article
Towards Disability Ethics:
a social science perspective

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Abstract

In the social sciences, debates about the discursive and material constitution of subjectivity and identity no longer appear to be at loggerheads. This has important implications for how we are to construct a framework for thinking about disability ethics. Following recent inroads in disability theory and in the sociology of ethics, we would argue that one of the aims of a disability ethics is not to view disability exclusively as a question of impairment, but to reclaim the social aspects of impairment in conjunction with the embodied aspects of disability. We would also suggest that the social and cultural construction of impairment, or abnormal corporeality, cannot be considered apart from the moral and existential relations that exist between disabled and non-disabled persons. The question we want to raise in this discussion is whether thinking disability ethics through a bioethics framework is adequate to this task.

Key Words: disability, impairment, embodied ethics.

Introduction

In recent years debates about the discursive constitution of subjectivity and the material constitution of identity no longer appear to be at loggerheads. This is especially true in the social sciences, and is due to the recognition that social processes and textual practices affect bodies as well as minds. Conversely, it is also acknowledged that embodiment and bodily practices affect the constitution of social subjects and social interactions. With good reason, however, Disability Studies has tended to be suspicious of attempts to re-theorise embodiment along these lines for fear that disabled persons will be reduced to nothing but their bodies and impairments. Consequently, it has had a strong social constructionist orientation, which has privileged explanations of identity constitution in terms of the complex interplay of power and knowledge in the creation of disabled subjects. In other words,

Disability Studies has drawn on a social constructionist model that prioritises 'processes by which the subject is marked, scarred, transformed, and written upon or constructed by the various regimes of institutional, discursive, and nondiscursive power as a particular kind of body' (Grosz, 1995, p.33).

At the same time, Disability politics has relied on a political agenda that has assumed commonality around the articulation of shared experiences of disability. In so doing it has constructed a politics that validates and takes as given a universal, discrete, and fixed disabled identity. While this has been undeniably important for ensuring the equitable distribution of rights and benefits, and for cohering interests based on community belonging, it has a number of pitfalls. One of these is that the inscription of the disabled body as a particular kind of body has occurred at the expense of phenomenological accounts of bodily impairment. This has had direct implications for how we are to construct a

framework for thinking about disability ethics. The foremost problem here is that the ways in which bodies are marked and inscribed by social laws and value do not necessarily correspond to the ways in which bodies are lived in the context of everyday life. Certainly if it is the case that one doesn't 'live in politics all the time', as Anna Yeatman (1993, p.236) sensibly observes, then we have to militate against the danger that 'identity works to foreclose politics, to substitute interest for ethics' (Yeatman, 1993, p.229).

This is not to say that ethics have no bearing on politics, but because ethics pertain to 'the domain of relations between the self and other' (Grosz, 1989, p.xvii) and to the sorts of obligations we have to one another in those domains, it is important to analyse and rethink the nature of those relations, especially if they are oppressive and discriminatory. What this requires politically is the acknowledgment of differences while simultaneously recognising similarities not only among disabled persons themselves, but also between disabled and non-disabled persons. In particular, it means analysing the structure or nature of the relations that exist between disabled and non-disabled subjects. In this regard it is important to note that because ethics occur in the process through which we become subjects, and because we are all subjects who inhabit different sorts of bodies, ethics will necessarily entail constant negotiation and re-negotiation with other embodied subjects.

In short then, and following Disability theorists Kevin Paterson and Bill Hughes (2000, p.42), we would argue that one of the aims of disability ethics is not to view disability exclusively as a question of impairment, but to reclaim the social aspects of impairment in conjunction with the embodied aspects of disability. We would also suggest that there are occasions where the identity politics of the disability rights movement need to be sublimated in the best interests of forging a disability ethics. With these points in mind, the social and cultural construction of impairment, or abnormal corporeality, cannot be considered apart from the moral and existential relations that exist between disabled and non-disabled persons. Both institutionally and in terms of negotiating the proxemics of everyday life, these relations are constituted for disabled and non-disabled persons by the recognition (and misrecognition) of human vulnerability, dependency, and care. The twofold question raised in this paper is whether thinking disability ethics through a bioethics framework is adequate to this task

and what a social science approach can contribute to this process of rethinking.

Problems of Definition
As a first step to answering this question, one immediate problem that springs to mind is definitional. There are a number of theoretical and disciplinary issues involved when using the terms 'disability' and 'ethics'. Where disability is concerned, much of the contestation has to do with representational politics or the politics of voice; that is, who says what, how, to whom, and on whose behalf? The issue over ethics is equally territorial and concerns guarding imaginary institutional boundaries between the perceived unified discursive entities of sociology and philosophy (see Bauman, 1992, ch.5; Shaw, 1996, ch.1). While some sociologists – positivists and economic determinists among them – have claimed that ethics is epiphenomenal to the discipline, the view frequently articulated from philosophy is that sociology deals mainly in ethno-ethics (i.e. sociologists tell us what people say, do, and believe to be right and wrong). In contrast, moral philosophy pronounces upon properly ethical statements (Bauman, 1995, p.10).

While these debates about the relationship between sociology and philosophy and who has the right to talk about ethics testify to the never ending quest for disciplinary certainty and homogeneity, they also serve to circumscribe and conceal the meaning of ethics, making it difficult to grasp. The fact is that this lack of terminological clarity around the term ethics arises from its many different meanings. For this reason both disability and ethics are best understood as essentially contested concepts and not as proper nouns. Obviously this point has not been lost on contemporary moral philosophers who think beyond characterisations of ethics as simply the philosophical study of morality (e.g. Walker, 1998). The recent resurgence of ethics across a number of philosophical traditions often thought to be unconcerned with questions of morality (e.g. deconstruction, phenomenology, post-analytic philosophy) also highlights this semantic instability. So too does the renascence of ethics within the discipline of sociology itself (see Haimes, 2002[1]; Russell, 2000; Shaw, 1996). Notwithstanding, it should be noted that this resurgence is not the spurious by-product of postmodernist discourse, but rather a consequence of wider cultural processes that have brought about a re-thinking of the status and meaning of ethics in the everyday lives of everyday people. The fact that ethics

has figured so prominently in recent debates thus prompts the question, 'what is ethics?' Correspondingly, it needs to be asked 'what is disability?' and are we talking about the same thing when we invoke this term.

In lay and popular understandings, as well as in general moral theory, ethics is ordinarily conceptualised as a theoretical reflection of morality or as principles, rules, or maxims that inform ethical conduct. According to this view, which enjoys considerable currency, moral agency and judgment are achieved by the exercise of universal cognitive faculties that guide our actions in a given situation. There are of course alternatives to these accounts. While several exist within the rubric of moral philosophy itself (e.g. Virtue Ethics, Narrative Ethics, Feminist Ethics), we are primarily interested in generating an account of ethics from outside the accepted framework of moral theory *per se*.

In keeping with our broad social science brief, we think the ideas from postmodern ethics have a number of contributions to make in this regard. Such ideas come out of the burgeoning sociology of (postmodern) ethics (Bauman, 1993; Shaw, 1996; Smart, 1999), as well as recent work in corporeal feminism[2] that takes up the idea of subjectivity as embodied. The first point of departure for this preliminary sketch is to reiterate the basic sociological tenet that: selves are embodied and constituted in relation to other selves. The beauty of this idea is that it enables us to develop a conception of ethics that extends beyond descriptions of moral agency and judgment as transparent self-conscious choice, or more banally, as something that can be summed up in terms of informed consent or individual rights. Certainly we still think it is important to retain the idea of ethics as a code of practice that regulates differential power relations between people (such as carers or assistants and disabled persons). However, our use of the term ethics does not refer to rules or principles for proper conduct or to a situation in which the moral conscientiousness of individuals takes precedence over responsibilities to another. Rather, in our rendering, which is drawn from a rapidly expanding corpus of knowledge (see Bauman, 1993; Diprose, 1994, 1998; Gatens, 1996; Grosz, 1989; Komesaroff, 1995; Price & Shildrick, 2002; Shildrick & Price, 1999; Shaw, 2003; Smart, 1999), ethics entails concrete responsibility for others or for another person. Hence, as Rosalyn Diprose (1994, p.1) stipulates, we are not interested in approaches to ethics that are based on social exchange relations 'between self-present,

autonomous, disembodied individuals' who occupy already fixed subject positions or roles. We are interested in the specificity of embodied, situated subjects and their relations with other subjects. When applied to the context of disability, this conception of ethics refers to an encounter that is situated in a particular social habitat, and to the notion of an embodied moral relationship that a person with a bodily impairment has with any other person, and vice versa. In this approach, which is derived in part from phenomenology, moral conduct does not emanate from the self or an atomised individual, but pertains to the intersubjective and intercorporeal domain of relations between self and other.

In attempting to provisionally answer the question 'what is disability?' it is important to note the complex web of analytical and political debates that surround the term. For disabled people, for example, the concept of disability needs to be distinguished from the phenomenon of impairment, upon which its meaning also rests. As it currently stands, impairment denotes a wide range of defective physical, sensory, cognitive, and psychological mechanisms of the body or mind, whereas disability is the disadvantage caused by the social, economic, political and environmental factors which restrict and/or exclude impaired people from full participation in their communities (adapted from UPIAS, 1976). These two approaches are known respectively as the medical and social models of disability. The impairment/medical model has its genesis in the natural and physical sciences of biology and medicine (see Hahn, 1987; Stone, 1985) and the social model originates in sociology (see Abberley, 1987; Finkelstein, 1980; Morris, 1991: Oliver, 1984, 1986, 1990; Sullivan, 1991; UPIAS 1976).

Regardless of the importance of distinguishing between these two models, the overwhelming view of disability is highly medicalised and narrow. It is thus problematic when disability, disability research, and disability ethics are considered through a lens that sees disability as synonymous with impairment. From the perspective of the disability rights movement, impairment and disability, while interrelated, need to be recognised as distinct and separate. For disabled people, disability is about social exclusion and discrimination, whereas impairment is organic to the individual body or mind. Problems clearly arise when the two notions are conflated.

In order to redress this kind of elision, and much like Erica

Haimes (2002), we want to make a case for the inclusion of social science discourses in the field of bioethics. There are a number of reasons for wanting to do this. First, we believe that sociological insights can shed light on the social and cultural processes by which bodies and subjectivities are produced as normal and abnormal. At the same time they allow us to interrogate, as Haimes (2002) suggests, the social processes by which ethical issues are themselves designated 'ethical'. Finally, without empirical studies and investigation, we can have no phenomenology of contemporary ethical life and thus no rigorous body of knowledge that enables us to move between the particular and the general. What is required then is systematic and ongoing social research in order to 'expand our repertoire of what counts as 'ethical'' (Haimes, 2002, p.105). This will alert 'us to the possibility of multiple perspectives on ethics', as Haimes (2002, p.105) says, and to multiple perspectives on the experience of embodiment.

We take the view that bioethics is best defined as 'the systematic study of the moral dimensions of the life sciences and health care, employing a variety of ethical methodologies in an interdisciplinary setting' (Jonsen, 1998, p.vii). Therefore, we believe it should be able to make space for the sorts of critical interventions offered by the sociology of ethics suggested in this paper. Included as part of the bioethics' repertoire, a social science approach can redress the narrow understanding of the biomedical paradigm that has tended to dominate the field and to hamper the progress of Disability Studies. In order to illustrate this it is necessary to briefly detour through a discussion of the medical and social models of disability and impairment.

The Medical Model
It has been argued that the medical model of disability is the product of the collusion of western medical science and the welfare state. In the 1850s germ theory developed with the discovery of microbes as the agents of illness and disease. At this time the onus was on medical practitioners to develop specific forms of intervention to effect cures. This was aided by technological developments such as the microscope, the X-ray machine, the ophthalmoscope, and the stethoscope. These allowed doctors to look inside a patient's body and diagnose disease on the basis of scientific measurement (Stone, 1985; Turner, 1987).

With the development of welfare, or charitable aid as it was

then known, the state was faced with the problem of separating out the deserving from the undeserving poor. It was easy to tell if someone was a widow or an orphan: the authority could just look up the births and deaths register. But disability could always be faked. How was the state to know if a person was genuinely blind, physically or intellectually impaired? What was needed was an objective index of capacity to work and a means to quantify incapacity. In other words, the state needed a way of objectifying disability in individuals as a means to legitimate their claims for social aid. Biomedicine, with its new diagnostic techniques, provided the answer (Oliver, 1990; Stone, 1985).

Medical definitions were subsequently written into legislation, which defined disability and disabled people purely in terms of functional impairment and capacity to work. Specialised institutions such as hospitals, clinics and asylums were sanctioned by statute to cure or care for disabled people. Individuals who couldn't be cured were passed on to the rehabilitation system where they were taught to adjust to their 'problem'. That is, they were socialised into believing and accepting their inferior status (Sullivan, 1991). The hospitals in turn provided the space in which a range of helping professions (such as nurses, physiotherapists, occupational therapists, counsellors, and social workers) emerged to 'help' impaired people to cope with their 'problem'. Locked away in institutions and surrounded by helpers, it is not surprising that disabled people came to be generally viewed as a different species of tragic beings that were passive, powerless, dependent; pitiable objects worthy of charity (Oliver, 1990; Sullivan 1991). Another major disabling outcome of medical domination was the fragmentation of impaired people into a whole series of diagnostic categories (e.g. cerebral palsy/CPs, muscular dystrophy/MSs, paraplegics, manic depressives, schizophrenics), which tended to constitute disabled people as isolated individuals with no collective sense of community based around shared experience (Hahn, 1987).

Viewed through the critical lens of the social model of disability and the disability rights movement, the medical model reduces disability to impairment, disabled people to their incomplete, flawed, lacking bodies and it legitimates segregation for cure, rehabilitation or care. From this view, one of the overwhelming problems with biological and medical research is that it therefore presupposes a mechanistic model of the body. This is clearly a problem for thinking about

disability because it reduces the body to a collection of parts that can be added to, subtracted from, augmented, and supplemented; a body that can be improved and made productive. The effect is ultimately to constitute disabled people as an assemblage of bits, parts, fluids, and tissues that do not mesh into a coherent whole. While this compartmentalisation is problematic in itself, the bits and parts of the disabled body are also rendered defective. In this respect, the mechanistic view tends to abstract 'the' body from people's actual bodies and from how they live them. Hence, at the centre of the medical model is a physically, sensorially, intellectually, or psychologically impaired body couched in terms of deficit and which medicine must remedy, cure or ameliorate. While the medical profession is guided by a fundamental duty or imperative to alleviate or prevent harm and suffering, disability activists argue that the approach the medical model adopts affronts disabled people, for it not only denigrates them as lacking but it also negates the possibility that disability can be a positive state of being.

The Social Model

Over the past thirty years, disabled people, drawing on their own experiences, have rejected the medical model with its individualised, psychologised and medicalised account of disability for a sociological account which views disability as an oppressive social creation. In this (social) model a distinction is drawn between 'impairment' and 'disability' (UPIAS, 1976) and the focus shifts from individual impairment to the disabling effects of social organisation and structures designed to meet the needs of non-impaired people. From this perspective, disability is unequivocally located outside the body and *in* society. As the UPIAS document puts it: '… In our view, it is society which disables … Disability is something imposed on top of our impairments …' (1976, p.3).

The social model has been tremendously important to disabled people and the disability rights movement in two key ways. First, it provided a political agenda for the elimination of disability via the removal of barriers from the built and social environments that exclude impaired persons from participating in their communities (NZDS, 2001; Sullivan, 2000). Second, it has had a positive effect on the consciousness of disabled people themselves. In other words, disabled people could now view themselves as an oppressed minority as opposed to flawed individuals; they were no longer at fault, society was; they could stop feeling sorry for themselves and feel angry. It

was no longer a case of being grateful for charity but of demanding their rights to equal participation in society and standards of living enjoyed by their non-impaired counterparts (Shakespeare & Watson, 2000).

While the social model has been a powerful force for positive change towards a non-disabling society, it has recently been criticised for its neglect or avoidance of impairment and embodiment. With the exception of Jenny Morris (1991), it is only in relatively recent times that disability theorists have begun to address the body and the question of impairment (e.g. Corker & French, 1999; Corker & Shakespeare, 2002; Crow, 1996; Thomas, 1999). This shift owes its debt to a number of wider discursive turns. Two of the more salient of these are to be found in feminism and in developments in poststructuralism that have sought to bring the 'body back in to' social theory and sociology. With reference to the latter intervention, Michel Foucault's (1979, 1984) work is of particular significance. Foucault's investigations as to how the historical constitution of bodily capacities and propensities shape, form, and stylise individual subjects and embodied selves has provided many theorists from a variety of social science and humanities disciplines with the requisite tools to begin their own subsequent inquiries. However, one problem that has been consistently identified with Foucault's work and with poststructuralism in general, is that it tends to emphasise the discursive production of the body, rather than focus on its specific materialities (see McNay, 1999).

Similarly, the social model of disability also pays insufficient attention to the materialities of the body and the realities of impairment. This is problematic because it results in an incomplete understanding of disability. Against this model, Sullivan (1996) for instance, has argued that for many people with disability their impairment has medical implications that compel them to adopt certain regimes of care without which they will deteriorate and die. In turn, these certain regimes of care require disabled people to organise their lives around the care of their bodies in such a way that body management takes precedence over everything else. This is made clear in the following reflections by a paraplegic on how his life now depends upon a disciplined and conscious monitoring of his body and how this had not only changed the way in which he lived his life but also his self-perception:

I think of my body as a baby now and I'm the mummy. In

my brain I have to think about and worry about it. How I'm sitting ... I have to think for my bodily functions, when I go to the toilet. What time I do it, how often, whether or not I'm sitting on an object and getting a pressure area. I worry about my kidneys. Drinking fluid, you know. I just generally am in tune with my body. (Quoted in Sullivan, 1996, p.159)

He has to know more about his body, precisely because it does not work. And it is in that lack of function that he forges identity. For instance, as he goes on to say:

It's a bit of a drag really. I hate – it's always a time for a reflection on the fact that you're a cripple. It's a constant reminder that you are paralysed because otherwise you just wake up in the morning and jump in your wheelchair and it really doesn't matter that you're in a wheelchair or not ... It's not until … say, in a pub, I've got to go and pass a catheter … [A]nd you've got to do it all in a certain way. You've got to have sterile, clean conditions, and it starts to manipulate your life. Your body dictates to you and it's always a reminder that you are different. Those are the things that keep you different; otherwise if you … had all your bodily functions … and you were in a wheelchair, really, in the end, it would make no difference that you couldn't walk (quoted in Sullivan, 1996, pp.159-60).

From this perspective, disability is not only the consequence of attitudes and the built environment, but also the subjective and practical experience of living as an impaired body. Notwithstanding, writing about impairment is a fraught project for disabled people because to re-engage the subject of impairment is to risk re-medicalisation. But to silence any discussion on impairment is to exclude an important reality of many disabled person's lives, that of the subjective experience of impairment, of their embodiment which cannot be separated from their subjectivity, and of their sense of self and their own physical and emotional well being (see Crow, 1996). In this context, discussion about subjectivity and the embodiment of impairment stands in stark contrast to the medicalised accounts of impairment found in biomedicine. Hence, we would argue, that to leave the body out of any discussion of the disabled subject gives a partial and incomplete view of what disability is about. What we are calling for as an alternative is a more specific kind of disability ethics: an embodied ethics.

The Need for an Embodied Ethics

While we have suggested that the social model of disability tends to avoid discussion of embodiment in relation to the lived experiences of disabled persons, we have also argued that it is not enough to research the body in isolation from its socio-cultural production. Research and analysis that views the body in terms of brute matter, and then takes that body as its ground for ethical discussion, is not immune from criticism either. This approach merely abstracts 'the body' from people's actual bodies and their experiences of them. It also enacts a refusal of the basic sociological dictum that 'we are bodies and we have bodies' (Turner, 1984, p.1), which entails recognising that we consciously inhabit a body as opposed to simply possessing a body that 'belongs to me'.

In addition, it is our perception that while consenting subjects are increasingly acknowledged as the centre of biomedical research (and this is a good thing), there remains the problem that their subjectivity will be eviscerated from their body while it is under repair or investigation. That is to say, although consent is imperative in ethics it can also fail to account for the ways in which ongoing changes to bodily experiences and states affect how we act and what we do, and how our interactions with others in contexts of care and dependency are affected in turn by our experiences and modes of being-in-the-world. In contrast, the analysts whose work we are drawing on all agree that the processes through which subjectivities are constituted are complex, on-going ethical processes that are bound up with human embodiment. What this means is that our bodies cannot be treated as raw matter or as the unacknowledged backdrop against which we debate ethical issues, without considering the cultural production of those bodily differences in the first place.

Because people's experiences are almost always embodied to some degree or another, and their interactions with and through their bodies occur with others and with the world around them, the body is a site of ethical and political identity. And it is precisely for this reason that we must ask how a body differentially 'lives' its identities. It is not enough, therefore, to focus merely on the ethical issues that arise from inhabiting a 'disabled body' or from a situation of physical impairment, just as it is not sufficient to think of the pain and suffering a disabled body feels only in terms of a socially constructed interpretation. What is crucial is to recuperate the importance of the concrete embodied experiences and practices of the

individuals who live those bodies. Arguing for an ethics that is generated from the body rather than the head entails taking these somatic dimensions of our lives into account. It also entails responsibility for the irreducible difference of the other person, which in our opinion, provides the basis for a thorough-going disability ethics.

Given its institutionally significant positioning as a site for the convergence of debate about the body and ethics, we urge the new discipline of bioethics to remain open to 'a variety of ethical methodologies'. This should include non-mainstream social science and philosophical interventions. Failing this, bioethics may not be the most appropriate home or dwelling place for an ethics of disability. This is not to say that impairment research should not be done, but that the sort of disability research we are advocating about the relationships between embodied subjects and their being-in-the world needs to be done in conjunction with biomedical studies of impairment that are sensitive to this requirement. It follows that the ethics appropriate for this sort of research will be an embodied ethics that includes, rather than excludes, the interests and experiences of disabled people within 'the institutions that distribute moral judgments' (Diprose, 1998, p.97).

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Notes
1   Thanks to the anonymous referee who suggested the Erica Haimes' (2002) article.
2   Corporeal feminism refers to feminist thinking and research that emphasises the concrete specificity of bodies, and pays particular attention to embodied differences between sexed subjects. It is often associated with the groundbreaking work in the early 1990s of several Australian feminists, especially the work of Elizabeth Grosz.

References
Abberley, P. (1987). The concept of oppression and the development of a social theory of disability. *Disability, Handicap & Society,* 2:1, pp.5-19.

Bauman, Z. (1992). *Intimations of Postmodernity.* London & New York: Routledge.

Bauman, Z. (1993). *Postmodern Ethics.* Oxford, UK & Cambridge, USA: Blackwell.

Bauman, Z. (1995). *Life In Fragments: Essays in Postmodern Morality.* Oxford, UK & Cambridge, USA: Blackwell.

Corker, M. and French, S. (eds) (1999). *Disability Discourse.* Buckingham and Philadelphia: The Open University Press.

Corker, M. and Shakespeare, T. (eds) (2002). *Disability/Postmodernity: Embodying Disability Theory.* New York: Continuum.

Crow, L. (1996). Including all our lives: renewing the social model of disability. In Barnes, C. and Mercer, G. (eds) *Exploring the Divide: Illness and Disability.* Leeds: The Disability Press.

Diprose, R. (1994). *The Bodies of Women: Ethics, embodiment and sexual difference.* London & New York: Routledge.

Diprose, R. (1998). Ethics. In Caine, B. (ed.) *Australian Feminism: A Companion.* Melbourne, Oxford, Auckland, New York: Oxford University Press, pp.90-98.

Finkelstein, V. (1980). *Attitudes and Disabled People.* New York: World Rehabilitation Fund.

Foucault, Michel (1979). *Discipline and Punish: The Birth of the Prison.* New York: Vintage Books.

Foucault, Michel (1984). *The History of Sexuality: An Introduction.* England, New York, Australia, Canada, New Zealand: Penguin Books.

Gatens, M. (1996). *Imaginary Bodies: Ethics, Power and Corporeality.* London and New York: Routledge.

Grosz, E. (1989). *Sexual Subversions: Three French Feminists.* Sydney, Wellington, London, Boston: Allen & Unwin.

Grosz, E. (1995). *Space, Time And Perversion: The Politics of Bodies.* NSW, Australia: Allen & Unwin.

Hahn, H. (1987). Civil Rights for Disabled Americans: The foundation of a political agenda. In Gartner, A. and Joe, T. (eds) *Images of the Disabled, Disabling Images.* New York: Praeger.

Haimes, E. (2002). What can the social sciences contribute to the study of ethics? Theoretical, empirical and substantive considerations. *Bioethics,* 16: 2, pp.89-113.

Jonsen, A. (1998). *The Birth of Bioethics.* New York: Oxford University Press.

Komesaroff, P. A (ed.) (1995). *Troubled Bodies: Critical Perspectives On Postmodernism, Medical Ethics, And The Body.* Australia: Melbourne University Press.

McNay, L. (1999). Gender, habitus and the field: Pierre Bourdieu and the limits of reflexivity. *Theory, Culture & Society,* 16:1, pp.95-117.

Morris, J. (1991). *Pride against Prejudice.* London: The Women's Press.

NZDS. (2001). *The New Zealand Disability Strategy. Making a World of Difference. Whakanui Oranga.* Wellington, New Zealand: Ministry of Health. http://www.nzds.govt.nz

Oliver, M. (1984). The politics of disability. *Critical Social Policy,* 11, pp.21-31.

Oliver, M. (1986). Social policy and disability: some theoretical issues. *Disability, Handicap & Society,* 1:1, pp.5-17.

Oliver, M. (1990). *The Politics of Disablement.* London: Macmillan.

Paterson, K. and Hughes, B. (2000). Disabled Bodies. In Hancock, P. (ed.) *The Body, Culture And Society: An Introduction.* Buckingham & Philadelphia: Melbourne University Press, pp.29-44.

Price, J. and Shildrick, M. (2002). Bodies Together: Touch, Ethics and Disability. In Corker, M. and Shakespeare, T. (eds) *Disability/Postmodernity: Embodying Disability Theory.* New York: Continuum, pp.62-75.

Russell, R. (2000). Ethical Bodies. In Hancock, P., Hughes, B., Jagger, E., Paterson, K., Russell, R., Tulle-Winton, E. and Tyler, M. (eds) *The Body, Culture And Society: An Introduction.* Buckingham, Philadelphia: Open University Press, pp.101-115.

Shakespeare, T. and Watson, N. (2000). *The Social Model of Disability: an outdated ideology?* Unpublished paper. tilting@windmills.u-net.com

Shaw, R. (1996). *'Survival Among The Remnants': Sociology And Ethical Revision.* Unpublished PhD Thesis. University of Auckland, Auckland, New Zealand.

Shaw, R. (2003) Theorizing Breastfeeding: Body ethics, maternal generosity and the gift relation. *Body and Society,* 9: 2, pp.55-73.

Shildrick, M. and Price, J. (1999). Breaking the boundaries of the broken body. In Price, J. and Shildrick, M. (eds) *Feminist Theory and the Body: A Reader.* New York: Routledge, pp.432-44.

Smart, B. (1999). *Facing Modernity: Ambivalence, Reflexivity and Morality.* London, Thousand Oaks, New Delhi: Sage Publications.

Stone, D. (1985). *The Disabled State.* London: Macmillan.

Sullivan, M. (1991). From personal tragedy to social oppression: the medical model and social theories of disability. *New Zealand Journal of Industrial Relations,* 16, pp.255-272.

Sullivan, M. (1996). *Paraplegic Bodies: Self and Society.* Unpublished PhD thesis, University of Auckland, Auckland, New Zealand.

Sullivan, M. (2000). Does it say what we mean, do we mean what it says, do we know what it says? Problematising the way disability is written and spoken about. *New Zealand Journal of Disability Studies,* 8, pp.36-46.

Thomas, C. (1999). *Female Forms: Experiencing and understanding disability.* Buckingham and Philadelphia: The Open University Press.

Turner, B. S. (1984). *The Body and Society: Explorations in Social Theory.* Oxford, Great Britain: Basil Blackwell.

Turner, B. (1987). *Medical Power and Social Knowledge.* London: Sage Publications.

UPIAS (1976). *Fundamental Principles of Disability.* London: Union of the Physically Impaired Against Segregation.

Walker, M. U. (1998). *Moral Understandings: A Feminist Study in Ethics.* New York and London: Routledge.

Yeatman, A. (1993) Voice and representation in the politics of difference. In Gunew, S. and Yeatman, A. (eds) *Feminism And The Politics of Difference.* NSW, Australia & Wellington, New Zealand: Bridget Williams Books, pp.228-245.