#### Current modes of transportation design reinforce the medical model of disability and result in forced social exclusion.

Ivonne Audirac, Florida State University, 5/16/2008[“Accessing Transit as Universal Design”, Journal of Planning Literature 2008, Sage Journals, http://jpl.sagepub.com/content/23/1/4.full.pdf+html]MW

Although influential transportation planners believe that given the low share of transit travel, transit cannot be the public strategy for improving mobilitydisadvantaged individuals (Pucher and Renne 2003, 74),4 disability theory and activism have challenged these views as exclusionary on several fronts (Corker and Shakespeare 2002; Pothier and Devlin 2006). First, on the basis that mode-split statistics are a poor measure of transit demand, since they do not account for suppressed trips (i.e., forgone trips for lack of transit service or impaired accesses to it) (Hine and Grieco 2002). Second, that mainstream transportation planning and design are based on the notion of a “universally able and disembodied” subject (i.e., without biological and social attributes) (Hine and Mitchell 2001; Imrie 2000; Langan 2001) and thus exclude not only impaired but also many nonimpaired people. Third, that transportation planning espouses the medical model of disability whereby the individual’s body, rather than the built environment and social attitudes against disabled people, is the main debilitating cause in personal mobility (Langan 2001). Fourth, that the transportation disciplines and lobbies have endorsed and promoted a universal system of auto-mobility that alienates impaired people and discriminates against all who, for financial, physical, temporal, or psychological reasons, cannot access or use automobiles (Imrie 2000; Hine and Mitchell 2001; Langan 2001). The literature on mobility and exclusion research identifies several forms of social exclusion (i.e., physical, geographical, from facilities) resulting from the organization of transportation and the quality of transit service provision and its relation to the built environment, urban form, and land use patterns (see Table 2). These mobility-limiting factors also include economic, fear-based, and time-based exclusions, which condition people’s immobility and capacity to participate in mainstream society (Cass, Shove, and Urry 2005; Church, Frost, and Sullivan 2000; Grieco 2003; Hine and Mitchell 2001; TCRP 1999).

The creation of the mobile body in transportation planning constructs disability as societal burden in need of eradication perpetuating exclusion.

Rob Imrie Department of Geography, Royal Holloway, University of London 2k[Disability and discourses of mobility and movement Environment and Planning volume 32 http://www.environmentandplanning.com/epa/fulltext/a32/a331.pdf]

Barnes et al (1999, page 121), for instance, note that UK households with a disabled person are half as likely as those without to own a car (also, see OPCS, 1993). In addition, most cars are designed for standardised bodies and few mobility-impaired or ambulant impaired disabled people are able to get into one. Specially adapted cars are expensive, and insurers regard disabled people as a risk and charge high motor insurance pre miums. These experiences are connected to the domination of medical discourses which are infused with conceptions of the incapacitated and immobile body, or the body which is malfunctioning due to a loss of functional capacity. Disabled people are portrayed as less than whole and as a population requiring particular forms of regulation, discipline, and control by state programmes and policies. Indeed, Levi-Strauss (1955) refers to modern societies as anthropoemic or, as Young (1999, page 56) defines it, societies that ``vomit out deviants, keeping them outside of society or enclosing them in special institutions''.

Such discourses see disability as a social burden which is a private, not public, responsibility. The impairment is the focus of concern, and biological intervention and care are seen as the appropriate responses. The problem of immobility is seen as personal and specific to the impairment; that it is this that needs to be eradicated, rather than transformations in sociocultural attitudes and practices, if mobility is to be restored. In particular, political and policy assumptions about mobility and movement are premised on a universal, disembodied subject which is conceived of as neutered, that is without sex, gender, or any other attributed social or biological characteristic (see Hall, 1996; Imrie, 1994; Law, 1999; Whitelegg, 1997). The hegemony of what one might term the mobile body is decontextualised from the messy world of multiple and everchanging embodiments; where there is little or no recognition of bodily differences or capabilities. The mobile body, then, is conceived of in terms of independence of movement and bodily functions; a body without physical and mental impairments.

The hegemony of the mobile body is also reinforced by professional discourses which seek to measure, characterise, and understand disability through the movement and mobility of disabled people's body parts. Such conceptions see disabled people as neither sick nor well but in a liminal state which is characterised by a (potential) movement from one bodily state to another (also, see Ellis, 2000; Leder, 1990; Paterson and Hughes, 1999). The underlying objective is the disciplining of the deviant or impaired body through the restoration of movement in body parts to facilitate independence of mobility (and the restoration of the `whole person'). For Ellis (2000), such (welfare) discourses emphasise the importance of individuals attaining an `independent body', or a body which revolves around self management, personal responsibility, and the projection of desirable bodily characteristics. As Ellis (2000, page 17) suggests, it is a carnality which propagates the aestheticisation of the body while seeking to exclude those (impaired) bodies which are, so some claim, a source of anxiety in contemporary culture (see, for instance, Lupton, 1994)

Indeed, as Paterson and Hughes (1999, page 604) argue, ``the information that animates the world is dominated by non disabled bodies, by a specific hegemonic form of carnality which excludes as it constructs''. These send out specific signals or codes which favour the corporeal status of nonimpaired people, or at least do little to facilitate the independent ease of movement of people with physical and mental impairments. (5) This, for Paterson and Hughes (1999, page 606), is indicative of ``a subtle interplay of micro and macro relations of power'', where specific design features, for example, prioritise forms of movement based on the bodily needs of the neutered body (which is devoid of physical and mental impairments). In this sense, intercorporeal encounters between the hegemonic world of the mobile body and disabled people tend to reinforce the former's sense of presence and the latter's sense of absence, in other words a recognition of disabled people being there but being unable to interact with the social or physical structures which surround them. It is, in Leder's (1990) terms, a projection of the absent body or bodies which ``dys-appear'' when confronted with the embodied norms of everyday life [see Paterson and Hughes (1999) for an amplification of these points].

The dys-appearance of disabled people's bodies is not unconnected to the work of transportation planners and operators who, as Whitelegg (1997, page 14) notes, make ``decisions about what kinds of travel are important and which journey purposes and destinations are to be favoured''. In particular, the impaired body is largely invisible in transportation planning and policy or, as Law (1999, page 566) notes, ``bodies appear in conventional transportation models as discrete entities with independent trajectories''. As Whitelegg (1997) suggests, this leads to the provision of transportation infrastructure which tends to prioritise the movement and mobility of ``productive bodies'' between a limited range of destinations (also, see Marshall, 1999). Thus, mobility policies largely revolve around the provision of commuter networks between home and the workplace, seeking to facilitate movement which is limited to specific social, geographical, and temporal ranges. (6) The effect is, as Huxley (1997, page 2) observes, one of reducing mobility to ``predictable, purposeful trips, origins and destinations'' rather than seeking to conceive of mobility as ``a messy, unpredictable, diverse and changeable reality''.

#### This is an act of symbolic violence which perpetuates medical understandings of disability. The built environment confirms disabled people as deviant restricting independence and naturalizing invisible forms of violence.

Claire Edwards Department for Work and Pensions, London and Rob Imrie Royal Holloway University of London, 5/1/2003[“Disability and Bodies as Bearers of Value” Sociology 2003 37: 239]MW

However, for some disabled people, their way of life, and their bodily identity, become something that appears to be natural to them, or where the oppressive nature of the social world is hidden or not necessarily understood as influencing their bodily (de)valuations. This, then, is symbolic violence, or, as Bourdieu (1998: 12) suggests, ‘a body knowledge that entices the dominated to contribute to their own domination by tacitly accepting, outside of any rational decision or decree of the will, the limits assigned to them’. For Bourdieu (1990: 128), ‘symbolic violence is found … at the heart of each social relation’ and in all institutions, and is reinforced by a process of mis-recognition. As Bourdieu (1977: 192) notes, ‘symbolic violence, the gentle, invisible form of violence, which is never recognised as such, and is not so much undergone as chosen’. This, for Jenkins (1992: 104), is nothing less than ‘the imposition of systems of symbolism and meaning upon groups or classes in such a way as they are experienced as legitimate’.Symbolic violence tends to reproduce a medical understanding of disabled people, or where disabled people’s bodies are labelled as deviant and disordered, requiring medical and charitable interventions. Thus, for one disabled person, their whole life had been a constant round of being cared for by organizations, or where their quality of life is subject to classifications used by occupational therapists. As she said: ‘they lay down the criteria and assess my needs, but it’s my body and I know what I need but you can’t do much to challenge their decisions … you take what you’re given’. Others concurred, with another person noting that their mobility was dependent on the local dial-a-ride bus service. However, as she suggested, ‘it’s nice to have it, but I can only go out when they’re available and I have to fit in with them. There’s no independence’. In both instances, disabled people were obligated to service providers and dependent on their rules and modes of domination which, as Bourdieu (1977: 194) says, is akin to a man who ‘possesses in order to give. But he also possesses by giving’. Likewise, for many disabled people, their dependence on going outside with a carer, or only being able to gain access to a building through a rear entrance, becomes a naturalized way of life, to which it is difficult to see alternatives, or openings for independence. For one person, ‘whenever I go out I just accept it as normal that I have to … use separate facilities … you do stand out though’. Similarly, Kitchen and Law (2001: 296), in referring to the absence of wheelchair accessible toilets in Ireland, note that disabled people are often accepting of the situation in which the lack of toilets is ‘naturalised and invisible to others’. The attitudes and responses of institutions and other people in society only reinforce the ‘naturalness’ and ordinariness of such situations.5 As one respondent noted of the local council’s attitude to providing for wheelchair users, ‘it is taken for granted that a person in a wheelchair won’t come out on their own, they’re always seen as a person who will be pushed’. For Bourdieu (2000: 169), such experiences are ‘exercised invisibly and insidiously through familiarisation with a symbolically structured physical world … informed by the structures of domination’. Thus, as a wheelchair user noted, ‘wherever I go there are obstructions, barriers, things that get in the way; it makes it difficult to move about. People with legs are OK and so nothing will ever change’. For others, it was normal to be given the ‘back-door’ treatment when seeking to enter a building. Thus, for another wheelchair user, ‘back door quality all the time! We go through side doors, back doors, back alleys, everywhere but the front; it’s degrading but we all accept it’. The impaired carnality of disabled people was highlighted as requiring different, yet unequal, treatment to the ‘normal’ body. As one respondent commented: I think even though we’ve got more choices, there’s still limits. If you want to go to a venue with more than one wheelchair user, you’ve got limits. If you want to go to thepictures and you want to go with a group, two will have to sit over there, another two over there. You don’t have to do that if you’re non-disabled. Disabled people are always expected to be separated. Likewise, a mobility-impaired person commented that: ‘you can guarantee that if you go somewhere with friends, it’s not accessible for you. You actually rely on your friends to get you around, even though I am independent. In this environment, I’m independent, if you put me in another environment, I’m not’.

#### This epitomizes the manner in which disabled bodies have been segregated and excluded from full participation in society – the view of disabled as inassimilable deems them eradicable laying the foundation for genocidal violence

David Mitchell, Professor and Director of Graduate Studies in the Department of Disability and Human Development at the University of Illinois at Chicago and Sharon Snyder, Assistant Professor in the Department of Disability and Human Development at the University of Illinois at Chicago, 2001[“Re-engaging the Body: Disability Studies and the Resistance to Embodiment”, Public Culture, Vol. 13 No. 3, Fall, Project Muse]

Foucault’s analysis of the overdiagnosed body offered the first recognition that the professional scrutiny of bodily differences threatens to overwhelm material bodies through its microscopic breakdown and perpetual analysis. Citing Johann Georg Zimmermann’s treatise of 1774, Traité de l’expérience en médicine, he writes: “Medical perception must be structured to look through ‘a magnifying glass, which, when applied to different parts of an object, makes one notice other parts that one would not otherwise perceive,’ thus initiating the endless task of understanding the individual” (Foucault 1975: 15). People with disabilities recognized the violative nature of this tendency toward overevaluation most viscerally. Not only had they endured hours of diagnostic scrutiny on medical examination tables (not to mention a representation in textbooks that replicated this process), but they had also been subjected to a variety of exclusive measures that marked the extent of their cultural participation: “ugly laws” barred their appearance on the streets; intelligence testing banned them from public educational settings; segregated education isolated them in institutions that denied them equal access to the privileges of their able-bodied peers; discriminatory reproductive expectations identified them as physical and cognitive forms to be eradicated from the continuum of varied human biologies; inaccessible transportation left them physically stranded in their homes. These discriminatory practices demonstrated that disabled people’s exclusion was the result of inflexible policies that rationalized cultural segregation. Consequently, disability studies has formulated the problem of the medicalized body in a manner similar to that undertaken earlier in body studies, taking up medical institutions (and the ancillary administering of diagnosis, sequestration, and case study) as the primary locus of its critique. The pathologization of human differences is theorized as an imposition on the body—a regulatory effort to standardize inherent dynamism. But while body studies provided a foundation for a more general model of critique around the categories of illness, health, pathology, and even bioethics, disability studies moves beneath these terms to encounter disability directly in the experiences of human populations which were merely referenced euphemistically by those more general terms. Disability studies narrows the focus of its investigation to the social implications for bodies deemed excessively aberrant. In doing so, scholars have expanded the domain of cultural understandings about disability beyond the walls of its scientific management. For disability studies, the disabled body is neither a matter of individual malfunction— as cast by medicine—nor an effect of the abstraction of the body within the health professions. Instead, disability translates into a common denominator of cultural fascination (if not downright obsession)—one that infiltrates thinking across discursive registers as a shared reference point in deciding matters of human value and communal belonging. In this emergent field, the able body is no longer characterized as merely a false quantitative ideal, as it had been in body studies, but rather as an aesthetic product of cultural forces that oppress those categorized as disabled. This subtle shift in emphasis allows humanities scholars in disability studies to extend the discussion of bodily deviance from the context of rehabilitative institutions to that of wider ranging cultural locations. For instance, Lennard J. Davis (1995) analyzes the role of institutions for the Deaf in the historical development of disability activism and community in eighteenth-century Europe. Martin Pernick (1996) analyzes the influential role of public health films in the promotion of eugenics in Chicago prior to World War II. Through readings of nineteenth- and twentieth-century U.S. literary texts and cultural spectacles such as the freak show, Rosemarie Garland Thomson (1997) argues that disabled people’s bodies have been represented as unassimilable within a normalizing biological ideology that marks the disabled body as the inferior contrast to an able-bodied, white, masculine citizenry. Paul K. Longmore (1997) assesses television genres, such as disease-of-the-week movies and telethons, to dissect mainstream representations of disability as tragedies in need of eradication or overcoming. In our own Narrative Prosthesis (Mitchell and Snyder 2000), we theorize the pervasive utility of disability to literature in Europe and the United States by discussing the longstanding artistic recourse to disability as a staple feature of characterization. Disability studies scholars have also analyzed the opportunistic use of corporeal metaphors to emblematize societal weaknesses in literary and philosophical figurations of disability

#### This medicalization of life and the biological degradation of certain segments of the species is the root cause of conflict—wars are fought and life is exterminated not because of a particular sovereign geopolitical interest but because of the biopolitical commitment to eugenic violence

Stuart Elden, politics at University of Warwick, 2/29/2002 [“The War of Races and the Constitution of the State: Foucault's «Il faut défendre la société» and the Politics of Calculation,” Boundary, <http://boundary2.dukejournals.org/content/29/1/125.full.pdf>]

The reverse side is the power to allow death. State racism is a recoding of the old mechanisms of blood through the new procedures of regulation. Racism, as biologizing, as tied to a state, takes shape where the procedures of intervention "at the level of the body, conduct, health, and everyday life, received their color and their justification from the mythical concern with protecting the purity of the blood and ensuring the triumph of the race" (VS, 197; WK, 149). 37 For example, the old anti-Semitism based on religion is reused under the new rubric of state racism. The integrity and purity of the race is threatened, and the state apparatuses are introduced against the race that has infiltrated and introduced noxious elements into the body. The Jews are characterized as the race present in the middle of all races (FDS, 76). 38 The use of medical language is important. Because certain groups in society are conceived of in medical terms, society is no longer in need of being defended from the outsider but from the insider: the abnormal in behavior, species, or race. What is novel is not the mentality of power but the technology of power (FDS, 230). The recoding of old problems is made possible through new techniques. A break or cut (coupure) is fundamental to racism: a division or incision between those who must live and those who must die. The "biological continuum of the human species" is fragmented by the apparition of races, which are seen as distinguished, hierarchized, qualified as good or inferior, and so forth. The species is subdivided into subgroups that are thought of as races. In a sense, then, just as the continuum of geometry becomes divisible in Descartes, 39 the human continuum is divided, that is, made calculable and orderable, two centuries later. As Anderson has persuasively argued, to suggest that racism has its roots in nationalism is a mistake. He suggests that "the dreams of racism actually have their origin in ideologies of class, rather than in those of nation: above all in claims to divinity among rulers and to ‘blue' or ‘white' blood and breeding among aristocracies." 40 As Stoler has noted, for Foucault, it is the other way around: "A discourse of class derives from an earlier discourse of races." 41 But it is a more subtle distinction than [End Page 147] that. What Foucault suggests is that discourses of class have their roots in the war of races, but so, too, does modern racism; what is different is the biological spin put on the concepts. 42 But as well as emphasizing the biological, modern racism puts this another way: to survive, to live, one must be prepared to massacre one's enemies, a relation of war. As a relation of war, this is no different from the earlier war of races that Foucault has spent so much of the course explaining. But when coupled with the mechanisms of mathematics and medicine in bio-power, this can be conceived of in entirely different ways. Bio-power is able to establish, between my life and the death of the other, a relation that is not warlike or confrontational but biological: "The more inferior species tend to disappear, the more abnormal individuals can be eliminated, the less the species will be degenerated, the more I—not as an individual but as a species—will live, will be strong, will be vigorous, will be able to proliferate." The death of the other does not just make me safer personally, but the death of the other, of the bad, inferior race or the degenerate or abnormal, makes life in general healthier and purer (FDS, 227–28). "The existence in question is no longer of sovereignty, juridical; but that of the population, biological. If genocide is truly the dream of modern powers, this is not because of a return today of the ancient right to kill; it is because power is situated and exercised at the level of life, the species, the race, and the large-scale phenomena of population" (VS, 180; WK, 136). "If the power of normalization wishes to exercise the ancient sovereign right of killing, it must pass through racism. And if, inversely, a sovereign power, that is to say a power with the right of life and death, wishes to function with the instruments, mechanisms, and technology of normalization, it must also pass through racism" (FDS, 228). This holds for indirect death—the exposure to death—as much as for direct killing. While not Darwinism, this biological sense of power is based on evolutionism and enables a thinking of colonial relations, the necessity of wars, criminality, phenomena of madness and mental illness, class divisions, and so forth. The link to colonialism is central: This form of modern state racism develops first with colonial genocide. The theme of the political enemy is extrapolated biologically. But what is important in the shift at the end of the nineteenth century is that war is no longer simply a way of securing one race by eliminating the other but of regenerating that race (FDS, 228–30). As Foucault puts it in La volonté de savoir: [End Page 148] Wars are no longer waged in the name of a sovereign who must be defended; they are waged on behalf of the existence of all; entire populations are mobilized for the purpose of wholesale slaughter in the name of life necessity. Massacres have become vital [vitaux—understood in a dual sense, both as essential and biological]. It is as managers of life and survival, of bodies and the race, that so many regimes have been able to wage so many wars, causing so many men to be killed. (VS, 180; WK, 136)

#### **The plan is critical- policy may never be perfect but it’s key to challenge existing structures**

P.J. Mackey, Memorial University of Newfoundland 2009, [“CRIP UTOPIA AND THE FUTURE OF DISABILITY”, peer reviewed Critical Disability Discourse Journal, <http://pi.library.yorku.ca/ojs/index.php/cdd/article/view/23383>]VN

The Utopian projects of Ratzka and Finkelstein, and the anti-Utopian reactions of Abberley and Shakespeare, all struggle with issues of equality, individual validation, environmental barriers, resource distribution, and resistance to normative values. As rates of impairment rise rapidly with an aging population, dispelling the ableist collective fantasy is not only vital to the well-being of disabled people, but people in general, for as biomedicine advances, concepts of impairment will shift along with what we consider to be the normal body. It is likely that this fluctuation of impairment due to advances in medicine will affect conceptions of disability as much as a strong political disability movement that strives to change both societal attitudes and environmental accessibility. A rapid increase in obese and geriatric populations contrasts sharply with the mass mediated presentations of the ideal body and are less tenable than ever, causing a mounting reliance on the health care system to manage the diverse number of aging related illness and disability. This population increase will both serve to swell the numbers of the disability movement and increase awareness of the social adversity involved, while at the same time push Medicine toward new cures and prostheses. This will likely further stigmatize those too impaired to work at present, while undermining any simplistic notions of disability as a coherent group. Shakespeare points out that “there are so many barriers to be removed, that perhaps it has not been necessary to think about what the inclusive environment might look like, when the Utopia is finally achieved” (2006, p. 44). However, I would argue that imagining a barrier-free Utopia is vital to the movement’s momentum. Predictions of future states of disability according to the social model’s assumptions that a barrier- free environment is possible and will do away with disability may seem naïve in retrospect, but its impetus in this regard may also be indicative of the structural limitations of new theory to provide motivation for such visions of the future. While there unfortunately have not been any anti-Utopian reactions to Ratzka’s brilliant narrative, it stands as an accessible and exemplary exploration into how our contemporary theory and policy offshoots are constantly diverging and growing back into themselves.

#### Our pedagogy should prioritize a transformative politics of disability. That provides a discourse to challenge status quo segregation.

Fitch E. Frank, Prof in the Department of Educational Philosophy with the University of Miami Fall 2002[“Disability and inclusion: From labeling deviance to social valuing,” [Educational Theory](http://search.proquest.com/pubidlinkhandler/sng/pubtitle/Educational+Theory/$N/34718?accountid=10422)[[Description: Description: Description: http://search.proquest.com/assets/r9.0.1-0/core/spacer.gif](http://search.proquest.com/indexingvolumeissuelinkhandler/34718/Educational+Theory/02002Y10Y01$23Fall+2002$3b++Vol.+52+$284$29/52/4?accountid=10422)52. 4, p.pq]](http://search.proquest.com/indexingvolumeissuelinkhandler/34718/Educational+Theory/02002Y10Y01$23Fall+2002$3b++Vol.+52+$284$29/52/4?accountid=10422)

Signs are part of an ideological struggle that attempts to create aparticular regime of representation that seeks to legitimate a certain cultural reality.54 Disability has historically played a central role in signifying otherness and justifying discrimination among other subordinate groups. Disabled people continue to be subject to a regime of representation that maintains a segregationist system of "special" and "regular" education. The significance of traditionalist discourse in maintaining this particular cultural reality is difficult to overestimate; it has perpetuated a dual system that remains deeply entrenched in the social commitments of categorically defined special interest advocacy groups; in the structure of health, education, and welfare programs at direct service levels; in the staffing of teacher training institutions; in other professional training programs and in general public thinking.55 The traditionalist or medical model of disability intersects with forms of oppression in complex and pervasive ways. It plays a pivotal role in maintaining an "ability" tracked system of education that covertly segregates by race, class, and ethnicity. As long as disability retains its naturalized biological status, it will continue in the service of domination. Labeling deviance theory has played a key role in challenging this regime of representation. In highlighting the linguistic, socially constructed nature of disability it has helped to problematize normal/deviant boundaries. However, because it has not recognized the ideological, normative, and discursive dimensions of power it has been less than transformative. It has failed to offer an alternative discourse that can effectively cross these boundaries, that can move beyond the contradictions and limitations of an affirmative approach. A discourse of transformative valuing offers a way to finesse these limitations. I have sketched what it would mean to adopt a transformative versus an affirmative discourse across various educational settings. Displacing traditionalist discourse and eliminating the dual system of special and regular education will require a long struggle. In addition to building on the emerging alliance between inclusive and multicultural education, disability studies must become an integral part of multicultural curricula in general. If the goal of critical multiculturalism is to render the ideological modes of domination visible, disability can no longer be overlooked as a site of political contestation and transformation. Any conceptual frame of reference or theory obscures some facts while rendering others visible and comprehensible. As outlined here, a transformative discourse of social valuing suggests an alternative language and perspective on the "facts" or "problem" of disability. Conceptualizing the nature and location of the problem has significant policy implications for general and special education, multicultural education, disability studies, and the inclusion movement. It renders visible the dimensions of power in the construction of disability and the legitimization of exclusion. It invites the kind of discourse and pedagogy that can help identify what represses and how it can be altered.56 It envisions the role of educators as transformative intellectuals who work to build alternative, inclusive public spheres.57 It opens up the potential to "analyze hitherto undreamt of possibilities by putting new linguistic and other practices into play and enacting new social constructs."58

#### Plan: The United States federal government should provide all necessary funding for Universally Designed transportation infrastructure.

#### FEDERAL action is crucial – it signifies the elevation of universal design to a CIVIL RIGHTS issue – and thus is both SYMBOLICALLY and ETHICALLY unique in a way that STATE GOVERNMENTS can’t solve

Stephen L. Percy, professor School of Public and International Affairs, Ph.D., Indiana University A.B., Hamilton College, ‘Disability policy in the United States,’ 2002

The Americans with Disabilities Act abandoned the condition-of-aid approach and set forth a variety of statutory mandates prohibiting some actions and pre-scribing others for state and local governments and the private sector. This shift in policy approach was congruent with the view of the ADA advocates that strong federal requirements bearing down upon both the public and private sectors were required to break down persistent discrimination based on disability. Through the ADA, national standards concerning non-discrimination and those providing reasonable accommodations were established across the nation through a single statute – pre-empting the governing authority of states and localities.40 Adopting a national rather than subnational, or centralized versus de-centralized, policy model for disability rights protections responded to a concern that not all states could be counted on to enact serious non-discrimination statuses. The Senate Committee on Labor and Human Resources (of the US Congress), in its report on the ADA, cited the testimony of one disability rights activist who claimed that “Enough time has, in my opinion, been given to the States to legislate what is right. Too many states, for whatever reason, still perpetuate confusion. It is time for Federal action.”41 The ADA’s federal pre-emption of state and local authority was also propelled by the general agreement in Congress that the ADA represented another in a series of civil rights policies for which the federal government had accepted primary responsibility for enacting and enforcing. Despite the fact that Republicans during the presidential administrations of Ronald Reagan and George Bush regularly railed against the creation of new federal mandates, there was widespread support for the ADA in both houses of Congress and in the White House – unusual bipartisan support for major civil rights legislation. While some Republicans, taking a conservative stance, voiced displeasure about ADA provisions concerning coverage, enforcement, and penalties, they were generally comfortable with the plan for a national civil rights bill for people with disabilities which would strengthen and expand the mandates included in earlier federal laws. Attorney-General Richard Thornburgh, for example, testifying on behalf of President Bush at congressional hearings on the ADA, claimed that “Over the last 20 years, civil rights laws protecting disabled persons have been enacted in a piecemeal fashion. Thus, existing Federal laws are like a patchwork quilt in need of repair. There are holes in the fabric, serious gaps in coverage that leave persons with disabilities without adequate civil rights protections.”42 The move to “nationalize” disability rights policy also reflected the willingness of Congress to enact pre-emption statuses in the area of civil rights43 and a shift in federalism away from aiding places and toward directly aiding persons.44 By the late 1980s, the disability movement had reached full political force, joining interest groups that had proliferated in other policy areas and who were having a growing impact on policy issues related to federalism.45 Scores of national, state, and local organizations representing persons with disabilities had, by this time, organized politically, adopted effective political tactics, and learned to cooperate in pursuit of national civil rights legislation to end discrimination based on disability. These groups demanded that people with disabilities be recognized as full citizens of the United States and that the federal government take action to ensure that they receive full benefits of that citizenship. They were joined by civil rights organizations representing women and minorities who helped sustain the push for enactment of comprehensive national civil rights legislation.

#### The status quo fails because it focuses on technical solutions to ‘fix’ disabled groups that stigmatize users. UD is key- it provides all necessary infrastructure in a single integrated system.

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UD applied to transit is an inclusionary strategy that seeks to redress the aforementioned forms of social exclusion. Accessible transportation focused previously on technical solutions to removing physical barriers affecting specific disabled groups and providing dial-a-ride or specialized demand services. These strategies largely segregated and stigmatized users as “seniors” or “disabled.” Instead, UD emphasizes transportation that caters to all users regardless of age and ability in a single integrated system that combines both mass transit and real-time demand-responsive systems (Grieco 2003; Mitchell 1997). Enabled by ICT and borrowing from freight logistics, the European literature refers to this systemas the “complete transportation chain” (Mitchell 1997; Organization for Economic Cooperation and Development 2000; Ståhl 1999), while the American literature terms it the new “mobility management model” (TCRP 1999, 2000, 2002). These models require seamless integration of the supply side (i.e., system’s operation, infrastructure, and quality of service delivery) with the demand side (i.e., mobility needs of the widest number of users). Consequently, this often entails a complete reorganization of transit operations from traditional fixed-route, hub-and-spoke, and setschedule systems to flexible schedule systems with intelligent reservation centers that can identify passenger needs and aggregate individual preferences in real time, providing door-to-door service (Hine and Grieco 2002). Despite its technical feasibility in the current ICT era, institutional, organizational, legal, and old market structures remain important barriers to the full realization of these integrated-transit models touted as the means to bring about “a new relationship between accessibility, mobility and the previously socially excluded” (Hine and Grieco 2002, 4). In a conceptual discussion of UD and accessibility, Iwarsson and Stahl (2003) differentiate between three dimensions of physical accessibility5: (1) micro accessibility related to the immediate proximal environment, (2) meso or neighborhood or city-level accessibility, and (3) macro or metropolitan or regional accessibility. This article applies these scales of accessibility to the previously discussed dimensions of mobility-related social exclusion (i.e., immobility) to assess the transit features requiring a UD approach. As shown in Table 3, a UD perspective applied to transit underscores the notion that: 1. Addressing physical exclusion at the micro level of accessibility involves planning, designing, and operating transit systems that are easy for all users. This includes not only passengers with physical, sensory, or cognitive impairment but also those with language or cultural barriers, people with children, individuals carrying baggage or parcels, or those who are new to the area (Suen and Mitchell 1999). Micro-level accessibility requires barrier-free retrofitting of the existing physical built environment; however, future development to be served with transit requires planning for UD to avoid the need for retrofitting or readaptation. This includes consideration of pedestrian infrastructure and streetscape (e.g., sidewalks, traffic signals, crosswalks, street crossings, and street furniture) and their interface with automobile facilities (e.g., park and ride, kiss and ride), and transit passenger facilities (e.g., terminals, stations, stops). Universally designed transit accessibility at the micro level requires bus-stop boarding pads and street curbs that are leveled with low-floor buses. This not only makes shorter and easier bus boarding and alighting for all (i.e., wheelchair passengers, frail and/or ambulant disabled people, patrons with small children or those carrying baggage or parcels), it also reduces bus dwell time. Low-floor buses with lifts or ramps meet barrier-free design criteria, but strictly speaking, ramps and lifts are ADA bus design readaptations that increase bus dwelling time and stigmatize wheelchair users or anyone needing them. Thus, although they are a form of inclusive design, they are not UD solutions to micro-level transit accessibility.

#### Universal design deconstructs the medical model through infrastructure that is more inclusive

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Many designers are now beginning to acknowledge the social model of disability by recognizing that in designing, they have the power to create or eliminate disability. A badly designed interface might unnecessarily create a population of users who are “disabled” with respect to that system (Mankoff 4). This lends to the importance of designing inclusively, to avoid marginalizing atypical users. Universal design seeks to design all products, buildings and interiors to be used by all people to the greatest extent possible regardless of their physical abilities (Bailey). Some key principles of Universal Design include equitability and flexibility in use, as well as avoiding the stigmatization or segregation of any set of users (1997 NC State University, The Center for Universal Design). These principles “provide designers with the tools to effectively eliminate disabilities caused from barriers within the environment” (Bailey). Examples of features in line with universal design principles include closed captioning on televisions, and visual and audio display of information in subway cars. When the needs of different people are considered in design, this is a step towards the social model of disability and towards acceptance of people with disabilities. Assistive technology is beneficial because it can allow greater independence and functionality to people with disabilities, bridging the gaps that might exist between what the people would like to do and what the existing social infrastructure doesn.t yet allow them to do (Hersh 15). However, assistive technology can often have a strong health or rehabilitation flavor. After WWII, most assistive technology research and development focused on medically related technology such as prosthetics and orthotics (Albrecht 675). This has linked the technology needs of people with disabilities with the health domain. Since the medical model focuses on the physical and functional limitations a person may demonstrate, assistive technology designers often see this as a clear design objective that would have measurable results (Mankoff 4). Thus when the medical model is used in the design of assistive technology, there is typically less emphasis on aesthetics or form, since the rehabilitative function has priority. In one study, people with disabilities indicated a belief that manufacturers of proprietary technology do not appear to make an effort to make their devices aesthetically appealing (Shinohara 5). Assistive technology designed for medical purposes such as “fixing “ the impairment has historically been designed for use in an institutional setting; this institutional appearance can stigmatize the individual and confirm the “otherness “ of disability (Bailey). The medical model of assistive technology depict its users as passive and dependent on others.(often professionals.) impressions of what is best for them. People with disabilities might often not be considered users or consumers, but rather poor and powerless patients (Newell 172). This is devaluing to people with disabilities. Letting the designers make decisions on behalf of people with disabilities without valuing them as users leads to the persistence of medical model views. Designers may have assumptions and stereotypes about people with disabilities that can become embedded within the design (Ratzka). A solution is to apply many of the universal design principles to the design of assistive technology: It is better to lean towards the social model in the design of assistive technology, where there is more of a focus on solving problems of access, rather than on fixing a person.s impairment. When the social model is incorporated, people with disabilities are valued as customers, consumers, and people in the design process (Newell 173). They thus have more of a say in the design of products and services they will use, and can take more charge of their lives rather than having someone else decide what is best for them. The US Government.s website on Disability Technology advocates for “Access and Independence through technology”, rather than treatment or assistance ("Technology: Disability.gov."). This phrasing represents steps towards acceptance of the social model of disability. Much assistive technology that exists has been designed with the medical model in mind, which serves to portray people with disabilities as deficient and dependent. When designers value those with disabilities as users and not as patients, the medical model is less prevalent. Universal design of technology is a step towards granting more access to all citizens and portraying people with disabilities as normal members of society. However, even with the growing popularity of universal design principles, the pre-existing attitudes of many designers (influenced by the media and other factors) may still be present in the design of technology. The medical model can portray people with disabilities as abnormal, dependent, and inferior, as less-valued members of society. We need to be conscious of these negative attitudes and how we may be reinforcing them. A solution is to aim for the adaption of more humanistic models of disability such as the social and diversity models. Attitudes and policies in line with these models recognize people with disabilities as important contributing members of society. Pushing towards these models of disability, towards less ableist views, and towards reduction of negative portrayals of those with disabilities, is optimal. While strides have been made towards this goal, the medical model unfortunately still remains entrenched in society to some extent and so long as it is, people with disabilities will be seen as different from “normal” people and will be marginalized in society. The Olin College survey showed that students held attitudes that were based primarily off the social model but still had some medical model tendencies. It is my hope that this paper will allow the reader to be more conscious and aware of how the models of disability influence their beliefs and attitudes, and to try to avoid thinking of people with disabilities as deficient or less capable people, but rather as unique individuals who have a lot to offer to society.

#### Absent federal funding Metropolitan Planning Organization compliance with ADA mandates will continue to decline. Investment now is necessary to transition to more inclusive infrastructure

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In an environment of diminishing public funding and transit patronage, to this day, some transit agencies have been slow in complying with ADA requirements. Disabled patrons complain of bus stops not being announced and bus drivers failing to stop for people with disabilities who are waiting to ride the bus (National Council on Disability 2005). Additionally, problems persist concerning maintenance of accessibility equipment (e.g., bus lifts), and ADA complementary paratransit systems are fraught with quality-of-service, reliability, trip-booking, and pick-up problems. Finally, inaccessible streets, sidewalks, bus stops, intersections, and crossings for people with disabilities remain a persistent problem throughout the United States (National Council on Disability 2005). Experience shows, even in European countries with the most advanced and integrated transit systems, that inaccessible pedestrian and transit facilities, vehicle fleets, and information and way-finding devices and services are the most difficult to get right. They also require the most attention from planners and operators, as well as the largest share of operating funds (Ireland National Disability Authority 2004, 16). Furthermore, inaccessible pedestrian and transit facilities are partially the result of poor coordination between local governments and transit agencies. In the United States, metropolitan planning organizations under the Intermodal Surface Transportation Efficiency Act of 1991 and subsequent reauthorizations are mandated to address these issues in Metropolitan Transportation Plans specifically focused on pedestrian and transit mobility and ADA-mandated accessibility. Yet funding shortages limit the capacity of many transit agencies to adequately meet these mandates.8 Furthermore, the notion that all users benefit from transit that meets the needs of Americans aged 65 and older, whose population is estimated to increase 80% by the year 2025, has encountered both skeptical and optimistic assessments. Giuliano’s (2004, 204) research finds that rather than shifting to transit, older people “prefer automobile travel and compensate for physical limitations by traveling less.” Her research also “suggests caution in considering more transit environments as a mobility strategy for the elderly,” since the transit service will have to be very high quality and mimic the car to effectively attract the elderly to transit (p. 204). Similarly, Rosenbloom (2003) asserts that older Americans prefer to drive and that restructuring transit and development patterns will provide more travel choices but not necessarily cause older drivers to switch to walking and transit for the majority of their trips. On the other hand, Bailey (2004), using data from the 2001 National Household Transportation Survey, finds that in 2001, public transportation trips by older nondrivers totaled an estimated 310 million—with older minority populations more than twice as likely to use transit than their white counterparts. Bailey (2004, 1) also finds that social exclusion through suppressed travel is high among older citizens with “more than 50% of non-drivers age 65 and older— staying home on any given day partially because they lack transportation options.” This confirms that for many older nondrivers, public transit is the only alternative to asking for a ride. Bailey recommends substantial increases in funding and investment in the Federal Transit Administration’s Section 5310 Grant: Specialized Transportation Program for the Elderly and Persons with Disabilities. Having carried out focus-group research on travel preferences of driver and nondriver senior citizens, proponents of the new “mobility management” both agree with the above skepticism and concede suppressed travel. They underscore the fact that tomorrow’s older persons are likely to have been car drivers all their lives, having lived in suburban and exurban areas lacking good public transit, and would be likely to demand highquality door-to-door services that can compete with cars. However, concurring also with the need for transit that addresses the immobility of impaired and senior citizens, they emphasize that geographical inaccessibility to jobs and regional services and facilities demands a regional approach beyond the neighborhood and city (Burkhardt, McGavock, and Nelson 2002). Metropolitan planning organizations and regional transit authorities are poised to tackle this issue by becoming mobility managers of traditional and nontraditional transit services that expand mobility choices for all (TCRP 1999). This implies “costeffective public transit solutions for low-density areas that can address the travel needs of high-income and high-mobility seniors while at the same time addressing the travel needs of low-income and low-mobility seniors” (Burkhardt, McGavock, and Nelson 2002, 44). Lack of funding and reluctance to change transit to fit users’ needs (rather than the current practice of fitting users to transit) are major roadblocks for which multiple studies and research, commissioned by the TCRP, offer guidance for addressing and overcoming (TCRP 1997, 2000). Although a review of this research is outside the purview of this article, it would suffice to say that TCRP literature converges on a paradigm shift along the line described here as UD of transit.9 Time will tell whether cities, transit authorities, and the Federal Transit Administration will fully embrace the paradigm. However, some progress in this direction has started to occur. In the United States, a few transit agencies have restructured their service model from fixed-route models focused on downtown to a family of services combining fixed and rider-request routes designed to serve both downtown and suburban demand. Fort Worth’s Transportation Authority made such a shift, ostensibly supported by constant user feedback and service assessment. Also, nonprofit service organizations, such as the Independent Transportation Network in Portland, Maine, are starting to offer a variety of demand-responsive services to older citizens on a 7-day, 24-hour basis. The Independent Transportation Network uses a combination of paid and volunteer drivers and a variety of payment innovations, including “gift-ride programs,” “trip-cost sharing” with merchants and professional offices visited by riders, “frequent-rider miles,” and a “road scholarship fund” for low-income users who cannot afford to pay full fare (Burkhardt, McGavock, and Nelson 2002). These examples are being emulated in different parts of the country and prove that a wider range of geographical accessibility and social inclusion can be achieved through transit designed for all. However, strapped for funding, transit agencies in the United States have been slow to embrace these and other UD innovations, perceived as “interesting” but beyond ADA’s legal mandate.

Federal funding is inevitable, but our redirection is critical- state interactions with MPOs are the cause of failure because they co-opt funding to increase sprawl

Benjamin K. Olson, Counsel in the Regulations Branch in the Board of Governors of the Federal Reserve System's Division of Consumer and Community Affair and Managing Counsel in the Office of Regulations at the Consumer Financial Protection Bureau  2001[“[Transportation Equity Act for the 21st Century: The Faulure of Metropolitan Planning Organizations to Reform Federal Transportation Policy in Metropolitan Areas”,](http://heinonline.org/HOL/Page?handle=hein.journals/tportl28&div=12&collection=journals&set_as_cursor=0&men_tab=srchresults) Transportation Law Journal, Vol. 28, Issue 1 (2000), pp. 147-184,

<http://heinonline.org/HOL/Page?handle=hein.journals/tportl28&id=184&type=text&collection=journals>]MW

As one commentator has observed, the burden placed on MPOs by ISTEA and TEA-21 has stretched them "almost to the breaking point. Most MPOs now have responsibilities that far exceed their authority.'126 This paper argues that, because ISTEA and TEA-21 charge MPOs with working radical change in a system of established interests and patterns without granting them the power or independence to effect meaningful reform, metropolitan transportation decisions continue to be made at the state level and transportation funds for metropolitan areas continue to be spent disproportionately on road-building for outer-ring suburban com munities.127 Although ISTEA and TEA-21 have created a more compre hensive, planned process for making transportation decisions in metropolitan areas, this paper argues that they have failed to alter the fundamental aspects of the decision-making and funding processes, thereby ensuring that substantive outcomes will remain the same. Pre-ISTEA, the combination of sprawled development requiring high levels of road-building and a federal transportation policy that focused on responding to increases in vehicular demand created a preference for road-building in metropolitan transportation planning.128 ISTEA sought to reform this system by placing planning in the hands of MPOs and requiring that they create long-term plans that consider the social and environmental impact of proposed transportation systems.129 However, MPOs have been unsuccessful in reforming transportation planning and federal funds continue to be used on new road-building rojects to satisfy the demands of outer-ring suburban communities.130 This paper will argue that this failure has occurred because MPOs lack institutional independence to resist state and local preferences for road building, because the planning requirements under TEA-21 are insufficient to counterbalance the weakness of MPOs, and because the federal agencies responsible for overseeing MPOs have been lax in enforcing these planning requirements when MPOs are not in compliance. This paper proposes that, in order to truly implement transportation planning reform in metropolitan areas, the federal government will have to play a more active role in the planning process. Because efforts to increase the independence of MPOs vis-a-vis state governments will not ensure reform if federal planning requirements and oversight are not strengthened, TEA-21 must be amended to make application - rather than mere consideration - of the planning requirements mandatory, and the FHWA and FTA must take a more aggressive role in ensuring that federal transportation planning mandates are observed by MPOs. Precise determinations of where federal transportation funds are going are difficult to make for a number of reasons: the complexity of IS TEA and TEA-21,131 the number of projects funded under those acts,132 the variance between the funds authorized by the acts and those actually appropriated by Congress and then obligated to specific projects at the state level,133 and, most importantly, the general refusal of federal and state transportation agencies to make relevant information available.134 Consequently, there is some disagreement over the success of ISTEA and TEA-21 in reducing automobile dependency and road-building.135 However, even assuming that ISTEA and TEA-21 funds have found their way to a significant number of alternative transportation programs, studies have nevertheless determined that states continue to subvert the intent of federal transportation policy reform by directing federal transportation dollars towards road-building projects that encourage "sprawl" develop ment in relatively unpopulated spaces within the metropolitan area and increase automobile traffic and environmental pollution.136 MPOs and state governments have continued to frustrate the intent of ISTEA and TEA-21 in three ways. First, a substantially smaller per centage of federal transportation funds continues to be spent on urbanized areas than the percentage of the population those areas represent.137 By directing transportation funds towards the least populated portions of the metropolitan area, MPOs and state governments encourage development of those areas rather than addressing the transportation needs of the more densely populated inner-cities and the developed suburban areas.138 This practice goes against ISTEA and TEA-21's purpose of making transportation decisions that addressed the needs of existing communities rather than encouraging development of new areas.139 Second, MPOs and state governments have continued to favor the funding of large road-building projects on the fringes of metropolitan ar eas.140 By building roads in relatively undeveloped portions of the met ropolitan areas, MPOs and state governments are using federal funds to encourage "sprawled" development patterns.14' Because "sprawl" development requires automobile-based transportation systems to accommodate its inefficient use of land, the construction of new roads in undeveloped areas facilitates inefficient land use patterns in metropolitan areas,142 a practice which ISTEA and TEA-21 sought to discourage.143 Third, states have continued to withhold funds from programs targeted to urbanized areas. Under ISTEA and TEA-21, the Surface Transportation Program (STP) was specifically designed to provide federal funds for metropolitan areas.144 However, state governments have severely underspent the funds provided under STP in relation to spending rates of other funds.145 While state governments have been spending an average of 96 percent of the funds provided under other federal transportation programs, many states are spending STP funds at rates less than 70 percent.146 The impact of state underspending of STP funds on nonvehicular forms of transportation in metropolitan areas is exacerbated by dramatic cuts in direct federal transit assistance since 1994.147 Because metropolitan areas relied heavily on these funds, the result has been an overall reduction in federal funding of mass transit systems.148 Thus, state governments have undermined ISTEA and TEA-21's purpose of promoting mass transit as an alternative to vehicular transportation by refusing to spend the funds appropriated by Congress for that purpose.