The social and medical model of disability

ASSIGN BUSTER

To what extent does legislation relating to disability support the social model? And to what extent does it still reflect a medical model of understanding?

Introduction

This study will discuss the extent of which legislation in relation to disability sustains the social model and to what measure it contemplates a medical model of understanding. This will be in the context of relevant sources including, current government legislation. This will be in relation toEducation, charity and access to goods and services. In addition, based on research, the findings will be summarised and a conclusion will be provided.

There are various models of disability that have been defined over previous years; two of the most value are the medical (Elkins 2009) and social model of disability (Giddens 2010). There are various models of disability that have been defined over previous years; two in particular being the medical and social model of disability. The moral model of disability refers to disability as a result of sin whilst the medical model, on the other hand, refers to disability as an illness which needs treatment through desired medical interventions (DDA, 2005). The disability model refers to the dictatorship attitude of the professionals, insufficient services of support from society, various kinds of attitudinal, sensory and cognitive barriers in the disability community as a generalised section of population facing difficulties in education services, employment and access to servcies (Barnes et al., 1999).

The medical model views disability as a ' problem' within the disabled individual with the most emphasis being solely placed on their ' impairment'

as opposed to any social or environmental influences. This in turn presents with the idea that people who have a disability can be cured, such that, society views them as ' normal'. This ' normality' can be achieved with the help of medical intervention. The model categorises individual conditions according to medical schema which includes disabilities such as Attention Deficit Hyperactivity Disorder (ADHD), Epilepsy and Dyslexia In modern society, the medical model continues to shape practice and provision, yet also manages to create inequality, being subjected to heavy criticism for being ' de-humanizing' and approaching individuals as a disorder and not as human beings.

During the 20th century the medical model became a dominant criterion as to how people viewed disability. The model is itself, based upon traditional understanding. This is further supported by the British Film Institution (BFI 2012) comments;

' During the period of the 18th century based on assessments of impairments from a deficit point of view against normality: what one cannot do instead of what one can do".

However a report by International Staff (2009, p. 1) argues;

'...the medical approach to disability is useful if it used to support the actual medical needs of disabled people and to improve their ability to function as independently as possible'.

In the 1960's and 1970's, many individuals who had a disability began to question and challenged the fact that they were being treated differently to

others in society specially in educational institutions and work place. This in turn presented with a backlash of criticism from supporters of the medical model. This lead to the beginning of the Disability Rights Movement (Fleischer & Zames 2001), which gave individuals the opportunity to gain acceptance and to secure equal opportunities and equal rights for all individuals with a disability. Additionally, the movement also gave people an alternative view to how they perceived disability called the ' social model'.

The history behind the model is due to the civil/human rightsmovements of the 1960's (Degener & Koster-Dreese 1995). Their view became further enhanced by the formation of the Union of the Physically Impaired against Segregation (UPIAS) a disability rights organisation who aired their own opinion on the issues found in disability (UPIAS 2012). In 1976 the UPIAS produced a document in response to The Guardian's printing of a letter by Paul Hunt in 1972 (Shakespeare 1998), calling for the formation of a group that would allow the views of disabled people themselves to be heard leading to the creation of the social model.

The social model approaches disability with a view that people that have particular incapacities, cannot function to the best of their ability and furthermore, how society perceives them overall. The social model began to remove barriers allowing a differentiation to distinguish between impairment and disability. This in turn allowed some of the aspects that emerged from the medical model to integrate within society; that is, make some of the exclusionist values of disabilities to be ' included' within the social world. The social model works on a large scale and is succeeding in tackling

discriminatory social structures and demonstrating our need forcivil rightslegislation.

The medical model of disability came in to existence in the 19th century when the role of the physician became eminent within society. People with perceived disabilities were expected to receive benefit within the medical directives. As per the medical model, the issues encountered by the disabled, due to their suffering, were perceived to be present within them and hence any solution to the problem when addressed would suggest that the problem could, in essence, just disappear. The wider society believed that there was noresponsibilityfor them to creating space for the disabled within their social worlds, as everyone has their own issues of concern (Audit Commission, 2002).

The individual is treated as a sick entity within the medical model and are looked upon by external society members as excluded individuals, who are set free of normal obligations of society which include attending education, taking up professional work and taking upfamilyresponsibilities. Furthermore, they are also given extra attention with regards to medical alertness in an attempt for the individual to be cured of the existing disability. It can therefore be concluded in short, that disability issues and associated policies are regarded as a matter of concern when coupled with education and services of work. This is due to the fact thathealthissues cause physicians to be treated as primary policy authorities (Burchardt, 2003).

Both the social and medical model has strengths and weaknesses. In regards to the social model, it aims to remove barriers so that disabled individuals

are given the same opportunities as able-bodied people. This will enable them to determine their own path in life. Furthermore Tom Shakespeare's chapter on the social model (Shakespeare 1998) has suggested that the issues individuals with disabilities face, are purely socially constructed. They face exclusion on a daily basis and therefore, it should be society's responsibility to encourage inclusion and to remove the burdens placed on disadvantaged individuals to further allow them to participate.

He further suggests that;

"…the social model has been effective psychologically by in improving the self-esteem of disabled people and building a positive sense of collective identity"(Shakespeare 1998, p. 199).

However, the social model has come under scrutiny. Although it may have changed the way people perceive individuals with a disability, it still seems to fall flat when it comes to approaching an individual's actual impairment. The model has strongly disregarded medical and individual approaches to disabilities, that it is beginning to risk suggesting that impairment is not a problem altogether.

The medical model also presents with a variety of weaknesses. It is too reliant on medical conditions per se and is preoccupied with being able to cure people with a disability. This may result in low self-esteem for the individual with the disability, resulting in them questioning as to why they are not like others. However, with that being said, the model also fails to recognise that people who are classed as disabled can have the same opportunities as other people who are viewed as ' normal' by society.

It is just that they have to adapt and fit into society without being judged because of their disability. However the strengths of the model are that although there is currently no cure for a large variety of disabilities, it is one of the only methods actively seeking ways for ways for people get better. In today's society, the medical model influences the disability public legislative policy, especially in terms of our social security system by where disability is defined as the incapability to take up any kind of professional work.

The medical model acts as a foundation for various problems for people suffering from disabilities who are interested in work. This is due to a fear of losing various public funds such as health care cover, social security, protection, allowances, personal functioning and home chore services if they are to start work. Numerous medical interventions are required by disabled individuals due to their chronic medical conditions which cannot be cured instantly. However, disabled people are capable of partaking in professional work and within society as a whole just as any other individual.

The entailing benefits of the medical model however are essential and the practice associated with the model in relation to detention and institutionalization of the disabled individual is not accepted by many social critics. Not to mention many subdivisions of the disabled individuals themselves (DfES, DH and DWP, 2007).

Alternatively, the disability model in terms of legislation has grown stronger due to the proposal of independent rights for disabled individuals. The disability model in comparison to that of the medical or rehabilitation model does not treat individuals as ' sick' or incapable but treats their disability as

a normal facet of life (Oliver, 2007). Research evidences also condemns that a disability should be treated as a factor of deviance as it degrades the moralrespectof the individual, and also makes them appear lethargic to the system. In addition, investigation also revealed that the disability model identifies socialdiscriminationas one of the most noteworthy issues faced by individuals and is directly responsible for other problems associated with other models. Researchers also focus that as per the definition of disability by the UN, ' disability' itself is regarded as a social construct by where people have a deeper understanding of what an actual disability is, when compared to ' handicapped' and ' impairment' (Goldstone, 2002).

To conclude, although there are many advantages and disadvantages which are specific to the relative disability model discussed in detail in the previous sections, there is always a question which remains unanswered with regards to how far these models are serving to benefit the disabled. Many research papers and arguments of sociologists have been referred to and studied as a part of this essay it has been identified that none of the identified disabled individuals likes to be treated as a separate ' entity' from society or as a discriminated individual (DfES, DH and DWP, 2007). All showed interest to carry on normal activities within society. There is however, an overall characteristic of greed within ' society' over various provisions of the government to support them. Many feared that they would lose the benefits if they rejected to be given priority under disability especially as per the medical model (Needels and Schmitz, 2006).

Overlooking the benefits of tagging themselves as disabled, the disability model as per UN definition highlights that there are primary advantages

which override apparent disadvantages. This refers to being considered normal within the community where the stigma and discrimination systems are aiming for eradication. Support has been rendered by most of the disability activists in this perspective to receive the cooperation of persons suffering from invisible disabilities (DCLG, 2006).

The supporters for this cause believe that freedom from discrimination is not a kind of privilege which can be obtained partially or in recurrent doses. Rather, it is a mode of identity to recognise one's own characteristics and true capabilities away from the hidden benefits of the system. It allows one to identify with facets of strength and allows for a development of self-respect. Research also reveals that the main cause of discrimination for disabled individuals, aside from the suffering disability, is the disgrace and stereotype held within society towards disability and the disabled (Hurstfield, 2007). It can therefore be condemned that disability is not the cause for discrimination at all. It is the social elements created within society towards disability that is marked as a real cause. To curb this anti-social element, putting forth the disability model in conjunction with the medical model is an essential approach, alongside certain social and legal activities which intend to challenge the postulations and assumptions governing disability discrimination. The primary objective in the future is to utilise the models of disability as discussed within this text and to exterminate the stigma (DCLG, 2006). To serve the intention, many disability rights movements and the utilisation of ever increasing technological tools present as essential, both as tool ofcommunicationand as enhanced method by which the disabled can live in comfort (Oliver, 2007).

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