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may hold the key to transformative thinking about disability
discrimination**

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This is a copy of the accepted author manuscript of the following article: Bunbury, S. (2019) Unconscious bias and the medical model: How the social model may hold the key to transformative thinking about disability discrimination. *International Journal of Discrimination and the Law*, 19 (1), pp. 26-47. doi:10.1177/1358229118820742 . The final definitive version is available from the publisher Sage at:

<https://dx.doi.org/10.1177/1358229118820742>

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Unconscious bias and the medical model: how the social model may hold the key to transformative thinking about disability discrimination.

Abstract

This article seeks to gain access to a new way to engage with disability discrimination and the legal approaches to it by focusing on the two central models: the medical and social models. It discusses how the law has based the definition of disability on the medical model, and suggests that this may strengthen some of the underlying factors that contribute to segregation and discrimination of disabled people. This article argues that the law should now switch focus to the social model, in an attempt to transform people's attitudes towards disabled people and be a positive force to reduce discrimination. It makes reference to the reasonable adjustment duty contained in s.20-21 Equality Act 2010, the Framework Directive and by way of comparison the American Disabilities Act 1990. Relevant critical theories are integrated as a means to explore the conception and the hierarchy that exists between able-bodied individuals and disabled individuals.

Keywords

Disability, medical model, reasonable adjustments, social model, social exclusion.

Introduction

It has been estimated that about 15 per cent¹ of individuals worldwide live with some form of disability of whom 2.2 per cent have difficulties with functioning (World Health Organization, 2011).² Disability is unique within discrimination, in that every individual has the possibility of becoming disabled at any point in their lives and 'disability' covers such a range of characteristics. With so many disabilities it makes it extremely difficult to address the inequalities that exist amongst disabled people. There are two different theoretical models which attempt to define and combat disability discrimination: the social and medical models. These conceptual models are crucial to the understanding of disability discrimination, and the intention of legislative provisions aimed at combatting disability discrimination. They provide a framework for interpreting the notions of disability (Cantor, 2009). A range of critical approaches to social theories that attempt to address inequality have emerged over the years. However, the critical awareness of and focus on one source of inequality, disability, has been less significant during this time, compared to other transformative areas such as feminism, queer theory and post colonialism (Goodley et al., 2011). These theories will be explored in this article, to the extent that they may provide a new means by which to view disability related inequality, by examining different ways of thinking about disability discrimination and the theoretical models used to define disability. This article will explore the unique duty to make reasonable adjustments contained in anti-discrimination legislation through the lens of the social and medical approaches to disability, by suggesting that a social model approach is a step in the right direction in order to eliminate disability discrimination, even though it may not be the panacea.

The development of the law in the United Kingdom is predominantly based on disability theories that challenge disability discrimination with reference to mechanisms that label disability as a problem in need of a solution, rather than recognition of disability as different but equal (Goodley., et al 2011). This is in contrast to the more radical models associated with feminism, queer theory and critical race discourses, which attempt to disrupt ingrained patterns of thinking which instantiate discrimination. Accordingly, a recognition of the narrowness of a medical framework of disability has been instrumental in America's aim to renew the *American with Disabilities Act 1990 (ADA 1990)* and has also been the basis for the EU Framework Directive (Cantor, 2009). It has been influential in shaping disability legislation in Australia in 1992 (*Disability Discrimination Act 1992*) and Great Britain in 1995 (*Disability Discrimination Act 1995*) (Heyer, 1999). In addition it has inspired movements worldwide, an example being the Canadian Human Rights Act which has made disability discrimination unlawful since 1985 (Heyer, 1999). However the initial focus on the medical model of disability has led other instruments to follow this approach.

This article will examine the different models and theories which attempt to explain inequality by focusing on how the law in the United States and UK interacts with the different theoretical models in transforming the experience of disabled people. It argues that were Parliament to embrace the social model it may increase the pace of the approaches to disability and reduce the levels of discrimination that disabled people face in the UK.

Defining Disability

Although the current influence of the moral model of disability is negligible, it is historically the oldest of all such models and views disability as a direct consequence of sin or fault (McTigue, 2010). It also suggests that, disability is divinely inflicted and arises due to some inadequacy of the individual (McTigue, 2010). While few would have any support for this model, its historical legacy adds insight to the pervasive negativity associated with disability which contributes to discriminatory discourse; the model still illustrates the stigma attached to being disabled (McTigue, 2010). Whilst the law attempts to remedy issues of inequality amongst disabled individuals, it has been suggested that in some cases the law perpetuates attitudes inadvertently that reinforce rather than combat discrimination, through use of the individual or medical model, as opposed to the social model. The UK definition is now contained in the *Equality Act 2010 (EqA 2010)* and disability is listed as a protected characteristic.³ Disability under the *EqA 2010* is defined as a physical or mental impairment which has a long-term effect on normal day to day activities.⁴ Impairment is defined as a biomedical property, which has been extended to include non-physical, sensory and intellectual forms of impairment.

Medical model

Previous research has identified that disabled individuals in the past have been associated with negative stereotypes which inevitably suggests that disabled individuals are pitiable and pathetic (Payne, 2006). Moreover, the medical model assumes that the disabled person's autonomy is limited due to the impairment, therefore if medical professionals cannot cure or rehabilitate the person, then she or he is considered as someone who as a consequence, has a limited ability to participate in society. Hence a person's disability may in some circumstances hinder participation, which in turn leads to social exclusion. Medical professionals or specialists have been tasked with the job of rectifying or curing the

impairment, which in some cases patronise or pity the disabled person (Woodhams and Corby, 2003). Unsurprisingly, this model has created controversy amongst disabled people, and has been challenged by disabled individuals themselves. This medicalisation role often reinforces the disabled person's dependency and sick role (Finklestein, 1998). It has been replicated in disability legislation which does not assist in transforming attitudes but instead perpetuates the issue.

In addition, the internalisation of capitalism means that disabled people are valued less (sub-consciously), as they are not as economically productive or do not appear to be; this marginalisation of a disabled individual has contributed to the oppression disabled individuals encounter (Anastasiou and Kauffman, 2013). Oliver has indicated that the idea of normality developed within the rise of capitalism, which focused on the need for a workforce to be usefully trained and productive (Terzi, 2004). This view does not assist disabled people since they are not given the opportunity to climb the capitalist ladder, if a disabled individual cannot contribute to 'the production of material goods' by providing their labour, they have no use in society. And this creates not just financial but social inequality. Marx suggests that 'those individuals who could not be included in the category of ability identified in terms of productivity became identified as dis-abled people' (Terzi, 2004: 144). This view implies that disability is a personal deficit in need of medical intervention (Terzi, 2004). In short, this view suggests that disabled people themselves are the source of the problem which over the years has had negative connotations. It must be noted that this view is not universally accepted, since many believe that it is not the physical, cognitive, sensory and emotional make-up of the individual that is the problem, but the social institutions and human made environments that were created without considering the differing characteristics of all people (Asch, 2001). If the impairment is a major contributing factor to inequality, participation in society for a disabled individual is likely to be difficult at best, impossible at worst. Commentators and disability activists have used the social model to challenge the medical model in an attempt to transform attitudes amongst disabled people, and argue that it is the solution to the issues disabled individuals encounter. It is to this model I now turn.

Social model

Unsurprisingly the social model has been developed due to the inadequacy of the medical model of disability (Lang, 2001) and in particular has attempted to change ingrained attitudes, whereas the medical model has struggled to do this through the use of the law. Interestingly the social model movement has been influenced by disabled groups in the 1960s and 70s due to the civil rights movement in America.⁵ It advocates for the removal of social barriers in an attempt to promote inclusion and social change leading to the transformation of society (Shakespeare and Watson, 2002). Instead of focusing on the impairment itself, the social model focuses on society being the cause of the problems which disable the individual, therefore illustrating a shift from 'means of production.' In the last decade the social model has had a significant impact in shaping public policy and education in the US (Anastasiou and Kauffman, 2013), and has led to re-defining disability in terms of the social environment (Bailey et al., 2015). The model ignores the functional, physiological and cognitive elements, but rather focuses on the wider external environment, suggesting that disability is socially constructed (Lang, 2001); it does so in an attempt to change ingrained attitudes that exist in disability discourse. Although some progress has been made by disability activists to tackle this problem, disabled people continue to be subjected to oppression (Kelly, 2011).

As a consequence, research focusing on care and disability has grown, and is a key player in shaping policies in the UK and other countries (Kröger, 2009). Care has been interpreted to

mean taking responsibility for someone, and therefore implies that the practice of caring for disabled people renders the disabled individual powerless (Morris, 1997:54). Kröger (2009) adds that the concept of care views disabled people as passive who struggle to manage their life. It has been noted that ‘...disability is seen as something imposed on disabled people on top of their impairment by an oppressive and discriminating social and institutional structure’ (Terzi, 2004: 143). Thus, the cause of disablement can be linked to the oppression of the social and economic structure on disabled individuals (Terzi, 2004). Therefore the care or treatment designed to correct or amend the body should not only focus on this issue, but instead emphasis should be placed on breaking down societal barriers to overcome the disadvantage, faced by the disabled population.⁶ Unsurprisingly, supporters of the social model argue that ‘care’ is a complex form of oppression and reject it as a term and concept (Kelly, 2011). It is in effect a critique of medical institution and social policy (Kelly, 2011). Advocates of the social model suggest that the law should be used as a mechanism to change embedded attitudes and unconscious biases by focusing on the social barriers disabled individuals face. This in turn assists in challenging complex ingrained attitudes and perceptions that exist which in some circumstances improve the care disabled individuals receive (Goering, 2010).

Indeed, differing theories that attempt to explain social inequality and social exclusion by unpacking the assumptions disabled individuals encounter. However defining disability is far from straightforward, the distinction between impairment and disability is crucial to understanding the social model, and its impact it has had on current legislation.

The social model: the distinction between impairment and disability

Importantly, in order to understand the social model fully in relation social exclusion it is crucial distinction between ‘impairment’ and ‘disability’. Impairment is attributed to functional limitation characterised by a physical or mental impairment, whereas disability is linked to the loss of opportunities in society caused by society’s failure to break down the barriers (physical and social) which hinder participation and equality within the community (Barnes, 1991).⁷ Additionally, it has been noted, that important contributing factors to the problem of disability discrimination are the issues of impairment and disability, and the relationship with the concept ‘normal people’. As discussed previously, the concept of caring can be closely linked to the issue of segregation, and the need to keep the disabled person or the person with a disease segregated from normal participation (Imrie, 1996). Studies have shown that ‘normal people’ struggle to accept disabled individuals fully. On the other hand, disabled individuals find it extremely difficult to accept help, since it is linked to low self-esteem because of a self-fulfilling labelling process (Imrie, 1996). Consequently, there is a need for not only able bodied people to change attitudes, but also those that make public policy (Wedderburn, 1974).

In order to understand inequality amongst disabled individuals, it is helpful to consider the interaction between illness and disability (Oliver, 2009). Thus, impairment is defined as a biomedical property which has been extended to include non-physical, sensory and intellectual forms of impairment. Disability on the other hand imposes restrictions and disablement has nothing to do with the body. Physical disability is seen as a form of social oppression which the social model aims to eliminate by trying to ‘denounce and remove the disabling barriers produced by hegemonic social and cultural institutions’ (Terzi, 2004: 143). Disability is therefore regarded as a social creation which causes the impairment to be a problem (Shakespeare, 2006). As such, the concept of disability is socially constructed, and based upon a dominant able bodied hegemonic model, which can be compared to the

hegemonic concept of masculinity as propounded by the male dominated institutions in societies globally and is reflected in disability discourse (Connell, 1993). Oliver has suggested that the medicalisation of the social model has not assisted disabled individuals, since these individuals are given low priority⁸ when competing against other disadvantaged groups (Oliver, 2009). These issues are not confined to physical or mental impairments, but also to the economic structures which exclude disabled people from participation in mainstream activities (Anastasiou and Kauffman, 2013) that result in exclusion from social and recreational activities.

Furthermore, the media has contributed to the social construction of disability by portraying men and women as different in terms of the dominant ideology, which in turn reinforces the socially constructed view of women, which is organised, financed and supervised by men (Connell, 1993). A similar parallel can be drawn with disability, since the dominant group (able-bodied) control how disability is understood, as well as how disabled individuals are viewed, and portrayed by society. These stereotypes operate within the area of disability discourse, and serve as an aid in understanding the stereotyping practices which arise in disability discrimination. Interestingly, the parallel drawn between impairment and disability is a convenient mental construct for advocates of the medical model, and is an abstract that ignores the social construct, biological and psychological issues and are often complex and difficult to tackle in disability discourse (Anastasiou and Kauffman, 2013). Disabled scholars argue that breaking the causal link with impairment is an important factor in order to eradicate or find a solution to the oppression disabled individuals encounter (Terzi, 2004). Notwithstanding the aforementioned matter, the social model has played an important role in understanding disability, in relation to inclusion (Terzi, 2004). Likewise, those with a disability require extra support depending on the illness or disability. Society is willing to accept some limitations but not all of them, the limitations which society cannot meet are labelled as a disability (Herring, 2013) which does not assist in challenging attitudes towards disability amongst society.

The complex relationship between the impairment and the social and physical environment challenges the medical model in that it places emphasis on society and the environment, rather than focusing on the individual's impairment (Woodhams and Corby, 2003). Ultimately this challenges our understanding of disability from a medical law perspective since the focus shifts from impairment, to the social exclusion of a disabled person, and the way society deals with or responds to this (Oliver, 2009). Moreover, this hinders participation amongst disabled people. Although this may be the case, this view is challenged in relation to the disabling barriers experienced by people with cognitive impairments⁹ and those that have impairments that are socially disabling (Shakespeare, 2006). In short, not all impairments are caused by the social arrangements, and therefore impairment is a social judgement, whereas disability focuses on the effects of the impairment (Shakespeare, 2006).

Although theories attempt to explain the issues that arise with social inequality, they fail to address the underlying issue of the way society has been and is still set up, which is mainly dominated by able-bodied men who wrote the law. These theories also fail to challenge ingrained attitudes and perceptions, which makes it difficult to address, as the law is currently based on the medical model (the individual's impairment). It is therefore not surprising that an individual with a disability would not be an issue in terms of social inclusion. Interestingly the law has attempted to combat some of these issues, however it has not tackled

the stereotypical assumptions that exist about disabled individuals, and has struggled to transform societal attitudes that exist.

Explaining social inequality

Is the inequality associated with disability discourse, necessarily a bad thing? It has been suggested that inequality in society is necessary in order for society to function. Although this is the case, society focuses on work as the core of life because we focus on a monetary value, and an earned money approach which does not serve the disabled person well. Functionalist theorists believe that certain positions in society are more functionally important than others, and not everyone in society is the same or has the talent or skills to fill these positions (Oliver, 1998). Functionalism stresses that stratification is needed; this benefits society because the best people are required for particular roles in society.¹⁰ But although stratification leads to distinctions between drawn between groups, it does not necessarily have to lead to inequality. It is the value placed on those distinctions that result in either “different but equal” or “different but unequal”. And it is that distinction that is at the heart of the two models in question here. For example, the “different but equal” approach can be illustrated with reference to a football match, most football players play to their strengths, with the aim of winning as a team.¹¹ The team values difference and knows that by building on the strengths of each player the team may be successful. If society adopted the same view, a broadly team-based or collectivist approach, then disabled individuals could play to their strengths; this would potentially breakdown barriers to exclusion. And yet an individualistic, capitalist approach has led to value judgements about worth being made, and thus stratification has led to inequality. Society’s approach may be functionalist (what functions can each individual perform) but it has been influential in understanding the difficulties disabled individuals encounter, it places emphasis on medicine’s role to cure and maintain the normal functioning of individuals and of society. In this model, the ‘sick role’ is viewed as predominant in disabled individuals’ identities and functionality and involves being compliant and wanting to get well in an attempt to integrate disabled individuals into society, and address the issues of social exclusion (Oliver, 1998).

Unsurprisingly, this view does not address societal attitudes and prejudice that arise because of an individual’s disability. This identifies the link between disability and social deviance that functionalists make which in turn influences the health care system and supports the dominance of health care support for disabled individuals (Oliver, 1998). This is not without precedent, and there is some evidence to suggest that sex inequality has resulted from similar value judgements being placed on women’s roles, which are universally less valued than men’s roles (Webley, 2011). Critics of this hypothesis argue that historically the lesser value placed on women’s work stem from biological factors, and that any stratification of roles and values that flow from this are as a result of the best socially constructed division of labour given inherent biological differences between men and women (Webley, 2011). Similarly, functionalists who argue for stratification in these circumstances would argue that in order for society to operate, it is necessary for the dominant group, to have this clear division of power and roles such that all may flourish. Their feminist critics, in contrast, suggest that functionalism is largely about the maintenance of a hierarchy, which serves a particular group (the dominant, the patriarchy) well (Webley, 2011). There are useful parallels here in the context of disability inequality, whether based on biological, functional or social construction distinctions. And gender and disability intersect too: evidence suggests that disabled women face higher levels of social disadvantage than disabled men (Payne, 2006). Unfortunately, functionalism does not serve women or the disabled well; it has been asserted that functionalism in some respects confuses impairment and disability with sickness and fragility

and contributes to societal attitudes by reinforcing discriminatory norms and values. It does this by failing to address the underlying cultural and economic issues that cause disability related inequality (Oliver, 1998), and the law reinforces the functionalist approach.

But it is not only feminist theory that allows us new ways of conceiving of disability inequality; exploration of critical race theory also provides similar opportunities. Critical race theory is founded on the understanding that ‘racism is not aberrant but rather the natural order of American life.’ (Asch, 2001: 405). We can draw comparisons between this and the suggestion that disability discrimination is a natural occurrence in life. Critical race theorists contend that in order to understand inequality, one should look at society including the public and courts. Critical race theory posits that there are subtle forms of bias that are cumulative and lead to stratification on grounds of race, with different ethnic groups being assigned differential value by dominant or hierarchically superior groups based on this social stratification; some groups (dominant group) end up with a better system than other groups. It has been suggested that ‘racism is an ingrained feature of our landscape; it looks ordinary and natural to persons in the culture’ (Asch, 2001: 393). A similar parallel can be drawn with disability, in that disability can be seen as a natural occurrence, with concomitant stratification and value differentiation asserted by those with power over those who do not. The legislative framework is drawn up by dominant groups, who view the world through their own lens, and the courts in turn apply the framework in-keeping with the legislature’s will. Society organises itself around the legal framework and a self-reinforcing cycle of unconscious biases serves some groups more favourably than others. The law has attempted to address this inequality amongst disabled individuals, however in some cases it has contributed to the oppression disabled individuals encounter. These models have caused contention in defining disability, and have been instrumental in shaping law and policy in the UK. In some cases it has attempted to transform attitudes through the introduction of disability legislation designed to combat anti-discrimination legislation.

Challenges: The Law

Unsurprisingly the main driver for disability equality legislation in the UK has been the impact of disablement after both World Wars (World War One and World War Two), and the social obligation to address discriminatory practices against disabled people (Barnes and Mercer, 2004). In the UK, a high number of the population were injured, and many combatants were left disabled. Furthermore, *The Disability Persons (Employment) Act 1944* had a positive impact on the employment of disabled people which primarily focussed on the issues disabled individuals encounter generally and enhanced their employment opportunities (Barnes and Mercer, 2004). This prompted a change in legislation, and as a result changed attitudes towards employing disabled people.¹² Additionally, the 1980s experienced organisations campaigning for disabled people which ultimately led to the enactment of the *Disability Discrimination Act 1995* (“DDA 1995”) (Barnes and Mercer, 2004) which was later amended by the *Disability Discrimination Act 2005*.

The *EqA 2010* mirrors the provisions contained in the *DDA 1995*,¹³ and has now replaced the *DDA 1995*. The provisions are similar to its predecessor, therefore, existing case law decided under the *DDA 1995* is still relevant to this discussion and remains good law.¹⁴ Disability is defined as a physical or mental impairment that has a long-term adverse effect on an individual’s ability to carry out their normal day to day activities.¹⁵ Although this definition may seem simplistic, the ‘gauging’ of applicants against the definition of disability has been

problematic (Woodhams and Corby, 2003). This medicalised statutory definition of disability has caused controversy for the judiciary in determining whether an individual qualifies as a disabled person, and in many cases has deterred claimants from pursuing their claims (Wells, 2003). Due to its restrictive nature and complexity, tribunals and courts have spent a considerable amount of time in trying to establish whether an applicant satisfies the criteria under the Act. Case law rulings have been used as a mechanism to interpret the convoluted definition and the duty to make reasonable adjustments.¹⁶ It is apparent that judicial interpretation and restrictive statutory language have prevented the definition from being interpreted purposively (Lawson, 2008).

Impairment is central to the medical model, and it has been noted that the focus on impairment is on medical diagnosis rather than societal barriers (Hepple, 2011). The *EqA* 2010 itself portrays disabled people as less economically productive, due to a disabled person's impairment. Some of the arguments adopted by the medical model 'endorse policies that at best are likely to be ineffective in promoting social participation and at worst reinforce disadvantage and social exclusion' (Payne, 2006: 253).

In considering whether an individual has an impairment 'the investigation is to be on the effect that it has on an individual, rather than on the underlying cause.' (Butler, 2014 p.3). Butler (2014) notes that this involves practical considerations that appear to fall outside the scope of the definition (Butler, 2014 p.3). Unsurprisingly 'each impaired individual is distinct and different and will combine these variables in different strengths.' (Woodhams and Corby, 2003). In *Walker v Sita Information Networking computer Ltd*¹⁷ Langstaff P ruled '...an impairment may be caused as a consequence of a condition which is itself excluded from the scope of the definition of disability'. Interestingly, in establishing whether obesity is a disability in *Karsten Kaltoft v The Municipality of Billund*¹⁸ the A-G made reference to the medical identification of obesity focusing on the individual's Body Mass Index (BMI) and concluded that individuals that were in Class III (BMI) would potentially be covered under the definition of disability; as they would most probably experience difficulties or limitations with mobility, endurance and mood (Ferris and Marson, 2014). This medicalised approach demonstrates the hurdles individuals have to overcome in order to satisfy the impairment criteria contained in the *EqA* 2010. It has been suggested that obesity impacts on an individual's mental wellbeing and because of this, must be a consideration in establishing whether the condition is an impairment. (Butler, 2014).¹⁹ In addition, previous legislation required the mental condition to be 'clinically well-recognised'. (Wells, 2003).²⁰ Unfortunately, tribunals and courts are still struggling to identify mental or physical impairments which in the majority of cases not only involve a physical impairment but also the possibility of a concurrent mental impairment (Butler, 2014). In determining whether an individual is disabled for the purposes of the Act medical evidence of disability is required and is a crucial factor in establishing disability as '...the definition relies on measurement, assessment and medical testament of the lack of functional activities as they relate directly to the impairment.' (Woodhams and Corby, 2003p.164). Medical evidence has proven to be problematic in establishing whether an applicant has an impairment and in many cases is costly and stressful for many potential applicants. (Woodhams and Corby, 2003p.164). Medical proof itself may not be determinative, as in some cases Employment Tribunals, not doctors, have to decide whether the applicant falls within [the meaning of disability] by considering medical evidence available in order to establish an impairment (Woodhams and Corby, 2003). Inevitably, this assessment involves a number of complex conditions which tribunals and courts do not have the apt level of expertise in reaching a decision based on medical evidence (Wells, 2003); and as a consequence restricts a number of individuals being

afforded protection (Woodhams and Corby, 2003).²¹ The requirement to provide medical evidence has in many cases perpetuated the labelling and stigma experienced by disabled individuals in trying to participate in the labour market. (Wells, 2003). These complexities in providing medical evidence have reinforced the medicalised definition which is at odds with the social model and in many cases has not assisted in transforming attitudes towards disability.

Not only does an individual have to provide evidence of an impairment, the individual then has to demonstrate how the impairment has an effect on their day to day activities. It is clear that the definition contained in the *EqA* 2010 reinforces the medical model by imposing the requirement that impairments must be linked to day to day activities (such as making, beds ironing and various minor DIY tasks),²² without taking into account any social or physical environmental factors. (Woodhams and Corby, 2003). Ignoring these environmental factors exacerbate ‘disableness’ and as a result generalises most people’s day to day activities (Woodhams and Corby, 2003). This assessment takes into account the ability to carry out day to day activities and includes general forms of mobility, as well as the ability to perform tasks of work (Ferris and Marson, 2014). Previous legislation provided a list of ‘normal day to day’ activities. However, the list has now been removed in an attempt to make it easier for disabled applicants to satisfy the definition and as a result has extended the interpretation of an impairment. A list of examples are now contained in the Guidance which is in fact remarkably similar to the list contained in the *DDA* 1995 and includes a non-exhaustive list of examples (Butler, 2014). The examples contained in the Guidance can be considered as a social approach to defining disability (Butler, 2014) in an attempt to transform attitudes and breakdown societal barriers. In order to establish a normal day to day activity for the purposes of the definition the activity should focus on whether the activity is carried out by a large amount of people on a regular basis (Butler, 2014). This restrictive approach has been demonstrated in *Goodwin v Patent Office*²³ where it was suggested that just because an individual can carry out normal day to day activities it does not mean that their ability to do so has not been impaired. Mr Justice Morrison stated:

What is a day-to-day activity is left unspecified: easily recognised, but defined with difficulty. What can be said is that the inquiry is not focused on a particular set of circumstances. Thus, it is not directed to the person’s own particular circumstances, either at work or home. The fact that a person cannot demonstrate a particular skill, such as playing the piano, is not an issue before the tribunal, even if it is considering a claim by a musician. Equally, the fact that a person had arranged their home to accommodate their disability would make inquiries as to how they managed at their particular home not determinative of the issue.

Although the decision in *Goodwin* is crucial in determining whether an individual is disabled, it fails to make a distinction between tasks performed at home or in work in assessing a normal day to day activity (Butler, 2014). In establishing whether the impairment has a substantial²⁴ and long-term adverse effect ‘...the first instance tribunal is stopped from holding that, because the disabled applicant can do most things, there is no substantial effect...’ (Jefferson, 2014).²⁵

It is clear that these decisions in the courts and tribunal demonstrate how restrictive nature of the definition is in practice. The definition places emphasis on ‘normal day to day’ activities, which is determined on a case by case basis creating barriers to potential applicants. This in turn reinforces the medicalised approach adopted in the *EqA* 2010 for defining disability.

As discussed earlier this model has been criticised for concentrating on the medicalisation of disability, which inevitably suggests that disabled people have something wrong with them, and also extends to associative discrimination based on disability.²⁶ These negative connotations contained in the definition do not assist a disabled person, which inevitably restricts the law in transforming attitudes. It is apparent that if a disabled individual is to be classified as disabled, the physical or mental impairment must be the factor taken into account in establishing whether the impairment itself has a substantial²⁷ and long-term effect²⁸ on their ability to carry out normal day to day activities.²⁹ Although most illnesses are treatable and can even be cured, most impairments are not curable, ‘disability can [therefore] be eradicated by changes to the way we organise society’ (Oliver, 2009: 44). Oliver believes that the only way to combat this is by trying to remove the barriers that disable an individual, rather than spending too much time and investment on individually based interventions (Oliver, 2009). This would inevitably involve challenging ingrained attitudes and perception about disability. A barrier free environment will not just benefit the disabled individual, but also benefit society as a whole (Oliver, 2009).³⁰ Moreover, the labelling of an individual as ‘disabled’ has been a contributing factor in relation to the stigma associated with disability, and as a consequence many disabled individuals reject the label. By way of illustration, people that have been diagnosed with cancer, HIV infection or multiple sclerosis in the UK are automatically protected and are regarded as disabled.³¹ Additionally, research suggests that the reason for the automatic classification once diagnosed appears to be the association of HIV/AIDS with ‘...behaviours that may be considered socially unacceptable by many people’ (McTigue, 2010: 1). This demonstrates the importance the law places on the stigma related to the disease, and not the impairment (McTigue, 2010: 1-9). Thus, Parliament’s decision to classify HIV as a “disability” under the *DDA 2005*³² protects those individuals living with the disease. Instead of challenging ingrained attitudes and perception, British legislation in some respects pities the disabled individual and reinforces discrimination by using the term impairment, whilst attempting to solve the issues by making reasonable adjustments for disabled individuals.³³ Lawson (2008) indicates that: ‘the notion of ‘reasonableness’ is objective in nature’ and is judged by reference to objectively demonstrable facts and circumstances (Lawson 2008). Although the duty to make reasonable adjustments can be interpreted widely there are limits. In *Monmouthshire County Council v Harris*³⁴ there was no finding of a continuing obligation to make reasonable adjustments as the medical evidence provided did not make any recommendations that could be implemented made to ensure the Claimant could return to work.³⁵

The rulings in these cases to date and the nature of this unique duty have added to the complexity in establishing ‘reasonableness’. In addition to establishing whether the applicant satisfies the criteria,³⁶ the duty to make reasonable adjustments is much dependent on the sector.³⁷ (Lawson, 2008). The duty is only triggered in an employee and employer relationship when the ‘disabled person concerned’ is substantially disadvantaged because of the employer’s behaviour, up until this point the duty is reactive (Lawson, 2008). This has been demonstrated in *Archibald v Fife*³⁸ where the House of Lords overturned the lower courts’ decision and ruled that the term ‘arrangements’ included situations where an individual could not perform their job due to a disability.³⁹ (Lawson, 2008). In comparison, the service provider’s duty is proactive in that service providers are required to take a proactive approach in accommodating customers, and other individuals by anticipating barriers individuals are likely to encounter, and where reasonable, attempt to remove them (Lawson, 2008). Service providers have struggled in adhering to this proactive duty and have

fallen foul of the anticipatory duty to make reasonable adjustments for disabled service users.⁴⁰ Not only are disabled individuals protected by anti-discrimination legislation; the law now extends to those individuals associated with disabled individuals (although they themselves may not have a disability) in an attempt to transform attitudes and breakdown the barriers that hinder participation in daily life.

Association and disability

The law now extends protection to those individuals that are associated with a person who has a disability. In so far as disability is concerned, discrimination by association⁴¹ highlights that it is not only the social barriers or physical barriers that hinder participation, but also the attitudes of people, which are socially constructed (Burke, 2010). This issue was addressed in the case of *Coleman v Attridge Law*,¹ where it was ruled that the employer unlawfully discriminated against the employee because her son was disabled, this amounted to discrimination by association. Research has indicated that family members perceive themselves as disabled if they have a family member that is disabled. In other words, if they are associated with a disabled individual they can be subject to disability discrimination (Burke, 2010).

Until recently, the UK predecessor (*DDA 1995*) of the *EqA 2010* was limited by not having provisions that protect individuals associated with a disabled person; however it is clear that the *ADA 1990* defines disability broadly. The renewal of the *ADA 1990* has changed the way judges define disability in America, by focusing on a social model which has been instilled into the Act (Cantor, 2009). The definition of impairment under the *ADA 1990* has not been limited to physical impairment. It has been acknowledged that an impairment can manifest from society's misconceived attitudes (Wenbourne, 2000). Following *Coleman*,² the *EQA 2010*³ now allows individuals associated with a disabled person to be afforded protection by introducing 'discrimination by association'. The Act now extends protection to those individuals that are associated with a person who has a disability and applies to all forms of protected characteristics (Jefferson, 2014). It has been highlighted that the decision in *Coleman* is reflective of the social model in that it focuses on external factors such as negative attitudes which disables individuals (De Paor, 2017). This serves as evidence to suggest that the law in the UK is moving towards a social model approach, in an attempt to eliminate discrimination amongst disabled individuals, and those associated with the disabled person. Interestingly, an individual may be subject to disability discrimination because of their association with a disabled person; it constructs a perception of disability, when in fact no perceptible disability may exist (Burke, 2010).

The solution: the Americans with Disabilities Act 1990 and the impact on Europe

The narrowness of the medical model was addressed in the United States in the 1990s, and has shaped disability civil rights in the UK and Europe (Wenbourne, 2000). The acceptance of the social model being a dominant model in Europe was fundamental in America's attempt to renew the *ADA 1990* (Cantor, 2009). Thus, the legislative framework serves as a fundamental tool in the longstanding debate in defining disability, and the use of both models. Unsurprisingly, the social model has been regarded as a benchmark for the EU and

¹ *Coleman v Attridge Law* Case C-303/06 [2008] IRLR 722.

² *Coleman v Attridge Law* Case C-303/06 [2008] IRLR 722.

³ S.13 *EQA 2010* defines discrimination by association.

abroad (Cantor, 2009). This was adopted in Europe which was based on the European Community Treaty Article 13 (Cantor, 2009). Consequently, the *ADA* 1990 has been crucial in defining disability and understanding the appropriateness in using the social and medical model to define disability in both the US and UK (Cantor, 2009). It is apparent that the medical model has created various problems for disabled citizens in Europe, since it is narrow and therefore cannot ‘realize the progressive remedial purpose behind the Framework Directive’s disability provisions’ (Cantor, 2009: 401). Although the *DDA* 1995 (*EqA* 2010 predecessor) has been the most radical legislation in Europe in so far as disability discrimination is concerned, it has no doubt had flaws (Wenbourne, 2000), and is unpopular since it has not transformed views and cannot, or is not prepared to change attitudes, compared to other types of legislation.⁴²

Commentators have highlighted that the renewal of the *ADA* 1990 was well received during the 1990s in the US, and more recently in Europe; which has been an inspiration for the Framework Directive on Employment (Cantor, 2009). Moreover, the renewal of the *ADA* 1990 attempted to alter the legislative interpretation of disability which included removing sections in the *ADA* 1990, and as a result there was less judicial reliance on a medical model, but rather the focus was on defining disability (Cantor, 2009). The definition contained in the *ADA* 1990⁴³ differs a little from the *EQA* 2010 in that the *ADA* 1990 adopts a social model approach in an attempt to transform attitudes. Although the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is not part of our domestic law it has been influential at both EU and national level (Lawson, 2011). It adopts a social model approach which assists in defining disability and reasonable adjustments, with the aim of removing barriers that prevent full participation (EHRC, 2017). Due to the reactive and individualised nature of the duty in the employment sector, employers are not required to make adjustments or take reasonable steps to accommodate the requirements of a particular disabled person (Lawson, 2008), and in turn fails to address wider societal barriers that exist. It is now accepted that the definition of ‘disability’ must be applied in conjunction with EU law.⁴⁴

The decision in *Chacón Navas v Eurest Colectividades SA*⁴⁵ has caused tension in relation to both the social and medical models. Although the EU have officially accepted and adopted a social model of disability, the European Court of Justice’s (ECJ) decision making was based on the medical model in *Chacón Navas v Eurest Colectividades SA*⁴⁶ which undermined the Directives goals (Cantor, 2009), and as a consequence contradicted the aim of the Framework Directive (Cantor, 2009). It is common practice that UK Employment Tribunals apply EU law in their decision making as it is enshrined in the Equality Directive which establishes the framework for equal treatment in employment and occupation; more importantly it prohibits discrimination based on disability and requires reasonable accommodation for disabled individuals.⁴⁷ Although disability is not defined in the Equality Directive, the ECJ has revisited this definition recently in a number of rulings. In *Ring v Dansk Almennyttigt Boligselskab*⁴⁸ the ECJ referred to the UNCRPD and highlighted that ‘...disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.’⁴⁹ These social barriers were also illustrated in *Banaszczyk v Booker Ltd*⁵⁰ where it was decided that the ‘pick rate’ imposed by the Respondent was a potential barrier that prevented full inclusion in working life.⁵¹ The EAT in this case applied *Chacón Navas v Eurest Colectividades SA*⁵² and concluded that the Claimant had a disability for the purposes of the *EqA* 2010. It was noted in the judgement that the EAT did not rely upon the 2011 Guidance but instead relied on the legal principles set out in the ECJ decision in *Chacón Navas v Eurest Colectividades SA*⁵³ and *Ring v Dansk*

*Almennyttigt Boligselskab*⁵⁴. The concept of ‘professional life’ was not restricted to the case ‘...of a special skill such as the silversmith or watchmaker limited in some activity that the use of their particular tools requires.’⁵⁵ Instead it was highlighted that the concept should be applied to activities that are common across the employment sector.⁵⁶ The EAT gave a broad meaning to work and professional life which related to the manual lifting and moving not the ‘pick rate’.⁵⁷ Different working environments in some cases make it difficult to assess whether an activity is a ‘normal day to day’ for the purposes of the definition.⁵⁸ It is clear that these rulings have adopted the social model approach by adhering to EU law in defining disability, and suggests that the law in some circumstances is beginning to adopt a social model approach in defining disability. However, inconsistencies in some rulings indicate that the current law is struggling to transform attitudes due to the restrictive medicalised definition of disability.

Although the *ADA* 1990 was regarded as ground-breaking the ECJ’s narrow medical model interpretation was predictable because of America’s interpretation prior to the renewal of the *ADA* 1990 and the decisions in the U.S. Supreme Court.⁵⁹ It is apparent, that the judiciary in Europe and America specifically have in the past been guided by the social and medical model in determining whether an individual is afforded protection, which determines the legislative decision making (Cantor, 2009). In order to overcome these issues or the inconsistencies, it is suggested that a potential solution could be to recognise difference in an attempt to transform attitudes.

Recognising and accepting difference – is this the solution to disability inequality?

Common assumptions exist about disability that suggest an integrationist or assimilationist ethos. These assumptions focuses on bringing the disabled person back to normality by adjusting conditions or creating an environment in an attempt to ensure inclusion. (Imrie, 1996). In turn this then assists the disabled person integrating into mainstream society, but supplants the idea that people with a disability should not be in mainstream society as they do not satisfy the category of ‘normal’ (Imrie, 1996). In order to eradicate exclusion amongst the disabled population, society should accept difference and recognise that individuals have vulnerabilities (Herring, 2013), in an attempt to change attitudes, and promote inclusion. By making reasonable adjustments or reasonably accommodating disabled individuals, society contributes to oppression by excluding the disabled person which does not assist in changing attitudes. Until society recognises difference and accepts that the definition of ‘normal’ does not exist when tackling disability discrimination, social exclusion will still remain. Although this solution is aspirational, a realistic solution would be to challenge ingrained attitudes. The medical model has been criticised for perpetuating the concept of normal, since it takes the notion of normality for granted and therefore as fixed (Payne, 2006). Importantly, it ignores the fact that normality is a socially constructed phenomenon. Evidence suggests ‘what is and is not normal is socially and culturally relative’ (Payne, 2006: 253). The duty to make reasonable adjustment involves adjusting environmental factors to enable a disabled person to participate in society.⁶⁰ This is also the case in relation to the reasonable accommodation contained in the *ADA* 1990 which focuses on a change in the work environment, or the way in which activities are carried out (Wenbourne, 2000). Reasonable accommodation and the reasonable adjustment duty is aimed at integrating the disabled person in society which effectively perpetuates disability inequality by not addressing the underlying issues associated with inequality. Employers are reluctant to adapt premises and equipment to suit the needs of a disabled individual (Payne, 2006), due to ingrained attitudes and perceptions

about disability, therefore the disabled individual is perceived as not economically productive. This suggests that the law is not setting society up to recognise difference, and challenge the hierarchy (the able-bodied individual and disabled individual). Even though this may be the case, having legislation in place to protect disabled people is a starting point. Nevertheless, there are issues with accepting difference.

On the other hand, if we deny a standard model, as a starting point within human functioning, it would be difficult to evaluate impairment and disability. If there was no normal functioning impairment and disability would cease to exist, thus bringing the social model to its knees (Terzi, 2004). This would not only have an impact on disability studies, but also the law. Another issue that one may be faced with is the idea of normality and accepting difference. This is even more problematic since it would contradict the aims of eliminating discrimination in society (Terzi, 2004). In order for disabled individuals to integrate and function in an oppressive society, ‘disability should be a “positive and central” part of their identity’ (Asch, 2001:415). In a somewhat similar vein, it is important to recognise disability as something positive. Research indicates that the majority of disabled people perceive disability as a minority status (Ash, 2001), which raises the issue as to whether it is realistic for society to cater for the minority as much as the majority.⁶¹ Therefore attention should be focussed on considering differing environments which could incorporate the majority of individuals whether disabled or not (Asch, 2001) in an attempt to transform ingrained attitudes and change perceptions amongst disabled individuals. Research suggests that instead of considering the kinds of impairments individuals have, which results in society classifying individuals as disabled and others not, it would be beneficial to consider people who cannot perform activities in different environments so that they are not disabling (Asch, 2001). This radical proposal suggests that any individual without any change to their environment whether it be physical, cognitive, sensory, employment and emotional make-up would be considered impaired (Asch, 2001). A barrier-free environment not only benefits disabled individuals, but also others (Oliver, 2009). The emphasis should focus on accepting that each individual has different needs which is unique (Herring, 2013), and perhaps should now be incorporated into legislation which may assist in transforming attitudes and breaking barriers that limit inclusion.

Conclusion

Differing theories and models attempt to explain the reasons for inequality. Although these models seem simplistic at first, it must be noted that there are limits to any model which restricts understandings of disability. The social model advocates for full inclusion and equality within society. Despite its theoretical limits, it serves as a reminder to society (Terzi, 2004). However one must note that models are a way of explaining the issues associated with disability discrimination, and the way the world perceives the issues rather than as an aid to combatting inequality. Oliver suggests that the social model should not be considered as a social theory, but should rather be seen as an aid to providing a definition of disability from a sociological perspective and as a result challenges the medical model (Terzi, 2004). It is clear that by changing the law, attitudes will follow. Where the law changes, people’s attitudes will generally change, and society will generally perceive disability as the ‘new normal.’ An example being women’s rights, where the law has transformed women’s rights (at least to an extent), however this has not been the case with disability. A contributing factor has been the use of the medical model used in legislation to combat disability discrimination. Many supporters of the social model have been critical of this claiming that it is the societal barriers that need to be addressed. Besides making some progress, the law

should now focus or reflect a more positive transformative social model, which would involve challenging people's perceptions and attitudes. As noted above, it has been argued that the *ADA* 1990 as opposed to the *EqA* 2010 is more compatible with the social model in that it attempts to address the social issues in society. It must be noted that we have achieved stage one, however we now need to focus on stage two which involves challenging perceptions and attitudes which would involve incorporating the social model into British legislation.

Recognising difference may be the solution, although there are fundamental issues with this which challenge the social model. Legislation and case law illustrate that we are constantly adjusting to able bodied individuals, this is in line with the individual (medical model), and we seem as a society to be measuring a disabled individual against a yardstick, instead of perhaps recognising difference. Whilst the law is there to assist in eradicating inequality, it leads to inequality by adjusting to what society perceive as 'normal'. More importantly, the push to export the *ADA* 1990 across Europe demonstrates that the social model is the model that should be followed; if this model is followed inequalities amongst disabled people can be addressed. Unfortunately, the law has failed to combat the underlying issues associated with exclusion and attitudes, despite making progress. In short, the law has not been transformative in addressing the issues compared to other forms of discrimination such as women's rights and gay rights; disability discrimination seems to be at odds with this. It is not just about accommodating disability, we now need to transform disability by incorporating the social model into the definition of disability. A model based on this may assist us in transforming attitudes.

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¹ Based on 2010 global population.

² Although the World Health Organization (WHO) estimates 10% dating from the 1970s. (World Health Organization, 2011). The rise in the global estimate is due to the population increasing, rapid spread of chronic diseases such as diabetes, cardiovascular diseases, and mental illness. (World Health Organization, 2011).

³ Section 4 *EqA* 2010

⁴ See also *SCA Packaging v Boyle* [2009] UKHL 3 and Section 6(1) *EqA* 2010 for the legal definition of a disability.

⁵ The model emerged in the 1970s by activists in the Union of the Physically Impaired Against Segregation (UPIAS).

⁶ These include the physical, attitudinal and organisational barriers.

⁷ The World Health Organisation (WHO) defines impairment as ‘...any loss or abnormality of psychological, physiological or anatomical structure or function.’ Disability on the other has been defined by WHO as ‘...any restriction or lack, resulting from an impairment, of ability to perform any activity in the manner or within the range considered normal for a human being. (World Health Organisation, 1980).’

⁸ For example the employment sector.

⁹ Such as memory loss, decision-making difficulties, inability to concentrate, and learning difficulties.

¹⁰ For example, blind people are excellent at piano tuning.

¹¹ For an individual will be allocated a particular position e.g. defenders, strikers and a goalkeeper.

¹² Other legislation include which attempted to address the problems faced by disabled people included the Education Act 1944, National Health Service Act 1946 and the National Assistance Act 1948.

¹³ These provisions are similar to the provisions contained in the *EQA* 2010.

¹⁴ Previous legislation (*DDA* 1995) listed day to day activities. This list has now been removed and is not contained in the *EqA* 2010. Although this is the case the former list and case law serves as guidance in establishing whether an activity may be deemed as a day to day activity.

¹⁵ S.6 *EqA* 2010.

¹⁶ This duty arises where a provision, criteria or practice places a disabled person at a substantial disadvantage (s.20(3) & 20(4) *EqA* 2010. This has been interpreted in case law – see *Smith v Churchill Stairlifts plc* [2006] ICR 524 per Maurice Kay LJ at para.34; *Environment Agency v Rowan* [2008] ICR 218 and *RBS v Ashton* [2011] ICR 632. This duty has been extended to the essential elements of the job as demonstrated in *Archibald v Fife* [2004] IRLR 651.

¹⁷ [2013] UKEAT

¹⁸ [2014] EUECJ 354/13

¹⁹ The strict approach contained in the *DDA* 1995 required that the mental impairment be clinically well-recognised has been removed, therefore case law pre-December 2005 should be interpreted with caution including the suggestion that ‘anxiety’, ‘stress’ and ‘depression’ may be generic terms to satisfy the requirement of impairment. (Butler, 2014).

²⁰ Refer to *Mc Nicol v Balfour Beatty Rail Maintenance Ltd* [2002] IRLR 711 and *Morgan v Staffordshire University* [2002] IRLR 190. In *Morgan v Staffordshire University* [2002] IRLR 190 at 194, para 20, the EAT stated that ‘...there is no good ground for expecting tribunal members (or Employment Appeal Tribunal Members) to have anything more than a layman’s rudimentary familiarity with psychiatric classification. Things therefore need to be spelled out.’

²¹ In *Sussex Partnership NHS Foundation Trust v Norris*, the EAT ruled that the medical evidence was not sufficient to establish whether the impairment had a substantial adverse effect on her ability to carry out normal day to day activities. Interestingly in *Vicary v British Telecommunications* [1999] IRLR 680 the employment tribunal relied on the employer’s doctor to decide whether the applicant had an impairment which caused a substantial effect (Woodhams and Corby, 2003)

²² In *Vicary v British Telecommunications plc* [1999] IRLR 680 activities such as making beds, housework inc, ironing, sewing, using scissors, minor DIY, filing nails and curling hair. In *Ekpe v MPC* [2001] IRLR 605 (EAT) normal day to day activities included putting rollers in and applying make-up. The case highlighted that it was immaterial that the activities were not performed by men (Jefferson, 2014).

²³ In *Goodwin v Patent Office* [1999] IRLR 4 the claimant had paranoid schizophrenia which affected his behaviour at work. This case confirmed the correct approach outlined in the *EqA* 2010.

²⁴ Define in s.212(1) *EqA* 2010 as ‘more than minor or trivial’.

²⁵ This was the approach taken in *Leonard v Southern Derbyshire Chamber of Commerce* [2001] IRLR 19 (EAT). In *Paterson v Commissioner of Police of the Metropolis* [2007] UKEAT/0635/06/2307. it was held that the effect dyslexia had in a high-pressure exam amounted a substantial adverse on his normal day to day activities, and therefore satisfied the definition of ‘disability’.

²⁶ *Coleman v Attridge Law* Case C-303/06 [2008] IRLR 722.

²⁷ S.212 *EqA* 2010 defines substantial as ‘more than minor or trivial’ See *Goodwin v The Patent Office* [1999] IRLR 4 EAT, where it was held that the tribunal had been misdirected.

²⁸ The impairment must have lasted 12 months - see *Patel v Oldham MBC* [2010] IRLR 280.

²⁹ *SCA Packaging Ltd v Boyle* [2009] UKHL 3, was a landmark decision in which the House of Lords clarified the correct approach in relation to defining disability.

³⁰ For example ramps that benefit non-disabled people such as parents with young children who use prams.

³¹ Schedule 1, paragraph 6 and paragraph 3 *EQA 2010*.

³² The law was previously contained in the *DDA 2005*, now it is contained in the *EQA 2010*.

³³ S20-22 EqA 2010 sets out the reasonable adjustment duty.

³⁴ [2015] UKEAT 0010/15

³⁵ *Monmouthshire County Council v Harris* [2015] UKEAT 0010/15 para 59

³⁶ S.6(1) *EqA 2010*

³⁷ For example, employment, goods, facility, services, transport, and education.

³⁸ [2004] IRLR 651

³⁹ In *Archibald v Fife* [2004] IRLR 651 the claimant was treated more favourably this is not a consideration the court will take into account (in this case the employer) in order absolve the duty if it is required in order to remove the substantial disadvantage (Lawson, 2008).

⁴⁰ In *Royal Bank of Scotland Group plc v Allen* [2009] EWCA Civ 1213 CA. The bank had failed to provide wheelchair access for disabled used, although an alternative service was offered the Court of Appeal ruled that the duty to make reasonable adjustments extended to installing a lift. For a further discussion in relation to the anticipatory duty, refer to *Ross v Ryanair and Stansted Airport Ltd* [2004] EWCA Civ 1751, [2005] 1 WLR 2447 and *Roads v Central Trains* [2004] EWCA Civ 1541.

⁴¹ *Coleman v Attridge Law* Case C-303/06 [2008] IRLR 722 and s.13 *EQA 2010* defines discrimination by association.

⁴² The *Civil Partnership Act 2004* is an area where the law has transformed attitudes towards same-sex marriages. These couples now have legal recognition and generally have the same rights and obligations which married couples have.

⁴³ The definition of disability is outline in s.42 U.S. CODE § 12102 *ADA 1990*. In order for the individual to be afforded protection under the *ADA 1990* an individual must (1) have a physical or mental impairment that substantially limits one or more major life activities of such individual; (2) has a record of such impairment; or (3) is regarded as having such an impairment.

⁴⁴ *Banaszczyk v Booker Ltd* [2016] UKEAT/0132/15/RN para 33

⁴⁵ C-13/05 [2007] All ER (EC) 59. The case of *Banaszczyk v Booker Ltd* [2016] UKEAT/0132/15/RN highlights the importance of adhering to EU law in the decision by making reference to *Chacón Navas v Eurest Colectividades SA* C-13/05 [2007] All ER (EC) 59 at para 35 in *Banaszczyk v Booker Ltd* [2016] UKEAT/0132/15/RN.

⁴⁶ C-13/05 [2007] All ER (EC) 59

⁴⁷ *Banaszczyk v Booker Ltd* [2016] UKEAT/0132/15/RN Para 20 -21 (Council Directive 2000/78/EC)

⁴⁸ [2013] IRLR 571

⁴⁹ *Ring v Dansk Almennyttigt Boligselskab* [2013] IRLR 571 para 3

⁵⁰ [2016] UKEAT/0132/15/RN

⁵¹ *Banaszczyk v Booker Ltd* [2016] UKEAT/0132/15/RN para 50

⁵² C-13/05 [2007] All ER (EC) 59

⁵³ C-13/05 [2007] All ER (EC) 59

⁵⁴ [2013] IRLR 571 Para 19-20

⁵⁵ *Banaszczyk v Booker Ltd* [2016] UKEAT/0132/15/RN para 20

⁵⁶ *Banaszczyk v Booker Ltd* [2016] UKEAT/0132/15/RN Ring para 20

⁵⁷ *Banaszczyk v Booker Ltd* [2016] UKEAT/0132/15/RN para 47

⁵⁸ The ECJ decision in *Chacón Navas v Eurest Colectividades SA* C-13/05 [2007] All ER (EC) 59 has interpreted ‘normal day to day’ activities depending on different working environments (*Chief Constable of Dumfries & Galloway V Adams* [2009] ICR 1034). In *Paterson v Commissioner of Police of the Metropolis* [2007] UKEAT/0635/06/2307 the EAT followed EU law and it was held that assessments for career progression constituted a normal day to day activity.

⁵⁹ There have been numerous cases which discuss the Supreme Court decision in relation to the warning signals, these cases demonstrates the extent to which these decisions have gone too far. This restrictive interpretation of disability was demonstrated in *Sutton v United Air Lines, Inc* 527 US 471 (1999). More importantly *Mangold v Helm*, 2005 E.C.R. I-9981, narrowed the scope of protection offered to a disabled individual.

⁶⁰ S.20-21 *EQA 2010*. The requirement to make reasonable adjustments in contained in s.20(3)-(5) *EQA2010* (also see sch.8 of the *EQA* and Code of Practice, Chapter 6). The failure to comply with the duty is set out in s.21 *EQA 2010*.

⁶¹ This can be compared with other minority groups, such as ethnic minorities.