

Critiquing “disability”: The Disability Discrimination Act’s interplay with society

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Abstract: *This paper presents a critique of the legal constitution of disability employed by the Disability Discrimination Act 1995. The concept of disability employed will be evaluated with reference to current social models of disability. These will be employed to evaluate to what extent, if at all, the Act’s definition accords with the contemporary models of disability. The definition of disability will be deconstructed and by reference to both legal and non-legal sources, key fault areas within the constitution of disability will be identified and critically evaluated. The interplay between the concept of “normality” and the legal constitution of disability will be explored, as will the constitution’s interplay with social disabilities and hidden disabilities.*

Legislation to prohibit discrimination on the grounds of gender and race was introduced in the mid 1970s.¹ It was not however until 1995 that discrimination upon the grounds of disability was prohibited following the introduction of the Disability Discrimination Act 1995 (“the Act”). During the Bill’s passage through the House of Commons, the government was clearly of the opinion that this would be an historic piece of legislation. They stated:

“It is a landmark [Act]. It is the only comprehensive [Act] for disabled people ever introduced by a British Government. It will mark the United Kingdom out as one of the world leaders in Europe and move towards comprehensive anti-discrimination legislation for disabled people...It sets this country on a clear, workable and unambiguous course to ending discrimination against disabled people. It will make a genuine difference to the opportunities and lives of our fellow citizens.”²

Indeed, once enacted, the scope of the Act was significant. It introduced a new regime of protection for disabled people in relation to employment and access to employment, the supply of goods and services, and the buying or renting of land or property. It is however, the objective of this paper to critically analyse the concept of “disability” employed by the Act and assess its effectiveness in ensuring equality and consistency towards disabled individuals.

Although arguably groundbreaking, it was also unwieldy. Mummery LJ noted that it is

“an unusually complex piece of legislation which poses novel questions of interpretation. It is not surprising that different conclusions have been reached at different levels of decision. This state of affairs should not be taken as a criticism of the Act or of the judicial disagreements about its interpretation. The whole subject presents unique challenges to legislators and to tribunals and courts, as well as those responsible for the day to day operation of the Act in the workplace.”³

The core concept of disability is contained in s 1(1) of the Act:

“Subject to the provisions of Sch1, a person has a disability for the purposes of this Act if he has a physical or mental impairment which has a substantial and long term adverse effect on his ability to carry out normal day-to-day activities.”

¹ See the Sex Discrimination Act 1975 and Race Relations Act 1976 respectively

² HC Deb vol 257 cols 904, 928 28 March 1995

³ *Clark v TGD t/a Novacold* [1999] ICR 951, at 954

A 'disabled person' is a person who has a disability (s 1(2)). The meaning is further expanded by Regulations⁴, Guidance⁵ and a Code of Practice⁶ which detail matters to be taken into account in interpreting the definition. It is therefore apparent that four requirements must be met, prior to an individual receiving the protection of the Act. There must be (a) a physical or mental impairment which (b) has a substantial and adverse effect upon the ability to carry out normal day-to-day activities, the effect of which is (c) long-term. Each of these merit further analysis.

Impairment

The term 'impairment' is not defined in the legislation. It should be given its ordinary and natural meaning, and it may result from or consist of an illness, regardless of how the impairment has been caused.

The term 'physical impairment' is also not defined within the Act, although Regulations provide that an addiction to alcohol, nicotine or any other substance does not constitute an impairment for the purposes of the Act.⁸ However, this exclusion does not have the effect of preventing a complainant from relying upon an impairment that was caused by an addiction. So, cirrhosis of the liver could be an impairment, even if it arose from alcoholism. Therefore, in *Power v Panasonic UK Ltd* (2003)⁹ it was held that where an impairment, (in this instance depression) is caused by an addiction to alcohol, the correct approach is to assess the depression in the absence of the addiction and assess whether it amounts to an impairment.

The term 'mental impairment' is also not defined. Again, the Regulations offer some assistance by providing that certain specified traits do not constitute an impairment for the purposes of the Act. These are a tendency to set fires; a tendency to steal; a tendency to physical or sexual abuse of other persons; exhibitionism; and voyeurism¹⁰. It has been held in *Murray v Newham Citizens Advice Bureau Ltd* (2003)¹¹ that, notwithstanding the fact that a tendency to violence was an excluded condition, a person with a history of violence resulting from paranoid schizophrenia was a disabled person for the purposes of the Act. The reasoning behind the decision was that the tendency to violence was a manifestation of a recognised disability, rather than a freestanding condition as contemplated by the exclusion in the regulations.

Impairment and models of disability

It is generally accepted that there are three dominant models of disability – the moral model of disability, the medical model of disability and the social model of disability.¹²

The moral model of disability is historically the oldest of the models, although its current influence is negligible (Kaplan, 1999). The model is simplistic and two distinct strands can be identified. First, it views disability as the direct consequence of sin. Second, it opines that disability is divinely inflicted and arises due to some inadequacy within the individual.¹³ When these elements of "sin" and "inadequacy" are combined, the model regards disabled individuals as spiritually and religiously inferior. Put simply, "there are higher and lower levels of spiritual development, and people with disabilities were on a lower rung of this divine ladder."¹⁴ For the individual with a disability this model is deeply offensive and has resulted in self hatred; whilst families with a disabled family member have

⁴ Disability Discrimination (Meaning of Disability) Regulations 1996 SI 1996/1455

⁵ "Guidance on matters to be taken into account in determining questions relating to the definition of disability" issued by the Secretary of State. Available via: http://www.drc-gb.org/the_law/legislation_codes_regulation/guidance.aspx [Accessed: 6th December 2006]

⁶ Under powers contained in s 53A of the DDA, the Disability Rights Commission has issued a Code of Practice, which came into force on 1 October 2004, and which addresses the elimination of discrimination in the field of employment. Available via: http://www.drc-gb.org/the_law/legislation_codes_regulation/codes_of_practice.aspx [Accessed: 6th December 2006]

⁷ See *McNicol v Balfour Beatty Rail Maintenance Ltd* [2002] EWCA Civ 1074

⁸ Reg 2 and 3(1). n 4 above

⁹ [2003] IRLR 151

¹⁰ Reg 4(1), n 4 above

¹¹ [2003] IRLR 340

¹² Academics are not however consistent in their use of terminology. The social model is also frequently referred to as the disability model, whilst the medical model is often referred to as the individual model.

¹³ Drimmer, J, *Cripples, Overcomers and Civil Rights: Tracing the Evolution of Federal Legislation and Social Policy for People with Disabilities*, 40 UCLA L. Rev. 1341

¹⁴ n 13 above at 1346

removed them from education and society and prohibited them from having any active involvement with society as a whole (Beaumont, 1996).

The medical model of disability locates disability within the individual. Disability is a medical condition and consequently, like all other conditions it can be treated by doctors to ensure that its symptoms are, ultimately, alleviated or eradicated.¹⁵ The nature of the model is that, from a social perspective, the disabled individual is placed in the sick role (Parsons, 1958), with this role containing four key elements (Drimmer, 1992). Firstly, the sick person is not held responsible for their illness – it is due to biological factors over which they have no control. Following on from this primary tenet, it is advanced that (2) the sick person is exempted from normal social obligations and (3) is in a socially legitimate position if (4) they co-operate with medical professionals in order to work towards recovery.

The medical model has been the dominant model of disability and its influence is evidenced by the World Health Organisation's ("WHO") development of an International Classification of Impairments, Disabilities and Handicaps (World Health Organisation, 1980). This document expounds the following definitions: -

Impairment: a permanent or transitory psychological, physiological or anatomical loss or abnormality of structure or function.

Disability: any restriction or prevention of the performance of an activity, resulting from an impairment, in the manner or within the range considered normal for a human being.

Handicap: a disability that constitutes a disadvantage for a given individual in that it limits or prevents the fulfilment of a role that is normal depending on age, sex, social and cultural factors for the individual."

From the above it is apparent that the WHO's definitions of impairment and disability essentially favour the medical model of disability. The prominent disability academic, Michael Oliver, has been highly critical of this model of disability. He contends that there are two fundamental aspects to the medical model of disability. Firstly, it locates the "problem" of disability within the individual and secondly, it sees the causes of this problem as stemming from the functional limitations or psychological losses which are assumed to arise from disability (Oliver, 1996).¹⁶ Oliver has also been highly critical of the WHO's definitions as he advocates that they favour the medical model of disability. He proposes definitions which ensure responsibility for the difficulties faced by disabled individuals lies entirely with society.

By way of example:

Impairment: lacking part or all of a limb, or having a defective limb, organism or mechanism of the body.

Disability: the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from the mainstream of society." (Oliver 1990, p.11)

In general, the Act, like the WHO, also adopts a medical model of disability. This decision is controversial as the model has been subject to substantial criticism by disabled individuals. They contend that it is, in fact, society, which disables physically impaired people as "Disability is something imposed on top of our impairments by the way which we are unnecessarily isolated and excluded from full participation in society" (UPIAS, 1976, p.14). Further criticism derives from that fact that a cure for many disabilities may never be found; and in any event, persons with disabilities are quite capable of participating in society and the practices of confinement that accompany the sick role are unacceptable (Kaplan, 1999). To combat these inadequacies, the use of a social model of disability has been advocated.

According to the social model, disability is any societal factor, which imposes restrictions on disabled people. These can range from individual prejudice to institutional discrimination and from inaccessible public buildings to inaccessible transport systems (Oliver, 1996). As Wendell (1996 at p.46) notes:

¹⁵ For further commentary, see Drimmer (1992), Oliver (1996) or Beaumont (1996).

¹⁶ Oliver consequently advocates the use of the term "Individual model" as opposed to "Medical model".

“The cultural habit of regarding the condition of the person, not the built environment or the social organization of activities, as the source of the problem, runs deep. For example, it took me several years of struggling with the heavy door to my building, sometimes having to wait until a person came along, to realize that the door was an accessibility problem, not only for me, but for others as well. And I did not notice, until one of my students pointed it out, that the lack of signs that could be read from a distance at my university forced people with mobility impairments to expend a lot of energy unnecessarily, searching for rooms and offices. I interpreted it, automatically, as a problem arising from my illness (as I did with the door), rather than as a problem arising from the built environment that has been created for too narrow a range of people and situations.”

Curiously in certain limited circumstances, the Act does favour the adoption of the social model of disability. This is most notably evidenced by the approach taken towards individuals with some form of disfigurement, a topic which will be addressed further below.

Ability to carry out normal day-to-day activities

The Act's adoption of a medical definition indicates that it fails to appreciate the subtle interplay between society, discrimination and disabled individuals. This is best illustrated by the Act's requirement that an impairment must affect the individual's ability to undertake normal day-to-day activities. By Sch. 4 para. 4(1), an impairment affects the ability of the person to carry out normal day-to-day activities only if it affects one of the following capacities - mobility; manual dexterity; physical co-ordination; continence; ability to lift, carry or otherwise move everyday objects; speech, hearing or eyesight; memory or ability to concentrate, learn or understand; or the perception of the risk of physical danger.

The Guidance (C2-3) also makes it clear that activities do not fall within the category of 'normal day-to-day' if they are normal only for a particular person or group. Indeed in *Goodwin v Patent Office* (1999) it was made clear that:

*'What is a day-to-day activity is best left unspecified: easily recognised, but defined with difficulty. Thus, it is not directed to the person's own particular circumstances, either at work or home. The fact that a person cannot demonstrate a particular skill, such as playing the piano, is not an issue before the tribunal, even if it is considering a claim by a musician.'*¹⁷

This invites further criticism of the constitution of disability employed by the Act; The Act stifles the impact of social variables on disabled status, ignoring the environmental factors that may exacerbate disability and requiring a judgement based on generalities of most people's day-to-day activities and not the specific circumstances of the individual (Woodhams and Corby, 2003). The decision in *Goodwin* makes clear that a concert pianist who is unable to play the piano would not be held disabled, if they were able to undertake other normal day-to-day activities. Woodhams and Corby (2003) contend that in the individual's eyes, unable to pursue their life's ambition, they would be disabled.

It also becomes apparent that Pfeiffer's (1998) criticism of the medical model applies by analogy to the Act:

“It depends on the concept of normal. That is, being a person with a disability which limits my mobility means that I do not move about in a (so-called) normal way. But what is the normal way to cover a mile...? Some people would walk. Some people would ride a bicycle or a bus or in a taxi or in their own car. Others would use a skateboard or in line roller blades. Some people use wheelchairs. There is, I argue, no normal way to travel a mile.”

¹⁷ *Goodwin v Patent Office* [1999] IRLR 4, at 7 per Morison J

This obsession with the concept of “normality” insidiously locates disabled individuals as socially inferior to non-disabled individuals. Arguably, the Sex Discrimination Act 1975 and the Race Relations Act 1976 also advance the concept that some societal groups are more “normal” than others, e.g. ethnic minorities only exist in relation to an ethnic majority and that the dominant white, male cultural model is the norm (Fredman, 2001). But by its very language, the Act unwittingly discriminates against disabled individuals. The definition employed is couched in a comparative manner, which advances the concept of the able-bodied being as “normal”. Disability is thus identified by reference to unfavourable deviance from the able bodied (Woodhams and Corby, 2003). Disabled individuals stray from this concept of normality – they are abnormal, unable to undertake “normal” day-to-day activities and in need of our help and support. The judiciary do little to redress this inadequacy and instead unwittingly develop the common law in a manner, which emphasises the limitations of disabled individuals and only serves to alienate them further. In *Goodwin Morison J* stated:

“The focus of attention required by the Act is on the things that the applicant either cannot do or can only do with difficulty, rather than on the things that the person can do.”
(para.34)

It is apparent that such a test further perpetuates the myth that disabled individuals are not “normal”, as what is required is an examination of the disabled individual’s limitations, weakness and deficiencies. Essentially, how they are inferior to the “able-bodied” individual and what differentiates and distinguishes them as different from “normal” society.

In the case of *Vance v Royal Mail Group plc* (2006)¹⁸, the claimant’s osteoarthritis was potentially the basis for a finding that he was disabled, and the issue of disability was explored at a pre-hearing review. On appeal, it was argued on his behalf that the initial employment tribunal had erred in law as it had taken a subjective, not objective view. He was unable bend without difficulty and thus unable to do housework. It was therefore irrelevant that he did not actually undertake housework (in fact, he employed his niece to do it for him). The Employment Appeal Tribunal disagreed, stating:

‘a person will not be treated as disabled because he is substantially impaired in his ability to carry out an unusual activity even if it is an activity that is normal for him. However, it is not a corollary of that that where a person does not, as part of his daily life, carry out an activity that is normal for others, that he is to be treated as disabled if he would not be able to do it’ (per Lady Smith at para 28).

It may be questioned whether this view is based on a correct reading of the Act. The Guidance on Matters to be taken into Account in Determining Questions Relating to the Definition of Disability (2006) make clear that ‘In deciding whether an activity is a normal day-to-day activity, account should be taken of how far it is normal for a large number of people, and carried out by people on a daily or frequent and fairly regular basis. In this context, “normal” should be given its ordinary, everyday meaning’. Consequently as Harvey (2006) notes:

“The fact that the draughtsman has not sought to limit the definition by inserting ‘his’ before ‘normal day-to-day activities’ is arguably a clear sign that the inquiry as to disability should go beyond the particular personal circumstances of the individual claimant.” (at L [1323.02])

From a legal perspective, the judgment also appears incorrect for a further number of reasons. Firstly if, following medical advice a claimant refrains from the undertaking of certain defined “normal” day-to-day activities, it would appear illogical that such an individual would be in an adverse position should the question of their disability status need to be considered. Indeed, from a legal perspective, they would be in a more favourable position if they disregarded medical instructions and continued to persevere in the undertaking of “normal” day-to-day activities. This may prove to have a detrimentally effect upon not only their own health and safety but also the wider public in certain scenarios.¹⁹ Secondly, the decision fails to take account of the fact that disabled individuals often adjust their lives

¹⁸ UKEATS/0003/06/RN, 7 April 2006, Judgement available via:

http://www.employmentappeals.gov.uk/Public/Upload/06_0003fhSMLMRN.doc Accessed 10th November 2006

¹⁹ For example if the individual in question was instructed to refrain from driving.

to accommodate their disability. This was a fact explicitly recognised by the Employment Appeal Tribunal in the *Goodwin* case. Morrison J observed:

“Thus a person whose capacity to communicate through normal speech was obviously impaired might well choose, more or less voluntarily, to live on their own. If one asked such a person whether they managed to carry on their daily lives without undue problems, the answer might well be “yes”, yet their ability to lead a “normal” life had obviously been impaired” (para. 34)

Thirdly, Harvey (2006) notes that the decision in *Vance* could lead to the surprising result that two individuals, whose ability to do household tasks was equally substantially impaired, could be differently categorised for the purposes of the Act according to whether they chose to employ assistance in the home.

From a wider social perspective, the judgment offends against the traditional foundations of equality laws. Equality laws have traditionally been founded on the grounds that they further the liberal goals of State neutrality, individualism and the promotion of autonomy (Fredman 2001). Neutrality is secured by removing any preference for either one section of society or one conception of the “good life”. Indeed, the State should ensure equality between all members of society. Individualism, whilst recognising that individuals may be members of a wider group, is positioned on the principle that each individual has unique qualities and attributes. Respect for that individual necessarily requires that they are treated on the basis of their individual attributes, regardless of their membership of a wider group. Finally, enabling the individuals to make their own choices, including how best to achieve the “good life”, furthers autonomy.

Vance offends these principles of equality, initially by failing to recognise the concept of individualism. As previously, noted, disabled individuals often adjust their lives to accommodate their disability. *Vance* fails to take either this, or the fact that each disabled individual is endowed with specific attributes, into account. It also removes their autonomy. Disabled individuals are not expected to make their own judgements as to their view of the good life. They are not to be afforded the opportunity to improve their personal, professional or domestic circumstances; and they are certainly not to be rewarded for attempting to do so. Disabled individuals must unquestionably accept their position and conform to the legal perception of disability. A failure to conform demonstrates autonomy. Autonomy represents independence, which represents the antithesis of disability.

Substantial adverse effect

The use of the word 'substantial' ensures that trivial conditions are not brought within the scope of the legislation. This is confirmed by the Guidance, which states that a 'substantial' effect is one that is more than 'minor' or 'trivial' rather than 'very large'.²⁰

It has been noted that the Act generally adopts a medical, rather than social, model of disability. Of note however is the treatment of “severe disfigurements”. Special provision is made both for the consequences of disfigurement and for different types of disfigurement. Where an impairment consists of a severe disfigurement, it will “be treated as having a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities” (Sch 1 para 3). However, severe disfigurements, which result from tattoos and body piercing, are excluded.²¹ In assessing whether the disfigurement is “severe”, the Guidance suggests that note should be taken of where it is (para. B21). The indication being that disfigurement is more likely to be “severe” if it is visible to third parties. This exception constitutes a visible adoption of the social model of disability. It recognises that whilst disfigurements may not cause any functional impairment, they instead may lead to disadvantage or discrimination because of other people’s reaction (Connolly, 2006).

²⁰ See Guidance Part II, para A1 and *Vicary v British Telecommunications plc* [1999] IRLR 680

²¹ Reg 5, n 4 above

The recent decision to deem certain specified conditions as disabilities for the purposes of the Act may signify a tendency towards an increasing use of the social model. As from 6 December 2005, persons diagnosed with cancer, HIV, and multiple sclerosis are deemed to suffer from a disability, irrespective of whether they exhibit symptoms of their disease (DDA 1995, Sch 1 para 6A). Although separate provision is made for 'progressive conditions' giving rise to a qualifying disability (Sch 1 para 8), there was a tendency, pre December 2005, to interpret this too strictly with the result that those who suffered from such conditions but whose symptoms were restricted might not qualify. The new deeming provisions introduced by the 2005 Act are intended to prevent such an outcome.

Individuals diagnosed with any of the progressive conditions cited by the Act may be the subjects of social stigma to some degree. Stigma can be characterised as the negative perceptions of so-called normal people to all individuals who are different from themselves (English, 1977). Indeed Goffman (1968) identifies three bases of stigma. First, abominations of the body. Second, blemishes of individual character and third tribal stigma, due to an individual's membership of a despised group in society. Ultimately of those progressive conditions deemed to be disabilities for the purposes of the Act, the social stigma associated with HIV is invariably the most pronounced. Watt (1996) advances one possible explanation as being the fact that stigmatisation of individuals with HIV rests upon all three of Goffman's bases. It is therefore logical to conclude that a person who bears all three stigmatising factors will be more highly stigmatised than a person who is shunned on one ground alone.

Whilst the decision to extend protection to individuals with progressive conditions is to be welcomed, it may create a number of anomalous outcomes. At the point of diagnosis many individuals with a progressive condition will, to the naked eye, appear not to be disabled. Of greater note is the fact that many of these individuals will not consider themselves "disabled", nor indeed wished to be perceived as "disabled". Newly diagnosed individuals often refuse to consider themselves disabled for a variety of reasons. Disability carries a stigma that many people want to avoid if possible, and it may take time for these newly diagnosed individuals to admit that they are members of a stigmatised group. These individuals may also hold opinions that are common among non-disabled people. They may perceive disability to be an absolute concept, i.e. disabled individuals are disabled in respect of every aspect of their lives. As they know that they are not disabled in all respects, they may resist attempts to label them as "disabled" for fear that others will perceive them as wholly disabled and consequently, fail to recognise their attributes and abilities (Wendell, 1996). Finally, disabled individuals may have hoped for a cure for their impairment and may resist being labelled as "disabled". They may perceive the acceptance of such a label as an acknowledgement of the fact they are disabled and an acceptance of the prospect that they may have to accept their altered abilities and body for the rest of their natural life (Wright, 1983).

"Hidden" Disabilities

Individuals newly diagnosed with a progressive condition, and indeed a significant number of other disabled individuals may appear outwardly healthy and "able bodied" to the naked eye. It could be said such individuals have "hidden" disabilities. The issue of such hidden disabilities has created further difficulties for courts and tribunals as they have attempted to delineate the link between the discriminator's knowledge and the less favourable treatment in question. It is often advanced that there is no need for an employer to have knowledge of an individual's disability. In *O'Neill v Symm & Co Ltd*,²² it was held that there could not be some less favourable treatment of a person by an employer for a reason that relates to that person's disability unless the employer has knowledge of the disability. Despite this early indication to the contrary, later cases have now shown that such knowledge is not necessary.²³ Indeed, some commentators have stated that there is no need for the employer to have knowledge of the disability (Connolly, 2006)²⁴. On a further reading of the *H J Heinz Co Ltd v Kenrick* case it is submitted that this would appear a misguided approach. Whilst the Employment Appeal Tribunal in this instance acknowledged that there is no requirement that the

²² [1998] IRLR 233 EAT

²³ See *Clark v TDG Ltd, t/a Novacold* [1999] IRLR 318, CA and *H J Heinz Co Ltd v Kenrick* [2000] IRLR 144, EAT
²⁴ Connolly (2006) makes this statement when considering disability related discrimination. He does not refer to the knowledge required in relation to direct disability discrimination. However in relation to the relatively new head of direct disability discrimination the Code of Practice states, "Moreover, direct discrimination may sometimes occur even though the employer is unaware of a person's disability" (para 4.11). There are as yet no reported decisions on whether actual or constructive knowledge is required and it remains to be seen what approach the Courts will take.

relationship between the disability and the treatment should be adjudged subjectively, they did state that the test should be an objective one. Indeed:

“unless the test is objective, there will be difficulties with credible and honest yet ignorant or obtuse employers who fail to recognise or acknowledge the obvious.” (Lindsay J at para. 26)

As it is submitted that the test is an objective one, it is incorrect to state that an individual can discriminate against an individual with absolutely no knowledge of their disability. Although subjective knowledge is not necessary, constructive knowledge is required. The alleged discriminator is imputed with the knowledge of the reasonable man. Consequently, the correct test requires a consideration of whether a reasonable person would have known the individual in question to be disabled from the symptoms they were exhibiting? If yes, then the alleged discriminator is attributed with such knowledge.

Such an approach, although logical, may present difficulties for those individuals with hidden disabilities. Unless such individuals expressly inform third parties of their disability, they may be subjected to unintentional discrimination. Disabled individuals may consider their disability a private matter and choose not to disclose their status. The decision to inform others of one's disability is an inherently personal choice influenced by a wide range of factors. Indeed many newly diagnosed individuals may either not consider themselves “disabled” or even resist such a label. Obviously, a person who refuses to accept him or her as disabled will not be in a position to disclose their status. The unfortunate effect is that such individuals will not be afforded sufficient satisfactory protection by the Act. This is a factor explicitly recognised by the Code of Practice²⁵, when discussing the duty to make reasonable adjustments within an employment relationship:

“An employee has symptomatic HIV. He prefers not to tell his employer of the condition. However, as the condition progresses, he finds it increasingly difficult to work the required number of hours in a week. Until he tells his employer of his condition – or the employer becomes aware of it (or could reasonably be expected to be aware of it) – the employer does not have to make a reasonable adjustment by changing his working hours to overcome the difficulty. However, once the employer is informed he may then have to make a reasonable adjustment.” (para 8.23)

Coupled with this is the problem-hidden disability present for successful equality policies and practices. It is inevitable that measures to promote equality must be conspicuous if they are to be perceived by society as successful. The conspicuousness of such measures is fundamental to liberal equality practice (Jewson and Mason, 1986). Society must be able to see that disabled individuals actually benefit in practice from such measures and individuals with hidden disabilities present a challenge to this notion. Although they may have benefited from equality practices, they are not visible advertisements for the success of such policies (Woodhams and Corby, 2003).

Long-term

The final element of the constitution of disability is the requirement that any impairment must be “long-term” if it is to qualify as a disability. Schedule 1, para 2(1) of the DDA 1995 provides that the adverse effect of an impairment is “long-term” if it has lasted for at least twelve months, or the period for which it lasts is likely to be at least twelve months, or it is likely to last for the rest of the life of the person affected. Where it has to be determined whether an impairment producing a substantial adverse effect was 'likely' to last for 12 months, the answer has to be given with reference to what was more probable than not at the date when the act of discrimination complained of took place. (Guidance, para B7)

In sum, it is apparent that the Act is a considerable piece of legislation, which has generated much comment and case law. Yet, through a deconstruction of the legal constitution of disability a number of criticisms, both legal and social, may be identified. However, perhaps the Act's greatest flaw is its inability to combat perceived discrimination. Perceived disability discrimination arises where a person treats another less favourably because he believes that person to have a disability. An example of an

²⁵ n 6 above

approach to combat such discrimination may be evidenced by the Americans with Disabilities Act, which defines disability as:

“(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;

(B) A record of such an impairment; or

(C) being regarded as having such an impairment²⁶ (emphasis added)

With perceived discrimination the fact that an individual may be mistaken and their perception incorrect makes no difference, the discriminator has still treated an individual less favourably on the grounds of disability. The Act takes a more restrictive approach with the requirement that any less favourable treatment be on the ground of *the disabled person's* disability. This more restrictive approach has the unfortunate consequence that an individual may be discriminated against on the mistaken belief that they are suffering from a disability and yet be afforded no statutory protection. This leaves members of certain stigmatised sectors of society particularly vulnerable to less favourable treatment. Due to their very nature, a discriminator is evidently more likely to discriminate against an individual whom he believes to be suffering from a hidden disability than an overt disability. As the individual in question appears outwardly healthy and “able bodied” to the naked eye; it is obvious that mistakes regarding disability status are more likely to be made and hence that perceived discrimination will more commonly be associated with such disabilities²⁷. Of the hidden impairments deemed to be disabilities under the Act, the social stigma associated with HIV is invariably the most pronounced. The danger in this area is that members of certain sectors of society which are already highly stigmatised will be perceived to be HIV positive, subjected to less favourable treatment on that ground and yet not be afforded any statutory protection. Those in question are members of sectors, which experience a higher prevalence of HIV infection than exists in the general population; examples include intravenous drug users, homosexual men and individuals from sub-Saharan Africa. Whilst the additional layer of discrimination further stigmatises the individual in question, it is somewhat ironic that they are not afforded the Act’s protection. This is a lacuna within the legal constitution of disability, which must be addressed before the Act can truly address the issue of disability discrimination.

²⁶ See 42 U.S.C. s12102 (2) (C) (1994) and Kaplan (1999)

²⁷ For example – mental illness, cancer, HIV, multiple sclerosis

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