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THE INTERNATIONAL CLASSIFICATION OF FUNCTIONING, DISABILITY AND HEALTH AND ACTION THEORY
A CLASSIFICAÇÃO INTERNACIONAL DE FUNCIONAMENTO, INCAPACIDADE E SAÚDE E A TEORIA DA AÇÃO
CLASIFICACIÓN INTERNACIONAL DE LA FUNCIONAMIENTO, INCAPACIDAD Y SALUD E A TEORIA DE LA ACIÓN

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KEY WORDS:

Functioning.
Disability.
Action theory.

ABSTRACT: In this study a conceptual framework, which is central to philosophical action theory was introduced. The purpose was to show that this framework is useful for the analysis of crucial concepts in the area of disabilities and handicaps. The recently introduced *International Classification of Functioning, Disability and Health (ICF)*, published by the World Health Organization (WHO) was used as a case of illustration. By the analysis of this classification according to the philosophical action theory, an important complication was derived from the way we communicate about disabilities. We often say simply that a person is unable to do this or that without considering the external factors or of the existence or non-existence of an opportunity. If these factors and the opportunities were considered, in most cases one surely would produce an opportunity that could compensate all these people. About the notion of disability and participation introduced by *ICF*, two distinct ontological categories have been formed. However, in the final version of the *ICF* these categories were in a sense amalgamated into one ontological category covering the same domain. To resolve this basic confusion of *ICF* and in order to uniform category activity/participation the action category was proposed to replace category activity/participation and to introduce the category opportunity as a supplementary qualifier.

PALAVRAS-CHAVE:

Funcionamento.
Incapacidade.
Teoria da ação.

RESUMO: Este estudo tratou da introdução de um modelo conceitual, central na teoria filosófica da ação, a fim de mostrar que este modelo é usável para a análise de conceitos cruciais na área de incapacidade e desvantagem. A título de ilustração foi usada a *Classificação Internacional de Funcionamento, Incapacidade e Saúde*, publicada recentemente pela *Organização Mundial da Saúde (OMS)*. Analisando esta classificação a luz da Teoria Filosófica da Ação, surgiu uma importante complicação relacionada ao modo como as incapacidades são comunicadas. Neste sentido, nós simplesmente dizemos que uma pessoa é incapaz de fazer isto ou aquilo, desconsiderando os fatores externos ou existência ou não de oportunidades. Se estes fatores e as oportunidades fossem considerados certamente, na maioria dos casos, haveria uma compensação para estas pessoas. Sobre a noção de atividade e participação introduzida na Classificação, mesmo sendo concebidas como duas categorias ontológicas distintas, elas foram, de certa forma, amalgamadas em uma categoria ontológica cobrindo um mesmo domínio. Para resolver a confusão básica dessa Classificação e para uniformizar a categoria atividade/participação foi proposta a categoria ação para substituí-las e introduzida a categoria oportunidade como um qualificador suplementar.

PALABRAS CLAVE:

Funcionamiento.
Incapacidad.
Teoría de la acción

RESUMEN: Se trata de un estudio sobre la introducción de un modelo conceptual, fundamentado en la Teoría Filosófica de la Acción, con el fin de mostrar que este modelo es válido para el análisis de conceptos cruciales en el área de incapacidad y desventajas. A título de ilustración fue usada la *Clasificación Internacional de Funcionamiento, Incapacidad y Salud*, publicada recientemente por la *Organización Mundial de la Salud (OMS)*. Analisando esta clasificación según la Teoría Filosófica de la Acción, surgió una importante complicación relacionada al modo como las incapacidades son comunicadas. En este sentido, nosotros decimos simplemente que una persona es incapaz de hacer esto o aquello, desconsiderando los factores externos y la existencia o no de oportunidades. Si estos factores y las oportunidades ciertamente fuesen considerados, en la mayoría de los casos, habría una compensación para estas personas. Sobre la noción de la actividad y la participación introducida en la Clasificación, aún siendo consideradas todavía como dos categorías ontológicas distintas, ellas fueron, de cierta forma, ligadas a una categoría ontológica cubriendo un mismo dominio. Para resolver la confusión básica de esa Clasificación y para uniformizar la categoría actividad/participación fue propuesta la categoría acción para sustituirlas e introducir la categoría de oportunidad como un calificador suplementar.

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INTRODUCTION

In this paper I will introduce a conceptual framework which is central to philosophical action theory. I wish to show that this framework is useful for the analysis of crucial concepts in the area of disability and handicap. My case of illustration will be the recently introduced *International Classification of Functioning, Disability and Health (ICF)*¹.

I shall not spend much time on its specific contents. I must, however, for the sake of understanding present the basic conceptual structure in the *ICF*.

First the positive concepts:

Functional and structural integrity	Activity	Participation
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and thereafter the negative corresponding concepts:

Impairment	Activity limitation	Participation restriction
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The general and intuitive idea here is that the structural and functional integrity of the human body is the basis for a person's activity, and the body interacts with the environment in such a way that the person can participate in certain life areas. On the other hand, the body may be impaired; an impairment may lead to activity limitation and activity limitation in its turn, possibly confronted with external barriers, may result in a restriction in the person's participation in a life area².

The concepts involved are defined and much better explained in the *ICF*. I will return to some of these explications in my critical commentaries, but let me first give my theoretical background.

THE NEED FOR ACTION THEORY

The development of a theory and conceptual framework in the area of disabilities and handicaps is interesting from a general scientific point of view. What is interesting is that we here find an attempt on the part of the medical and health sciences to move outside the health-disease dimension and instead theorize about the place of the human body and human activity in the environment, and in particular the confrontation with society. The concepts to be used here are not medical, nor are they simply biological; they do not, with the exception of some of the concepts of functioning and impairment, belong to natural science.

They are concepts belonging to the humanities and the social sciences.

The theoretical basis for the development of these concepts is *action theory*. Action theory has its proper place in philosophy and it has been particularly developed among philosophers who deal with the arts and social sciences. In all sciences where action is a central concept, action theory must be central. And now action has become central in some of the sciences of health care.

Unfortunately, however, the WHO has in its conceptual development hardly acknowledged the existence of the field of action theory and has therefore not systematically used insights gained in philosophical action theory. Therefore, today, I will, as an example, present a simple reasoning, introduce a few basic notions from action theory and from there show that one of the principal distinctions made in the recently introduced *ICF* is highly confused and that it is therefore difficult to see how this classification can be successfully put to work.

INTRODUCTION TO ACTION THEORY

First a word of caution. This area is more difficult than one can foresee at first glance. One should not be deceived by the fact that the words for actions in ordinary language are so familiar. It is no wonder that people get into difficulties in attempting to systematize actions. One reason for this is that what is classified is abstract. An action is an abstract object, around which it is difficult to draw borders. The difficulty is even greater with entities as nebulous as disabilities. Linnaeus was a lucky taxonomist who could observe and put a pin into the plants that he classified.

The first concept pair that I will introduce is: capacity - opportunity. A capacity can be understood as a person's inner possibility for action. The capacity is what a person's inner resources permit him or her to do. By inner resources I mean the biochemical, physiological and psychological conditions inherent in the person. The opportunity, on the other hand, is the person's outer or external possibility. It includes such factors as surround the person: physical as well as psychosocial, cultural as well as legal. To take an example: the inner resources of a Volvo mechanic permit him to engage in his craft, to use his hands in the way he wishes. The external arena, the workshop, gives him the opportunity to use the tools necessary. The rules of the company and the laws of the country permit him to have the work he has and they constitute

the ultimate opportunities for him with regard to this set of activities. Together the mechanic's capacity and opportunity for engaging in his craft form his whole possibility for action. The amalgamation of a person's capacity and opportunity is sometimes called the person's *practical possibility for action*. Capacity plus opportunity is the person's practical possibility for a particular action.

That there exists a practical possibility on behalf of an agent for an action F, however, does not necessarily mean that the agent actually performs the action F. I have, for instance, now the practical possibility of leaving this room. I have both the inner capacity and the external opportunity; nothing prevents me from leaving this room. However, I am not going to leave it at this moment. Why not? The answer is simply that I do not want to leave this room now. There is a *lack of will* on my part. The will is thus a crucial notion in all action theory. But the will is quite absent in the theory of the *ICF*. I shall return to this later.

A capacity and an opportunity are necessary conditions for all action. The two are needed even for the simple action of lifting one's hand and certainly for complex actions such as driving a car or writing a doctoral dissertation. Consider first the simplest example: In order to lift my hand, my physiology and perhaps also my psychology must be in order. I need a capacity. I need the inner possibility. But there must also in this case be an outer possibility; the medium must be penetrable, as in the case of the air. Had the medium been concrete I could not have moved my hand. There would not have been an opportunity. The same holds for the case where somebody is actually holding my hand and prevents me from moving it.

Thus, all action is performed in a context; all action is performed in some place where there is some type of nature and sometimes also a culture. Thus, when an action is performed there is always a fusion of a capacity and an opportunity. This was an insight that was partially lacking in the for-runner of the *ICF*, the so-called *ICIDH*². The disabilities classified in that manual were taken to be completely independent of the external world. It was only on the handicap level that the environment was introduced at all. Here an improvement has taken place in the latest document.

A COMPLICATION

I will now introduce an important complication in this theory, which is derived from our way of communicating about disabilities. As we all know, there is much talk, both in ordinary speech and also in

medicine and science, about the fact that a person is incapacitated or disabled, period, without mention of any external factor or of the existence or non-existence of an opportunity. We often say simply that a person is unable to do this and that. We say that Jones cannot walk up or down stairs, that Smith cannot drive a car or that Brown cannot speak Italian. This sounds as if these persons have an absolute property of incapacity or disability that is independent of the external world.

In most situations where a disability is ascribed to a person the speaker has some internal deficiency in mind. Jones who cannot walk up or down stairs is normally taken to have some impairment. Smith, who cannot drive, either has not been trained to drive or has some illness that prevents him from driving, and Brown, who is said not to be able to speak Italian, may not have been trained to speak this language, or again, but less plausibly, there may be some defect preventing him.

But if this is the interpretation intended one could surely in most cases produce an opportunity that could compensate all these people. Somebody can support Jones in climbing the stairs; somebody can monitor also Smith and Brown in their driving and talking Italian (if they at least have some minimal capacity), so that there is a practical possibility for them to perform these actions. Thus, a practical possibility can be *created* so that the actions in question will be performed by these people. But what does it, then, mean to say that Jones, Smith and Brown are incapacitated or disabled with regard to these actions, period?

The natural interpretation of this situation is that something is *implicit*. There is an implicit presupposition of a set of circumstances, taken for granted in the communication situation. When one says that Smith is unable to drive a car, one implies that there is an opportunity there, viz. that there is a car to be used and that there are no other factors preventing Smith from driving. This means that one takes for granted some standard situation in the community where Smith is living. Smith can be said to be unable to drive the car, given *standard* circumstances. And since the circumstances are considered to be standard, one does not particularly refer to them.

This common presupposition is of course at the same time quite vague. Do we really know what is the standard background? Do we presuppose exactly the same between us? Is the Danish standard context always the same as the Swedish one? And is the Scandinavian standard context the same as the Central

African context? It is obvious that this is not always the case. In fact, what is implicit can vary also within a country. All of you who have worked in the rehabilitation area know that there is a great risk of misunderstanding even within a culture. Thus, the trained physio- or occupational therapist would not just say that Smith cannot walk up or down stairs. He or she would specify and say that Smith cannot walk up or down stairs of such and such a height, of such and such a construction and under such and such circumstances. All professional talk in this area must to be made quite precise.

All talk of capacities thus presupposes – in order to be comprehensible – some fixation of the environment. This need is most salient when we try to identify and assess an inner capacity. A capacity for F is, as we have noted, always a capacity for F in relation to a particular opportunity for F. Therefore, when we say that a person has a particular disability (to a certain degree), then, for this statement to be understandable, we must have a particular environment in mind. If we do not specify the opportunity, then the opportunity must be implicit. And what can the implicit opportunity be other than some standard circumstance? (Or a circumstance within a range that we consider standard: for example, with respect to temperature, we might for the action of writing consider the range +15 to +25 standard, but for the action of walking consider the range -20 to +30 standard.) In a way, then, we cannot get rid of the notion of a standard environment, although we should always be fully aware of its variable nature. It might also be wise in the field of rehabilitation to change from implicit to explicit reference to environments⁴⁻⁵.

The idea of a standard background has been acknowledged in the latest version of the *ICF*. A modifier has been introduced which is called a *capacity given a uniform or standard background*. This is a positive sign. But the question can be asked, how is it followed up? To this I will return in the following section.

ON THE NOTIONS OF ACTIVITY AND PARTICIPATION IN THE ICF

The *ICF* has introduced two action categories, Activity and Participation. These two categories have been understood to form two ontologically distinct categories in some earlier proposals, for instance in the Beta 2 and the Prefinal document from October 2000. In the final version of the *ICF* the categories of Activity and Participation are in a sense amalgamated

into one ontological category covering the same domain. Still, they constitute two distinct concepts given two different definitions:

An activity is the execution of a task or an action by an individual. Participation is involvement in a life situation.

Questions can be asked both about the intended amalgamation of the two categories and about the half-heartedness of this amalgamation. We have just shown that there cannot be any activities performed independently of any environment. All action must be involvement in a life situation. But what, in that case, is the point of the distinction? When one looks closer it becomes evident that the notion of activity is normally supposed to cover the “capacity aspects” of an action, whereas the notion of participation is supposed to cover the “performance aspects” of the same action. The notion of capacity is characterized in the terms of the activity definition: “The capacity qualifier describes an individual’s ability to execute a task or an action.” And: “The performance qualifier describes what an individual does in his or her current environment. Because the current environment brings in a societal context, performance as recorded by this qualifier can also be understood as “involvement in a life situation[...]^{5:214}” And involvement in a life situation is included in the very definition of participation.

Thus, there is no talk in the *ICF* of activities performed in the current situation and no talk of a capacity to be involved in a life situation. The matrix is not filled, so why this multiplicity of concepts? Why distinguish between activity and participation, when the job needed is done by the qualifiers [capacity and performance]?

This basic confusion in the *ICF* can be resolved in a radical way. The uniform category activity/participation could remain uniform throughout and simply be called: action. Activity/participation could then simply be replaced by action. An action can be qualified in many ways relevant to the context of rehabilitation. We can talk about the ability or capacity to perform the action, both in a standard environment and in specified environments. We can talk about the opportunity to perform the action and we can discuss whether such an opportunity exists today or whether it can be easily created. And we can ask whether the action is ever performed by the individual, even if he or she has the full ability and opportunity of performing it in the current situation.

[The very broad action category can also be

subdivided in many ways, according to different dimensions. One subdivision can be made in terms of simplicity and complexity. There are some simple actions, sometimes called basic actions, to which I shall return, which are of particular importance for the medical profession, viz. those actions which almost exclusively consist of bodily movements (performed in a certain context). These could be singled out as a special category. But the idea of juxtaposing activity as the execution of a task and participation as involvement is not, I think, comprehensible. All activities, i.e. all actions, entail some involvement in the external world.]

Let me now comment on the choice of qualifiers in the *ICF*, the capacity qualifier and the performance qualifier. Given the analysis I have previously given it would have been more natural to choose a capacity and an opportunity qualifier. But the manual seems to suggest that we should classify people according to what they *actually perform* on a particular occasion. Observe: we are supposed to classify what people *in fact* do, not what it is possible for them to do. But is this a task for a medical classifier? Should the medical classifier primarily be concerned with how people decide to steer their lives, should they be concerned with people's interests and inclinations?

You will remember that I said that capacity and opportunity are not sufficient for the performance of an action. In order to actually act one must first *intend to act* or *want to act*. And in this respect people differ very much without there necessarily being anything for the institution of health care to consider. Some people are active and want to do a lot of things, whereas others want to do little. As a result there is a great difference in their actual performance. But, often, there is nothing of particular medical interest behind these differences.

A benevolent interpretation of the intention of the constructors of the *ICF* is that they have mainly had in mind such tasks as most people *need to fulfil* for managing their daily life. Thus, it may have been presupposed that people want to act in the specified

manner. Or, if they, in extreme cases, do not want to perform these actions, they still have to perform them. We can have in mind such actions as eating, sleeping and performing basic hygienic activities. I do not wish to deny that it can be of medical interest to know whether a person actually performs such fundamental activities as are necessary for his or her survival. But clearly this is only a minor part of what people do. There are many activities/participations as classified in the *ICF* that it is not necessary or even reasonable for everybody to perform in a regular manner.

Thus, it is much more neutral and clear to introduce the opportunity category as the supplementing qualifier. This is not to deny that with some fundamental actions it is crucial to ascertain that these are actually performed by a particular individual.

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