

SCARED OF VALUES? THE GOALS OF DISEASE DEFINITIONS AND THE PROBLEM WITH NATURALISM[1]

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Abstract

This paper is a modest attempt at outlining the most common difficulties that philosophers run into when trying to come up with value-free accounts of disease. It also argues that creating such an account is neither possible nor necessary or practically useful, as health/disease definitions double as labels which have the potential to shape sick people's social roles and medical identities. Rather than casting that social and ethical aspect of their functioning, we ought to embrace it as a tool for promoting desirable social changes, e.g. improving physician-patient relationships.

Keywords: disease definitions, philosophy of medicine, social philosophy, ethics, values, norms

1. Introduction

Of all the biologically-informed cultural concepts that influence our lives and our notions of 'normality', there is a couple which have stubbornly resisted reinterpretations and continue to pose challenges for those who attempt to define, analyze or re-model them. 'Health' and 'disease' have proved more than just a couple of terms with fuzzy boundaries – if anything, they should be regarded as the paradigm examples of such terms. The goal of this paper is to identify the main difficulties with which philosophers are confronted during their attempts to pin down these terms.

Working on topics such as health and disease, and especially engaging in conceptual analysis of these terms, has required a lot of un-learning and un-doing on my behalf: attempting to abandon stereotypes and clichés in favour of unbiased thinking, investigating whether there is such a thing as a transhistoric, transcultural concept of illness, and exploring different cultural tropes of health, just to name a few examples. Over time, I have gradually come to the conclusion that Western medical thinking's preoccupation with objectivity and

quantifiability, as well as its deliberate effort to remain culturally blind, are themselves a form of bias and the result of a very specific cultural climate. This has made me deeply skeptical about the possibility of a value-free account of health/disease, and led me to question the very usefulness of such an account, if it were to be devised. Furthermore, it has also increased my sensitivity to the strong connections between rigid naturalist/objectivist standards of ‘normality’ and a wide range of undesirable social phenomena such as the exclusion and discrimination faced by ill people, the increased paternalistic control and surveillance they experience, the stigmatization and negative stereotyping to which they are sometimes subjected.

In a culture obsessed with ‘fitting in’, competing against one another and ‘overachieving’, persons whose life stories differ from those artfully structured socially acceptable narratives are often made to feel inadequate, disvalued and isolated (especially when the very features which make them stand out are used as a justification of the limited opportunities these persons are given to interact with others and contribute to society). Discrimination based on health status is not a myth, but a sad reality experienced by many: a reality that could be cemented by a discourse on disease as an objectively measurable deviation or deficiency.

These issues have received insufficient attention in health/disease definition debates, where the focus lies predominantly on a proposed account’s sophistication and applicability to the purposes of policy-making, rather than its potential impact on the way ill persons are treated or perceived in social situations (both in a clinical context and outside it). Therefore my first task in this paper will be to convince my readers that the problem presented above deserves serious consideration, to explain what its underlying causes are, and to suggest an effective strategy based on the notion that language is, first and foremost, a means of instruction that we could shape and use to our advantage.

2. Between ‘neutral’ concepts, positive ideals, and negative stereotypes.

Feminist writers have worked hard to show how the members of a society can be held jointly responsible for the existence of harmful culturally perpetuated stereotypes. Books like *The Beauty Myth* have successfully argued that even seemingly unimportant individual choices can have permanent consequences on others by intensifying the pressure to fit into a

potentially destructive collectively shaped societal ideal – like that of attractiveness [Wolf, 1991]. It has been proposed that instead of adapting to harmful concepts of beauty or normality, we should strive to change them from within and promote self-acceptance. As already discussed, evidence suggests that this may currently be happening, as recent developments in media and the fashion industry show a great difference between the way the ‘abnormal’ body was portrayed a decade ago versus how it is presented today. But while there appears to exist general agreement that beauty is meant to remain ‘in the eye of the beholder’, that does not seem to be the case with categories like ‘health’, where deviation from the ‘norm’ more often than not can bear negative connotations. Occasionally, the difference between ‘health’ and ‘disease’ could mean – quite literally – the difference between life and death (for instance in the context of screening, diagnosis and prognosis). In that sense, in science-centric societies (i.e. the majority of Western and industrialized societies), statistics and standards are often perceived as more reliable assessment tools than subjective experiences. They also hold the further benefit of lending credibility to the judgments they underpin; of providing them with additional dimensions like measurability, verifiability and manageability.

3. Quantifiability, objectification and the rhetoric of deviation.

We have come to believe in the quantifiability of natural biological phenomena in order to gain a sense of control over them, because it is convenient to think that if something is measurable, it should also be manageable, predictable, understandable [King 1954: 195]. [2] Traditional Western philosophical ideals like autonomy and freedom mix with a sort of contemporary cult for science and fact-fetichization (as presented by Bruno Latour in his works *On the Modern Cult of the Factish Gods* and *We Have Never Been Modern*), making us epistemically dependent on certified scientific and professional authorities, yet oddly confident that we are independent thinkers and – exactly because we have unprecedented access to information – that we are free individuals in control of our own choices. However, this ideal does not appear to extend to those among us who have been marginalized as ‘invalid’ or ‘deviant’ and who, because of this, have very limited power in society.

Feminist author Jenny Morris – a disabled woman herself – has famously noted that disabled people’s self-image is dominated by the non-disabled world’s reactions to them

[Morris, 1991: 28], as is every disability-related public policy in existence [Ibid: 118].^[3] Disease and disability conditions alike are locked in a fatal embrace with the rhetoric of deviation, deformity, incompleteness; the ensuing assumptions about incapacitated autonomy often serve as justifications for invading the affected person's privacy [Ibid: 29],^[4] providing little support (if not outright limiting the available options) for their educational, professional and social development, or judging their lives as 'not worth living'. Most importantly, this divisive rhetoric and the behaviours that result from it all contribute to the corrosion of an already strained relationship – the one between patient and practitioner. Here I will outline the inherent imbalance already present in this relationship, and examine the ways in which it is modified by the application of different conceptual frameworks, in order to show how attitudes to patients and 'sufferers' are subject to the influence of language, and language-borne concepts and notions. This approach reflects the simple truth that doctors do not heal body parts – they heal patients: persons, living, thinking and feeling human beings. Even when focusing on the technical aspects of diagnosis, prognosis and treatment, they still have to consider the patient as a whole – how will the treatment of one organ or body system affect other parts or the monolithic whole of the organism? How will the patient function as a result of the treatment? Will there be any undesirable side-effects of an emotional or social nature?

4. Language, epistemic profiles, and 'webs of significance' as mediums of instruction.

The majority of meaningful social interactions in the human world rely on language as a medium of communication, *instruction* and shared understanding [Cassell, 2004: 5].^[5] Productive communication occurs through the channel of a shared language, but in the clinical context, there are two distinct types of languages, which appear to address two separate social and epistemic realities. Ideally, the reality of disease would be a mutual one where practitioner and patient share similar observations and opinions over the phenomenon of disease, and express them through the same language, leaving little room for disagreement or doubt. However, due to a variety of factors – such as differences in social 'situatedness' and inhabited cultural 'webs of significance'[Kirkengen, 2005: 19] ^[6], or the epistemic rift and power imbalance inherent to the interpersonal dynamic of the professional relationship between expert and layman (physician and patient) – the languages employed by the two can

sometimes differ dramatically. In his monograph *The Discourse of Medicine*, Elliot Mishler [1985] talks about the conflicting ‘voice of medicine’ (which acts as a normative force in debates as it is usually construed as the more formal and reliable one) and ‘voice of lifeworld’ (which is perceived as an irrelevant and even disruptive influence because of its biographical, contextual nature). In clinical judgement, there is a strict hierarchy of relevance which prioritizes the ‘voice of medicine’ as a source of ‘proper’ evidence, while the ‘voice of lifeworld’ resides at the level of mere testimony, and is considered to be lacking in terms of legitimacy. Even the events that physicians and patients address in their acts of speech seem to belong to two separate spheres of reality, as the patient visits with a complaint about ‘abdominal pain’ but is *instructed* that she has a ‘pelvic inflammatory disease’ upon examination. Some authors, like Toombs, have attributed these confusing features of patient-physician communication to a ‘fundamental disagreement about the nature of illness’ [Toombs, 1987: 219] [7], and others – to a supposed double relation between sociocultural meaning and embodiment, suggesting that a person’s body and bodily experiences at once influence and are influenced by the meaning assigned to them by that person – a meaning which provides lived bodies with a ‘specific logic’ and rationality. Thus acquiring a good grasp of this significance must necessarily be *instructed* by the act of ‘unfolding’, i.e. making explicit, the personal context of the experienced symptoms [Ibid: 19-20].

Of course, symptoms often represent but a fraction of what occurs in the diseased body, and the physician’s professional training understandably includes *instructions* about seeking the ‘hidden’ source of disruption from ‘normal’ functioning, and examining reliable objective signs rather than counting on patient testimony to determine it. In my dissertation [Traykova, 2017: 103-134] I have shown how this line of thinking, which suggests that proper diagnosis is essential for optimizing cure prospects, is almost directly inherited from the legacy of nineteenth century physiologists like Bernard, for whom there was little doubt that structure defined function. Here it suffices to state that, as a result, quite often even seemingly basic concepts like ‘health’ and ‘disease’ are viewed and defined differently by practitioners and their patients, since the former continue to rely on a very ‘still’ and artificial [Toombs, 1987: 9], and arguably antiquated [Ibid: 7] disease theory, while the latter define illness idiosyncratically, and therefore unreliably. However, while expertise, especially one supported by a solid education in the biomedical sciences and by related professional

experience, is without doubt worthy of recognition, we have already seen that the first-hand knowledge of the chronically sick, frequently hospitalized in-patient, cannot be dismissed lightly. Indeed, some have suggested that practitioners' understanding of disease can be facilitated through the application of phenomenology – integrating patients' lived experiences of disease, and using them *instructively*, as an interpretive frame of reference [Kirkengen, 2005: 21].

The patient relies on first-person utterances and describes unique, existentially meaningful, subjective symptoms – personal experiences of which she tries to 'make sense', and to which she tries to adapt in order to prevent their overwhelming effect on her physical well-being, social functioning and emotional life.[8] In order to *instruct* her physician, she employs an 'involved' language of concern – mostly concern about the way her life will change in relation to the diagnosis. Practitioners, on the other hand, adopt the detached, objective third person point of view during their pursuit of reliable, tangible signs, and use a professional language that may seem abstract and unclear to the layman whom it objectifies and *instructs* in a unified, general, standardized way. Preoccupied with tasks like diagnosis, detecting, observing and correcting deviant physiological functions, they are in particular subject to quantification tendencies, even framing prognosis in terms of calculation-based estimates (e.g., 'survival chance', 'expected quality of life'), rather than terms borrowed from the patient's language of pain, discomfort or everyday tasks and abilities. They are not overly concerned about the patient's social performance or emotional state, unless it is either integral to the purposes of diagnosis and treatment (as is the case with psychiatry and clinical psychology, for example), or has very drastic effects on the patient's overall 'quality of life'. The 'personal life experience' aspect of the patient's complaint is, more often than not, irrelevant to the physician's essential task, and thus patient narratives and histories hold little *instructive* power over the way physicians' conceptual resources and explanatory models are constructed. Therefore one cannot reasonably expect a significant conceptual overlap between these two distinctively separate realities, since patients and physicians do not share similar conceptualizations of illness [Toombs, 1987: 220]. Furthermore, their conceptualizations appear to stem from their allegedly different '*instructions*' – finding answers and solutions to a problem (patient), and providing a diagnosis and treatment for a physical condition (physician) [Ibid: 224].[9] How, then, are we expected to construe a single unified account of

health/disease that will acknowledge the multidimensionality of the phenomenon it tries to define without sounding vague?

5. Health and disease as complex, multidimensional phenomena.

Most noteworthy attempts to define health/disease have been unsatisfactory, either because they have failed to reflect it as a truly complex, multilayered concept, or because they went too far in their attempt to achieve the latter, and resulted in vague, over-inclusive definitions (see, for example, the World Health Organization's definition, according to which health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'[10]). These difficulties have usually been attributed, depending on the accuser's own ideological commitments, to the attacked author's allegiance to either normativism or naturalism, and thus to their conviction that values or scientific objectivity respectively can lead us to the 'correct' definition. However, by focusing exclusively on the big philosophical debate we have boiled the matter down to the level of conceptual disagreement and lost sight of the very simple, yet very important practical notion that even formal legal definitions (on which laws and policies are based, and which are presumably the ultimate goals of such debates [11]) are just as preoccupied with functionality as they are with accuracy; that, unfortunately, by obsessing over the latter, we have overlooked the former.[12] As a result, most accounts are not well adapted to serve their intended purpose, as they have been rendered dysfunctional by their own ideological influences, which produce simplified one-dimensional views on what is otherwise a complex, multilayered phenomenon.

Disease is neither purely a discursively shaped value-laden concept, nor simply an objectively existing natural category; it is both and neither. Among the challenges faced by philosophy of medicine, an especially problematic one is the rather common assumption that only these two approaches (or any hybrid combinations thereof) are likely to produce plausible results. An additional difficulty arises from the pressure to 'pick a side' – an unnecessary constraint imposed on thinkers who engage with this topic, as the two sides of the debate have far too much in common to be rightfully posited as the radically opposing polar extremes they are made out to be. I would like to suggest that there is no real need for discussions of disease definitions to be restricted by the artificially created framework of the

naturalism-normativism dispute. Before one even considers engaging in the arduous task of providing an account of disease, one would need to: 1) break away from the constraints of this intellectually misleading format, and 2) be realistic in one's expectations about what naturalism can achieve. One of the main goals of my dissertation will be to demonstrate that naturalism is not, nor should it be, value-free, and that we should give up the futile ambition of defining phenomena which have strong moral implications in a neutral, detached way. Instead, we should be aiming to frame definitions in terms which promote and cultivate the values that are fundamental to our purposes within the clinical context – and outside it.

Indeed, even supposedly impartial descriptive definitions already serve a normative purpose: they dictate our expectations of the defined thing; they shape (and are shaped by) our values by determining what the thing 'ought to be' like. But the point to be made here goes deeper than that – it is not simply that naturalism's conceptual limitations make it an implausible candidate for the mission of defining health/disease, and it is not simply that even the inherently value-laden act of defining already makes neutral definitions impossible; there are certain practical characteristics of health/disease phenomena per se which make them impossible to interpret fully, in their entire complexity, through the lens of naturalism alone. The characteristics in question can be roughly grouped in three categories, which I will refer to as the 'moral charge' characteristic, the 'multidimensionality' characteristic, and the 'dynamic polarity' characteristic.

6. The Moral Charge Characteristic: Phenomena which elicit emotionally and morally charged responses cannot be defined in neutral terms.

A possible objection against forced attempts at value-free discussions of the body and anything that relates to it could be derived from the body's complex status in the phenomenological life-world. The body is not simply our gate into the life-world that phenomenologists speak of; it does not serve only as a medium of experiencing. It is also the way we present ourselves to others, the way we partake into the shared moral world of meaningful social interactions.

Acting both as seats and as instruments of human rationality and will - of autonomy, freedom, moral principles, beliefs and passions - bodies have logically been granted a special moral status in Western cultures. The Western body is seen – with slight variations across

cultures – as a precious ‘vessel’ (even ‘sacred’, depending on the context), or as an embodied ‘soul’ or ‘personality’. Universally, though, its moral standing as the ultimate limit and physical boundary between Self and Other is recognized without a shadow of doubt, and discussions about freedom, choice, autonomy and self-determination are, almost without exception, carried out within a discourse shaped by the belief that moral actions necessarily involve an aspect of physicality, i.e. that they are the physical acts of finite biological beings, which can influence other finite biological beings.

Therefore the body, with its crucial interactive role, is valued highly and perceived as something worthy of protection and care, as any physical threat to it is also an existential threat to our presence in the life-world. Consequently, states that can be interpreted as a threat to the body’s ‘default’ state of life and health are disvalued.

While that does not mean that every physical threat disvalued by society is automatically a disease, it does mean that, no matter how we define the terms ‘health’ and ‘disease’, they are bound to elicit (and be shaped by) the same emotionally and morally charged psychological responses. The (positive and negative, respectively) connotations attached to these concepts will not vanish simply because we have replaced the terms with new ones; instead they are much more likely to ‘stick’ with newer terminology and resist our forced attempts to create new meanings.[13] Most importantly, it is not possible to define a strongly (albeit implicitly) morally charged phenomenon such as health or disease in an entirely value-free way - though that does not mean we should not try to avoid terms with overtly negative connotations, such as Cooper’s ‘bad’, ‘unlucky thing to have’ [Cooper, 2002], or Megone’s ‘incapacitating failure’ [Megone, 2000], where ‘failure’ is problematic due to its implication that someone or something was unsuccessful, did something wrong, or is somehow ‘deficient’.

Normativist accounts of disease have a long history of associating disease with predominantly negative experiences, whereas new works on the philosophy of illness [Carel, 2007; Kidd, 2013], along with works from the related field of philosophy of disability [Morris, 1991, 2001], attempt to resist negative stereotypes and promote ethical and political correctness. Therefore defenders of normativist accounts should still exercise a degree of caution when choosing how to express their philosophical stance, or risk creating a definition that neither patient nor physician would willingly relate to.

7. The Multidimensionality Characteristic: A more ‘factual’ approach may fail to grasp the complexity of health and disease phenomena in real life.

Accounts of disease do not necessarily have to take the form of an undisputed fact or a scientific endeavour in order to be successful, and are even hindered by such approaches. Values are always present (whether explicitly or implicitly) in choices, and designing a unified account of health, for example, necessarily involves settling with a specific selection of characteristics universally present across all specimens who exhibit the property of health, and effectively reducing health to this selection. The process of selection will be guided by values just as much as by rational judgements based on epistemic factors.

A somewhat similar objection has already been raised in a paper written by the philosopher Kingma, in which she critiqued the most influential naturalist definition of disease – the one proposed by Christopher Boorse [Kingma, 2007]; three decades before this, Reznick [1987] correctly pointed out that scientific methodology and reliance on facts can be of little use when dealing with what is essentially a non-scientific question. Overall, attempts to ground abstract definitions on scientific data or statistics usually result from the epistemic confusion produced by the conflation of logical categories such as ‘fact’ (part of reality in Russellian and Wittgensteinian logical atomism) and ‘truth’ (property of propositions and utterances). This categorical mistake can lead to an indiscriminate acceptance of ‘fact’ as a sole truth-bearer, as in the position defended by Frege [1956], rather than an element of reality subject to all its hindrances: chance, false reports, (mis)interpretation, flawed methods, or bias.

Indeed, even the most rigid and systematic interpretation of factual data cannot be expected to deliver absolute, undisputed ‘truth’ in the philosophical sense. But that is not even the goal of a definition. As already stated, the declared target of philosophers of medicine is to provide a functional and relatable account of health/disease which will be well-adapted to the purposes of social interaction, clinical practice, law and policy making.

A possible objection needs to be addressed here. Let us first consider that in the shared reality of social interaction, meaning is shaped by context, and an utterance can carry a wide variety of moral nuances, ranging from negative through neutral to positive connotations and anything in-between. This could present a challenge to my claim that the ideal of an objective, impartial account of disease is an unattainable one. Practically every word can be used both

neutrally and with added value, though not in the same sense or theoretical framework. The success of that use, however, will necessarily depend on the goals of the project.

Arguably the primary purpose of definitions, for example, is to make a concept epistemically ‘clear’ and ‘distinct’, i.e. not only to introduce the term to those unfamiliar with it, but also to explain the underlying phenomenon in an understandable manner, thus making it epistemically accessible. Definitions can be either intensional (connotative) or extensional, meaning that they will (respectively) either list necessary and sufficient conditions for something to belong to the class of objects called ‘x’, or attempt to map out the very essence of ‘x’, as per the philosophical tradition inspired by Classical Antiquity. Both types of definition are instances of ontologization of information, or of ‘sense-making’/‘meaning making’ [Saab and Riss, 2011], where we selectively present and combine data and meaning in a socioculturally meaningful way, i.e. through ‘cultural schemas’ that have been developed in ‘collaborative interaction’ with others and are meant both to be influenced by, and to influence, others.

Therefore, defining terms is an inherently value-laden activity. As such, it will not allow for the same kind of neutral use of terms that can be observed, for instance, in simple factual observations. There can be little doubt that even value-laden terms such as ‘disability’ can be used in neutral protocol sentences to make simple factual observations in a value-free manner, as in these examples:

1) ‘Dyslexia is not disabling in cultures which do not rely on written speech.’

2) ‘Severe nearsightedness is a disability in cultures which do not possess the means to counteract its effects, like glasses or contact lenses.’

These observations may rely on non-value-neutral terms, but they express established aspects of certain practical realities, rather than generalized personal opinions, moral judgements, or socially conditioned beliefs. Applied to their specific contexts, they would hold true in front of every person, regardless of her ideological or professional commitments. It is context sensitivity, then, that defines the truth-value of such observations, rather than the exact terminology applied. The preciseness of the factual claim, just as its truthfulness, would remain unaffected even if I replace the term ‘disabling’ from the first example with a term of related meaning, such as ‘problematic’, ‘harmful’, or ‘potentially dangerous’ – as long as there is general agreement that the terms can be used synonymously in similar contexts.

The real difficulty arises when there are attempts to make universal or near-universal generalizations with the same undisputable epistemic truth-value and to regard those as value-neutral factual observation. What works well with small-scale observation-based generalizations will not work for large-scale generalizations (such as ‘All dysfunctions are necessarily harmful’), due to their lack of specificity and contextualization. Detached claims which reside on an abstract level are anything but factual, therefore they will not be value-free in the normative sense, even in occasions of most careful and deliberate use of ‘neutral’ terms.

8. The Dynamic Polarity Characteristic: Accounts of health/disease need to reflect the biological truth that bodies are flexible, adaptable entities which actively respond to internal and external stimuli.

Last but not least, the majority of health/disease accounts present a static model that has little in common with the ‘biological normativity’ or ‘dynamic polarity’ [Canguilhem, 1991] of life. For example, Christopher Boorse’s famous naturalist definition (which will be discussed in greater detail in Chapters 3 and 5), for all its preoccupation with evolution theory, teleological explanations and causal contribution factors, conveniently ignores the evidence that ‘unhealthy’ bodies do not necessarily stay that way.

Virtually everything we know today – either from personal experience or from science-based, peer-reviewed evidence – seems to point to the fact that the diseased body is capable of devoting considerable resources and applying most amazing strategies to its own recovery, and will almost definitely do so on most occasions. Homeostasis – a term referring to the model of life originally coined by biologist Walter Cannon – has often been used to describe this continuous cycle of balance-seeking self-maintenance, during the process of which bodies actively respond to influential factors from their environment, while also regulating their own internal milieu.

For highly intelligent life forms like humans and other primates, being well attuned to one’s bodily signals may be just another part of this sophisticated self-preservation system, with clusters of symptoms representing perhaps a similar function to that of pain mechanisms in helping the organism detect, avoid or otherwise counteract potentially threatening exterior influences. Symptoms could be better described as the person’s unique reactions to the changes she experiences under the influence of disease. For example, the nausea and loss of

appetite experienced by sufferers from gastroenteritis are provoked by an inflammation of the intestines due to viral or bacterial infections of the digestive tract.

Symptoms, however, have a psychosomatic component and thus are also influenced by the subject's unique psychological constitution, attitude, emotions and expectations about their condition. For instance, a gastroenteritis sufferer with low bacteria counts might still experience severe nausea due to stress, fear, discomfort at the thought of disease, or a low tolerance for pain and suffering, while another person with the same signs (i.e., same bacteria counts) might not experience any nausea at all. In addition, introducing the notion about symptoms as reactivity can help develop an account of disease that captures 'mental' illnesses, some of which are notorious for their difficult diagnosing and conceptualization due to the frequent lack of observable objective signs (e.g., a person suffering from a severe case of narcissistic personality disorder would have a different social experience in the 'life-world', and a lot of the time her activities and interpersonal relationships would be limited under the influence of her condition; at the same time, brain scans performed on this person may never reveal anything out of the ordinary).

An obvious problem arises when we define symptoms and reactivity in relation to homeostasis, as Boorse has already argued successfully that many life functions are not homeostatic and even upset the organism's balance rather than maintain it (perception, growth and pregnancy are examples of this), and that there is no point in 'trying to view corresponding diseases such as deafness..., dwarfism..., or sterility as homeostatic failures' [Boorse, 1977: 550]. Secondly, another difficulty with health-as-homeostasis accounts lies in their inflexibility, which does not allow for health in puberty – or in old age, where changes in the organism are just as abundant and frequent as they are during active growth.

Therefore I shall suggest that we look back to Canguilhem, whose theory depicts life and health as a type of reactivity, 'dynamic polarity' or 'biological normativity' in which certain things or states are avoided, while others are sought, and these all change over time in accordance with the organism's evolving needs. This phenomenon is best represented not by homeostasis, but by the similar yet more sophisticated concept of homeorhesis (originally coined by developmental biologist C. H. Waddington). The term 'homeorhesis' describes systems regulated around certain factors and 'points' which do not remain fixed, but instead gradually change over time, i.e. in the natural process of aging. Diseases often appear as

results of the more drastic or peculiar changes which are not a part of the organism's growth, metamorphosis or aging.

9. Summarizing the goals of a philosophical account of disease.

In sum, the solution we are looking for needs to reflect a biologically, psychologically and socially complex, multi-layered phenomenon. I have demonstrated why this is unattainable via value-neutral discussion (as all discussions of such phenomena are inherently value-laden), but also why an overstated normativist position can become idiosyncratic and profoundly skeptical, almost to the point of collapsing into full-blown epistemological solipsism, after which it can no longer serve the purpose of generating meaning through the act of defining (which necessarily involves a synthesis of knowledge and values). A 'hybrid'[14] account, which combines philosophical astuteness with a relatable 'language of pain and reactivity' (with which patients will readily associate), can present the sought-after solution. As already stated, the task of a disease account would be to 'unify' the two distinctive languages of physician and patient, and to make their separate practical realities overlap for the sake of effective communication; that would make for a fully functional definition to which the two sides can relate, and which can therefore be applied effectively for the purposes of law and policy making, without generating misunderstandings or instances of political incorrectness, and without contributing to social oppression, manipulation, or covert control.

Practitioners and scientists, as well as philosophers whose methodology operates within similar theoretical frameworks (naturalists), are not the best equipped candidates for this task due to their tendency to equate biological normativity to strict natural laws. I am not the first philosopher to have expressed this opinion: Alvan Feinstein's concept of 'intellectual infirmity' in clinical judgment has exposed the threat of covert bias masquerading as neutrality or 'cultural blindness' in medical thinking decades ago. Furthermore, naturalism's ideological roots can easily be linked to those of the broader traditions of disease objectification and quantification in medicine, both of which originated as a counter-reaction to 19th century vitalism; thus it is far from objective. Health/disease definitions double as labels which can determine the moral, social and political dimensions of living as an ill person by affecting selfhood through the creation of medical identities. Once we recognize that, we

would be in a better position to design an account of disease which reflects the phenomena of ‘dynamic polarity’ and ‘biological normativity’, bridges the communication gap between patient and practitioner, and represents disease in rhetorically neutral terms which capture its complex multidimensional nature without explicitly relying on negative stereotypes (like many of the associations that Western culture tends to make between diseased states and ‘harm’, ‘failure’, ‘incapacitation’, ‘deficiency’, or ‘defects’).

REFERENCES

[1] This paper is a substantially edited excerpt from the first chapter of my doctoral thesis ‘Optimizing hybridism: a critique of naturalist, normativist and phenomenological accounts of disease in the philosophy of medicine’, which was defended on 03 March 2017, then published online under the name Traykova, Aleksandra Krumova on 26 September 2017. The original full text is available at Durham University’s official website at the following link: <http://etheses.dur.ac.uk/12312/>.

[2] P. 195 reads: ‘To understand health or disease we must have some objective measurements in addition to the introspective account. If we can weigh or measure something, then we have a little more confidence, and we feel more firmly grounded in objective reality.’

[3] I am referring to the following bit: ‘Those who make and implement public policy, whether they be politicians, administrators or professionals, have historically worked with a set of assumptions about disabled people which makes segregation inevitable.’

[4] P. 29 reads: ‘Our physical difference makes our bodies public property...’

[5] ‘We are able to speak together only because of a common language for objects and events. A common language for something implies a common interpretation of the events signified by the words; the more exact our use of language, the more exact our common interpretation.’

[6] ‘Human beings are suspended in webs of significance they themselves have spun. Every person, be s/he healthy or sick, patient or doctor, is *situated*; that is profoundly shaped and influenced by the cultural time and place s/he inhabits.’

[7] ‘In discussing my illness with physicians, it has often seemed to me that we have been somehow talking at cross purposes, discussing different things, never quite reaching each other. This inability to communicate does not, for the most part, result from inattentiveness or insensitivity but from a fundamental disagreement about the nature of illness.’

[8] This Husserlian notion about the uniqueness of the world of immediate experience appears to be shared by most authors writing on phenomenology and its applications to the medical context, but is most explicitly stated in the works of S. Kay Toombs [1987: p. 221].

[9] Also see p. 227: ‘The physician defines the “problem at hand” in light of certain goals of medicine: diagnosis, treatment and prognosis. These goals appear to be shared with the patient. However,... the patient defines the “problem at hand” in terms of different goals.’

[10] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (*Official Records of the World Health Organization*, No. 2, p. 100) and entered into force on 7 April 1948.

[11] Although some philosophers have argued that public health policy and law do not require a definition of disease in order to function, but should rather be conceived of in terms of promoting other goals – such as ‘physical safety’, for instance. For a relatively recent example, please see Stephen John [2009].

[12] I am not trying to suggest that linguistic precision should not be among our priorities. Rather, I am suggesting that an optimal philosophical account of disease would also have other, more practically significant goals – such as being socially progressive.

[13] See, for example, Christopher M. Fairman’s critique of the US debate on the ‘r-word’ [Fairman, 2010].

[14] I am using the term ‘hybrid’ rather loosely here, as I have already stated why I do not consider naturalism as a legitimately value-free approach; therefore on this particular occasion the term ‘hybrid’ is applied only for convenience rather than descriptively.

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