he directly refers to the varying functional or experiential states of people with conditions labelled as disabilities, but his point in this particular section of the paper is not focused on the multitude of variations of disability-experiences, but on the justifiability of a neutral social approach to disability (and thus, only indirectly to the plausibility of the umbrella-conception). He does, in fact, start off with the problem of a neutral definition of disability, but it is not as clear whether he means that the multitude of various conditions makes disability unsuitable for philosophical work, or if he refers, as this formulation stands several paragraphs later, to the neutral model of disability. Beaudry identifies the problem of causation (biology or society) of disability as the fundamental dissension on the matter of a neutral definition, remarking that such a definition would make it easier for an ontological disagreement to progress. He allows for an example of a neutral definition to frame disability not only as a limitation, but also one that most people do not have (based on species-related statistics), is long-lasting or recurrent, and affects people with an impairment understood as a biological dysfunction (remarking that social modelists have no problem granting this last part, that disability only affects biologically impaired people – which is certainly true, but only a part of the framework of social modelling). Beaudry thinks that such a definition would always be incomplete, because disability undoubtedly has a normative dimension, because it calls for a medical, social, or other response. The knowledge about the suitable response to disability comes from knowing its roots; knowing how to address it means knowing what causes the aspects that need to be addressed. What seems to bother him most is that as long as it has the idea of causality as its key, disability will remain an essentially contested concept. He points out Silvers' (2003) concept of a neutral, value-free model of disability, as overly optimistic for its plausibility and feasibility.

²⁴¹ However, the fact that there are too many variations of the supposed issues to the point of oversaturation, over-broadening, overloading, and thus, blurring the line of where the set ends and of what content it holds, should not pose as a threat to any systematic philosophical approaches to disability. While it is true that researchers in philosophy with personal involvement might have their judgement clouded and their objectivity diminished by their own experiences of disability, it does not mean that they, precisely because they have their own immediate perspective on the issue, cannot largely contribute to raising awareness, not only about the obstacles of disability, but of the obstacles of including and interpreting disability within philosophical discourses.

room for improvement. Disability has been a shadow issue for bioethics (Oullette, 2011, xiii), but it is gaining traction.²⁴²

The physical, social and environmental factors in affecting disability experiences and outcomes are also acknowledged in the ICF, and should be recognised in any serious endeavour of pluriperspective study of disability. Functioning and disability should always be viewed as a complex interaction between the health condition of the individual and the contextual factors of the environment, for only through this interplay can the attempt at understanding of the factors and dimensions of “the person in his/her world” be suitably made. This is why the option of framing disability based only on social exclusion and stigma does not distinguish it from race, gender, ethnicity etc. (Bickenbach, 1993), thereby not just failing to clarify what disability is, but also obfuscating other issues. The ICF underlines that disability is a “dynamic interaction between health conditions and environmental and personal factors”, which does justice to its complexity.

In definitions of disability, two common aspects, or features, are usually emphasised: a physical or mental characteristic perceived and labelled as *impairment* or a dysfunction; and a personal or social limitation caused by, or associated with that impairment.²⁴³ The labelling of physical or mental characteristics and variations as impairments or dysfunctions is based on statistical data (consider-

²⁴² While “disability perspective” was a formulation rarely heard in discussions of bioethics, disability is nowadays a part of the conversation. However, for Oullette, these transformations are only a basis for what she is hoping for, which is bioethics that incorporates disability as a central issue and engages disability experts in the enterprise, which cannot be achieved only in theoretical. Within the context of disability as having a social location and reproduction (and not just pertaining to the individual as an isolated tragedy), Newell looks at the power relations associated with bioethics and its largely uncritical use of the biomedical model (see Newell, 2006). Goering looks at several examples that demonstrate what she sees as a cause for concern – the troubling tendency in much of mainstream bioethics to discount the views of disabled people. Adhering to a stance of humility and sensitive inclusion for people who have been marginalized, she recommends that bioethicists adopt a presumption in favour of believing, not discounting, the claims of disabled people. Her main point is that bioethicists may learn an important lesson about human fragility and resilience, by taking the claims of disabled people at face value and engaging with them over impairment and disadvantage in open dialogue (Goering, 2008). On critical disability studies as an emergent field of academic research, teaching, theory building, public scholarship, and something she calls “educational advocacy”, and their relationship with bioethics (see Garland-Thomson, 2017). The field of bioethics is presented as an appropriate arena of knowledge-building and practice, into which critical disability studies can be brought. The author offers a speculative proposal for developing a practice called *disability cultural competence* that can be developed as a component of the emergent field of disability bioethics, and explores how and why interdisciplinary critical disability studies can be applied to both the knowledge and practice of biomedicine and healthcare.

²⁴³ See World Health Organization (1980; 2001), the U. N. Standard Rules on the Equalization of Opportunities for People with Disabilities, and, since much of the disability rights movement has originated in the United Kingdom, see the Disability Discrimination Act (U. K.) 1995.

ing the average in certain reference groups), biological features (according to the theory and expectations of human functioning), or normative dimensions of envisaged human flourishing.

Impairments are usually considered characteristics, or traits, of the individual who has them, they are not (strictly) transitory, or easily alterable. Seeing them as attributes, or traits, does not mean that they constitute the entire identity of the person of whom they are characteristic – the impairment or chronic illness does not define the impaired/chronically ill person.

Biological and social approaches to disability have been contested (see Hedlund, 2000, for Sweden; Mann, 1967, for Canada), but there has been a shift since 1970, and references to social restrictions, environments, and contextual attitudes have started to emerge (Shakespeare attributes this to the first stirrings of disability activism, the civil rights and feminist movements, and the academic dominance of labelling theory, as well as others in sociology – Shakespeare, 2006, 19-20). Silvers (2003) warns against drawing a sharp line between impairment and disability, as some social model adherents have wanted, thinking of impairment as a natural (because biological) fact, as opposed to disability, an artificial social classification. However, there is nothing about social model theory, however, Silvers remarks, that entails or otherwise calls for this dichotomization. Impairment itself has no fixed standard - what counts as being physically, perceptually or cognitively impaired is relative to the abilities and limitations taken to be typical of the species or its members who belong to a particular society/prominent social group (2003, 24-25).²⁴⁴

As Shakespeare frames it, "... the benefits of the social model approach are that it shifts attention from individuals and their physical or mental deficits to the ways in which society includes or excludes them" (Shakespeare, 2006, 29). The social model is social creationist or social constructionist (in this passage he refers to Oliver, 1990), not biologically determinist, it shows that the experience of disabled people is influenced by society, with varying presentations in different times and cultures. This means, however, that since disability is not biological, but socially constructed and depending on social constellations, it can be reduced or altogether surpassed.

Impairment and disability are sometimes interchangeably used, but it should always be clear that they refer to different things, and that the distinction between them is in the core of the social model: impairment, as it was mentioned, is de-

²⁴⁴ Also see Barnes, who underlines that disabilities are not merely physical or related to the body, for disability is both a biological condition and a social construct (Barnes, 1999, 578).

defined in biological terms, while disability is a social creation.²⁴⁵ The impairment is an individual biological situation, but disability makes this impairment a problem. Within the social model, this means that disability is the totality of social obstacles and oppression, which can be transformed with research, and change of consciousness (like through campaigning). Examples about participation or exclusion by disabled people are sometimes rather obvious: if no ramps are built, the structure is wheelchair inaccessible; if no interpreters for sign language are available, the hard of hearing people cannot participate in the general discourse. However, the discomfort, pain and concurrent emotional reactions caused by impairments should not be overlooked. In fact, pain is very often the result of interplay of physiological, psychological and socio-cultural factors, making it difficult to distinguish between purely individual psycho-physical experience, and the broader, social context (Wall 1999), especially since constant or frequent pain and discomfort have serious implications on the way disabled people function in the world.

Impairment is the *conditio sine qua non* of disability (without an impairment, there is no experience of disabling obstacles and limitations).²⁴⁶ It is also important to acknowledge that impairments, although biological, are often caused by social arrangements (Abberley, 1987). Poverty, malnutrition, access to proper public health care services, etc., are all caused by collectively imposed social processes, which is why Abberley suggests that impairment itself could be conceptualised as socially created. Shakespeare thinks that since not all impairment is

²⁴⁵ There is the claim that many individuals who would be said to qualify as “disabled” in society would still be disabled in a Utopian discrimination-free society (see Terzi, 2004), and this is true in a sense that a biological dysfunction creates limitations (even if we abstract from society, a blind person still faces obstacles in orientation, for example). In simplified terms, the main difference is between impairment and disability. The social model’s stance is that a blind person is impaired or limited, not disabled; a blind person is disabled when he or she is disabled by society. However, disability should not be debased by mocking the very concept of inability – being deaf or hard of hearing is very different from being tone-deaf as demonstrated in bad singing, no matter how obviously unpleasant for the others the latter is. In a society that only communicates through song/music, tone-deafness would be very similar to actual deafness, having rendered the person unable to communicate. Sometimes, the classification of traits as impairments is dependent on societal perception, which is why there is the danger of characterising as impairments the unwanted variations most disadvantageous in a certain context, and therefore most prone to prejudice and stigma.(this might account for at least a part of the normative fluctuation of the classification of impairments).

²⁴⁶ The difference between a biological impairment and a social limitation, on a normative and policy-making level influences whether the aspect to be addressed and modified is the disabled person, or his or her social and contextual environment. The motto “Nothing about us without us” (see the eponymous book, Charlton, 1998), voices the demand for constant inclusion of actual disabled people in research of disability, and all matters concerning them in policy making. Only their clear and unmediated perspectives truly grasp their needs, and should therefore be included in all matters concerning their conditions and the social replies to (Charlton, 1998; Stone, 1997).

caused by social arrangements, this argument works not to uphold, but to undermine the social model (2006, 35). It should be kept in mind, however, that if impairment is defined as biological, and disability - as social, there is the risk of leaving impairment as an essentialist category (Shakespeare, *ibid*); which is why some authors think that impairment is not a pre-social or pre-cultural biological substrate (Thomas, 1999, 124).

Some definitions imply (or seem to imply) that biological impairments are the only cause for limitation (the definitions in the WHO's International Classification of Impairment, Disability, and Handicap from 1980, and the United Kingdom's Disability Discrimination Act-DDA), some appear opposite, by attributing the limitations that disabled people face to contemporary social organisation (the definition in the UK'S Union of the Physically Impaired Against Segregation in 1976, which is not surprising for the disability rights organisation that established the principles that led to the development of the social model of disability).

In addition, there is disagreement on the need for two categories of limitations – one involving personal activity, and the other social or political participation (see Wright, 1983; Edwards, 1997; Nordenfelt, 1997; Altman, 2001).

Models of disability

The concept of disability is multifaceted, far-ranging and fit for an investigation with multidisciplinary approaches. Disability can be considered a biological/physical impairment or dysfunction, or a personal and social limitation caused by, or associated with that impairment. Within some disability studies, disability is seen as a form of social oppression, a form of stigmatization, experienced by people with impairments. The models of disability refer to either the physical or mental attributes that some institutions, medicine in particular, view as needing to be remedied – this is the medical model, or to limitations imposed on people by the expectations and restrictions of an ableist society – this is the social model.²⁴⁷

The models of disability provide definitions of disability, based on (perceived) needs, in order to guide the formulation and implementation of policies, they are not value neutral, they determine (and in some instances, narrow down) which academic disciplines apply to people with disabilities, they shape the self-identity of disabled people (which, albeit on some level useful, could lead to additional problems), and can cause prejudice and discrimination (for the purposes that the different models serve see Smart, 2004, 25-29, also see Smart, 2009).

²⁴⁷ The exclusion of people with physical and mental characteristics from major domains of social life manifests not only in deliberate segregation, but in the environment and social activity organised in such a manner that they prevent or restrict the participation of people with disabilities.

There are several models of disability. The following list summarises the typology offered by Retiefl & Letšosa (2018), using many of their carefully picked useful references. The religious model, typical for the Judaeo-Christian tradition, sees disability as an act of God, either as a repercussion for a transgression/sin, or as a special test for the person suffering. This belief in divine punishment sometimes equates disabilities with sacrilege, mixes chronic illness with issues of impurity and danger, and explains mental illness with evil possession (McClure, 2007, 23; Henderson & Bryan, 2011); the punishment is executed directly on the person, or indirectly, to members of the persons' family, even throughout generations, thus emphasising the negative impact of this view in the sense of continuous exclusion from ritual and social participation in the communities (for a comprehensive approach to these issues, see Rimmerman, 2013). The belief in disability and suffering as a test of faith, piousness and endurance means that some individuals or families get to prove their worth and resilience, and remain pure, thus attaining grace and redemption; similarly, disability can be viewed as character-building, and, as most forms of suffering, granting a unique view of the inexplicability of the divine ways, and the relationship between the believer and the deity. In cultures with religious or magical worldviews, where the religious (or moral/religious) model of disability is still the predominant view (Karna, 1999, 13; Dunn, 2015, 10), disabled people are often severely marginalised, stigmatised, attacked.

The identity model (or affirmation model) of disability is closely related to the social model, but while it shares the stance that the experience of disability is socially constructed, it slightly differs in claiming disability as a positive identity (Brewer et al., 2012). The point is that within the identity model disability is a marker of membership in a minority identity, much like gender or race, defined by a certain type of social or political experience in the world. This model, while sharing the identification of social obstacles with the social model, is more interested in forging a positive definition of disability-identity based on experiences and circumstances that constitute the minority group of people with disabilities (Brewer et al 2012, 5); however, this could be a problem, if it is taken to lead to pressure to identify with a specific group culture (Fraser, 2003).

The human rights model takes disability as a human rights issue, which, again, is quite similar to the social model, to a point that some researchers treat them interchangeably. The differences between them identified by Degener are the following: the human rights model moves beyond explanations offered by the social model, outlining a theoretical framework for disability policy that emphasises the human dignity of people with disabilities; includes both first and second generation human rights (civil and political rights, as well as economic, so-

cial and cultural rights); is more accommodating to the facts of pain and suffering of some disabilities, underlying the need to take them into account in the development of social justice theories; gives space to minority and cultural identities, as opposed to the lack of attention the social model pays to the importance of identity politics – although this could be said for the identity model as well; underlies the importance of properly formulated policies for the prevention of disability as an example of human rights protection;²⁴⁸ does not stop at merely explaining why so many disabled people live in poverty, like the social model, but also proposes ways for improvement of their life situations (Degener, 2017, 47-54).

The cultural model of disability, developed in the North American context, thanks to interdisciplinary approaches, especially by the social sciences and humanities (Michalko, 2002; Titchkosky, 2007 in Retief1 & Letšosa, 2018, non vidi), does not define disability in any specific way, but rather focuses on how different notions of disability function in the context of a specific culture (Retief1 & Letšosa 2018). Junior and Schipper (2013) explain that the cultural model differs from the medical and the social model in that, while they each focus on only one factor in their approach to disability, the cultural model focuses on a range of cultural factors, which may include medical and social factors, but are not limited to them (in Retief1 & Letšosa, 2018, non vidi).

The charity model of disability considers people with disabilities victims of their circumstances of impairment, who should elicit pity, and whom should be treated in special manners, due to their suffering and inabilities. This model is often criticised for portraying disabled people as tragic, helpless, impotent, which leads to the proliferation of harmful prejudices and stereotypes (Seale, 2006, 10).²⁴⁹

²⁴⁸ See footnote 18.

²⁴⁹ This is important in the sphere of educational possibilities for disabled students – they should not be treated like victims, but merely given equal opportunities to learn and prosper. Seale focuses on the fact that, while most practitioners know that e-learning should be made accessible to students with disabilities, it is not clear exactly how this should be done, and examining the social, educational and political background behind making e-learning accessible in higher and further education, comprehensively considers the role of key stakeholders - lecturers, learning technologists, student support services, staff developers, senior managers - involved in e-learning provision, and provides advice for them. While cooperation between the parties involved in the facilitation of education is still difficult, an aspect that could be easily improved is the development of learning technologies for students with disabilities. The Faculty of philosophy, through the Erasmus+ Project “Fostering Accessible Study Technologies: Accessible Learning Management System in Humanities and Social Sciences” is working on the development of a learning management system, wherein students with disabilities (deaf and hard of hearing, visually impaired, students with specific learning disabilities such as dyslexia and students with mobility issues), are a vital part. This should potentially accommodate most of the specific educational needs of students with disabilities and should therefore be a huge step towards a

The economic model depicts disability as a challenge to productivity, highlighting the various disabling effects of an impairment on a person's capabilities, and in particular on labour and employment capabilities, mainly focusing on benefit-cost analyses, and is often used for reference in governmental formulation of disability policies (Retief & Letšosa 2018).

Retief & Letšosa continue with the limits model, a distinctly theological model of disability developed by Creamer (2009), which sees disability as embodied experience and emphasizes the importance of people accepting the fact all human beings experience some level of limitation in their everyday lives (Creamer, 2009, 109), and some varying degrees during all the phases of life (Creamer, 2009, 118), making the limits (which might/will be faced) a matter of fact, a common aspect of being human (Creamer, 2009, 31) – for an extensive summary of this model (see Retief & Letšosa, 2018).

The medical and the social model of disability

The medical model is rarely defended, but often adopted by medical and health care professionals, bioethicists, and philosophers who downplay the influence of social and environmental factors to the obstacles and limitations faced by people with disabilities. The social model (in different versions) seems to be the dominant paradigm for understanding disability in legislation, social-sciences, and humanities.²⁵⁰

A number of social models (or variations of the social model) are accepted by researchers of disability and activists (both in and outside of philosophy and bioethics). The aforementioned stance from the UPIAS definition from 1976, associated with the British social model, seems to negate the causal role to impairment in disability,²⁵¹ a denial that, while countering the prevailing, and sometimes exaggerated focus on the biological causes of handicap, might be considered as somewhat limiting the scope of disability to the categories and implications of exclusion and discrimination (see Beaudry, 2016).²⁵²

full inclusion of students with disabilities in the entire process (see “Fostering Accessible Study Technologies: Accessible Learning Management System in Humanities and Social Sciences”).

²⁵⁰ Silvers thinks that 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 (Silvers, 2003, 20). She reminds us that a model is a standard, example, image, simplified representation, pattern etc., often executed in miniature so that its components are easy to discern. Since the components of disability are not empirically discernable or represented, neither the medical nor the social model, she purports, presents a replica or representation of disability.

²⁵¹ Beaudry, for example, claims that impairment is closely, but not causally related to disability. He claims that it is a vector of it; characterizing the victims of social oppression (Beaudry, 2016).

²⁵² The strength and the reductionist tendencies of the British social model have been subject to criticism, in terms of the need to distinguish disability discrimination from other types of dis-

Models that treat the inadequate relationship between atypical embodiment and typical environment as a point de départ, see disability as an interplay between biological and social causes (neither of which has priority), and as having an interactive character, while maintaining the emphasis on the social aspects (see Bickenbach, 1993; Altman, 2001).

As it was shown, disability can be analysed through two ways in which society inflicts problems on disabled people by imposing limitation – either through exclusion of people with impairments, who are seen as a minority, which is the minority group model, or through the reality of how society is organised, meaning that the contemporary societal organisation fails to accommodate people with disabilities, which is the human variation model. The former view purports that people with disabilities face exclusion and discrimination in ways similar to those experienced by racial or ethnic minorities, for which the proper reactions are in the forms of which civil rights protections and laws against discrimination (Hahn, 1997; Oliver, 1990). According to the latter view, the obstacles that disabled people face are not directly stemming from their intentional exclusion, but are by-products of the fact that their features and the physical and social environment are just not adequately matched. Disability is an extension of the variety of attributes, physical and mental, and society's inability to routinely respond to them (see Scotch and Schriener, 1997).²⁵³

crimination (Bickenbach, 1993), the need for impairments to be recognised as an objective foundation for classification, and not denied or understated as sources of disadvantage (Anastasiou & Kauffman, 2013; Terzi, 2004, 2009; Shakespeare, 2006 certainly stresses this throughout the book). Beaudry (2016) finds that such criticism fails to see that the British social model does not deny the importance of impairments, but simply restricts the notion of disability to social exclusion and oppression.

²⁵³ The responses to disability of these models are, accordingly, different. The medical model seems to reinforce the medical intervention and correction of the biological variation (condition); the minority group model supports measures of elimination or reduction of unjust instances of exclusion and oppression; the human variation model favours a reconstruction of the physical and social environment to make it more accommodating to the varieties of human functions (this could work also as a baseline for antidiscrimination measures of the minority group model), underlying the suitable social responses to disability where exclusion and oppression are not an issue. The allocation of resources, certainly plays a role in the arguments for and against the adoption and implementation of some models, and the rejection of others. If the accent is on adjusting the environment for the needs of the disabled – if disability is in the circumstances of the environment and not in the people who inhabit them – then, more funds will go into environment transformations, and fewer will be allocated to resources directly applicable to the medical aspects of disability. Another, related, danger of the intense application of the social model would be the implication of the acceptance of the biological dysfunctions by the disabled people – the more people happily live with disabilities and thrive in an environment increasingly adapted to their inclusion, the more the risk-benefit ratio for the medical intervention on biological dysfunctions will shift, and, resources might be removed from healthcare, and with that, from disability prevention.

Some objections to the medical and the social model of disability, or rather, different versions of the same objection, focus on the (perceived) fallacious dichotomy between biological impairments and social limitation: either through the stance that since disability is such a complex phenomenon, impairment and exclusion and/or oppression are intertwined and difficult to disassociate, or through the dismissal of the treatment of disability as a (strictly) biological condition.²⁵⁴

Tremain argues that impairments “... must no longer be theorized as essential biological characteristics (attributes) of a ‘real’ body on which recognizably disabling conditions are imposed” (2001, 632), but rather understood as an integral part of the social process of disablement. The dichotomy is, therefore, seen as oversimplified and downright futile by some researchers, and even if one claims that the impairment classification works in biomedical terms, one cannot deny that such biological variations are subject to discrimination (especially since it can be seen as a reaction to objective biological traits).

It was briefly mentioned that Silvers (2003) argues for a model of disability that is value-free, identifying atypical forms and functions only through descriptive criteria. Silvers places the medical and social models as foils, and on some accounts antitheses (Silvers, 2003, 19). The medical model takes disability to be a problem which requires medical intervention, and as such, a responsibility of the medical professionals, while the social model understands disability as a political problem, calling for a transformation of people’s attitudes and a reformation of societal practices. Scully underlines, however, that the strong social model is just not that interested in the subjective experience of the impaired person, or its psycho-emotional aspects, or the processes through which disability is constructed by cultural representations (Scully, 2008, 27). Abstracting from the subjective experience of impairment would prevent from fruitfully tackling, theoretically or politically, the problem of the marginalisation of disabled people (Scully, 2008). Scully (2008, 28-29) and Crow (1996) see the social model as too amenable to the traditional Cartesian mind-body dichotomy, artificially splitting the person-

²⁵⁴ For the first version see Martiny, 2015; Anastasiou & Kauffman, 2013. The second version regards impairment as a social construction, no less than the obstacles faced by impaired people, and sheds doubts on the assumed stable biological basis for the classification of certain variations as impairments. It should not be overlooked that the changes to the classification, by the medicalization or demedicalization of some conditions, change the status of the variations - a thing once considered as impairment ceases to be so, and vice-versa. Sometimes, it is precisely the social environment that not only identifies, but also creates impairments. For example, in a non-literate society, dyslexia would not be a learning disability (see Cole, 2007; Davis, 2002; Tremain, 2001; Amundson, 2000 and indubitably Shakespeare, 2006). See Wasserman, Asch, Blustein, Putnam (2016) for the summary of the argument – what is seen as an impairment may depend on which variations appear most disadvantageous, or most susceptible to social prejudice, which makes it difficult to establish the objectivity of the classification of impairments by appeal to unambiguous and uncontested biomedical norm.

al and the political apart, and thus failing to acknowledge that embodied perception disassociates the experiences of disabled people from those of the able-bodied. Silvers claims that 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, should still not adopt the values that drive the medical model (Silvers 2003, 20). She believes that 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 (30).

In a pluralistic society, we should expect that different models of disability will be appropriate to incorporate and realize different values, and that these will be as compatible, or as antithetical, as the values they serve, suggests Silvers, and since contention between models can be traced to tension between values, it cannot be expected that science confirms (or refutes) any model of disability. For a pluralistic society, many models of disability are better than one (Silvers, 2003, 35).²⁵⁵

Some of the most obvious issues with defining, framing, and discussing disability were outlined in this text, as were the main characteristics and implications of the medical and the social models of disability. Perhaps time will come when a bioethical model of disability will fix some of the problems of the established models, and we can only hope that the integrativity of bioethics lives up to its expectations.

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²⁵⁵ She welcomes the fact that the social model's entrenchment may be approaching the medical model's, striving for a practical balance between adjusting diverse people and uniform environments to one another. However, unwelcome news is that the philosophical struggle to align the fundamental values that these two models express is nowhere near to achieving accommodation or resolution. Still, an encouraging step 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 (Ibid.).

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