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## DISABILITY AND NORMALITY

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About one in five U.S. residents is disabled, a proportion that according to the U.S. Census Bureau has remained steady through the last two census counts (U.S. Census Bureau 2012). Given the abundance of disabled individuals in the population, each of us most likely encounters several disabled people every day. But how should it be decided that an individual is disabled, and what are the consequences of being included in this group?

The idea of disability is more problematic, and identification of people who are disabled more challenging, than the large number found among us may suggest. Medical diagnosis is central to determining who is disabled and who is not. Yet attributions of disability are not like typical diagnoses of medical conditions. Moreover, just how identifying disability goes beyond diagnosing is not clear.

Current practice in ascribing disability has been portrayed as especially frustrating for both physicians and patients (Carey and Hadler 1986; Sokas et al. 1995; O'Fallon and Hillson 2005). One reason for concern about whether disability assessment is inherently dubious comes from physicians' variability in distinguishing people who are disabled from those who are not. To illustrate, 73 physicians participating in a study of the practice of determining disability differed significantly as to the degree of disablement from which the same patient with chronic back pain suffered: 20% concluded that the patient was totally disabled, 40% concluded that the patient was subject to marked activity limitation due to partial disability, and the remaining 40% concluded that the same patient had no disability at all (O'Fallon and Hillson 2005). Such sharp variations of opinion among medical professionals raise questions about whether their divergent assessments of disablement refer, even roughly, to the same thing.

The nature of the linkage of disability to disadvantage is another problematic aspect of disability ascription. Some people cannot even imagine that an individual could be disabled, yet also be no more disadvantaged than similar nondisabled individuals are. Is the tie so tight that deciding about disability is inherently normative, so that we cannot even conceive of individuals being disabled without also thinking this must be a damaging aspect of their lives? To securely capture a normative thrust, some theorists have urged that the concept of disability be explicitly revised. They propose crafting a more determinate definition according to which disability is ineluctably bad for well-being and therefore is necessarily disadvantageous. To illustrate, Savulescu and Kahane (2011) offer a proposal according to which disablement, by definition, makes life worse.

Adopting this stipulated definition, they believe, is commendable, for doing so builds a reason for societal intervention to address disability's difficulties into the very meaning of the term (Savulescu and Kahane 2011: 46). To revise the idea of disability so that disadvantage is inescapable in this way makes it inconceivable that disabled individuals can ever pursue

opportunity on a level playing field. Freeing them from disadvantage would require nothing less than eliminating their disablement.

Savulescu and Kahane call their approach "revisionary" because it gives "disability" a new, more determinate meaning. A further strength of their proposal, in their view, is that it is overtly normative. There will be no equivocating: to identify an individual as disabled will express an assessment that the person is markedly deficient or deprived (Savulescu and Kahane 2011: 45). Alluding to disabled people's privations as an element of the expression used to refer to disablement will, they contend, make the case for assisting them a matter of logic rather than of the heart.

Other theorists have taken a diametrically different approach to revising the concept, proposing instead to strip away the familiar stereotyping that stubbornly binds being disabled to disadvantage (e.g., Silvers 2003; Barnes 2016). With their approach, people can be judged to be disabled without having disadvantage necessarily attributed to them. Disablement is understood to bear only a contingent connection to detriment, so as to leave open to discovery in each particular case whether contingencies call for a neutral or instead a value-propelled response to concluding that the person is disabled (Silvers 2003). Of course, to hold this view is not to deny that people with disabilities often experience disadvantage, nor that they may be especially vulnerable to having disadvantage imposed on them, nor that they deserve resources that are effective given their circumstances for acquiring equitable access to personal welfare, but it is to think people who are disabled need not be disadvantaged as well.

**Being Disabled and Not Disabled—No Contradiction Here!**

Yet another puzzle about the idea of disability is that a person may, without contradiction, identify or be identified as both disabled and not disabled at the same time. A key to elucidating the perplexing issues about normativity and consensus encountered in conceptualizing disability may be found by exploring how this escape from contradiction has come to be. Doing so may suggest a propitious approach to the link between disability and disadvantage.

In 1994 Carolyn Cleveland suffered a stroke that impaired her language capability to speak, read, and write, as well as to concentrate when executing these functions and to bring up in memory information conveyed in words. Three weeks after onset she filed for benefits under the U.S. Social Security Disability Insurance (SSDI) program, with medical documentation that she was totally disabled supporting her claim. But three months later, withdrawing her SSDI claim, she returned to her job.

After another three months had elapsed, however, she was fired for failing to meet performance standards. She then reinstated her application for the disability insurance payments based on her physician's testimony attributing total disability. Nevertheless, in a lawsuit filed simultaneously against the employer under the Americans with Disabilities Act (ADA), Cleveland also claimed that the employer discriminated by firing her even though she would have been able to execute the essential elements of her work, an assessment also supported by her physician's medical testimony. The employer asked the court to issue a summary judgment against Cleveland, preventing her ADA complaint from being tried. The employer argued that Cleveland contradicted herself by (a) presenting medical testimony that she was totally disabled to substantiate the SSDI claim that she could not work, while also (b) presenting medical testimony that she could execute the essential functions of her job in support of her ADA complaint (Kohrman and Berg 2005).

Initially puzzling as Cleveland's seemingly conflicting testimony may be, in their decision in *Cleveland v. Policy Management Systems Corporation* (1999), the Supreme Court justices found unanimously in her favor. It was the Court's opinion that Ms. Cleveland might be both

disabled and nondisabled, so her case was remanded back to the lower court for trial on the facts. This precedent now governs what U.S. courts must allow about people with disabilities. But what can it mean for individuals to be disabled and at the same time not be so?

Neither Cleveland nor her physician could claim without contradiction both that she had suffered a stroke but also had not suffered one. Nor could her physician diagnose without contradiction that aphasia both had and had not been a sequela of the stroke. The physician's testimony she submitted invoked the stroke and resulting aphasia in identifying her as totally disabled. But of course neither Cleveland nor her physician had denied these medically described facts for purposes of the ADA civil rights complaint, after affirming them for the SSDI insurance benefits application.

In the ADA complaint, Cleveland asserted, and the physician affirmed, that she suffered a stroke and resulting aphasia but could have executed the essential work of her position but for the employer's discrimination. In the Court's view, plaintiff's and physician's testimony affirming, and their testimony denying, that the same individual is disabled need not be contradictory. The Court's unanimous opinion explained that attributions of disability, such as were at issue in this case, are not about such purely factual matters as "The light is red/green" or "I can/cannot raise my arm above my head."

According to the Court, something more than assertions of pure fact appear to be conveyed by testifying that individuals are disabled. But if attributions of disability are not purely claims of fact, what more is meant or otherwise conveyed when people are identified as disabled? And to what standards ought medical testimony attributing disability be held if contemporaneous declarations can legitimately be made by the same expert that a patient is totally disabled, yet not so?

#### Disability—Heritage of the Idea

The idea that individuals with biologically based physical, sensory, cognitive, or emotional deprivations can be collectivized for medical or public policy purposes into a class of "the disabled" is a relatively recent invention. Prior to the 19th century, classification occurred in terms of physical, sensory, psychiatric, or cognitive diagnoses, such as being crippled, deaf, blind, mad, or feeble-minded. Then "disability," a status that already had a clear meaning under the law, was given a new usage as a term of art crafted to link judgments made in medicine with responses mandated by various kinds of public policy. Understanding how the concept of disability evolved is a step toward understanding the judgments its origin continues to shape today.

Originally, referring to individuals as "disabled" signified only that the person bore a statutory incapacity or lacked a legal qualification to do something. Individuals with disabilities suffered from legally imposed restrictions on their political participation. In the domain of law, little pretense is made that such legal disabilities, however convincingly justified, originate in anything more than social convention.

To illustrate, married women, but not unmarried ones, were disabled from owning property. Theories explaining, as a way of justifying, the deprivation typically turned on considerations of the stability of prevailing social arrangements. The leading explanation was expressed as an hypothesis that successful domestic arrangement required husband and wife to be as one person, permitting only one procurer of income per household (Blackstone 1765: 442–445). Given their domestic role, married women must refrain from disrupting the household by ceding over management rights to their own property. In contrast, unmarried women could retain oversight and decision-making rights to what they owned.

Such paternalistic convention maintained powerful sway long after 1920, when the 19th Amendment gave U.S. women the right to vote. To illustrate, in *Goesaert v. Cleary* (1948),

the Supreme Court refused to overturn a Michigan law allowing women to serve drinks only in public houses over which their husbands or fathers exercised property rights. The Court readily acknowledged that, according to science, some women were brawny enough to safeguard themselves from problems bar life could pose for their sex, but for the typical woman and therefore for women generally, oversight by a proprietary male was required to ensure against societal disruption.

Medicine shares with law the understanding that a disability is disadvantageous to whoever is classified as such, but the presumed reason for disadvantage differs in the two domains. In its original usage in the law, disability is understood to be a condition assigned as a socially constructed response when a kind or group of persons appears to be socially dysfunctional by not complying with ordinary societal convention.

#### The Medical Model: Naturalizing the Disadvantage of Disability

In medicine, however, disability has come to be equated with biological dysfunction, caused by an inability to maintain one or more species-typical biological processes. The medical idea of disability, which began to develop in the middle of the 19th century, differs in an important respect from the older one found in the law. Legal disability is understood to be a social artifact, whereas in medicine disability has been portrayed as a natural fact.

In the latter context, disablement usually refers to being in a biological state that scientific discovery discerns to be dysfunctional. For example, the current edition of *The American Heritage Medical Dictionary* defines *disability* as a "disadvantage or deficiency, especially a physical or mental impairment [emphasis added] that prevents or restricts normal achievement." In both domains, attributions of disability are normative, but they are not normative in the same way, for medicine naturalizes the association between disability and disadvantage.

In the 19th century, proposals about how to apply biological statistics to represent the average human individual forged ahead, propelled by methodological commitment to the usefulness of such mathematical understandings of human beings in preventative and therapeutic medicine. Confidence abounded that statistical research could distinguish between health and illness in living organisms. Bolstered by the presumption that humans have proven to be successful as species go, the method called for discovering how most people function, followed by the inference that these modes are not merely typical for our species but are the species norms as well. The improbability that a species whose members are mostly unsound could survive seemed to underwrite equating the most frequently seen kinds of humans with healthy ones, while anomalous individuals were subjected to suspicion about their impact on social stability and continued species success.

As medicine pursued becoming more scientific in this way, the older era's interpretation of certain physical, sensory, psychological, and cognitive anomalies being punishments for people's moral transgressions—an account now generalized as the moral model of disability—was superseded by a model of disability meant to offer a medical rather than a moral explanation. Positing biological failure rather than social transgression as the cause of individuals' physical or mental dysfunction offered a new, scientific route for averting or ameliorating the disadvantage from which persons who are disabled suffer, as well as forestalling the burdens these individuals are envisioned as imposing on their families and the community. To the extent promoting these techniques is beneficial to both the targeted persons and the general community, the advent of the medical model marked a progressive trend.

Medicine offers benign ways of preventing healthy individuals from experiencing disabling injuries or illnesses, and of mitigating disabling outcomes of injuries or illnesses. Yet not all biological conditions designated as disabilities are subject to effective medical measures. The

medicalization of disability magnified concern about the continued existence of people with apparently irremediable dysfunctions, individuals whose conditions regrettably appeared to defy scientific efforts to elevate the species' achievement of health. As the science of causes and cures of disabling conditions grew, the deployment of societal resources to address disablement was more pressingly perceived as affecting community interests as well as personal ones. Dealing with disablement came to be viewed as a proper purpose for public policy that aimed at safeguarding individuals diagnosed with dysfunctions who otherwise could be overwhelmed by their disablement, but also safeguarding families and other caregiving groups, and the human species generally, from stressful interaction with members of the disabled minority. The older charitable efforts to offer incurables assistance in forms that improved moral character now were augmented by public welfare services ranging from institutionalization for medical care to disability pensions and segregated education supposed to be specially suited for the societal roles disabled children were expected to play.

To inhibit these measures from having an inflationary effect on the size of the disabled population, the medical model offered intervention in the reproductive process. Eugenics programs, aimed at wiping apparently dysfunctional variation out of the human gene pool by destroying, sterilizing, or otherwise impeding their carriers from reproducing, were pursued vigorously throughout most of the 20th century in the name of the common good to prevent the creation of more supposedly burdensome sufferers. Their targets were primarily intellectually disabled individuals, but also deaf, blind, seizure-prone, psychiatrically ill, and crippled and maimed people. Accurate knowledge about how biological inheritance may result in these very different impairments was not readily available, so some of the people swept up and bundled into the targeted class had experienced disablement due to non-inheritable injury or infectious disease. They too were sterilized, or in some places even euthanized, in the name of saving the human species from inheriting defects and society from noncontributing or burdensome members (Kevles 1985; Proctor 1988; Lombardo n.d.).

Even people whose behavior violated mere social norms were sterilized, based on false beliefs that their transgressive conduct was inheritable. Compulsory sterilization began in the United States in Indiana in 1907, followed by California and Washington two years later. In the infamous *Buck v. Bell*, 274 U.S. 200 (1927), for example, Justice Holmes upheld Virginia's sterilization of a teenager who had been raped because her mother and grandmother also had been unmarried mothers. In *Skinner v. State of Oklahoma, ex. rel. Williamson*, 316 U.S. 535 (1942), the U.S. Supreme Court ruled that sterilization could not be used as a form of punishment, but hastened to observe explicitly that this ruling did not similarly constrain sterilization for eugenic reasons, as the Court had approved that practice in *Buck v. Bell*, 274 U.S. 200 (1927).

Concern remains today that contemporary versions of the old eugenics programs continue to flourish (Holmes 1991; National Institute for Health and Care Excellence 2008; Chew 2013). Prenatal testing and subsequent termination of pregnancy if the fetus is found to be at risk of or have certain disabling conditions are common. Selective abortion prompted by prenatal testing seems to some to be propelled by the familiar stigmatization of people with disabilities.

Disability advocates usually do not challenge women's right to choose, but many object to the frequency with which termination of pregnancy is influenced by assumptions that children who fall outside of the normal ability range cannot live good lives. That such bias, whether overt or implicit, continues to affect how medical technology is used is evidenced by, for example, the uproar that has greeted the rare instances in which prospective parents with disabilities—persons who themselves lead satisfactory lives—propose to employ reproductive medicine's technology to bear children who, like themselves, do not satisfy standards of

normality (Scully 2008). Some writers present or even press intuitions assigning preference to the lives of patients whose impairments can be fixed over the lives of those who are stable but not curable. (See Savulescu and Kahane 2011; Kamm 2013; Bogner 2014; Kamm 2015; Bogner 2016 for different views on the epistemic strength of such intuitions about the comparative value of nondisabled and disabled people's lives.) To be made persuasive, this kind of bioethics narrative often is illustrated by examples of rare illnesses or injuries that are characterized by irremediable anguish. Bias must be suspected when such worst-case scenarios are rolled out to represent the lives of the entire membership of the disability class. Nussbaum's trail-blazing book, *Frontiers of Justice* (Nussbaum 2006), examines the question from a wider angle, asking whether theories of justice that consider only people with species-typical capabilities to represent subjects of justice generally can be fair.

The medical explanation of the disadvantage to which disabled people are vulnerable improves over the moral account for several reasons. Medicine offers a larger, more effective repertoire of preventative measures or other progressively supportive responses to medical conditions associated with disability. Although the medical model resembles the moral model in locating the cause of disability-produced disadvantage in flaws within disabled individuals themselves, occasions to blame the victims for being so are reduced, although not completely eliminated. But medicalization's focus on personal biological deficits creates pressures to acquiesce to risky medical treatments with low rates of providing relief (Andrews 2011), as well as to allow segregated public services or overt removal of disabled people from the community.

### Sameness and Singularity

Disability as discussed on the terms the medical model supplies invites dividing the human population into two parts, four-fifths of whom function similarly and thus count as normal, while the remaining one-fifth function disparately due to dysfunctions traceable to anomalous biological conditions. (See U.S. Census 2012 for the proportion of disabled people in the population.) But as the philosopher of science and physician Georges Canguilhem observed, the human species persists because our biological system is capable of very diverse modes of functioning executed under a great variety of conditions, including unusual ones that call for physiological or psychological adaptation (Canguilhem 1978; Canguilhem 1991). Canguilhem (1991: 196) argues that anomalous individuals should be diagnosed as diseased or disabled only in relation to specific contexts that affect people's functional success. Health care policy should proceed according to research models that can acknowledge as valuable statistically anomalous modes of functioning that may be useful, even if only under conditions that may be rare.

Functional determinism supposes that there is a natural, species-typical mode of carrying out each human function. It is by invoking this supposed standard that the medical model magnifies diagnoses of specific illnesses and injuries into attributions of functional disablement. Philosopher of science and disability studies scholar Ronald Amundson (2000) calls for abandoning this misleading doctrine of functional determinism to which, he contends, medical thinking continues to cling.

Amundson points out that for a species, variation in how essential tasks are executed is not unusual and can be eminently useful. The data about species persistence made available to us by biological science do not substantiate claims that average or species-typical modes of functioning always are preeminently effective or otherwise superior. A related mistake is that evolution results in the normalization of species by fixing certain traits through the process of selection, which subsequently remain set in their role in speciation. Biologically adaptive plasticity, such as occurs with the human brain, is well-known. Amundson illustrates with the case

of a student with only 10% of the usual human brain tissue owing to subclinical hydrocephaly whose IQ and social life were indiscernible from that of other people.

Since Amundson published his influential article, advances in molecular medicine have revealed more and more ways in which people who appear to be average individuals at the level of the phenotype can vary enormously at the level of the genome. Among the three billion base pairs in which a human individual's chromosomes consist, there is an enormous number of distinct variations that can make this individual more risk prone or more resistant to different diseases and disabilities than most others (Rose 2009). Conceivably, the rarest states of body or mind could be the healthiest because the most effectively adaptive or resilient, which may be especially advantageous if the physical or social conditions in which species members must function undergo change.

Amundson therefore rejects conceptualizing human health as if the difference between species-typical and less-common modes of functioning is that the latter also are less good. That a biological state is found in a majority of humans does not make it a healthy state. Yet, as he notes, despite the well-known facts of functional variation and genetic variation within the human species, "the notion of a fixed species design with determinate limits on functional potential still plays a dominant role in health care" (cf. Boorse 1975; Wachbroit 1994; Boorse 1997). In health care, as well as other areas of policy, social norms that impose conformity on modes of functioning often have been camouflaged as biological norms by casting familiar modes as normal and thereupon naturally suited to promote the species' success.

The explanatory framework that assumes functional determinism is true has been used to justify political approaches and social arrangements that exclude kinds of people who, according to that framing theory, are not normal. Based on the mistaken theory that species-typical modes of functioning are the most valuable, anomalous biological functional conditions such as blindness, deafness, or missing limbs are taken to permit or even call for societal arrangements that disadvantage atypical individuals. For Amundson, an illustrative case of illegitimately using such a normative assumption can be found in bioethicist Norman Daniels's influential proposal about the proper policy for distributing health care resources (Daniels 1985; Daniels 1987), which relies on the assumption that functional determinism is true.

According to Daniels, preserving or restoring species-typical functioning is a primary goal of health care. He stipulates that "[T]he kinds of [health care] needs picked out by reference to normal species functioning are objectively important because they meet this high-order interest persons have in maintaining a normal range of opportunities" (Daniels 1987: 301). The normative power accorded to species-typical modes of functioning is supposed to be confirmed by the frequency with which these modes are exhibited in the general population.

That these occur so often in the population is taken to show that nature favors these familiar functional modes and, further, to explain why they are taken to be norms. Consequently, allocation of health care resources to people whom medical intervention cannot normalize should have the lowest priority, because even with treatment they will never be able to take advantage of the normal range of opportunities (Daniels 1985: 48). This policy conclusion is the outcome of invoking the hypothesis of functional determinism in order to explain and then manage disability by naturalizing it.

### The Social Model: Addressing the Disadvantage of Disability

In the last part of the 20th century, a social model of disability was advanced to compete with the medical model. Disability advocates contended that shaping social arrangements so as to be receptive to average or normal people, but inflexibly intolerant when it comes to anomalous

individuals, restricts disabled people's well-being more than their biological anomalies do. In other words, the expectation that the normality standard should govern the way things are done narrows the opportunity range for atypically functioning individuals.

Applying a social model perspective, Silvers criticizes Daniels's placing greater value on conforming to species-typical modes of functional performance than on effectively executing the function in whatever way the atypical individual can (Silvers 1998: 101; Silvers 2003). People who cannot function effectively by using the same modes of performing that species-typical individuals do nevertheless may achieve workplace and daily living aims if their alternative modes of functioning are allowed. This insight is appreciated by promoters of the social model of disability, which applies materialist analysis to explain the disadvantage of living with disabling biological conditions when the social arrangements that are circumstances of contemporary life are organized to provide only for species-typical people. The social model captures a significant aspect of disabled people's experience, namely, the striking improvement in their functionality that an accommodating environment often makes, and the precipitous deterioration if accommodations are withdrawn. In particular, the social model accounts for the frequent connection of disablement with social exclusion, as their familiar modes of executing actions may seem more comfortable, more efficient, or otherwise preferable to the nondisabled majority (O'Brien 2001).

In Carolyn Cleveland's case, the accommodations she needed were never made. Factually, therefore, she was totally disabled because she was unable to execute her job without accommodation. A counterfactual claim also may be true, however: had the employer not denied her reasonable accommodation request for such accommodations as an augmented communication device, a computer program with word prediction, word search, and speech output software, training, and additional time for some work tasks, she could have functioned effectively in her job. In other words, Cleveland's claim was that she was totally disabled only because her world was one where the employer maintained an unaccommodating work environment that was hostile to her atypical modes of functioning.

It is as if in the SSDI claim Cleveland and her physician were speaking in a world in which functional determinism is true. Were that so, inability to function in the species-typical way would leave people with biological deficits no option other than to abandon employment for subsistence on disability benefits. On the other hand, the ADA claim spoke of a world where the norms endorsed by the outdated theory of functional determinism have not continued to influence medical practice. In that world, employers would appreciate rather than disdain accommodating differences in employees' modes of functioning. Individuals who in the SSDI world count as totally disabled could, in the ADA world, remain on the job.

As neither the medical nor the social model is meant to be a definition of disability, neither should be used to distinguish who is disabled from who is not. Rather, the models provide different explanations for understanding the connection between disability and disadvantage. The social model differs from the medical one as to the cause of the exceptional disadvantage to which disabled people are exposed, but it also diverges from the medical model in regard to a remedy. The social model cites social facts or conditions as the relevant kind of restricting cause. The theme here is not to reject medical ministrations categorically but to focus on nonmedical factors that not only are alterable but that, if altered, can ameliorate the social exclusion that is so prominent a part of many disabled people's lives (Silvers 2003: 476).

Different versions propose social structures, prejudicial or fearful attitudes, economic interests, or similar societal phenomena as sources of the barriers disabled people face. All are subject to amelioration through political action aimed at rescuing people with disabilities from social isolation and integrating them into the community. The social model originally was

devised to be of practical political service in propelling rights-driven, liberating social progress for disabled people. It was aimed initially at revising UK social support programs that required disabled people to live in nursing homes and to enable them to reside in, and enjoy the opportunities offered by, the wider community.

The course of action the social model recommends is to pursue rights claims to access and inclusion, accommodating practice, and other kinds of societal change that will allow people constrained by illness or injury more and better opportunity. Locating the problem of disability in correctable social biases rather than in disabled persons whose bodies or minds need correction has proven to possess persuasive power (Silvers 2011). Evidence of the social model's capacity for stimulating action is confirmed by the achievements of the global disability movement in codifying disabled people's rights, not only through national legislation such as the ADA in 1990 but also in the United Nations' Convention on the Rights of People with Disabilities (CRPD) in 2006, as well as in legislation in many nations and in programs adopted by regional organizations such as the European Union.

### Multiple Meanings

In a 2007 report called *The Future of Disability in America*, the U.S. Institute of Medicine (IOM) designated disability as a pressing problem for public health. Extolling the effectiveness of medical technology to prevent or remedy disability, the report applauds the reduction of activity-limiting biological dysfunction in older adults but warns that increases in physical inactivity, diabetes, and obesity place younger and middle-aged adults at growing risk of disability.

Identifying such biological conditions with disability is typical of the medical model. Nonetheless, the IOM's press release announced the report's findings with words that appear to promote the social model as well:

Increasingly, scientific evidence reveals that disability results, in large part, from actions society and individuals take [and is] the result of interactions between people and their physical and social environments. Many aspects of the environment contribute to limitations associated with disability—for example, inaccessible transportation systems and workplaces, restrictive health insurance policies, and telecommunications and computer technologies that do not consider people with vision, hearing, or other disabilities.

(National Academies of Sciences, Engineering, Medicine 2007)

The IOM appears agreeable to a multivariant explanatory model of disadvantage based on disability. Despite the *Cleveland* case, tension between these different normative directions is hard to eliminate completely, even though no contradiction between the assertions they propel exists (Kohrman and Berg 2005). How comfortably this tandem strategy of advocating medical technology while also invoking anti-discrimination law can be pursued remains to be seen. This is, of course, not the only area of current medical practice where picturing the patient as a defective dependent now must be integrated with the patient's status as a respected bearer of rights.

In 2012, a U.S. Census Bureau report commented:

Because health professionals, advocates, and other individuals use the same term in different contexts, disability does not often refer to a single definition. . . . As a demographic category, disability is an attribute with which individuals may broadly iden-

tify, similar to race or gender. In contrast, certain federal programs narrowly define disability. . . . The agencies and organizations that provide benefits to, advocate for, or study these populations, each refer to their targeted group as people with disabilities; but because of the differences in definitions, an individual may be considered to have a disability under one set of criteria but not by another.

(Brault 2012)

Theories about disablement can neither engage each other nor be robust if they do not refer to the same thing. After the ADA became law, implementation often was undercut by this problem, despite the Supreme Court's attempt in *Cleveland* to evade it (Kohrman and Berg 2005). To counter medical testimony that a plaintiff's condition satisfies criteria for disablement, defendants would appeal to some other account of that state and insist that the plaintiff did not qualify for protection. Eventually, in 2008, an almost unanimous Congress amended the ADA to reduce the importance of determining whether individuals seeking redress for discrimination based on disability actually are disabled (Stein, Silvers, Areheart, and Francis, 2014). But variability in attributions of disability identity—whether by medical professionals, policy makers, or disabled people themselves—is unlikely to resolve the lack of consensus among policy makers, lay people, and disabled people about the purpose of identifying individuals as disabled.

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