

Author's version of review by Rachel Cooper forthcoming in Mind.

Health Problems, by Elizabeth Barnes. Oxford: Oxford University Press, 2023. Pp. xii + 285.

Health Problems by Elizabeth Barnes is an interesting and well written book that makes a valuable contribution to the ever-growing philosophical literature on health and disease.

Barnes argues for a position she calls *Ameliorative skepticism*. Her starting point is that our concept of health is essentially confused. The internal tensions within our thinking about health mean that it will not be possible to give a unified account of the concept (certainly not in terms of necessary and sufficient conditions). Barnes thinks that the internal tensions within our concept of health are likely a common feature of social categories more broadly. The root cause is that the social world is shaped by the ways in which humans talk about and act on social kinds. Our ways of speaking and acting, though, are often inconsistent, and 'we should expect that there can be aspects of our collectively shaped social world that inherit those same inconsistencies and tensions' (p.202).

In the case of health, the inconsistencies are so deep rooted that they cannot be corrected. At the same time that our concept of health is a mess, however, talk of health tracks real and important features of the world and plays a central role in our ways of thinking about ourselves and organising society. Simply discarding our concept of health, as eliminativism suggests, is thus not a viable option. Rather, the ameliorative skeptic thinks the best that can be done is to 'explain why our understanding of health is a mess, and how it might still be useful and helpful to talk about health in spite of this inherent messiness' (p.6).

In this review, I will suggest that Barnes' core insight - that our practices surrounding health often involve tensions, leading to an essential messiness in our concept of health - is plausible. At the same time, I am not overly convinced by her detailed claims about precisely where the tensions in our thinking about health might lie. However, Barnes' claims do not have to be accepted or rejected as a package deal. As long as our practices around health contain tensions and inconsistencies in some places or other, Barnes' overall argument for Ameliorative skepticism can be maintained.

In this review I will, first, consider Barnes' method. I then discuss some doubts I have about the specific tensions that Barnes claims infect our concept of health, before ending by suggesting some possible alternative sources of messiness.

1. Barnes' methodology

The promotional blurb for Barnes' book claims that *Health Problems* is the first philosophical book to consider the nature of health (OUP website). This claim is simply untrue. Long before *Health Problems*, there was Canguilhem's (1978) *The Normal and the Pathological*, and more recently Nordenfelt's (1995) *On the Nature of Health*. And, of course, many, many papers have been written on these issues.

Barnes' ameliorative skepticism can be read as a contribution to the ongoing research programme in the philosophy of medicine that seeks to understand concepts of health and disease (and the first chapter of the book offers an overview of this literature). It's true,

though, that she frames her problem rather differently than is usual in this literature. Standardly, philosophers interested in concepts of health and disease have focussed their efforts on the concept of 'pathological condition' or 'disorder'. They have sought to explain what it is for a condition to be pathological and taken it as given that health is merely the absence of pathology.

Barnes' approach is slightly different in that her efforts are primarily directed at understanding the concept of health. In itself, this methodological choice may be unimportant. Barnes' 'health problems' are equivalent to other writers 'pathological conditions' or 'disorders', and in so far as 'health' and 'disorder' are obverse concepts, whether one starts with one or the other should make little difference.

Notably, though, the questions around health that interest Barnes diverge from those that have energised existing philosophical debates about health and disorder. Others have wanted to know how we might determine whether an individual is disordered or healthy, or whether particular conditions should be considered pathological. Barnes instead worries principally about the challenges associated with comparing and measuring health. Her arguments often focus on puzzles around cross-person, cross-condition evaluations. As a typical example, Barnes asks who is healthier

One person, though otherwise biologically normal, says he cannot function due to feeling overwhelmed by stress, a result of 'burnout' from his job at a tech start-up; another is undergoing chemotherapy from an aggressive cancer but says he's feeling optimistic and coping very well. (p.203)

It is in considering such questions that Barnes thinks we end up being pulled in incompatible directions. Thinking through the tensions in our thinking about such cases motivates Barnes' central claim: that our concept of health is shifty and unstable.

I have some concerns about Barnes' tendency to take cross-individual, cross-condition comparisons as paradigm cases for assessing the adequacy of our concept of health. Barnes argues that our concept of health has been developed through social practices. It is because our practices around health pull in multiple directions that our concept of health has developed internal contradictions. A corollary of such claims should surely be those seeking to show that our concept of health is irredeemably messy should look to those points at which our practices and concepts can reasonably be expected to be most refined - that is at practices that are entrenched and central.

There are debates around health and disorder which are of practical importance and where questions about the concept of health naturally arise. For example, there are contexts where we are concerned with questions as to whether some particular condition should be considered a disorder (Is alcoholism a disorder or choice? Is depression associated with bereavement a normal response to loss or pathological?). There are also contexts in which we want to know whether people with a certain condition are improving or getting worse (as in evaluating health in drug trials). In contrast, contexts in which we have to assess the relative healthiness of two individuals with different conditions don't arise all that often. Barnes suggests that cross-condition comparisons are necessary for deciding health care priorities. This may be true, but (i) such decisions tend to be focussed on populations rather than individuals (should we prioritise the group of people who need hip replacements, or the group

of people with cancer?) - while many of Barnes' puzzles concern such decisions at the individual level, and (ii) the use of cross-condition measures of health in such decision making is comparatively recent and contested, rather than core to our thinking; the use of QALYS – the best developed measure for such comparisons - dates only to the 1980s (MacKillop & Sheard 2018).

If I'm right and cross-condition, cross-individual comparisons of health are unusual and only peripheral to our practices around health, why do they energise Barnes? My guess is that here Barnes' background as an Arché-trained metaphysician shows. Puzzles around the pair-wise comparison of individuals are the bread and butter of analytic metaphysics (Can Pete who has one less hair than Paul be bald while Paul is not? Can a lump of clay be identical with a statue and survive while the statue is destroyed?). I'm not convinced though that the best way to get a grip on our concept of health is to consider puzzles about ranking the health of individuals with different conditions.

I worry that in terms of thinking about health and disease, the question of whether individual A with condition X is more or less healthy than individual B with condition Y is not a common question. If so, then if our concept of health is not refined enough to be able to deal with such puzzles, this isn't all that surprising. I think that Barnes' idea that our concept of health has inherited confusions that lie in tensions in our practices around health is plausible, but later in this review I will suggest that she should look for these tensions elsewhere.

2. The details of Barnes' argument – locating tensions in the concept of health

Barnes claims that our concept of health is messy. We are unable to consistently say all the things we might want to say at once. Chapters 2-5 outline three specific axes on which Barnes claims our thinking about health can be pulled in conflicting directions. Barnes thinks there are tensions in our thinking about (i) the relationship between health and wellbeing (Chapter 2), (ii) whether health can be objectively measured or depends on subjective elements (Chapter 3), and (iii) the relationship between disability and health (Chapter 4).

Of these chapters, Chapter 3, which argues that the objective and subjective features of health can pull us in different directions, is the most straightforward. Barnes argues that in assessing health we must necessarily take into consideration both objective facts about loss of functioning (e.g. the fact that someone's lung capacity is reduced) and also the individual's subjective assessment of their levels of pain, fatigue, and so on. These objective and subjective components are entangled (depression, for example, can make various objective health measures worse), and can pull in opposite directions. As a result, there may sometimes be no good answer to the question of which of two individuals is in worst health.

The arguments of Chapters 2 and 4 are more technical and I found them harder to follow. Barnes' arguments in these chapters are too detailed to summarise fairly here, but I will discuss two key parts of her argument where I struggled, which will give some sense of Barnes' approach, and of my difficulties.

In Chapter 2, Barnes seeks to argue that wellbeing and health are intimately linked (loss of health very often diminishes wellbeing), can come apart (unhealthy people can have high wellbeing, and people with high wellbeing can be unhealthy), and have a complex, non-linear relationship. Barnes wants particularly to argue against 'the contribution view', which would have it that health is valuable to individuals only in so far as it contributes to their wellbeing.

Barnes claims instead that loss of health can harm you even if it has no effect on your wellbeing (p.77).

Barnes argues for her claim via considering how we might evaluate particular cases. For example, there is evidence that Asian-Americans tend to cope better with pain than white Americans. In considering how we should conceive of the pain of the stoic Asian-American, Barnes says

We shouldn't deprioritize the treatment of the Asian person's pain because 'she can handle it better' or because 'pain isn't as bad for her'. The fact that she might cope very well with pain – that it really might impact her overall wellbeing less because of a broad range of cultural influences in how people cope with and interpret pain – doesn't diminish the badness of her being in pain. (p.87)

Barnes' argument – that health states can be bad even if they don't affect wellbeing- depends substantially on what we might think about these types of case. In reflecting on such examples, though, I am much less sure what to say than is Barnes. I'm tempted to think that if someone copes better with pain, such that pain reduces their wellbeing less, then pain is less bad for them, and it's less bad that they are in pain (indeed all four of these claims seem to me to be much of muchness). I accept that it might not straightforwardly follow that a pain-stoic's treatment should be deprioritized – as such questions might depend also on issues of justice in addition to the badness of the pain - but, it's at least not obvious to me that someone who copes well with pain shouldn't go to the back of the paracetamol queue.

I'm tempted to think that the pain of the pain-stoic is less bad than the pain of a pain-wimp, for two reasons. First, consider the limit case where someone copes so well with pain that it doesn't hurt at all. Such a person simply has no need of any pain relief and can clearly be removed from the treatment queue altogether. Second, in some other cases there is a consensus that it's right to deprioritize the treatment of those who cope better with pain. Consider, for example, our expectation that children should be prioritised over adults when it comes to pain relief. We expect adults to have developed various coping strategies, and to be better able to cope with pain than small children - and, in this case, we do deprioritize treatment for adults accordingly. Barnes' needs readers to agree with her intuitions around her puzzle cases – but I struggled to always share her intuitions or to follow her distinctions.

I found the argument of Chapter 4, which considers the relationship between health and disability, to be no easier to follow. For Barnes, the key difficulty is that disability can often both legitimately be seen as biomedical pathology and also as a (potentially valued) socially embedded phenomenon. These perspectives both seem legitimate but in tension.

Barnes' key argument seeks to adapt David Lewis' thinking about the statue-clay puzzle to understanding the dual nature of disability. In the statue-clay puzzle, a lump of clay is fashioned into a statue. The statue is the clay, but it seems reasonable to say that the statue would be destroyed if it were smashed, while the lump of clay would remain. Lewis' solution to this puzzle is to say that different contexts evoke different counterparts. In artistic contexts, the most important features of the statue have to do with shape. From such a perspective, the counterparts of the statue are individuals in other worlds that are similar with respect to shape. When one focusses on shape, there are worlds in which the statue may have suffered the odd chip, but in worlds where the statue has been smashed up, it has been destroyed and

has no counterparts. In other contexts, the material nature of the clay is more salient. From such a perspective, the counterparts of the lump must be similar with respect to the stuff with which they are composed but can assume many different shapes. From such a perspective, in worlds where the lump is smashed with a hammer, there are flattened counterparts of the lump of clay and we will say that the lump can survive smashing.

Barnes seeks to apply an analogous approach to thinking about disability. Suppose a specific individual has an incomplete L3 spinal cord injury. At one and the same time this is bodily pathology and also a (potentially valued) socially-embedded phenomenon. Barnes seeks to resolve the tension, by applying Lewisian counterparts. She says that there are contexts in which

salient counterparts...are other ways that bodies can be that are stigmatized, that we're trying to promote inclusion and justice for, that provide unique and rich social experiences that depart from the norm, that can shape a person's sense of who they are – trans bodies, femme male bodies, brown-skinned bodies (in white dominated contexts). In this context – with these counterparts – it's true to say that disability should be embraced, destigmatized, and treated as a part of the spectrum of human diversity. It's true that we should focus in changing our norms and our social arrangements rather than changing people's bodies' (p.156)

At the same time, there is also a biomedical context, where

counterparts are other physical states that can cause similar types of harm – cancer, infectious disease. And so in this context – when viewed qua biomedical pathology – it's true to say of bodily states like these that we ought to work to minimize and treat them where we can. (p.156)

Barnes says that her argument about the dual nature of disability parallels Lewis' treatment of the statue-clay puzzle, but I could have done with Barnes walking through her deployment of Lewisian counterparts a little more slowly. In Lewis' argument, the counterparts of the statue-lump are individuals in other possible worlds that, depending on the perspective adopted, are similar in either shape or material composition. Analogously, I'd have expected the counterparts of the individual with a spinal cord injury to be individuals in other worlds, who have much in common with the individual in this world, but differ in key respects. For example, there might be counterparts to the individual with a spinal cord injury who live in worlds where disability is less stigmatised than in this world, or counterparts to the individual with a spinal cord injury who live in worlds where medical science is more advanced and their injury has been repaired. The social and medical approaches to disability might then be characterised as disagreeing over which of these counterparts would live better lives, or as taking different stances on which of these alternative possibilities it would be best to actualise. However, although an argument something along those lines is what I'd expected (and might have sympathy for), this doesn't seem to fit with Barnes' discussion.

Rather, in her application of Lewis, Barnes says that the counterparts of the individual with a spinal injury are variously 'other ways that bodies can be stigmatized' (and gives the example of being brown skinned in a dominant white society) or 'other physical states that can cause similar types of harm – cancer, infectious disease' and so on. I struggle, though, to follow how the counterparts of the individual with a spinal cord injury might be stigmatized bodies

or physical states like cancer or infectious diseases. I'm unclear whether Barnes wants to claim that the counterparts of the individual with a spinal cord injury are individuals with brown skin in some contexts, and individuals with cancer in other contexts. And, if that is the claim, then I'm also unclear how that informs the alternative ways in which we might respond to the person with a spinal cord injury.

A complication in making sense of Barnes' application of Lewis, is that it's unclear how closely her argument is actually supposed to follow a Lewisian approach. In introducing her argument, Barnes says 'The relationship between disability and reduction in health... can be seen analogous to David Lewis' approach to the relationship between the statue and the clay' (p.153), and in developing her argument she makes use of Lewisian terminology and cites Lewis. But then Barnes also says 'To be clear, I don't intend to endorse a Lewisian account of the relationship between health and disability – whatever that might be – or to take on board all of the technical details of Lewis' preferred solution' (p.153). The difficulty for the reader is that Barnes doesn't make it explicit which parts of a Lewisian approach she's using and which are superfluous, and so her 'clarification' doesn't much help clarify her argument. Here, and elsewhere, I found the detailed arguments of Chapters 2 and 4 tough to follow.

3. An alternative suggestion – other sources of tension in our concept of health

The above section was somewhat critical. For Barnes' overall argument for ameliorative skepticism to be plausible, though, she just needs it to be the case that in some way or other our practices around health and disease are inconsistent and lead to the concept of health itself being intractably messy. Some readers may see tensions where Barnes locates them, some might be persuaded by a suggestion I will make in this section, others might locate tensions elsewhere – so long as there are intractable tensions somehow or other it won't much matter for the overall view.

As discussed already, Barnes herself suggests that tensions within our concept of health originate in tensions in our practices around health. Earlier, I suggested that those looking for irredeemable tensions in our concepts should focus on locating tensions in practices that are long-standing and central.

Here's one possibility: historically, some aspects of medicine can be traced back to practices that aim at improving the health of groups of people, while others can be traced back to practices that aim at improving the health of individuals. As modern health care developed, some medical care was state-sponsored and aimed at improving the efficiency of groups (armies, school-children, workers, for example). Other medical care was provided on an individual basis by doctors who sought to improve the health of paying clients.

The aims of these two types of activity can differ and be in tension. Top-down, group-directed healthcare seeks to improve the efficiency of groups. In such healthcare, the preferences of individual patients can be ignored and the individual may sometimes be sacrificed for the sake of the group. In contrast, when healthcare is provided to individual paying patients, the interests of the paying patient come to the fore.

I suggest that the tensions between these two types of activity come out particularly sharply in how they are tempted to think of atypical bodies and minds. From the perspective of top-down group-directed healthcare, an unusually short soldier, or a child who can only concentrate for ten minutes, needs to be 'normalised'. Group efficiencies can only be

maintained if all soldiers can use standard issue kit and all children can concentrate in standard-length classes.

The viewpoint of individually commissioned healthcare is different. In contexts in which patients pay for private medicine, it is also reasonable to expect that the social and material environment can be tailored to the individual. In such contexts, short adults and children who can't concentrate for long, can be understood as being unusual as opposed to disordered. It becomes reasonable to think that their individual bodies and minds don't need altering, and that instead tools and clothes, and methods of schooling, should be changed.

I suggest that a tension in our current concept of health might be traced to such conflicting practices. In certain contexts, we are tempted to think that healthy bodies must be typical bodies. In other contexts, we are tempted to think that atypical bodies that can achieve adequate functioning with environmental adaptations are just fine.

This, though, is just a suggestion, the key point is that for Barnes' Ameliorative Skepticism to be a plausible position, she just needs it to be the case that there are irresolvable tensions in our concept of health – where exactly those inconsistencies might lie doesn't much matter.

4. Summary

In this review, I've quibbled with details of Barnes' argument and raised some concerns about her methodology. There is much of the book, though, that I think very good. In particular, I recommend Chapters 1, 5 and 6, and the Appendix on the Empirical Research on Disability and Subjective Wellbeing (which gives an excellent discussion of this literature). Overall, I'm much more tempted by Barnes' end point – Ameliorative skepticism – than I am by the particular arguments she employs to get yet there. And, in arguing for Ameliorative skepticism, Barnes manages to provide a plausible and novel 'no-account account' of health which should be taken seriously by philosophers of medicine. Over the past few decades, a huge amount of work has been published on concepts of health and disease. Amid the volumes of work in this area, Barnes' book stands out as one that should be read by all philosophers interested in health and disease.

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RACHEL COOPER

Lancaster University, UK

r.v.cooper@lancaster.ac.uk