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Questioning the Medical Model of Disability

Ntobeko Shozi
Department of Philosophy and Applied Ethics, Faculty of Humanities and Social Sciences, University of Zululand, KwaDlangezwa, South Africa.
Corresponding author: ShoziN@unizulu.ac.za

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Abstract: The medical model of disability remains the dominant framework in both everyday discourse and academic theorising, largely due to its apparent ability to deliver clear verdicts on paradigm cases of disability. However, this paper suggests that the dominance of the medical model might be philosophically unjustified. While existing critiques rightly challenge the model's tendency to locate disability solely in the impaired body, they often fail to interrogate a deeper normative assumption underpinning the model, its implicit equation of disability with diminished personal autonomy. By reconstructing the medical model's reliance on species-typical functioning, this paper shows that functional deviation is treated as problematic primarily because it is assumed to undermine autonomy, understood in individualistic terms of self-sufficiency and independence. Drawing on African communitarian philosophy, the paper challenges this assumption by offering a relational conception of personhood in which dependence, interdependence, and communal belonging are constitutive of human wellbeing rather than marks of deficiency. Through this lens, disability cannot coherently be understood as a state of non-autonomy, since autonomy itself is not the primary basis of moral worth. The paper concludes that the medical model not only mislocates disability but also universalises a culturally specific ideal of the autonomous individual, thereby rendering disabled persons morally deficient by design. An African communitarian perspective exposes this limitation and points toward a more relational and culturally inclusive understanding of disability.

Keywords: African communitarianism, Autonomy, Disability, Medical model, Relationality

Introduction

The question of how disability ought to be defined remains deeply contested. In recent years, even the disability rights movement itself appears divided between two broad positions. On the one hand is the view that "disability is the disadvantage produced by social prejudice against certain types of persons (persons with impairments) … it just is the negative net effects of having an impairment in a society that discriminates against those with impairments" [1]. This position, commonly referred to as the social model, understands disability primarily in terms of social disadvantage and exclusion. On the other hand is the view that disability is whatever those within the disability rights movement say it is, on the grounds that disability is not merely a theoretical concept but a lived experience; consequently, it is those who live with *disability* who are best placed to define it [1]. Call this the solidarity model. Roughly speaking, the social model adopts an objective approach, while the solidarity model adopts a subjective one.

Although these positions continue to generate debate within the disability rights movement, they receive comparatively little support outside of it. One central reason is that neither model appears capable of delivering correct verdicts on paradigm cases of disability, that is, of reliably distinguishing cases that clearly are disabilities from those that clearly are not. As Elizabeth Barnes [1] notes that "A successful account of disability needs to say that paradigm cases of disability are in fact disabilities (and that paradigm cases of nondisability are not)".

Consider, for example, dysautonomia, a non-visible condition that is typically classified as a disability [2]. Is dysautonomia genuinely a disability, and can the social and solidarity models provide a satisfactory answer? According to the social model, disability consists in being disadvantaged through social prejudice against deviations from what is considered typical human functioning. Yet in cases such as dysautonomia, the condition may be known only to its bearer, with no outward markers accessible to the public. If no one else is aware of the condition, and no social prejudice is activated, does this imply that the individual is not disabled? The social model appears committed to the view that disability arises only once the condition attracts discriminatory treatment. This overlooks the fact that dysautonomia may be intrinsically physically disadvantageous to its bearer, independently of social recognition or stigma. The disadvantage precedes, rather than follows, exposure to the gaze of others.

A similar difficulty arises for the solidarity model. If disability is whatever the disability rights movement recognises as such, individuals with dysautonomia may fall outside its scope, particularly if they do not identify with or participate in disability activism due to the largely private nature of their disadvantage. This concern mirrors earlier debates within the Deaf pride movement, where some advocates accepted the assumption that disability is bad but denied that deafness is bad, leading to claims such as "Deafness is not a disability" [1]. The question then arises: does a physical disadvantage known only to its bearer exclude a condition from the category of disability? From the standpoint of paradigm cases, both the social and solidarity models appear to suggest that it does.

By contrast, the medical model of disability treats this conclusion as problematic. Roughly stated, the medical model holds that disability is a negative deviation from species-typical form or function [3]. On this view, a human being who possesses the aesthetic and functional characteristics typical of the human species is not disabled, whereas one who deviates negatively from these norms is. The medical model is widely regarded, in both academic and public discourse, as the standard or default account of disability. As Indeed, it is often treated as more legitimate than its social and solidarity counterparts. As Christie Hartley [4] observes that "The everyday usage of disability is similar in some respects to the medical model of disability". Commonly, disability is understood as that which makes a person look or function in ways that are regarded as less aesthetically desirable or less functionally effective. This intuition underlies John Harris's [5] claim that disability is something any rational person would choose not to have.

For many people, then, debates over the definition of disability appear puzzling or unnecessary. As Jon Tøssebro [6] notes that "In everyday communication, disability tends to be seen and used as an unproblematic concept. 'Everyone knows' what it means—and what 'everyone knows' tends to be some version of a biomedical perspective". On this view, disability is understood as a bodily condition involving functional limitation, caused by disease, disorder, or injury. It is largely on the basis of this resonance with everyday intuitions that the medical model remains dominant in both public and academic disability discourse.

Another reason is that the medical model is often credited with its ability to deliver correct verdicts on paradigm cases such as dysautonomia. In determining whether dysautonomia is a disability, the medical model asks whether it is typical of human beings to experience chronic fatigue, dizziness, fainting, and an abnormally accelerated heart rate, and whether these features negatively affect functioning. If such a state is atypical and functionally limiting, then it qualifies as a disability. It is also this apparent clarity and decisiveness that sustains the medical model's continued appeal.

This paper questions whether that dominance is, in fact, deserved. Specifically, it interrogates an assumption that is strongly suggested by the medical model but rarely made explicit: its implicit connection between disability and diminished personal autonomy. By examining the medical model's insinuation that disability amounts to a form of personal non-autonomy, this paper challenges the legitimacy of the model itself. To this end, the paper starts by outlining the medical model of disability and then critically examine its underlying assumptions about autonomy and human agency.

The medical model of disability explained

The point of departure for the medical model of disability is the notion of normalcy. It is grounded in the assumption that there is a particular way human beings are supposed to be, such that deviations from this standard are understood as abnormalities, that is, as failures to conform to what a human being ought to be. On this view, conditions such as blindness, cerebral palsy, multiple sclerosis, Down syndrome, and dyslexia are taken to indicate that those who have them are not as they are supposed to be, and are therefore disabled. Disability, in this sense, consists in a deviation from the biologically determined, essential characteristics that are taken to be typical of the human species. As a result, "When physically or mentally 'deviant' people are defined, normality is also defined" [7].

A further step in explicating the medical model concerns the basis of the species-norm itself. According to this model, the species-norm is grounded primarily in aesthetics and performance, or appearance and function. To fail to look the way human beings typically look is to be abnormal in a manner that suggests disability (or injury or disease). Likewise, to fail to perform or function in ways typical of the human species is to be abnormal in a manner that signals disability. Disability, on this account, is thus identified with atypical bodily form or functioning.

This raises an important question: do all deviations from the human species-norm amount to disability? Norman Daniels [3] argues that this cannot be the case, since some deviations from species-typical functioning are clearly advantageous. Consider, for example, the former Olympic swimmer Michael Phelps, who possesses several atypical physical traits, including hypermobile joints, an arm span longer than his height, unusually large feet, and low lactic acid production [1]. As Barnes [1] notes, these deviations significantly contributed to his extraordinary athletic success. Yet it would be implausible to conclude that Phelps is disabled. This suggests that disability cannot be identified with deviation from the species-norm per se. The question, then, is whether disability can be meaningfully separated from disadvantage.

Defining disability as any deviation from species-typical functioning appears to cast the net too wide. In response to this concern, proponents of the medical model refine their account by introducing a disadvantage condition, maintaining that "disabilities are negative departures from statistically typical functioning, where 'negative' means deviation from the organism's design, rather than something normative or value-laden" [1]. On this revised view, disability is not just atypicality, but atypicality that undermines the organism's proper functioning. Thus, a normally functioning person has two eyes and can see with them; if one lacks two eyes or cannot see with either of them, one is disabled. A normally functioning person has ears and can hear with them; a Deaf person cannot, and is therefore disabled. And so on.

However, the medical model does not stop at describing what disability is. It goes further to prescribe how disability ought to be addressed. Because disability is understood as a negative deviation from the species-typical norm, it is taken to warrant medical correction whenever possible. As Hartley [4] summarises, the medical model rests on two core claims:

1. A disabled individual is unable to function at the species-typical level due to a persistent biological impairment.
2. Whenever possible, disability should be corrected or prevented.

In this way, the medical model carries with it a moral imperative to intervene. Disability is framed not merely as a difference, but as a condition in need of repair or elimination. This corrective orientation has profound ethical implications. It positions disability as a biological defect rather than as a legitimate form of human variation, and in doing so raises pressing questions about the moral justification of medical interventions and about how societies value diversity in physical and cognitive functioning.

The medical model implicitly assigns value to looking and functioning in ways that are typical of the human species. The question, however, is why deviation from this norm should count as disability. The answer lies in the model's underlying commitment to autonomy. The medical model presupposes that human beings are expected to be autonomous agents, and species-typical functioning and aesthetics are treated as essential because they are taken to underpin autonomy. Those who lack autonomy are often regarded as burdensome or even useless to themselves and to others. As Geert Hofstede [8] notes, modern societies operate on the expectation that "everyone is expected to look after him/herself and her/his immediate family only."

Autonomy, in this framework, is understood in terms of three interrelated dimensions which are self-determination, self-governance, and self-authorisation. As Catriona Mackenzie [9] explains, self-determination involves having genuine freedom and opportunities to shape the course of one's life; self-governance consists in the capacity for deliberation and reflection required to live in accordance with one's values and commitments; and self-authorisation refers to regarding oneself as normatively entitled to take responsibility for those commitments and act upon them. On this understanding, disability is implicitly associated with the absence of one or more of these dimensions, or with a lack of the physical or cognitive capacities required to exercise them. Disabled persons are thus treated as inseparable from their condition, since their perceived lack of autonomy is, as Michel Foucault puts it, "hooked in into life itself" [10].

Within the medical model, those who lack autonomy are understood as necessarily dependent on those who possess it, and such dependence is taken to be undesirable. This logic extends beyond function to appearance as failing to "look the part" raises doubts about one's capacity for autonomous agency. For example, a person is expected to have a straight leg, if a leg is bent or shaped otherwise, doubts immediately arise about whether the person can even walk.

In this way, bodily aesthetics operate as proxies for judgments about functionality and, by extension, autonomy. As Jeff McMahan [11] observes, disabled individuals are often characterised as those who are "wholly dependent on others for their continued existence and for whatever other goods their lives contain". A full reading of the medical model therefore reveals the following structure: to be human is to be autonomous; to be autonomous is to function in species-typical ways; and those whose bodies or minds do not adequately display such functioning are deemed abnormal and in need of medical correction. In this sense, the ability "to be in control of and make decisions about one's life" [12] is treated as the defining marker of full humanity.

Where the medical model gets it wrong

Throughout its history, the medical model has attracted sustained criticism, most notably the charge that it mislocates the source of disablement in the impaired body rather than in society itself [13]. Consider, for example, a student who uses a wheelchair and wishes to access a computer laboratory located on the second floor of a building that has staircases but no lift. Like many others, the student is reluctant to ask to be carried upstairs, as this would be experienced as humiliating, an experience most people would likewise find degrading. In this situation, the student is clearly disadvantaged. The crucial question, however, is whether this disadvantage arises from her physical condition or from the absence of inclusive architectural design.

The medical model attributes the disadvantage to the student's impairment, thereby overlooking the role of the non-inclusive built environment. Critics of the medical model argue that this approach wrongly restricts disablement to the body while ignoring its social production. On this view, if a lift were present, the disadvantage, and hence the disablement, would not arise. The source of disablement, therefore, lies not in the student's physical condition but in societal and architectural planning that fails to accommodate bodily diversity.

While numerous criticisms have been levelled against the medical model, few explicitly interrogate one of its underlying assumptions, its appeal to personal autonomy. That is, critics rarely examine the medical model's implicit claim that disability is problematic primarily because it involves a loss of personal autonomy. On closer inspection, the medical model appears to understand disability as a state of non-autonomy, where what ultimately disables a person is their functional limitation and the resulting dependence on others. Personal autonomy thus functions as the conceptual fulcrum of the medical model.

However, once the medical model is structured in this way, significant problems emerge. First, it treats autonomy as the normal or default condition of human existence, thereby implying that dependency is abnormal. As Carolyn Ells [14] observes that "an illusion is created that disabled people are dependent while able-bodied people are independent". Yet dependence is a pervasive feature of everyday life, including for those typically regarded as functionally autonomous. Take food, for instance. Most people have little knowledge of how their food is produced beyond where it is purchased. For food to reach the table, consumers depend on merchants, merchants on agricultural producers, and producers on suppliers, and so on. This network of reliance is a clear form of dependency, but because it is widely shared and socially normalized, it tends to go unnoticed.

We routinely take for granted the extent to which our own functioning depends on others and on complex social systems. However, when one is confronted with conditions such as leg amputation, this dependency becomes too visible to ignore. The difference between amputations and non-amputations, therefore, is not the presence or absence of dependence, but rather that amputations reveal "something that is true of everyone but obscured from the standpoint of the privileged" [14]. In other words, such conditions make explicit a dependency that is already universally present.

Dependence, then, is common to both impaired and non-impaired people. The difference lies in how it is interpreted. For non-disabled people, dependence is often normalized and rendered invisible, such as when assistance is required to perform seemingly simple tasks like changing a light bulb. Although normalized, this reliance remains dependency nonetheless. Disabled people are frequently described as dependent because their need for assistance is more visible and framed in terms of capacity. Yet the underlying condition of reliance is shared. What distinguishes the two is not dependency itself, but whether that dependency is socially normalized or problematized.

A further and more fundamental limitation of the medical model of disability lies in its implicit normative commitment to autonomy as the primary marker of human functioning. Although often presented as a neutral, scientific framework, the medical model is embedded within a distinctly Western individualistic worldview that treats autonomy as a strictly personal capacity. As has been noted "individualism remains a distinguishing feature of the West in twentieth-century civilizations" [15], having emerged as a defining social orientation between the fourteenth and fifteenth centuries. Within this context, personal independence, self-sufficiency, and individual achievement are highly valued, and "in individualistic cultures, people behave according to self-interest and personal preferences and consider independence

and self-sufficiency very important" [16]. These values profoundly shape Western interpretations of health, wellbeing, and human difference.

It is within this individualistic moral horizon that the medical model locates disability primarily in the impaired body or mind and interprets it as a deviation from normal functioning. Crucially, this deviation is not merely biological but normative, disability is implicitly framed as a lack, loss, or failure of autonomy. The disabled person is understood as someone who cannot function independently, who requires assistance, and whose dependence is treated as a deficit rather than as a normal feature of human social life. In this way, the medical model equates disability with diminished self-sufficiency and constructs dependence as a problem to be corrected, managed, or minimised through medical intervention.

However, this equation of disability with diminished autonomy reflects the values of Western individualism rather than a universal account of human flourishing. By prioritising independence and self-reliance, the medical model marginalises alternative moral frameworks in which dependence, care, and relationality are not signs of failure but constitutive dimensions of personhood. The assumption that autonomy is the primary criterion of wellbeing therefore renders disability intelligible only as a personal tragedy or functional loss, obscuring the social and cultural dimensions through which human lives acquire meaning and value.

In many African sociocultural contexts, by contrast, autonomy does not enjoy the same moral primacy. The human person is understood as fundamentally social and relational, constituted through ongoing participation in communal life. African communitarianism emphasises interdependence, shared values, and collective responsibility as the foundation of identity, morality, and wellbeing. The community is not merely the context in which individuals exist but the defining source of social, moral, political, and religious identity. Consequently, the individual is not conceived as autonomous in a strong or atomistic sense, rather, identity and wellbeing are inseparable from communal relationships.

Bernard Matolino [17] identifies three core features of radical African communitarianism that directly challenge the assumptions of the medical model. First, an individual's existence is intelligible only within the community, which provides meaning, recognition, and purpose. Second, individuals are products of their communities through socialisation, moral education, and participation in communal practices. Third, the wellbeing of individuals and communities is mutually constitutive: personal flourishing depends on communal flourishing, and vice versa. Personhood, on this view, is constituted by relationships of identity and solidarity that are intrinsic rather than instrumental.

From this communitarian perspective, the medical model's treatment of disability as diminished autonomy is deeply problematic. If personhood and wellbeing are realised through social belonging and mutual dependence, then reliance on others does not diminish one's moral status or humanity. As Uwaezuoke Obioha [18] argues, communal values take precedence over individual ones, and individual welfare can only be understood through the welfare of the community. Similarly, Nancy Jecker [19] maintains that individual dignity is grounded in participation in social life rather than in self-sufficiency. Disability, therefore, cannot be coherently understood as a lack of autonomy alone, since autonomy itself is not the primary basis of moral worth.

In this light, the medical model does not merely mislocate disability in the impaired body, it also imposes a culturally specific ideal of the autonomous, independent self as the standard of human normalcy. This renders disabled persons morally deficient insofar as they fall short of this ideal. An African communitarian critique reveals that what the medical model treats as pathological dependence is, in fact, an ordinary and morally meaningful feature of human social existence. Consequently, a disability framework informed by African communitarianism calls for a re-evaluation of autonomy, dependence, and care, not as opposites of wellbeing, but as interconnected dimensions of a relational conception of personhood.

Conclusion

This paper has argued that the medical model of disability is undermined not only by its mislocation of disablement in the impaired body, but more fundamentally by its implicit normative commitment to a culturally specific conception of autonomy. Although the medical model presents itself as a neutral, biomedical account of disability, closer examination reveals that it rests on the assumption that species-typical functioning is valuable primarily because it enables personal independence and self-sufficiency. Disability is therefore construed as a problem insofar as it is taken to compromise autonomy, rendering the disabled person dependent and, by implication, deficient.

By reconstructing the medical model in this way, the paper has shown that its authority does not stem from purely biological facts about human functioning, but from an unexamined moral ideal of the autonomous individual. This ideal reflects the values of Western individualism, in which independence is treated as the hallmark of full personhood and dependence as a condition to be avoided or overcome. Within this framework, disability is intelligible only as loss, tragedy, or failure, something that ought to be corrected, managed, or eliminated wherever possible.

However, once this autonomy-centred framework is exposed, its limitations become clear. Dependence is not unique to disabled persons, nor is it an abnormal feature of human life. Rather, it is a pervasive and unavoidable condition of social existence that is rendered invisible only when it aligns with socially normalised forms of reliance. The medical model's pathologisation of dependency therefore rests not on an accurate account of human vulnerability, but on selective moral judgment.

African communitarian philosophy provides a powerful lens through which to challenge this judgment. By understanding personhood as fundamentally relational and wellbeing as inseparable from communal belonging, African communitarianism rejects the notion that autonomy, conceived as self-sufficiency, is the primary basis of moral worth. On this view, individuals are constituted through relationships of identity and solidarity, and dependence is not a mark of deficiency but an expression of shared social life. From this perspective, the medical model's treatment of disability as diminished autonomy appears not only culturally parochial but conceptually misguided.

The implications of this critique extend beyond theoretical debates about disability. If autonomy is not the universal standard of human flourishing, then disability frameworks grounded in autonomy will inevitably marginalise those whose lives do not conform to individualistic ideals of independence. A relational account of personhood, by contrast, allows disability to be understood without reducing it to biological defect or moral lack. It opens space for recognising disabled lives as fully human, not despite their dependencies, but through the meaningful relationships that sustain them.

In conclusion, the medical model fails not merely because it focuses too narrowly on impairment, but because it universalises a particular moral vision of what it means to be human. An African communitarian critique reveals this vision to be neither neutral nor inevitable. By decentring autonomy and foregrounding relationality, such an approach offers a more inclusive and philosophically robust foundation for understanding disability, one that better reflects the social nature of human existence.

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About the author:

Ntobeko Shozi is a philosophy lecturer at the University of Zululand whose work is situated within social philosophy, with particular emphasis on disability, education, wellbeing, and social cohesion in African contexts.