

Review Article

Bourdieu meets Foucault the medicalization and (in) visibility of the disabled body

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ABSTRACT

The world health organization estimates that 15 percent of the global population, or over one billion people, live with some form of disability. Yet, many disabled people remain invisible, living in poorly adapted places, or not having full control over medical decisions they want to make over their very own bodies.

Historically, biopower emerged with the transformation of power structures in Western societies in the 17th century but had its most drastic development in the 18th century. The sovereign whose sword could take or pardon life got replaced by a complex society which developed the power to life; this is, the mechanisms to care for, limit, and even terminate life. Whereas the power of the sovereign is a power that “lets live”, bio power is a power that “makes live”. It targets life as to improve, optimize and ensure it.

Along with bio politics, a new type of medicine developed, whose main function was to ensure public hygiene. Institutions centralized the power of this new medicine, integrated its knowledge and coordinated the care given to the patients. Bio politics also was concerned with estimates and forecasts, so that regulatory mechanisms were put into place to prescribe norms, seek out averages, and compensate for variations in “the general population”. For Foucault, the body (not mattering whether disabled or not) isn’t there a priori but rather constructed through discourse. Human sciences such as medicine produce a discourse, a knowledge that shapes how the disabled body is perceived and treated. The contemporary disabled subject has then emerged in tandem with the vast apparatus put in place to secure the well-being of the general population.

This machinery has been comprised of asylums, income support programmes, special education programmes, rehabilitation regimes, prostheses, and prenatal diagnostic procedures, among many others. These practices have been methods to classify, codify and manage social anomalies, and through which people have been divided from others and labelled as (for example) “physically impaired” “insane” “handicapped” or “deaf”.

Similarly, as Foucault described in the birth of the clinic the process of medicalization shifted the location of care from the home to hospitals, especially after World War II, because it was assumed that this would increase efficiency. This has now become an accepted truth, and we usually assume that better care can only be gotten outside the home. If a person is indeed, discharged and transferred into their home, the personal care services received might be highly medicalized, a service that could look very different under the “independent living” model developed by people with disabilities. Another negative impact of medicalization for the disabled population is that if they’ve been defined as vulnerable or unable to speak or judge for themselves, then someone “who knows better” is given the power to make the important decisions. Here, the Foucauldian notion of the construction of discourse shines through. So, there is no real appeal to medical decisions, at best one can none comply or refuse treatment.

Keywords: Medicalisation, Handicapped, World Health Organization (WHO), Alienation, Bio power

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INTRODUCTION

Few things are as painful for the human soul as a constant feeling of alienation. Yet, this is the reality given in the daily lives of many disabled people. Fortunately, disability is increasingly being recognized as a universal human condition with enormous social and economic consequences. The World Health Organization estimates that 15 per cent of the global population, or over one billion people, live with some form of disability [1]. Yet, many disabled people remain invisible, living in poorly adapted places, or not having full control over medical decisions they want to make over their very own bodies.

Taking a closer look at the disabled body from a sociological perspective means flying against the trend that asks sociologists to understand society through abstractions such as structure, class, and function. Instead, it requires us to do as Bryan Turner did, "To bring the body back" and make it the axis of our exploration. The disabled body should be read as a multi-dimensional medium for the constitution of society because it's formed in the interaction with it: through labelling, perception, diagnosis, and discourse. For the body is a generative of the properties of social structures, as much as the location for their effects to show. We need a lucid guide through the density of the sociology of the body and disability theory, and that's where our theorists come in.

While it might not seem so at first glance, there are a few natural connections between Foucault's and Bourdieu's work. Even if Foucault's analysis of medicalization may be fraught with ambiguities at times, it seems useful for establishing an explanation for medicine today and for presenting an astute interpretation of modernity. Even though he did not explicitly address disability in his writings, he was one of the first and most persuasive in describing how through discourse constructed surrounding knowledge of "the normal case" differences between people turn them into targets of control. Key to Foucault's work is the motivation to question everything, particularly what is seen as natural or inevitable [2].

Following his and Illich's analysis, we can see that the development of modern medicine has occurred in tandem with a profound medicalisation that has changed the meaning of health and disease. People with disabilities have not escaped this process, which has made them the winners as much as the victims. The objective of this paper is by no means not to entirely demonise this process, but to approach it as something with upsides and downsides, and to offer theoretical elements to allow for a better understanding of its impact on the disabled body.

Pierre Bourdieu's work provides a framework to understand how our position on the social ladder is shown on our bodies and is expressed in our mannerisms. For Bourdieu, each body is a result of the compositions of diverse capitals acquired through a lifetime, and it can be a powerful tool or a handicap [3]. One of the aims of this paper is to explore how his approach can be used to analyse the body and understand the inequalities that are ubiquitous in the lives of disabled people. In doing so, we can explore to which extent we can view disability as more of an institutional rather than an individual problem and how the definitions of disability and its realities are rooted in social, political, and economic interactions and structures. Especially since the 1970's, disabled people in countries such as the United Kingdom have started to challenge their marginalisation and isolation and have centered on self-organised movements led by the disabled and for the disabled that have also been documented

elsewhere in the world. They are speaking up for themselves, demanding civil rights and not tolerating exclusion and silencing anymore [4]. Of course, the disabled community is far from homogeneous, and each individual faces different struggles. There's a big difference in the life of a person with a disability that can move freely, and one that is always exposed and vulnerable. As an illustration, women with disabilities are two to three times more likely to be victims of physical and sexual violence.

I have chosen this question because it seems to me that the similarities between Bourdieu and Foucault are somewhat under-analyzed, and I'd like to see which bridges can be built, given the importance of both French theorists. The challenges surrounding the lives of disabled people are an important social issue that needs to be addressed in academia. I want to see in how far sociology of the body can be applied in conjunction with disability theory to use the conclusions for practical improvements and better policy. My aim is to outline what the effects of medicalization are, and how fruitful concepts such as the habitus, field and symbolic violence will be to understand the social perception of disability.

Included in this question are how the contemporary disabled subject has emerged in medicine, and how the (in) visibility of disability operates in the social context. Nobody is exempt from the possibility of having a disability. It might as well be a reminder of the frailty of human existence, the brutality of life as a consequence of embodiment, and the process of aging.

LITERATURE REVIEW

Bio power

Michel Foucault introduced a new conception of power during his time lecturing at the Collège de France, that he claimed to have been widely ignored in political philosophy. This form of power is crystallised in the final chapter of the first volume of the history of sexuality. The concept of "bio power" and the derived "bio politics" is central to any Foucauldian analysis of disability.

Historically, bio power emerged with the transformation of power structures in Western societies in the 17th century but had its most drastic development in the 18th century. The sovereign whose sword could take or pardon life got replaced by a complex society which developed the power to life; this is, the mechanisms to care for, limit, and even terminate life. Whereas the power of the sovereign is a power that "lets live", bio power is a power that "makes live". It targets life as to improve, optimise and ensure it [5].

For Foucault, this power evolved in two directions, the anatomo-politics of the human body (discipline of the body to make it useful for capitalist society) and the bio politics of the population (the management of birth, death, behaviour, health, and sanitation). The bio politics of the population required an enormous collection and interpretation of data in order to produce the knowledge which led to the birth of demography and statistics (ibid).

Along with bio politics, a new type of medicine developed, whose main function was to ensure public hygiene. Institutions centralised the power of this new medicine, integrated its knowledge and coordinated the care given to the patients. Bio politics also was concerned with estimates and forecasts, so that regulatory mechanisms were put into place to prescribe norms, seek out averages, and compensate for variations in "the general

population”.

For Foucault, the body (not mattering whether disabled or not) isn't there a priori but rather constructed through discourse. Human sciences such as medicine produce a discourse, a knowledge that shapes how the disabled body is perceived and treated. The contemporary disabled subject has then emerged in tandem with the vast apparatus put in place to secure the well-being of the general population. This machinery has been comprised of asylums, income support programmes, special education programmes, rehabilitation regimes, prostheses, and prenatal diagnostic procedures, among many others. These practices have been methods to classify, codify and manage social anomalies, and through which people have been divided from others and labelled as (for example) “physically impaired” “insane” “handicapped” or “deaf” [6].

Habitus and discipline

The habitus describes a set of norms and expectations unconsciously acquired by individuals through experience and socialisation as embodied dispositions, internalised as second nature, predisposing us to act spontaneously in certain ways within the constraints of particular social fields. It includes ways of seeing, moving, talking, and so on. It functions to mediate between individual subjectivity and the social structures of relations [7].

In *Outline of a theory of practice* Bourdieu writes: “Through the habitus, the structure which has produced it governs practice, not by the processes of a mechanical determinism, but through the mediation of the orientations and limits it assigns to the habitus operation and invention.” So, the habitus could be described as an orchestration without a conductor, similar to Foucault's idea of docile bodies and the panopticon, where the subject is at the same time the observer and becomes both productive (because the surveillance turns the body into an object of knowledge) and effective (because it becomes calculable and compliant).

For Bourdieu, the processes by which individuals are then governed are neither strictly external nor internal and understanding them doesn't require any set of formally stated rules. So, no sovereign power has to necessarily exist to direct the actions of the actors within the fields. This way, actions are not predetermined, nor do they exist alone, instead they are bound up within references to the past, within agents motivations for action, and within the cultural contexts that regulate and order the courses of such action. The habitus then sets norms without the need for any specific or overt structuring agent. It is here where we can find a bridge toward Foucault's notion of discipline [8].

No formal set of rules was established to implement the discipline, it was understood as the ordered way to live, the way culture was regulated in every social arena, and it was taken as the natural way of living. It permeated every aspect of life, so that questioning it became almost unfathomable. Discipline had long existed in places such as monasteries or the army, but in the course of the 17th and 18th centuries, it became a form of living for the general population. The era of disciplinary life characterized the habitus of the individuals. The taken for granted and regulated, yet altogether unspeakable way of existing within the boundaries and definitions of these structures constituted a state of being handed down by no one yet accepted by everyone. We can see the connection to Bourdieu because the homogeneity of the habitus is what makes rituals, mores, and

practices to be immediately recognised and taken for granted.

The connection of the habitus and the disciplines in Bourdieu's and Foucault's work present a unique standard of cultural existence that embodies ways of ordering and regulating the social without a formal explication. In both works, the individual agents are missing, such that no discussion of them is warranted because the way of living is produced on a large scale, reproduced by those practicing it, and fortified within the boundaries of established order through the modes of habitus and discipline.

Symbolic violence and govern mentality

“If power were anything but repressive, if it never did anything but say no, do you really think one would be brought to obey it?”. Foucault's theory of disciplinary power and Bourdieu's theory of symbolic power are among the most innovative attempts in recent social thought to come to terms with the increasingly elusive character of power in modern society.

In language and symbolic power Bourdieu puts it this way “for symbolic power is a power of constructing a reality that is invisible power which can be exercised only with the complicity of those who do not want to know that they are subject to it or even that they themselves exercise it”

Just like Foucault sees bio power as a form of somatised power, so does Bourdieu speak of somatisation of the ruling structures. Symbolic violence is then rooted in the body because it operates in it. Abnormalities and deviations from “the normal”, which can be perceived in the body, and which are framed as health relevant, or performance reducing are generally regarded as a priorly given and medically definable damage or impairment rather than a socially differentiating characteristic. If one goes further with Bourdieu's approach, then the medical categories that are used for impairment or damage, should not be read as ‘natural’ but as historical, cultural, and political constructions. Not only with Foucault, but also with Bourdieu, one can argue for a reversal of the analytical view: Disability is not a dependent variable found in a causal relationship resulting from body dysfunction, but rather the construction of disability has the function of creating the naturalised intervention level of impairment, making the latter seem a pre-existing natural phenomenon, rather than a social one [9].

The concept of symbolic violence also contains another presupposition: What is meant are relations of domination that act as violence, namely not only by expecting subordination but also by enforcing it. On a material and concrete level, disability is in fact a matter of relations of violence if we look at the coercive apparatuses surrounding it. An arsenal of rehabilitation techniques ensures the smoothest possible integration of those classified as “disabled” in the systems communication, consumption and production processes, promising (or forcing) an adaptation to a non-disabled order. For those affected, this attribution has very real and very disadvantaging effects. As a social position, disability is socio structurally associated with discrimination, precariousness, and the risk of impoverishment, whilst being institutionally associated with exclusion and lower participation.

Softness and symbolism are the disguises that the exercised power has to wear in order to be accepted by the dominated. More precisely, the care offered to disabled people comes with the promise of being “gentle” “compassionate” “charitable” or “generous”. In the case of disability, symbolic violence appears

benevolent, supportive, even. Only this way would the dominated accept the relations of violence to which they are subject. In these instances, the authorities forming the discourse of and diagnosing disability, are well meaning doctors and not, for example, Foucault's prison guards. These interventions are legitimised by relying on consent and appealing to the self-interest of the affected, who are left with no choice but to submit since, after all, who would want to refuse the glittering promise of integration?

In Bourdieu's thought, symbolic violence has become doxa, because it is seen as "the normal way of living" and people simply accept it as it is. Although there are some differences between Bourdieu's and Foucault's approaches to power, we can draw a parallel between symbolic violence and governmentality. According to Jensen, Foucault first traced the word 'government' back to Machiavelli's the prince, where the ruler governs without much concern for his population. He then turned to an opposing view and found Guillaume de La Perriere's definition of government as "the right disposition of things" (notice here how this reflects Bourdieu's idea of doxa).

As I have illustrated in the section on bio power, Foucault argues that sovereign power transforms into disciplinary power, and then into governmentality through surveillance and control. Sovereignty's objective is to make people obey, and it would use laws to do so. On the other hand, we've got governmentality, where the population is controlled without its full awareness, a concept closer to Bourdieu's symbolic violence. In short, governmentality is all about using patience, wisdom, diligence, and subtle techniques to create welfare for the general population.

The medicalization of disability

Being human in a time of "normalcy or pathology".

Following Foucault, knowledge gives us power over others, and the power to define others. And who has more authority in the modern world to define us than a doctor?

Medicalisation is the process in which non-medical issues are redefined in terms of illnesses or disorders to be treated. The notion of medicalization is closely linked to Ivan Illich's Pathogenesis. For Illich, the medical profession has become a threat to the health of societies, because of misdiagnosis or the loss of autonomy. Social Pathogenesis refers to the process of society becoming dependent on the medical system. In his book *Medical Nemesis: The expropriation of health* he writes: A radical monopoly feeds on itself. Iatrogenic medicine reinforces a morbid society in which social control of the population by the medical system turns into a principal economic activity it labels the handicapped as unfit and breeds even new categories of patients. People who are angered, sickened, impaired by their industrial labour and leisure can escape only into a life under medical supervision and are thereby seduced or disqualified from political struggle for a healthier world.

So, an individual who is disabled would not have the capacity for self-care that is expected by society and will need someone who is responsible for their health throughout their lives. We could see it as a troubling phenomenon when an institution or conjunction of actors gains exclusive expertise over one particular domain. This has been most concretely seen in the application of medicine and the concepts of health and illness to aspects of daily living, including disability. A reading of medical texts or magazines clearly documents the permeation of medicine

to a wider range of social arenas; be it implementing healthcare programmes at schools, trying to decide who should be "allowed" into this world, or who should be "helped" out; the very fragile elderly or those with Alzheimer's disease [10]. In its initial wave of popularity, the phenomenon of medicalisation was seen as a reform; a replacement of the mystical with the objective and the progressive, but in recent years its results have been recognised as mixed. This is not to downplay the importance of this development; the evolution of medicine has had many very positive impacts on humanity, but it certainly is no panacea, especially regarding societal issues. Childbirth is one of the examples where medicalisation has had significant benefits, diminishing the chances of maternal and child mortality.

Growing old or having a disability (two phenomena that often go hand in hand; all disabled people who don't suffer from a sudden death will grow old, and many people growing older will end up with a disability) are not themselves pure medical conditions. As such, they have benefited as much as suffered from their association with medicine, and they will continue to do so. Some of the positive effects of medicalised policy could be the protection of healthcare when budgets are being cut or architectural adaptations for better access to disabled residents. As apparent from my disquisitions so far, I am however more concerned with the rather negative impact of the phenomenon. Conrad and Schneider so outline the disadvantages:

- Being medical doesn't guarantee universal and continued humanism. Being "kept" until cured can be a deprivation of civil and human rights, and hospitals and nursing homes have often been exposed for their unliveable conditions.
- Overgeneralisation of a disease/medical model. All aspects of life come under scrutiny with the resulting objectification of the patient. The authority of medical expertise sometimes negates the right of appeal, and thus the ability of patients and their families to question certain decisions.
- A shift in levels of responsibility. The notion of "sin" may still lurk below the surface, the individual living with a disability may not be blamed for having a disability, but for "what they do about it" and for not "overcoming" their disability.

Following these issues, the increasing usage of advanced technologies to assist people with disabilities can make sense from a cost effectiveness perspective, but it somehow obscures the fact that replacing a body part with a machine, or a caregiver with a robot could objectify and invalidate the disabled individual even more. It's difficult to find humans to engage in such intimate tasks as dressing, feeding, or bathing, but the promise of technology might just be a short-term gain. Medical care is not a technological task, but one that involves quite a few personal aspects. Human qualities can't simply be replaced by mechanical skills.

Similarly, as Foucault described in the birth of the clinic the process of medicalisation shifted the location of care from the home to hospitals, especially after World War II, because it was assumed that this would increase efficiency. This has now become an accepted truth, and we usually assume that better care can only be gotten outside the home. If a person is indeed, discharged and transferred into their home, the personal care services received might be highly medicalised, a service that could look very different under the "independent living" model developed by people with disabilities [11]. Another negative

impact of medicalisation for the disabled population is that if they've been defined as vulnerable or unable to speak or judge for themselves, then someone "who knows better" is given the power to make the important decisions. Here, the Foucauldian notion of the construction of discourse shines through. So, there is no real appeal to medical decisions, at best one can non-comply or refuse treatment.

The provision of care is no more seen as infinite. Economic and material resources are increasingly perceived as limited and in need of rationing. When this happens, some segments of the population are ruthlessly seen as "less deserving" or "unworthy". It comes as no surprise that such groups are often of lower socio-economic status or minorities. It's no accident that groups labelled as "the fragile elderly" or the "very disabled" are particularly vulnerable because they are also less powerful. Doctors having to choose who would get devices for assisted breathing and who would have to renounce during the heights of the Covid-19 pandemic in countries such as Italy or Spain is one of the most recent and horrifying examples.

The rise of industrial capitalism excluded disabled people from the process of work and its consequent social relations. But it also changed the way individuals viewed themselves and others. It encouraged the view of people being a commodity for sale in the labour market. To this day, the requirements for the capitalist economy remain for individuals to sell their labour in a free market.

The body of individuals and the body of populations appears as the bearer of new variables, not merely between the scarce and the numerous, the submissive and the restive, rich and poor, healthy and sick, strong and weak, but also between the more or less utilizable, more or less amenable to profitable investment, those with greater or lesser prospects of survival, death and illness, and with more or less capacity for being usefully trained. Ultimately this implementation lay as the foundations of capitalism, the "birth of the economy" and thus the able bodied and disabled were segregated to maximise the economic potential of the population. Disabled people were pushed to one side and sent to be "corrected" or "normalised" in asylums or rehab clinics.

The theory of the panopticon can also help us understand the relationship between governmentality and power because the idea of surveillance from a clinical gaze is still a key element. The doctor becomes a prominent figure in constructing the discourse surrounding disability, he becomes the advisor given administrative responsibilities, and ultimately given the role of observing, correcting, and improving the social body.

How disability has come to be seen as an individual problem can be well understood with Foucault. The idea of disability only becomes possible if we have the idea of individual able bodiedness/mindedness, even if it's taken for granted. For example, in an attempt to mainstream disability equality, the UK government colonised the social model of disability during the 90's, adopting it through various departments, and using it to justify their cutting of social health care services, indulging in a personalisation that dismantled the structures of the state, especially in relation to disabled people. Residential institutions were closed in favour of individual living in community settings, special schools were closed in favour of mainstream education, and disability medical provision (such as physiotherapy) was restructured to become an individual service rather than a group activity. The individual is the expert.

It is argued that the contemporary concept of disability is linked

to the rise of industrial capitalism and the ability of an individual to operate dangerous machinery in competition with his peers. Prior to this, individuals had worked co-operatively within the family or community. Under industrial capitalism, disabled people could not meet the demands of waged labour and became controlled through exclusion. And as Foucault has pointed out, once a separation between individuals has occurred, it becomes necessary for a specifically designed group to legitimate it. In the case of the disabled individual, this became the medical profession.

DISCUSSION

If I can't dance, it's not my revolution.

The medical model of disability is primarily concerned with analysing the physical body and conceiving it as something to be cared for through the application of medicine. It's linked to the reductive understanding that the limitations of the body directly influence societal relations. It somehow isolates the disabled individual as a consequence of the impairment, and it turns a blind eye to how social attitudes towards disability affect a person's identity. On the other hand, the social model tries to understand disability as a socially generated category, related to experiences outside of the body. But in doing so, it often forgets about the corporeal and lived body, conceiving the disabled body as a theoretical space that often remains neglected as an object of analysis.

An understanding of the relationships between disabled people's bodily functions, and broader socio-cultural values and practices seem to be underdeveloped in disability studies because it has tended to revolve around the dichotomy of the medical and social model. It would be of great use if we could apply our sociological imagination to better explore the link between structural conditions and people lived experience of disablement. In this line, Shilling called for the analysis of the body to become a meeting place for sociological and disability theory. This could be approached in a range of different ways, and it has been done, such as seeing the 'body as a text', the body as a site of power/knowledge (noting that our capacity for language and consciousness is contained within, and limited by, our body) or as Merleau-Ponty's body as an active creator of significance. Like Shilling suggests, "acting people are acting bodies" so that any theory of human agency requires an account of the body.

A way of doing this is to use Bourdieu's habitus, where the management of the body is crucial to the obtainment of social status. In his outline of a theory of practice, he makes a distinction between rules (made by institutions, not necessarily automatically adopted by the people) and these rules taking on a practical form in the habitus (body automatisms/practices). For someone who suddenly becomes disabled, the learnt dispositions of the habitus may be shattered. Practices may have to be relearned in a conscious way. For disabled people, practices that are usually spontaneous may not be anymore. Bodily dispositions are not themselves determined by the habitus, but by their relations with social fields. These fields identify and structure particular categories of social practices, and for disabled people, a dominant social field is medicine, and the propagation of biomedical discourses that "ensure the physical vigour and moral cleanliness of the social body; it promised to eliminate defective individuals".

However, the relationship between the fields and the habitus is a mutually constitutive one. The body becomes inscribed with

values related to the field, inscriptions which define groupings. In this way, the habitus and its embodied practices are implicated in establishing the location on the social ladder and inequalities. The attainment of corporeal status for disabled people is limited by societal views that categorise the disabled body as “abnormal” or without value. For disabled individuals, their body is symbolically understood merely as the deviation of the norm, a threat, or “the other”.

The invisibility of disability leaves people vulnerable. And among minoritised groups, exclusion is a form of symbolic violence. This exclusion is taken for granted and institutionalised, encoded in language and reproduced in social interaction. In the lives of people with disabilities, symbolic violence also means no-or public misrepresentation. People with disabilities are often treated as “planning problems” for governments rather than citizens. The dehumanisation to which the individual is subjected can be hard to discern (as elaborated in the first section) because it can be clothed in care and compassion.

Persons with disabilities lack symbolic power in society (due to the perceived inability for them to work as productively as non-disabled persons) and are positioned (through medical discourse and the symbolic power which underlies it) as ‘naturally’ inferior.

Members of ethnic minorities usually grow up in the context of group members who suffer exclusion in a similar way, helping them not to internalise demeaning treatment. But most people with congenital disabilities grow up as the only disabled person in the family, and probably the entire social network, and thus lack this support.

Sexuality is an important part of a person’s life, and when it comes to this matter, representations of desirable sexuality and sexual bodies are dependent on ability, and closely aligned with gendered aesthetics. So, persons with disabilities may experience a lack of access to sexual healthcare and education may also face harmful attitudes from providers or have to bear social and sexual exclusion. On the other hand, there’s data suggesting that women with disabilities are at particular risk of sexual violence. Having to constantly defend oneself against intrusion and sensing that one’s own position is vulnerable is dehumanizing. There is also a tendency to think of disabled people as less sexual or genderless, “less of a woman”. We are to think of these forms of disablism as a form of symbolic violence, encoded in everyday life, language, architecture, and social norms. As disabled people’s visibility has slowly increased a little over the years, the discourses of their organisations may have been embraced by policy, but this has also created a ‘disabling corporatism’, as Oliver puts it, and the social model and independent living movement may have lost a bit of their radical spirit. This ‘corporatisation’ is a double edged sword because it can foster the development of inclusion technologies, but it can also drown bodies and minds in the economic agenda of service consumption. As future policy initiatives are developed, disabled people will be involved in the creation of new professions and institutions. As mainstream political and financial opportunities for disabled peoples organisations arise, there will be struggles as well. Inequality is repainted in colonised spaces that mostly attend to corporate interests and attempt to rebrand the disabled body, mind, and lifestyle as part of the political and economic projects of impairment management and inclusion.

The history of disability sadly is a story of segregation and concealment, and the international disability movement today

faces the enormous challenge of mobilising groups that are highly dispersed, individually isolated, and not homogeneous. But it also is a history of change, movement, and hope. There is a broader struggle at stake here, and this is the struggle to make disability not only more visible but more possible to talk and think about, to foment real, lived, experienced and embodied inclusion.

CONCLUSION

The contribution of Foucauldian theory has elsewhere been argued to be limited because it assumes that disabled bodies are subject to the power of the norm regulating systems that favour rationality, set boundaries and pathologise “dysfunction”. (For example, in Bill Hughes’ what can a Foucauldian analysis contribute to disability theory?) But this overlooks the liberatory effect that social movements in recent years have had on disabled people’s status in society. Disabled people have gathered and grouped in formal organisations and have brought winds of change through collective political movements. These actions can be read as resistance to oppression, and they are not only grand ideas that bring legislative change or views such as the social model, but also personal moments of pride and acceptance. A new language of resistance is needed to advance an inclusion agenda so that the broadest collective of people associated with disability can push for positive social change in togetherness. This also includes figuring out how disability rights work for older people, disabled prisoners, those with addictions, and those with unfamiliar disabilities.

The negative picture I’ve painted of the medicalisation of disability doesn’t mean it’s irreversible. There are several things one can do to feel more empowered at the micro level of a doctor-patient encounter, such as showing up prepared with pen and paper, writing down questions, taking time to absorb the information, and bringing a significant other. On the macro level, a redress of the power imbalance and resurrection of choice and control on behalf of the disabled community is possible. For example, if the conceptions of others help shape images of one, then public media images have reinforced negative stereotypes surrounding disability for years. This can be changed by organised public response, or campaigns showing the reality and the capacities in the lives of disabled people. Learning from the home birth movement as well, it would be possible to work to decentralise medical services that are currently perceived to be capable of being given only at medical centers, using attendant care or home health services. Finally, too many programmes give too little recognition to the role that consumers should play. Such decisions have only been thought to be taken in the realm of expert opinion. Whether it is in the design of a building or a health coverage system, there must be the input of the disabled community.

It is time to reconceptualise the disabled away from the label of a vulnerable group of potential patients needing protection and recognise them simply as a minority group seeking its rights and an equitable place in society. The main problem with medicalisation here is that it puts the spotlight on individual issues, treatments, and patients, instead of on the political and social dimensions of the situation.

Perhaps another one of the biggest problems for people with a disability is the misfit between the person’s capabilities and the environment. Many disabled (and elderly) people are institutionalised in medical institutions simply because their own

homes are not accessible and inaccessibility can be easily corrected in a surprisingly high percentage of cases.

I've established that the relationship between power, knowledge and discourse is central to Foucault's work. For him, power is a productive and shared resource, it isn't centrally located or specific, nor completely negative and seeking to control, but it can be reformative and offer new alternatives. "Power circulates through a web of human social relations, connecting and engaging people as both the oppressed and the oppressor, the liberated and the liberator, the ethical and the unethical, the powerful and the powerless". But power can also be subverted and reclaimed, reworking oppression, and making space for liberation and equality. No matter how powerful or oppressive a system may be, it can be resisted, and resistance can be seen as the ultimate form of power in line with Foucault's thinking.

If discourse is a system of representation and signifiers that creates reality, something that provides a way of speaking and knowing things through language, then statements or concepts regarding things such as disability show that disabled people and their impairments have become artefacts of knowledge embedded in a net of historical, political, and social structures.

I conclude saying that there are enough similarities between the selected concepts in the thought of Bourdieu and Foucault to address these overarching social problems jointly. I want to point out especially how important bio power is to understand the negative effects that medicalisation has had on the disabled, and how symbolic violence operates in the effacement of disabled experiences.

This paper has the limitation of not having been able to delve deep enough into theory, especially on Bourdieu's side. It would be very interesting to further apply concepts of Bourdieu to the field of disability, because it seems that the results could be fruitful, especially to improve social sensibilities and make better integration policies. I would find it very interesting if further research were conducted interviewing disabled people asking about their social and corporeal experiences, seeing how these theoretical concepts operate on a practical basis, and overcoming the dichotomy of the medical/social model towards a more integrative, embodied one, to do so helped by a sociology of the body.

My grandmother once told me "when you are blind, the world is missing. But when you are deaf, the people are missing". Individuals living with disabilities, disabled bodies, however we want to see it, are not a separate group. They are profoundly ordinary people sharing the same need to feel seen, included, recognised, and loved. It's our neighbour, our mother, our future child. We could come to this world with a disability, or suddenly see ourselves living with it after an accident. We could lose our hearing with age and have to learn to live and exist in the language of a new world. It could be a partial disability or one that requires full assistance.

We need to follow our humanity towards solidarity, that superior yet elusive form of intelligence. We have nothing to be hesitant about. Every person has the right to live a dignified life. We should get to work, kneel, and roll our sleeves up, get to pen and paper because this world is yet very young, and there is still much work to do.

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