STEVEN D. EDWARDS

DISMANTLING THE DISABILITY/HANDICAP DISTINCTION

ABSTRACT. This paper discusses the distinction between disability and handicap as it is proposed by the World Health Organization (WHO) in their publication *International Classification of Impairments, Disabilities and Handicaps* (WHO, 1993 (first published, 1980)). Following criticism of this an attempt to salvage the distinction by Nordenfelt (1993, 1983) is discussed. It is argued that neither the WHO nor Nordenfelt are successful in their attempts to preserve the distinction between disability and handicap in a theoretically well-motivated manner. Contrary to the WHO, it is argued that what they term 'disabilities' and 'handicaps' *both* have external causes. And contrary to Nordenfelt's position it is shown that "basic actions" do not provide a firm theoretical foundation for the concept of disability. Moreover, the criticisms of these two sets of views reveal that attempts to describe the phenomenon of disablement which focus on the individual suffer from a serious methodological shortcoming.

Key Words: disability, handicap, Nordenfelt, World Health Organization.

This paper discusses the distinction between disability and handicap as it is proposed by the World Health Organization (WHO) in their publication *International Classification of Impairment, Disabilities and Handicaps* (1993). Following criticism of this, an attempt to salvage the distinction by Nordenfelt (1993, 1983) is discussed. It is argued that neither the WHO nor Nordenfelt are successful in their attempts to preserve the distinction between disability and handicap in a theoretically well-motivated manner. Moreover, the criticisms of these two sets of views reveal that attempts to describe the phenomenon of disablement which focus on the individual suffer from a serious methodological shortcoming.

Steven D. Edwards, PhD, Centre for Philosophy and Health Care, University of Wales Swansea, Swansea SA2 8PP, U.K.

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I. THE WHO'S ACCOUNT

The WHO offers the following definitions:

Disability: In the context of health experience, a disability is any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being (1993, p. 28).

Handicap: In the context of health experience, a handicap is a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex and cultural factors) for that individual (1993, p. 29).

Crudely, their suggestion is that, in general, these are related in such a way that handicaps "result from" disabilities, which, in turn, "result from" impairments. Impairments are claimed in most circumstances, to result from diseases.

A. *Disability*

Consider the WHO definition of disability. Impairment is considered a necessary condition of disability. If the relevant impairment restricts or prevents the person from undertaking acts within a specified range, then the person satisfies the definition of being disabled. The relevant range of acts are defined by reference to the range of acts considered normal for a human being regardless of the particular social context inhabited by that person. Hence, there is an appeal to universality in the WHO definition of disability. It is supposed that the question of whether or not a person is disabled can be determined without reference to the person's specific social context.

With regard to this claimed universality, for the WHO, the question of disability is supposed to arise at the level of the person. It is claimed that there are a range of actions which are "expected of the individual in virtually every culture" (1993, p. 38). Moreover, the WHO provides a clear indication of the kinds of actions which it considers to have this universal character. The first concerns orientation; the second concerns independence in activities such as feeding and personal hygiene; the third concerns an individual's capacity to "move around effectively in his environment" (1993, p. 39); the fourth involves "occu-

pying time" (ibid.); the fifth refers to an individual's ability to participate in social relationships; and finally, the sixth refers to an individual's ability to sustain himself economically. These six areas of activity are said to denote "survival roles" and to be "broadly transcultural" (ibid.).

If an individual is not able, due to impairment, to undertake any one of these survival roles, then he can be judged to have a disability. Thus, the concept of disability is applicable across cultures in a way in which, it is claimed, the concept of handicap is not.

Examples of disabilities which compromise a person's ability to pursue survival roles are said to include: "behaviour disabilities" such as "disability relating to situational behaviour," an example of which is: "disturbance of the capacity to register and understand relations between objects and persons . . ." (1993, p. 150); "personal care disabilities" such as "double incontinence" (1993, p. 157); "locomotor disabilities" such as "ambulation on flat terrain" (1993, p.161); and "dexterity disabilities" such as "difficulty in coordination" (1993, pp. 166–167).

For example, blindness counts as a disability since this is claimed to impinge upon the ability of an individual to engage in the range of acts considered normal for humans; and the same applies to deafness, paraplegia, color-blindness, vertigo and so on.

Finally, it is claimed that disabilities are "intrinsic" to individuals whereas, it is claimed, handicaps are said to have a crucial "extrinsic" component (1993, p. 31). The term 'intrinsic' here is supposed to indicate that descriptions of disabilities can be made in terms which focus solely on the individual concerned. This is in contrast with handicaps which have an 'extrinsic' component in the sense that features of the social context inhabited by the individual will be referred to in any judgment that an individual has a "handicap" or is "handicapped".

In summary, then, at least three characteristics of disabilities can be identified: (a) they are said to result from impairments; (b) they are context-neutral in the sense that they are not determined by the specific social context of the individual; and (c) disabilities are intrinsic to persons.

B. *Handicap*

According to the WHO definition, handicaps are disadvantages for individuals which result from disabilities or impairments. Although impairments are necessary conditions of handicaps, disabilities are claimed not to be. The WHO offers the example of severe facial disfigurement as a handicap which results from an impairment but is not a disability (1993, p. 30). This may amount to a handicap in the sense that the impairment limits the roles which the person may be able to take up. Similarly, deafness may constitute a handicap in the sense appealed to by the WHO if it "limits or prevents" (1993, p. 29) the range of opportunities open to the person. It may be claimed, for example, that employment opportunities are limited by deafness and hence that deafness, a disability, becomes a handicap.

It is worth pointing out that the WHO suggests that the category 'handicap' is one which has a strong social element, as they put it, the category is "socialized" (1993, p. 30). In explanation of this, recall that for the WHO a handicap is a disadvantage to a person that results from that person's impairment or disability. Clearly, the claim that a person is disadvantaged presupposes a group in relation to whom the person's condition is judged. Reasonably enough, the WHO supposes the relevant group is a social group. As stated in the definition, this is dependent upon the person's age, and so on. Thus a person is judged to be disadvantaged relative to a particular social group. Hence, for the WHO, the phenomenon of what it terms 'handicap' requires specification of a relevant social group. That is the rationale for qualifying "handicap" with "socialized".

Furthermore, this element of socializaton in the definition of handicap, is said to bring with it a value-component (1993, p. 26). For judgments that a person is handicapped express a value about such a person. The reason being, that the person is so judged due to his inability to engage in acts or roles which are considered valuable among persons who share a particular social context.

It follows from this that the concept of *handicap* is imbued with a high degree of context-relativity. For, according to the WHO's account, it follows that two individuals might have the same impairment or disability (e.g., color-blindness) but that, due

to cultural factors, only one of them may be handicapped (1993, p. 31). For example, suppose one person lives in a culture in which color-vision is not necessary for one to engage in any of the six survival roles described above. An individual who is color-blind will not be disadvantaged in such a cultural setting, and thus will not be handicapped. Suppose that in the other person's cultural setting color-vision is essential for the fulfilment of any of the six identified survival roles. In this case, the disability generates a disadvantage to the individual and so constitutes a handicap.[1]

The six survival roles described earlier are each exploited in the WHO conception of handicap. They are each listed as "dimensions of handicap" (1993, p. 184). Thus, the list includes: "orientation handicap," "physical independence handicap," "mobility handicap," "occupation handicap," "social integration handicap," and "economic self-sufficiency handicap" (ibid.). So a person is handicapped in one or more of these dimensions if he is not able to perform the actions necessary to meet them. For example, if a person cannot orient himself, he would have an orientation handicap; if he were not able to feed himself, he would have a physical independence handicap, and so on. It is perhaps worth emphasizing that these standards of orientation, independence and so on, are relative to age and cultural norms. Hence a newborn is not handicapped if it cannot walk at birth.

Two features of the term 'handicap' are worth drawing attention to. The first is that the WHO notion of *handicap* is said to be evaluative, in contrast to *disability* which, it is suggested, is non-evaluative (1993, p.28). Second, handicaps are identified by pointing to the significantly lower level of performance in social role when the performance of that individual is compared with his cultural peers (i.e., those of the same age, sex, and culture). This difference in performance, in the case of handicap, results from the individual's impairment or disability. Hence it is held, that

> Handicap is thus a social phenomenon, representing the social and environmental consequences for the individual stemming from the presence of impairments and disabilities (1993, p. 29).

So a relevant social consequence of a disability may be his difficulty in finding employment. This, in turn, it is claimed, gen-

erates handicaps since one's unemployment is a consequence of one's disability. Hence a disability in conjunction with relevant social factors may result in a handicap. It is in this sense that a handicap (in contrast to a disability) is said to be "extrinsic" (1993, p. 31).

II. WHO'S TWO WAYS OF DISTINGUISHING DISABILITY AND HANDICAP

The WHO offers two ways of distinguishing disability and handicap. (A) The concept of disability is not value-laden, whilst handicap is. (B) Disabilities are "intrinsic" (1993, p. 31) whilst handicaps are not.

A. *The concept of disability is not value-laden, whilst handicap is*

Nordenfelt has pointed out that the disability classifications adopted by the WHO are clearly not value free. One disability, for example, includes the expression "other irresponsible conduct" (WHO, 1993, p. 150). And, at a deeper level, in common with the concepts of health, illness, and disease, it is plausible to suppose disability to be a value-laden concept, for, a contrast with an ideal range of abilities is implied.

If we are charitable, we can conjecture that the WHO allows that whilst *both* concepts are value laden, the concept of handicap is so to a significantly greater degree. This presents us with the difficult task of accounting for the purported difference between the two concepts. Clearly, if one concept is value-free and the other value-laden, we can be sure that they are different concepts. But that is not the case here. So how might the difference in degree of value-ladenness, sufficient to distinguish the two concepts, be spelled out? The WHO's attempt to do this appeals to contextual factors. The view seems to be that the concept of handicap has a greater degree of *sensitivity to contextual factors* than has the concept of disability.

But the view that an appeal to degrees of value-ladenness can help to anchor a distinction between the concepts of disability and handicap is open to serious objection. In attempting to do so, we seem already to allow that the concepts have something significant in common, namely being value-laden. When we

distinguish light blue from dark blue we are distinguishing shades of one color, blue. So more is needed than an appeal to *degrees* of value-ladenness to distinguish the concepts of handicap and disability.

Suppose we appeal to the greater degree of context sensitivity of handicap in order to anchor the distinction. But if this move is made, the basis for the distinction originally claimed has now changed. The appeal now is to degrees of context sensitivity. But even this move should strike us as strange. As we saw earlier, the WHO seems to claim that disability is intrinsic to people. It seems to follow from this that no contextual details can be relevant to the determination of whether or not a person has a disability. But, let us be charitable again and allow this initial worry to pass.

B. *Disabilities are "intrinsic", whilst handicaps are not*

As seen, the WHO claims that disability is "intrinsic" (1993, p. 31) to persons whereas handicap is not. An obvious strategy in attempts to demonstrate that two concepts are distinct is to identify characteristics exemplified by one of the concepts but are absent in the other. We have seen that any attempt to distinguish the concepts of disability and handicap on the grounds that one is value-laden and the other not is unlikely to succeed. What, then, of the view that the concepts are distinct on the grounds that disabilities are intrinsic and handicaps are extrinsic?

The sense in which handicaps are thought *extrinsic* to individuals seems to be this. As stated in the WHO manual, the question of whether or not an impairment (or disability) constitutes a handicap is determined by the nature of the cultural context (recall the example given above concerning color-blindness). So there is an apparent causal relationship between two sets of factors. The first are factors within the body of the person. For present purposes it can be supposed that these are impairments. This is entirely reasonable given that impairments are posited as necessary conditions of handicaps in the WHO classification. The second set of factors which generate handicaps are, plainly, the values which prevail in a specific culture. For, as seen, according to the WHO, handicap occurs when a person is unable to act in ways in which he is expected to act (and where this is due to his impairment) (WHO, 1993, p. 42).

Given this understanding of how the extrinsic nature of handicap is to be construed, consider how the intrinsic nature of disability should be understood. A reasonable construal of this claim is that the causes of the disability lie within the individual. This seems a plausible construal of "intrinsic" and also is cogent with the WHO's claim that the concept of disability applies at the level of the person.

However, analysis of the concept of ability strongly suggests that no account of ability can be given which avoids reference to phenomena beyond the person. The ascription to X of an ability A seems to presuppose at least the possibility of X's manifesting that ability. This, in turn, presupposes some conception of factors beyond the boundaries of X's body. For example, it is not possible to ascribe to X the ability to read unless there are books. Nor is it possible to ascribe to X the ability to swim unless there are places where it is possible to swim (if only possible places). Hence it is plausible to conclude that ascriptions of abilities to persons requires some consideration of phenomena beyond the person. This feature of the concept of ability extends to the concept of disability. Just as it is not possible to ascribe to X an ability A independently of consideration of phenomena beyond X's body, it is not possible to ascribe to X a disability independently of consideration of such phenomena.[2]

If this conclusion is accepted, it follows that no adequate account of disability can be gleaned from conceptual resources which make no reference to phenomena beyond the body of the person. In fact, the WHO's own description of disability is open to the charge of tacitly appealing to such phenomena. For example, it can be claimed that its account of the concept of disability is ultimately elaborated by reference to survival roles. The reason for this is that, within the broadly individualistic framework presupposed by the WHO, abilities are thought significant insofar as they enable an individual to engage in survival roles. So disabilities are thrown into relief, so to speak, against a background in which independent performance of survival roles is considered standard. And, of course, survival roles (iv)–(vi) all make explicit reference to phenomena beyond the person. The fourth survival role refers to activities such as "bringing up children" (1993, p. 39), the fifth to "social relationships" (ibid.) and the sixth to "socioeconomic activity"(ibid.). These, uncontroversially, make reference to phenomena extrinsic to the person.

Moreover, if the analysis of ability (and disability) just given is accepted then even the first three of the survival roles identified by the WHO will also presuppose some reference to extrinsic factors. For example, survival roles (i)–(iii) make reference to the ability to orientate oneself in one's environment, to meet one's own physical needs, and to move around independently (1993, pp. 38–39). The extrinsic factors which are presupposed here relate to the manifestation conditions necessary for it to be possible to act in these ways: suitable environment, absence of physical restraints, and so on.

A second set of extrinsic presuppositions are value-related. For example, it is taken for granted in the WHO manual that individuals cannot rely upon other members of their communities to meet the conditions necessary for the survival of disabled individuals; and it is taken for granted that non-disabled individuals will not provide the conditions necessary for the disabled person to meet his own survival needs. The emphasis placed upon *independence* in the specifications of survival roles is open to the charge of presupposing that a particular moral view prevails in all cultures; the moral view is that of individualism (see Lukes, 1973). Also, along these same lines, it should be pointed out that the WHO classification, with its emphasis on independence, presupposes not simply the prevalence of an individualistic value-system, but also a view of persons such that they are essentially social 'atoms' (Taylor, 1985), the existence conditions of which owe nothing to other members of society. It is, thus, an oversimplification to claim that the *disability* classification focuses solely on individuals and that the causes of disability lie solely in the individual – are intrinsic.

The discussion so far enables us to call into question two other supposed points of difference between handicap and disability. The first is the WHO's claim that whilst the concept of handicap is tied to specific cultural contexts, the concept of disability is not. Clearly, given the possibility of a non-individualistic value system such a claim is not plausible. The concept of disability merely *appears* to be transcultural if one exports moral individualism into all cultures.

The second view to be challenged, is the view that whilst handicap can be conceived of as a disadvantage, caused by an impairment or disability, disability is caused by impairments. Clearly this requires modification. For the above points suggest that, as with handicap, the causes of disability are two-fold: they

are partly intrinsic (impairments) and partly extrinsic (social and environmental phenomena). So given that for the WHO it is extrinsic social values which lead to handicaps, in conjunction with impairments, and given that our discussion suggests that the same is true for disabilities, it seems plausible to claim that disability be conceived of as a disadvantage brought about by factors both internal and external to the person.

Hence, it can be concluded that the grounds appealed to by the WHO to distinguish the concepts of disability and handicap are vulnerable to serious objection. However, the distinction has been articulated and defended in a different way by Lennart Nordenfelt and I turn to discuss his claims.

III. NORDENFELT'S DISTINCTION BETWEEN DISABILITY AND HANDICAP

Lennart Nordenfelt has put forward an interesting theory of disability (1983; 1993). He defines disability and handicap as follows: "A disability, as well as a handicap, is a non-ability – given a specified set of circumstances – to realize one or more of one's vital goals . . ." (1993, p. 22).[3] In his theory, he expresses agreement with the WHO that there are handicaps and that these are distinct from disabilities. So he clearly wishes to retain a legitimate role for the term 'handicap'.

Nordenfelt's distinction is put like this,

> a disability is a non-ability to perform a basic action, for instance a non-ability to lift one's arm; [and] a handicap is a non-ability to perform a generated action, for instance, a non-ability to perform one's work properly (1993, p. 23).

'Non-abilities' is a technical term of Nordenfelt's. It refers to the class of abilities which an individual lacks. So, for example, if one cannot play chess, this is among one's non-abilities. Basic actions are those which do not result from some other action (Nordenfelt, 1993, p. 22). They include simple intentional movements of limbs. Generated actions *are* caused by other actions (1993, p. 22). An example of a generated action given by Nordenfelt is that of building a house (p. 22). This results from several other actions, moving bricks, hammering nails, and so on, but ultimately rests upon the performance of simple movements of limbs (basic

actions). Other examples of generated actions include playing the piano or writing a book.[4]

With specific reference to the disability/handicap distinction, suppose a person wants to ice-skate but is unable to stand due to some physical cause within his body. The non-ability to stand is a disability and the non-ability to skate is a handicap. To take another example, suppose a person wishes to write a letter, but is unable to pick up a pen (or type). The inability to move one's finger is a non-ability to perform a basic action and is, thus, a disability. The inability to write is a handicap.

A slightly different way to draw the distinction is to note that descriptions of basic actions are typically couched in terms which refer only to the person's body. Hence, basic actions involve movements of limbs. Non-abilities to perform basic actions, similarly, typically invoke terms which make reference to the person's limbs. Descriptions of generated actions, on the other hand, invoke terms which refer to phenomena beyond the person's body, or to what can be termed "*social* concepts." Hence, descriptions of handicaps will include terms such as 'work,' 'write,' 'travel,' 'shop,' 'study,' 'drive,' and so on. These are terms which seem to make some reference to social practices – to social conventions and institutions.

Nordenfelt's general proposal is that there are these two broad types of actions: the non-ability to perform a sub-class of the first type comprises disability; the non-ability to perform a subclass of the second type constitutes handicap (providing this non-ability derives from non-ability to perform certain basic actions).

With regard to intellectual disabilities, Nordenfelt suggests that, in effect, the relevant set of 'mental' or cognitive non-abilities will be non-abilities to perform fairly primitive types of cognitive operations. Typically, these relate to manipulating information, reasoning, planning, and so on (1983, pp. 47–48).

So suppose a person has a serious intellectual disability. And suppose it is said that the person is handicapped due to the fact that he is not able to go to work – say as a clerk or computer operator. The class of (mental) basic actions which the person will *not* be able to perform may include those calculations involved in, say, planning how and when to travel to work, what to wear, when to get up, and so on. So intellectual disabilities will concern the simple cognitive operations needed to plan an activity such

as travelling to work or working. Non-ability to work, or to use public transport due to disability at the planning level, so to speak, constitutes handicap.

One general comment worth making in relation to Nordenfelt's way of distinguishing disability and handicap is this: we saw how he seeks to anchor such a distinction in the distinction between *basic and generated actions*. But it is worth pausing to consider the very significance of basic actions, and hence those non-abilities which are disabilities. The class of basic actions seems only of relevance insofar as it relates ultimately to the class of generated actions. Explanations of why people act are explanations of generated and not basic actions. In fact, it is plausible to assert that generated actions are actions which are of interest at the level of the person. Basic actions, it seems, are intelligible only in light of their relations to generated actions. I return to this point below, for now, I consider an objection to the term 'handicap' arising from broadly moral sensitivities.

IV. OPPOSITION TO THE TERM 'HANDICAP'

It should be noted that the term 'handicap' is not universally considered acceptable. In 1993, the journal *Disability, Handicap and Society* changed its name to *Disability and Society*, thus dropping the term 'handicap' (1993). And it is fair to say that a significant proportion of groups which represent disabled people find the term 'handicap' offensive.

However, from the perspective of a philosophical inquiry into the phenomenon of disablement, what is most relevant to consider is the category of *non-abilities* (to stick with Nordenfelt's term) which are supposed to comprise the class of handicaps. Thus, we can distinguish two kinds of reasons for abandoning the term 'handicap'. The first is that many people with disabilities reject that term for a variety of reasons, and it seems respectful to give great weight to their views. The second set of reasons derive from the view that the term has no theoretical significance; that is, it does not refer to a distinct or legitimate theoretical category.

Suppose it is accepted that due to the offense caused by the term 'handicap' the term should no longer be used. Of course, it may still be argued that the theoretical category – the class of

non-abilities to which the term has been used to refer – is a legitimate one. In which case it could then be claimed that a different term be chosen to apply to the same range of phenomena. A theorist who took this option might, instead of referring to disabilities and handicaps, simply refer to disabilities with a small case 'd', and Disabilities with an uppercase 'D'. So for example, if Nordenfelt agreed that the term 'handicap' should be abandoned, he might still hold on to the theoretical integrity of the class of non-abilities he described previously as handicaps. Given this, he may simply invoke another term to refer to the same group of non-abilities.

A strategy such as that just described would respect the wishes of people with disabilities but *retain* a distinction between two kinds of non-abilities: e.g., between disabilities (disabilities) and Disabilities (handicaps).

A different, more radical response is to reject both the term and the theoretical integrity of the class of non-abilities to which it is supposed to refer. If I understand him, this more radical response is made by Oliver (1996, pp. 34, 22). The claim seems to be that the terms 'impairment' and 'disability' are adequate to cover the range of phenomena covered by the terms 'impairment', 'handicap' and 'disability'.

Earlier on, in discussion of Nordenfelt's distinction between basic and generated actions, I suggested that it may be thought that the significance of basic actions is parasitic upon that of generated actions. Hence, if there is an ordering of priority between these, it is generated actions which are the more fundamental. This may lend support to a position such as the more radical one just described, as I shall try to show.

V. THE THEORETICAL SUPERFLUITY OF 'DISABILITY'

Suppose we accept the distinction between basic and generated actions – which Nordenfelt employs in order to anchor the disability/Disability distinction (i.e., the disability/handicap distinction). For both the WHO and for Nordenfelt, disability is supposed to arise at the level of the person. Suppose we ask what kinds of actions people perform. At present I am writing, this is part of my work. I work, amongst other things, for financial payment. This enables me to live comfortably, to have a reason-

able place to live, to socialize, to have children, etc. I have just been speaking to another person, a colleague. What was he doing? Well, he was just about to leave the office, to board a bus, to catch a train in order to visit his parents. Prior to that we had coffee. Prior to that we each travelled separately to our place of work.

Notice that in these fairly trivial but typical descriptions of actions, no mention has been made of basic actions. Indeed, these points seem to suggest that basic actions are mere bodily movements. They are actions which bodies perform; they are not in any interesting sense, the actions of persons. Of course one can say of a person "J moved his finger." But one would only dream of saying this where the movement had special significance – e.g., J was thought to be paralyzed, or where J's movement seals the fate of someone else (suppose J is a Roman Emperor).

These points add considerable weight to the suggestion that the importance of basic actions derives from their relations to *generated* actions. Basic actions are not interesting in their own right, but only in so far as they have an effect at the level of persons. If it is accepted, this point does *not* show that basic actions cannot serve to anchor the concept of disability as a theoretical category, but it strongly suggests that *disability* is only of theoretical significance due to its relations with *Disability*.

I will now try to show the dispensability of the concept of disability in an account of the phenomenon of disablement. The strategy taken here will be to try to show that basic actions are neither necessary nor sufficient conditions of the kinds of actions which comprise Disabilities. It is worth making explicit that impairments will be supposed to form the 'internal' partial cause of Disabilities, with external factors completing the causal relation.

Recall the brief descriptions of some of the actions which I undertook earlier – traveling to work, conversing with a colleague, writing, making coffee, going shopping, etc. Consider a person who has paraplegia. Which of these generated actions might such a person not be able to perform?

A first, and not implausible answer, is that the person may be able to perform all of the above actions. The person may have a wheelchair and a car which make traveling to work unproblematic, and there is no reason to suppose that the person may have difficulties in undertaking any of the other actions

mentioned in the previous paragraph. In such an example, responded to this way, there is no appeal to basic actions. Here a person is able to perform *all* the basic actions necessary to get him to work. So an individual's non-ability to perform a range of (basic) actions is not a sufficient condition for that person's being Disabled. The reason is *that the person may still be able to perform an extensive range of types of actions whether or not it is possible for the person to perform a particular range of basic actions.* So non-ability to perform a range of basic actions is not a sufficient condition of Disability.

It is worth noting, too, whilst we are on the subject of ranges of actions, that the WHO and Nordenfelt specify different ranges of actions. As we saw, the WHO appeals to the range of actions "considered normal for a human being" (1993, p. 28), and for Nordenfelt one has a disability when one is not able to pursue the range of actions which one wishes to pursue (Nordenfelt, 1993, p. 17). The above point concerning the irrelevance of basic actions to an account of Disability applies to both of these construals of disability (i.e., that of the WHO and that of Nordenfelt). To take the WHO definition, the reason here is that the range of actions considered normal for a human being is open to wide interpretation. As noted earlier, if this involves social concepts, then the person with paraplegia is well able to perform actions within that range: he can work, shop, study, travel, converse, be a good parent, etc.

Nordenfelt's position seems even more congenial to an account of Disability in which no reference is made to basic actions. For him, the question of whether or not a person is disabled is bound to that individual's "vital goals" (Nordenfelt, 1993, p. 19) or life-plan. It is plausible that such life-plans will be couched in the language of generated rather than basic actions. A life plan seems much more likely to include plans to travel, or study, or be a better parent than to include "plans" to move a finger, or a foot, etc.

To return to our main theme. I have argued that non-ability to perform a certain range of basic actions is not a sufficient condition of Disability. The fact that one cannot, say, move one's foot is not sufficient for it to be the case that one cannot engage in the types of actions characteristic of persons (i.e., pursuing life-plans). It is easy to show that it does not follow from one's being able to perform an extensive range of basic acts that one

can engage in either the range of acts referred to by the WHO or the range of acts referred to by Nordenfelt. For example, regarding the WHO conception of disability, if the relevant range of acts are construed in such a way that they include acts likely to comprise a typical or 'normal' life plan, they will include studying, traveling, etc. But if there are no books, one cannot study. If there are no means of transport, one cannot travel; of course if one is imprisoned, one cannot travel. So it does not follow from the fact that one is able to perform a range of basic actions that one can undertake those actions which comprise a life plan. This point can be generalized to extend to Nordenfelt's conception of disability: if the social context necessary to perform certain kinds of actions is not in place, then one cannot pursue those actions (e.g., one cannot undertake a university degree if there are no higher education institutions.) This is the case regardless of whether one can undertake a relevant range of basic actions.

So the following two conclusions can now be drawn: (a) It does not follow from the fact that a person *is not* able to perform a "full range" of basic acts that the person is hereby not able to perform the range of acts characteristic of persons. (b) It does not follow from the fact that a person *is* able to perform a "full range" of acts that the person is, thereby, able to perform the range of acts characteristic of persons.[5]

It can be concluded, then from (a) and (b), that the range of basic actions are not relevant to the meaning of Disability; they perform no conceptual function. By the constraint on theorizing known as Ockam's Razor the disability/handicap distinction can be expunged from our theorizing about the phenomenon of disablement. In other terms, the theoretical category of "disability", where this is construed as distinct from "handicap", is an idle wheel.[6]

NOTES

[1] An actual exemplification of this point is described by Oliver. He points to a study of life on an island off New England where there was an extremely high incidence of deafness (due to "intermarriage and the presence of a dominant deafness gene" (1990, p. 16)). Apparently, the overwhelming majority of the island's inhabitants learned sign language (were bi-lingual) and so deaf people

"were not excluded from society" as Oliver puts it. The implication is that deafness is not a handicap in this social context.

[2] I have set out this argument in much more detail elsewhere: Edwards, S. D., 'Ability, capacity and impaired capacity,' paper for European Commission Research Project on Impaired Capacity, 1997 (unpublished).

[3] The vital goals of a person are goals which are of great importance to a person. As Nordenfelt describes them, "A person may have the goal to travel to a particular place, take an exam or perform some other specific act. If these goals are very important to the person, they are his or her vital goals" (1993, p. 19).

[4] Something close to the distinction between basic and generated actions is referred to by the WHO. For example, the WHO refer to "compound or integrated activities" (1993, p. 28).

[5] The expression "characteristic of persons" can be applied to the WHO or to Nordenfelt's views. The WHO construes the range of acts considered characteristic of persons along statistical lines as in their expression "the range of acts considered normal for a human being" (WHO, 1993, p. 28). For Nordenfelt, this range will be determined by the individual concerned. Either way, the two conclusions just drawn are not affected.

[6] In the above paper I have not discussed the proposals of two important Canadian documents, written by the Canadian society for the ICIDH (1989, 1990), these are respectively: 'Consultation: proposal for the revision of the third level of the ICIDH: the handicap,' *ICIDH International Network* 2 (1); and 'Comments on the proposition of revision of the handicap concept,' *ICIDH International Network* 3(2). The reason for this is that, as I understand their position, they in common with both the WHO and Nordenfelt seek to maintain the three-fold distinction between impairment, disability and handicap. They dispute the way the WHO defines handicaps in relation to societal norms and argue for a more person-focused definition. Nordenfelt (1993) takes issue with both the WHO's definition of handicap and the proposed modification of it by the Canadian Society. However, in so far as these three positions just referred to maintain a distinction between impairment, disability and handicap they seem vulnerable to the criticism developed in this paper.

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