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Deficient bodies and inefficient resources: the case of the disability assessment in Bulgaria

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Abstract

This paper analyses disability assessment, conceived as a dominant way of assigning disability status within the modern welfare state. It explores the procedure and outcome of the assessment in their intrinsic relation to defining humanness by utilising an approach which is novel for disability studies – a Heideggerian, existential-phenomenological critique of the modern reduction of human beings to objects and/or resources. This critical philosophical framework is supported by a sociological analysis, drawing on the science and technology studies concept of ‘boundary object’. Using the legally codified disability assessment in Bulgaria as its case study, the paper nevertheless formulates broader conclusions concerning the reduction of disabled people to deficient bodies and inefficient resources, linking it to the modern domination of medicalisation and productivism. In conclusion, it proposes an alternative, holistic view of what it means to be a human being, drawing on Heidegger’s notion of ‘being-in-the-world’ and his critique of modernity.

Keywords: disability assessment; existential phenomenology; Heidegger; science and technology studies; boundary object

Introduction

Every statement about what it means to be a disabled person is also implicitly a statement about what it means to be a human being. The meaning of disability is intrinsically tied to the meaning of humanness, because picking up features that define disability presupposes deciding on the most important characteristics of being human – albeit in negative terms, in terms of ‘negative ontology’ (Campbell 2005). For example, if to be disabled means to be unable to produce, then production is implicitly given a privileged place in defining what it means to be a human being. Existential phenomenology has shown that these decisions about the pivotal characteristics of humanness engage in a *reduction of the human* – whereas both phenomenology and existentialism share a ‘belief that what it is to be human cannot be reduced to any set of features about us (whether biological, sociological, anthropological, or logical)’ (Wrathall and Dreyfus 2006, 5). This is because every foregrounding of certain features as *defining* humanness simultaneously *obliterates* others and thus impoverishes our being-in-the-world (Heidegger 1962). Explaining the meaning of the latter concept, Blattner (2006, 44-45) provides the following example:

To describe me as weighing a certain amount is (or at least, can be) to “disregard the existential state of being-in.” ... So, if we disregard a person’s existentiality and treat him or her simply as a physical object, we can describe that person in terms of his or her factual determinations. In doing so, however, we are missing what makes his or her life *the life* it is. People do not just weigh x pounds; they live such a weight as being

overweight or underweight or as being indifferent to their weight. Weight, as a way of being-in-the-world, is not an indifferent physical property...

Blattner speaks here about reducing the human to a 'physical object', but other modes of reduction are also possible. In his essay 'The question concerning technology' Heidegger (1977) argues that modernity is characterised by an increasing and totalising reduction of humans (together with non-human entities) to resources. He criticises this tendency to regard everything in terms of 'standing-reserve' (*Bestand*) – i.e., as orderable for the enhancement of the overall system's effectiveness. The following analysis is based on the observation that the dominant understanding of 'disability' in a certain socio-political context is founded upon such reductive operations. Consequently, one can study the procedure and outcome of the legally codified disability assessment by exposing the mechanisms through which human beings show up in modern society as entities of certain, clearly identifiable, decidable kind.

The aim of the paper is to analyse how modern reductive ontologies of the human underlie the socio-political rendering of certain people exclusively in terms of deficient bodies and/or inefficient resources. This will be achieved through bringing existential-phenomenological ideas in contact with disability studies – an area which (at least in Britain) has been dominated by materialist approaches (Thomas 2002), epitomised by the social model of disability (Oliver 1996). Indeed, the last two decades have witnessed an increasing discontent about the social model's alleged naturalisation and exclusion of the body and the 'personal' (Crow 1992; Shakespeare and Watson 2001), coupled with disregarding culture, meaning and identity (Tremain 2002). Yet as a rule these critiques

focus on *embodiment* (Hughes 2007, 674), thus sidestepping the more general question of the meaning of human *being* and its relationship to disability. In this respect, the existential phenomenology of Martin Heidegger, albeit ignored by disability scholars to date, is particularly cogent. It provides a sound conceptual foundation for addressing human being in a holistic manner, and consequently – for criticising modern reductions of the human, which pervade all aspects of disabled people’s lives. This general, philosophical understanding of humanness will be supported by sociologically informed analysis of the everyday working out of disability-related identities and meanings through recourse to the science and technology studies (STS) concept of ‘boundary object’ (Star and Griesemer 1989). Being itself a newcomer to disability studies, this concept is particularly useful for sharpening the sociological attention to the ‘nuts and bolts’ of identity and meaning construction. That said, the aim of the proposed analysis is not to provide any extended exposition of Heidegger’s or STS ideas. Rather, it appropriates certain intuitions, stemming from the Heideggerian (1962) notion of being-in-the-world and his subsequent (1977) critique of modernity, in order to stimulate a novel and analytically promising way of looking at the issues of disability.

The paper will focus on disability assessment in Bulgaria, although many of its arguments will also be valid for other socio-political contexts. Due to the country’s state-socialist past, the Bulgarian approach to disability-related issues has been heavily influenced by the over-medicalised Soviet approach of *defectology* (Grigorenko 1998; Stubbs 2002, 17). Consequently, the assignment of disability status in Bulgaria has for decades been exclusively dominated by medical professionals and procedures, mimicking Russian practices in the area (International Disability Network 2007, compare 65-66 and

360-361). This over-medicalisation and standardization of disability makes Bulgarian social policy particularly illustrative for exploring how certain reductions of the human dominate disabled people's lives. Such mechanisms operate in Western societies too, but in subtler, more inconspicuous ways. For example, UK regulations do not posit a necessary requirement to undergo special medical examination when applying for Disability Living Allowance (DLA) – yet additional medical information about the applicant *may* be collected and s/he *may* be asked to be examined by a health care professional (<http://www.direct.gov.uk/en/DisabledPeople/FinancialSupport>). The procedure for applying for Social Security disability benefits in the United States is somewhat similar, although unlike UK's DLA, these benefits are dependent on the applicant's occupational status (<http://www.ssa.gov/disability/professionals/bluebook>). Importantly, in both these countries no single procedure and/or document exists, which measures impairment in standardized terms and which is supposed to certify 'disability status' before all support systems concerned.

On the other hand, as currently practiced in Bulgaria, the medicalised disability assessment provides an all-powerful statement of crucial importance for both understanding and management of disability-related issues. Thus, it can clearly illustrate how disability is produced as an intensification of more general reductive tendencies haunting modern societies, where to be a (fully) human being means to have a normatively circumscribed body, capable of taking part in the process of production. I will begin my exploration with the reduction of the human to a *physical body*, analysing the procedure followed by medical expert commissions in charge of disability assessment in Bulgaria. This reduction is most conspicuous with regard to assessing physical and

sensory impairments¹ and is less pronounced when it comes to assessing psychiatric and/or mental impairments – therefore, I will take the former as my case example. I will further explore the reduction of the human to a *resource* by focusing on the disability assessment statement. This excludes children, for they are not regarded as economically productive and therefore in Bulgaria the assessment of their impairments is rendered not in terms of ‘decreased ability to work’, but in terms of ‘decreased capacity for social adaptation’, thus calling for a separate analysis. Further, the disability assessment statement will be regarded as a ‘boundary object’ in order to analyse how the meaning of ‘disability’ is constituted within different social worlds. I will conclude with a critique of disability’s naturalisation and will rearticulate the concerns about the reduction of the human, highlighted in the beginning.

Disability assessment in Bulgaria and its two reductive operations

In Bulgaria, the medicalised disability assessment dominates all disability-related support structures and processes (Panayotova and Todorov 2007, 11). It is *only* in terms of this legally codified assessment procedure that a person can officially be recognised *as disabled* – not solely by the Bulgarian welfare state with its system of financial support and service provision, but also by the private service providers. The very definition of ‘person with disability’ within Bulgarian legislation hinges on the outcome of the expert medical assessment (Law for the Integration of People with Disabilities, Additional Provisions, paragraph 1,

¹ Where possible, I use the terms ‘impairment’ and ‘disability’ in line with the social model distinction between the two (e.g., Oliver 1996). Nevertheless, the analysis of the disability assessment inevitably muddles the terminology, because the assessment itself does not recognise such distinction.

http://www.mlsp.government.bg/bg/law/law/ZIHU_74_15_9_09.doc). One can legitimately claim disability benefits only after being medically assessed and certified as disabled. Other types of support like the provision of assistive technology and medical devices, personal assistance services, adaptation of the workplace, and inclusive education arrangements are also directly dependent on the assessment outcome. Official disability statistics, when present, relies heavily on the distinctions brought about by this process (CIL 2002, 8). Finally, the disability-related social security is ultimately based on the single document issued by the disability assessment commission (Social Security Code, chapter VI, section II, <http://www.mlsp.government.bg/bg/law/law/KSO.doc>).

This dominance of the medicalised disability assessment has also been highlighted in international evaluation reports like the *International Disability Rights Monitor* (International Disability Network 2007). In its 2007 issue, the report states that ‘[i]n countries where a purely medical disability model is used, such as Bulgaria and Armenia, the responsibility of assigning disability status is left solely to medical agencies’ (x). The document also underlines that the legal definition of ‘disability’ in Bulgaria is exclusively based on the medical assessment, which assigns to each individual a certain percentage of decreased ability to work. It criticises this as ‘show[ing] the domination of the medical model of disability as opposed to the social one – the focus is on the individual’s inabilities as opposed to environmental barriers’ (65).

Bulgarian disability assessment reproduces two types of reduction of the human – to an object (a physical body) and to a resource (a productive entity). The first is mostly related to the procedure for assigning disability status, and the second – to its outcome, the

assessment statement. Let me begin with former, which in Bulgaria is termed ‘Medical expert assessment of the ability to work’ and is detailed in the Regulations for the medical expert assessment of the ability to work (<http://www.mlsp.government.bg/bg/law/regulation/Narmedicexpertizairabotosposobnost.doc>). The assessment is carried out by ‘territorial/national expert medical commissions’, comprised exclusively of medical doctors. It is conducted in a medical setting – article 1 of the Regulations states that ‘[t]he medical expert assessment of the ability to work is an inseparable part of the diagnostic-treatment and prophylactic activity of the medical treatment settings’. The assessment consists of correlating a clinically determined diagnosis or functional condition of the body with certain percentage of ‘decreased ability to work’ (see the Regulations, article 57). Clearly, the primary feature of Bulgarian disability assessment is its *medicalisation*, defined as ‘expansion of medical jurisdiction’ or ‘the power and authority of the medical profession’ (Conrad 2005, 4). Disability scholars have described this domination of the ‘medical jurisdiction’ over the lives of disabled people as the medical model of disability (Thomas 2002, 40). It reduces disabled people to their bodies, rendered in biomedical terms as incomplete or flawed. Thus, exposed to the medicalised gaze of the experts, the human being is stripped down to its purely physical dimension, regarded at that as deficient.

This reduction to the material corporeality goes hand in hand with a second reductive operation. The outcome of the medicalised disability assessment is formulated in strictly *productivist* terms (Giddens 1994, 175), thus further reducing the human to a productive entity – or, in modern managerial jargon, a ‘human resource’ (see Heidegger 1977, 18). It is the *ability to work* that is being assessed by the medical experts. This ability is

expressed by a percentage, where 0% equals no loss, while 100% designates total loss. For example, a loss of an upper limb at the level of the armpit gives 75% decreased ability to work, while a loss of a lower limb at the level of the calf – between 50 and 60% (see the Regulations, Annex 1). Thus, the human being is reduced to his/her productive capacity, clearly imagined against the background of routine, mechanical, physical labour in the factory, characteristic of the industrial mode of production. This implies the ethos of productivism, which ‘imposes both an economic and moral imperative to embrace the world of work’ (Anderson 2008, 110, drawing on Giddens 1994). Importantly, productivism ‘*reduces* people and the environment to the status of human and natural resources for economic exploitation’, thus overlooking ‘*the complex and interdependent nature of human existence*’ (120, emphasis added). It should be noted that Marxist disability scholars like Abberley (1987), Finkelstein (1980) and Oliver (1990) have repeatedly highlighted the close relationship between productivism and disability. For example, Abberley (1987, 15-16) states that

the ‘problem’ of disability is why these people aren’t productive, how to return them to productivity, and, if this is not seen as economically viable, how to handle their non-productivity in a manner which causes as little disruption as possible to the overriding imperative of capital accumulation and maximisation of profits.

Linking medicalisation and productivism

Bulgarian disability assessment also illustrates how *medicalisation coalesces with productivism* to serve the dominant socio-economic order. Historians of medicine have

analysed this close interlinking between medicine and the industrial mode of production in the heyday of modernity. Thus, '[a]t a time when medicine and its institutions were being reoriented around a deliberate concern to maintain and manage a fit and efficient industrial population, ... medical sciences offered a functional understanding of health and illness which both legitimized such a reorientation and provided a technical basis for establishing standards of public provision' (Sturdy and Cooter 1998, 28). In other words, medical science and technology provided productivism with the means to distinguish between the 'lazy' and the 'unproductive' and to compensate the latter, while disregarding or punishing the former. Historically speaking,

[m]edical validation of physical incapacity solved the problem of malingering by circumventing the testimony of the individual. Under this confirmation scheme, the doctor sought direct communication with the body regarding its condition, eliminating the patient's ability for self-disclosure and, ultimately, for self-determination. ... As a result, "disabled" became, in the twentieth century welfare state, a medicalized category by which the state could administer economic relief in a seemingly objective and equitable manner. (Thomson 1997, 50)

Thomson points out that this medical-productivist administration of the 'economic relief' follows the 'logic of compensation', in which "disabled" connotes not physiological variation, but the violation of a primary state of putative wholeness' (49). As already shown, this 'state of putative wholeness' can be ascribed a value: 0% decreased ability to work equals a whole worker. This wholeness though should be distinguished from the *existential* wholeness, for the former is defined as *physical* integrity, related in biological-

functional terms to industrial productivity, whereas the latter – to human being-in-the-world (Heidegger 1962, 78-79), the meaning of which will be elaborated on later. In the same work Thomson (1997, 49) counterposes the ‘logic of compensation’ to the ‘logic of accommodation’, which ‘suggests that disability is simply one of many differences among people and that society should recognize this by adjusting its environment accordingly’. Thus, compensation alleviates individual incapacity, whereas accommodation corrects environmental inaccessibility. The distinction between ‘compensation’ and ‘accommodation’ then parallels the distinction drawn by Oliver (1996, 32) between the individual and the social model of disability, where the former focuses on the individual, while the latter – on the environment. The tension between these two approaches within Bulgarian disability legislation will be highlighted in the next section.

Transformations of modernity and attempts at changing the *status quo*

The reduction of the human being to a self-enclosed, normatively circumscribed, industrially productive entity has been complicated by certain developments in late modernity. In the modern framework the body is regarded as fixed, as ‘an essence, a timeless, material thing’ (Hughes 2000, 12), while production is predominantly factory-based (cf. Oliver 1990, 27) – that is, manual, repetitive, and routinisable. On the other hand, in *late* modernity with its ‘knowledge economy’ (Powell & Snellman 2004), both the status of the body and that of resources changes – and Bulgarian society partakes in this important historical transformation. Firstly, in late modernity the body no longer shows up as fixed, but as *flexible* (Hughes 2000, 13). Consequently, ‘opportunities for

biomedicalization extend beyond merely regulating and controlling what bodies can (and cannot) or should (and should not) do to also focus on assessing, shifting, reshaping, reconstituting, and ultimately transforming bodies for varying purposes, including new identities' (Clarke et al. 2003, 181). Secondly, late modern 'human resources' are no longer understood primarily as physically, but rather as *intellectually* productive – that is, as generating and disseminating *knowledge*. Thus, Powell and Snellman (2004, 201) state that '[t]he key components of a knowledge economy include a greater reliance on intellectual capabilities than on physical inputs or natural resources'.

Bulgarian society partakes in these transformations. Yet, the case of the disability assessment is exempt from their predicaments because the country's social policy, especially in the domain of disability, has so far remained rooted in the more 'traditional' version of modernity. Indeed, attempts have been made to update the Bulgarian disability legislation in line with the new socio-political, socio-economic and socio-technical realities, as well as with a different set of values and visions. Yet these attempts have been largely unsuccessful, leaving the practices of disability assessment virtually untouched.

Recent Bulgarian legislative history has witnessed a process of setting up an alternative disability assessment procedure, which would arguably be based on expanding the meaning of human being to include the non-medical and the non-productivist aspects of one's existence. With the adoption of the new Law for the Integration of People with Disabilities in 2005 (http://www.mlsp.government.bg/bg/law/law/ZIHU_74_15_9_09.doc) a 'social

assessment' has been introduced (article 12), ostensibly focusing on the social and not medical circumstances of the disabled individual. As currently regulated by the law, the 'social assessment', among other things, is argued to evaluate 'the possibilities for social integration' and to produce an 'individual plan for social integration' (article 12), including 'suggestions for social inclusion' (article 13). On its basis an 'allowance for social integration' (article 42) is provided as a certain monthly amount of money to aid integration. The problem is that the law explicitly *grounds* the 'social assessment' on the medical assessment by stating that '[t]he social assessment is conducted *on the basis of the medical expert assessment*' (article 12, emphasis added). The 'allowance for social integration' is also explicitly made dependent on the 'degree of the reduced ability to work' (article 42), certified by the medical expert commissions. All these provisions render impotent the possibility of the social assessment to function as an alternative to the medical expert assessment.

Back in 2004 – 2005 several different versions of the new disability legislation were proposed. At that time I worked for a Bulgarian advocacy organisation of disabled people (Center for Independent Living – Sofia, <http://www.cil.bg>), which developed and lobbied for one of the alternative bills. An attempt was made to supplement the 'logic of compensation' with the 'logic of accommodation' (Thomson 1997, 49) and to introduce the considerations of the social model of disability (Oliver 1996) within the disability policy equation – by introducing a social assessment of disability, which should be *completely independent* of the medical one. Yet such independence was met with suspicion by the policy-makers (see Coalition of NGOs 2004, 10) and eventually the Parliament voted for the most conservative amongst the new bills, grounding as

already shown the social assessment on the medical assessment. A similar scenario repeated itself in 2009 – 2010 (see <http://cil.bg/Новини/114.html>). Thus, the system of institutionalised medicalisation of disabled people strongly resisted any substantial changes of the *status quo*. The outcome is the continuing dominance of the medicalised disability assessment, which reduces disabled people to deficient bodies and inefficient resources.

Disability assessment statement as a boundary object

The medicalised disability assessment has also a positive function to play. From a sociological point of view its statement can be regarded as a ‘boundary object’ (Star and Griesemer 1989), consolidating the boundaries around different domains of practice, while at the same time making the interaction between them possible. ‘Boundary object’ is a concept widely utilised in the context of science and technology studies to designate a material/conceptual entity which facilitates meaning and identity construction. Thus,

[b]oundary objects are objects which are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. ... These objects may be abstract or concrete. They have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable, a means of translation. The creation and management of boundary objects is a key process in developing and maintaining coherence across intersecting social worlds. (Star and Griesemer 1989, 393)

In short, boundary objects ‘maximize both the autonomy and communication between worlds’ (Star and Griesemer 1989, 404). Further, Williams, Wainwright, Ehrich and Michael (2008, 16) point out that boundary objects have an ‘anchoring’, as well as a ‘bridging’ function – they anchor actors in their local worlds or forms of life, while also bridging the gaps of incommensurability between these localities. Hence, a boundary object is defined through a set of *binary oppositions*: it is both ‘plastic’ *and* ‘robust’, maximising ‘autonomy’ *and* maximising ‘communication’ (Star and Griesemer 1989), acting as an ‘anchor’ *and* acting as a ‘bridge’, ‘enabling’ *and* ‘disabling’ (Williams et al. 2008), ‘promoting translation’ and ‘resisting translation’ (Fujimura 1992), etc. Importantly, a boundary object does not reconcile or overcome the oppositions in a dialectical unity, but keeps them vital *as oppositions*. In fact, this is exactly what makes it a *boundary* object – that is, an exemplary mediator, an entity which is always in-between.

The statement of the medicalised disability assessment in Bulgaria can be regarded in a similar vein. From such perspective it is a boundary object, partaking in the pragmatic and semantic consolidation of the social worlds of medical assessment procedure, social services/welfare provision and individual existence, while simultaneously facilitating the interaction between these three domains of practice. The analysis which follows is based on the observations of the author during his nearly ten-year professional experience in the area of Bulgarian disability policy, and also on a review of relevant documents. It is preliminary and experimental – an attempt at thinking differently about seemingly well-known phenomena. So far, disability assessment statement has not been regarded as a boundary object and this fresh science and technology studies perspective might

stimulate fresh insights into the mechanisms of translating modern ontological reductions into disability.

Three social worlds

As used by Star and Griesemer (1989, 388), the term ‘social world’ denotes a distinct domain of human practice, in which individuals create and sustain their identities in distinct ways. The notion is useful precisely for capturing this *distinctiveness* (or localness). I borrow it in order to distinguish and analyse three domains, in which the disability assessment statement plays a pivotal role in identity construction, functioning as a ‘boundary object’. These are the social worlds of the medical assessment procedure, the social/welfare work and the individual existence.

In the world of the assessment procedure the statement about the ‘decreased ability to work’ provides the doctors participating in the expert medical commissions with an opportunity to exercise their medical expertise through fixing a diagnosis and assigning a number. The socio-political space of the assessment is heavily hierarchised. The Regulations for the medical expert assessment of the ability to work grant the experts the exceptional power to manage the lives of the individuals who seek certification, while unequivocally rendering the disabled person as ‘diseased’. Consequently, s/he cannot help but passively await the authoritative diagnostic decision of the commission, with which no negotiation is possible. Thus, her or his body becomes an ‘object and target of power’ or a ‘docile body’ (Foucault 1991, 136), orderable and manageable in its very minute details – the list of diagnostic categories and functional conditions, correlated

with percentages of ‘decreased ability to work’ in the Annex to the Regulations for the medical expert assessment, exceeds 16 000 words. The impaired body is implicated in a web of diagnostic terms and degrees of incapacity, which will further regulate the individual’s access to services and welfare. All these positionings and meanings are organised around the outcome of the disability assessment, expressed as a diagnosis, tied to certain percentage of ‘decreased ability to work’, and fixed in a document to be circulated to other disability-related sites. Besides reassuring the medical doctor’s professional identity, this piece of paper stabilises the meaning of ‘disability’ within the confines of the expert medical discourse. As a boundary object, it renders disability in terms of a medical *diagnosis*, thus circumscribing the domain of medical knowledge/power.

The world of the social/welfare work is also organised around the outcome of the assessment. In Bulgaria the statement of the expert medical commission is required every time social service are provided to disabled people (Regulations of the Implementation of the Law for Social Assistance, article 40, http://www.mlsp.government.bg/bg/law/law/ZSP_15_9_09.rtf). Thus, it both controls the access to service provision and organises its procedures. For example, presently there are five personal assistance (PA) schemes for disabled people in Bulgaria – four national and one municipal (CIL 2009). Different service providers are involved in these schemes, including state agencies, municipal agencies, business and non-profit organisations. Yet effectively transcending this diversity, *all* service providers base their ‘admission’ decisions on the outcome of the expert medical disability assessment (CIL 2009). Thus, disabled people can access PA services only if certified as ‘appropriately’ disabled (that

is, being assigned a certain percentage of ‘decreased ability to work’) by the expert medical commissions. It is clear that the world of social service provision in Bulgaria is dominated by the medicalised disability assessment. Consequently, social work in the area of disabilities is often reduced to administering disability certificates – a manifestation of the often criticised ‘[e]xcessive bureaucracy in the [Bulgarian] social support system’ (Platform ‘Social Policies’ 2009, 37). Social workers exercise their disability-related expertise by correlating percentages of ‘decreased ability to work’ with services available. Thus, within the confines of the Bulgarian social service system, the expert medical certificate stabilises the meaning of ‘disability’ in terms of *admission to resources*. Again, it functions as a boundary object, structuring relationships, building hierarchies and organising discourse and action within a distinct social world.

Finally, the disabled person’s individual existence is also at stake in the disability assessment. Subjected to the already described double reduction, the person undergoing the medical assessment procedure is constituted *both* as a deficient human body *and* an inefficient human resource. At that, the more deficient and incapable the body-resource, the more open the access to support services and financial benefits. The twofold function of the boundary object – to be simultaneously *enabling* and *disabling* with regard to social action (Williams et al. 2008, 15) – is clearly evident here. As a boundary object, the statement of the medicalised disability assessment *enables* people’s access to welfare resource, while at the same time consolidating their status as *disabled* by fixing (anchoring) their corporeal ‘deficiency’ and productive ‘incapacity’ through assigning a medically determined percentage of ‘decreased ability for work’. Such subject position breeds passivity and acquiescence, but it also provides access to social services and

financial benefits. The medicalised disability assessment is rarely (if at all) informative with regard to the actual life circumstances and capacities of the person. Nevertheless, it implicates the disabled individual within a system of power/knowledge which effectively incapacitates, while also being *productive* – it produces identities and enables action in terms of consuming welfare resources. Foucault (1982, 220) highlights this productive capacity of modern power. In this respect, the medicalised disability assessment might be regarded as a paradigmatic instance of the exercise of biopower. Through its mediation, a certain mode of being is developed. As a boundary object, the assessment organises individual lives around *deficiency* and *access to welfare resources*.

To summarise, the medicalised disability assessment statement means different things for different groups of people within their different social worlds. In the world of the medical assessment procedure it means *expertise and medical diagnosis*. In the world of social work and welfare provision it means *administration and admission*. Finally, in the world of individual existence it means *deficiency and access to resources*. Thus, in all these different and divergent social worlds the assessment functions as a boundary object – it draws the boundaries of meaning, distinguishing and distributing priorities, stakes, and modes of being. Through the assessment some become experts, others – administrators and gatekeepers, yet others – deficient body-resources and social assistance/welfare receivers. No wonder that it has been difficult to change or displace this boundary object – as the case with the already mentioned Bulgarian disability legislation testifies.

The administrative and the socio-political: coordination, standardization and naturalisation

The disability assessment statement not only partakes in the construction of local meanings and identities, but also facilitates the interaction between these localities. Thus, the medical domain of the disability assessment is *connected* to the social domain of the service provision through a *document* certifying the percentage of ‘decreased ability to work’. This boundary object effectively crosses the gap between the medical and the welfare social worlds, building a bridge of coordination. It also relates the domains of the medical and the welfare to the domain of the individual existence, tightly attaching people’s lives and identities to medical diagnoses, percentages of inability, and inputs of social/welfare assistance. Thus, a network of associations between sites and agencies can be traced (Latour 2005), constituting what is commonly regarded as ‘disability’. The coherence of this network relies on the mediation of boundary objects like the assessment statement, which has been circulated in a very *material* way among its ‘nodes’. Bruno Latour (2005, 66-68) points out that the social can be stabilised only through the recruitment of the non-social, the ‘inert’, the material. Thus, certain non-human elements can be regarded as ‘agents’, actively partaking in the construction of meaning and the performance of ‘intentional’, human action. The medicalised disability assessment statement is an example of such non-human mediator, effectively binding together sites, people, meanings, actions, and resources.

The more standardised this mediation, the more effective the ‘government of disability’ (Tremain 2005). Consequently, the statement of the expert medical commission functions as a special type of boundary object – a *standard*, allowing for manageability, efficiency, accountability and comparability. The point is that ‘standards can enable heterogeneous

systems of people and things to interact and combine across time and space' (Smart et al. 2008, 409). In the case of the medicalised disability assessment the standard comprises of a common unit used to measure 'disability', much like temperature is commonly expressed in degrees centigrade (except in the US). The common unit of 'disability' in Bulgaria is the percentage of the 'decreased ability to work'. Being assigned this number, people become orderable on a *single* scale. Such homogenisation makes their comparison and management within the system of the welfare provision possible; it makes distribution of resources and accountability feasible. Finally, it enhances the overall effectiveness of the networked localities through avoiding repetition and reducing uncertainty associated with face-to-face human interaction.

Notably, all these arguments regarding the utility of standardisation are of an instrumental nature and tend to leave out such considerations as human diversity, freedom, and self-determination. Thus, the administrative overshadows the socio-political. Furthermore, with its routine and widespread application, the standard of the medicalised disability assessment gets *naturalised*, covering up its socially constructed origins. In similar terms, Smart et al. (2008) analyse a nationwide process of standardisation in the context of race/ethnicity. They describe how UK biobanks have uncritically adopted the UK Census classification of ethnicity, driven by the need for coordination and stabilization of action (416). The 'dark side' of this unreflexive utilization of the Census classification is the erosion of 'the epistemological status of its categories as sociopolitical constructs' (417), which opens up bleak possibilities for the communal being. The authors remind us that '[t]he history of racial science shows the potential for socio-political constructs of population groupings to be transformed into

innate, immutable and natural categories, with dire social consequences' (418). The standard produced by the expert medical disability assessment and 'materialised' in the form of the assessment statement also tends to naturalise the otherwise socially constructed, highly contested and ambiguous category of disability (Thomson 1997, 13-15). Consequently, it becomes a matter of *common sense* to regard disabled people as deficient bodies and/or incapable resources.

Concluding remarks

Disability scholars and activists have resisted the ubiquity of the medical-productivist reduction of disabled people to (deficient) objects and/or (inefficient) resources with bold statements like 'disability is beautiful' (Peters 2000, 596), but most notably by decoupling the body and society through the development of the social model of disability (Oliver 1996, 35). Yet it has always been difficult to effectively overcome the reductive tendencies in this manner, as the critiques of the social model demonstrate. For example, Tremain (2002, 33-4) notes that the social model's rendering of impairment in strictly biological terms amounts to 'a failure to analyse how the sort of biomedical practices in whose analysis Foucault specialized have been complicit in the historical emergence of the category of impairment and contribute to its persistence'. Similar criticisms have been proposed by Hughes and Paterson (1997), Shakespeare and Watson (2001), and others. Nevertheless, at present the social model remains the most powerful tool for socio-political analysis of disability. In Bulgaria, it has been embraced by disability advocates as a general framework for informing progressive policy changes (see <http://www.cil.bg/en>) – thus being what Shakespeare and Watson (2001, 10) termed

the ‘ideological litmus test of disability politics’. Yet the social model’s exclusive, materialist focus on the structures and processes oppressing disabled people, albeit strategically relevant, seems analytically too narrow. The reduction of disabled people to deficient bodies and incapable resources is rooted in a complex of more general forces, encompassing both disabled and non-disabled individuals, and non-human entities as well.

Existential phenomenologists like Martin Heidegger (1962) have demonstrated how these reductive tendencies underlie the whole history of western civilisation, which has been dominated by fascination with detached self-presence or what Heidegger terms ‘presence-at-hand’ (*Vorhandenheit*). The reduction of the human to physical body is an instance of this general domination of the present-at-hand – i.e., the ‘metaphysics of presence’ (Derrida 1976). It impoverishes human being, whose basic state is not disconnected and objectifiable, but being-in-the-world – a ‘structure which is primordially and constantly *whole*’ (Heidegger 1962, 225). Consequently, ‘one cannot think of [being-in-the-world] as the Being-present-at-hand of some corporeal Thing (such as a human body) ‘in’ an entity which is present-at-hand’ (79). Thus, from existential-phenomenological point of view humans are more than just discrete bodies occupying physical space, but tradition has tended to reduce them to detached, objective, self-present entities – and medicalisation is a modern epitome of this tendency. Indeed, one can attribute to humans object-like properties, but with this one deprives them of their basic constitution of being-in-the-world (Blattner 2006, 45). In his later work Heidegger (1977) has also tackled the question of the reduction of human beings to productive resources. He has analysed the technological ‘Enframing’ (*Gestell*), which ‘does not

simply endanger man in his relationship to himself and to everything that is [but also] banishes man into that kind of revealing which is an ordering' (27). This 'ordering' is a tendency to regard everything, including human beings, in terms of resources or 'standing-reserve' (*Bestand*) (17-18), utilisable for the enhancement of the overall system's effectiveness.

Consequently, the reduction of disabled people to deficient bodies and inefficient resources disclosed by the analysis of the Bulgarian medicalised disability assessment is a limit-case of certain general tendencies, inherent in modernity. It is *because* human beings tend to be regarded as detached objects and/or utilisable resources *that* disabled people can be rendered exclusively in terms of *flawed* objects and *un-*utilisable resources. This might be designated as the 'global', existential-phenomenological level of analysis. It was supported here by another, 'local' level of analysis, which explored the constitution of disability on the 'micro-level' through recruitment of the disability assessment statement as a boundary object. Thus, if *philosophically* disability is to be regarded in a holistic way, on the basis of an existential-phenomenological understanding of being-in-the-world, *sociologically* it can be analysed in terms of associations between disabled and non-disabled, human and non-human actors, within and across distinct social worlds. The potency of this approach for informing critical thinking about disability-related issues seems promising. Its role in social policy formulation – that is, in informing *praxis* – still remains to be explored.

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