The Prevalence of the Medical Model of Disability in Society

AHS Capstone Disciplinary deliverable
Katie Sullivan May 2, 2011

Introduction

In early America, people with disabilities were often abandoned, sent to asylums, sold off to freak shows, and even sterilized (Jaeger 27). Such confinement and isolation of people with disabilities reflected the negative societal attitudes held toward human difference. People with disabilities were commonly feared, pitied, and neglected (Braddock & Parish 13). Even today, people with disabilities are still often seen as “different” from “normal” people in society and are frequently attributed stereotypical characteristics such as weakness, dependency, and incapacity.

Recognizing the presence of these negative perceptions and attitudes towards people with disabilities is important for a variety of reasons. For one, attitudes are known to shape and direct people’s actions. When low expectations are held for people with disabilities, for instance, employers may be less likely to hire them. Such discrimination, intentional or not, has a detrimental effect on the lives of people with disabilities. In addition, most of us reach a determination about our intelligence, appearance, and intrinsic worth through a process of learning how others see us (Jenkins 30). If people with disabilities feel that they are constantly perceived in a negative light, this can lead to a cycle of dependency and exclusion, turning the negative perceptions into a self-fulfilling prophecy (Rieser 118).

The models of disability are conceptual frameworks for understanding disability which can provide some insight into why certain attitudes exist and how they are reinforced in society. The two main models are the medical model and the social model. Both models will be explored in more depth. Briefly, the medical model sees disability as a medical problem, a defect, lying within the individual. This model is the root of most negative attitudes held towards people with disabilities; they are seen as defective and dependent, in need of cure or rehabilitation (Oliver 15). The social model on the other hand, having emerged from the disability rights movement of
the 1970s, sees disability as stemming from societal and environmental barriers. People with disabilities are seen not as defective, but rather as valued, “normal” members of society. A closely related model is the diversity model, which sees people with disabilities as part of the fabric of society. The social and diversity models lend to much more positive and humanistic portrayals of people with disability; unfortunately the medical model is still quite prominent in many aspects of life, ranging from language and the media to education and technology. In this paper I will describe both models in more depth, and explore their influences on many aspects of life. In particular I examine how the medical model’s presence serves to propagate negative perceptions of disability. As an addendum to this paper I administered a survey to Olin College students designed to reveal which model of disability Olin students tend to lean towards. The survey results showed that while the social model is currently more acceptable, the medical model still has lasting effects on attitudes towards disability.

**Medical Model**

With the rise of the medical profession in the late 19th and early 20th century, the medical model began to dominate views of disability (Midgley 446). In this model, also known as the individual model, the problems associated with disability are seen as lying solely within the individual and his or her medical condition or impairment. The desired solution to these problems is often the cure or rehabilitation of the individual, in order to fix the “defect” so that he or she can become closer to “normal.” Under this model it thus easy for people with disabilities to be viewed as weak and defective, needy and dependent (since they are assumed to require the aid of medical professionals), and generally incapable of getting good jobs, living on their own or participating fully in society. When people with disabilities are seen as sick, as in the medical model, they may tend to be excused from normal obligations in society and are isolated from the rest of the population. These low expectations are damaging both to those with disabilities and to society as a whole. When the medical model is the dominant view of disability, it is therefore easy to see how negative perceptions of disability are constructed and reinforced, and how people with disabilities are marginalized in society.

In the medical model, society is not seen as having any underlying responsibility to accommodate people with disabilities; people must instead adapt themselves to existing
circumstances, usually with help from medical professionals who provide treatment and rehabilitation (Kaplan). It is assumed that any problems or issues of access that one might face are a direct result of one’s medical impairment and would disappear if only the person were “cured”. This goes to show the emphasis the medical model places on disability being an individual deficiency, a medical condition that ought to be fixed. Making society accessible is not a solution in this model. As long as barriers exist in society, those with disabilities are made to feel and seem like they do not belong in the “normal world.”

There are some situations in which the medical model may make the most sense. For instance, when disabilities have chronic pain and reduced chances of living a long and healthy life, it may be alright to focus on finding some sort of a cure. It is not solely the finding-a-cure part, however, that makes the medical model the root of many negative stereotypes of disability. It is mainly the view that people with disabilities have a problem that makes them different from “normal” people. Because of this view, there is a tendency to separate people with disabilities from the rest of society, which has shaped social roles and classifications for many years (Jaeger 33), explaining the presence of pity, fear, and patronizing attitudes that are encountered even today.

Social and Diversity Models

In the 1970s, following the Civil Rights Movement in the United States, people with disabilities rallied for equal rights and access and adopted a new social model of disability (Shinohara 1). The social model rejected the idea of disability as a medical condition. In this new model, people with disabilities are seen not as “different” and defective individuals, but as valued members of society who have the right to full participation.

The view that people with disabilities are inferior, or in need of a cure to become “normal”, is rejected. Rather than designating the individual’s impairment as the source of the problems associated with disability, this model locates the source within society, noting society’s hostility towards some bodies and not others (Jaeger 15). In the social model, disability is therefore everything found in society that isolates and excludes disabled people: prejudice and discrimination, inaccessible buildings and transportation systems, segregated education, and so forth (Oliver 33). Instead of the solution being to “cure” the disability within the individual, the
solution is to fix society, to enable access, and to reduce discrimination and negative attitudes in order to ensure all its citizens can participate fully. The social model proposes that without all of these social and environmental barriers, there would be no disability.

Because there is so much less of an emphasis on any deficiency or problem lying within the individual, and more of an emphasis on societal inclusion, the social model allows for a much more humanistic portrayal of people with disabilities.

The social model was proposed mainly by those with physical disabilities who frequently encounter architectural and physical access barriers. It is easy to see why they would choose to adapt a model calling for societal responsibility to accommodate everyone by eliminating all barriers. The diversity model of disability does not explicitly call for societal change yet is very similar to the social model in the sense that every member of society is valued and should be active and capable. While the medical model explains disability as a deviation from what is considered normal, the diversity model explains disability “as a variation of the human condition, another characteristic among the broad range of traits present in society” (Mackelprang 16). Diversity can indicate a healthy thriving society, so this model tends to look into the gains that come with physical differences, and portrays disability in a positive light. According to psychology professor Harlan Lane, deafness may not be viewed as a deficiency but rather as a culture with its own marvelous language, shared ancestry, common stories and artistic traditions, and a community that perpetuates cultural norms through the generations (Sanger-Katz). This example of “Deaf gain” shows how Deaf culture is a positive effect of the existence of disability in the world. Some disabilities allow people to develop strengths by virtue of the necessary adaptations; for instance, blind people may develop heightened auditory and tactile senses. Even without such special skills, people with disabilities, like everyone else in society, have experiences and backgrounds that make them unique and valuable individuals. In other words, human difference is seen as a good thing. This way of looking at people with disabilities encourages them to acknowledge their strengths and assert their capabilities rather than remain objects of pity and dependency (Mackelprang 17).

**Prevalence of the Medical Model**
Even though the medical model has been rejected by Disability rights activists, and the majority of recent US public policy is now in favor of the social model, medical model views are nonetheless still prominent in society. It is important to be conscious of which models are used, because the models heavily influence people’s attitudes and actions. In the following sections I look at several areas where the medical model is still prevalent and contributes to the reinforcement of negative attitudes.

**Language**

One area where we can see the lasting influence of the medical model is language. Language is “the architecture of our thoughts and a primary conveyer of a culture and its attitudes,” both expressing and shaping ideas (Shapiro 37). Language has the potential to be labeling and oppressive, to perpetuate misconceptions, and to reinforce stereotypes of disability such as weakness, dependence and incompetence. In the survey on perceptions towards disability administered to Olin College students, several questions were designed such that the language of the responses could be evaluated to reveal attitudes toward disability. Terms such as “lame”, “crippled”, and “retarded” often have negative connotations, evoke unattractive images, and dehumanize those with disabilities.

Language can also show how society views the nature of the relationship between a person and his or her disability. A phrase such as, “That person is a *victim* of cerebral palsy” disempowers the person with the disability, making it look as if the disability is a condition that defines one, reducing his or her independence and ability to function as a “normal” member of society (Linton 25).

Grouping people with disabilities together, such as in the term “the disabled” describes a homogenous group unified by a medical condition; it ignores the diverse types of disabilities and the uniqueness of individual people. Putting emphasis on the person and not the impairment is a step towards the social model, for the person is seen first as a member of society instead of just being defined by a medical impairment. This is the reasoning behind people-first terminology, which has been adapted as the standard in the United States. Instead of the term “disabled person”, in which the world “disabled” seems to be the defining characteristic, the term “person with disability” is used to put primary emphasis on the person.
Despite efforts to use more socially-conscious language, negative language (often having its root in the medical model of disability) is still used every day. When language that stems from the medical model is used, intentionally or not, the views of this model are constantly reinforced in society.

**Media**

The media as a whole is a major proponent of medical model views of disability, not just through language but through the overall portrayal (or lack of portrayal) of people with disabilities. Literature and mass media reinforce the view that disabled people are more different from us than they are like us (Bowe 110). As in the diversity model, human difference can be a positive thing. However when it becomes an “us versus them” issue, people with disabilities are left shown as less capable and separate from the rest of “normal” society. This is significant because much of the general public gets a lot of its information from the media and will be strongly influenced by what is shown.

Although people with disabilities represent around 20% percent of the American population (under the World Health Organization’s definition of disability, according to The World Bank) they are often absent from the media. Even when they are present, it is very rare for people with disabilities to be showcased as “normal” characters; people with disabilities in the media tend instead to be one-dimensional characters with a flavor of evil, danger or pity (Bowe 110). Just as how the medical model doesn’t see people with disabilities as capable of participating in “normal” society, the lack of disabled characters in “normal” roles in the media perpetuates their absence in social structure (Wood). The media can even go as far as to imply that life with disability is a deficient, incomplete life not worth living, an extreme case of medical model beliefs. This was evident at the end of the 2004 film *Million Dollar Baby*, where the main character’s desperate request to be euthanized (after a boxing injury paralyzes her and she sees no further reason to live) is granted as a “happy” ending.

Two major examples of media portrayal categories that stem from the medical model of disability are the pitiable poster child and the inspirational supercrip. The pitiable poster child is used in the media as a dramatic element intended to evoke sympathy. The drama and emotion of misfortune and tragedy are mainly used to elicit strong response from viewers, and do not give
an accurate portrayal of disability (Schwarts 1992). A famous example of the use of this type of representation can be found in the Jerry Lewis MDA Telethon. This is a long-running telethon intended to raise money for the Muscular Dystrophy Association. Central to the program is the constant depiction of cute and courageous children, who are shown smiling despite their cruel fates. These poor adorable children are often referred to as the “most beloved American symbol of disability” and are supposed to influence the American public to make contributions towards curing and treating those with disabilities (Shapiro). Muscular dystrophy is actually an example of a disability where the search for a cure is legitimate; MD can have pain and very troublesome health effects in the long term and cannot really be compared to a disability such as deafness where there is mainly a cultural and communication difference. Despite this justification for seeking a cure, the pitiable poster child representation still manages to devalue those with disabilities and leads to perceived inferiority. The Jerry Lewis Telethon represents medical model views because not only does it portray those with disabilities as needy, weak, and dependent, but it also puts forth the message that the ultimate goal is only for the cure of the disability rather than for any changes in society and the environment.

The inspirational supercrip is another portrayal which reveals how the medical model is rooted in the media and which succeeds in projecting unrealistic views about disability. Supercrips are people or characters who conform to the medical model by overcoming disability, and becoming more ‘normal’, often in a heroic and extraordinary way (Roper). For example Wilma Rudolph, a woman who was paralyzed from polio as a child and went on to become a track star, was portrayed in the media as brave and inspirational for “overcoming” her disability. A year 2000 children’s book telling her story says, “If it had not been for the kindness of a local black doctor, Wilma might never have had the courage to overcome her disability.” (Flanagan 19). The medical model of disability is very clear in this statement, which associates Rudolph’s success with her “cure” and which shows her as greatly benefiting from the care of medical professionals. The amount of praise and admiration for the success of a person with a disability implies one is not expected to succeed if one has a disability. As a deaf student, I often hear from acquaintances how my academic success “despite my hearing loss” is inspirational to them. Seeing disability as a flaw or tragic medical condition that must be overcome (through bravery and perseverance) suggests individuals with disability must “overcompensate and become superhuman to be accepted by society,” a very unrealistic expectation (Jaeger 116). In the
previously mentioned Olin survey on disabilities, students were asked to describe their first impression of a man in a wheelchair playing basketball. While some gave expected answers that might apply for watching anyone play basketball (e.g. “fit”, “active”), quite a few gave supercrip-like adjectives such as “brave”, “heroic”, and “inspirational.” Would it be normal to see a non-disabled man playing basketball and think of him as brave? This may indicate lowered expectations of those with disabilities if we are awed and blown away by them participating in “normal” activities.

There have been several attempts at more accurately showcasing people with disabilities in the media. Acknowledging the fact that disability is a part of daily life adding to the diversity of society and avoiding one-dimensional sensationalist characterizations are good practices when it comes to portraying disability in the media. Characters with disabilities should be represented in a wide variety of everyday roles and situations. Several movies, such as Notting Hill, The Replacements, and Four Weddings and a Funeral, have taken the step to portray people with disabilities in more everyday roles. The first two include characters in wheelchairs, and the latter includes deafness and sign language, neither essential to the plot nor given special attention, but simply there to represent normal scenarios in society (Erin). These kinds of media portrayals represent a step away from medical model views and showcases people with disabilities as “normal” people who participate in society.

Despite sporadic success in switching over to social model representations, the media is still largely responsible for propagating medical model views. One reason for this is the under-representation of people with disabilities in the media workforce. This prevents those with disabilities from influencing how they are portrayed in the media, so stereotypes remain prominent (Wood). Filmmakers may capitalize on the pitiful, tragic, or inspirational stereotypical media portrayals of disability as an easy way to aid their plot.

Unlike in the civil rights movements for racial and gender equality, the disability community has never had many role models or famous public figures to advocate for the social model of disability. Christopher Reeve is an example of a well-known movie star with a disability who had the potential to strongly influence how the public perceived disability, yet did not. His words and actions showed that his beliefs were in line with the medical model. Reeve,
who became a paraplegic after a horse accident, made it clear that he thought disability should be fixed (what with his intense focus on finding a cure) and that he was unconcerned with improved access such as lower sidewalks and better wheelchairs (Areheart 206). Acquiring a disability suddenly and late in life can be very hard to accept so Reeve’s attitudes were not unexpected. Nevertheless, given his high reputation, there is no doubt that his attitude played a role in allowing medical model views to remain in society.

**Legislation**

In the past, many states had laws allowing local school districts to deny access to education (Banks 320) and laws permitting the involuntary confinement of people with disabilities (Parry 4). Such laws operated on the view that people with disabilities had no place in “normal” society. However, in the 20th century, particularly after the disability rights movement of the 1970s, public policy has leaned towards the social model. One example of legislation where this can be seen is the Americans with Disabilities Act. This act, passed in 1990, was intended to provide access for and reduce discrimination against people with disabilities when it came to mainstream education, employment, and recreation (“Americans with Disabilities Act of 1990”).

While legislation can mandate behavioral change, it doesn’t always have an immediate impact on attitudes. It takes more of a wide-spread effort (including dialogue, advertising, and media presence, for example) to alter public perceptions and social norms. In fact, so long as the media still puts forth negative medical model views, legislation will not be able to successfully push society towards the more humanistic social and diversity models.

While the ADA was intended to make a transition to a social model view of disability, the ongoing public representations of disability and the federal courts’ treatment of disability have prevented the full realization of this goal (Areheart 184). Cases involving the ADA are potential opportunities to raise awareness of social issues regarding disability such as access and discrimination. However, the Supreme Court’s interpretations of the ADA have for the most part served primarily to place more and more limitations on who qualifies for protection under disability laws. Under the ADA, if one feels that he or she has been discriminated against, then one must prove he or she has a disability that substantially limits major live activities (often
through medical diagnosis), that he or she has taken all possible mitigating measures, and then of course also that discrimination has actually occurred (Jaeger 45). It is often easier for defendants to make the claim that the person does not really have a disability or that the person has not taken enough corrective measures, rather than to argue that discrimination didn’t take place. This resulting preoccupation with the medical definition of disability takes focus away from the actual problems in society that the ADA was designed to address.

**Education**

One major issue within disability policy is the education of people with disabilities. In early America, children with disabilities were often isolated or even barred from schools. The historical practice of denying children with disabilities equal access to education meant that students with disabilities were often uneducated, socially stigmatized, and emotionally traumatized (Banks 320). Now, however, with public policy leaning towards the social model, people with disabilities have much more educational equality and opportunities. The 1975 Education for All Handicapped Children Act mandated that schools provide free public education to all students with disabilities (“Special Education Inclusion –WEAC”).

However, this often meant students with disabilities were still segregated and placed into separate classrooms. Such special education can propagate negative stereotypes; for instance, that students with disabilities are different and less capable than mainstream students. When some students are isolated and stigmatized, others see them as different and incompetent, and because of their isolation, easily avoidable (Linton 63). These stereotypes are all rooted in the medical model of disability which sees disability as a problem within the individual and sees the person as separate from “normal” society. This is a problem because the attitudes of teachers, staff, and fellow students play a huge role in shaping a student’s views of him or herself.

When education is inclusive, disability is seen as part of, not outside of, everyday life. A policy of inclusion is better, but only if the education is accessible to the student. The Individuals with Disabilities Education Act (IDEA) modified the Education for All Handicapped Children Act to require that children with disabilities be educated in the "least restrictive environment appropriate" to meet their “unique needs” where the least restrictive environment begins with placement in the regular education classroom (“Special Education Inclusion –
Even though this was intended to guarantee equal access to public education, it has had obstacles such as inadequate funding, emphases on standards, and disagreements over best practices (Jaeger 64). If teachers are not prepared to work with students with disabilities, then the students will just be isolated in the classroom.

US Secretary of Education Arne Duncan expressed what appeared to be a social model view in his March 2011 remarks on the education of students with disabilities. The government takes an inclusion standpoint, believing that students with disabilities should be held to the same high expectations as all other students and that local educators must be empowered to accommodate all types of students. In his speech, Duncan discussed the abolishment of the 2% rule (a previously-existing rule within the No Child Left Behind Act whereby schools had the option of disguising the educational performance of the lowest 2% of students). The abolition of this rule was meant to show that the government expected the very best from all students and that “all students should be given the support and services they need” and not be merely excused or disregarded (Duncan). However, bringing up this rule in a speech regarding disability hints towards Duncan’s low expectations for those with disabilities: Even though the original law had nothing to do with disability (“No Child Left Behind- ED.gov”) he seems to assume people with disabilities would be in this group of underperforming students. Despite striving to adhere to the social model, negative attitudes like these serve to marginalize people with disabilities. Quotes within Duncan’s speech such as “Equality and inclusion are at the heart of the American ideal” illustrate admirable goals but are not necessarily what happens in real life, thanks to the persistence of medical model views.

**Technology**

One last area where we can examine the influence of the models of disability is within the design and use of technology. Wherever mainstream technology is inaccessible to a portion of the population, those people are seen as different and are neglected. Technology can reflect concepts of what is “normal” and how “normal people function” (Albrecht 431) so people with disabilities are marginalized when they do not have access to certain technologies. The problems people with disabilities have in interacting with technology may be attributed to their impairment; it may seem that if only they were “cured” and made normal again, they would be
able to use the technology and function in society. With this line of thinking, people with disabilities are not seen as “normal” valued members of society who should be accommodated, and so the negative stereotypes associated with the medical model prevail.

Many designers are now beginning to acknowledge the social model of disability by recognizing that in designing, they have the power to create or eliminate disability. A badly designed interface might unnecessarily create a population of users who are “disabled” with respect to that system (Mankoff 4). This lends to the importance of designing inclusively, to avoid marginalizing atypical users. Universal design seeks to design all products, buildings and interiors to be used by all people to the greatest extent possible regardless of their physical abilities (Bailey). Some key principles of Universal Design include equitability and flexibility in use, as well as avoiding the stigmatization or segregation of any set of users (1997 NC State University, The Center for Universal Design). These principles “provide designers with the tools to effectively eliminate disabilities caused from barriers within the environment” (Bailey). Examples of features in line with universal design principles include closed captioning on televisions, and visual and audio display of information in subway cars. When the needs of different people are considered in design, this is a step towards the social model of disability and towards acceptance of people with disabilities.

Assistive technology is beneficial because it can allow greater independence and functionality to people with disabilities, bridging the gaps that might exist between what the people would like to do and what the existing social infrastructure doesn’t yet allow them to do (Hersh 15). However, assistive technology can often have a strong health or rehabilitation flavor. After WWII, most assistive technology research and development focused on medically related technology such as prosthetics and orthotics (Albrecht 675). This has linked the technology needs of people with disabilities with the health domain. Since the medical model focuses on the physical and functional limitations a person may demonstrate, assistive technology designers often see this as a clear design objective that would have measurable results (Mankoff 4). Thus when the medical model is used in the design of assistive technology, there is typically less emphasis on aesthetics or form, since the rehabilitative function has priority. In one study, people with disabilities indicated a belief that manufacturers of proprietary technology do not appear to make an effort to make their devices aesthetically appealing
(Shinohara 5). Assistive technology designed for medical purposes such as “fixing” the impairment has historically been designed for use in an institutional setting; this institutional appearance can stigmatize the individual and confirm the “otherness” of disability (Bailey).

The medical model of assistive technology depicts its users as passive and dependent on others’ (often professionals’) impressions of what is best for them. People with disabilities might often not be considered users or consumers, but rather poor and powerless patients (Newell 172). This is devaluing to people with disabilities. Letting the designers make decisions on behalf of people with disabilities without valuing them as users leads to the persistence of medical model views. Designers may have assumptions and stereotypes about people with disabilities that can become embedded within the design (Ratzka). A solution is to apply many of the universal design principles to the design of assistive technology: It is better to lean towards the social model in the design of assistive technology, where there is more of a focus on solving problems of access, rather than on fixing a person’s impairment. When the social model is incorporated, people with disabilities are valued as customers, consumers, and people in the design process (Newell 173). They thus have more of a say in the design of products and services they will use, and can take more charge of their lives rather than having someone else decide what is best for them. The US Government’s website on Disability Technology advocates for “Access and Independence through technology”, rather than treatment or assistance (“Technology: Disability.gov.”). This phrasing represents steps towards acceptance of the social model of disability.

Much assistive technology that exists has been designed with the medical model in mind, which serves to portray people with disabilities as deficient and dependent. When designers value those with disabilities as users and not as patients, the medical model is less prevalent. Universal design of technology is a step towards granting more access to all citizens and portraying people with disabilities as normal members of society. However, even with the growing popularity of universal design principles, the pre-existing attitudes of many designers (influenced by the media and other factors) may still be present in the design of technology.

**Conclusion**
The medical model can portray people with disabilities as abnormal, dependent, and inferior, as less-valued members of society. We need to be conscious of these negative attitudes and how we may be reinforcing them. A solution is to aim for the adaption of more humanistic models of disability such as the social and diversity models. Attitudes and policies in line with these models recognize people with disabilities as important contributing members of society. Pushing towards these models of disability, towards less ableist views, and towards reduction of negative portrayals of those with disabilities, is optimal. While strides have been made towards this goal, the medical model unfortunately still remains entrenched in society to some extent and so long as it is, people with disabilities will be seen as different from “normal” people and will be marginalized in society. The Olin College survey showed that students held attitudes that were based primarily off the social model but still had some medical model tendencies. It is my hope that this paper will allow the reader to be more conscious and aware of how the models of disability influence their beliefs and attitudes, and to try to avoid thinking of people with disabilities as deficient or less capable people, but rather as unique individuals who have a lot to offer to society.


