Introduction to the Social and Medical Models of Disability

Attitudes towards disability affect the way people think and behave towards disabled people. They also impact on outcomes for disabled people in the way they are treated and able to participate in society. The attitudes disabled people experience inevitably affect the way disabled people interact with others.

There are two main models in terms of disability how disability is considered:

(i) The social model
(ii) The medical model

The Problem with Models…

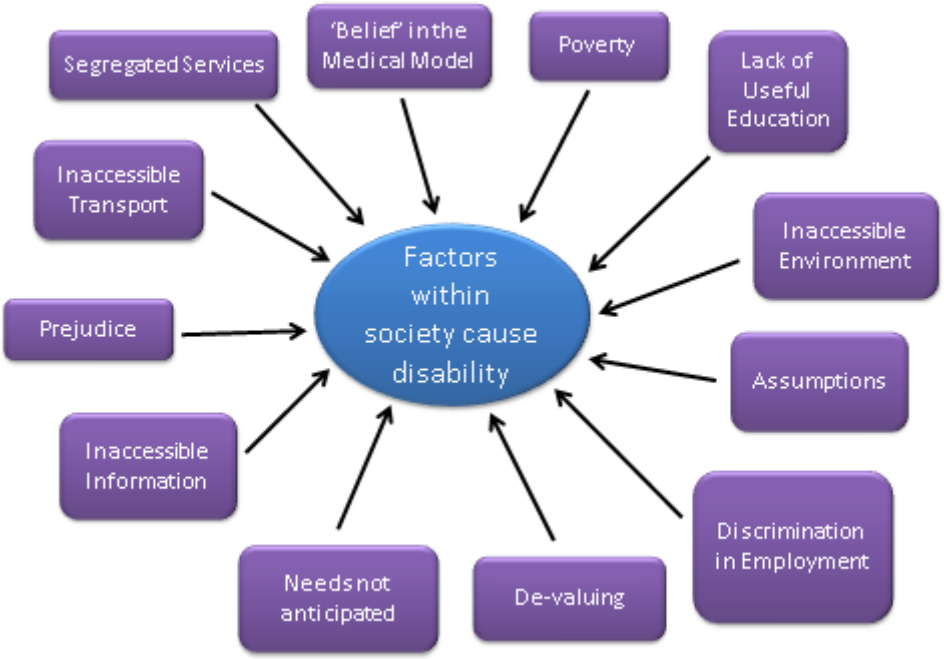
Models are a useful tool to help us think about and discuss a topic, but they can be simplistic and make things appear more clear cut than they are. In reality, most organisations sit somewhere between the social and medical models and use aspects of both models in the way they interact with disabled people. At PHSO we want to use the social model as far as we can, but we acknowledge this is not always possible.

Social Model of Disability:

The social model is generally the preferred model when thinking about disability. The social model has been adopted by most disabled people's organisations. In August 2014 the social model was endorsed by the Government Equalities Office who recommended the model for use by all government departments in the way they interact with disabled people.

The social model was created by disabled people themselves and looks at the barriers erected by society in terms of disabled people being able to participate fully in day to day life. The social model seeks to remove unnecessary barriers which prevent disabled people participating in society, accessing work and living independently. The social model asks what can be done to remove barriers to inclusion. It also recognises that attitudes towards disabled people create unnecessary barriers to inclusion and requires people to take proactive action to remove these barriers.

The social model identifies the problems faced by disabled people as a consequence of external factors. For example, in the way organisations produce information (not offering a variety of formats such as Braille, large text etc), or inaccessible venues.



The social model distinguishes between impairment and disability. Impairment is described as a characteristic or long term trait which may or may not result from an injury or health condition which may affect a person's appearance or functioning of their mind or body. The characteristic may cause pain, fatigue, affect communications or interfere with mental capacity. The social model in no way rejects the idea of a person seeking medical intervention to minimise the impact of their impairment as far as this is possible.

According to the social model a person does not 'have' a disability – disability is something a person experiences. The disability experienced is often caused by the approach taken by society/individuals which fails to take account of people with impairments and their associated needs. This can result in people with impairments being excluded them from mainstream society. For example; an individual is not prevented from reading a magazine because of blindness, but because of the absence of alternative formats. A person is not prevented from going to see a play because they are a wheelchair user rather it is the absence of accessible transport and access to venues that causes the disability and exclusion.

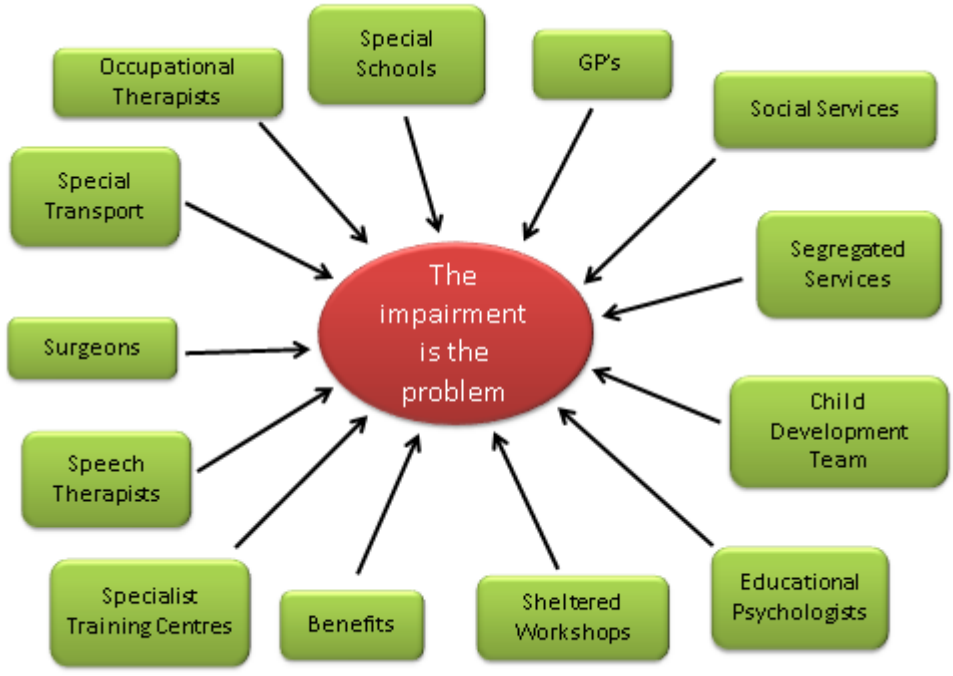
The social model of disability also focuses on people's attitudes towards disability and recognises that attitudes towards disability can present barriers for disabled people in the same way the physical environment can. These attitudes are many and varied, ranging from prejudice and stereotyping, to unnecessary inflexible organisational practices and procedures and seeing disabled people as objects of pity / charity.

Medical Model of Disability:

The medical model looks at a person's impairment first and focuses on the impairment as the cause of disabled people being unable to access goods and services or being able to participate fully in society. Statements such as 'he can't read that newspaper because he's blind' are an example of people being influenced by the medical model of disability.

It is this medical model that has informed the development and structure of the legislation, and is reflected in people's attitudes and associated negative outcomes. Aspects of the Equality Act 2010 (the Act), in relation to disability discrimination, follow the medical model of disability as they focus on what a person is unable to do. The Act also sets out specific criterion which must be met if an individual is to be protected under the legislation.

As you can see from the diagram below, the medical model focuses on the impairment and what can be done to 'fix' the disabled person or provide special services for them as an individual. The diagram is not intended to suggest that medical intervention and support for disabled people are in any way negative in themselves but to show how the medical model focuses on the individual as the problem rather than looking more widely at society.



The Models in Action:

The table on the following page gives some simple examples of how the Medical and Social Models of disability differ in some everyday situations. As you will see from the examples in most areas what happens in society is generally somewhere on the spectrum between the two models.

Issue	Medical Model	Social Model
Transport	Specialist transport is provided for people who cannot access mainstream transport.	Mainstream transport and infrastructure is made accessible for everyone.
At Home	Homes are adapted and specialist products are recommended by professionals such as Occupational Therapists to meet the needs of individual disabled people.	Mainstream retailers (kitchen and bathroom shops) offer more options such as different heights and depths of units as standard. Products around the home are designed with accessibility in mind so that specialist products are not required.
Education	Disabled children receive specialist provision in special schools and are entered for alternative qualifications.	Disabled children are educated in accessible mainstream schools alongside non-disabled children. Education provision is accessible to all with the same qualifications and opportunities open to all who wish to access them.
At work	Sheltered workplaces are created for disabled people to work alongside other disabled people in a specially adapted environment doing specific work.	Workplaces are made accessible for disabled people and training and development available to disabled people enables them to apply for a range of roles
Communication	Communication takes place in 'standard' ways e.g. letters are in size 12, if someone is unable to read them they can be given magnifiers or ask someone to read the information for them.	Communication is tailored to meet the needs of the individuals involved and information is available in a range of formats.
Language	Language usually refers to a person's medical condition, what is 'wrong' with them and what they can and can't do.	Language is focussed around the barriers faced by an individual and what can be done to remove them.
Attitudes	People make assumptions about what someone is capable of based on information about their medical condition for example using internet searches.	People talk to individuals about their needs and experiences and the barriers they face.