Disability as Medical and as Social Category

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Abstract

This chapter draws attention to several philosophical issues raised by the phenomenon of disablement and then focuses on two main ones pertinent to philosophy of medicine: the definition of disability and the relationship between disability and identity. Two kinds of approach are identified in relation to the question of the definition of disability, one of which focuses on the individual concerned and is sometimes described as a “medical model” of disability and another approach which places more emphasis on the environment beyond the individual. The World Health Organization’s (WHO) taxonomy is presented below to represent the first kind of approach, and the theory devised by Professor Lennart Nordenfelt is presented as representing the second. The chapter then turns to discuss disability and identity. It is shown that on standard ways of conceiving of the identity relation, disability seems closer to a contingent (and so non-identity-constituting) characteristic of persons as opposed to an essential, identity-constituting one. However, another strategy is also described in which certain kinds of contingent properties can be identity-constituting. So if the latter strategy proves successful, then it may be true that disability can indeed be identity-constituting.

Introduction

Disability raises many philosophical questions regarding, for example, its definition, its normative character, its causes, its relationship with a person’s identity, the question of a person’s moral status and entitlement to life, as well as their entitlement to social justice. Since this handbook’s primary focus is on philosophy of medicine, the two main issues addressed are two which seem most pertinent from a medical or health-care perspective. The first of these is the very definition of disability. This discussion highlights two distinct approaches, one which focuses on the individual concerned and is sometimes described as a “medical model” of disability and another approach which places more emphasis on the environment beyond the individual. The World Health Organization’s (WHO) taxonomy is presented below to represent the first kind of approach, and the theory devised by Professor Lennart Nordenfelt is presented as representing the second. The question of how disability should be defined has obvious relevance to philosophy of medicine in particular since if it is true that the causes of disability lie in the individual concerned, then attempts to diagnose and respond therapeutically to disability will be directed primarily at the individual. But if the real causes lie beyond the individual, the role of medical practitioners in responding to disability is much less clear. It may even turn out that disability could be completely severed from the domain of health care since it would, at most, be a social problem as opposed to a medical one – something more in common with poverty or sexual discrimination as opposed to appendicitis or schizophrenia. In the latter part of the chapter, the question of the relationship between disability and identity is discussed. Somewhat paradoxically, theorists who claim that disability is largely caused by factors beyond the person maintain that disability is an essential part of who they are.

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sounds prima facie paradoxical since it seems more likely that a person’s identity would be determined by factors intrinsic to them, such as their genetic constitution, as opposed to extrinsic factors, such as social conditions.

**Defining Disability: A Medical Model**

No human being is wholly able, so to speak, able to do everything. There are some kinds of activities which a person may not be able to accomplish, yet this does not entail they have a disability or are disabled (Nordenfelt terms these “nonabilities”). Yet, historically, human beings have been identified as lacking certain abilities considered typical of humans and identified as such. Thus, Braddock and Parish (2001) note that a distinction was frequently drawn between those people with what would now be thought of as physical impairments (e.g., lacking limbs), those with sensory impairments, those with what would now be thought of as intellectual disabilities, and those with severe mental health problems. Braddock and Parish emphasize the significance of a distinction between impairment and disability since they endorse the view that while impairments are grounded in actual physical difference and thus to a significant extent independent of social context, this is not true of the category of “disability” which they say is much more closely bound up with local values and norms.

The view that there is indeed at least this level of complexity in the classification of disability became widely recognized in the twentieth century and led to increasingly sophisticated attempts to taxonomize the phenomenon of “disablement” (e.g., Nagi 1965; WHO 1980; Oliver 1990; Nordenfelt 1983/1997). Of the various approaches attempted, two general emphases can be discerned – reflected in the division referred to by Braddock and Parish – between on the one hand a primary focus on the physical constitution of the person concerned and approaches which have contextual factors as their primary focus on the other. Between these two extremes, as might be anticipated, are approaches which seek to acknowledge both internal and external factors as opposed to focusing narrowly on either one or the other.

The World Health Organization’s (WHO) taxonomy from 1980 can be taken to represent approaches which at least appear to have the individual person as their primary focus. The conditions with which it is concerned are those which it describes as the “consequences of disease” (1980, p. 1). In their *International Classification of Impairments, Disabilities and Handicaps* (ICIDH), it is observed that disease can lead to impairment, which can lead to disability, which can lead to handicap. This is represented in a schema presented thus which illustrates the sense in which impairment, disability, and handicap are conceived of as consequences of disease:

“disease >>> impairment >>> disability >>> handicap” (WHO 1980, 11; see also Altman’s depiction of Nagi’s schema (2001, 113))

Disease is defined in terms of “aetiology >>> pathology >>> manifestation” (WHO 1980, p. 10). Thus, consider the former Olympic and Paralympic athlete Oscar Pistorius. Due to a genetic anomaly, he was born without fibulae; the aetiology would be the anomaly itself (a genetic difference or more strongly disease), the pathology it leads to is the lack of fibulae, and its manifestation is the missing fibulae.

Impairments are defined as follows: “Impairment: In the context of health experience, an impairment is any loss or abnormality of psychological, physiological or anatomical structure or function” (ibid. p. 27) and are said to arise at the level of “parts of the body” (ibid. p. 28). So the missing fibulae would qualify as impairments because their absence constitutes an abnormality – statistically speaking – in anatomical structure since it is statistically typical for humans to be born with fibulae.

According to the ICIDH, impairments are consequences of disease and disabilities consequences of impairments. So consider the definition of disability offered. “Disability: In the context of health
experience, a disability is any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being” (ibid. p. 28). Whereas impairments arise at the level of “body parts” such as organs, disabilities are said to arise at the level of the individual person (ibid.). So to focus on Oscar Pistorius (OP) again, since walking is an activity within the range considered normal (statistically) for humans, the impairment leads to a lack of the ability to walk (unaided). Also, of course the relevant comparator group here is humans at a particular chronological stage of development: it is not statistically abnormal for babies to be unable to walk.

Turn now to the third consequence of disease as presented in the ICIDH, that of handicap. “Handicap: In the context of health experience, a handicap is a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex and cultural factors) for that individual” (ibid. p. 29). As mentioned, impairments are properly attributed only to body parts and disabilities only to persons, so it is said that handicap is a “social phenomenon” (ibid.). For in contrast to the other two consequences of disease, this category makes explicit reference to social and cultural factors. So it might be said that OP’s missing fibulae constitute a “disadvantage” to him since they limit the range of activities and social roles open to him just as being unable to see, for example, may be said to be a handicap since it limits the social roles open to the person.

It is evident, then, that on the ICIDH schema, impairment may be a necessary condition of disability but is not a sufficient condition. Fused toes may count as impairments as they comprise a structural abnormality, but providing they don’t limit the person’s ability to walk, they fall short of disabilities. Here there are structural abnormalities with no functional consequences. (So impairments differ from diseases.) Also, as the case of OP illustrates, there may be provision to mitigate adverse functional consequences of impairments such as walking blades, spectacles for the shortsighted, insulin for diabetes, and so on. So again here we have impairments but no disability, provided relevant “external” compensating conditions are present, such as the availability of walking blades, spectacles, or insulin. Other kinds of contingent cultural factors can also be shown to be relevant to the question of whether a disability leads to a handicap. In the island known as “Martha’s Vineyard,” situated off the coast of North America (Sacks 1989), a high proportion of the residents were deaf, and most residents of the island were competent in using sign language. In this context deafness may be a disability but does not lead to a handicap (Oliver 1990, p. 16; Sacks 1989).

As may be anticipated perhaps, the ICIDH taxonomy generated substantial amount of criticism (see Oliver 1990); the most influential criticism focused on an interpretation of the kind of causal claim made in the document (see esp. Wasserman (2001) for philosophical discussion of this). Critics claim that according to the ICIDH, because it is a “consequence of disease,” it follows that the causes of disability lie in the individual. But, it is argued that the causes of disability lie wholly in the social environment not in the individual with the impairment (UPIAS 1975). The force of this claim is captured well in the front cover picture of Oliver’s The Politics of Disablement which depicts a person in a wheelchair at the foot of a flight of steps of a building which is a polling station. The clear message is that the wheelchair user is perfectly able to vote but is “disabled” from doing so by the wheelchair-unfriendly social environment.

Moreover, it is argued that if it is held that the cause of disability is to be found within the “diseased” individual, they will be conceived of as suffering from a medical problem which requires a medical response (indeed Harris has claimed that a disabled person “will inevitably suffer” (2000)). This so-called “medicalization” of disability (Oliver 1990) fosters the impression that disability and handicap are inevitably accompanied by illness and this is a mistake it is said. A person might have an impairment which leads to a disability (say lack of ability to walk) but consider themselves perfectly healthy. One can think of many Paralympic athletes in this context to reinforce the conceptual separation between disease, impairment, and health. Thus, it may be held that even impairments which lead to deviations from species-typical functions as fundamental as seeing, hearing, and walking need not impede health (see esp.
Nordenfelt’s work, of which more below). So, there is no necessary relationship between disability and illness, contrary to the impression fostered by a medicalized view of disability. Moreover, the view that the cause of disability lies in the individual has clear implications regarding the focus of attempts to remedy it, namely, the “diseased” person themselves. Hence, from the perspective of the contrasting “social model” (Oliver 1990) according to which the cause of disability lies in the social environment, the medicalized ICIDH model is seriously flawed. Lastly, the claimed medicalization of disability generated by the ICIDH led to it being regarded as a medical problem requiring the input of medical and other health-care personnel, and this, it is argued, is wholly inappropriate given the contingent nature of the relationship between impairment, disability, and illness (Oliver, op. cit; Swain et al. 1993).

Many of these criticisms of the ICIDH and the claimed “medical model” of disability it presents were accepted, and a revised WHO schema appeared in 2001 (WHO 2001). The International Classification of Functioning, Disability and Health (usually abbreviated to ICF) stressed the multidimensional nature of disablement and emphasized that “a person’s functioning and disability is conceived of as a dynamic interaction between health conditions (diseases, disorders, injuries, traumas, etc.) and contextual factors” (ibid. p. 10); these contextual factors include “features of the physical, social and attitudinal world” (ibid.). So even if the earlier schema did express a much simpler causal picture, the latter model is explicitly of the view that the causes of disability are manyfold and include factors beyond the body of the individual concerned. Despite this major change of emphasis, the basic categories remain more or less unchanged; impairment is much as before what were disabilities are now labeled “activity limitations” (ibid. p. 191), and what were labeled handicaps are renamed “participation restrictions” (ibid.).

Also, as was the case in the ICIDH, each of the main categories is defined with reference to statistical norms: the definition of impairment in ICF is explicit that “Abnormality here is used strictly to refer to a significant variation from established statistical norms” (ibid. p. 190); the relevant comparator group in relation to activity limitations is the “manner or to the extent to that is expected of people without the health condition” (ibid. p. 191); and in the case of participation restrictions, the comparison is with “that which is expected of an individual without disability in that culture or society” (ibid). The kinds of norms these three categories appeal to are much narrower than biostatistical norms and make reference to cultural or local norms, but, nonetheless, the possibility arises that a person may be categorized as having an activity limitation or participation restriction even if they themselves deny this.

Nordenfelt’s Theory

In an interesting series of publications, the philosopher Lennart Nordenfelt argues that the question of whether or not a person has a disability is not, in most cases, separable from the values of the person themselves. So rather than tie classification to statistical norms, Nordenfelt argues for a theory in which the categorization of a person as having a disability depends to a large extent on what is of value to that person (see Nordenfelt 1983/1997, 1993, 1995, 2000, 2001). His approach is one which is part of his general theory of health in which the question of a person’s health is similarly bound up with the person’s own views regarding what is a good life (Nordenfelt 1995; 2001). The approach tries to tread a fine line between being a subjectivist one in which the question of whether or not a person is disabled is wholly determined by them and what might be described as an objectivist one – such as that which is found in the WHO schemas – and in accordance with which a person can be categorized as disabled irrespective of their own values or opinion on the matter.

A central component of Nordenfelt’s theory is that of a vital goal. The definitions of disability and handicap given by Nordenfelt are these: “A disability, as well as a handicap, is a non-ability – given a specified set of circumstances – to realize one or more of one’s vital goals (or any of its necessary
conditions)" (1993, p. 22). By “vital goal” Nordenfelt means “a state of affairs that is a necessary condition for the realization of A’s at least minimal happiness” (1993, p. 20). It is made plain that vital goals may include activities which are important to an individual such as cinema-going, bird-watching, and, more controversially perhaps, even sports-related goals involving high levels of achievement (Nordenfelt 2007; Schramme 2007). The idea here is familiar enough, namely, that most people perform everyday acts with some longer-term goal in mind and these acts and the goals they aim for manifest a particular view about what is a good life – or a happy life as Nordenfelt uses the term. He does not equate happiness with mere pleasure or even to preference satisfaction in a crude sense; rather, it is closer to an Aristotelian conception such as flourishing. Satisfaction of the physiological needs necessary for survival (such as needs for oxygen and water) is also necessary of course since satisfaction of these is a necessary condition for the realization of goals such as cinema-going, bird-watching, or even sporting success. So a person has a disability in a specific set of circumstances if, due to an impairment, they are unable to pursue their vital goals.

To give an example to try to illustrate an important implication of Nordenfelt’s theory, recall again the example of Oscar Pistorius. Clearly, he appears to be physically fit and healthy and reportedly does not consider himself to be disabled. True he has an impairment of course; but then, so do those with mild hearing loss or shortsightedness. Just as the provision of spectacles addresses the vision of the short-sighted, Pistorius’ prostheses remedy his inability to walk. It follows from Nordenfelt’s theory that he is not disabled.

A further interesting implication of Nordenfelt’s approach is one such as the following. Consider a person with a severe intellectual disability accompanied by severe physical disabilities which have a negative effect on the person’s mobility. Suppose further the person lives in a supported environment with 24-h individual care. As it happens the person is a great fan of the cinema and would happily spend up to 4 h per day watching films in their local cinema. This brings so much pleasure to the person that it is reasonable to state that cinema-going is one of their vital goals. The person feels that life is much less rich if they are deprived of the opportunities to pursue their favorite hobby. Happily, due to the provision of 24-h support, they are able to pursue their vital goal of cinema-going. Were the level of support for this person to be reduced to the extent that regular visits to the cinema are not possible, then the person becomes disabled – due to the nature of this change in the “social” environment – namely, the economic decision to withdraw such a high level of support to the person. So it can be seen that in contrast to the “medical model” allegedly found in the ICIDH, Nordenfelt’s theory recognizes a clear role for the social environment, broadly construed, as a causative factor of disablement, among other factors, including properties of the individual concerned, such as impairment. In contrast to the ICF, it is sensitive to the personal values reflected in the vital goals of the individual; the emphasis in the ICF is to be found on statistical norms and not personal values.

With reference to the so-called social model of disability (Oliver 1990), if it is interpreted straightforwardly as the view that the cause of disability lies wholly in the social environment, with no causal role acknowledged for factors intrinsic to the person, then there is a clear difference between it and Nordenfelt’s theory. However, as Wasserman observes, there is good reason to suppose that “the claim of exclusive social causation is a calculated overstatement, a corrective for the opposing and more damaging misrepresentation [that the cause of disability lies in the individual]” (2001, p. 228). In the early days of the social model, in order to emphasize the role played by the social environment in the causation of disability – especially its physical architecture – it is suggested that causal role was perhaps overemphasized for purely tactical purposes. Also, the social model has been subjected to criticism for its apparent neglect of the significance of impairments, especially the debilitating effects of chronic symptoms of phenomena such as pain and fatigue (Shakespeare 2013; Wendell 2013). The reality of life with some impairments, it is pointed out, is that there are accompanying health problems. So altering the
physical environment will leave the significance of those aspects of disablement at risk of neglect. Moreover, as described earlier, the cover of Oliver’s influential and important book in 1990 strongly suggests that by modifying the social architecture, apparent disability evaporates. But critics point out this way of addressing difficulties resulting from disabilities and impairments applies less straightforwardly in conditions such as sensory disabilities and intellectual disabilities. So the social model has itself been subjected to some challenging criticisms.

Criticisms of Nordenfelt have tended to focus on his appeal to vital goals. Critics find a tension between respecting the values of the individual in the formation of vital goals while resisting the collapse into a subjectivist approach which he would obviously reject (1987, pp. 90–91). Nordenfelt appeals to a notion of welfare, which he uses as a synonym for “happiness.” But Nordenfelt uses this term in a way that has more in common with flourishing in a purportedly objective sense, and this is perhaps the best way to think of it. Further specification of that brings further problems of course, but it at least indicates that, as far as Nordenfelt is concerned, his theory does not rest upon subjectivism with respect to vital goals.

A further kind of criticism leveled at Nordenfelt concerns the more general theoretical problem of whether “disease” is a normative or nonnormative, purely descriptive concept. This is relevant since as seen above the WHO classificatory schemes regard impairments as consequences of disease and as purely descriptive. The most well-known non-normativist account of health has been developed by Boorse (esp. his 1975). According to him disease classifications are purely scientific descriptions of abnormal functions. So if one defines health as a state involving the absence of disease, wherever there is abnormal function, there will be ill-health – irrespective of the view of the person whose health status is in question. By contrast, in Nordenfelt’s theory, the question of whether or not a person is healthy is not independent of the values of that person – as manifested in their vital goals – and the same applies in relation to the question of whether or not they have a disability (Nordenfelt 2001). Of course, while maintaining this, Nordenfelt accepts that some statements about, for example, the incidence of disease are descriptive, e.g., one might observe that there is a high prevalence of a particular disease in a particular region, and that would be a descriptive claim. However, the very identifying of certain physical states as diseases – according to Nordenfelt – is due to their propensity to impact negatively on the capacity of people to be “happy,” i.e., achieve their vital goals (2001, p. 78). The same is true with regard to physical states referred to by the term “impairments.” So there are these two main positions with regard to the kinds of physical states which, for example, taxonomies such as the ICIDH and ICF claim to be necessary for disability: on a nonnormative approach, they are purely descriptive; on a normative approach, they involve tacit reference to values and so are inherently normative. Nordenfelt’s theory is of the latter kind due to the connection – albeit a contingent one – between impairments and ill-health.

Disability and Identity

Several commentators make the point that disability is an intrinsic part of who they are – part of their very identity. For example, Oliver argues against the expression “people with disabilities” because it implies the separability of the disability from the person; this is not the case he claims because “far from being an appendage, disability is an essential part of the self” (1990, p. xiii; also Toombs 1995). Similar views can be found in the ICIDH (28), though that discussion moves on to distinguish “being [disabled] rather than having [a disability]” (ibid.); the former expression aligns with Oliver’s position, whereas the latter clearly implies that disability is a contingent rather than identity-constituting aspect of the person. Also, as Davis explains (2013), a significant strand of disability scholarship has sought to emphasize the view that there is a distinct “disability identity,” such that disability really is an identity-constituting feature of the person. This strategy has been exploited in part to fuel what has become known as “identity politics” (see, e.g.,
Davis, ibid; Siebers 2009, 2013) in which establishing a distinct identity for a group serves as a political expedient to securing increased recognition and respect. This can also help to attack discriminatory practices relating to employment opportunities and health and education. So if it could be shown that disability is on a par with race and gender – accepting for the sake of argument for the moment that these are identity-constituting – then the political strength of those who campaign for the rights of disabled people would be considerably strengthened.

In spite of these proposals, from a philosophical perspective, the claim that disability is identity-constituting does not seem a promising one. When one thinks of people who become disabled due to bodily trauma, it looks more plausible to claim that numerically the same person has undergone a qualitative change albeit sometimes a radical change. The contrary claim – that a numerically different person now emerges – does not sound very plausible. But the “identity claim” as it can be called may be easier to sustain in relation to genetically caused disabilities. If personal identity is considered to involve bodily continuity, then in so far as the disability-causing genetic characteristics figure in that then they might be considered identity-constituting.

However, two kinds of objections have been raised against this view. It has been pointed out that in attaching so much significance to physical properties, the importance of psychological ones is implausibly neglected. What lies behind such objections is the kind of considerations which might lead one to adopt the main alternative approach, relying on psychological continuity. What seems essential to our identity is our values, together with the sense of continuity of existence which we characteristically possess through our memories. Also, it is possible to induce radical changes in a person’s physical nature; for example, by using gene therapy genetic makeup can be altered. More radically, one’s body parts could very gradually over time be replaced by synthetic substitutes (see Haraway 1991) to the point when one loses all genetic human identity, only psychological continuity. By contrast some commentators have focused on one’s origin, but it is fair to say that similar difficulties have been leveled at that: it neglects what is really important in identity and faces an “infinite regress” charge in the search for origins (Edwards 2007).

In light of these kinds of problems faced by attempts to develop theories of personal identity which are constrained by the search for a particular set of essential properties, alternative approaches have emerged which attach less significance to the search for a set of essential properties which are identity-constituting. These approaches have tended to rely on concepts such as that of narrative identity (Ricoeur 1991; also DeGrazia 2005). They stem in part from work undertaken by MacIntyre in his classic After Virtue (1981; see also Schechtman 1996). MacIntyre reminds us that, normally, identity judgments are relatively straightforward and that they rest upon a less strict understanding of the identity relation than that which constrains the philosophical literature on the problem. The suggestion is that the philosophical concept of “strict” identity is a distillation of a more familiar concept which serves its function perfectly adequately, except when required to determine the kinds of problem cases thrown up by the philosophical discussions – e.g., regarding brain swapping, time travel, etc. (see, e.g., Parfit 1985; Williams 1973). If this is accepted, then the kind of work undertaken by, for example, Ricoeur (1991) and Taylor (1989) can be exploited to show how disability might indeed be understood as something more than a mere contingent aspect of the person. This “something more” can then be exploited to support the kinds of identity claims quoted above and thus to sustain the distinction between being a “person with a disability” and a “disabled person.”

According to Ricoeur’s approach to the problem of self-identity, any plausible theory must include the resources capable of answering the question “Who?” when asked of the person whose identity is in question. It can be seen that answering that question with a proper name is somewhat inadequate unless one already knows something about that person. An adequate answer, by contrast, would be parasitic upon a narrative conception of the self: a conception of the self which possesses the kind of unity characteristic of persons. The unity of a human life can be understood in terms of a narrative – with a
beginning, middle, and end. Certain central “structural concepts” provide a framework within which the narrative is filled out. These constitute the form of the narrative which is given content from the life of the particular person. Candidates for such structural concepts would be those such as space, time, embodiment, a “self-conception” (understood as a sense of the kind of person one wants to be (cf. Taylor 1989)), and a “self-project” (van Hooft 1995) where this latter is one’s actual attempt to enact or operationalize one’s self-conception. Of course, all lives of persons can be understood in relation to these five structuring concepts. But when disability colors the mode in which each of them is experienced, then it may be said plausibly that disability is identity-constituting: that one is disabled as opposed to being a person with a disability.

An example of this kind of approach can be found in the philosophical autobiographical writing of S. K. Toombs (1993, 1995; also Carel 2008, 2013; Merleau-Ponty 1945). She is a philosopher who developed multiple sclerosis and writes philosophically about it. She describes how, due to tiredness and muscle fatigue, the way she experienced space was gradually transformed. Distances hitherto considered short, now were perceived as much greater, thus her conception of space “as lived” became fundamental to her way of being in the world. A similar account is provided in relation to time: activities which previously took little time, such as dressing, became major tasks taking up much more time. With reference to embodiment, as many have observed, when one is healthy, one’s body is almost unnoticed, but illness changes that. The body can seem as if it is an obstacle to pursuance of one’s self-projects. In a chronic condition such as multiple sclerosis, Toombs documents how this is experienced by her in terms of the body as lived. With respect to her self-conception and self-project, radical changes were needed to this due to the levels of concentration needed to pursue analytical philosophy at the highest level which were jeopardized by the effects of MS.

So this is one illustration of a theoretical framework in which apparently contingent aspects of one’s life can be characterized as identity-constituting. This approach thus makes sense of claims to be a “disabled person” as opposed to a “person with a disability” which are made by others who become disabled in later life.

Summary Points

- Two main approaches to defining disability can be distinguished, one which focuses primarily on the individual concerned, another which focuses on factors beyond the person such as the social environment.
- In contrast to the theories of disability developed by the WHO, Nordenfelt has developed a theory which defines disability by reference to the values of the person concerned. On such a theory, a person defined as disabled by either WHO taxonomy may not be disabled.
- Some commentators hold that disability is part of their identity, is identity-constituting.

Key Terms

Disability (medical model): a physical or psychological abnormality, resulting from impairment and associated with disadvantage.

Disability (social model): a disadvantaged state caused by social factors, possibly in conjunction with the presence of impairments.

Impairment: physical or psychological state which is associated with reduced function.

Identity-constituting: a characteristic which is fundamental to a person’s identity.
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