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Globalization and ICF Eugenics: Historical coincidence or connection? The More Things Change the More They Stay the Same

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Are there links between globalization, ICF[1] and the development of the human genome project? How does it impact on the economics of biotechnology and eugenics? And what connection do these phenomena have to other pending world events? This article intends to explore possible associations and conjunctions with a particular focus on how these events coincide (synchronism).

The fact that the newly unveiled ICF and the push for globalization emerged at approximately the same time suggests that a new social reality will result from this shift in ideology. There are two common denominators between the two trends that would lead us to this conclusion.

First, the World Bank has researched, perhaps for the first time, and from a global perspective, a document on disability and poverty in which the ICHID2 was acknowledged (Elwan, A., 1999). Both this document and the notion of ICHID2 are making somewhat similar statements on the locus of the problem, using the individualism \ medical model with regards to impairment.

Secondly, both are attempting to create identicalness; i.e., the standardization of everyday human activities needed for participation in the economic, political and social processes that shape our lives. Establishing a rationale for these standards involve evaluating, promoting and rewarding or punishing the participants. This homogeneity could lead to physical, cultural, and economic hegemony and thus, colonialisation.

The need to create uniformity of terms, as is being done with both versions of ICIHD and the new ICF (May 2001), is similar to what is happening in the social world (globalization, standard for trading, etc.) and therein, what happens in the relationship between impairment and the social world. This approach informs us that standardization has always been problematic, primarily because those with the power to define impairment and disability were rarely those with impairments themselves, and less often representative of

the grass roots. Similarly those who define set rules for globalization and standards for trading are rarely part of the general population that lives by the consequences of these decisions. Therefore, evaluating everyone with the same standards could lead to the misrepresentation of the reality lived by people with disabilities in a minority position, including gender reality.

As is pointed out in a recent book about the ICIHD2 by Bedirhan and Somnath (2001), throughout history there has always been cultural and regional inequity in understanding and treating people with disabilities. Inequity occurs when the social structures and spaces, social norms, culture and the tools of social interaction are constructed without taking differences, and therefore, equity, into account. Inequity, or the application of uniform standards, results is a singleton society built on the premise that everyone is the same and that those who are not must either learn to live within the structure established for the majority or perish.

In extreme terms, from a disability standpoint, this notion of "sameness" would give everyone the same accommodations. To better illustrate the point let us take the example of ramps. Ramps are of great benefit for people who have mobility impairment but useless for people who are Deaf, hearing-impaired, blind, or visually impaired. As often happens, ramps are built with the assumption that they provide accessibility to the "disabled," without taking into account that - in reference to disability - ramps are only essential for people with mobility impairment. Similarly, impairments are understood and experienced differently in different parts of the world, depending on the social, economic, and cultural interpretation of impairments and the availability of resources to eliminate disabling environments.

One alternative is to acknowledge that "same" does not always mean "equal." A notion clearly affirmed in a Canadian legal precedent, which indicated that "equality" does not necessarily mean "identical treatment" (see Huck vs. Odeon Theatres in Boyer, 1985). Also, it is important to validate the notion that each impairment is different from the other, and therefore, different solutions must be found to accommodate all individuals with diverse impairments so that they can fully participate in society.

Consequently, if we recognize that equality does not always mean "same," why have millions of dollars been spent on creating standardized definitions and classifications for people who live in different parts of the world, with different impairments, and with completely different histories and lifestyles?

Moreover, the codification/standards in ICF and its preceding versions say nothing of the grave inequity between developing and developed countries and inter-community inequity within each country. The social and cultural interaction in these different communities produce different reactions, leading to differing modes and levels of self-understanding, as well as different opportunities for

participation.

The ICF and its preceding versions do not acknowledge historical inequity, making no mention of previous classification initiatives, and never recognizing that ICIHD (1980) has contributed to some of the inequalities and must therefore carry the onus for historical inequity.

Similarly, globalization is attempting to create a standardized social, economic, and political life in a world that has been perpetually unequal. Even among the self-identified democratic countries, the concept and practice of democracy are unparalleled. To say nothing of the dichotomy between developing and developed countries, between the rich and the poor. Furthermore, equality between genders is definitely uneven. In some countries, gender equality is not permitted on the political agenda, or anywhere else for that matter. When we hear about globalization, we do not hear about affirmative/equalizing action for countries or people that are in lower economic, social, or physical brackets.

Likewise, although ICF claims to be less biomedical, it does not take into account that in the previous definition, the extremely biomedical classifications were assimilated by the medical rehabilitation community dominant in the disabilities community, as well as the general public. Moreover, the previous overtly biomedical definition was connected to the rehabilitation and medical industries (Albrecht, 1992), which created a large economic market, seemingly resistant to some forms of change.

Therefore, enforceable equalizing provisions are required to promote the political-social model in order to begin creating a balance between the predominant existing mindset of the biomedical establishment and the emerging political/self-determining social understanding that people who live with impairments have been advocating.

Classification & Language

Attitudes are formed by the words we speak and the meanings we attach to those terms. The language used to discuss disability has been controversial at best and oppressive at worst. Accordingly then, it is important to look at how people who live in disabling conditions are named, in order to increase our understanding of what role, if any, language plays in forming social perceptions and attitudes.

In most countries, the common perception of disability has been historically embedded in the medical, individualistic model of disability; an approach that locates the problem primarily in the individual. The problem, as Oliver (1990a) states it, is "rooted in an undue emphasis on clinical diagnosis, the very nature of which is destined to lead to a partial and inhibiting view of disabled individuals" (p. 61). This leads to a socio-medical view of people with disabilities based on common perceptions. J. Bickenbach (1993) maintains that: "[t]he most commonly held belief about disablement is that it involves a defect, deficiency, dysfunction, abnormality, failing or medical 'problem' that is located in

an individual... someone who is biologically inferior or subnormal" (p. 61).

Moreover Bickenbach (1993), Oliver (1990b), and Goundry (1993), among others, make a connection that goes beyond mere medical thinking. They demonstrate that the medical characterization of disability is itself "defective." This in turn leads to other undesirable, pity-enhancing, disability-phobic attitudes. Nevertheless, generally speaking, most people still perceive disabled people as different -- in a negative way -- from themselves, as demonstrated by the Canadian Decima study (1992).

Previous Definition

Confusing terms such as "disability," "impairment" and "handicap" are used interchangeably. This is partially rooted in a triple-layered definition of disability known as the ICIDH (International Classification of Impairments Disability and Handicapped), set out by the World Health Organisation in 1980. These widely accepted terms are promoted in official government documents, policies and practices, as well as in academic publications and by researchers. In addition, health-care workers use the terminology in the course of everyday health care. As it is acknowledged by ICF, "Since its publication as a trial version in 1980, ICIDH has been used for various purposes..." (p. 5), all of which are linked to professional statistic, rehabilitation and educational assessments, etc.

Amundson (1992), Bickenbach (1993) and Pfeiffer (1998) inform us that this terminology was intended as a classification system with codes for various physical and mental abilities. However, due to deeply entrenched social perceptions, at least two components of the ICIDH convey disability-phobic values.

All the following definitions pertain only to "the context of health experience." Impairment, "in the context of health experience," is defined as "any loss or abnormality of psychological, physiological, or anatomical structure or function." Disability is defined as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being. " Handicap" is a disadvantage for a given individual, resulting from an impairment or a disability that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual" (World Health Organisation, 1990).

In a literature survey reviewing the definition of disability, Solomon (1993) alludes to the trickle-down effect that this terminology has on the majority of the population. In the community at large, the ICIDH terminology reinforces the fear of impairment and the medical perception of disability. Oliver (1990a) explains that the principal problem lies with the disability definitions in general. He centralizes the problem in the notion of power, explaining that this definition gives those in positions of power

financial rewards and prestige. Oliver (1990a) further illustrates how this definition localizes problems within the individualism and tragedy models.

On a different note, "Wendell reveals how the fragmented concepts of 'impairment,' disability,' and 'handicap' (ICIDH) tend to impact negatively on the lives of women with disabilities. By trying to define impairment and disability in physical terms, and handicap in cultural, physical, and social terms, the UN document appears to be making a shaky distinction between the physical and the social aspects of disability" (Wendell, 1989, p. 5).

Wendell further points out that within the ICIDH definition, "women can be disabled but not handicapped, by being unable to do things which are not considered part of the normal role for their sex" (p. 6). Solomon (1993) illustrates how the above definition creates unclear identification of disabilities in women. Yet, other critics of this definition have linked it to eugenics because, as Pfeiffer (1996; 1998) states, "the ICIDH encourages thinking about the quality of life of persons with disabilities, which leads us to eugenics" (26). Pfeiffer (1996) cites Wood as follows:

> [The disability] code could be used as a means of screening that could be applied not only to job placement in vocational rehabilitation but also to school placement, re-housing the disabled, identifying vulnerability in the elderly, and other related purposes. (p. 26)

Whereas, Wood does not refer explicitly to new reproductive and genetic technologies, the implication is there. Thus, either ICIHD2 or ICF can potentially preserve and promote the medical perception of people with disabilities in all areas, including genetics.

The relationship between medical professionals and people with disabilities has been a turbulent one, predominantly because of the medical establishment's power over the lives of people with disabilities and its abuse of that power during various periods throughout history and even today. Still, the medical professionals themselves appear to be harbouring "ableist" sentiments. For example, 16% of doctors in English Canada and 27% of doctors in Quebec currently believe that "it is a socially irresponsible act to have a child with a genetic disorder when prenatal diagnosis is available" (Basen, 1994). Given such attitudes, Day's remarks to the Royal Commission are not surprising: "The fact of the matter is that the disability community feels as though doctors are a real problem, not just in this context but in general" (Royal Commission, p. 31).

Furthermore, research conducted in 1996 by Newell explores general practitioners' (GPs) definition of disability. He found that although GPs did not have a clear definition for the term "disability,"

> ...it is interesting that most of them identified it in terms that were similar to the World Health Organization's approach to impairment, disability and handicap, which, as various commentators in the disability-studies literature have noted, is informed by the biomedical model. (Newell, 1996, http://www.comm.utas.edu.au/Publications/CNewell/html)

The two parts of the ICIDH definition - disability and impairments - which relate to a medical perception of disability may have contributed to, and might further promote, stereotyping of and discrimination against, women and men with disabilities.

The New Definition

A first look at the new final version of the ICF and the ICIDH2 definitions indicate a divorce of disability from the medical mentality, since there is an explicit separation of disability from the concept of normalcy. However, we see many components that camouflage the notion of normalcy by way of the individualism/medical model.

The multi-layered classification still gives predominance to ideas and values that link it to the medical mode of thinking. It uses words such as "disability," "health," and "functioning impairments," which are historically based in medicine. Both ICF and ICIDH2 do try to change the meaning of some of these charged words but the definitions are still weighed down with archaic notions and terms. For example, the ICF defines "impairment" as "problems in body function or structure such as a significant deviation or loss" (p. 10). Although this definition appears less medical and allows for diverse interpretations, it also centers the "problem" in the body and mentions "deviation."

Given the historical understanding of deviance as differing from the norm, and Goffman's attachment to disability (Goffman, 1963), one must assume that "deviation" implies a set of norms do exist and that the "deviation" refers to pathology of the body. This, of course, brings us back to the medical viewpoint once more.

In the section outlining its background, the classification states,

> ICF has moved away from being a "consequences of disease" classification (1980 version) to become a "components of health" classification. "Components of health" identifies the constituents of health, whereas "consequences" focuses on the impacts of diseases or other health conditions that may follow as a result. (p. 4)

However, later in the document, in the "Contextual Factors" section, it is attested that: "A person's functioning and disability is conceived as a dynamic interaction between health conditions (diseases, disorders, injuries, traumas etc.) and contextual factors. Contextual factors include both

personal and environmental factors" (p.8). "Functioning" is an umbrella term referring to all bodily functions, activities and participation. Similarly, "disability" serves as an umbrella term for impairments, activity limitations or participation restrictions (p. 3).

Moreover, by constructing negative and positive terms, that is, by framing impairments as negative, and functional and structural integrity as positive (p. 11), the classification is making shaky assumptions about how these standards will be used by the primary users of the classification. How will professionals use it to classify and assess individuals with disabilities? And will professionals keep the new definition in mind? or will they apply the old ones, which have been internalised by the majority of people?

While this classification resembles the combination of ideas put forth by the Processus Production du Handicap model (Fougeyrollas, 1998) and a watered-down version of other social models, it seems less clear than either of the original ideas. The classification still centers the locus of the "problem" in the individual's body. The individualistic ascription of the "victim approach" and the pathology are camouflaged but are still present. Moreover the classification makes a confusing and somewhat oppressive point.

The classification remains in the broad context of health and does not cover circumstances that are not health-related, such as those brought about by socioeconomic factors. For example, because of their race, gender, religion or other socioeconomic characteristics people may be restricted in their execution of a task in their current environment, but these are not health-related restrictions of participation as classified in ICF. (p. 7)

Given that the classification itself specifies the above, one is left to assume that it does not account for impairment caused by specific situations, like wars and imprisonment, where people are singled out to endure violence and as a result, end up with some type of impairment. The classification of the ICF does not account for this, thus implying that these factors are not restrictions to participation (p. 7).

When addressing personal factors, this ICF states:

> Personal factors are the particular background of an individual's life and living, and comprise features of the individual that are not part of a health condition or health states. These factors may include gender, race, age, other health conditions, fitness, lifestyle, habits, upbringing, coping styles, social background,... all or any of which may play a role in disability at any level. Personal factors are not classified in ICF. (p. 17)

One aim of ICF is to:

> establish a common language for describing health and health-related states in order to improve communication

> between different users, such as health care workers, researchers, policy-makers and the public, including people with disabilities. (p. 5)

Given the multiple definition of words and the various segments, the classification appears confusing. One can speculate that most people that wish to use these classifications will have a difficult task in utilizing it in theory and in practice. And this, despite the fact that ICF posits itself as being not only about people with disabilities:

> There is a widely held misunderstanding that ICF is only about people with disabilities; in fact, it is about all people. The health and health-related states associated with all health conditions can be described using ICF. In other words, ICF has universal application. (p. 7)

This classification attempts to divorce socio-economic factors from disability. Historical evidence shows that race, gender, social class and, in some cases, religion have been intertwined with economic issues. Impairments and disabilities are no exception. Albrecht (1992) states that "a person's position in society affects the type of severity of physical disability one is likely to have..." (p. 14)

From a disability point of view, Oliver's (2001) citing of The New Internationalist (July, 1992), further shows that

> Of the 500 million disabled people in the world, 300 million live in developing countries, and of these 140 million are children and 160 million are women. One in five, that is one hundred million of the total population of disabled people, are disabled by malnutrition. (p. 14)

Although 80% of disabled people live in Asia and the Pacific, they receive only 2% of all the resources allocated to disabled people around the world. Oliver (2001) further states that 60% of disabled people in Britain and America live under the poverty line (p.14).

In Quebec, L' Office des personnes handicapTes du QuTbec (1997) indicates that 42% of women and 34% of men with disabilities live below the poverty line. Thus, the linkage between socio-economic status, gender, and race exist. However, if the ICF implies that environmental barriers that discriminate against people based on race or gender are not covered by this definition, when placed alongside these statistics, this statement seems almost narrow-minded.

In her report, Ann Elwan (1999) seemingly disagrees with the statement made by the ICIDH2. In the conclusion of her report, Elwan states: "The links between poverty and disability go two ways - not only does disability add to the risk of poverty, but conditions of poverty add to the risk of disability" (p. 34).

If, as ICF mentions:

> ICF is based on an integration of these two opposing models. In order to capture the integration of the various perspectives of functioning, a "biopsychosocial" approach is used. Thus, ICF attempts to achieve a synthesis, in order to provide a coherent view of different perspectives of health from a biological, individual and social perspective. (p. 20)

However, if the majority of those who advocate the social model agree that environment and economics are crucial to issues of disability, then how can any document that aspires to truly account for the issue of disability dismiss the link between economics and disability? This gives rise to questions concerning the document's avowed intention to include the notion of a social model: "ICF attempts to achieve a synthesis, thereby providing a coherent view of different perspectives of health from a biological, individual and social perspective" (World Health Organization, 2001, p.20).

The roots of the ICIDH classification problem reside in three main areas. First, this classification has historical roots in an individualistic/medical model, which imbues it with a dominant power that this newer version further emphasizes rather than abolishes. Second, the classification highlights the inability or deviation of the body parts and the individual's body. Third, a large part of the text is a classification of body parts, a pathology similar to the previous one. These factors serve to remind us of the historical negativism of the past and promote old disability-phobic perceptions still prominent among professionals and the general public, including some persons with disabilities.

Moreover the new term, "International Classification of Functioning, Disability and Health," consists of words associated with the past, further encouraging disability-phobic attitudes. The prominence of these attitudes at a time when the Human Genome Project is seducing the general public with ideas promoted by eugenics is, as Pfeiffer (1998) has eloquently stated, "a threat to the disability community world wide" (p. 503).

Eugenics, Economics & Global Bio-medical Industries

The interconnection between economics and the medical industry is not always apparent. Nevertheless, the links between economics and disability can be traced back to the original relationship between economics, the bio-medical world, and eugenics.

The economics and eugenics debate began as early as 1920, when psychiatrist Alfred Hoche and Karl Binding, a prominent scholar of criminal law, proposed the idea that economic savings justified the killing of "useless lives:" "idiots" and the "congenitally crippled" (http://www.holocaust-trc.org/hndcp.htm). At various times in history, medicine has aligned itself with the belief that

economic burden could be alleviated through the elimination of those members of society deemed "undesirable." This was done either through "hygienic programs" or by the creation of "cure industries."

Nowadays, a different motivation prevails in the economics and eugenics debate. This new motivation has created a disability-related market that delivers goods and services just like any other industry. Albrecht (1992) demonstrates how the concept of physical disability is now being defined as a commodity that can be transformed into services, products, and professional industries that serve, amongst others, the medical industry, and in particular, biotechnology.

If we examine new reproductive and genetic technologies from an economic perspective (Shannon, 1987), we see that the primary goal of biogenetics is the maximisation of production, including reproduction of human lives (cloning), at a minimal cost. In 1993, Langelder and Jeungst reported that the "Human Genome Project is a major industry with a budget of three billion dollars." Only 5% of this amount was set aside for the non-biomedical aspects of the project, namely the study of ethical, legal and social implications (1993). It is not yet known just how much this venture will cost. However, according to the Techno-Eugenics Email Newsletter:

> Social, political, and financial momentum are fast gathering behind the increasing technical powers and cultural clout of genetic scientists. The coming months and ...years are a critical juncture for efforts to shape public discussion and policy on the new human genetics-and to ensure that these technologies be developed in ways that foster democracy, justice, ecological soundness and human dignity. (Number 10 August 4, 2000, p.?)

From the Canadian perspective, Fuller has observed that:

> [T]he underlying premise of NAFTA is that all aspects of North American society must conform to the free-market principle embraced by the corporate community.... Most of the growth in the private sector has occurred in the biomedical, biotechnology and medical devices industries. (NAC, 1994, p.9)

In the Canadian government's 1998 paper "Canadian Biotechnology Strategy," it is acknowledged that "the human genome technology sector could have an impact similar in magnitude to the information revolution" and predicted that it could "be the next critical issue for policy development on a global scale." It further averred that "biotechnology is a huge economic venture that will continue to grow" and that funding from government would be forthcoming (www.sgc.gc.ca/WhoWeAre/PPC /Portfolio/eHumanGenome/eHumanGenome.htm#Canbiotech).

This acknowledgement of a growing "economic venture

support[s] the views expressed ten years earlier by those who connected genetics and bio-genetics in all its forms to the creation of capital" (Barile, 1990). Since many components of biotechnology aim at the elimination of characteristics for the purpose of creating a "generation free of undesired characteristics," biotechnology is clearly linked to eugenics.

Consider the issue at a more human level: what about the everyday reality of women and men who make choices based on misinformation about the cost of disability to society and to the individual families (Green & Statham, 1996, in Shakespeare, 1998, p. 665)? Not all women feel that they have a real choice when considering the termination of an affected pregnancy. For some, "the socio-economic realities of caring for a disabled child deprives them of any real option..." (Shakespeare, 1998, p. 670.)

In his conclusion, Shakespeare (1998) points out that often the cost-benefit rationale is given as the most common argument in favour of selective termination of a possibly disabled foetus. This happens because society does not value disabled people and sees them as an unnecessary social cost. This view is maintained by many in the disabled community.

In the end, will economics determine eugenics practices? Will the bio-genetic industries associated with the elimination of 'undesirable traits' prevail because they bring in more capital than the services and products that accommodate people with disabilities?

Other Problems With International Standards

At an international consultative Expert Group Meeting on International Norms and Standards relating to Disability, convened by the United Nations in 1998, the notion of new international standards were discussed. Some of the comments from participants recognized the historical problems of standardization and the issue of disability. Other concerns were more fundamental, questioning how problems originated: "[P]articipants were concerned with the inadequate representation of persons with disabilities at this meeting and recommended that future meetings of this sort should have such representation" (http://www.un.org/esa/socdev/enable/disberk1.htm).

This is the old problem stemming from individualistic, patronizing models, in which others decide on behalf of those concerned, in this case, people with disabilities. Interestingly, this paper is progressive in the sense that this paper recognized its own model as a past problem in the section on defining. Unfortunately, this historical reality seems to have been repeated at this meeting.

Some concerns expressed at this meeting addressed international standards that have not worked and therefore give some indication as to why this happened:

> [M]any of the existing norms, principles, declarations, standards, and guidelines dealing with disability issues are dispersed through various instruments; some are not

> sufficiently specific, legally binding; others are not overall, they do not ensure widespread and effective legally operative freedom from discrimination on the basis of disability. (www.un.org/esa/socdev/enable/disberk1.htm.)

Under the section "Enforcement Mechanisms," this article makes reference to various international human rights provisions, treaties and so on. Yet we must acknowledge that many have not been successful in securing the human rights of people with disabilities in some countries. In others, there has been little success. It further states: "Prior efforts by the international community to address the rights of persons with disabilities have been inadequate or too limiting of rights."

Furthermore:

> [S]ome norms have had the effect of limiting the State's responsibility to integration "within the limits of the State's capacity;" while others limit the responsibility of the State based on the "capacity" of individuals to exercise their rights. Concern was expressed that a new instrument might have the unintended consequence of marginalizing persons with 'disabilities.' (http://www.un.org/esa/socdev /enable/disberk1.htm).

Exposing and Eradicating the Misconceptions

The way in which disability is contextualized influences our perception of people with disabilities. As long as medical classifications predominate the norms of what is healthy, and these standards are used to address and describe the issues, identify situations, and make recommendations, eugenics will camouflage the issues and lives of persons living in disabling situations.

For those who see eugenics as a negative development in all its forms, there are numerous challenges. Rephrasing disability and the locus of the problem is only a tiny part of an immeasurably formidable task. The task is made more difficult given that historically, society has formulated, accepted and constructed its beliefs around the notion that the problem belongs in the pathology of the individual. Financial concerns and the strong paternalistic views of society's decision-makers play key roles in the construction of institutions which are popularly seen as the best alternative for individuals with disabilities and for society as a whole. This view is maintained and reinforced by the various classifications of disease, impairment, disability, handicap, function, and health, because these reinforce or allude to the idea that the problem is rooted in the individual.

If we contextualize the historical understanding put forth by the social models of disability as a distinctive component, and incorporate the notion of "euthenics - a

science concerned with improving human functioning and well-being by improving the environment and the living conditions of all of living beings from a human-rights perspective" (Wolbring, 1997), we may have a collaborative classification of environmental standards. We would therefore have a collaborative environmental approach.

This proposed collaborative environmental approach - a system based on the recognition of all diversities - could validate the need to improve the human condition. A task best accomplished by first admitting that our present environment needs to be changed as it currently meets the needs of only a few.

The collaborative classification of environmental standards would include not only a restructuring of the physical world to fit persons with impairments, but standards that take into account global warming, environmental sensitivity and allergies in all living beings. Also, this new approach would confront global poverty, the cause of immense impairment in developing countries, and the continuous lack of resources obligating some people to live in poverty both in developing and developed countries. Global violence, brought about by the economic and social greed of developed countries and wealthy individuals, which finds its greatest form of abuse and violence against the world's people and resources, must be considered as well.

By creating classification standards for environments, we would create a parallel classification for the historically dominant ICIDH. Then and only then could the two ideas of impairment (body) and disability (social) find common ground for implementation. The weakness of a system - which was historically constructed to meet the needs of few and resulted in unequal opportunities for the majority of people - would be recognised, resulting in the development of environmental equalisers at different levels of society to address these various issues.

Although ICF, globalization and the human genome project are still in the early stages of development, we have no way of judging their full impact. The question remains whether their inception is coincidence or another level of synchronism in the perpetuation of the old idea that the sameness of human bodies and social relationships is good, and desired, while difference is "undesired".

In the end, it is important to be aware of the new social world relationships being formed and that there are questions that arise because of this shift. Are these changes occurring spontaneously and simultaneously? If not, what role is played by the sudden "desirable values" of identicalness, which seem to be camouflaged into the standardisation of people as body parts, that is the various classifications of impairment handicap disability (ICF); the standardisation rules for global trading; the norms for identifying the worth of human lives, as dictated by eugenics under the disguise of new genetics and reproductive technologies? Overall, these seem to be historical events of the past, but are these modern-day

synchronisms required for survival in the evolving new world?

Note

1. In May 2001, the ICF International Classification of Functioning, Disability and Health was presented by WHO. In this paper, the writer uses ICF (Introduction) primarily, but references are made to both the 1980 ICIDH, International Classification of Impairments, Disabilities, and Handicaps (as it was previously known) and the beta version, ICIHD2 International Classification of Functioning, Disability and Health (pre-final draft, December 2000).

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