

## **The social model of disability: an outdated ideology?**

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### **Abstract**

The papers explore the background to British academic and political debates over the social model, and argue that the time has come to move beyond this position. Three central criticisms of the British social model are presented, focussing on: the issue of impairment; the impairment/disability dualism; and the issue of identity. It is suggested that an embodied ontology offers the best starting point for disability studies, and some signposts on the way to a more adequate social theory of disability are provided.

## **The Social Model of Disability: An Outdated Ideology?**

“Few new truths have ever won their way against the resistance of established ideas save by being overstated.” Isaiah Berlin, *Vico and Herder* (1976)

### **Background**

The social model of disability has been called ‘the big idea’ of the British disability movement (Hasler, 1993). Developed in the 1970s by activists in the Union of the Physically Impaired Against Segregation (UPIAS), it was given academic credibility via the work of Vic Finkelstein (1980, 1981), Colin Barnes (1991) and particularly Mike Oliver (1990, 1996). The social model has now become the ideological litmus test of disability politics in Britain, used by the disabled people’s movement to distinguish between organisations, policies, laws and ideas which are progressive, and those which are inadequate.

The core definition of the British social model comes in the UPIAS document, *Fundamental Principles of Disability*, an edited version of which is reprinted in Oliver (1996), and which we quote here at length:

“... In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society. To understand this it is necessary to grasp the distinction between the physical impairment and the social situation, called ‘disability’, of people with such impairment. Thus we define impairment as lacking all or part of a limb, or having a defective limb, organism or mechanism of the body and disability as the disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of people who have physical impairments and thus excludes them

from participation in the mainstream of social activities.” (Oliver, 1996, 22).

The British social model therefore contains several key elements. It claims that disabled people are an oppressed social group. It distinguishes between the impairments that people have, and the oppression which they experience. And most importantly, it defines ‘disability’ as the social oppression, not the form of impairment.

North American theorists and activists have also developed a social approach to defining disability, which includes the first two of these elements. However, as is illustrated by the US term ‘people with disabilities’, these perspectives have not gone as far in redefining ‘disability’ as social oppression as the British social model. Instead, the North American approach has mainly developed the notion of people with disabilities as a minority group, within the tradition of US political thought. While the work of Hahn (1985, 1988), Albrecht (1992), Amundsen (1992), Rioux et al (1994), Davis (1995), and Wendell (1996) explores important social, cultural and political dimensions of disability, we argue that none have made the firm distinction between (biological) impairment and (social) disability which is the key to the British social model. However, we believe that many of our comments in this paper will also be relevant to versions of the social model current in American disability studies.

The social model was massively important in the British disability movement, in two main ways. First, it enabled the identification of a political strategy, namely barrier removal. If people with impairments are disabled by society, then the priority

is to dismantle these disabling barriers, in order to promote the inclusion of people with impairments. Rather than pursuing a strategy of medical cure, or rehabilitation, it is better to pursue a strategy of social change, perhaps even the total transformation of society. In particular, if disability could be proven to be the result of discrimination (Barnes, 1991), then campaigners for anti-discrimination legislation saw civil rights - on the model of the Americans with Disabilities Act, and the British equal opportunities and race relations laws - as the ultimate solution.

The second impact of the social model was on disabled people themselves. Replacing a traditional, 'medical model' view of disability - in which the problems arose from deficits in the body - with a social model view - in which the problems arose from social oppression - was and remains very liberating for disabled individuals. Suddenly, people were able to understand that they weren't at fault: society was. They didn't need to change: society needed to change. They didn't have to be sorry for themselves: they could be angry. Just as with feminist consciousness raising in the seventies, or with lesbians and gays 'coming out', so disabled people began to think of themselves in a totally new way, and became empowered to mobilise, organise, and work for equal citizenship. Rather than the demeaning process of relying on charity or goodwill, disabled activists could now demand their rights.

We argue that the very success of the social model is now its main weakness. Because it is such a powerful tool, and because it was so central to the disability movement, it became a sacred cow, an ideology which could not easily be challenged. Part of its effectiveness arose from its simplicity. It could be reduced to a

slogan: 'disabled by society not by our bodies'. Organisations and policies could be easily evaluated: did they use the (social model) term 'disabled people' or did they use the (medical model) term 'people with disabilities'? Did they focus on barrier removal, or did they focus on medical intervention and rehabilitation? The social model could be used to view the world in black and white, even if this was not the intention of those who originally framed it.

Psychologically, people's commitment to the social model was based on the way it had transformed their self-esteem. Any individual who had become an activist on the basis of joining a collective united by the social model ideology had a deep investment in the social model definition of disability. 'We' were oppressed: 'they' were oppressors. 'We' talk about disability, we don't mention impairment. You can't be a proper activist, unless you accept the social model as your creed.

This reading of the history of the British disability movement will be contested by some. We are in danger of constructing a 'straw person', it will be suggested. After all, no one really takes such an extreme position. The issue of impairment was never really ignored. The social model does not really produce such a rigid dichotomy. But our contention is that many British activists in their public discourse use exactly this 'strong' version of the social model that we are critiquing. It may be that in private, their talk is at odds with the 'strong social model'. Most activists concede that behind closed doors they talk about aches and pains and urinary tract infections, even while they deny any relevance of the body while they are out campaigning. Yet this inconsistency is surely wrong: if the rhetoric says one thing, while everyone behaves

privately in a more complex way, then perhaps it is time to re-examine the rhetoric and speak more honestly.

Within academia, while some of the leading exponents of the social model now claim to operate a less rigid approach, they still simultaneously reinforce the 'strong' social model. For example, Mike Oliver (1996, 34) supplies a table in which two columns list the differences between the 'individual model' and the 'social model'. In the first column, we find words such as 'medicalisation', 'adjustment', 'prejudice', 'attitudes', 'care', 'policy' etc, and in the second column we find the alternatives: 'self-help', 'affirmation', 'discrimination', 'behaviour', 'rights', 'politics'. Oliver's commentary genuflects to the need for flexibility:

"It should be noted that, like all tables, this one oversimplifies a complex reality and each item should be seen as the polar end of a continuum." (Oliver, 1996, 33)

before immediately reinforcing the social model dichotomy:

"Nevertheless, underpinning [the table] is the same fundamental distinction between impairment and disability as defined by UPIAS..." (Oliver, 1996, 33).

Jenny Morris' very popular and influential book, *Pride Against Prejudice* (1991) blurred the distinction between impairment and disability in several ways: she discussed the role of impairment and personal experience in the lives of disabled people; she talked about cultural representation; and she used terminology inconsistently, sometimes talking about 'disability' when in strictly social model terms she was talking about impairment. For these reasons, her work was regarded by some in the British disability movement as 'ideologically doubtful'. This

tendency, to evaluate ideas on the basis of their conformity to social model orthodoxy, can be seen regularly in the pages of the international journal *Disability and Society*. For example, recent reviews by Colin Barnes (1998, 1999) of books by American disability scholars have strongly criticised such perspectives because they ignore British disability studies work, and particularly because they fail to adhere to the social model definition of disability. Barnes writes:

“... most American and Canadian accounts are impairment specific in that they limit their discussions to ‘people with physical disabilities’ or the body; ‘disability’ is both biological condition *and* a social construct, and the terms ‘disabled people’ and ‘people with disabilities’ are used interchangeably. As Mike Oliver has repeatedly made clear, this is about far more than simply ‘political correctness’. It’s about the crucial issue of causality, the role of language, its normalising tendencies and the politicisation of the process of definition.” (Barnes, 1999, 578)

Carol Thomas has discussed the way that some disability studies academics police writing on disability, in order to exclude anything which does not comply with the social model approach (Thomas, 1998). We argue that similar processes occur within activism: for example, impairment-based organisations are viewed as problematic (e.g. Hurst, 1995). The recent UK government campaign ‘See the person [not the disability]’ was opposed by activists largely because it used the term ‘disability’ to refer to physical impairment (e.g. Findlay, 1999, 7). While we do not believe that ‘See the Person’ was an adequate response to the poverty and exclusion of disabled people, nor do we believe that the main problem with the UK government’s approach to disability



is about terminology, which is the impression that the disability movement is in danger of presenting.

In suggesting that the social model of disability has become a rigid shibboleth, we do not mean to ignore the important current of dissent which has arisen since Jenny Morris' work. Several writers, particularly coming from a feminist perspective, have highlighted the problems of the British social model. For example, Liz Crow (1996) led the way in criticising the failure of the model to encompass the personal experience of pain and limitation which is often a part of impairment. Sally French (1993) wrote about the persistence of impairment problems. She also explored the reasons for resistance to these alternative perspectives:

“It is no doubt the case that activists who have worked tirelessly within the disability movement for many years have found it necessary to present disability in a straightforward, uncomplicated manner in order to convince a very sceptical world that disability can be reduced or eliminated by changing society, rather than by attempting to change disabled people themselves...” (French, 1993, 24).

Most recently, Carol Thomas (1999) has developed a promising new materialist approach to disability which explores the role of what she calls 'impairment effects'. Many of these critical voices have encountered strong opposition from within the British disability movement and disability studies.

The difference between our position, and that of Jenny Morris, Sally French, Liz Crow or Carol Thomas is that we believe that the 'strong' social model itself has become a problem, and that it cannot be reformed. Our claim is that the British version of the social model has outlived its usefulness. Rather than developing piecemeal criticisms or supplying alternative arguments to fill the

gaps and compensate for the inadequacies of the social model, it is time to put the whole thing to one side and start again. The dangerous tendency to equate the social model with purity and orthodoxy in disability politics and disability studies has to be rejected. After all, it is only in Britain that the social model has played this role. In the USA and other countries, civil rights and social change have successfully occurred, in the absence of the 'strong' social model of disability. Indeed, in Britain itself, the UPIAS-led social model approach was not the only perspective at the beginning of the disability movement. For example, the Liberation Network of People with Disabilities developed the concept of disabled people as an oppressed minority group without needing to define disability as social oppression: Allen Sutherland, a member of the Network, wrote the pioneering *Disabled We Stand* (1981) without drawing upon the social model in his argument for a radical politics of disability.

In the remainder of this paper, we will explore three of the main criticisms of the British social model of disability. Through these arguments, we will try to substantiate our claim that the model is outdated and creates more problems than it solves. In the conclusion, we will begin the difficult task of constructing an alternative and more adequate approach to disability politics, based on a materialist ontology of embodiment.

### **Impairment, the absent presence**

We have already cited the work of feminist commentators arguing that the social model has traditionally either avoided or excluded the issue of impairment. As French suggested above, this seems mainly to have been for reasons of radical rhetoric. It sounds

much better to say 'people are disabled by society, not by their bodies' than to say 'people are disabled by society as well as by their bodies'. But the result is that impairment is completely bracketed, just as sexual difference was the taboo subject for the women's movement in the early 1970s. In properly rejecting the causal role of the body in explaining oppression, disabled radicals have followed their feminist precursors in denying difference entirely: after all,

"Once feminists admit the mildest degree of sexual difference, they open up a gap through which the currents of reaction will flow. Once let slip that pre-menstrual tension interfered with concentration, that pregnancy can be exhausting, that motherhood is absorbing, and you are off down the slope to separate spheres." (Ann Phillips, quoted in Cockburn, 1991, 161).

We argue that the denial of difference is as big a problem for disability studies, as it was for feminism.

Experientially, impairment is salient to many. As disabled feminists have argued, impairment is part of our daily personal experience, and cannot be ignored in our social theory or our political strategy. Politically, if our analysis does not include impairment, disabled people may be reluctant to identify with the disability movement, and commentators may reject our arguments as being 'idealistic' and ungrounded. We are not just disabled people, we are also people with impairments, and to pretend otherwise is to ignore a major part of our biographies. As Linda Birke argued in the case of gender,

"Feminist theory needs to take into account not only the ways in which our biology is interpreted, but also the very real ways in which biology does in practice affect our lives." (Birke, 1986, 47)

Analytically, it is clear that different impairments impinge in different ways. That is, they have different implications for health and individual capacity, but also generate different responses from the broader cultural and social milieu. For example, visible impairments trigger social responses while invisible impairments may not - the distinction which Goffman (1968) draws between 'discrediting' and 'discreditable' stigma. Congenital impairments have different implications for self-identity than acquired impairments. Some impairments are static, others are episodic or degenerative. Some mainly affect appearance, others restrict functioning. All these differences have salient impacts at both the individual and psychological level, and at the social and structural level. This is not an argument for disaggregating all disability, and referring solely to clinical diagnoses, but for recognising that the different major groupings of impairment, because of their functional and presentational impacts, have differing individual and social implications.

Moreover, denying the relevance of impairment has some unfortunate consequences. Thus, the disability community has often criticised the mainstream emphasis on 'cure' for impairment, and have opposed the maximising of functioning. For example, Oliver and others have argued against conductive education for people with cerebral palsy (1989). Recently there has been a backlash from people directly involved, arguing that some of the Peto interventions can generate significant outcomes for people with these impairments (Beardshaw, 1989; Read, 1998). Why is it so wrong to maximise functioning and seek to reduce the impact of disease? Clearly, some of these interventions cause more harm than good. Equally, the obsession of many clinicians with cure is

misguided. Yet, at the same, it would be to commit an equivalent error if we discounted all possibility or benefit of impairment-avoidance and reduction.

A special case of this argument applies to genetics. Many activists have opposed all attempts to reduce the incidence of genetic conditions. Yet, while we would ourselves have major criticisms of contemporary genetic rhetoric and practice, we cannot see a problem in seeking to avoid serious and debilitating conditions. The woman who takes folic acid in her pregnancy is being sensible, not being oppressive to people with spina bifida. While we would oppose blanket selective screening of all impairments, there are times where it seems appropriate and desirable to take advantage of genetic technologies. Impairments such as Tay-Sachs disease and anencephaly are both terminal and very unpleasant and most people would want to avoid them if at all possible (Shakespeare 1998).

If the social model argument was pushed to its logical extreme, we might not see impairment as something which we should make efforts to avoid. As a consequence, we might be unconcerned about road safety, gun control, inoculation programmes, and mine-clearance. Of course, no activist in practice actually makes such arguments. However, both British advocates of the 'strong' social model and some American minority group approaches seem sometimes to suggest that having more disabled people is by no means a bad thing, and that we should not always try to avoid impairment.

One come-back from social model traditionalists may be to distinguish between impairment and chronic illness, and to welcome medical relief of the latter. But as Bury (1996) argues,

there is little real difference between the two phenomena. Many impairments are changeable and episodic. Few have no medical implications whatsoever. The majority of disabled people do not have stable, congenital impairments (such as blindness or deafness) or sudden traumatic lesions (such as spinal chord injury), but instead have rheumatism or cardio-vascular disease, or other chronic degenerative conditions mainly associated with ageing. Even conditions such as polio and spinal chord injury are not 'once-for-all' changes without subsequent variations: post-polio syndrome is now well documented, and people with SCI have to manage urinary-tract-infections, pressure sores and other problems. Equally, Corker and French (1998, 6) show how it is wrong to assume that sensory impairments do not cause pain.

Paul Abberley (1987) is one of the few materialist disability studies theorists to take account of the impairment. He makes a distinction between social identities which do not have a bodily dimension which causes limitation – such as gender, race and sexuality – and the example of disability, where the body is a problem:

“While in the cases of sexual and racial oppression, biological difference serves only as a qualificatory condition of a wholly ideological oppression, for disabled people the biological difference albeit as I shall argue itself a consequence of social practices, is itself a part of the oppression. It is crucial that a theory of disability as oppression comes to grips with this real inferiority, since it forms a bedrock upon which justificatory oppressive theories are based and, psychologically, an immense impediment to the development of political consciousness amongst disabled people.” (Abberley, 1987, 8)

Abberley's strategy is to show that impairment often has social causes. He argues that work, war, poverty and other social

processes generate impairment, and therefore that impairment is itself part of disabled people's social oppression. Yet this move, while unassailable in its political validity, is not analytically sustainable. After all, it may account for those impairments which are socially caused, but it cannot account for those impairments which idiopathic, random, or just bad luck.

We entirely concur with the political imperative to remove disabling barriers. We also believe that the overwhelming stress on medical research, corrective surgery and rehabilitation at all costs is misguided. The priority should be social change and barrier removal, as social models of disability have suggested. Yet there is no reason why appropriate action on impairment - and even various forms of impairment prevention - cannot co-exist with action to remove disabling environments and practices. People are disabled both by social barriers and by their bodies. This is straightforward and uncontroversial. The British social model approach, because it 'over-eggs the pudding', risks discrediting the entire dish.

### **A sustainable dichotomy?**

Social model theory in the UK rests on a distinction between *impairment*, an attribute of the individual body or mind, and *disability*, a relationship between a person with impairment and society. A binary division is established between the biological and the social (Oliver, 1996, 30). This distinction is analogous to the distinction between sex and gender, as it was established by feminists such as Ann Oakley (1972). As with second-wave feminism, the move enables disability studies to illustrate that disability can only be understood in specific socio-historical

contexts, and that it is a situation which is dynamic, and can be changed.

Yet, within feminism, the sex/gender distinction has largely been abandoned (see for example Butler, 1990). Theorists and activists do not thereby root woman's being in biology, as the patriarchal tradition has done. Instead, it is observed that sex itself is social. Everything is always already social. John Hood-Williams concludes his discussion of the problems of dualism by saying:

"The sex/gender distinction dramatically advanced understanding in an under-theorised area and, for over twenty years, it has provided a problematic which enabled a rich stream of studies to be undertaken, but it is now time to think beyond its confines."  
(Hood-Williams, 1996, 14)

The same, surely, applies to impairment. Impairment is not a pre-social or pre-cultural biological substrate (Thomas, 1999, 124), as Tremain (1998) has argued in a paper which critiques the untenable ontologies of the impairment-disability and sex-gender distinctions. The words we use and the discourses we deploy to represent impairment are socially and culturally determined. There is no pure or natural body, existing outside of discourse.

Impairment is only ever viewed through the lens of disabling social relations. As a crude example, one could cite the labels used to describe a particular impairment: idiocy, mongolism, Down's syndrome, trisomy-21 are words which have been used to describe the same impairment situation, yet their connotations differ, as does a generic term such as person with learning difficulties which might be preferred by many people with that condition. Therefore we do not agree with Mike Oliver, when he seeks to deal with the problem of impairment by arguing that a



social model of impairment is needed alongside the social model of disability (1996, 42). While his recognition of the importance of impairment, and the limitations of the social model is welcome, it would be neither straightforward or desirable to make the distinction between impairment and disability that he takes for granted.

The unsustainable distinction between impairment (bodily difference) and disability (social creation) can be demonstrated by asking 'where does impairment end and disability start?'. As Corker and French argue (1998, 6) not only can sensory conditions include pain, but pain itself is generated through the interplay of physiological, psychological and socio-cultural factors (see also in this respect Wall, 1999). While impairment is often the cause or trigger of disability, disability may itself create or exacerbate impairment. Other impairments, because invisible, may not generate any disability whatsoever, but may have functional impacts, and implications for personal identity and psychological well-being.

Of course, some impairment/disability distinctions are straightforward. If architects include steps in a building, it clearly disadvantages wheelchair users. If there is no sign language interpreter, deaf people are excluded. Yet, it could be suggested that the 'barrier free environment' is an unsustainable myth (a fairy tale, such as in Finkelstein, 1981). For a start, removing environmental obstacles for someone with one impairment may well generate obstacles for someone with another impairment. It is impossible to remove all the obstacles to people with impairment, because some of them are inextricable aspects of impairment, not generated by the environment. If someone has an

impairment which causes constant pain, how can the social environment be implicated? If someone has a significant intellectual limitation, how can society be altered to make this irrelevant to employment opportunities, for example? Does mainstream sport disable impaired athletes by imposing oppressive criteria – such as being able to run to play football?. Some of these examples may seem ridiculous. But they point to the problem of pushing the social model to its implications, and highlight a flaw in the whole conception.

Again, Paul Abberley (1996) has been one of the pioneers in pointing out this limitation. He suggests that a barrier-free utopia, in which all disabled people can gain employment, is not viable. He points out that however much investment and commitment and energy is devoted to making work accessible, there will always be a residuum of people who, because of their impairment, cannot work. However, again we would disagree with his solution to the problem. While displacing work as the central social value would be undoubtedly an important social development, it is not the most obvious solution to a problem which is generated mainly by the limitations of social model reasoning. We see no reason why we cannot accept that not everyone will be able to achieve inclusion into the economy, and argue instead that a mature society supports everyone on the basis, not of the work they have done, but of the needs they have.

The critique of dualism within gender studies has been informed by the work of post-structuralists such as Jacques Derrida, and post-modernists such as Judith Butler. Mairian Corker (1999) has been a pioneer in applying such ideas to the field of disability, and we believe that it would be fruitful for

disability studies to engage more extensively with the mainstream of contemporary social theory, while remaining accessible and politically engaged (see also Cashling, 1993). We would also claim that a modernist theory of disability – seeking to provide an overarching meta-analysis covering all dimensions of every disabled person's experience - is not a useful or attainable goal. For us, disability is the quintessential post-modern concept, because it is so complex, so variable, so contingent, so situated. It sits at the intersection of biology and society and of agency and structure. Disability cannot be reduced to a singular identity: it is a multiplicity, a plurality.

Social model theory has worked within a modernist context, and within rules of logic which are now actively being contested. Nancy Jay writes about the principle of contradiction (nothing can be A and not-A) and the principle of the excluded middle (everything must be either A or not-A) (Jay, 1981, 42). These modernist principles have been applied to disability, to deny that both the body *and* social barriers together can be the cause of disablement, and to argue against a middle ground between the medical model and the social model. As an example, look again at the table Mike Oliver provides to show the distinction between the individual/medical model and the social model (1996, 34). We believe that an adequate social theory of disability would include all the dimensions of disabled people's experiences: bodily, psychological, cultural, social, political, rather than claiming that disability is either medical or social (Shakespeare & Erickson, 2000).

**Only and always disabled?**

“No one today is purely one thing. Labels like Indian, or woman, or Muslim, or American are no more than starting-points, which if followed into actual experience for only a moment are quickly left behind.” (Said, 1994, 407)

Disability politics, by its very nature, often rests on a fairly unreflexive acceptance of the distinction disabled/non-disabled distinction. Disabled people are seen as those who identify as such. Non-disabled people are often not welcome. Disabled leadership is seen as vital. But Liggett argues:

“From an interpretative point of view the minority group approach is double edged because it means enlarging the discursive practices which participate in the constitution of disability. [...] [I]n order to participate in their own management disabled people have had to participate as disabled. Even among the politically active, the price of being heard is understanding that it is the disabled who are speaking.” (1988, 271ff)

Liggett is following those post-structuralist authors who point out the costs to identity politics. To be an activist - whether as a gay person, or a woman, or a disabled person - is to make the label into a badge, to make the ghetto into a oppositional culture. Yet what about those who wish to be ordinary, not different?

Many disabled people do not want to see themselves as disabled, either in terms of the medical model or the social model. They downplay the significance of their impairments, and seek access to a mainstream identity. They do not have a political identity, because they do not see themselves as part of the disability movement either. This refusal to define oneself by impairment or disability has sometimes been seen as internalised oppression or false consciousness by radicals in the disability movement. Yet this attitude can itself be patronising and

oppressive. People do have a choice as to how they identify, within obvious limitations. What is wrong with seeing yourself as a person with a disability, rather than a disabled person, or even identifying simply as a human being, or a citizen, rather than as a member of a minority community? After all, identity politics can be a prison, as well as a haven.

The unwillingness to identify as disabled - either in a political sense, or in a medical sense - is very evident in our recent research with children with impairments (the 'Life as a disabled child' project, funded by the UK Economic and Social Research Council). We started with the intention of imposing our social model perspective on their lives. Yet, because we were also following the precepts of the new sociology of childhood, and treating children as agents, and their testimony as reliable, we were forced to rethink our adult-oriented social model assumptions. The children easily identified the social barriers which they experienced, and were often vociferous in complaining about the treatment which they received. But most of them wanted to be seen as normal, though different, and actively resisted definition as disabled (Priestley et al, 1999). It has been argued that many people with learning difficulties resist being defined as disabled or different (Finlay & Lyons, 1998). We hypothesise that the same might apply to older people with impairments or chronic illnesses, who make up the majority of 'disabled people' in Britain and America.

There is also the issue of multiple identities. While some people with impairment resist identification as disabled, because they want to see themselves as normal, others are more likely to identify in terms of alternative parts of their experience. For

example, gender may be more salient, or perhaps ethnicity, or sexuality, or class, or marital status. Research on disabled sexuality has found gay people, for example, who prioritise their sexual identity, and ignore their experience of impairment (Shakespeare et al, 1996). Social model perspectives have not proved very effective in reconciling the dimensions of gender, race and sexuality within or alongside disability (Morris, 1991, Vernon, 1996). Most people are simultaneously situated in a range of subject positions. To assume that disability will always be the key to their identity is to recapitulate the error made by those from the medical model perspective who define people by their impairment. Any individual disabled person may strategically identify, at different times, as a person with a particular impairment, as a disabled person, or by their particular gender, ethnicity, sexuality, occupation, religion, or football team. Identity cannot be straightforwardly read off any more, it is, within limit, a matter of choice. Here we are with Foucault:

“Do not ask me who I am, and do not ask me to remain the same: leave it to our bureaucrats and our police to see that our papers are in order.” (quoted in Kritzman, 1990, ix)

## **Conclusion**

In the foregoing, we have developed three important criticisms of the British social model of disability, in order to substantiate our argument that it is time to move beyond the limitations of this approach. Before sketching some main features of an alternative position, we need to make an admission. We have been amongst those who have policed the social model within academia (Shakespeare and Watson, 1997), despite our own attempts to

produce a more adequate version of it (Shakespeare, 1994; Shakespeare and Watson, 1995). There is an element of inconsistency, therefore, in our current critique of the social model, and we cannot claim, with Mike Oliver, that we are now holding to the same position that we have always espoused (Oliver, 1996, 1). We would relate our changed thinking both to our personal experiences, and to the changing context. A model which was developed in the early 1970s no longer seems as useful at the beginning of the twenty-first century. As Bailey and Hall argue,

“It is perfectly possible that what is politically progressive and opens up discursive opportunities in the 1970s and 1980s can become a form of closure – and have a repressive value - by the time it is installed as the dominant genre.... It will run out of steam; it will become a style; people will use it not because it opens up anything but because they are being spoken by it, and at that point you need another shift.” (1992, 15).

To use the familiar Kuhnian metaphor, perhaps the medical model was the traditional paradigm of disability (Kuhn, 1970). As disabled people began to see that it was an inadequate way of understanding their lives, there was a paradigm shift towards various social models. These approaches were more successful in explaining the experience of disabled people, and identifying the cause of disadvantage. In the Kuhnian metaphor, we could see the shift from the medical model to the social model as analogous to the move to Newtonian physics in the Enlightenment. Yet, just as twentieth century scientists began to realise that there were limitations to the Newtonian approach, so it has become clear in the 1990s that there are problems with the social model, at least in its strong versions. We believe that it is time for another paradigm

shift, towards a model which will account for disabled people's experience more effectively.

But it is important to remember that in physics the replacement of Newtonian mechanics by the Einsteinian theory of relativity did not invalidate the former approach, but merely showed its limitations. So, by arguing against the social model we are not denying that for much of the time the priority remains to analyse and campaign against social barriers, merely that we require a more sophisticated approach to disability. This should revolve around the following points.

1. Impairment and disability are not dichotomous, but describe different places on a continuum, or different aspects of a single experience. It is difficult to determine where impairment ends and disability starts, but such vagueness need not be debilitating. Disability is a complex dialectic of biological, psychological, cultural and socio-political factors, which cannot be extricated except with imprecision.
2. Much opposition to the 'medical model' is an opposition to being defined solely on the basis of impairment, or having clinicians rule our lives. Yet it is possible to challenge these processes, without having to resort to the equally crude determinism of the social model. Disability should not be reduced to a medical condition. It should not be overlaid with negative cultural meanings. Neither should it be reduced to an outcome of social barriers alone, however important these might be in people's lives.
3. It remains vital to distinguish between the different levels of intervention, as Oliver also argues (1996, 36). Sometimes it is



most appropriate to intervene at the medical or individual level. For example, a newly spinal-injured person will almost inevitably require spinal stabilisation, rehabilitation, and possibly counselling. Yet subsequently, alterations to their personal environment will be important. In a broader sense, anti-discrimination measures will be vital to their future quality of life. Intervention at physical, psychological, environmental and socio-political levels is the key to progressive change, yet one cannot be a substitute for the other. Social change remains the most expedient measure to remove the problems presented by impairment and its consequences: this emphasis encapsulates the distinction between disability studies and medical sociology (Thomas, 1999).

4. Following Fraser and Nicholson's (1990) arguments about feminism, we suggest that disability studies should not forego meta-narratives, because disabling social relations are everywhere. However, these theoretical responses must be situated in specific contexts. For example, responses to the problems of disabled children in education, or responses to the particular issues of black and minority ethnic disabled people. As we ourselves have realised, it is tempting to generalise, but that temptation should be resisted.

5. Currently, disability studies and disability politics share the assumption that we know who the disabled subject is. Yet this cannot be taken for granted. There are over six million people with impairment in Britain alone, and our theories and campaigns relate tangentially to most of them, let alone to the half billion elsewhere in the world. Failure to follow a social model line, or join with the disability movement, may be less of a failure of particular individuals, and more a limitation of the model or movement itself.

We propose these five points as signposts in the coming construction of a more adequate social theory of disability. However, as grounding for this social theory, we want to suggest an alternative ontology of disability, which has implications not just for disability studies, but for the broader ways in which sociologists and philosophers conceive of the body. Writers on both sides of the Atlantic have proposed that it is most meaningful to consider that everyone is impaired. For example, we cite the work of Irving Zola (1989), or Allan Sutherland's suggestion that:

"A more radical approach is needed: we must demolish the false dividing line between 'normal' and 'disabled' [meaning impaired] and attack the whole concept of physical normality. We have to recognise that disablement [impairment] is not merely the physical state of a small minority of people. *It is the normal condition of humanity.*" (Sutherland, 1981, 18, italics in original).

No one's body works perfectly, or consistently, or eternally. We are all in some way impaired. Illness, as Antonovsky (1979) argues, is the human condition. Mortality, as Bauman (1992) has written, is the inescapable essence of being alive. These central truths are obscured within the Western tradition of mind/body dualism: since the Enlightenment, humans have been defined in terms of their rational capacities, that is, what separates us from animals, rather than the physical nature which connects to animals. Only minority voices such as Sebastiano Timpanaro (1975) have reminded us of the inherent frailty and vulnerability of our embodiment.

Acceptance of the ubiquity of impairment and physical limitation offers a different definitional strategy for disability studies. The British social model attempts to break the link between

impairment (the body) and disability (the social creation), in opposition to the traditional view of disabled people as medical tragedies. The argument is that the difference between disabled people and non-disabled people is not that we have bodies or minds which do not work, but that we are an oppressed minority within a disabling society. An embodied ontology would argue instead that there is no qualitative difference between disabled people and non-disabled people, because *we are all impaired*. Impairment is not the core component of disability (as the medical model might suggest), it is the inherent nature of humanity. For example, the Human Genome Project has shown that every individual's genome contains mutations: as well as predispositions to late onset diseases such as cancer, heart disease and dementia, these include four or five recessive conditions which might cause impairment in offspring, if the other parent also carried a matching recessive allele.

The ubiquity of impairment is an empirical fact, not a relativist claim. We are not trying to say that short-sightedness is equivalent to blindness, or that being unfit is a similar experience to being paralysed. Clearly, the limitations which individual bodies or minds impose (always in specific contexts) vary from the trivial to the profound. There are important differences to which theory and practice should be sensitive, but these differences cannot be straightforwardly allocated to two distinct ontological statuses. Our point is that everyone has limitations, and that everyone is vulnerable to more limitations and will, through the ageing process, inevitably experience functional loss and morbidity. Many of us will be supportive of attempts to minimise or eliminate these limitations, where possible, which does not mean 'cure at all costs'.

Moreover, while all living beings are impaired - that is, frail, limited, vulnerable, mortal - we are not all oppressed on the basis of this impairment and illness. Only a proportion of people experience the additional disabling processes of society. Put another way, societies have evolved to minimise the problems of the majority of people with impairment, but have failed to deal effectively with the problems of a minority of people with impairment. In fact, societies have actively excluded, disempowered and oppressed ('disabled') this minority. Of course, the size and nature of this minority changes. It is very difficult to achieve a core definition of 'disabled people', because it is not clear who counts as disabled or not. This is because different societies treat particular groups of people with impairments in different ways. For example, in the medieval period, being unable to read was not a problem, because social processes did not demand literacy: learning difficulties only became salient and visible once a complex social order required literate workers and citizens.

Rather than trying to break the definitional link between impairment and disability, we should expose the essential connection between impairment and embodiment. After all, as Shakespeare (1994) also argues, part of the psychological origins of hostility to disabled people may lie in the tendency of non-disabled people to deny their vulnerability and frailty and mortality, and to project these uncomfortable issues onto disabled people, who they can subsequently oppress and exclude and ignore. The continuum of impairment and embodiment is translated into a dichotomy between 'able-bodied people' and 'disabled people', as Davis (1995) and others have demonstrated. Understanding these

processes of exclusion and discrimination is where the core focus of an empowering disability studies should lie.

The central argument of this paper has been that the British social model has been an excellent basis for a political movement, but is now an inadequate grounding for a social theory. This social model was a modernist project, built on Marxist foundations. The world, and social theory, has passed it by, and we need to learn from other social movements, and from new theoretical perspectives, particularly those of post-structuralism and post-modernism. We believe that the claim that everyone is impaired, not just 'disabled people', is a far-reaching and important insight into human experience, with major implications for medical and social intervention in the twenty-first century.

### **Notes**

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