THE INDIVIDUAL AND SOCIAL MODELS OF DISABILITY

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Paper presented at Joint Workshop of the Living Options Group and the Research Unit of the Royal College of Physicians

on

PEOPLE WITH ESTABLISHED LOCOMOTOR DISABILITIES IN HOSPITALS

Monday 23 July 1990

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There is a danger that in discussing issue related to disability, that we will end up with more models than Lucy Clayton. This is dangerous in that, if we are not careful we will spend all of our time considering what we mean by the medical model or the social model, or perhaps the psychological or more recently, the administrative or charity models of disability. These semantic discussions will obscure the real issues in disability which are about oppression, discrimination, inequality and poverty.

As one of the originators of recent discussions about disability models, it is important that I clarify some of the issues I intended to raise. It is necessary to state at the outset however, that in claiming parental rights to disability models, I am not seeking personal aggrandisement nor indeed have I ever deliberately talked about or attacked the medical model of disability, whatever that is.

I originally conceptualised models of disability as the binary distinction between what I chose to call the individual and social models of disability (Oliver. 1983). This was no amazing new insight on my part dreamed up in some ivory tower but was really an attempt to enable me to make sense of the world for my social work students and other professionals whom I taught. The idea of the individual and the social model was taken quite simply and explicitly from the distinction originally made between impairment and disability by the Union of the Physically Impaired Against Segregation (1976).

I wanted to put this distinction into a framework that could be understood by professionals with a limited though expanding knowledge of disability issues. The individual model for me encompassed a whole range of issues and was underpinned by what I call the personal tragedy theory of disability. But it also included psychological and medical aspects of disability; the latter being what I prefer to call the medicalisation of rather than the medical model of disability. In short, for me, there is no such thing as the medical model of disability, there is instead, an individual model of disability of which medicalisation is one significant component.

In this paper I shall initially discuss the differences between the individual and social models of disability before going on to suggest why the medicalisation of disability is inappropriate. I shall then attempt to articulate ways in which the social model of disability can provide a more adequate basis for all kinds of professional involvement including that of medical intervention.

INDIVIDUAL AND SOCIAL MODELS

There are two fundamental points that need to be made about the individual model of disability. Firstly, it locates the 'problem' of disability within the individual and secondly it sees the causes of this problem as stemming from the functional limitations or psychological losses which are assumed to arise from disability. These two points are underpinned by what might be called 'the personal tragedy theory of disability' which suggests that disability is some terrible chance event which occurs at random to unfortunate individuals. Of course, nothing could be further from the truth.

The genesis, development and articulation of the social model of disability by disabled people themselves is a rejection of all of these fundamentals (Oliver 1990). It does not deny the problem of disability but locates it squarely within society. It is not individual limitations, of whatever kind, which are the cause of the problem but society's failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its social organisation. Further, the consequences of this failure does not simply and randomly fall on individuals but systematically upon disabled people as a group who experience this failure as discrimination institutionalised throughout society.

It would be possible to devote the rest of this paper, and much more, to discussing differences between individual and social models but neither time nor space will allow. Instead, I have attached a table in the form of an appendix to this paper which summarises some of these differences. Quick reference to this will show that I locate the medicalisation of disability within the individual model and as I have argued that this model is inappropriate, so, it logically follows, is the medicalisation process. It is to the reasons for this that I shall now turn.

THE MEDICALISATION OF DISABILITY

Why then is the medicalisation of disability inappropriate? The simple answer to this is that disability is a social state and not a medical condition. Hence medical intervention in, and more importantly, control over disability is inappropriate. Doctors are trained to diagnose, treat and cure illnesses, not to alleviate social conditions or circumstances. (1)

Justification for this criticism rests upon the distinction between illness and disability and the fact that they are not the same thing; some illnesses may have disabling consequences and many disabled people have illnesses at various points in their lives. Further, it may be entirely appropriate for doctors to treat illnesses of all kinds, though even here, the record of the medical profession is increasingly coming under critical scrutiny. Leaving this aside however, doctors can have a role to play in the lives of disabled people: stabilising their initial condition, treating any illnesses which may arise and which may or may not be disability related.

The problem arises when doctors try to use their knowledge and skills to treat disability rather than illness. Disability as a long-term social state is not treatable and is certainly not curable. Hence many disabled people experience much medical intervention as, at best, inappropriate, and, at worst, oppression. This should not be seen as a personal attack on individual doctors, or indeed the medical profession, for they, too, are trapped in a set of social relations with which they are not trained or equipped to deal.

The problem is that doctors are socialised by their own training into believing that they are 'experts' and accorded that role by society. When confronted with the social problems of disability as experts, they cannot admit that they don't know what to do. Consequently they feel threatened and fall back on their medical skills and training, inappropriate as they are, and impose them on disabled people. They, then appear bewildered when disabled people criticise or reject this imposed treatment.

Of course, one could pursue this image of doctors as threatened and bewildered too far. As society's experts they have a great deal of power and this gives them control over fundamental aspects of people's lives and they have not been noticeably reticent about using this power to make decisions about disabled people's lives; where they should live, whether they should work or not, what kind of school they should go to, what kinds of benefits and services they should receive and in the case of unborn disabled children, whether they should live or not.

However, it's not just decisions that doctors make about disabled people that are questionable; it's also about what they do to them. The whole medical and rehabilitation enterprise is founded upon an ideology of normality and this has far reaching implications for treatment. It's aim is to restore the disabled person to normality, whatever that may mean. Where that is not possible, the basic aim is not abandoned; the goal is to restore the disabled person to a state that is as near normality as possible. So, surgical intervention and physical rehabilitation, whatever its costs in terms of the pain and suffering of disabled individuals, is always justified and justifiable -the ideology of normality rules.

Further, the medical profession, because of its power and dominance, has spawned a whole range of pseudo-professions in its own image; each one geared to the same aim -the restoration of normality. And each one of these pseudo-professions develops its own knowledge base and set of skills to facilitate this. Increasingly, disabled people, individually and collectively, are coming to reject the prescriptions of the 'normalising' society and the whole range of professional activities which attempt to reinforce it.

Instead, we are increasingly demanding acceptance from society as we are, not as society thinks we should be. It is society that has to change not individuals and this change will come about as part of a process of political empowerment of disabled people as a group and not through social policies and programmes delivered by establishment politicians and policy makers nor through individualised treatments and interventions provided by the medical and para-medical professions.

This, obviously, offers a very different and challenging view not just about the nature of the problem of disability but also about what can be done about it. Equally importantly, for today at least, it raises the question of whether medicine has a role to play in dealing with disability. In the next section I will answer this in the affirmative and attempt to suggests some ways forward. I hasten to add, however, that I will not be imposing my views on doctors, I will not be telling them what to do, nor will I be prescribing treatments for their own disabilities. (2)

DOCTORING THE SOCIAL MODEL

I have already indicated that the medical treatment of illness is perfectly appropriate in most circumstances. What is at issue here is whether there is an appropriate role for doctors within the social model of disability. Answering in the affirmative does not mean that the precise nature of that role can be specified in advance for to be able to do that would be to merely replace one orthodoxy with another. It is a central tenet of the social model that problems can only be resolved by groups or collectivities working together on them; effective solutions cannot be imposed from outside or from above.

From this it is obvious that doctors and disabled people must work together to identify and tackle the problems of disability. But to say only this is so trite as to be almost meaningless. Working together requires the recognition of each other's experiences; doctors must attempt to understand why and how disabled people experience disability in the way that they do and disabled people must attempt to understand how doctors are socialised into thinking about disability in particular ways.

Most importantly, both sides must recognise that way power shapes the experience of disability for both groups. To put the matter unequivocably, the medicalisation of disability have given doctors power and left disabled people powerless. The social model is not an attempt to take power way from doctors and give it to disabled people, but a prescription for sharing power. Given that doctors have power now and disabled people don't, this inevitably implies that doctors must learn to give up some of their power and disabled people must learn how to empower themselves and what to do when they have.

By understanding the implications of the social model, power sharing may come but that by itself will not be enough. The organisational and administrative machinery which facilitate such co-operation will need to be developed if this power sharing is to be something more than tokenistic, something which most talk about but few practice. The imagination and commitment for such a task should not be underestimated for the lack of such machinery has bedevilled the welfare state since its inception and still stands as a serious bar to future progress.

Once such machinery is in place, an immediate task becomes apparent; what might be called demarcation; that is, deciding what are the relevant roles for doctors in working with disabled people and what are and are not appropriate areas for medical intervention and treatment. Only when this task has been accomplished can further issues be identified and jointly worked on. The temptation to specify further tasks is one that should be avoided for that would simply be to repeat mistakes of the past; yet another small (but different) group of experts attempting to impose their views on everyone else.

CONCLUSIONS

In this paper I have suggested that the medicalisation of disability is inappropriate because it locates the problems of disability in the wrong place; within the individual rather than in society. Further, once the true nature of the problems of disability are identified, it becomes clear that doctors neither have the skills nor the training to deal with them. Doctors and disabled people therefore, are both trapped in a set of unsatisfactory social relationships. The only escape for all concerned is to jointly work on the problems of disability within the parameters of the social model which while it does not guarantee a cure, nevertheless offers the possibility of developing a more fruitful relationship between doctors and disabled people.

Footnotes

(1) In making this statement I am not seeking to deny the long and honourable tradition of community medicine in this country; but perhaps to suggest that it has had no significant effect on the lives of disabled people.

(2) Their own disabilities, in the social model sense of the term, are the disabling barriers of the doctor patient relationship, which render the experience of disability inaccessible to doctors.

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