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Why the concepts of health and disease cannot be grounded in social justice alone

Walter Veit

Abstract

In a recent publication, Kukla (2014) has argued that we should we abandon naturalistic and social constructivist considerations in attempts to define health due to their alleged failure to account for their *normativity* and instead define them purely in terms of 'social justice'. Here, I shall argue that such a purely normativist project is self-defeating, and hence, that health and disease cannot be defined through recourse to social justice alone.

Keywords: health; disease; conceptual engineering; conceptual analysis; naturalism

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1 Introduction

Within the last decade, the philosophy of medicine has largely moved on from hardened fronts between so-called naturalists, social constructivists, and normativists about how to define the concepts of health, disease, pathology, and the like. More and more authors are defending the possibility of hybrid accounts that keep what is best about other approaches (see Simon 2007; Kingma 2014; Powell and Scarffe 2019; Broadbent 2020; Conley and Glackin 2021), and yet, there hardly appears to be any progress in developing a consensus on how these notions should be defined.

A radical alternative has been proposed by Quill Kukla (2014) [writing as Rebecca Kukla], who has responded to these conflicts by arguing that we should we abandon naturalistic and social constructivist considerations in attempts to define health due to their alleged failure to account for their *normativity* and instead define them purely in terms of 'social justice'. This makes her account one of the first explicit attempts for the conceptual revision and design of the concepts of health and disease for the sake of morality. Health and disease, Kukla argues, are intuitive and normative concepts and hence do not naturally fit with the explications by a "social constructionist understanding of health, wherein health and disease are whatever we take them to be, and a scientistic understanding of health, wherein health and disease are biological concepts" (p. 525). Instead, they should help us in the normative projects of deciding how health institutions should be designed and who deserves medical treatment. But as long as "we think that health has to be either a natural, biological category or a mere social construction" Kukla maintains that we cannot use the concept for normative purposes (p. 525).

While I agree with the set-up of their argument - the sentiment that the naturalist-constructivist framing is a false dilemma, and the fact that the folk concept of health and disease has an explicitly normative dimension, I strongly disagree with their conclusion that the concepts of health and disease are to be designed as conditions that *should* or *ought* to be medicalized. Indeed, I shall here argue that any attempt to ground the concepts of health and disease in social justice alone must be self-defeating since it would eliminate their distinctiveness from other conditions of moral concern in addition to making the institution of medicine inevitably blur recognizably with all other institutions seeking to promote social justice.

Article Outline

This article is structured as follows: In **Section 2**, I expand on Kukla's sketch of the debate, explicating the three competing projects in the philosophical discussion on health and disease. In **Section 3**, I draw on a recent distinction between two kinds of conceptual engineering, utilizing them to show that the goals of these groups are ultimately irreconcilable. In **Section 4**, I use Kukla's proposal to explicate the idea of a purely normativist approach to health and disease. In **Section 5**, I argue that Kukla's social justice account of health - and for that matter any purely normativist account

- must ultimately prove self-defeating. Finally, I conclude the discussion and respond to possible objections to my arguments in **Section 6**.

2 Three Competing Projects

Instead of framing the debate in the usual terms of conceptual analysis, regarding whether naturalism or social constructivism is correct, Kukla (2014) distinguishes between the different goals of both approaches. This is praiseworthy. Whereas theorists such as Boorse (1977) have attempted to capture health and disease in biomedical terms, appealing to the idea of *dysfunction* and *normal functioning* of a biological organism as it is used in medical practice, social constructivists such as Glackin (2010) have highlighted the importance of 'medicalization' within the social and institutional practices of medicine. During the medicalization of a condition, "clusters of symptoms are identified as unified diseases and brought under medical surveillance and management" (Kukla 2014, p. 515). Both of these approaches have been met with much opposition, occupying much of the literature in a back-and-forth volley of counterexamples. Kukla (2014) thinks that both approaches are inherently misguided and thus ultimately fail even when some people attempt to provide hybrid accounts. This is because, Kukla argues, health is an "intuitive notion and not a technical term" (p. 515) and should ultimately be used to inform policy and ethical decision-making regarding the treatment of those suffering from a disease.

So far, so good. But what does it mean to assert, as Kukla does, that this sense of health is 'intuitive'? Is it merely the idea that humans talked about health and disease *prior* to the arrival of modern medicine? Perhaps even prior to any form of medication? Since many species have been found to engage in grooming and self-medication behavior, such as the consumption of plants with the propensity to reduce or prevent harmful effects of pathogens and parasites (see Clayton and Wolfe 1993; Martin and Ewan 2008; de Roode et al. 2013; Neco et al. 2019), and this has been found to be especially prevalent in primates (see Huffman et al. 1997; Huffman 1997; Huffman and Hirata 2004), it is probable that our species, *Homo sapiens*, has always engaged in at least a minimal form of proto-medical practice. Perhaps Kukla intends to say that we don't need to know the biological basis or the causal underpinnings of injury and disease to recognize them as detriments to health.

Maybe Kukla's opening paragraph highlighting the 'intuitiveness' of health is thus intended to capture our corresponding folk concept. That is, is in the words of the Canguilhem, a different way of life:

> In the final analysis, would it not be appropriate to say that the pathological can be distinguished as such, that is, as an alteration of the normal state, only at the level of organic totality, and when it concerns man, at the level of conscious individual totality, where disease becomes a kind of evil? To be sick means that a man really lives another life, even in the biological sense of the word.

– Georges Canguilhem (1991, pp. 87-88)

For Canguilhem the lived experience of disease came prior and he argued it should be central in our understanding of it. It is unclear, however, how this recognition necessarily lends itself to the social-justice based account of health and disease that Kukla has in mind. Indeed, it is unclear why the folk concept of health and disease must lend itself at all to Kukla's alternative project to locate the concepts of health and disease within what they call "social justice projects" (p. 516) which roughly corresponds to what I have dubbed 'real normativism'. Capturing all of the intuitions associated with the folk concept within a single definition has proven to be exceedingly difficult, if not impossible. It is as if the concept has to do *too much* for a single definition to achieve all of these ends. There is plenty of reason to think that different approaches can focus on different components of the folk concept without thereby claiming that it must be *the* right approach. Pluralism may well be the right approach here.

Indeed, Kukla explicitly recognizes that despite the 'intuitiveness' of health and disease it has been far from straightforward to arrive at an agreed-upon definition. Nevertheless, to motivate their alternative approach, Kukla distinguishes two markedly different projects, one they call 'scientistic projects' and the other, as just noted, 'social justice projects'. Here, it is best to cite them in full:

> 1. *Scientistic* projects: The primary goal of such projects is to understand health and disease as respectable concepts from the point of view of the natural sciences. This is possible only if we can characterize what counts as a disease or a state of health independent of our specific, contingent social categories and practices. Such accounts avoid appeals to social or personal values, as these play no role in the categories and explanatory strategies of the natural sciences. Instead, they appeal to notions such as statistical normalcy, adaptive fitness, and biological function.
>
> 2. *Social justice* projects. In this context, an understanding of health and disease is a part of a specific type of *normative* project—namely, that of determining the role that health *should* play in a larger theory of social justice. Political philosophers, policy makers, and others ask questions such as: To what extent and in what sense is there a universal right to health, or health care? What counts as a fair social distribution of health resources? When does a health inequity count as a justice issue in need of moral redress? How shall we balance health needs with other social needs in a just state? To answer such questions, we need an understanding of what health is. But not any old understanding will do: This has to be the kind of understanding that will guide and clarify health policy and normative questions about the role of health care in a just society.
>
> – Kukla (2014, pp. 515–516)

These naturally need not be the only projects, but it is perhaps possible to idealize and cluster many different projects under these two separate and broad headings. Because Kukla introduces their project by comparing naturalist and social constructivist approaches, however, readers might be misled into thinking that social justice projects map onto the latter. There is something slightly disingenuous about this false dichotomy, since we are thus invited to conclude that we have to either embrace the much-criticized naturalist accounts of health and disease such as that of Christopher Boorse (1977, 1997, 2014) or realize that the concept should ultimately be grounded in concerns of justice. For purposes of clarity, it is thus useful to sketch a third kind of project in this debate that we may analogously call a *social science* project:

> 3. *Social science* projects: The primary goal of such projects is to understand health and disease as concepts used by particular linguistic communities at a particular time and place in history (including the present). Here, contingent social categories and practices that have been deemed irrelevant in the naturalist project, play the central role. In these projects, homosexuality and drapetomania may be accurately called diseases at a particular time and place, even though they are no longer today. The concepts of health and disease are thus here unlike in the other two projects - relative to the norms of a society, depending on the social processes and mechanism of *medicalization*.

This three-fold distinction between three different projects will help us to map the terrain of goals in the philosophical debate on health and disease. Indeed, it strengthens Kukla (2014)'s insight that one of the reasons why "the various attempts to define health and disease have been so unsatisfactory is that those using the notion are driven by deeply diverse theoretical and practical goals" (p. 515). Unlike Kukla, however, I maintain that the different goals for which the concept has been put to use are *the* very reason for the lack of progress in the debate. This will become apparent once we turn away from traditional conceptual analysis and instead focus on conceptual engineering. In the next section, I draw on a recent distinction between two different kinds of conceptual engineering in order to cash out the futility of trying to achieve a satisfying definition of health and disease.

3 Two Kinds of Conceptual Engineering

Historically, *conceptual analysis* (i.e. the descriptive analysis of a concept) has been assumed to play the central, if not only, role in settling the philosophical debate on health and disease (Schwartz 2007; Lemoine 2013; Schwartz 2014). The goal was to arrive at a list of necessary and sufficient conditions that would allow us to tidy up the world into conditions that are diseases and those that are not. This approach might be expressed quite ambitiously as the search for the true meaning or more moderately as the search for "criteria of application" that people use when employing

the concept (Neander 1991, p. 171). Neither of these goals, however, is particularly well suited for the application of conceptual analysis. Due to considerations of space, rather than arguing for it independently, I merely wish here to announce my alignment with those who have already argued that conceptual analysis within this debate is flawed and should be replaced with conceptual engineering (Schwartz 2007; Lemoine 2013; Schwartz 2014; Matthewson and Griffiths 2017; Griffiths and Matthewson 2018; Veit 2021a).

Throughout the last decade, methodological debates about the tools and methods of philosophy itself have resurfaced.[1] The origins of this debate can be located in Sally Haslanger (2005), who argued that we should ameliorate our concepts, rather than just analyze them. Concepts ought to be 'engineered'. *Conceptual engineering* is focused on the purposes and goals a specific concept is intended to fulfill. This is just what we need in order to make progress in the philosophical debate on health and disease. But while conceptual engineering has been a core tool among philosophers since the very origins of the field (Burgess et al. 2020), philosophers have only recently begun to seriously engage in meta-philosophical discussions about the nature of this activity.

In a another article authored with Heather Browning, I have made a distinction between two kinds of conceptual engineering that bear similarities to the two projects Kukla (2014) has sketched, although I do see them as quite a bit broader and have applied them to the various positions in the 'normativism vs. naturalism' debate (Veit and Browning 2020). The first of these, I have called *naturalist conceptual engineering* (**NCE**):

> **Naturalist Conceptual Engineering** = (i) The scientific assessment of concepts, categories, and classificatory systems, (ii) determination of their relevant context and purposes to which they are and should be put to use, (iii) reflections on and proposal for how to improve them, and (iv) proposals for and active participation in the implementation of the suggested improvements.
>
> – Veit and Browning (2020, p. 10)

NCE may appear quite familiar to anyone who is acquainted with Carnap's (1950) concept of 'explication', yet, this understanding would narrow it down too much. Carnapian explication is merely one form of **NCE**, and for the purposes of this paper we do not need to specify the different forms it can take. The important lesson here, is that this way of 'designing' concept contrasts strongly with the second kind, I have dubbed *moral conceptual engineering* (**MCE**):

[1] Cf. Cappelen et al. (2016) and Sytsma and Buckwalter (2016).

> **Moral Conceptual Engineering** = (i) The moral, political, and social assessment of concepts, categories, and classificatory systems, (ii) determination of their relevant context and purposes to which they are and should be put to use, (iii) reflections on and proposal for how to improve them, and (iv) proposals for and active participation in the implementation of the suggested improvements.
>
> – Veit and Browning (2020, p.9)

In the case of health and disease, these two kinds of conceptual engineering match well with two of the three projects outlined in Section 2. Indeed, they perhaps allow us to understand why Kukla (2014) didn't include those projects I called *social science* projects. Whereas what Kukla called *scientistic* projects and *social justice* projects design concepts for a particular purpose - i.e. they are ameliorative - the social science project is merely descriptive. There, we are merely interested with how a specific community uses or has used the term. This fits better with traditional conceptual analysis, or perhaps with some of the tools advocated by experimental philosophers.

Kukla's goal is ultimately **MCE**, i.e. the amelioration of the concepts of health and disease to serve the purposes of what they call social justice by furthering collective wellbeing. Other purely normativist accounts may target a different moral value, but they would nevertheless still constitute **MCE** for being aimed at a moral end. As I shall argue, however, their own arguments may put a premature end to the very idea of this project. Indeed, Kukla recognizes "that there is no prima facie reason to think that our best attempts to specify a scientifically rigorous definition of health and our best attempts to specify a politically and normatively useful notion of health will correspond with one another" (p. 516). Kukla expresses skepticism that health and disease can be expressed within unified concepts that would prove satisfactory with regards to the different goals to which the concepts are put to use. Once we have moved away from the traditional method of conceptual analysis we should become skeptical that they can be thought of as natural kinds or that there is anything like a single essence only waiting to be discovered by an ingenious philosopher. Kukla's opposition to this idea may stem from their endorsement of **MCE**. In passing, they note that disease could possibly be understood as biological pathology from a scientific point of view. But this is not the project Kukla is engaged in, since they endorse a variant of Canguilhem's view of medicine, an appeal to the folk concept that fits somewhat uneasily with their goal of conceptual engineering. After all, it is precisely the goal of refining the folk concepts of health and disease that drives attempt at a conceptual analysis of these notions.

For instance, Kukla (2014) refers to the common idea that medicine as an *institution* is "designed, first and foremost, to promote, restore, and protect health" and that the "protection of health and distribution of health services is, almost all societies would agree, an important component of justice" (p. 515). The patient, and their suffering, comes first. Unlike Canguilhem, however, Kukla's view is oriented

not on the patient-doctor relationship but rather the collective relationship between humans and medicine as an institution, hence the emphasis on *social justice*. This emphasis, Kukla argues, may ultimately lead to a different perspective on health, such as "poor nutrition among low-income children" even when biological science treats it only as a state that is causally linked to actual diseases.[2]

I whole-heartedly agree with the suggestion that "in considering the best definition of health, we need to keep clearly in view the theoretical and practical purposes to which we want to put the concept, while keeping an open mind as to how unified a definition is possible" (Kukla 2014, p. 516). While **NCE** and **MCE** do not have to come apart, this will only be the case if the goals of each project are not in conflict. In the case of health and disease we should be skeptical that the widely different goals of the different parties can be satisfied with a single concept (see also Veit 2021b). Let us therefore examine Kukla's proposal for an account of health and disease that serves the purposes of social justice. An account that, I argue, beautifully demonstrates that the very notion of a purely normativist account of health and disease must ultimately fail.

4 Engineering 'Health' for Justice

In Kukla's paper, we are presented with Boorse's (1977; 1997; 2014) biostatistical theory (**BST**) account as the paradigm example for what Kukla locates within the 'scientistic project'. The **BST** takes, as the name would lead one to expect, statistical normal function as the core of health. Normal functioning for Boorse concerns the body (both as parts and as a whole) of an individual within a particular population (class) in which "a statistically typical contribution by it to their individual survival and reproduction" (Boorse 1977, p. 555). Health, for Boorse, is merely the absence of disease, which in turn "reduces one or more functional abilities below typical efficiency" (Boorse 1977). While evolutionary concepts (survival and reproduction) play a role in the **BST** account, one should resist Kukla's appeal to classify Boorse's account as an evolutionary one - indeed, Boorse explicitly argues against the selected-effects view of functions and has argued that evolutionary biology has little to add to our understanding of health and disease (see Boorse 1976). Boorse's account is thus problematic even as a naturalist one and may be better classified as a social constructivist account that focuses on the concepts of health and disease as they are employed by the medical profession.[3]

[2] The attested inadequacy of the naturalist position may be premature. Multiple authors (Griffiths and Matthewson 2018; Matthewson and Griffiths 2017; Veit 2021a) have argued that a naturalist account of health and disease may very well be able to account for categorising such states as pathological.

[3] See also Griffiths and Matthewson (2018); Matthewson and Griffiths (2017); Veit (2021a).

By disassociating social constructivism from normativism, we can see that some of the problems of Boorse's account may stem from its uncomfortable hybrid role as both a naturalist account of health and disease and a social constructivist account of actual medical practice. These may obviously come apart. The way scientists conceptualize a concept and the target phenomena they are trying to capture can obviously be mismatched. And if the science is a value-laden one such as medicine, there are reasonable expectations that moral values may have slipped into the concept of disease. Since these various goals can take different shapes in their own right, there is little hope for thinking that there must be something like a uniquely correct concept of health and disease that would address all of these concerns.

An important, but often neglected point that Boorse (1997) once made, is that "there can be diseases that are neither disvaluable nor worthy of therapy" and conversely, "physicians can be justified in nontherapeutic activities. So the concepts of health and disease are far from settling all clinical or social questions" (p. 99) even if this is often assumed and taken to be a substantive criticism of Boorse's account. Boorse thus emphatically denies that his project has anything to do with what I dubbed **MCE**. It is therefore, as Kukla (2014) recognizes, "explicitly devoid of normative force or practical upshot" (p. 517). Any naturalist account that arises from **NCE** makes it impossible to simply assume, as Kukla notes, "that there are any ethical or practical implications that follow in any direct way from determining that something is a disease, or that someone (or some group of people) is (or is especially likely to be) in ill health" (p. 517). This does not mean that a naturalist account cannot lead to normative facts, but rather that it cannot be *a priori* assumed that it will. And it is precisely this reason why many have been dissatisfied with Boorse's analysis, yet it elegantly shows how **MCE** and **NCE** can pull in entirely different directions. But to require that health *must* somehow be conceptually linked to justice is, as we shall see, a poor argument even within a social justice project.

Firstly, we can deny that a concept such as disease conceptually entails some sort of moral right for treatment, while nevertheless recognizing that both for evolutionary and empirical reasons - pathological states are strongly linked to reductions in wellbeing, autonomy, and other 'intrinsically' important features of human (or for that matter, animal) life (Veit and Browning 2021). It is hard to see why there must be a conceptual link between health and justice in something like an entailment relationship, as opposed to an empirical link via the bridging concepts of, say, wellbeing. Doctors, after all, frequently engage in procedures to improve the wellbeing of patients, regardless of whether their intervention is properly classified as the treatment of a disease and sometimes do so even at the cost of a patient's health such as the use of strong opiods. It is unclear why, *even if* health is intuitively a moral good, our best account of health and disease must turn this into a conceptual truism. Kukla's repeated emphasis of the folk concept of health is an odd move to say the least in a paper that attempts to use moral conceptual engineering, which allows for the possibility of a drastic change from the usual folk understanding of a term.

Yet, the goal to have an account of health and disease that satisfies both **MCE** and **NCE** is what motivated many in the debate to declare Boorse's account (and any other purely naturalist accounts) as inadequate. They maintain instead that we need something like Wakefield's (2001) hybrid account for the purposes of policy-making, in order to account for both sets of goals. Like Kukla (2014), I believe that such hybrid accounts will ultimately fail to provide consensus. The projects are undermined by the very idea that we can have a single concept that satisfies the demands of both **MCE** and **NCE**. While something like a equilibrium point is a theoretical possibility, it has rarely been attempted to make the trade-offs and conflicts between these two goals explicit. I have my doubts that we will ever create a consensus on the topic of how much weight should be given to moral and naturalist considerations.

This is not to say that hybrid accounts cannot be provided - indeed, I suspect that many of the accounts usually seen as naturalist or normativist turn out to be hybrid accounts once we make a more fine-grained distinction between naturalism, normativism, and social constructivism.[4] And these commitments can come in different gradations and varieties. Engelhardt (1986), for instance, is straightforwardly both a social constructivist and normativist. Nordenfelt (1993, 1995), however, while coming close to being a 'real' normativist in his defense of a holistic account of health and disease, appears to (at least implicitly) allow some role for social constructivism due to his emphasis on the role of conceptual analysis, rather than conceptual engineering. But the mere fact that many, if not most, philosophers have in actuality defended hybrid accounts does not, of course, undermine the existence and usefulness of drawing the distinctions I made in Sections 2 and 3. These are distinctive projects and it is in principle possible to conceive of a purely descriptive account of how these terms are used within a linguistic community (although this may be the task for a social scientist or linguist rather than a philosopher), and the possibility of a purely naturalist conception of these terms to describe a natural phenomenon in, say, evolutionary dynamics between predators, prey, and pathogens. The problem with hybrid - unlike with pure - accounts is that there is no *one* standard on which to measure these accounts, since there is no a priori weighting that can be attached to the different goals for which the concepts is put to use.

This is why I find much of value in Kukla's discussion of two recent attempts at hybrid accounts that fail in pricely this regard: Norman Daniels' (2007) *Just Health: Meeting Health Needs Fairly* and Powers and Faden' (1999) *Social Justice: The Moral Foundations of Health and Health Policy*. However, I am not entirely happy with the way Kukla sets up their criticism. Instead of simply arguing that these accounts fail due to a conceptual rift between the conflicting goals of both projects, Kukla provides a controversial 'list of facts' about the body that is supposed to show that it is "impossible to build a normative, social justice project on top of a scientistic

[4] Recall Boorse.

conception of health and disease" (p. 519). Because of considerations of space and the fact that Kukla provides few arguments in support of this list, I will not go into more detail here. Since they are merely asserted, rather than argued for little can be said either for or against them. It would have instead been sufficient for their argument to simply point out the inevitable trade-offs faced by any hybrid concept.

Nevertheless, Kukla takes this supposed impossibility of the existence of a truly normativist account based upon either naturalist or social constructivist foundations, to motivate their own 'purist' account. If someone is interested in pure constructivism, they are simply engaged in social science and will define that a "condition or state counts as a disease if and only if it is medicalized, where medicalization is a social and institutional process, and health is the absence of disease" (Kukla 2014, p. 517). But the mere fact that conditions such as homosexuality or drapetomania were once seen as diseases provides us with no guidance of whether they *should* be seen as diseases, i.e. whether they should be cured.

As I argued in **Section 3**, the social constructivist is engaged in a descriptive project. even when they are trying to provide a hybrid between a normativist (in the sense of justice) and a descriptive (social science) project - as for instance Engelhardt and Nordenfelt - the disparate goals between the two endeavours may pull even more strongly in opposite directions than they did between naturalism and normativism, that could at least plausibly be bridged through the concepts of wellbeing and autonomy. Glackin (2019), who comes close to something like a pure social constructivism, neverthelesss rejects Kukla's argument and sees it as "no objection to SOCIAL CONSTRUCTIVISM, or to any other normativist account of disease, that it does not provide us with an expedited route to socially just treatment of patients" since "no version of the concept is going to do that" (p. 273). He argues, that if "we want social justice [...] we must do the hard, patient work of argument and advocacy for it; just agreeing on the descriptive facts will not be enough" (p. 273). When Glackin speaks here of normativism, he has social contructivism in mind - an excellent showcase for why the label normativism is confusing, since it denotes both the project of identifying what *is* being disvalued as a disease and the question of what *should* be cured or treated. While I agree with Glackin's opposition to the pure social justice project, he gives little argument for the claim that no version of the concept could possibly succeed at promoting social justice. Again, we are only presented with assertion and it is the goal of this paper to remedy this omission.

An elegant philosophical move made by Kukla was to turn social constructivism on its head by replacing the *what is being* medicalized component of social constructivism with a *what should be* medicalized ingredient.

> *The Institutional Definition of Health*: A condition or state counts as a *health condition* if and only if, given our resources and situation, it *would be best for our collective wellbeing* if it were medicalized—that is, if health professionals and institutions played a substantial role in understanding, identifying, managing and/or mitigating it. In turn, *health* is a relative absence of health conditions (and concomitantly a relative lack of dependence upon the institutions of medicine)

– Kukla (2014, p. 526)

This account has obvious appeal, as it denies the naturalist treatment of homosexuality as a disease and the social constructivist treatment of drapetomania or masturbation as diseases in the past. It seems to be able to treat these judgements as mistakes, without appealing to ad-hoc additions of value criteria. As Kukla puts it, the "connection to justice is *built in* [...] from the start" (2014, p. 529). But there are number of damning arguments against this approach, that ultimately undermine the very goal of the moral normativist to offer an alternative account of health and disease.

5 Why Pure Normativism is Self-Defeating

While Kukla's arguments are a welcome contribution from the anti-naturalist side and expose many of the underlying conceptual problems in the debate, Kukla's proposal is ultimately more flawed than the accounts they have criticized. Rather than give up on the idea that the notions of health and disease must intrinsically be valued or (dis)valued, Kukla (2014) seeks to detach the concepts of health and disease from their intended targets within both biology and ordinary discourse, instead labelling them as whatever would contribute to social justice if it were medicalized. But the problem with treating statistically abnormal sexual preferences such as homosexuality or 'gender identity disorder' as mental disorders is not a mis-characterization of biological reality per se, but the empirical fact that medicalization has the unintended side-effect of treating these conditions as 'bad' - As something that should be cured, something that it would be better not to have.

Kukla (2014), instead of abolishing this problematic part of the folk concept of health and disease - one that has been criticized by utilitarians and disability rights advocates alike as something that should not intrinsically matter - embraces it and discards any underlying biological or social phenomena. One should immediately be worried as to why it is the normativity, rather than say the naturalness of the folk concept of health that should be our focus. Idealizing away all factors aside from the moral role of these concepts is, of course, only a move worth making if the underlying goal of the pure normativist to define health exclusively in terms of justice could thus be better promoted. But is this actually an instance of **MCE**? Kukla argues that their account (or at least a purely normativist account of some kind0 must be right since there is an asserted intrinsic association in people's minds between the abnormal and the 'bad'. But the mere fact that an empirical study or conceptual analysis of the common usage of these terms would reveal a normative component is irrelevant for the conceptual engineer interested in revising the concept for a specific goal. We could equally take the naturalist route that revises the concept in a way such that there is no longer a conceptual connection between what is called a disease and what should be treated. Despite appealing to the goals of conceptual engineering, Kukla falls prey to the old ideals of conceptual analysis.

The resulting problem is precisely what Kukla has criticized hybrid accounts for: they fail to carve nature such that disease constitutes a special moral domain. Indeed, this is precisely what numerous bioethicists in the enhancement literature have argued for: there is no important moral distinction between the treatment of a disease and an enhancement beyond what is typically considered healthy (Savulescu et al. 2011; Veit 2018b,a). Both methods enhance human bodies to promote the wellbeing of the patient; whether the underlying condition is understood as a disease or not is irrelevant. Note that this is **MCE**, without proposing a new definition of health. They simply maintain that we should use different criteria, such as autonomy and wellbeing, when making medical decisions. Our *collective wellbeing* could be promoted in all kinds of ways by medicalizing certain states: think of hair loss in old age and many other conditions that are perhaps unfortunately left untreated because they are a natural result of the aging process. Since Kukla (2014) gives up the dysfunction criteria of disease, many conditions that aren't currently treated by medical practitioners, on the sole ground that they don't constitute actual diseases, would have to be reevaluated. This would naturally lead to a radical revision of current medical practice. But here I want to step in: why then keep the concepts of health and disease at all? What is gained by keeping these terms? Why do we need this intermediary concept between facts about the body and concerns of justice, if medical professionals are now simply in the 'business' of using the current tools of medicine for the promotion of what Kukla calls *social justice*? In fact, Kukla appears unaware that their own argument would lead to a slippery slope that is ultimately self-defeating. Let us spell this important point out in more detail.

Why is a purely normativist account bound to fail? Kukla's account provides a beautiful example for why those interested in justice cannot simply define health, disease, and pathology in terms of moral concerns. The problem lies in the connection between the institution of medicine and the concepts of health and disease. Let us for the sake of the argument assume that medical practice, medical practicioners, and the tools of medicine are simply a given. Those like Kukla, or us for that matter, who are concerned that medical institutions can misuse their authority to promote unwanted goals such as racism or homophobia. It is historically well documented, for instance, that homosexuals have been discriminated against on grounds of living a supposedly 'unnatural' life-style, something that was assumed must be pathological since it lowers one's fitness. Homophobia has been justified by hiding behind the veil of medical authority. Neither the naturalist nor the social constructivist account of health and disease *seems* to offer much to prevent such misuse. This is why Kukla wants to put the normative component of health and disease centre stage - eliminating the need for any naturalist or social constructivist basis of health. There is an intuitive appeal to the idea that we should simply look at our institution of medicine and then think about which conditions *should* be considered diseases or health-problems in order to promote social justice.

The first major problem is this: Kukla leaves social justice entirely undefined, treating it loosely as some concept of collective wellbeing. Indeed, Kukla responds

to this possible criticism by treating it as a *strength* of their account: "[w]hether one is a consequentialist, a libertarian, a Rawlsian, or whatever else, one can be invested in what we have called the normative project of figuring out how a just state should manage health policy and health needs, and our definition of health can be slotted into any such project" (p. 526). But this neutrality is not a strength - it is a blatant weakness. It amounts to little more than the unhelpful statement that we should define our terms in a way that promotes justice - whatever it is. The conceptual possibility proof is philosophically useful in terms of further exploring the conceptual possibility space, but it is pragmatically useless, since our modern societies obviously do not consist of a homogenous group in which everyone agrees about what justice should entail. If we accepted Kukla's proposal, the very concepts of health and disease would become another battleground for those with widely different moral views. Despite aiming to accommodate the apparent 'failures' of the naturalist and social constructivist to condemn the medicalization of homosexuality and drapetomania, Kukla does in fact do the opposite.

Consider for instance a society in which strict conservative religious views are in the majority, leading to the medicalization of attitudes like an unwillingess to bear the child of one's rapist, the desire to love someone of the opposite sex, and the opposition to the dominant religion; classified as mental disorders on the grounds of 'collective wellbeing'. It is thus not hard to imagine that Kukla's own proposal would be used to justify the very things they aimed to condemn. Naturalists and social constructivists, on the other hand, can simply criticize old definitions of health as having been biased by the moral views of those that endorsed the medicalization of drapetomania. This I do not see as a failure, any more than the biological definition of a human being may fail to provide animals with human rights.[5] Leaving the content of social justice empty is thus a weakness of Kukla's account, not a strength.

Furthermore, I simply do not see how such a world would be preferable to our current one, in which our institutional definitions for health and disease are widely shared and pragmatically accepted among many as something that deserves treatment - not because justice is somehow built into these concepts, but simply because we *know* that biological wrongs are highly correlated with losses in autonomy, agency, and wellbeing. So unless we were to live in a world where everyone shares the same concept of justice, it would appear that the institutional definition of health Kukla proposes would surprisingly fail to promote the goals of collective wellbeing - even though this was precisely the *one* goal it was supposed to achieve. Indeed, we may simply be better off by accepting that we should respond those conditions that lead to losses in wellbeing, regardless of whether these are diseases - something that can almost universally be agreed upon regardless of one's ultimate view on justice.

The first problem also emphasizes a larger problem that any purely normativist account of health and disease will share: a failure to ground health and disease states as distinctive from other states of moral importance and concern. To explicate this

[5] Although animal rights advocates may disagree.

second and much more fundamental problem that underlies the motivation of this paper, let us assume for the moment that we had a universally agreed upon definition of collective wellbeing and social justice. In that case the institutional account of health would inevitably classify as a health condition all and only those things that are perceived to be something social justice should address. The institutional account is incoherent because it fails to recognize that institutions are inherently flexible and can change over time, changes that would lead to excessive broadening of the concepts beyond the point of usefulness.

Let me elaborate on my argument in more detail: If one approaches medicine from the perspective of justice, it is natural to ask what the tools of medicine should be used for. If one then rejects any connection between medicine and disease as a natural phenomenon, it becomes tempting to argue that medicine should treat and classify conditions as diseases if their medicalization by the institution of medicine would benefit collective wellbeing. What makes this suggestion incoherent is a neglect of the simple fact that the tools of medicine have been designed, first and foremost, to deal with diseases. These tools are continuously improved and expanded for that very purpose. We no longer use outdated practices because they have been shown to be flawed or replaced by better ones. If we now classify any possible condition that current medical tools could address to improve collective wellbeing as a health disorder, the tools of medicine will inevitably shift to become better at dealing with those conditions. In fact, Kukla's institutional account underestimates the plurality of medical practice that already exists: many of the current tools used by medical practitioners can and often are used to improve people's lives. One only needs to think of cosmetic surgeries or mood-enhancing drugs, regardless of whether these conditions are classified as health disorders.

Nevertheless, medical research has historically been tied to a biomedical, rather than a social justice, understanding of health and has constrained its scope accordingly. Kukla's proposal not only changes the definition of health conditions into something much more flexible but also alters the very institution of medicine. The tools of medicine will evolve to better address concerns of justice, and more and more states we deem concerns of justice will thus be classified as health conditions—precisely because the medical toolkit will inevitably expand to address these concerns. Unless Kukla (2014) insists that the current definition of medicalization remains fixed, medical practice would ultimately co-evolve into the practice of 'social justice promotion,' thereby losing the distinctiveness that the concept of health and disease is supposed to capture. This is a highly unattractive proposal because it would turn anything seen as an injustice into a health condition. Justice would no longer be built into the concept of health: health would simply become justice. The very criticism Kukla applied to hybrid accounts, i.e. that they fail to demarcate a unique normative role for these concepts, appears to apply even more forcefully to pure normativism.

It would lead to Rudolf Virchow's famous dictum that "politics is nothing else but medicine on a large scale"[6] except for the qualifier *on a large scale* being eliminated. Surely, such a result must be considered self-defeating, yet what could possibly stop it unless we draw on either naturalist or social constructivist resources to constrain what can legitimately be considered within the domain of medicine? Pure normativism can be "pure" in name only. It must rely on some grounding in one of the other frameworks.

As a result, an application of **MCE**, rather than explicating a novel concept of health and disease, would lead us to draw on either naturalism, social constructivism, or both, resulting in something like an implicitly hybrid account. Another approach would be to reject this entirely and, as some bioethicists suggest, focus on wellbeing and autonomy instead of health. I maintain that what Kukla has demonstrated with their account is not that we should build moral values into the concepts of health and disease, but rather that this part of our folk conception is no less problematic than the intuitions driving the naturalist or social constructivist in their accounts. The popular notion that health and disease are intrinsically moral concepts serves neither the goals of the naturalist nor, as I have demonstrated here, those of the normativist.

6 Conclusion

The idea that the concepts of health and disease can serve the goals of naturalism, social science, and justice is ambitious, to say the least. Decades of debate should make us wary of thinking that there is a single concept waiting for philosophers to discover, one that preserves all of its 'intuitively' compelling properties. Kukla's article highlights an insoluble dilemma within the concepts of health and disease. Naturalists, social constructivists, and moral normativists simply have different goals for how these concepts are to be used. An obvious solution, then, is to embrace a more pluralist view, in which there could be at least three alternative accounts of health and disease, corresponding to each of these projects. Purely naturalist and social constructivist accounts have been proposed in the past, but they have gained very little traction. This raises the question of whether a pure normativism could be more compelling. Kukla's institutional definition of health is one of the first attempts to achieve this through conceptual engineering rather than conceptual analysis. However, what this article aimed to demonstrate is that a purely normativist account will ultimately prove self-defeating, despite its perhaps 'intuitive' appeal.

The first reason Kukla's account may appear intuitively compelling as a purely normativist account of health and disease is the deliberate refusal to define what 'collective well-being' or 'social justice' are—terms that sound nice but will inevitably cause much more conceptual disagreement than the old debate about the proper conceptual analysis of health and disease. Secondly, there is a neglect to admit that

[6] See Ashton (2006).

for the account to work, the institution of medicine itself would have to be held fixed, thus making it a purely normativist account in name only.

The first problem makes Kukla's definition an excellent model to demonstrate that the arguments presented here will undermine any purely normativist account unless there is complete moral consensus. However, this is hardly a feature worth wanting if one is interested in defending such an account. For the purposes of **MCE**, we may very well also want to engage in some **NCE** or social construction to constrain these concepts or replace them with alternative notions such as wellbeing and autonomy to ground moral decision-making. For health and disease states to matter, it would be sufficient if these states have some empirical, rather than conceptual, link with those notions. To assume that something must intrinsically matter in order to be morally relevant, or to be used in decisions regarding public policy, is nothing more than an illusion.

The second problem reveals the self-defeating nature of the very idea of a purely normativist approach. If we ask what the unique tools and institution of medicine are, we must do so through recourse to our concepts of 'health' and 'disease.' This is precisely why this question has remained at the heart of the philosophy of medicine. But unless these concepts can somehow be held fixed or constrained through naturalist or social constructivist means, medicine would simply become whatever promotes justice. Yet a definition that fails to distinguish health from justice and disease from injustice can hardly be considered a definition at all. Pure normativism must fail, but this does not mean that the concepts of health and disease cannot play an important role within moral deliberation and public policy, nor that social justice considerations should play no role in these decisions.

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