

Health

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Author's abstract

Many practical issues in medical ethics depend on an understanding of the concept of health. The main question is whether it is a purely descriptive or a partly evaluative or normative concept. After posing some puzzles about the concept, the views of C Boorse, who thinks it is descriptive, are discussed and difficulties are found for them. An evaluative treatment is then suggested, and used to shed light on some problems about mental illness and to compare and contrast it with physical illness and with political and other deviancies which are not illnesses.

This paper is a shortened and revised version of the first John Locke Lecture given to the Society of Apothecaries in London in 1978, under the title *What Can Philosophy do for Medicine?*

The concept of health is one the understanding of which would help with both theoretical problems in philosophy and practical problems in medicine. The theoretical problems arise because philosophers, at least since Plato and Aristotle, have used what may be called the medical analogy when discussing morality; they have claimed that expressions such as 'good man' behave in some ways like the expression 'healthy man', and that if we have no difficulty in applying the latter, we should have no more difficulty in applying the former. Thus advocates of descriptivist ethical theories (ie those which assimilate moral words, in respect of their logical properties, to standardly descriptive words like 'red' or 'triangular') often claim that since 'healthy' is a descriptive concept, so may 'good' be. The obvious reply, for those who reject descriptivism, is to ask whether 'healthy' is purely descriptive either; and that is what I shall be doing in this paper.

That this discussion is of practical importance should be clear to anybody who reflects on the bitter disputes that have been going on recently about what is called 'mental illness'. We have for example, psychiatrists in the Soviet Union arraigned by their colleagues from other countries for classing as mental

illness, and treating by allegedly inhumane methods, what is really only political deviancy (1); and we have 'anti-psychiatrists' like Thomas Szasz (2) accusing their colleagues even in the West of treating what they call 'mental illness' as if it were the analogue of physical illness, whereas, he says, it is nothing of the kind. We shall never be clear about these disputes until we are clear about the meaning of the term 'illness', whether applied to mental or physical conditions, and about its opposite 'health', and its near synonyms 'disease' and 'disorder'.

But even if we confine ourselves to physical health, there are severe practical problems which would be easier to handle if we were clearer about the concept. Take, for example, the treatment of children born with spina bifida, which has been much discussed recently. Spina bifida is in the ordinary sense a disease and I suppose an illness; but what counts as 'treatment' let alone as 'cure' of it? If medicine is the art of healing, how near to normality has the patient to be brought before it can be said that the exercise of the art was justified? And how could we answer that question, without deciding what we mean by 'heal' and therefore by 'health'?

I will start, as Aristotle used to (he was the son of a doctor) by looking at some of the conceptual difficulties (the symptoms of our ignorance of what we are saying when we call a person healthy). Is health perhaps the absence of disease or illness? But is illness the same thing as disease, and health just the absence of these, or is it something more positive? A patient can have a disease (say diabetes), and yet not be ill if the disease is well controlled. He will *become* ill, if he does not observe the prescribed diet and take the prescribed remedies; but he is not ill now. Also, we say that there are two different diseases, if there are two different causes (for example, when it was discovered that some dysenteries were caused by amoebae and some by bacilli, it was said that there were two different diseases, amoebic and bacillary dysentery); but are there two different illnesses? The whole notion of counting or classifying illnesses, as opposed to diseases, in this way is a bit strange. As we shall see, some philosophers have made more even than this of the difference between the concepts of disease and illness. Professor Boorse (of whom more below)

Key words

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considers the interesting suggestion that illnesses are particulars, diseases universals (3).

Doctors tend, in fact, to use neither of these words, but the more non-committal word 'condition'. They do this because it is useful to be able to describe the patient's condition without committing oneself about its aetiology, and by saying that he has a certain disease one may so commit oneself. Secondly, not all conditions are pathological, but all diseases are, by definition. If a doctor says that his patient has a certain condition, he does not presuppose that it is a bad condition to be in (the condition might, for example, be pregnancy, both normal and desired). As we shall see, this is very important for our understanding of the concepts.

Not all the conditions treated by doctors are diseases, therefore. There are even bad conditions which are not diseases, such as injuries and wounds. If I am bitten by a dog and go to the doctor for repair, I am not suffering from a disease (assuming that the dog did not carry rabies). The same is true if I am knocked down by a lorry (assuming that I have got over the shock and just require a few stitches). But if it is a virus that has attacked me, I do have a disease.

Why do the attacks of viruses count as diseases, but not the attacks of larger animals or of motor vehicles? Is it just a question of size? Or of invisibility? I believe that doctors call the attacks of intestinal and other worms diseases, though there are also more precise words like 'infestation'. If I have a tape or a guinea worm (which are quite large), do I have a disease? Does it make a difference if the worm can be seen but its eggs cannot? Or does it make a difference that the worm, although it can eventually be seen, is in some sense, while active, *inside* the patient, whereas dogs and lorries, and also lice and fleas, whose attacks are likewise not called diseases, are always outside the body? Does a disease have to be something *in* me? And in what sense of 'in'? Some skin diseases such as scabies are so called, although the organisms which cause them are in the skin, and do not penetrate the body. They penetrate the *skin* indeed; but then so does the ichneumon maggot, and the body too. Is the difference between these maggots and the scabies mite merely one of size? Or of visibility?

Or is it simply that our conceptual classification of these terms grew up before we knew as much about the causes of diseases as we do now? Now, we can actually see viruses and bacilli through microscopes; but the diseases they cause came to be called diseases before we could do this. On the other hand we could always see dogs. So perhaps we use the word 'disease' for conditions whose cause was not visible before the invention of microscopes. We must note, though, that in order to identify a condition as a disease we do not have to *know* what its cause is (think of cancer, for example). But we do have to commit ourselves to there being a cause, ascertainable in principle, of the same general sort as the causes of diseases whose aetiology we understand. Thus the names of diseases are what

logicians call 'natural kind' terms (4).

Fortunately the puzzle about why dog-bites are not diseases does not affect our main problem very much, because, whether they are diseases or not, they can certainly claim the attention and care of doctors. The patient, if he is in the army, will be 'on the sick list'. However, the puzzle that I am now coming to is crucial to our understanding of the role of doctors. Before we classify something as a disease, does it have to be something *bad*? Could there be a wholly beneficial disease, or one which was neither beneficial nor harmful? It seems not. But we have to be careful. If a soldier is prevented by a mild attack of malaria from being sent back to the battle in which he is very likely to be killed, it was in his interest to have the disease. The device which philosophers use for dealing with this complication is called the '*ceteris paribus* clause'. Malaria can be classified as a disease because *other things being equal, or in general*, it is a bad condition to be in; that does not prevent its being a good condition to be in in this soldier's particular circumstances.

But there are worse complications. Who or what does the disease have to be bad for? Consider the diseases of plants, and in particular of weeds. Let us assume for the sake of argument that the word 'disease' has the same meaning when applied to plants as it has when applied to dumb animals and to man. If I have in my garden a bad infestation of ground elder, and the ground elder plants get a disease and die out, I shall be pleased; so the disease is not a bad thing *for me*. (The same applies if in a battle the *enemy* has an outbreak of disease like the army of Sennacherib, or like the Greeks in front of Troy.) In what sense is the disease a bad thing for the ground elder? Do plants have interests, so that things can be good or bad for them? The same problems that afflict the concepts of health and disease afflict also the more general concepts of good and bad; philosophers who discuss these issues are deeply divided, as we shall see.

Conversely, there is a mildew of vines (and mildews are classified in the gardening books as diseases and not as pests) called *pourriture noble*, which actually improves the taste of the wine. Do we rightly call it a disease, because it is bad from the vine's point of view? But does the vine *have* a 'point of view' if it cannot think about the question?

There is said to be a tribe in South America in which the disease of dyschromic spirochetosis, marked by coloured spots on the skin, is so prevalent that it is accepted as normal, and those without the spots are regarded as pathological and excluded from marriage (5). In that tribe, is dyschromic spirochetosis a disease? Recently I had a painful boil removed from the middle of my back, and the report from the laboratory said that it was caused by an organism which exists normally in the bowel, but which, if it gets into the blood-stream, causes this sort of trouble. So whether this organism is pathogenic seems to depend on where it is. Are we to say that whether the spirochete I have just mentioned is pathogenic depends on whether it is

on the skin of a South American Indian of that tribe or on that of a European?

If, frightened by such puzzles, we try to define the notion of disease without bringing in the notions of good and bad, we get into other difficulties. We might try, without mentioning the goodness or badness of the conditions, saying that they were diseases if they had, or were likely to have, certain specified alternative effects. For example, we might say to begin with that a condition is a disease if and only if it has a tendency to cause either pain or death or both. This obviously will not do, because a condition would be called a disease if it had a tendency to cause not pain or death, but, say, blindness. It may be said that if a disease causes blindness, it can tend to cause pain or death indirectly, because the blind are more likely to hurt themselves; but this indirect causation is irrelevant to our problem. We do not want to have to say that courage is a disease because it leads to the greater likelihood of being killed in battles.

Perhaps, in view of the blindness example, we should be moved to extend the definition a bit and say that a condition is a disease if it has a tendency to cause suffering (which will include pain and other kinds of suffering) or incapacity (which will include, as the extreme case, death; for only the dead are totally incapacitated). But then we are on a 'slide'. For what is to count as suffering or incapacity? Can we define those notions without bringing in the requirement that to count as an incapacity or as suffering, a condition has to be the cause of some effect which is thought of as *bad*?

I have raised enough problems, in this more or less unsystematic way, to make us think twice before swallowing too easily the arguments of writers like Szasz. He says that what has been called 'mental illness' is a 'myth'; physical illness, he says, is an established and acceptable concept, but the concept of mental illness has been invented by a false analogy with it. Szasz's ideas have led some psychiatrists to make drastic alterations in the way they treat patients; but we cannot know whether they are well founded unless we know whether we can share his assurance that the concept of *physical* health is a clear and incontestable one. I have been trying to cast some doubt on this assurance, not because I think that the concept of physical health is not perfectly viable, but rather because it may well be that, in the process of showing how it is viable, and what its definition should be, we shall discover that the notion of health so characterised is, after all, extensible to include mental health, for all that Szasz says. And that might make a very big difference to the practice of psychiatrists.

It is time now to be more systematic. I shall achieve this by considering first the approach to this problem of one of the parties to the philosophical dispute, and then, after pointing out some difficulties in this approach, giving my own view of the question, which is favourable to the other party, though with qualifications.

The approach I shall consider rests heavily on the notion of *natural function*. This is supposed to be a

purely descriptive notion – ie, we can, it is claimed, say which functions are natural without committing ourselves as to whether they are good or bad for the organism or for anything or anybody else. Professor Boorse has suggested a definition of 'health' which well expresses this approach:

An organism is *healthy* at any moment in proportion as it is not diseased; and a *disease* is a type of internal state of the organism which:

- (i) interferes with the performance of some natural function – ie, some species-typical contribution to survival and reproduction – characteristic of the organism's age; and
- (ii) is not simply in the nature of the species, ie is either atypical of the species or, if typical, mainly due to environmental causes (6).

He later gives a partial defining characteristic of 'illness' which distinguishes the meaning of this term from that of 'disease':

A disease is an *illness* only if it is serious enough to be incapacitating, and therefore is

- (i) undesirable for its bearer;
- (ii) a title to special treatment; and
- (iii) a valid excuse for normally criticisable behaviour (7).

Boorse thus distinguishes 'illness' from 'disease' by including evaluative terms like 'undesirable', 'valid' and 'title' in the definition of the latter. I have already indicated that the two terms are to be distinguished; but I do not agree with Boorse that this can be done by treating 'illness' as evaluative while keeping 'disease' descriptive; for, as I shall argue, 'disease' is evaluative too. But quite apart from this Boorse's definition of 'health' presents difficulties, of some of which he is aware.

What does 'internal' mean? As we have seen, a skin disease may be in no stronger sense *in* (ie inside) the organism than are maggots, which are not a disease. They are indeed, a condition of the organism; but this wider description will not bear the weight put upon it by Boorse's definition. Being hung in a noose is also a condition of the organism; it, likewise, interferes with species-typical contributions to survival and reproduction. The same is true of the condition of being tarred and feathered, and of being bitten by dogs or run over by lorries. None of these is a disease.

The difficulty is not overcome by clause (ii). If to qualify as a disease malaria has to be 'not simply in the nature of the species', then being tarred and feathered satisfies this condition. And if malaria, though typical, counts as a disease because it is due to environmental causes, then so would being hanged. There might be a sense of 'typical' in which malaria was typical but being hanged was not; but this would not help Boorse, because then being hanged would be 'atypical of the species', and so would not be excluded by clause (ii), and so, if it satisfied clause (i), as it does, would be a

disease. We shall return in a moment to these problems about what is species-typical, and shall see that the expression 'environmental causes', like 'internal', is too imprecise to bear any weight. A person is tarred and feathered by other people; he is caused to have skin diseases or malaria by fungi or other organisms; but where precisely is the difference? Boorse has not explained either what he means by 'internal' or what he means by 'environmental causes'.

However, as we saw, such difficulties with the definition of 'disease' are not going to affect the question of whether doctors should be professionally concerned with a condition. Whatever the cause of the condition, and whether it is inside or outside the skin, if it is a condition of the organism, and interferes with some species-typical contribution to survival and reproduction, doctors will be professionally concerned with it.

The expression '*state of the organism*' also presents a difficulty, albeit, perhaps, a somewhat pedantic one; are not some diseases processes rather than states? In so-called functional disorders, for example, there may be no state of the organism which causes the malfunction; there may be just the malfunction. But this difficulty I shall not press; it looks fairly easy to surmount.

Looking again at the numbered criteria (i) and (ii) in the definition of 'disease': they both contain the expressions 'species' and 'typical'. These terms have already given us trouble. What is the species, and what is typical of it? Species are subject to mutations; evolutionary changes occur. Some of the mutations give rise to what are called hereditary diseases; others alter the species, or produce a new strain of it, so as to cause that species or strain to multiply at the expense of others. Bacteria develop resistance to penicillin, and rats to the poison, warfarin.

How are we to say which of the changes due to mutations are diseases and which are not? Suppose that the change which makes rats resistant to warfarin is *in itself* (apart from producing this resistance) a minor impediment to reproduction and survival: in an environment free of warfarin, that is, the rats that had not been affected by this change would be more likely to survive than those that had; whereas, of course, if there is warfarin around, the ones that have mutated survive and those that have not are killed by the poison. A somewhat similar situation obtains in the case of sickle-cell anaemia and malaria: if there is malaria around, one is more likely to survive if one has sickle-cell anaemia, but if there is no malaria, those who have sickle-cell anaemia are a bit less likely to survive and reproduce.

Does it depend on the presence or absence of warfarin in the environment whether we say that the rats who have suffered the mutation (if the latter is in itself a minor impediment to reproduction or survival) are the victims of a hereditary disease? In both cases the mutation will be, by definition of 'mutation', atypical of the species. So it will satisfy condition (ii). So if, given the warfarin, the mutation is conducive to

survival, but without the warfarin it is inimical, we might think that it does so depend. However, Boorse can escape this difficulty in the same way as we escaped the difficulty about the soldier with malaria. He can say that the mutation is a disease because *other things being equal* it is inimical to survival and reproduction; but the presence of warfarin makes other things not equal.

Another difficulty with the expression 'species-typical' is this: there are certain diseases which *are* typical of certain species. Only elm trees get Dutch elm disease. So, if Boorse had not put in the phrase 'or, if typical, mainly due to environmental causes', he would have been open to the objection that, on his definition, Dutch elm disease would not be a disease, because it is typical of that species, or in the nature of that species.

Actually, however, the phrase does not help him out of the difficulty. For it is hard to say what is or is not due to environmental causes. Ultimately, I suppose, everything is. An individual is literally produced by its environment, including, first of all, its parents, ie their reproductive mechanisms; secondly the other causes, such as nutrition, water, air, warmth and so on, which are necessary for its growth and survival. So everything that happens to it is due to environmental causes. What Boorse seems to mean is that, given an already existing individual at a certain stage of its development, changes which are to be called diseases have to be produced by *new* environmental factors at that stage. But even this will not do to make the distinction. Nearly everything that happens to the organism at a given stage in its development is due to an interaction between the organism and its environment. So Boorse's definition might count as diseases some conditions which are not diseases. It might also exclude some which are. A hereditary disease which became apparent, without any further damage arising from the environment, at a certain age, would not count as a disease.

A further difficulty is raised by the expression 'characteristic of the organism's age'. Boorse's purpose in putting this in must be to avoid the objection that some natural changes, for example the menopause, are inimical to reproduction but are not diseases. He can get over this difficulty by saying that it is not characteristic of ages over fifty to bear children, and therefore the menopause which prevents this is not a disease unless it occurs at an unusually early age – when no doubt it *would be* called some kind of pathological sterility, and any condition which resulted in this would be likely to be called a disease.

The same applies to survival: species have a natural life-span, and to die what is called a 'natural death' after that span is over is not disease. But this might be contested. It might be said that nobody dies literally of old age; we all die of one disease (or injury) or another. So there is no age of which, for example, breathing, which is a natural function, is not characteristic. Yet it might also be said that it is uncharacteristic for someone to be breathing at the age of 120, so that a man who survived to the age of 119 and on his next birthday contracted pneumonia would not, on Boorse's

definition, be entitled to call it a disease, since it did not interfere with any natural function characteristic of that organism's age.

Let us, however, waive these subsidiary difficulties in Boorse's definition, some of which, as we have seen, he might overcome, and some of which would affect other definitions besides his – even those which introduced evaluative concepts like 'bad', as I shall later be doing. We must now come to the most difficult phrase, 'natural function'. How are we to tell whether functions are natural or not? Boorse glosses 'some natural function' by the phrase 'some species-typical contribution to survival and reproduction'. But this will hardly do. There are some functions which, though natural enough, do not contribute to survival or reproduction. The growing of hair on the legs seems to be a natural function, and it seems that a condition which prevented it might, if caused by some organism, be called a disease (though in a moment we shall find reason to qualify this suggestion). But how does hair on the legs contribute to survival or reproduction? I do not believe that the ladies who shave it off find it harder to find boy-friends.

It may be that such a condition would be called a disease by analogy with one causing baldness, which would naturally be so called. But baldness too is not inimical to survival or reproduction. The reason why we call conditions causing it diseases is simply that people do not *like* being bald. It is evident from this example that at least part of the differentia between pathological and non-pathological conditions is that the former do, and the latter do not, result in something *bad* for the sufferer.

Suppose that the genetic engineers developed an organism, guaranteed not to spread from one part of the body to another or to other people, which had this effect of preventing hair growth; and suppose that it came to be sold commercially as a depilatory for use on women's legs. Would we then, or would we not, call the condition which it induced a disease? I suspect that, if we did, we should put quotation marks round the word, and would hesitate to say that the skins of the ladies who used it were not healthy. Doctors would probably not concern themselves with this condition if it were thought *harmless*.

If it is true that we would call the condition producing baldness a disease, but would hesitate to use this word of the depilatory-induced condition, this may be an indication that the differentia between pathological and non-pathological conditions is the *badness* of the effects of a condition, and not its interference with survival or reproduction, nor with natural function. For in neither example is there interference with survival or reproduction; and in both there is interference with natural function in the ordinary sense of that expression. It is the fact that the ladies want to get rid of their hair, but balding men want to keep theirs, that makes the difference.

There seems, then, to be missing from Boorse's definition of 'disease' as cited, and thus of 'healthy', an

element which he does include in his definition of 'illness': the evaluative element. He is compelled to rely so heavily on the rather wobbly notion of natural function because he wishes to avoid saying that what makes us classify conditions as diseases is that *in general*, though not always in particular cases, they are *bad* things for the patient to have. This in itself is not enough; for otherwise, as we have seen, we should have to call dog-bites diseases. But given that the other criteria are satisfied (and I have not been able to give more than hints as to what they are) we seem to classify conditions as diseases if and only if they are bad things for the patient, in general.

At this point it may strike us that one is perhaps being over-ambitious if one thinks that one will be able to capture our understanding of words like 'health' and 'disease' in cut-and-dried definitions. Wittgenstein has made us familiar with the idea that a word may have a spread of meanings; there are a whole lot of conditions for its use, and perhaps none of them is necessary or sufficient. On a particular occasion the word will be understood although one of these conditions is absent. So although, for example, a word like 'disease' is used of men and of other animals and of plants in the same sense, in a way, yet in another way it is being used in subtly different senses. Understanding its use consists, not in being able to propound a hard-and-fast definition which will work for all cases, but in having learnt to recognise all these conditions, and when they are present or absent in a particular case. Doctors should not need reminding of this, because they will often agree that a patient has, say, dengue, even though one of the common symptoms of that disease is absent, provided that he has the rest.

So I shall not insist that in every case where we call a condition a disease it has to be in general bad for organisms to have it. I shall merely claim that this is one of the standard constituents of the notion: a person who did not know that it was would not understand the notion. And this gives the clue to the importance of the concepts of disease and health, which is more than theoretical or academic.

'Bad' is what moral philosophers call a normative or evaluative word (I myself often use the term 'prescriptive'). To call a thing bad is to imply that it has qualities which, other things being equal, *ought* to be avoided or remedied in things of the kind in question. If I have bad eyesight, for example, I ought to go to the oculist and he ought to prescribe spectacles if they will make my eyesight better. So if 'illness', 'disease' and 'health' involve standardly the notions of 'good' and 'bad', the classification of conditions as diseases is going to have great practical importance. It will determine what actions we think we ought to take with regard to people who have them. If a person has a disease, and we know, and can remove, its cause, or in other ways cure the disease, then, other things being equal, we ought to do so.

This explains the attraction of the expression 'mental illness'. It came into fashion at a time when

people began to be more optimistic about *curing* such conditions, because they thought they were on the way to discovering their *causes*. The present reaction against the notion is due to a disillusion, in certain quarters, about both these dreams. The actions which seemed to be called for, once we had classified certain mental conditions as diseases, turned out to be either unsuccessful in curing them or objectionable for various reasons, or both.

We can perhaps begin to understand the point at issue between the two sides in this dispute by considering the following form of argument:

0) *A* (a person) exhibits observable features *F* . . . *F*
 So *A* has a condition *C*
 But *C* is a disease
 So *A* is not healthy
 But *T* is the treatment most likely to remove *C*
 So *A* ought to be given *T*.

This, it might be thought, gives the form of the inference which all doctors make when they decide what to do to their patients. *F* . . . *F* might be, for example, high temperature at two-day intervals, and the presence of a certain organism in the blood; *C* might be malaria; and *T* might be the giving of quinine or one of its more up-to-date successors.

The inference then becomes:

1) *A* has a high temperature at two-day intervals, etc.
 So *A* has malaria
 But malaria is a disease
 So *A* is not healthy
 But giving quinine etc is the treatment most likely to remove the condition
 So *A* ought to be given quinine.

But now suppose that we use the same form of argument in some cases which are not physical but mental 'diseases'. We then have, for example:

2) *A* is at recurrent periods intensely dejected, apathetic, wakes early, etc
 So *A* has depression
 But depression is a (mental) disease
 So *A* is not (mentally) healthy
 But giving amitriptyline is the treatment most likely to remove the condition
 So *A* ought to be given amitriptyline

This looks all right; and one wonders at first sight what Szasz and his supporters find to object to in it. We may perhaps be able to find a clue if we consider, not this example, but some others which look more dubious:

3) *A* is unable to conform to certain expected patterns of behaviour
 So *A* has schizophrenia
 But schizophrenia is a (mental) disease
 So *A* is not (mentally) healthy

But giving ECT is the treatment most likely to remove the condition (assuming for the moment that this is true, though many psychiatrists might doubt it; see below)

So *A* ought to be given ECT.

4) *A* is sexually excited only by members of *A*'s own sex
 So *A* is a homosexual
 But homosexuality is a (mental) disease
 So *A* is not (mentally) healthy
 But aversion therapy is the treatment most likely to remove the condition
 So *A* ought to be given aversion therapy.

And lastly, for good measure:

5) *A* goes round criticising the regime
 So *A* is a political deviant
 But political deviancy is a (mental) disease
 So *A* is not (mentally) healthy
 But confinement in a mental hospital with frequent doses of apomorphine is the treatment most likely to remove the condition
 So *A* ought to be confined in a mental hospital and given frequent doses of apomorphine.

Most of us, I suppose, have qualms about 5), and for some of us these qualms extend successively to 4), 3) and even 2). We have here another 'slide'. The trouble is that we cannot find any firm line on which to dig in our heels and stop. Szasz wants to stop the slide right at the beginning, at the transition between physical and mental illnesses. If we find this unacceptable, we shall have to find some other stopping place, and what is much more difficult, give reasons for stopping there.

The earlier part of this paper ought to have suggested to us a factor which, if we pay attention to it, enables us to stop the slide fairly easily and on good grounds. This is the *evaluative* character of the term 'disease' on which I have been insisting. The third line of each of the above inferences says that a certain condition is a disease. Supposing that the condition has been descriptively defined by an enumeration of the observable symptoms which are necessary and/or sufficient conditions for diagnosing it, this third line will be the first value-judgement in the inference. It does not follow in strict logic from the previous lines (which is why I have begun the third line with 'But' and not with 'So'). We are introducing a new, independent, and in this case evaluative, premiss.

The important thing to notice is that, when we introduce an evaluation into an argument, it makes a difference *whose* evaluation it is. In inferences 1), 2) and possibly 3) it is fairly clear that it is going to be an evaluation made by the patient. It is the patient who deems it bad that he should be in the condition in question. So those inferences rely on a third step to which the patient may be presumed to agree, and therefore their conclusions, given the truth of the factual premisses in the first and fifth lines (on which

the doctor is the authority) are likely to secure his agreement too.

I say 'are likely to' because the operation of the *ceteris paribus* clauses mentioned earlier has to be allowed for. If the patient is a soldier who, if cured, will be sent back to the battlefield and killed, he may agree that the skin infection he has is a disease, because it is *ceteris paribus* and in general bad for people to have; but he may not think the doctors ought to give him whatever would cure it, because this will result in harm to him. In this case, where all are subject to military discipline, it might be held that all have a *military duty* to co-operate in the cure of the disease; but this has nothing to do with the duty of the doctor *qua* doctor, as can be seen by considering a civilian patient with the same disease who for some reason does not want it cured. In that case the doctor would be doing wrong to cure it against the patient's wishes, unless there is a serious danger of harm to others through his or her infecting them.

There is also the possibility, ignored in the above schematic inferences, that the treatment might have side-effects which the patient did not wish to undergo. Mention of these (perhaps by including them in the fifth premiss) would make this premiss evaluative, if they were specified in evaluative terms. If, on the other hand, they were specified in descriptive terms, we should have to add an additional premiss saying that these side-effects were preferable to the continuance of the condition. In either case, we should have an additional evaluative premiss to which, also, the patient would have to agree if the conclusion were going to follow for him. This complication could be dealt with, but in the interests of simplicity I shall ignore it. It is likely to affect the later inferences more than the earlier, and provides an additional reason for a reluctance to follow them. But the main ground for distinguishing them, and thus stopping the slide, is the evaluative character of the third premiss.

Attention to this evaluation will enable us to differentiate clearly between inferences 5) and 1). The 'patient' in 5) will not agree that political deviancy is a disease, because he will not agree with the evaluation of members of the regime who so label it. So the psychiatrists will be doing wrong to try to 'cure' it against the patient's wishes; it will be a breach of *another* principle, that of political freedom, to which we all attach importance. Inference 1) does not breach this principle, simply because the patient agrees with the evaluation in the third line.

This sheds light on inference 4). If the patient agrees that homosexuality is a bad condition to be in, he may agree that it be labelled a disease; and then, if he takes the doctor's word for the fifth premiss, he will agree with the conclusion of the inference, and willingly undergo aversion therapy. But if he does not mind, or even likes, being in that condition, he will not agree, and it will then be an infringement of liberty to make him submit to aversion therapy.

A difficulty is presented by the fact that there are two distinct reasons why he may think it a bad condition to

be in. One is that he would like to fall in love with members of the opposite sex and detests his abnormality as such. The other is that he suffers social or even legal disabilities because of the condition, and, though he does not in the least mind being a homosexual as such, wants to avoid these disabilities. In the second case his predicament could be made tolerable, without altering the condition, by altering the law or social attitudes. It is a political and moral question, not a medical one, whether this ought not rather to be done. Doctors should be grateful to a philosopher who makes this point clear; for he thus relieves them, *qua* doctors, of the responsibility for answering this moral and political question, while, of course, leaving with them the responsibility which they share with all other citizens for answering it.

Now consider 2). Having clarified the evaluative character of the third line, we see that patients are just as likely to agree to it as they are to the corresponding line in 1), and therefore to welcome the treatment. So we can perhaps, in standard cases where such agreement will be forthcoming, classify 2) with 1).

In inference 3), there is often a difficulty in ascertaining the wishes of the schizophrenic patient; and this makes the case more problematic than 2). In the film *Family Life* (8) it was suggested that it was not the patient that made the necessary evaluation, but the patient's parents, backed up by society and its agents, the doctors. If that were so, then the liberty of the patient would be being wrongly infringed. But the makers of the film and the anti-psychiatrists who inspired them were hinting that this is *always* the case where ECT and other strenuous treatments are given. I believe this to be a gross exaggeration. Indeed, from recent articles in *The Times* (9), it looks as if the latest Mental Health Act, which was partly motivated by the sort of thoughts which the film aims at engendering, may have gone too far in the direction of protecting individual liberty. The articles suggest that in some cases schizophrenic patients cannot get the help they need because psychiatrists are too reluctant to do anything which would incur a charge of undue interference.

But the main trouble still is that we do not know enough either about schizophrenia (which may not be a single disease at all but a family of diseases), or about the effects of ECT. If we knew more about both these things, we might be able to be more certain about the first and fifth lines in the inference, and thus form a sound judgement about whether the treatment ought to be used in a particular case; these difficulties are the concern of the medical researcher rather than of the philosopher.

However, one difficulty, already mentioned, would remain. Many mental patients are in no state to give an opinion as to whether their condition is a bad one to be in. In many cases the psychiatrist, if he is to care for the patient at all, cannot avoid judging *on behalf of the patient* whether it is bad. The case resembles that of children. If a child has an incipient but so far not

painful disease, his parents and the doctor may rightly begin treatment in the assurance that if the patient knew the facts about what would happen if the treatment were not given, he would agree in accepting the third premiss and therefore the conclusion of the inference.

It is an attraction of the move I have made that it deals with inference 2); but it cannot be extended to inferences 4) and 5), because in those cases, we may presume, the 'patient' already knows all the relevant facts. In case 3), if we were better informed about the causes and cure, (or cures) of schizophrenia, we should at least be able, with more confidence than at present, to set out the prospects for the patient if one or another treatment were used, in factual terms. This would, however, leave us in ignorance as to what the patient would wish done, were he in possession of this information.

I should guess that a great many schizophrenic and other mental patients could, if the information I have postulated were available, give the doctor an idea of what they wanted; and this should be respected. Cases where this is not so have to be assimilated to those of children. If the patient is unable to form a correct factual picture of his own situation and prospects, there is nothing that the doctor can do, if he is going to care for the patient, but judge, in the light of the patient's situation, what the patient *would* wish if he were able to form such a picture. I stress that by 'factual' I mean 'factual'. It is not within the doctor's province to import his own evaluations into the patient's supposed judgement of his situation.

There is obviously a lot more to be said about this. I have tried only to show, from the point of view of a philosopher, how we might *begin* to handle questions like these. I hope I have said enough to indicate why I think that the wholesale rejection of the concept of mental illness, and of psychiatry with it, was too hasty. Mental health and disease have enough in common with physical health and disease to make them proper fields for the exercise of medical skills. But in order to

show this I have had to examine the concepts of health and disease in greater depth than might have been thought necessary – though in fact I have only scratched the surface.

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References and notes

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- (3) Boorse C. Health as a theoretical concept. *Philosophy of science* 1977; 44: 552.
- (4) See my article Supervenience. *Proceedings of the Aristotelian Society*, 1984; supp vol 58: 11 ff.
- (5) See Sedgwick P. Illness, mental and otherwise. *Hastings Center studies* 1973; 1, 3: 32, citing Mechanic D. Medical sociology: 16. I have profited from other papers in this issue.
- (6) What a theory of mental health should be. *Journal for the theory of social behaviour* 1976; 6: 62 ff.
- (7) See reference (6) and On the distinction between disease and illness, *Philosophy and public affairs* 1975; 5: 61. I cite Boorse's definitions in these earlier papers because they well illustrate our problem. I shall not have room here to discuss his arguments in full detail, nor his later writings, in which he has developed his views in the direction of treating *both* illness *and* disease as purely descriptive concepts, and has defended them further. See his Health as a theoretical concept (cited above), reprinted revised in Caplan A L, Engelhardt H T, McCartney J J, eds. *Concepts of health and disease*. Reading: Addison-Wesley, 1981: 560, and Concepts of health in Regan T, VandeVeer D, eds. *Border crossings* (forthcoming).
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