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Disability, Impairment, and Marginalised Functioning

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ABSTRACT
One challenge in providing an adequate definition of physical disability is that of unifying 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's account struggles to deliver principled unification of the category of disability, whilst Howard and Aas's account risks inappropriately sidelining the body. We argue that this impasse can be broken by 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—unify the category of disability without sidelining the body.

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1. Introduction

Existing accounts of physical disability can be divided into two categories. Naturalistic accounts understand disability as a biological property, whereas constructionist accounts hold that it is, at least in part, a socially constructed phenomenon. 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 (physical) disabilities. Being blind, being an amputee, and having chronic fatigue are ways of being physically disabled; but the bodies, experiences, needs, and social situations of people with these conditions are not homogeneous.

In response, Elizabeth Barnes [2016] proposed an account of disability that appeals to the judgments of the Disability Rights Movement. Howard and Aas [2018] object that it doesn't explain what, if anything, those judgments 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 by proposing a novel concept—*marginalised functioning*. This concept 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. Using this concept, we develop three different models of disability, all of which unify the category of physical 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 are interested in what makes something a (physical) disability.[1] Moreover, we accept the desiderata provided by Barnes [2016: 10–13]. Accordingly, an adequate account of disability should

(i) be extensionally adequate concerning paradigm cases of both disability and non-disability
(ii) without entailing that disability is necessarily bad or suboptimal in terms of welfare; and
(iii) explain what it is for something to be a disability
(iv) 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 natural terms. One such account conceives of disability as a *negative departure from normal functioning* [Daniels 1985]. According to Boorse [1977], normal function is functioning that is statistically typical in a particular species. Since most humans are sighted, being blind is statistically atypical. Moreover, since 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].[3] 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 [ibid.: 14].[4] Similarly, being gay or lesbian is a (physical) disability on this account because it is statistically atypical and is not conducive to biological reproduction.[5] 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.

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[1] We use 'disability' to mean 'physical disability' unless otherwise stated. But, although we follow Barnes [2016] in limiting our focus to physical disabilities, in section 5.4 we explore the possibility of broadening our concept of marginalised functioning, so that it can also be applied to cognitive and psychological disabilities, and we explain why this is more complicated than one might initially think.

[2] Since our argument is addressed to those who also agree with these desiderata, we don't argue for them in this paper. However, it's important to note that some accounts are developed with different desiderata in mind.

[3] This account of normal function is not used by Boorse to define *disability* but instead to define health and disease.

[4] We attribute *marfanoid habitus*—not the Marfan *syndrome*—to Phelps. The former is a constellation of symptoms resembling those of the latter.

[5] Of course, not everyone agrees that being gay or lesbian is a *paradigm* case of *non*-disability, but note that naturalistic accounts claim that being gay is or lesbian is a *physical* disability. So, it matters whether we are discussing physical disability only, or disability more broadly.

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 socially. 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 (wrongful) social phenomenon. As Michael Oliver [1996: 22] puts it, 'it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society.' On this view, then, even if Michael Phelps *has an impairment*, he *is not disabled* because his impairment isn't operating as the basis for social exclusion.

However, the Social Model inherits some of the problems faced by naturalistic accounts of disability [Barnes 2016: 25–7]. To see this, notice that being gay or lesbian counts as a (physical) disability on the Social Model: it is an impairment because it is a negative departure from normal functioning, and it is a disability because sexual orientation *is* a site of oppression. This might not be a knock-down objection, but, for those troubled by this consequence, several alternative constructionist routes are available.

One option is to deny that there is a distinction between impairment and disability that maps onto 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 to 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. Tremain's 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 these desiderata and 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 are better able to satisfy the desiderata to which we're committed.

4.1 Barnes's Solidarity Model

Barnes appeals to the judgments made by the Disability Rights Movement (*DRM*) on the basis that activists must distinguish between those conditions for which they are seeking to promote justice and those that fall outside of their purview. Hence, Barnes offers the following account of disability [2016: 46], which Howard and Aas [2018: 1156] call the '*Solidarity Model*':

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

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'—namely, by 'judgements about solidarity' [ibid.: 47]. Barnes appeals to the judgments made by the *DRM* because she thinks that it's impossible to give an adequate independent account of *which* physical conditions these judgments are tracking. Nonetheless, Barnes claims that these judgments 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 not be either explicit or transparent, but can be extrapolated from the judgments 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 [ibid.: 45]

> 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.

To summarise, on Barnes's view, to be disabled is to have one of the bodily 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.[6] 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, we raise a Euthyphro-style dilemma for Barnes:

> Either (a) the judgments of the *DRM* are tracking something;
> or (b) the judgments 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 judgments of the *DRM* are tracking. Accordingly, she endorses (b), which involves 'rigidifying on the *actual*, *present* rules for making solidarity judgements' [ibid.: 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 that there is a possible world W* where people with (what we would think of as) acquired disabilities are not discriminated against, but where people with

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[6] Employing cluster-concept reasoning will result in vagueness and borderline cases [2016: 45] as well as indeterminacy [ibid.: 49–50]. Like Barnes [ibid.: 50], we do not find this problematic.

(what we would think of as) congenital disabilities are. Further, suppose that in W* there is a movement (the *DRM**) that fights for justice for people with congenital disabilities but not for those with acquired disabilities. According to Barnes, people in W* with *acquired* disabilities are, in fact, disabled because the *DRM* in *our* world counts them as disabled, even though the *DRM** doesn't. It strikes us as odd to prioritise the rules of the *DRM* over the rules of the *DRM** in determining whether an inhabitant of W* is disabled. In other words, although the judgments of the (actual) *DRM* are rule-based, those rules could easily have been otherwise, and so we worry that enshrining them in the definition of disability is arbitrary.[7]

Howard and Aas [2018: 1127–8] make a similar objection, and Barnes [2018: 1156–7] herself concedes that her account suffers from a problem of this sort. For Barnes, then, her account appears to be a fall-back option motivated by her dissatisfaction with existing models [ibid.: 1151].

4.2 Howard and Aas's Social Exclusion Model

Howard and Aas offer an alternative—the '*Social Exclusion Model*' [2018: 1128–9]:

> 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, and
> (iii) in the dominant ideology of C, that someone in x has an impairment explains why they can be appropriately pitied, stigmatised, and excluded from socially valued activities and statuses.
> (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.

For Howard and Aas, what matters for disability is the *social perception* that some condition is an impairment, rather than whether it *really is* an impairment [ibid.: 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' [ibid.: 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 [ibid.: 1121].

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

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

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]. On 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 *judgments* about bodily differences. As Howard and Aas [2018: 1130] put it, '[d]isability … is about an ideology of impairment, not necessarily impairment itself', allowing society to be wrong about which conditions are impairments. Bodily difference is thus two steps removed from disability on the Social Exclusion Model.[8] Although this model 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.

Here we take Barnes to be introducing a new desideratum for an account of disability: not sidelining the body. This desideratum appears to be motivated by the thought that '[d]isability is, at least for many people, a combination of social factors … and more personal, embodied, and sometimes even medical factors' [Barnes 2018: 1158]. Although we are sympathetic to Barnes's criticism that the Social Exclusion Model, in sidelining the body, 'miss[es] something crucial about the nature of disability' [ibid.: 1161], we note that the lived experiences of disabled people are extremely complex and heterogeneous. Hence, Howard and Aas may wish to claim that the way in which the Social Exclusion Model sidelines bodily difference is not problematic.

We will not assess the prospects for defending this claim, however. Our aim at present is simply to outline the current impasse in the literature. The challenge is to unify the heterogenous bodily conditions that are relevant to disability. Barnes's Solidarity Model struggles to offer a principled non-arbitrary unification, in virtue of relying on the rule-based judgments of the *DRM* rather than appealing directly to the similarities in features of bodies that justify those rules. In contrast, Howard and Aas appeal to exclusionary social treatment and an ideology of impairment to define disability. This delivers a more principled unification at the putative cost of sidelining bodily features. Importantly for our purposes, both parties seem to agree that we cannot provide a principled unification of the category of disability by appealing directly to features of disabled bodies.

5. A New Concept: Marginalised Functioning

We propose to break the impasse by 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 by developing models of disability that unify the category without sidelining the body.

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[8] Hence, on that model [2018: 1129–30],

> 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.

5.1 Introducing Marginalised Functioning

The concept that we have in mind concerns the relationship between the bodily capacities of individuals and the presuppositions about bodily capacities that shape the social contexts in which those individuals are situated. Consider the inclusion of stairs in buildings. Decisions about how to design buildings reflect a set of norms about what people are typically physically able to do—for example, that people can climb stairs.[9] Of course, some people are not able to physically function in the ways that these norms presuppose. There is something 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.[10]

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 are conceived of as special accommodations, the initial assumptions represent norms that serve 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 can walk up and down steps, and so the building includes steps. However, the designers recognise that some people cannot use stairs—because they use wheelchairs, say—and so they include ramps or lifts in the building. However, they needed to consciously remember that some people cannot use stairs, whereas they did not need to consciously remember that, say, people cannot move between different floors of a building without some kind of provision. That is, even when ramps are built, they are typically—although 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 it differently, a design for a building with *no* provisions for moving between different levels would be regarded as ludicrous; whereas a design for a building with stairs but no ramps would *not* be regarded as ludicrous (although it would be discriminatory). Under these circumstances, the norm 'people can use stairs' serves as a default in the sense we have in mind.

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[9] 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: ch.1].

[10] We note that our concept of marginalised functioning has some interesting points of connection with Elizabeth Guffey and Bess Williamson's 2020 'design model of disability'. We agree that 'design—broadly conceived as the processes of planning and making the material world—played an active role in shaping the meaning of disability in the modern world.' However, marginalised functioning differs from the design model, since the latter focuses on 'the way that design has been deployed as a "fix" for the psychological and social experiences of disability' [ibid].

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 these: '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.'[11]

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. Therefore, simply being unable to do something that *most* people are able to do doesn't automatically constitute marginalised functioning. For example, 'people can swim' might be a true generic, but it's not a norm that is used to structure our social world: we have footpaths, not swimming canals. Hence, being unable to swim doesn't count as having marginalised functioning. As another example, most people can roll their tongues, but some can't. 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.[12]

Of course, there will be borderline cases. Consider the norm of serving caffeinated beverages at a conference. Does someone who has a caffeine intolerance thereby have marginalised functioning? Conference organisers do tend to assume that people can drink (and enjoy or even need) caffeine. 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, arguably, the norm 'people can drink caffeine' isn't playing a role in structuring social interactions, even at academic conferences, which means that those with a caffeine intolerance don't thereby have marginalised functioning.[13]

What of 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's drinks receptions, non-alcoholic beverages may be seen as a special accommodation for those who cannot drink alcohol. Moreover, there may be some 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.

It's also important to note that many of the norms in *N* are time-sensitive. Moreover, there are many norms in *N*, and often, in order to engage in a social activity, we must

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[11] Or 'dialect' (rather than 'language') if the variations between dialects of a language are sufficiently different.

[12] 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. In section 5.2, we say more about what counts as a relevant context.

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

satisfy multiple norms, either at the same time or one after another. To see this, note that not only is a university campus designed with the assumption that a student can walk from one building to another in, say, ten minutes (between classes), but that the student can pay attention to the lecture or participate in discussions immediately after that walk.

Another complication is that some norms include information about assistive technology. For example, most, if not all, norms about vision allow for the use of glasses or contact lenses, although many norms about mobility don't 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 wheelchair-users. Relatedly, many norms will have in-built expectations about *who* will be navigating the social spaces. For example, norms governing spaces where children are not expected to be present without adult supervisions 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 under the supervision of an adult who assists them when necessary. In this sense, accompanying adults function rather like commonly accepted 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 does 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 does 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 the case of **Anne**, who has achondroplasia and is a 4-feet tall adult. Anne has marginalised functioning in the contemporary UK. Given the placement of light switches, the height of the buttons in lifts, how high ATMs and pumps at petrol stations are located, etc., that 'people can reach things that are at least 1.5—metre high unaided' is a norm that serves, in the contemporary UK, as a default for the purpose 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 her. A particular building may be specially designed with needs like Anne's in mind. But, since the design of this building is conceived of as a special accommodation for people like Anne, the initial assumptions represent a norm that serves 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, people are situated in many overlapping social contexts at once. Consider now the case of **Beatrice**, who is a D/deaf person who has been D/deaf since birth. 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 and 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 onto 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 the contemporary UK, could corroborate the seemingly incompatible claim that D/deafness is a *paradigmatic* case of disability. We 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's 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.[14] 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 bodies such as Anne's. In this world, it would be wrong to think of her 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 special accommodations, rather than as the default way of structuring the social environment.

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[14] Even if these norms set an upper limit on arm span such that someone whose arms are so long that they cannot walk unaided would fail to satisfy them, this is clearly not the case for Phelps.

Conversely, being marginalised in virtue of bodily difference does not entail having marginalised functioning. Consider **Sam**, who has a noticeable skin disfigurement on their hands that does not affect their sensation or movement. Suppose that people, especially strangers, avoid shaking Sam's hand because of the 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, others' perception or treatment of Sam doesn't 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).[15]

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, say, but, of course, they weren't physically incapable of using them. Therefore, being a person of colour even in an extremely racist society doesn't amount to having marginalised functioning.

We think that a similar point applies to other kinds that involve oppression enacted on the basis of actual or perceived bodily difference. 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 groups may end up having marginalised functioning in some specific limited respects. For example, some male-dominated occupations may not have equipment that is suitably sized or positioned for an average-sized woman. Similarly, some trans men might not be able to comfortably use urinals (even discounting concerns about transphobic responses from other bathroom-users). Accordingly, some women and some trans men have a degree of 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. Moreover, the marginalised functioning that someone may experience on the basis of social group membership, such as gender or trans status, is only a small part of their experiences. Most gender oppression, for example, is not centred on inappropriately sized equipment.

Since one objection to naturalistic accounts was that they entail that being gay is a physical disability, it is worth exploring whether being gay amounts to having marginalised functioning. Although some norms that structure the social world are heteronormative, by and large they are not such that someone who is gay cannot *physically function* in accordance with them. For instance, a gay man is physically able to bring a woman date to a dinner party, even though he is unlikely to wish to do so. Perhaps fertility clinics (or health insurers) that refuse to treat (or to cover treatment for) same-sex couples might seem like a context in which people in same-sex couples have marginalised functioning.[16]

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[15] Facial disfigurement is counted as a disability for the purposes of discrimination law in the United Kingdom and elsewhere. Given the specificity of the protected categories in much discrimination legislation, if disfigurement-based discrimination is to be included, disability seems like the closest protected category under which it can be included. Since discrimination 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 account of disability.

[16] Thanks to an anonymous referee for suggesting this case.

However, such clinics or insurers usually treat or cover different-sex couples whose relevant physical capabilities (to produce gametes, or to carry a pregnancy) are just the same. This suggests that same-sex couples are discriminated against in this case *despite not having marginalised functioning*. And even if some such cases involve some marginalised functioning, it will be in a narrow set of contexts, meaning that being gay is not straightforwardly an instance of 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 accounts 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 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, in order to determine whether an individual has marginalised functioning, we look to whether she lacks some capacity to physically function in accordance with the default social norms in the relevant contexts. Suppose that someone's OCD means that they cannot shake hands, because the prospect of doing so 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. This expanded concept, then, could feature in an account of disability *simpliciter*. Although this is a promising thought, it requires further exploration, for which we lack the space here. This is because of two features of our concept. 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, 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 are norms about *physica*l functioning. Hence, 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 of 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. (Suppose that Dan could learn to sing *Bella Ciao* if someone helped him with the phonetics of the Italian lyrics.) Elena has lived in Italy all of her life but cannot communicate in Italian, or indeed any other language, due to a cognitive disability. If we extend our definition to apply to all functioning, physical and non-physical, then 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.

These obstacles could be overcome by introducing a new feature that speaks to our capacities to learn *and* to specify the right kinds of (typical) circumstances. But we lack the space to explore this feature, especially since the capacities and circumstances that are relevant would vary greatly among different non-physical disabilities. So, here, we can only propose an account of marginalised functioning that is restricted to physical functioning, although we note the potential for an expanded concept.[17]

6. New Directions for Disability and Impairment

We now return to the impasse identified at the end of section 4. The difficulty lay in providing an account of disability that specifies *which* bodily differences matter for disability, and that says how they are unified. Faced with this difficulty, Barnes opts to make bodily difference central, and to appeal to the judgments of the *DRM* in order 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—an implication that Barnes finds unpalatable. This makes it seem as though we need to decide which is more important—centring the body, or principled unification. However, the notion of marginalised functioning enables us to construct models of disability that deliver principled unification whilst centring the body, thereby rendering this choice unnecessary.

Recall that what matters for marginalised functioning is whether 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 or impairment.

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

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[17] We should note that, while Barnes [2016] restricts her account to physical disability, Howard and Aas [2018] do not. This introduces an added complexity in comparing the models of disability that we develop in the next section with the Social Exclusion Model, although not with the Solidarity Model.

stigma in more detail below. For now, we 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 to 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 that 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: 32–3]—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. This *Simple 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 that prevent one's marginalised functioning giving rise to any 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. Moreover, this model can explain the contested status of D/deafness as a disability, since whether D/deafness constitutes marginalised functioning is context-dependent.[18]

However, one might argue that this model faces some serious counterexamples and thus cannot satisfy desideratum (i). Consider **Cora**, who has a fall on a climbing trip and severely fractures her leg. Her leg will eventually heal, but suppose that she must use a wheelchair for at least a month. When 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

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[18] Recall our discussion of Beatrice in section 5.2.

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 in the third trimester of pregnancy. Thus, the defender of the Simple Model must bite the bullet and claim that someone like Cora *is* disabled (albeit temporarily).

We don't think that this is completely implausible. After all, Cora 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. Although questions of paradigm status can be controversial, arguably, cases such as that of Cora are not *paradigm* cases of non-disability.

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.[19] 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 traditional Social Model, to be disabled is to be oppressed on the basis of having an impairment.[20] One challenge was that of offering an adequate account of impairment. So, one natural option is to equate impairment with marginalised functioning, and to claim that to be disabled is to experience some form of oppression on the basis of impairment.[21] Our *Social Model Redux* improves on the traditional Social Model, because marginalised functioning is not *naturalistic*, and therefore avoids the problems of naturalistic accounts of impairment, whilst also keeping a direct focus on the body.[22]

This model avoids some of the putative counterexamples to the Simple Model: Cora (with a broken leg) 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 misogynistic 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.

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[19] On the other hand, one might argue, even given ameliorative aims, that it would be good for the account to allow us to examine critically our pre-theoretical intuitions about whether heavily pregnant people, say, are disabled. Hence, the fact that the Simple Model counts heavily pregnant people as disabled might not be a cost of this view. (Thanks to an anonymous referee for this point.)

[20] 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].

[21] 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 [Haslanger 2012; Barnes 2016: 28–33], or at the level of a certain sort of bodily state, as with Howard and Aas's account [2018].

[22] It is important to note that what we say about the Social Model in this section does not necessarily apply to the Social Exclusion Model, in virtue of the latter's different structure. It might be possible to craft a version of the Social Exclusion Model that incorporates the notion of marginalised functioning, perhaps to cash out the idea of an 'ideology of impairment' in a way that accords the body a more central role. However, we lack the space to explore this here.

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—although 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*.[23] We lack the space to engage with these issues. However, for our purposes, it suffices that the Social Model Redux fares no worse than do the existing versions of Social Model with respect to this desideratum, and it fares significantly better when it comes to defining impairments.[24]

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 to use a non-normative criterion to pick out a subset of cases of marginalised functioning that constitute disability. This might appeal to those who, like Barnes, are reluctant to build oppression into an account of disability, but who are nevertheless troubled by the implications of the Simple Model. 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 those with a duration of three months are not. 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.[25]

The main challenge for a proponent of the Restricted Model is to show that the restriction of disability to lasting impairment is not an *ad hoc* attempt to avoid counterexamples. We think that the best way to meet this challenge is to argue that limiting disability to lasting impairment not only avoids putative counterexamples, but also allows the category of disability to perform useful political work. After all, a lasting case of marginalised functioning gives rise to different interests than does marginalised functioning of short duration. To see this, compare Cora—who currently uses a wheelchair, but expects to stop doing so in one month—with **Cam**, who uses a wheelchair 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. 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 arguably gives a principled reason for thinking that *individuals with lasting marginalised functioning*

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[23] Using Barnes’s terminology, being oppressed may not be a *global* bad, even if it’s a *local* bad [2016: 80–3].

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

[25] 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 note 6.)

form a socially significant—albeit fuzzy—kind around which it makes sense to form a social justice movement.[26]

The duration of marginalised functioning has other implications. For one thing, having marginalised functioning that is lasting rather than brief is more likely to affect one's sense of self and to be incorporated into one's identity. Of course, experiences need not be lasting to become part of one's identity. Someone who has been married for many years might never really think of herself as 'a wife', whereas 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 such 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 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 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, the Restricted 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

We have argued that our concept of marginalised functioning, which concerns the relationship between our bodily capacities and our social world, can be used to construct different models of disability. Each of these unifies the heterogeneous conditions that count as disabilities without sidelining the body, thus breaking the impasse we identified.

The three different models of disability that we have outlined also have, at least, four 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 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

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

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 that 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, it is clear that the novel concept of marginalised functioning opens up fertile ground for constructing models of disability.[27]

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