Disability, Impairment, and Marginalised Functioning

Abstract: One main challenge in providing an adequate definition of physical disability is the ability to unify the heterogeneous bodily conditions that count as disabilities. We examine recent proposals by Elizabeth Barnes (2016), and Dana Howard and Sean Aas (2018), and show how this debate has reached an impasse. Barnes' account struggles to deliver principled unification of the category of disability, whilst Howard and Aas' account risks inappropriately sidelining the body. We argue that this impasse can be broken using a novel concept: *marginalised functioning*. Marginalised functioning concerns the relationship between a person's bodily capacities and their social world: specifically, their ability to function in line with the default norms about how people can typically physically function that influence the structuring of social space. We argue that attending to marginalised functioning allows us to develop, not one, but three different models of disability, all of which—whilst having different strengths and weaknesses—fare better than the existing models.

1. Introduction

Existing accounts of physical disability can be divided into two categories. Naturalistic accounts understand disability as a biological property which may be cashed out in terms of departure from some species norm, or in terms of a lack of a (physical) ability that most individuals have. In contrast, constructionist accounts hold that disability is, at least in part, a socially constructed phenomenon: what makes a person disabled is some fact about their social situation.

Perceived shortfalls in naturalistic accounts have led to greater philosophical interest in constructionist accounts. But a major challenge for any account is to offer a way of unifying the apparently disparate and diverse bodily conditions that count as disabilities. Being blind, being an amputee, and having chronic fatigue are all ways of being physically disabled; but the bodies, experiences, needs, and social situations of people with these conditions are very different from one another. More recently, in response to this challenge, Elizabeth Barnes (2016) proposed an account of disability that appeals to the judgements of the Disability Rights Movement. Howard and Aas argue that this is less than fully satisfactory as it doesn't explain what, if anything, those judgements are tracking. Consequently, they propose that disability is a matter of exclusionary social treatment based on an *ideology* of bodily impairment (and not on impairment itself). Barnes, in turn, argues that this inappropriately sidelines bodily difference. The debate thus stands at something of an impasse. We respond to this impasse by proposing a novel concept: *marginalised functioning*. The concept of marginalised functioning concerns the relationship between a person's bodily capacities and their social world: specifically, their physical ability to function in the ways that are treated as social defaults. We show how the concept can be used to develop three different constructionist models of disability, all of which unify the category of disability without sidelining bodily difference. While these models have different strengths and weaknesses, they compare favourably with existing accounts and thus deserve further investigation.

2. Desiderata for an Account of Disability

We, like Barnes, seek an account of physical disability.[1] That is, we are interested in what makes something a (physical) disability. Barnes provides the following desiderata:

(i) Delivers correct verdicts for paradigm cases;

(ii) Doesn't prejudge normative issues;

(iii) Is unifying or explanatory; and

(iv) Is not circular. (2016: 10-13)

We accept these desiderata: An adequate account of disability should be extensionally adequate concerning paradigm cases of both disability and non-disability without entailing that disability is necessarily bad or suboptimal in terms of welfare. In addition, an adequate account of disability should explain what it is for something to be a disability without circularity.[2]

3. Disability: Naturalistic and Constructionist Accounts

Naturalistic accounts of disability claim that disability is a natural kind that can be cashed out in purely physical terms. One such account conceives of disability as a negative departure from normal functioning. For example, Boorse (1976) appeals to the notion of *normal function* that is statistically typical to a particular species.[3] Since most humans are sighted, being blind is statistically atypical. Moreover, since

[1] Accordingly, we will use 'disability' to mean 'physical disability' unless otherwise stated. Of course, physical disability is not the only form of disability. Although we follow Barnes (2016) in limiting our focus to physical disabilities, in §5.4, we explore broadening our concept of marginalised functioning so that it can also be applied to cognitive and psychological disabilities and explain why this is more complicated than one might initially think.

[2] Since our argument is primarily addressed to those who also agree with these desiderata, we won't say anything further about them here. However, it's important to note that some accounts are developed with different desiderata in mind.

[3] This notion of normal function appears in Boorse's accounts of health and disease. Hence, we're not attributing this naturalistic account of disability to Boorse even if we are appealing to the notion he discusses. Thanks to an anonymous referee for this clarification.

being sighted contributes to the survival and reproduction of individual members belonging to that species, being blind is a *negative* departure from the species norm (Boorse 1997). So blindness is a disability on this account.

The main criticism of this sort of naturalistic account is that it will deliver incorrect verdicts about some paradigm cases of non-disability (Barnes 2016: 13-16). For example, on this account, the swimmer Michael Phelps is disabled because his lanky physique (marfanoid habitus) puts him at higher risk for cardiac problems (Barnes 2016: 14). Similarly, being gay or lesbian is a disability on this account because it is statistically atypical and is not conducive to biological reproduction.[4] The general objection here is that these kinds of cases can only be ruled out by appealing to normative or social considerations. Hence, currently, naturalistic accounts have fewer defenders than their rivals, constructionist accounts.

In contrast to naturalistic accounts, constructionist accounts reject the claim that what unifies cases of disability is some natural property of bodies. Rather, they hold that social factors, of one sort or another, perform at least some of this unifying role. However, some constructionist models repurpose certain aspects of naturalistic models because they distinguish between *impairment*—understood naturalistically—and *disability*— understood to concern social factors. One prominent constructionist account of this kind is 'The Social Model' according to which the social factor that characterises disability concerns disadvantage caused by prejudice, oppression, exclusion, or some similar (and wrongful) social phenomenon. As Michael Oliver puts it, "it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the

[4] Of course, not everyone agrees that being gay or lesbian is a *paradigm* case of *non*-disability. We return to this point later in §6.1.

way we are unnecessarily isolated and excluded from full participation in society" (1996: 22).

Since the Social Model appeals to a naturalistic notion of impairment, it inherits the problems faced by naturalistic accounts of disability, simply moving these to the level of impairment (Barnes 2016: 25-27). Without a clear definition of impairment, there can be no clear definition of disability because we will not know *which* forms of oppression and exclusion are the ones that constitute disability. For example, race and gender are forms of oppression that are related to bodily difference; but an account according to which all women and all people of colour are disabled would not meet the first desideratum.

The seriousness of this problem depends on the strength of the original criticisms of naturalistic accounts as applied to the notion of impairment. Perhaps it's not problematic to say that Michael Phelps *has an impairment* if we can say that he *is not disabled* because his impairment isn't operating as the basis for social isolation and exclusion. But this move cannot be made for being gay or lesbian, since this *is* a basis for oppression. For those convinced by this objection to the Social Model, several different constructionist routes are available.

One option is to deny that there is a distinction between impairment and disability that maps on to the natural-social distinction. Shelley Tremain (2001, 2002), for example, regards both impairment and disability as effects of a historically specific political discourse—indeed, as *one and the same* effect. Drawing on Michel Foucault, and echoing Judith Butler's critique of the sex-gender distinction, she argues that the ontological distinction that many have perceived between impairment and disability is illusory: What have appeared to be objective and intrinsic properties of bodies (impairments) are in fact constituted by the

performances of social subjects. This is summed up in Tremain's Butlerian claim that "impairment has been disability all along" (2001: 632).

Tremain's account does not offer a non-circular criterion for distinguishing cases of impairment/disability from other stigmatised embodiments, such as being a woman or being a person of colour (Barnes 2016: 26). Perhaps, in our actual world, we may well be able to simply point to the specific historical formation that is impairment/disability and intuitively tell it apart from gender and race; but if we think about how Tremain's account applies to other possible worlds containing slightly different historical formations, this move is not available, leaving it unclear what counts as disability/non-disability in such worlds. Tremains account thus struggles with desiderata (i), (iii), and (iv). We note, however, that Tremain's account does not seem to have been *designed* to satisfy the desiderata to which we're committed, and therefore may well succeed by its own lights.

4. Recent Developments

More recently, theorists who have found criticisms of existing accounts compelling have defended new constructionist accounts of disability that appeal to the judgements of some group in order to unify the category of disability. The thought here is that what different disabilities have in common—say, being blind, being an amputee, and having chronic fatigue—is something to do with the fact that they are all the object of certain sorts of judgements on the part of a certain group.

4.1 Barnes' Solidarity Model

Barnes appeals to the judgements made by the Disability Rights Movement (DRM) on the basis that the activists must distinguish between those physical conditions for which they are seeking to promote justice and those which fall outside of their

purview. Hence, Barnes offers the following account of disability, which Howard and Aas calls the 'Solidarity Model' (2018: 1156):

> A person, *S*, is physically disabled in a context, *C*, iff
>
> i. S is in some bodily state X
>
> ii. The rules for making judgements about solidarity employed by the disability rights movement classify X in context C as among the physical conditions that they are seeking to promote justice for. (2016: 46)

On this account "whether you have a disability is partly determined by what your body is like" but the 'objective features' of your body are determined to be a disability by "the application of social features (judgements about solidarity)" (47). The reason that Barnes appeals to the judgements made by the DRM is that she thinks that it's impossible to give an adequate independent account of *which* physical conditions these judgements are tracking. Nonetheless, Barnes claims that these judgements are unifying and non-arbitrary because they are rule-based. The inference rules about which physical conditions are among those for which the DRM is seeking justice need neither be explicit nor transparent, but can be extrapolated from the judgements that are actually made by the DRM. She suspects that employing these rules involves "cluster-concept reasoning" and that the features that inform this reasoning include "being subject to social stigma and prejudice, being viewed as unusual or atypical; making ordinary daily tasks difficult or complicated; causing chronic pain; causing barriers to access of public spaces; causing barriers to employment; causing shame; requiring use of mobility aids or assistive technology; requiring medical care; and so on" (2016: 45).

To summarise, on Barnes' view, to be disabled is to have one of the physical conditions for which the DRM is seeking to promote justice. This account can accommodate the fact that heterogeneous physical conditions count as disabilities, delivering correct verdicts about paradigm cases.[5] Moreover, these disparate conditions are *unified* by the fact that they are the very conditions for which the DRM is seeking to promote justice.

At this point, a question arises for Barnes, which can be framed as a Euthyphro-style dilemma:

Either: (a) the judgements of the DRM are tracking something;

Or: (b) the judgements of the DRM simply determine what counts as a disability.

Barnes rejects (a) because she thinks that there is no adequate way of cashing out what the solidarity-based judgements of the DRM are tracking. Accordingly, she endorses (b), which involves "rigidifying on the *actual*, *present* rules for making solidarity judgements" (2016: 52; our emphasis), using them as a reference for determining what counts as disability in any possible world.

We are concerned that this move makes the category of disability somewhat arbitrary. Suppose there is a possible world W* in which people with (what we would think of as) acquired disabilities are not discriminated against, but people with (what we would think of as) congenital disabilities are, and in which there is a movement (the DRM*) that fights for justice for people with congenital disabilities but not acquired disabilities. According to Barnes, people in W* with acquired disabilities are disabled *simpliciter* because they are counted as disabled by the DRM

[5] Since the DRM employs cluster-concept reasoning, this means that there will be vagueness and borderline cases (2016: 45) as well as indeterminacy (2016: 49-50). Like Barnes, we do not find this problematic. (2016: 50).

in the actual world, even though they are not counted as disabled by the DRM*. It strikes us as odd to prioritise the rules of the DRM over the rules of the DRM* in talking about whether or not an inhabitant of W* is disabled. To put the point another way: Although the judgements of the (actual) DRM may be rule-based, those rules could easily have been otherwise; we worry that enshrining them in the definition of disability is arbitrary.[6]

Howard and Aas make a similar objection (2018: 1127-1128), and Barnes herself concedes that her account suffers from a problem of this sort (2018: 1156-7). As she puts it, the worry is that the "solidarity judgements 'float free' of what they are tracking" (2018: 1157). For Barnes, then, the Solidarity Model appears to be a fall-back option motivated by her dissatisfaction with existing models (2018: 1151).

4.2 Howard and Aas' Social Exclusion Model

In response, Howard and Aas attempt to specify what the judgements of the DRM are tracking. According to their 'Social Exclusion Model':

> A person *S* is disabled in a context *C*, iff:
>
> (i) S is in some bodily or psychological state *x* [such that]
>
> (ii) *x* is regularly assumed in the ideology in *C* to involve an impairment: a dysfunctional bodily state that limits a major life activity,
>
> (iii) in the dominant ideology of *C*, that someone in *x* has an impairment explains why they can be appropriately pitied, stigmatized, and excluded from socially valued activities and statuses.

[6] Of course, Barnes acknowledges that this category of disability (identified by rigidifying on the solidarity-based judgements of the actual DRM) can vary in its significance "both across times and across worlds" (2016: 52).

(iv) The fact that *S* is in this state plays a role in *S*'s systemic disadvantage: that is (i)–(iii) actually explains why *S* is involuntarily excluded from certain valued activities or relegated to a marginal status along some significant social dimension. (2018: 1128-9)

For Howard and Aas, what matters for disability is the *social perception* that some condition is an impairment, rather than whether or not it *really is* an impairment (2018: 1130). Nevertheless, this doesn't obviate the need for a definition of impairment because we still need to know which kind of social perceptions matter. They offer only a rough definition of impairment as "a dysfunctional bodily state that limits a major life activity", claiming that '[i]mpairment is a technical term, which has its home in medicine and the philosophy thereof' (2018: 1119). The task of fully defining impairment is thereby delegated to medical experts. Howard and Aas are non-committal about the exact nature of impairment: Impairment could be a socially constructed phenomenon that is produced by the classificatory practices of medical practitioners and experts, or a natural kind that experts in medicine are tracking (2018: 1121).

Howard and Aas argue that their model improves on Barnes' Solidarity Model by explaining *why* the judgements of the DRM are largely appropriate: they're responsive to a particular kind of social treatment, namely exclusion (2018: 1129). These judgements, they contend, largely track the kind picked out by the Social Exclusion Model, and, where they deviate from this, Howard and Aas can and do claim that they are mistaken (2018: 1129). If successful, the Social Exclusion Model would represent a vindication of option (a) in our Euthyphro-style dilemma.

However, Barnes, in turn, objects that the Social Exclusion Model leaves out something important about disability, namely that "part of what it is to be

disabled—at least in many cases—is less directly about how other people treat you because of your bodily difference … and more about that difference itself" (2018: 1161). According to the Social Exclusion Model, disability is intrinsically a matter of exclusionary social treatment, and bodily difference or impairment plays only a supporting role in defining which instances of exclusionary social treatment are to count as disability. Moreover, impairment is not identified by bodily differences *directly*, but rather by the medical establishment's *judgements* about bodily differences. As Howard and Aas put it, "[d]isability … is about an ideology of impairment, not necessarily impairment itself." (2018: 1130). They even allow that "[s]ociety might be wrong … that any condition is or could be an impairment" (*Ibid.*). Bodily difference is thus two steps removed from disability within the Social Exclusion Model.[7] Although Howard and Aas's account entails that "being disabled … involves having a body of a certain kind" (*Ibid.*), the 'certain kind' in question is distinguished via its status in a social ideology, not by its actual bodily features. Hence we are sympathetic to Barnes' criticism that the Social Exclusion Model keeps bodily difference at arm's length in a way that "miss[es] something crucial about the nature of disability" (2018: 1161).

We thus face an impasse in the literature. The challenge is to unify the heterogenous bodily conditions that are relevant to disability. Barnes' Solidarity Model struggles to offer a principled, non-arbitrary unification by relying on the rule-based judgements of the DRM rather than appealing directly to the similarities in features of bodies that justify those rules. In contrast, Howard and

[7] Hence, on their account, "you can be disabled, but not actually impaired. If you are in some bodily or cognitive state that is falsely believed, in your society, to be [a] life-limiting dysfunctional state; then you are disabled, even if that state is, medically, a non-pathological difference" (2018: 1129-1130).

Aas appeal to exclusionary social treatment and an ideology of impairment to identify the relevant instances of social treatment. This delivers a more principled unification at the cost of sidelining bodily features. Both Barnes and Howard and Aas seem to agree that we cannot provide a principled unification of the category of disability by appealing directly to the objective features of disabled bodies. We thus appear to be facing an unpalatable choice between sidelining the body to offer a principled unification of the category of disability, on the one hand, and attributing a more central role to bodily difference at the cost of accepting arbitrariness in our category of disability, on the other.

5. A New Concept: Marginalised Functioning

We propose to break the impasse using a hitherto overlooked concept. In this section, we introduce the concept, and in the next section, we show how it can be used to break the impasse.

5.1. Introducing Marginalised Functioning

The concept we have in mind concerns the relationship between the bodily capacities of individuals and the presuppositions about bodily capacities that shape the social context in which those individuals are situated. Think about the inclusion of stairs in many house designs. Decisions about how to design houses reflect a set of norms about what people are typically physically able to do—for example, that people can climb stairs.[8] Of course, some people are not able to physically function in the ways that these norms presuppose. There is something

[8] This general idea is familiar from disability studies and architectural theory. For example, Amie Hamraie describes "architectural design for an unmarked, normate inhabitant" or "mythic average user": "Examine any doorway, window, toilet, chair, or desk in [a] building … and you will find the outline of the body meant to use it" (2017: Chapter 1).

distinctive, we suggest, about the social situation of being unable to physically function in the ways that are presupposed by the norms that govern the construction of common social environments and the structuring of common social interactions. Individuals in this social situation have what we call '*marginalised functioning*' relative to the social context in question.

The key notion that interests us, then, is that of a norm or expectation about how individuals are able to function being *treated as a default* for the purposes of constructing common social environments and structuring common social interactions. Decisions about how to design and build a university campus, or how to plan and run an academic conference, say, are based on assumptions about how people are typically capable of functioning. Sometimes (and increasingly) this is accompanied by the recognition that some people are not capable of functioning in that way and that accommodations must be put in place for them. Whenever these things are conceived of as special accommodations for people with atypical functioning, the initial assumptions represent norms that are treated as defaults for the purposes of constructing common social environments and structuring common social interactions.

For example, suppose that a new university building is designed on the assumption that people walk up and down steps, and so includes steps. However, the designers recognise that some people cannot use stairs—because they use wheelchairs, say—and so they include ramps or lifts. However, they needed to consciously remember that some people cannot use stairs, whereas they did not need to consciously remember that, say, people cannot transition between different floors of a building without some kind of provision such as stairs. That is, even when ramps are built, they are typically—though not always—conceptualised

as special provisions for people who are not able to use stairs, and the stairs are conceptualised as the normal way to travel between levels. To put the point a different way, a design for a building with no provisions for transitioning between different levels at all (such as stairs, lifts, or ramps) would be regarded as ludicrous; whereas a design for a building with stairs but no ramps would *not* be regarded as ludicrous (though it could and should be regarded as discriminatory). Under these circumstances, the norm 'people can use stairs' serves as a default in the sense we have in mind.

Here is a more precise definition of marginalised functioning:

A subject *S* has marginalised functioning relative to a context, *C*, iff:

(i) There is a set of social norms *N*, comprising n_1, n_2, ... n_n, each of which serves as a default for the purposes of constructing common social environments and structuring common social interactions in *C*; and

(ii) There is some norm in *N*, n_x, such that S cannot physically function in a way that satisfies it.

Examples of norms n_1, n_2, ... n_n in the context in which we are writing might include: 'People can climb several flights of stairs at one time'; 'People can hold a face to face conversation for several hours', 'People's speech can be easily understood by strangers who speak the same language[9]'.

Importantly, there can be social norms that don't count as part of *N* because they do *not* serve as defaults for the purposes of constructing common social environments and structuring common social interactions. For example, 'People can swim' might be true (as a generic), but it's not a norm that is used to structure our social world—our cities do not have swimming canals instead of pavements.

[9] Or dialect if the variations between some dialects of a language are sufficiently different.

Hence, not being able to swim does not count as having marginalised functioning. That is, simply not being able to do something that most people *are* able to do doesn't automatically constitute marginalised functioning. As another example, most people can roll their tongue, but some people cannot. Even if being able to roll your tongue is typical human functioning, there is no tongue-rolling-related norm that serves as a default for organising our social space. Accordingly, not being able to roll your tongue doesn't constitute marginalised functioning in our world.[10]

Of course, there will be borderline cases. Consider the norm of serving caffeinated beverages at an academic conference. Does someone who has a caffeine intolerance have marginalised functioning? Conference organisers do tend to assume that people can drink (and enjoy or even need) tea/coffee. But it's not a problem for someone to take part in a coffee break without drinking coffee since it doesn't prevent them from participating in the social interactions. Hence, the norm 'people can drink caffeine' isn't playing a major enough role in structuring social interactions even at academic conferences. Accordingly, someone with a caffeine intolerance doesn't have marginalised functioning.[11]

What about someone who has an alcohol intolerance? This is more of a borderline case since there are many more professional and social settings in which the norm 'people can drink alcohol' does serve as a default. For instance, at some conference drinks receptions, non-alcoholic beverages may be seen as a special accommodation for those who cannot drink alcohol. Moreover, there may be some

[10] Given the context-sensitivity of our concept of marginalised functioning, the inability to roll one's tongue would constitute marginalised functioning in a possible world where the default social greeting involves rolling one's tongue. We say more about what counts as a relevant context in §5.2.

[11] Recall that on our definition, failing to satisfy any norm in *N* is sufficient to count the person as having marginalised functioning.

contexts—business entertainment contexts, perhaps—in which the expectation that people *will* drink alcohol is *so* strong that refraining from drinking alcohol constitutes a serious social problem. In such contexts, a person who cannot drink alcohol counts as having marginalised functioning, because the norm 'people can drink alcohol' is serving as a default in structuring social interactions.

A further complication is that norms in *N* may include information about assistive technology. For example, most, if not all, norms about vision allow for the use of glasses or contact lenses, but many norms about mobility do not allow for the use of assistive technology such as wheelchairs. This difference is reflected in the fact that standard cars can be driven by people who wear glasses, but not by many people who use wheelchairs. Relatedly, many norms will have in-built expectations about *who* will be navigating the social spaces. For example, there are many social spaces where children are not expected to be present without adult supervision. Norms structuring these spaces may assume physical capabilities that many children lack. But this doesn't mean that children have marginalised functioning since the expected way for children to navigate these spaces is in the company of an adult who assists them where necessary. In this sense, accompanying adults function rather like assistive technology for children.

Furthermore, an individual can have marginalised functioning to a greater or lesser extent. An individual who cannot satisfy *many* of the norms in *N* has marginalised functioning to a greater extent than an individual who cannot satisfy *one* norm in *N*. Also, an individual who cannot satisfy a norm that plays a *central* role in organising social space has marginalised functioning to a greater extent than an individual who cannot satisfy a norm that plays a *trivial* role in organising social space. Accordingly, marginalised functioning comes in degrees.

5.2. Further Illustration

Consider:

> ANNE: Anne has achondroplasia (a common cause of dwarfism) and is a 4-feet tall adult.

Anne has marginalised functioning in the contemporary UK, according to our definition. Think about where the light switches are placed, how high the buttons go in lifts for high-rise buildings, how high ATMs, pumps at petrol stations, etc, are located, and so on. There is a norm 'people can reach things that are at least 1.5-metre high unaided' that serves, in the contemporary UK, as a default for the purposes of constructing social environments and Anne cannot satisfy this norm. This is not to say that there are no social environments that are accessible to Anne. A particular building may be specially designed with little people in mind. But to the extent that the design of this building is conceived of as a special accommodation for people like Anne, the initial assumptions represent a norm that is treated as a default. Thus, Anne has marginalised functioning in the contemporary UK.

So far, we have been speaking as if there is *one* relevant social context for any given individual. But, of course, this is not the case. We are situated in many overlapping social contexts at once. Consider:

> BEATRICE: Beatrice is a D/deaf person who has been D/deaf since birth and is fluent in sign language.

Beatrice is, at the same time, situated in the contemporary UK, in a particular city, in a particular community, and in a particular workplace or place of study. None of these is *the* relevant context when it comes to Beatrice's functioning; rather, which

context is relevant depends on the inquiry at hand. For example, if we want to know whether Beatrice is being treated as an equal citizen by her municipal authority when it comes to the provision of services, then the relevant context is the city in which she lives. But since she is situated in many social contexts at the same time, Beatrice could have marginalised functioning relative to some contexts, but not others. Relative to the context of a D/deaf community space, for instance, Beatrice does *not* have marginalised functioning because the space is not structured by the norm 'people can hear'.

We have not yet explored the relationship between marginalised functioning and disability. But we can already see how the context-sensitivity of marginalised functioning maps on to the contested nature of D/deafness as a disability. The fact that D/deafness does not constitute marginalised functioning relative to the context of D/deaf community spaces could substantiate the oft-made claim by the D/deaf community that D/deafness is *not* a disability. At the same time, the fact that D/deafness constitutes marginalised functioning in wider contexts, such as contemporary UK could corroborate the seemingly incompatible claim that D/deafness is a *paradigmatic* case of disability. We will return to this point in the next section.

Now recall Michael Phelps who "has hypermobile joints, an arm span three inches longer than his height, unusually large feet, and muscles that produce a surprisingly small amount of lactic acid compared to normal ranges" (Barnes 2016: 14). Although Phelps' physique is species-atypical, he does not have *marginalised* functioning because he can physically function in ways that satisfy the default social norms. Certainly, norms about arm span *are* employed in constructing social environments—for example, in the placement of light-switches, door-handles, and

so on. But his atypical arm span does not *prevent* him from meeting these norms. That is, these norms involving arm spans merely set a *minimum* threshold for arm span, not a maximum.[12] So Phelps, despite having atypical physiology, does not have marginalised functioning. This point generalises: Typically, norms are satisficing, setting a minimum threshold of functioning without imposing an upper limit. Consider a norm 'people can walk 1 kilometre in one go'. A person who cannot walk 1 kilometre even at a slow pace doesn't satisfy this norm, and has marginalised functioning. But a person who is able to walk a much longer distance, still satisfies this norm and so does not, at least in this respect, have marginalised functioning. Hence, not all atypical functioning, understood naturalistically or statistically, counts as marginalised functioning.

5.3. Having Marginalised Functioning and Being Marginalised

Importantly, having marginalised functioning is different from being marginalised, oppressed, or discriminated against *on the basis of* one's functioning. In particular, having marginalised functioning does not entail marginalisation, stigma, discrimination, or oppression. Imagine a world much like ours but in which there are strongly enforced legal obligations to provide the kind of accommodations that Anne—who has achondroplasia—needs, and in which there is no stigmatisation of people with embodiment such as Anne's. In this world, it would be wrong to think of Anne as being marginalised, stigmatised, oppressed or discriminated against. However, she would still count as having marginalised functioning even relative to this possible world because the provisions that she needs are conceptualised as

[12] If these norms set an upper limit on arm span at all, it is not a limit that Phelps is anywhere near exceeding; perhaps a person whose arms were so long in proportion to their body that they could not walk unaided would fail to satisfy some social norm of the type we are concerned with, but this is clearly not the case for Phelps.

special accommodations rather than as the default way of structuring their social environment.

Conversely, being marginalised, oppressed, or discriminated against in virtue of bodily difference does not entail having marginalised functioning. Consider:

> SAM: Sam has a noticeable skin disfigurement on their hands that does not affect their sensation or movement.

Suppose that people, especially strangers, do not want to shake Sam's hand because of their disfigurement, although shaking hands is a default social greeting in many contexts. Sam's skin disfigurement may be a basis on which they are marginalised, oppressed, or discriminated against. However, the fact that others do not want to shake Sam's hand does not change the fact that Sam is, in fact, physically capable of shaking hands. So despite experiencing marginalisation, Sam does *not* have marginalised functioning, at least in this respect.[13]

This serves to distinguish the social kind *individuals with marginalised functioning* from social kinds that involve oppression on the basis of actual or perceived bodily difference, such as race and gender. Consider the case of being a person of colour—for example, being Black under Jim Crow. Even when social space was officially racially segregated, it's not the case that Black people were unable to function physically in ways that met the default social norms. Black people were legally prohibited from using particular water fountains, but, of course, they weren't physically incapable of using them. Therefore, being a person

[13] Facial disfigurement is counted as a disability for the purposes of discrimination law in the United Kingdom (and elsewhere such as the U.S. and Canada). Given the specificity of the protected categories in discrimination legislation, if dsifigurement-based discrimination is to be included, disability seems like the closest protected category under which it can be included. Since discrmination legislation should cover disfigurement-based discrimination, it might be appropriate to regard disfigurement as a disability for the purposes of discrimination law even if it turns out not to count as a disability according to our best philosophical account of disability.

of colour in even an extremely racist society does not amount to having marginalised functioning.

We think a similar point applies to other kinds that involve oppression enacted on the basis of actual or perceived bodily difference, including gender, sexual orientation, and trans or cis status. This is not to say that marginalised functioning can never enter the picture in relation to these kinds. To the extent that social norms reflect the experiences of the dominant group, members of oppressed kinds may end up having marginalised functioning in some specific respects. For example, some male-dominated occupations may not have equipment that is suitably-sized or positioned for an average woman, meaning that some women have marginalised functioning in these contexts. However, there is still an important difference between being marginalised on the basis of bodily difference, and having marginalised functioning.

5.4. Marginalised Functioning and Non-Physical Functioning

In the next section, we explore how our concept of marginalised functioning can be used to construct an account of disability. As we have said, our focus is on physical disabilities only; accordingly, our definition of marginalised functioning is restricted to *physical* functioning. Here, we consider and reject the possibility of lifting this restriction. However, we should first note that our definition already counts some non-physical conditions as marginalised functioning. This is because to determine whether an individual has marginalised functioning, we look to whether or not she lacks some capacity to physically function in accordance with the default social norms in the relevant contexts. Suppose someone's OCD means that they cannot shake hands because the prospect is severely anxiety-inducing.

Although OCD is regarded as a mental health condition, since it can result in an inability to perform certain kinds of *physical* actions in certain contexts (as specified by our default social norms), individuals with OCD can have marginalised functioning.

Nevertheless, perhaps we can broaden our definition of marginalised functioning to include *non-physical* (cognitive, or psychological) functioning as well as physical functioning. This expanded concept, then, could feature in an account of disability *simpliciter*. Although this is a promising thought, it faces significant challenges. This is because of two features of our concept as it currently stands. First, given the context-relativity of our concept, which norms count as the default norms that matter for marginalised functioning is a context-dependent matter. Second, our concept concerns (physical) actions that people cannot currently perform *even if they could learn to do so*. That is, even without expanding our concept, a person who cannot swim (even if they could learn to swim in some typical period) would have marginalised functioning in a possible world that is similar to ours except that people travel mostly by swimming, rather than on foot.

These two features generate challenges for expanding our concept because norms about non-physical functioning are even more context-sensitive than norms about physical functioning. This means that we don't have to invoke far-fetched possible worlds to see how one might gain and lose marginalised functioning in different contexts. After all, plausibly, in the UK, there is not only a norm 'people can verbally communicate' but also a norm 'people can verbally communicate in English'. This means that, relative to the UK context, all those who cannot communicate in English have marginalised functioning even if they can communicate in a different language.

For many cognitive or psychological disabilities, however, what matters is not simply one's incapacity to function in a particular way at some specified time, but whether one could, given some typical circumstances, *learn* to function in that way. To see this, compare Dan and Elena. Dan, a native English speaker, recently moved to Italy but has not yet learned Italian. He cannot satisfy the norm 'people can verbally communicate in Italian' which is a default norm in Italy. Importantly, this is a norm that is not only about physical functioning: One can fail to satisfy this norm even if one is physically capable of producing Italian sounds. (After all, Dan could learn to sing *Bella Ciao* if someone helped him with the phonetics of the Italian lyrics.) Elena has lived in Italy all her life, but cannot communicate in Italian or any other language due to a cognitive disability. If we extend our definition to apply to all functioning, physical and non-physical, then both Dan (at least for now) and Elena would each have marginalised functioning because neither can satisfy the norm 'people can communicate verbally in Italian'. That is, the concept of marginalised functioning doesn't differentiate between Dan and Elena. Hence, there are some obstacles to expanding our definition to apply to all functioning with a view to using this to construct an account of disability.

There are two available responses. One could either bite the bullet and accept that both Dan and Elena have marginalised functioning; or one could introduce a new feature that speaks to our capacities to learn *and* specify the right kinds of (typical) circumstances. But we lack the space to explore whether this feature only applies to non-physical functioning (and if so, whether and how a non-arbitrary line can be drawn between non-physical functioning and physical functioning) let alone the space to examine whether we *should* introduce such a feature and how it would need to be defined. So here, we can only propose an account of marginalised

functioning that is restricted to physical functioning, though we note the potential for an expanded concept.

6. New Directions for Disability and Impairment

We now return to the impasse identified at the end of §4. The difficulty lay in providing an account of disability that specifies *which* bodily differences matter for disability and says how they are unified. Faced with this choice, Barnes opts to make bodily difference central and appeal to the judgements of the DRM to perform the unifying work, a move which she acknowledges is not wholly satisfactory. Howard and Aas, on the other hand, claim that to be disabled is to be subject to exclusionary treatment on the basis of an ideology of impairment, yielding an account on which disability is twice removed from bodily difference. If we were to accept these terms of debate, we would need to decide which is more important: centering the body, or principled unification. However, the notion of marginalised functioning enables us to construct models of disability that render this choice unnecessary.

Recall that what matters for marginalised functioning is whether or not an individual can physically function in ways that satisfy the relevant default social norms. Thus, this concept is crucially about the relationship between one's *actual bodily functioning*, on the one hand, and *social presuppositions* about typical bodily functioning, on the other. This way of bringing the body into the picture doesn't depend on naturalistic claims, such as claims about species-atypical functioning, thus avoiding the problems associated with the naturalistic accounts of disability.

Moreover, individuals who have marginalised functioning form a social and politically interesting *kind*. They are *dependent* on accommodations in order to

access and navigate certain social spaces, and this dependency renders them *vulnerable* to marginalisation. Furthermore, the types of bodily differences that constitute marginalised functioning are *ripe* for stigmatisation, even if they are not stigmatised in all contexts. We will discuss the relationship between marginalised functioning, vulnerability, and stigma in more detail below. For now, we can note that the type of bodily differences identified by the concept of marginalised functioning is not arbitrary, but has great social significance.

The concept of marginalised functioning therefore illuminates a non-arbitrary social kind without sidelining the body. This makes it a promising starting point for constructing an account of disability that breaks the impasse identified above. Moreover, as we saw, being marginalised, oppressed, or discriminated against in virtue of bodily difference does not entail having marginalised functioning. Hence, marginalised functioning could help define disability as distinct from other social kinds that involve oppression on the basis of bodily difference, such as gender and race. Furthermore, although marginalised functioning is context-relative, there are objective facts about whether one has marginalised functioning in a particular context which are independent of perception of self or perception of others. Hence, those with invisible disabilities or even disabilities of which they are not themselves aware count as having marginalised functioning. Conversely, someone who is presenting as having a disability that they do not in fact have—for instance, in a case of factitious disorder (Barnes 2016: 32-33)—does not thereby count as having marginalised functioning. In the following subsections, we explore three ways of using the concept of marginalised functioning to define disability.

6.1. Simple Model: Disability as Marginalised Functioning

One option is to equate disability with marginalised functioning. On this 'Simple Model', being disabled just is having functioning that is, in fact, marginalised by the current default norms that operate in the relevant social context. This model has some virtues: It is simple and parsimonious (since it does not invoke a further notion of impairment). Moreover, the Simple Model can explain why individuals who have marginalised functioning are vulnerable to marginalisation, oppression, stigmatisation, and discrimination without holding that having a disability *entails* being marginalised, oppressed, stigmatised, or discriminated against. Relatedly, on this model, disability is not something that is an automatic or intrinsic cost to your well-being. After all, one can have marginalised functioning even if one is provided with special accommodations to offset one's marginalised functioning, and so suffers no disadvantage.

The Simple Model also delivers correct results for many paradigmatic cases of disability and non-disability. Anne, who has achondroplasia, has marginalised functioning and so is disabled, but Michael Phelps doesn't have marginalised functioning and so is not disabled. This upholds a link between disability and atypical functioning, whilst maintaining that atypical functioning is neither necessary nor sufficient for disability: Atypical functioning matters for disability because it matters for default social norms, but one can have atypical functioning without being unable to meet default social norms, as is the case with Phelps. Moreover, this model can explain the contested status of D/deafness as a disability since whether D/deafness constitutes marginalised functioning is context-dependent.[14]

[14] Recall our discussion of Beatrice in §5.2, pp. 17-18.

However, one might argue that this model faces some serious counterexamples and thus cannot satisfy desideratum (i). Consider:

CORA: Cora has a fall on a climbing trip and suffers a severe fracture in her leg.

Cora's leg will eventually heal, but suppose that she must use a wheelchair for at least the first month. While she is using a wheelchair, she cannot function in ways that satisfy some of the default norms (such as 'people can use stairs'). But we wouldn't usually regard her as disabled. Indeed, we can list many individuals who have marginalised functioning for a brief period but aren't considered disabled, partly because we expect them to return to non-marginalised functioning. Consider those who have recently had surgeries and those who are in the third trimester of pregnancy. Thus, the defender of the Simple Model must bite the bullet and claim that someone who has marginalised functioning temporarily *is* disabled (albeit temporarily).

We don't think this is completely implausible. After all, Cora, who cannot climb up steps, is dependent on accommodations in order to access and navigate certain social spaces. Moreover, the issue isn't merely whether having a broken leg and being heavily pregnant don't count as disabilities, but whether they are *paradigm* cases of *non*-disability. But what counts as a paradigm case is controversial. For example, Barnes (2016: 15) considers being a gay a paradigm case of non-disability, whilst Howard and Aas (2018: 1131) suggest that the pathologisation and exclusion experienced by gay people at various times and places mean that, at those times and places, gay people were disabled.[15] So some

[15] Of course, we think that it is an advantage that none of the three models we outline claims that being gay is a disability because being gay doesn't amount to marginalised functioning.

might think that the Simple model can deliver correct verdicts for paradigm cases, satasifying desideratum (i).

We note, however, that this option might be less attractive to those who think that disability is a legally and politically weighty kind that gives rise to solidarity movements. This is because although those who have marginalised functioning for a brief period are dependent on accommodations during this time, their dependency is sufficiently different from the dependency of those who are paradigmatically disabled. Hence, one might think that the DRM should *not* advocate for people with broken legs or those in advanced stages of pregnancy.[16] If so, then despite the simplicity and other virtues of this model, one might look to another option.

6.2. Social Model Redux

Recall that on the Social Model (and its variants), to be disabled is to be oppressed on the basis of having an impairment.[17] One challenge for these models was offering an adequate account of impairment. So one natural option is to equate impairment with marginalised functioning and claim that to be disabled is to experience some form of oppression on the basis of impairment.[18] This model improves on existing versions of the Social Model because marginalised functioning is neither *naturalistic*—avoiding the problems of naturalistic accounts

[16] On the other hand, one might argue, even given ameliorative aims, that it would be good for the account to allow us to interrogate critically our pre-theoretical intuitions about whether heavily pregnant women, say, are disabled. Hence, the fact that the Simple Model counts heavily pregnant women as disabled might not be a cost of this view. Thanks to an anonymous referee for this point.
[17] We focus, here, on incorporating oppression but it is worth noting that there may be independent reasons to distinguish between disability and impairment; see Francis (2018).
[18] The exact way that oppression/subordination is built in could vary; for example, it could be at the individual level, as with the Haslangerian account that Barnes constructs, or at the level of a certain sort of bodily state, as with Howard and Aas' account.

of disability—nor does it appeal to an *ideology* of impairment, at the risk of sidelining the body.

This model also avoids some of the putative counterexamples to the Simple Model: Cora is not disabled, even though she is impaired, because her temporary impairment does not give rise to oppression. Similarly, although heavily pregnant people are oppressed, their oppression, in a misogynist society, is largely in virtue of having the kind of body that is *capable* of becoming pregnant, rather than in virtue of the marginalised functioning that results from being heavily pregnant.

However, it's unclear whether the Social Model Redux can satisfy desideratum (ii): Can this model according to which disability is necessarily a site of oppression deny that disability is necessarily bad for one's well-being? A proponent of the Social Model could argue that being oppressed—though morally bad—isn't necessarily bad for one's well-being. Or perhaps even if being oppressed is always bad for one's well-being at a particular time, it isn't always bad for one's well-being *on the whole*.[19] We lack the space to engage with these issues. However, for our purposes, it suffices that the Social Model Redux fares no worse than the existing versions of Social Model with respect to this desideratum, since it fares significantly better when it comes to defining impairments.[20]

6.3 Restricted Model: Disability as Lasting Impairment

A third option is to equate marginalised functioning with impairment, as in the Social Model Redux, but using a non-normative criterion to pick out a subset of

[19] Using Barnes' terminology, being oppressed may not be a *global* bad even if it's a *local* bad (2016: 80-83).

[20] Moreover, having latent pathologies (such as "early tumors or diseases that predispose one to cancer") doesn't entail having marginalised functioning. Hence, unlike existing versions of the Social Model, there is no need to appeal to impairments that "limit major life activities" (Howard and Aas (2018: 1119-20)).

cases of marginalised functioning that constitute disability. We take our cue from the fact that some of the putative counterexamples to the Simple Model involved cases of *temporary* marginalised functioning. This suggests the 'Restricted Model' that equates marginalised functioning with impairment, and holds that to be disabled is to have a *lasting* impairment. Life-long impairments are clearly lasting, whereas a duration of three months isn't. Of course, there will be some vagueness in the model given the vagueness in what counts as a *lasting* impairment, but we're happy to accept that it's indeterminate whether some cases of impairment count as disabilities on this model.[21]

Limiting disability to lasting impairment not only avoids putative counterexamples, but allows the category of disability to perform useful political work for us. This is because when a case of marginalised functioning is more lasting, it gives rise to different interests than it would if it were of short duration. To see how this is so, compare Cora—who currently uses a wheelchair, but expects to stop doing so in one month—with Cam, who is a wheelchair user due to paralysis and expects to be a wheelchair user for the rest of their life. Both Cora and Cam have an interest in there being ramped access to public buildings, but Cam's interest is much more significant than that of Cora. To see this, suppose that there is no ramp at their local museum. Cora will miss the current exhibition, but Cam will miss *all* of the exhibitions unless and until the museum installs a ramp. To access the museum, Cora can simply wait for her functioning to change; but for Cam, changes need to be made to the layout of the museum itself. This difference between Cam and Cora gives a principled reason for thinking that

[21] See Barnes (2014) who rejects the inference from the vagueness of a social kind to the claim that it isn't metaphysically robust or interesting. (See also our footnote 3.)

individuals with lasting marginalised functioning form a socially significant—albeit fuzzy—kind around which it makes sense to form a social justice movement.[22]

The duration of marginalised functioning has other implications. For one thing, having marginalised functioning that is lasting rather than brief is more likely to impact on one's sense of self and be incorporated into one's identity. Of course, experiences need not be lasting to become part of one's identity. For instance, someone who has been married for many years might never really think of herself as 'a wife', and conversely, someone who served in the military for three months may identify strongly as 'a soldier' for the rest of her life. However, the experience of having marginalised functioning is more likely to become incorporated into a person's identity if that experience is lasting rather than brief. In addition, experiences that are lasting may function more readily as the basis of stigma. Again, there are exceptions: The stigma associated with sex work still attaches strongly to a person who spent a brief period of time doing sex work many years ago. However, to the extent that stigma often involves essentialising a social kind, it attaches more readily to kinds that are defined by lasting rather than transient experiences.

These features of lasting marginalised functioning can illuminate the relationship between disability and oppression without requiring oppression as a necessary condition for disability. That is, this model is particularly well-suited to explain why disability is *likely* to be a site of oppression. After all, social exclusion and stigma are key components of oppression and, as we have argued, someone with lasting marginalised functioning is substantially reliant on accommodations

[22] Of course, the achievements of this movement will also benefit those people whose functioning is temporarily marginalised.

for access to social spaces as well as being especially liable to stigmatisation. However, since oppression is not a condition on disability, particular individuals count as being disabled even if they don't experience oppression. Hence, this model can deliver the verdict that a possible world where there is no ableism or disability-based oppression can still contain disabled people.

7. Conclusion

By proposing a novel concept, *marginalised functioning*, we can break the impasse faced by the current terms of the debate. We have argued that our concept of marginalised functioning, which concerns the relationship between our bodily capacities and our social world, offers ways to unify the heterogeneous conditions that count as disabilities without sidelining the body. Moreover, the concept of *marginalised functioning* can be used to construct different models of disability. These models have, at least, four further advantages in common. First, they can explain why atypical functioning matters for disability—because it matters for default social norms—even though it's neither necessary nor sufficient for disability. Second, the context-sensitivity of the concept allows the models to explain the contested status of D/deafness as a disability since D/deafness counts as marginalised functioning in some contexts but not others. Third, whether one has marginalised functioning in a context is objective and independent of perception, delivering correct verdicts about invisible disabilities as well as latent conditions that are not disabilities. Finally, having marginalised functioning is distinct from being a member of other oppressive social kinds (such as race and gender), allowing us to distinguish between disability and other social kinds. But at

the same time, since having marginalised functioning makes one vulnerable to oppression, these models can explain why disability is often a site of oppression.

The three different models we canvassed have different strengths and weaknesses. Although we have outlined which argumentative burdens must be shouldered by proponents of each model, a full assessment of the relative merits of these models is beyond the scope of this paper. However, the novel concept of marginalised functioning opens up fertile ground for constructing models of disability that are more compelling than existing models.

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