Introduction

This chapter seeks to understand the tourist experiences of people with disabilities, including the seniors who also constitute the accessible tourism market. Tourism experiences can be viewed through many approaches. The following discussion is situated within the framework of critical theory in tourism studies and critical disability studies theory, both of which focus on ends rather than means, examining social power structures with a commitment to emancipation. The lived experience of the person is the subject matter and within the approaches of critical tourism and critical disability studies, the lived experience is a bodily experience. This chapter examines the embodied experience of those with disabilities within the tourism context. For the purposes of this chapter, the authors take Osborne’s (2000: 51) definition of embodiment where ‘’embodiment’’ is used to describe the way in which the bodily bases of individuals’ actions and interactions are socially structured: that is, embodiment is a social as well as natural process’. In this case, embodiment as it relates to disabilities includes mobility, hearing, vision, cognitive/learning, sensitivity and mental health but, in the developing field of critical disability and tourism studies, the areas most researched are mobility and vision. While it is recognised that disabled/non-disabled subjectivity intersects with other subjectivities such as gender, age, culture, ethnicity, sexuality, economic position etc., a dearth of research in tourism and disability studies (and the word length of this chapter) prevent a discussion of these intersections.

Boorstin (1987) in The Lost Art of Travel distinguished between travellers of the past and today’s tourists, noting that ‘until almost the present century, travel abroad was uncomfortable, difficult and expensive’ (p. 80). Indeed, the word travel comes from travail – ‘meaning “trouble”, “work”’
or "torment" (Boorstin, 1987: 85). He viewed the traveller of the past as someone who worked at the experience, whereas the tourist of today waits for things to happen to them. Boorstin (1987) claimed: ‘Nowadays it costs more and takes greater ingenuity, imagination and enterprise to fabricate travel risks than it once required to avoid them’ (p. 117). Today’s travel might be seen as easier than travel of the past. Today, air travel allows us to cross the globe within a day. Travel companies now have organised tours to places unimaginable even since Boorstin wrote his chapter – computers allow us to seek travel information, purchase the holiday and check-in without leaving home and, for some, have virtual tourism experiences (Turner et al., 2005: 43). We don’t need ‘real’ money to travel – we have credit cards. Mobile phones and email allow us to stay in constant touch with home while away. And so on. The commonplace of travel today and the ease with which many non-disabled people engage can conceal the socially constructed barriers and constraints encountered in travel by those with access needs. Developments in travel technology can be a blessing for some but those who are restricted in their access to a computer, ATM, mobile phone or other technology remain segregated. In many ways, services and facilities for people with disability have increased but in other ways service personnel are scant and travel has become a DIY venture. Where are the porters of yore at travel termini – not everyone can carry a suitcase! Travel is still geared for bodies and minds that conform to a very narrow definition of embodiment.

A Critical Approach to the Tourist Experience of People with Disabilities

Critical theory in tourism is an approach to research that has developed in the last 20 years. As explained below, the criteria of critical theory are that:

It must be explanatory, practical, and normative, all at the same time. That is, it must explain what is wrong with current social reality, identify the actors to change it, and provide both clear norms for criticism and achievable practical goals for social transformation. Any truly critical theory of society, as Horkheimer further defined it in his writings as Director of the Frankfurt School’s Institute for Social Research, ‘has as its object human beings as producers of their own historical form of life’ (Horkheimer, 1993: 21, in Bohman, 2005)

Wilson et al. (2008: 16) explained that critical theory is not simply a criticism of past grand tourism theories but one that challenges enquiry to seek a solution for inequalities where they exist:

While ontological, epistemological and methodological differences may exist, those employing a critical approach would generally be
concerned with resisting positivist modes of enquiry, unmasking power relations, seeking emancipation, addressing inequalities, or calling for change or action within the field they are exploring. (Brookfield, 2005; Hooks, 2003)

While sharing some traditions with critical theory, critical disability studies\(^1\) is a challenge to a dominant medical discourse that pervades all social structures for people with disabilities. In disability studies, the critical approach challenges the traditional medical model which is founded on the ‘personal tragedy theory of disability’ (Oliver, 1996: 31). The medical model locates the problem of disability within the individual as their ‘fault’, and sees the cause of the problem as emanating from the functional/psychological losses (their impairment/embodiment) arising from the disability. This medical discourse views able-bodiness as the social norm and, hence, excludes the ‘abnormal’ (people with impairments) from citizenship. Critical, or social approaches to disability, on the other hand, place the lived experiences of people with disabilities at the centre of understanding, focus attention on the disabling environment and hostile social attitudes, and seek solutions through the creation of enabling environments (Barnes, 1996: 43).

The fundamental distinction between the medical and social models lies in the difference between impairment and disability (UPIAS, 1975). The social model changes the focus of disability from the agency of the individual to the social structure of society. It is the disabling social practices that transform the individual’s impairment (embodiment) into a disability. Social model analysis focuses on disabling barriers, hostile social attitudes and the material relations of power (see Figure 5.1).

While the social model is more emancipatory than the medical model, Shakespeare and Watson’s (2001: 22–23) critique of social model approaches identifies three central criticisms of the social model that focus on: impairment; the impairment/disability dualism; and the issue of individual identity. It is suggested that an embodied ontology would contribute towards developing a complexity and richness to the social model by creating a space and place for embodiment within the paradigm. Shakespeare and Watson conclude that an embodied ontology offers a starting point for disability studies to begin to develop a more adequate social theory of disability. As they suggest, developing an embodied ontology of disability needs to consider that impairment and disability are not dichotomous but are different places and times on a continuum. They suggest that disability should not be reduced to just a medical condition or to just social barriers alone as it is more complex. In effect, the embodied ontology challenges the dichotomies of impairment/disability and illness/health and offers a model that intertwines structure
The Medical Model

Figure 5.1 Social versus medical approaches to disability

Source: See Chapter 2 and modified from http://www.disease.org.uk/Medical_Social_Model.htm
and agency. To summarise, Figure 5.1 presents a representation of the differences between the models.

Critical approaches in tourism studies also recognise that the lived tourist experience is a bodily experience. Firstly, it is a corporeal experience of the senses, organs and emotions. The tourist body sleeps, eats, aches, sunburns, relaxes, cries, laughs, smells, hears, sees and so on. Secondly, it is a body that is socially constructed. Different bodies have different social images, meanings, value and worth. The body is gendered and aged and disabled/non-disabled etc. Thus the tourist experience is an embodied experience. For some postmodernists the body is solely discourse but as Bordo (1989: 13) says, the body is more than ‘a text of culture’. It is also ‘a practical, direct locus of social control’. Harper (1997: 161) refers to ‘the ongoing tension between the body as constructed and the body as experienced, the body as an inscribed exterior and the body as a lived interior’. Grosz (1993: 196) deals with this tension by connecting the ‘two’ bodies and explains the body ‘as a kind of hinge or threshold: it is placed between a psychic or lived interiority and a more socio-political exteriority that produces interiority through the inscription of the body’s outer surface’. To avoid the dichotomous, mutually exclusive categories of mind and body, new terminology is required. Grosz (1994: 22) suggests that ‘some kind of understanding of embodied subjectivity, of psychical corporeality, needs to be developed’. The body is matter but it is not a fixed essence on which the social is inscribed. As Holland et al. (1994: 22) say, ‘The material body and its social construction are entwined in complex and contradictory ways which are extremely difficult to disentangle in practice’.

Representation

Hargreaves (1986: 14) comments that, ‘The body is clearly an object of crucial importance in consumer culture and its supply industries’. Tourism is an industry in which the body is central to its purpose and consumption. How the body is represented in tourism can provide some context for how a person might experience tourism. Analyses of tourism images of the body indicate that Western tourism discourse constructs the tourist body in a particular way: young, non-disabled, slim, tanned, Caucasian and what would generally be considered ‘attractive’. Underlying the discourse are power relations that posit youth and the idealised body as the focus of the ‘tourist gaze’ (Urry, 1990). While tourism managers may present a politically correct public attitude by recognising the importance of employing people with disabilities (e.g. valued social roles) they still choose to exclude people based on their ‘abnormal’ appearance (Ross, 1994). This attitude of managers extends to the context of tourist to tourist interaction, where people with disabilities are
considered *inappropriate other* for social consumption by non-disabled tourists (Urry, 1990: 141).

Attitudes of non-disabled managers become evident through decisions made on marketing of how tourism product is represented. One example of representation research focused on the production of images in Qantas brochures. Edelheim (2007) in a study of Qantas brochures for Australian domestic destinations found that only 10% of the people pictured in the brochures were aged 45 and over although at the time 35% of the population was over 45 years of age. In addition to age discrimination, ‘not one photograph in any of the twelve brochures portrayed people with any types of visual signs of disabilities’. He added, ‘Although the accommodation providers in the brochures have indicated if there are facilities suited to people with disabilities, the invisibility of disabilities tends to further highlight the hegemonic norm these brochures are focusing on’ (Edelheim, 2006: 104). A study of Air New Zealand and Qantas in-flight magazines similarly revealed that, of the people pictured in the advertisements, there was no evidence of a person with a disability (with one exception being a Qantas advertisement for the packaging and assembly service of Disability Services Australia). The finding that representations of people in tourism material privilege the hegemonic gaze is continually reported in the tourism literature.

**Travel Patterns and Embodiment**

Woodside and Etzel (1980) established that on a regional level, households with people with disabilities travelled less than non-disabled households did. Darcy (1998) noted that of those who did not travel, a proportion of people with a disability would *like* to travel but did not due to socially constructed constraints rather than their impairment. Only Australia has collected data at a national level to provide an insight into the comparative travel patterns of people with disabilities and the non-disabled at a national level (BTR 1998; 2003). This work was recently reinforced through a more extensive analysis that estimated the economic contribution of accessible tourism to the economy (Dwyer & Darcy, 2008). As Figure 5.2 shows, people with disabilities travel at lower levels than the non-disabled for overnight stays and outbound travel. Interestingly, they travel at the same rate for day trips where the complication of overnight/outbound travel includes the provision of accessible accommodation. The significance of the research by these authors was that it clearly established the significantly lower travel rates of people with disabilities when compared to the non-disabled population.

What becomes apparent in interrogating the constraints-related research is that the difference in travel patterns can be explained by a series of socially constructed constraints by people with disabilities (Daniels *et al.*, 2010).
2005; Darcy, 2004; Turco et al., 1998). This work clearly establishes that people with disabilities travel at a lower rate to the general public, have different embodied experiences at different levels of disadvantage and for the most part this is not the outcome of their embodiment. Further, as shown in Figure 5.3, there are significant differences in the travel patterns of disability groups (Darcy, 2003). While constraints theory has provided insights into the relative disadvantage that people with disabilities experience, critics of positivist approaches and constraints-related research have called for a greater understanding of the disability experience through listening to the voices of those with disability (Samdahl & Jekubovich, 1997a, 1997b).

**Embodied Tourist Experiences**

The major conceptualisations of embodiment have drawn on medicalised discourses where social approaches focus on the creation of enabling environments through inclusive and universal practices (Preiser & Ostroff, 2001; Swain et al., 1997). This changes the medicalised discourse to one of social inclusion where the emphasis is on changing the disabling environment and hostile social attitudes to one that empowers people with disabilities. Rather than focusing on the individual’s impairment (their embodiment), the attention is directed towards creating an enabling environment for their dimension of access. The major dimensions discussed under human rights legislation include: Mobility; hearing; vision; cognitive/learning; sensitivities; health related (cancer/HIV); mental
The way that the United Nations (2006) Convention on the Rights of Persons with Disabilities and, hence, national disability discrimination legislation is framed, disability is an evolving construct. What was acceptable 20 years ago is no longer acceptable as the material position of people with access needs continues to develop. For example, online environments that were not conceived of 20 years ago have now evolved through browser development, PC-based software for interpreting web-based communication to people with vision impairments (e.g. Jaws software) and organisational commitment to accessible information. These developments have been reinforced through common law precedent (e.g. ‘Maguire v SOCOG [HREOCA H 99/115]’, 2000).

A great deal of the tourism research and practice is focused on people with mobility disabilities. There has been some limited research on people with vision, hearing, children with cancer and sensitivities. More recently there have been significant discussions about embodiment, obesity and air travel (Vedelago, 2009) with legal arguments as to whether obesity could be regarded as a disability and the consequent implications for air carriers. Table 5.1 identifies examples of inclusive and universal practice that provide an enabling environment for six of these groups. The table is presented as a foundation for understanding what promotes independent, dignified and equitable access that is at the core of the definition of accessible tourism (Darcy, 2006).
Table 5.1 Examples of inclusive practice in tourism for the dimensions of access

<table>
<thead>
<tr>
<th>Mobility</th>
<th>Hearing</th>
<th>Vision</th>
<th>Cognitive</th>
<th>Sensitivities</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous pathway</td>
<td>Telephone typewriters (TTYs)</td>
<td>Tactile ground surface indicators; Audio signals</td>
<td>Plain English text</td>
<td>Chemical free environments</td>
<td>Medical support</td>
</tr>
<tr>
<td>Circulation space</td>
<td>Hearing loops</td>
<td>Alternative formats e.g. large text, Braille; audio</td>
<td>Attendant support</td>
<td>Dietary considerations</td>
<td>Supportive environment</td>
</tr>
<tr>
<td>Specialist Equipment</td>
<td>Captioning</td>
<td>Areas for guide dogs</td>
<td>Opportunities for group travel for those in communal supported accommodation</td>
<td>Non-smoking areas</td>
<td>Opportunities for group travel</td>
</tr>
<tr>
<td>Low-floor buses</td>
<td>Sign language interpreters</td>
<td>Sensory trails</td>
<td>Activity programming</td>
<td>Organisational promotion</td>
<td>Advocacy and philanthropy programs</td>
</tr>
<tr>
<td>Customer service attitude</td>
<td>Customer service attitude</td>
<td>Customer service attitude</td>
<td>Customer service attitude</td>
<td>Customer service attitude</td>
<td>Customer service attitude</td>
</tr>
<tr>
<td>Wayfinding systems</td>
<td>Wayfinding systems</td>
<td>Wayfinding systems</td>
<td>Wayfinding systems</td>
<td>Clearly labelled areas</td>
<td>Specialist equipment</td>
</tr>
<tr>
<td>Information systems</td>
<td>Information systems</td>
<td>Information systems</td>
<td>Information systems</td>
<td>Information systems</td>
<td>Information systems</td>
</tr>
</tbody>
</table>

Source: Constructed for the chapter

Research Design

The rest of this chapter seeks to explore the embodied experiences of people with mobility and vision impairments that emerged from three studies of the authors based on modified grounded or phenomenological approaches. Elsewhere in the book, other embodiments are specifically explored including people with mental health issues, vision impairment, seniors and children with cancer. The research design of each of these studies has been comprehensively outlined in the original sources (Darcy, 1998, 2004; Packer et al., 2008). The remainder of the chapter takes the lived experience of people with disabilities from these studies and seeks to understand their journey through their own words. It does so by firstly presenting an overview of the journey through presenting key stages with quotes identifying the experiences of people with mobility impairments.
(MI) and people with vision impairments (VI). The chapter then seeks to present an understanding of the action between people with disabilities and the tourism environment using the accommodation sector as a focal point. For this last section, only people with mobility impairments experiences will be presented.

**Embodied Tourist Experiences – Understanding the Journey**

| ‘I have not had a holiday for 35 years. I have not had a day trip for over eight years.’ (MI) |
| ‘I think if people have very little sight, they don’t bother about travelling . . .’ (VI) |
| ‘Well I’ve given it up. Yeah, well, it’s too hard.’ (VI) |

The reasons for non travel can be simply a consequence of the person’s impairment. However, a great deal of the research suggests that for most, impairment collides with social circumstances. Being a quadriplegic, on a full pension and with three children it is very hard to travel great distances and find suitable accommodation at a reasonable price – almost impossible. That’s why we do not travel very much at all. (MI)

Depending upon their embodiment and dimension of access, the experiences of those who do travel can differ dramatically. Tourism can bring joys when all the travel plans come to fruition but those with disabilities carry with them an anxiety and trepidation through each stage of the journey. Countless experiences tell us that people with disabilities are expecting their plans to go wrong, not because the travel agent has not booked the flights but because their access needs have been overlooked by the socially constructed environment. Those with disabilities need to place a great deal of trust in others including strangers.

The quotations in Table 5.2 highlight the elation, the nightmares and the frustrations of travel. Tourism is a journey with many components, beginning before one leaves home. Satisfaction or dissatisfaction can occur at any of the stages of the journey and with any of the industry sectors or non-industry relationships experienced at any of the stages. How one experiences any of these ‘moments’ of travel can affect the pleasure or displeasure of the whole trip.

The remainder of the chapter documents experiences that emerged from the journeys undertaken. The headings that emanated from the grounded approach reflect the sequential process of undertaking a journey.
Table 5.2 The elation, the nightmares and the frustrations of travel

... regardless of whether I have a disability or not, I still like to live and I enjoy travelling and on that general principal I don’t feel I’m much different to anyone else. I just like to be able to see the world or see the country and just get out there and live, whether it involves travelling and making friends or just going up the road or to a different country. I think it’s all exciting, just the same as anyone else that would enjoy it. To find somewhere near and the sense of adventure isn’t lost on someone vision impaired. (VI)

Travelling with a disability is a never-ending nightmare, hell on Earth, indescribable, nerve-wracking, stomach churning, unbelievably expensive experience. (MI)

[Travel] can be very, very, very, scary and I think more so for those people who are blind or have low vision than those who are sighted. And I think [a] daunting thing for a person with no disability, let alone one that has one. And it’s not being recognised, because if it were then it’d be a lot more accessible. (VI)

Table 5.3 presents examples of embodied quotations from tourists with mobility (MI) and vision impairment (VI) at each of the key stages identified. Following the overview, is a detailed examination of the interaction between impairment, and accommodation provision in the lived experiences of people with mobility disabilities. The reason for examining accommodation is that people with mobility disability cannot undertake an overnight stay without being certain of an accessible place to stay. This section concludes with a discussion of the essence of the embodied tourism experiences of people with impairments.

Access, Embodiment and Accommodation

For tourists with mobility disabilities, physical access into and within accommodation can be critical to having a tourist experience. This section draws on two studies to examine specifically the accommodation experiences of people with mobility disabilities (Darcy, 1998, 2004). Kristy (below), whose impairment affects her mobility, stipulates her access requirements as ground floor accommodation:

We’ve been stuffed around quite a few times and we’ve been really aware of making sure that what they [providers] say is in fact actually going to eventuate ... even though you think you already have [made sure]. It’s amazing what goes wrong nevertheless ... we’ve gone
### Table 5.3 Tourist voices: Examples of embodied experiences

<table>
<thead>
<tr>
<th>Stage/system</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Travel planning</strong></td>
<td>(1) … the frustration I guess of having to put so much planning into a travelling trip which almost exhausts you before you start. (MI)</td>
</tr>
<tr>
<td></td>
<td>(2) Access to information I think is the biggest barrier, even before you go overseas. It’s non-existent. So you can’t research that country because you don’t have access to information such as the ‘Lonely Planets’ or brochures from tourist agencies [these are only in printed format]. The internet is inaccessible for people who use adapted technology. So you’re very much relying on word of mouth, somebody else reading it to you. (VI)</td>
</tr>
<tr>
<td><strong>Travel agents</strong></td>
<td>(3) I tried to explain to a senior staff member at Harvey World Travel my need to take up two place seats because of my stiffened legs. This travel agent told me that if the plane was not full, then I would be able to have two seats, but unless I wanted to pay for the extra seat, he could not assure me of the two seats. He curtly told me that he did not think this was discriminatory because other people often bought two plane seats – fat people for instance, and people who travel with large musical instruments. (MI)</td>
</tr>
<tr>
<td></td>
<td>(4) I was talking [to the travel agent] about wanting to go on the European tour for a holiday five-day trip. He made a phone call and basically said to the operator, ‘I have this person here who is legally blind and he uses a cane and do you think you could possibly get him on the tour?’ The person on the other end of the phone said, ‘That sounds a bit risky, I am not so sure’. So I went to another travel agent because I was not happy about his approach, you know, every phone call was becoming harder to book things. The second travel agent called exactly the same place and said, ‘Oh, I am just booking this European tour for a guy here: he has a vision impairment but he is very capable, he has no night vision, and may need to hang onto someone’s arm from time to time, otherwise he is completely mobile and totally independent. That is not a problem is it?’ ‘No of course not!’ It’s the way you sell yourself! It was true, all I needed was to hold onto someone else’s arm from time to time and it was fine. (VI)</td>
</tr>
<tr>
<td><strong>Transportation to and from destination</strong></td>
<td>Air travel</td>
</tr>
<tr>
<td></td>
<td>(5) You get the odd one who is quite rough, and they pick you up like a sack of potatoes. They do not really have any idea of safe lifting and positioning, they just dump you and walk off. I have had that happen before, that was terrible … As soon as you get out of your motorised chair, you often feel very vulnerable. You can’t move anywhere. (MI)</td>
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</table>
I found the airline was really quite rude, in that June and I went to get on the plane and he yelled down the corridor, ‘I’ve got a couple of carry ons here’ . . . That whole bad attitude to the customers’ rights . . . not realising that people with disabilities know what they’re talking about and deserve respect. (MI)

If I choose to inform them that I am visually impaired, the meet and greet service with the airlines is great. They escort me onto the plane, find my seat. Also then they will give me an aisle seat if that is possible. (VI)

This lady [flight attendant] said, ‘Ok you just walk down the aisle and past first class, blahblahblah’. And I went, ‘Right did you just comprehend . . . I’m vision impaired’. And it was almost as if I was this really insecure young adult that was fibbing a disability to get additional assistance. Because I really had to justify how much I could and couldn’t see. Almost to the extent where I had to say, ‘I can see these many fingers’. You know, really get down to their level. Really insulting, really unnecessary, particularly when you’ve got all the additional anxieties. So that was a horrible, horrible experience. (VI)

I have had some airlines coming out with wheelchairs to take me on the plane. I go, ‘Oh no, I don’t think so. I can adequately walk, thank you’. (VI)

. . . we phoned up Sydney Railway Station to ask for information about catching a train to the Blue Mountains. And he said it is tricky . . . we could arrange to get you into a carriage, at this end, but I’m not sure whether you can get out of Katoomba Station. I said, that’s not terribly helpful. (MI)

And one couple that was on that [Italian coach] tour . . . he had just had a hip replacement and she had just had a triple by-pass . . . and had no idea that the buses wouldn’t drive them up to the Baptistery in Florence . . . all the brochures have these silences. They don’t tell you things . . . (Older tourist)

On our last trip away, we rang and checked with the place about wheelchair accessibility and were assured it was fully accessible. However, upon arrival there we discovered the door was not wide enough to fit my wheelchair, the step which I was told was only four inches high was in fact closer to 14 inches high. My wife checked inside and discovered there was no way possible to get to the bed or even move inside with the wheelchair. When this was mentioned to the manager, their response was they had nothing else and the information in the NRMA directory was incorrect. They suggested we travel 40km back and try there. However, we were lucky and found accommodation at a motel just down the road. They were only too pleased to help
us and informed us that they had heard many complaints about the other place. (MI)

(13) When I stayed in London, they took me up and the gentleman was brilliant. He was like, ‘You’ve got . . . the light switches . . . here. The remote control is here. Do you want me to describe the room?’ . . . And he was great. He was great. And he said, ‘Ok, in the morning, just give me a yell, I’ll come down, and take you down to the restaurant, and I’ll make sure that I tell the other receptionist downstairs’ . . . so they were good. They were good. (VI)

(14) Certainly being able to get a shower commode chair over the toilet, so that you can actually use the loo . . . A roll-in shower, a hand held hose, I need a sink that I can actually get my knees under, rather than having facia boards underneath the sink and vanity so you can’t wheel under the sink. Otherwise if I try and clean my teeth, have a wash, do whatever, I finish up getting my shirt and my trousers very wet . . . And I need the razor plug to be in an accessible position rather than over behind the sink or up too high. (MI)

(15) I don’t know of a hotel access room I’ve been in other than the Crown Plaza, Terrigal, that you actually got a view of the water, if you’re near water that is. The one in the Novotel in Woolongong looks out over the air-conditioning plant; the one in the Park Royal in Darling Harbour looks straight on to the office building next door . . . (MI)

(16) Well my ideal hotel would have a simple layout, I suppose it’s unlikely that it would not have a large open space for its foyer, because they all do, but ideally it would have some identifiable path from the entrance doors to the reception and that might be that the floor of the hotel foyer was marble, but there was a carpet that took you from the entrance doors to the reception desk. I don’t really care what it is, just that it is identifiable. That the street entrance was not too complicated or had too many stairs (I mean stairs are ok, but you know, not a huge flight of stairs), not revolving glass doors that are always very difficult to negotiate as a vision impairment person. (VI)

(17) Hotels are set up visually not ‘auditorily’ . . . I travel with a guide dog and most hotels are not really set up for guide dog travel. Unfortunately it’s still the case that a lot of accommodation providers don’t realise that they have to take the dog. It tends to be the smaller single operators, not the big ones. And I don’t think that has ever happened to me personally, but I’m aware of the fact that it’s quite a frequent occurrence. I have certainly experienced [it] in relation to hospitality mainly . . . restaurants and cafes. (VI)
(18) I couldn’t even get in to the top of the bath, into the bathtub, the wall was so high on it ... If I’d been twenty years younger I could have. (Older tourist)

(19) The bedroom had a double bed in it, but the bed was so low I knew I’d never get out of it, with my arthritic knee ... (Older tourist)

<table>
<thead>
<tr>
<th>Destination experience</th>
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<tbody>
<tr>
<td>(20) Byron’s great because you do not feel like a freak; everybody is feral with whatever goes hairstyle, tatts, piercings, drugs ... nobody stares. It’s like you’re normal. (MI)</td>
</tr>
<tr>
<td>(21) Get on a bus ... the best time that I had has been with other tourists that just happened to be there, you know, have a chat with somebody and talk about normal, touristy type things. And rather than being segregated, going in special purpose taxis or in a van by yourself where you do not get that social interaction. (MI)</td>
</tr>
<tr>
<td>(22) I found that ... because it is a small town, at night when I brought out my cane, it was almost like an alien film ... I suddenly got looks and people just couldn’t comprehend ... I had people ask, well if you’ve got the cane, how can you still see my face? You know, just didn’t quite fathom or well, rather comprehend that you can have low vision, use a cane. You don’t have to be completely blind. So I thought that was really interesting in terms of the education there, [it] was a lot more dated ... their knowledge and awareness of people who are blind and vision impaired ... (VI)</td>
</tr>
<tr>
<td>(23) I think Melbourne, in many ways [is] a lot more accommodating [than Sydney] for people who are blind/vision impaired. Their Tactile Ground Surface Indicators are placed correctly, for starters, and they use them a lot more than we do. And the fact that they are placed correctly, it plays a very important role when you’ve got low vision, like myself. (VI)</td>
</tr>
<tr>
<td>(24) I started to wheeze and produce mucus. This doesn’t happen these days unless there is environmental tobacco smoke ... I felt pain and discomfort ... When I started struggling to breathe I looked around and saw some women smoking. I went to the women’s toilets fairly quickly because I hoped that it would be a safer place. I was feeling pretty distressed physically (Francey &amp; Meeuwissen v Hilton Hotels, 1997). (S)</td>
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<thead>
<tr>
<th>Restaurants</th>
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<tbody>
<tr>
<td>(25) Restaurants are badly lit and dim and I really cannot see ... suddenly I am confronted by a meal I don’t know how to eat. I often don’t know what’s on my plate. (VI)</td>
</tr>
<tr>
<td>(26) Menu is not in large print or Braille. You have to listen to someone read out the whole menu. That is very frustrating. It would be great if I could do it on my own ... It’s frustrating going through a menu that</td>
</tr>
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</table>
seems to have 400 items on it. You suddenly think ‘now which one did I like again?’ You don’t want to ask the person to go through it again so you have to quickly make up your mind and get on with it, without making too much of a fuss about it. (VI)

Tourist attractions

(27) It is frustrating that many places of historical interest etc. are not accessible but that is a penalty of being in a wheelchair and sometimes can’t be helped. One thing you have to pack first is a sense of humour, the fact that you may not be able to see everything you would like and that sometimes others have to be your eyes through description and pictures. (MI)

(28) … I have gone to get into it, and they tip my chair back. I have got my front wheels on, I’m driving forward and, being a narrow doorway, it actually caught the control function (on the power wheelchair), and I’ve tipped back on a steep 25 degree angle. I couldn’t control the control button and the gondola is still moving! So I’ve got the front wheels up on top of the gondola floor and it’s moving, and I am stuck, and couldn’t control the chair. Ohhh, like panic stations … What got me was, that won an award for tourism. (MI)

(29) For me, I need to touch it; if I can I’ll walk on it, sit on it whatever. But I need to touch it, I need to do the activity to be able to get that experience. (VI)

(30) I am not one for art galleries and museums, because that is a lot of visual stuff so I will avoid them … But we had a great time in the Vatican City because there was a lot of tactile stuff. You could feel, carvings and … because I could feel it … I was blown away by it … Commentary is good, but sometimes it is too much. In Europe, they have lots of audio tours, but they are in such detail that I would just say, ‘Let’s move on, I have had enough now’. (VI)

Desire & solutions

(31) I have learned now not to think of possible problems, but to confront problems as they arise which seems to be a lot less than the problems you imagine before you leave. ‘Get out there and do it’; these problems are not as frequent or difficult as you may think. (MI)

(32) Just because you can’t see the Eiffel Tower, or you can’t see the Silk Road, it doesn’t necessarily mean that you can’t experience the ambience, the culture, the food, the language. And I think that that’s the underlying issue there in itself, and hence the reason why there are no accommodations out there for people who are blind and vision impaired, because people’s ignorance [is] … because you’re blind, or you’ve got low vision, why would you want to travel anyway? (VI)

Note: MI = Mobility Impairment; VI = Vision Impairment; S = Sensitivities
places where the unit was on the ground floor and then it was actually booked out or something and you have to go upstairs . . . we’ve stood our ground and refused to move our bags . . . (Kristy).

The experience of being ‘stuffed around’ when requesting accessible accommodation is a common one. Kristy’s experience is disconcerting in that a request for ground floor accommodation would be the most basic of access requirements but even this request could not be relied upon within the booking process. As Tim (below) suggests, what people with impairments may regard as an information issue has a much broader organisational context:

... You go to the owner or the manager and they have no idea, they have had one woman arrive in a wheelchair who can actually walk and they say, ‘oh yeah, we’ve had somebody in a wheelchair’ (Tim).

As Tim suggests, if the owner or manager is unsure of the level of access of their property then this cannot be communicated with any degree of reliability. Many people with impairments said that staff reported that they had disabled facilities that had been successfully used by ‘the disabled’. However, many staff may have had limited experience with people with impairments, generalising from a single experience. This generalisation becomes compounded where staff, managers and owners may not understand the function of the inclusions in an accessible room. People with impairments consistently mentioned this lack of knowledge of disability and access as a reason for their experiences. It is not surprising that many of the general public hold the belief that all wheelchair users can walk if they need to. To develop an explanation of these issues, the perceptions held by accommodation managers about people with impairments are examined in Chapter 9.

The next accommodation requirement is level access of ground floor accommodation. As one person states, ‘The percentage of ground floor accommodation with no steps is very small’. Ideally, all rooms have threshold-free entry as physical access is also a social issue.

... I think too few resorts provide good access. They may provide one or two rooms but that doesn’t allow you to get around the resort all that well. Why can’t all rooms within a resort be adaptable and at least visitable (Don).

The next criterion after level access involves ingress and egress from the room. The method of access to rooms requires little consideration for the non-disabled person but can offer insurmountable issues of dependence for people with impairments. Don’s experience highlights some of these issues for people with limited hand function:
Door heights or door handles are a real pain. As a person who has very limited hand function, I find it difficult to operate those mini-card entry door locks ... I have had to punch a hole in the top of the card and put a little bit of string through it so I can hook my finger in and whip it out. If they have got a lever handle door knob on the outside, I can get in ... that's if the door closer isn’t too heavy but even with the Crown Plaza Canberra, the inside door knob is round so I can’t get out. Very smooth, satin finish and I’ve got to ring the porter to come and open the door when I want to get out of my room! That’s just bloody nonsense, even then getting them to remove the door-closer. The hotels won’t do it. They insist on fire regulations and that makes it very hard (Don).

Don’s point also raises issues of conflicts between access and fire regulations. Once inside the room the next criterion is the organisation of space to maximise circulation. Many people related that they physically change the configuration of the room for their needs. This may involve removing furniture excess to their needs or changing the position of the bed. It is not just the size of the room that is critical but the furniture provided must also meet the needs of his travel companions. ‘... I might want two single beds or a double’ (Tim). Access is an issue of spatial use which involves an understanding of designing rooms that accommodate use by people of all abilities. In Don’s case, this involves a multitude of considerations to promote independent access:

Light switches at a reasonable height, wardrobes with hangers actually down at a reasonable level rather than six foot in the air, with long detachable coat hangers. I take my own coat hangers away because I can never get a coat hanger on, and a table within the room that you can actually get to. I was delighted to see the Crown Plaza had taken out their previously low desk, a fixed desk, and put in a table that has 700mm clearance underneath so I was able to wheel in. That was a perfect height for me to access my meal or writing or doing whatever I needed to do there ... I usually try and get a telephone with a longer cord so that I put that on the bed when I’m there on my own (Don).

With these design issues incorporated, Don was able to independently use the room. For others, it involves modifying the height of the bed to allow transfer from a wheelchair or easier access for people with arthritis or back problems. As Andrew (below) suggests, this can involve make-shift modifications:

... we went to the Western Plains Zoo just before Christmas because I am a keen photographer, went with a couple of others from the camera club and I just said when we got there, ‘Well the bed’s a bit
low. Can we pack it up on a few bricks?' Next thing the girl was out finding bricks and we packed it up. It wasn’t any problem ... (Andrew).

This was a simple example of finding a solution to create an enabling environment for the individual using the room. However, once this has been identified by an individual, the organisation should respond by noting the adaption, seeking more than a makeshift solution that can be easily found – in this case by providing bed raisers.

Room and bathroom accessibility is critical not only for ease of manoeuvrability but because of personal care issues, the interaction with an attendant (if needed) and the equipment required for personal care. If personal care tasks cannot be carried out successfully and reliably then the tourism experience will not be possible. This level of accessibility then requires a greater level of communication with the intermediary or accommodation provider:

My needs aren’t that great but ... I went to a friend’s wedding up in Alice Springs at Lasseter’s Casino, asked for a disabled room ... but when I got there the door to the bathroom opened inward and it opened straight in onto the toilet. Once you got in there with a wheelchair, you couldn’t shut it behind you because there wasn’t enough room. You couldn’t get onto the toilet so I had to get them to take the door off the bathroom just so I could use the bathroom and the shower ... It was meant to be a disabled room. They were more than helpful and in the end it didn’t wind up being a problem, but ... if you ask for a disabled room you expect to be able to go in and do your thing (Justin).

An Explanation of Their Lived Experiences

The above quotations come from two studies focusing on constraints for people with mobility disabilities (Darcy, 1998, 2004) where thousands of individual accessible inclusions were identified. The question arises: How can people with impairments and providers of accommodation have such different understandings of access? What emerged from these experiences was a greater understanding of what contributes to the discourses of access to accommodation. The most important access criteria, and, hence, information requirements involve detailed dimensions and organisation of space at the premises.

The socially constructed understanding emerging from these experiences and other studies focusing on experience is both simple and complex. Disability can be deconstructed into an understanding of access needs that can service discrete group cohorts of disability outlined at the beginning of chapter. When seen in conjunction with the guidelines for
the built environment, standards for access, universal design principles and the voices of people with disabilities – the core set of access considerations can be constructed. Investigation into human rights disability discrimination complaints regarding accommodation has identified the complexity of the issues and recommended that they should not be reduced to simplified ratings or icons (Eichhorn et al., 2008).

The complexity is that the embodiment of each individual will interact with the accommodation environment depending on their particular needs. This interaction is a product of their impairment, the level of independence, mobility aid used, cultural background, equipment needs, and sociodemographic circumstances. The resulting discourse of access comes down to the individual involved and their needs. For example, two wheelchair users may have totally different set-ups when it comes to using toilets and showers. One may transfer onto the toilet or the shower bench and another may use a commode within that same space. The accommodation can cater for hundreds of individuals if the information is documented in a way that allows informed decisions to be made. Table 5.4 presents a summary of other considerations within premises, rooms and bathrooms outlined by the legislative requirements, which are remarkably similar across nations with building codes that include access and mobility.

Research has consistently shown that information about tourism accommodation was not available, was not provided accurately when requested or was misunderstood by the managers and staff interacting with guests (Daniels et al., 2005; Darcy, 1998, 2002; Gallagher & Hull, 1996; Murray & Sproats, 1990; Ray & Ryder, 2003; Turco et al., 1998; Upchurch & Seo, 1996). The general accessibility of properties, the associated facilities and the specific criteria of rooms and bathrooms require detailed and accurate information provision, communication and marketing. Otherwise, as one person notes, the essence of the tourist experience for people with disabilities can be, ‘soul-destroying, exhausting and you are left with the feeling “why did I bother?”’. The experiences create a cynicism about the accommodation sector practices. A great deal of these experiences is because, ‘just so many do not know what is required as far as access’. Yet, where good customer service exists people with impairments acknowledge the benefits with repeat patronage.

The authors posit that people with disabilities understand access from their individual needs and they communicate this to providers. Specific providers have a limited understanding of access based on their experiences of customers with disabilities. A communication disconnection occurs where the lived experience of one person with a disability is significantly different to another person with a disability. Hence, the provider’s past customers may not match the needs of future customers. The communication of access information for accommodation needs to
brokered through the different understandings or discourses of access from:

(1) the technical considerations (planning, architecture, design and construction industries);

(2) how individuals express their needs (demand); and

(3) how the operations of the accommodation sector represent their properties.

Some of these issues have been fully explored in the European situation and provide a way forward to having better information provision of information based on accessibility schemes documents (Eichhorn et al., 2008).

### Table 5.4 Accommodation access needs – general, room-specific and bathroom-specific

<table>
<thead>
<tr>
<th>Accommodation General</th>
<th>Room-specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parking</td>
<td>• Uncluttered furniture layout</td>
</tr>
<tr>
<td>• Drop off points at reception</td>
<td>• Window position</td>
</tr>
<tr>
<td>• Continuous pathways – from parking or drop off throughout</td>
<td>• Location of cupboards, fridge, TV, clock radio, microwave, telephone,</td>
</tr>
<tr>
<td>all hotel facilities and to the room</td>
<td>ironing equipment, air cons etc.</td>
</tr>
<tr>
<td>• Kerb ramps throughout grounds</td>
<td>• Access to balconies</td>
</tr>
<tr>
<td>• Door widths</td>
<td>• Table heights</td>
</tr>
<tr>
<td>• Door stops weight</td>
<td>• Bed heights, circulation space</td>
</tr>
<tr>
<td>• D type door handles</td>
<td>• Clearance under beds</td>
</tr>
<tr>
<td>• Reception counter height</td>
<td>• Access to room controls from bed</td>
</tr>
<tr>
<td>• Assistance with luggage if required</td>
<td></td>
</tr>
<tr>
<td>• Table height in restaurants</td>
<td><strong>Bathroom-specific</strong></td>
</tr>
<tr>
<td>• Circulation space in corridor</td>
<td>• Hobless roll-in showers</td>
</tr>
<tr>
<td>• Circulation space in all rooms</td>
<td>• Lever taps</td>
</tr>
<tr>
<td>• Access signage</td>
<td>• Mirror location</td>
</tr>
<tr>
<td>• Directional signage</td>
<td>• Hand basin positioning and bench space for toiletries</td>
</tr>
<tr>
<td>• High contrast surfaces</td>
<td>• Space under the hand basin</td>
</tr>
<tr>
<td>• Good lighting levels</td>
<td>• Adequate shower chair or bench</td>
</tr>
<tr>
<td>• Appropriate hand rails</td>
<td>• Location of handrails</td>
</tr>
<tr>
<td>• Slip resistant surfaces</td>
<td>• Toilet height and positioning (distance from walls and front clearance from obstructions)</td>
</tr>
<tr>
<td>• No steps into rooms (&lt; 5mm)</td>
<td>• Hand held shower hose and length of hose</td>
</tr>
<tr>
<td></td>
<td>• Non-slip floor surface</td>
</tr>
</tbody>
</table>

**Sources:** Australian Council for Rehabilitation of Disabled (ACROD) Ltd. (1999); Darcy (2004); Europe for All (2007); Standards Australia (2001)
Conclusion

In this chapter, we have listened to the voices of people with a disability – their joys, disappointments and frustrations. The above discussion not only details how the tourist body experiences the holiday trip but how society understands and responds to impairment. The above discussion is critical in that it tells us what is right and wrong with current social reality, it identifies the actors to change the reality – the tourism industry, community and people with impairments themselves who are agentic. Exclusionary practices identified in this chapter involve considerations of whether the tourism industry is being politically correct in their treatment of people with impairments by superficially addressing the requirements of the disability discrimination legislation without treating this group as it does other market segments. As the following quotation suggests, the tourism environment is changing and the nature of disability and access evolves as time goes on. Watershed shifts have occurred in the past and will continue in the future. While people with disabilities empower themselves through human rights legislation it is up to all other tourism stakeholders to assist in bringing about change for the inclusion of all. The voices also inform us how tourism has already been transformed for the benefit of all.

Having travelled a fair amount before a vehicle accident in 1978, I have ‘battled’ to enjoy further travel, but have many experiences and disappointments because of so many places of interest and accommodation not being accessible. Much is being accomplished and attitudes of management and staff has improved enormously since 1981 – ‘The International Year of the Disabled’.

Note
1. The term critical disability studies is used to differentiate social approaches to disability from medicalised discourses.

References


