

Challenges to the Biomedical Model of Disability

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“All too often, the way we see the problem (meaning our explanatory paradigms), is the problem” (Harper, 1991, p. 534). Models of disability provide definitions of disability, offer the explanation for the cause of the disability, and present the solution or treatments based on the perceived needs of the individual with a disability. Presently, there are challenges to the Biomedical Model of Disability. Proponents of the Sociopolitical Model of Disability define disability as a loss or limitation of opportunity brought about by social and physical barriers and, therefore, the appropriate solutions are the transformation of policies, laws, and public attitudes. The Biomedical Model considers pathology, impairment, or dysfunction to cause disability, while scholars and disability advocates who subscribe to the Sociopolitical Model assert that it is society that disables people who have impairments. Moreover, advocates of the Sociopolitical Model believe that much of the prejudice and discrimination experienced by people with disabilities occurs not **in spite of** the Biomedical Model, but **because** of the Biomedical Model. Indeed, Harlan Hahn (1985, 1988, 1993) termed the Biomedical Model of Disability a “metahandicap,” while others state the search for the origins and causes of prejudice against people with disabilities inevitably leads back to the Biomedical model.

The specific challenges to the Biomedical Model include: 1) This model relieves society of any responsibility to provide accommodations or civil rights to people with disabilities 2) This model has guided both legislation and the payment systems for people with disabilities and therefore has resulted in the daily-lived lives of people with disabilities and 3) This model has fragmented the disability community into diagnostic categories and thus robbed them of their collective history and memory. The rather dated criticisms of the Biomedical Model of Disability, including the pathologization, categorization, objectification, and privatization of disability, are once again discussed, but in the Sociopolitical Model, these shortcomings are viewed as having far-ranging effects.

1. The Biomedical Model of Disability Relieves Society of Any Responsibility to Provide Civil Rights and Accommodations.

The Biomedical Model has had dominance in shaping the public’s understanding of disability because of the following factors: a) the long history of the Biomedical model, b) its reliance on the prestigious and authoritative academic disciplines of medicine and science, c) its strong explanatory power, and 4) the public’s intuitive understanding of medical diagnoses. Moreover, many disability scholars feel that the dominance of the Biomedical Model will continue, and increase, as the profession of medicine evolves into more specializations.

According to proponents of the Sociopolitical Model, society considers disability to be solely a medical concern and therefore society has not afforded people with disabilities the right to make claims on social justice (Liachowitz, 1988; Longmore, 1995). Indeed, until recently, the Biomedical Model itself has been silent on issues of social justice. While no one believes that medical professionals deliberately created injustice and discrimination, nonetheless, the result has been injustice. Scholars feel that disability has been “misrepresented” as only a health concern and because of this discrimination and prejudice based on disability result, but also frequently remain

unrecognized. Further, to the general public, this discrimination and prejudice does not **appear** to be prejudice and discrimination because it is the medical professions who have been given the mandate to respond to all the needs of people with disabilities.

Defining disability as solely a medical concern that requires high levels of expertise, training, and technology also lends scientific credibility to the idea that all of the difficulties experienced by people with disabilities are the result of their physical abnormalities or physical inferiority. However, many individuals with disabilities report that their greatest difficulties have nothing to do with the disability itself. Rather, their greatest difficulties are the result of social isolation, prejudice, and discrimination. A disability scholar, Higgins (1992) summarized this when he remarked that we make people with disabilities foreigners in their own country.

The well-defined normative basis of disability of the Biomedical Model also relieves society of any need to provide accommodation. The entire focus is on changing the individual (rehabilitation) rather than changing the environment (accommodation). In the Biomedical Model, disability is thought to be dysfunction, abnormality, pathology, disease, or defect. Simply stated, it is better not to have a disability. Disability is deviance, not a valued difference. Therefore, individuals with a disability understand that they belong to a devalued group, regardless of their individual attributes, achievements, or resources. Often individuals with disabilities eventually accept the disabled role of inferiority and deviance. Others, like the Deaf Culture, refuse the “disabled role” and consider themselves to be a cultural group defined by the use of American Sign Language, rather than a disability group.

Due to the normative basis of the Biomedical Model, many individuals with disabilities have felt that physicians and other medical professionals have consistently underestimated their quality of life. While medical professionals often view disability as an unending, personal tragedy, many individuals with disabilities feel that the disability is a valued part of their self-identity and take pride in their mastery of the disability. Difficulty does not automatically translate to tragic.

In addition, the Biomedical Model considers the disability to exist solely within the individual and, due to this privatization of the source of the disability, the responsibility attribution for the treatment of the disability is also privatized, resting solely with the individual and his or her family. In the Biomedical Model, pathologizing and privatizing disability was another way in which to effectively absolve “society” from any responsibility to deal with disability issues. It was the individual who was required to adapt and adjust.

2. The Biomedical Model of Disability has resulted in the Daily, Lived Lives of People with Disabilities.

The Biomedical Model has provided the basis for much of the legislation that mandates services for people with disabilities and also guides the reimbursement and payment systems of government agencies and insurance companies (Berkowitz & Hill, 1986; Wolfensberger, 1972; Zola, 1993). Therefore, both the services and funding the individual with a disability receives are based on the Biomedical Model. The profession of medicine has, for centuries, been based on the two outcome paradigm of cure or death and vestiges of this paradigm are reflected in payment systems. Therefore, after medical stabilization, much of the funding is withdrawn, not taking into consideration the individual’s greatest needs (Yelin, 1992). Nonetheless, disabilities are chronic conditions which

require care and not cure. Health maintenance, patient education, maintaining the highest quality of life, avoiding secondary conditions, and responding to interaction of the disability with the aging process are all medical services that are necessary for someone with a disability, but typically are not funded.

Simply because the Biomedical Model does not take the environment into consideration, payers will not see the individual benefits (or overall social benefit) of paying for services such as marital counseling or other types of counseling. Environmental and social interventions frequently are not funded. Interprofessional collaboration is often thwarted when government agencies and insurance companies do not facilitate the funding, assuming that medical practitioners are the sole authority on disability. The cultural identification of the individual is often ignored because the Biomedical Model is based only on biological, organic needs. Psychiatric disabilities, which are highly dependent upon the environment of the individual, are not well-funded. Such environmental accommodations could render the individual highly functional (Wright, 1991).

It is true that the *International Classification of Impairments, Disease, and Handicaps* (World Health Organization 2001) does provide a separate axis or domain on which to code some aspects of the individual's environment; however, "the user of the ICDH cannot record or measure the effect that an unaccommodating environment has on people's lives. The user can record changes in a person's level of ability, but would have no way of knowing whether that was the result of changes to the person (rehabilitation) or changes to the social and physical environment (accommodation.) As far as the ICDH is concerned, the social and physical world is immutable and benign" (Bickenbach, et al. 1999, p. 1175).

3. The Biomedical Model Has Fragmented the Disability Community into Medical Diagnostic Categories.

The Sociopolitical Model asserts that the Biomedical Model, by dividing individuals into groups based on diagnostic categories or functional traits, has effectively fragmented people with disabilities into competing interest groups. Thus, there are interest and advocacy groups for "the blind," "the deaf" and for the "mentally ill" and each of these groups must compete with each other for social attention. The various disability groups must compete for tangible resources and services.

Due to this fragmentation, until recently there were no broad-based groups representing people with all types of disabilities. Indeed, some disability advocates credit this medical fragmentation for the relatively late date (1990) of the passage of the Americans with Disabilities Act (ADA). When disability groups are polarized, a victory for one category of disability is often viewed as a loss for competing groups. (Walkup, 2000, p. 410). The lack of such broad coalitions has also deprived individuals with disabilities of a collective history or memory.

Physicians and other medical professionals understand the purpose of diagnoses and categories is simply to direct the treatment and intervention plans. Nonetheless, people with disabilities are often sensitive to such categorization. Many individuals with disabilities resist this categorization because they feel that the different resources and needs of individuals with the same diagnosis can differ greatly but, nonetheless, all individuals with the same medical diagnoses are treated with uniform procedures.

Conclusion:

Both the Biomedical Model and the Sociopolitical Model are reductionistic because each emphasizes some aspects of the disability experiences and each model ignores other aspects. No one, including the proponents of the Sociopolitical Model, advocates abandoning the Biomedical Model of Disability. Rather, the Biomedical Model should be questioned and challenged. Further, individuals who experience disability do not conceptualize their lives in terms of these neat, somewhat artificial, models.

Medical practitioners will benefit from an understanding of these challenges. Often, our theoretical orientation and assumptions about professional practice remain invisible to us. If we are compelled to think about the definition of disability, we are also required to consider the meaning of normality. Models of disability can be a useful tool for conceptualizing these important concepts.

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