Special Section: Open Forum

Normal Functioning and Public Reason

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Introduction

Many people agree that social justice requires meeting population health needs fairly under resource constraints. On Norman Daniels's view, meeting health needs means promoting species-typical normal functioning. Moreover, Daniels argues that health needs can be distinguished from other kinds of human needs and interests with sufficient objectivity by employing the methods of the bio-medical sciences. This thesis is supported by a philosophical analysis of the concept of health that ascribes importance to naturalistic accounts of normal functioning, while allowing values to play a secondary role in the definition of what counts as disease. I shall point out that the justification Daniels offers for relying on a naturalistic approach in defining such contested boundary is flawed.

Daniels's theory draws a line between bona fide health needs and adventitious or course-of-life needs, those that are contingent on individual life plans or desires. He argues that human societies have a general duty of social justice to meet citizens' health needs, but not their adventitious needs. A reasonably clear distinction between health needs and other kinds of human needs—Daniels argues—can be defined with sufficient objectivity, relying on the methods of the biomedical sciences.[1,2]

On the one hand, the distinction between normal functioning and pathology defines a political obligation to meet health needs that can be administered in the real world and that society can afford. By contrast, a definition of health as "a state of complete physical, mental and social well-being,"[3] as in the WHO definition, leads to a thousand and one conflicts over the social commitment to providing a decent level of healthcare. For instance, the WHO definition leaves room to argue that public funding for cosmetic surgery and other enhancements are duties of health justice, a claim dismissed by many people otherwise committed to funding universal healthcare.

On the other hand, the centrality of an account of normal functioning, in this approach, has troubling ethical implications. Daniels is willing to let the *limits* of certain kinds of moral duties be decided by scientific arguments, eschewing appeals to other kinds of arguments and values. One may balk at this aspect of Daniels's prescription for health policy. After all, the claim that the distinction between health and disease can be considered ordinarily scientific relates to one of the most hotly debated questions in the philosophy of medicine.[4,5]

What reasons does Daniels's argument have on its side? He argues that extreme normative views (those not constrained by a naturalistic account of normal functioning) are a threat to public agreement concerning the primary role of healthcare.[6] What he means is that it is impossible to share a reasonable view of the proper limits of the societal duty to meet the needs of citizens (as a matter

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of justice) if the definition of health needs does not rely, at some stage or another, on a naturalistic account of normal functioning. This limits the range of considerations that can enter the definition of people's health needs and the range of interventions that can be considered pertinent to the primary rationale of healthcare.

In what follows, it is argued that Daniels's argument for relying on the allegedly scientific distinction between normal functioning and pathology is flawed. As an alternative, I sketch out a political approach to the problem of defining health needs that is hospitable to conceptions of health that are normative all the way down.

Daniels's Argument

Daniels argues that a definition of health needs that is not "constrained by an independent account of departures from normal functioning"[7] contradicts linguistic practices or conceptual intuitions about what we mean by "health." Notice that, in mentioning an "independent" account of normal functioning, Daniels means a *naturalistic* one.[8]

This argument can be rejected by showing that it rests on a conflation of two senses of *strong normativism*. Strong normativism A is the simple view that disease just is an unwanted condition. Daniels allegedly presents a convincing argument that strong normativism A is intuitively implausible.

Strong normativism B, by contrast, is the view that the definition of disease and disability need not presuppose any *naturalistic* account of normal functioning. By rescuing only weakly normative theories of health (described in what follows), Daniels commits to rejecting strong normativism B, as well as strong normativism A. But his argument has teeth only against strong normativism A, or so it is argued herein. Daniels offers no reason to reject strong normativism B. Yet strong normativism B and weak normativism have strikingly different implications concerning the role played by moral (and other normative) reasons in public deliberation concerning health needs.

To show that the two forms of strong normativism are different, I produce examples of definitions of health and disease that qualify as forms of strong normativism B, but not as forms of strong normativism A.

The first example is based on Elselijn Kingma's[9] argument that the choice of the reference classes (sex and age, relative to which biological normality is defined) is arbitrary from a naturalistic point of view. I argue that the mere *possibility* of selecting reference classes on normative grounds implies that there can be a view that is a form of strong normativism B, but not a form of strong normativism A. The second example is constructed by pointing out that the definition of the "normal" range of functional performance as, say, falling two standard deviations below the population means, can also rest on normative grounds. Again I do not argue that it *must* rest on normative grounds. Rather, the mere possibility of a normatively based choice implies that there can be a view of disease that is a form of strong normativism B, but not of strong normativism A.

Naturalistic and Weakly Normative Theories of Health

Christopher Boorse maintains that health, understood as the absence of pathology, should be considered a value-free notion.[10,11,12] In his 1985 book *Just Health Care*,

Daniels endorses Boorse's theory as far as the definition of the concepts of health and disease is concerned.[13,14] However, Boorse's view remains a highly controversial position in the philosophy of medicine, and in later years Daniels has taken further steps to distinguish his approach from Boorse's, making it more inclusive. Daniels claims that his solution is compatible with some, but not all, analyses of the concept of health that employ value notions. The acceptable ones, for Daniels, are those according to which nothing counts as a pathology that does not represent a deviation from *normal species functioning*, defined in naturalistic terms. In this way Daniels can include views—such as Wakefield's—that define disease as a condition that is both dysfunctional and harmful to its bearer.[15,16] On Wakefield's view, for instance, dyslexia (a departure from normal functioning) does not count as a disease in the illiterate societies in which it does no harm.

To sum up, Daniels's view of the health *concept* does not demand that everyone accept a purely naturalistic definition of "disease." It is compatible with full-blown naturalistic conceptions such as Boorse's, but it is also compatible with weak normativism, given that weak normativism (like Daniels's own definition of health needs as amounting to an *opportunity-reducing* pathology) takes the characteristic of being a departure from normal functioning as a *necessary condition* that must be satisfied for something to count as a health need. That is, one can accept Daniels's normal function framework even if one maintains that not all departures from normal functioning are diseases, but only those that harm a person. After all, weakly normative views also presuppose a naturalistic description of dysfunction, pathology, or departure from normal functioning. In any weakly normative definition of disease, the content of this naturalistic module is by definition independent from normative assumptions; thus when defining health needs for policy purposes, Daniels can appeal to the naturalistic module shared by both naturalistic and weakly normative views.

Finally, Daniels discusses and rejects normative views that do not share the naturalistic module, arguing on conceptual/linguistic grounds that they are utterly implausible. To sum up, Daniels wants to be able to claim that his solution to the problem of defining health needs is compatible with all sound philosophical analyses of the concept of pathology, whereas the theories with which it is not compatible (those not constrained by any naturalistic account of normal functioning), being utterly implausible, pose no serious threat to the public acceptability of his view.

The Problem of Reference Classes

Kingma's argument attempts to show that the concepts of normal functioning and pathology, as characterized by Boorse, are not value-free. My argument is independent of the validity of her conclusion. I want to draw attention to her argument because it shows a way of constructing full-blown normative conceptions of health and disease that are immune from Daniels's objections.

Kingma claims that Boorse's definition of normal functioning is not naturalistic because it relies on a choice of reference classes (sex and age) that cannot be justified in a naturalistic perspective. Roughly speaking, Boorse's definition of health states that a part or process of an organism is healthy when it functions normally for that kind of organism. The function of that process or part is defined by its statistically typical contribution to the survival and reproduction of all organisms belonging to the same species *of the same sex and age group*. The relativization to sex and age is

necessary to account for the fact that a function or trait we call healthy in a female organism at age 2 may differ from a function or trait we call healthy in a male organism at age 40. Thus, Boorse defines normality within classes that are more restricted than that of the species, namely age groups within a sex of the species.[17,18]

Kingma argues that the selection of sex and age as reference classes cannot be justified in a naturalistic perspective. There is no way within naturalism to show that sex and age (or, better, only sex and age) fit the general definition of reference class given by Boorse, namely that of "a natural class of organisms of uniform functional design."[19] Kingma argues that the idea of a "natural class of uniform functional design" does not belong to biological science.[20] Thus, *no* particular choice of reference classes is more justified than any other, from a naturalistic point of view.

The choice of reference classes is a crucial element in Boorse's definition of normal functioning, because different reference classes imply different boundaries between normal functioning and pathology. For instance, if the group of deaf people is selected as a reference class, deafness becomes the statistically normal performance of the hearing function for members of the nonhearing reference class and hence ceases to be a pathology. This is politically relevant because some deaf people might view themselves not as pathological but as members of a cultural minority. Assuming deafness as a reference class in Boorse's analysis of disease, the deaf-culture argument that deafness should not be considered a pathology turns out to be analytically true. The answer to the question of whether deafness is pathological depends on a prior choice of reference classes. In Boorse's framework, the question of whether deafness is a reference class must be answered before the question of whether deafness is pathological.

Kingma argues that because the former question does not admit of a naturalistic answer, the latter does not either.[21] Hence, the question of whether deafness ought to be considered a pathology or a cultural trait is not one for biology to decide. I do not rely on this conclusion as a premise of my argument. The argument I develop on the basis of Kingma's idea of an arbitrary choice of reference classes is independent of whether the selection of sex and age can indeed *only* be based on normative considerations (as Kingma argues) or can be justified naturalistically (as Boorse holds).

My argument rests on the weaker premise that reference classes *could* be selected on normative grounds. If so much is conceded, there is room for a normative debate on what reference classes ought to be. For example, according to Boorse, homosexual inclinations are deviations from normal functioning, because people with such inclinations tend to reproduce less than people with statistically normal—that is, heterosexual—ones.[22] But the classification of homosexuality as pathological logically depends on the choice of reference classes. Let us now consider a scenario in which sexual inclination is regarded as a reference class, an example Kingma herself discusses.[23] We can call it Xoorse's definition, and it is identical to Boorse's, except that it includes an additional reference class, namely sexual inclination. The normal function of sexual inclination for members of the reference class of male homosexual human beings aged 30–40 is the statistically normal performance of sexual inclination among homosexual adult male human beings—"performance" being a shorthand for "contribution to survival and reproduction" (the characteristically biological goals of organism). If the reference classes are indeed age, sex, and sexual inclination, Xoorse's view entails that

homosexuality is not pathological. Homosexual inclinations contribute nothing to reproduction, but in the reference class of homosexual people, that is normal. Thus, like menopause, it is the normal condition relative to the relevant reference class.

Unlike the case for deafness being a mere difference, the case for homosexuality *not* being a pathology is nowadays less controversial than the opposite one. One could ask how Daniels could commit himself to the opposite view, seeing as, in 1985, he seemed committed to Boorse's conception of health. Actually, neither Daniels nor Boorse approved of medicalizing homosexual inclinations, and this is compatible with the naturalistic view of normal functioning they both endorse(d). For instance, Boorse claims that his classification of homosexuality as a pathology should be understood as a theoretical and descriptive claim, which has no practical and prescriptive implications. According to him, the claim that homosexual inclinations deserve clinical attention is a prescriptive one, and it does not follow from the claim that homosexuality is pathological. The latter states a value-neutral fact that is deprived of practical implications as such. The former states a prescriptive claim, which follows if one supplements the missing normative premise that all pathologies deserve clinical attention. Boorse rejects the normative premise, on account of its morally controversial implications.[24,25]

Boorse's and Xoorse's account of normal functioning differ as to whether homosexuality should be considered a deviation from normal functioning. Now suppose that some disputes arise as to whether homosexuality should be regarded as a pathology, in general. Boorse's definition implies that (a) the answer logically depends on the answer to the prior question of whether sexual inclination is a reference class; moreover, Kingma also argues that (b) no scientific answer to the latter question exists. Obviously, one can accept (a) without accepting (b). All that is needed for the sake of my argument here is (a). More precisely, I shall rely on (a) and remain agnostic on (b).

Against Daniels's Argument against Strong Normative Views

Daniels claims that if disputes arise concerning how to draw the distinction between normal functioning and pathology, they can be solved by appealing to "the publicly accessible methods of biomedical sciences."[26] How are scientists to decide between Boorse's and Xoorse's account, if either choice is equally justifiable—and therefore equally arbitrary—from a naturalistic perspective? If alternative boundaries are all equally arbitrary from a naturalistic standpoint, then such disputes cannot be resolved by appealing to the methods of biomedical science alone. This is a possible argument against Daniels's position, but it is not the argument I develop in what follows. It presupposes Kingma's conclusion (b), namely, that Boorse's choice of sex and age cannot be justified based on naturalistic considerations. A thorough examination of the truth of (b) involves a careful examination of a debate in the philosophy of biology that lies outside the realm of public reason. By this I mean that one cannot expect reasonable people making use of their best philosophical skills to reach a stable and binding agreement on such questions. By "reasonable people" I mean those who are willing to seek unforced agreements with others on matters of basic justice (including equal opportunities and societal provisions of healthcare) while remaining aware of their cognitive limitations on ultimate philosophical matters (what Rawls calls "the burdens of judgment").[27] Relative to the burdens of judgment, ultimate questions in the philosophy of biology are just

like ultimate questions in the fields of religion or metaphysics. Fortunately, it is not necessary to grant the truth of (b) to claim that Daniels's linguistic/conceptual argument is wrong, as I shall do.

Daniels claims that definitions of health and disease that are not constrained by an independent (naturalistic) account of normal functioning fail to explain the distinction between health needs and other kinds of needs.[28] Even after relaxing his commitment to Boorsian naturalism, Daniels claims that his approach is only compatible with *weakly* normative accounts of disease (those constrained by a naturalistic module): "It will not matter if what counts as a disease category is relative to some features of social roles in a given society, and thus to some normative judgments, provided that the basic notion of normal functioning is left intact."[29] Reasonable people may endorse normative views of health and disease, including, possibly, normative conceptions of normal functioning. What argument can Daniels offer them, to show that they should appeal (in public debates about justice and health) to a conception that "can be reformulated into a nonnormative (or naturalistic) distinction between normal functioning and pathology"?[30]

It cannot be plausibly claimed that naturalism is implicit in the public political culture of democratic society, nor can he maintain that it is entailed by scientific results that are not controversial within the scientific community, as required by the Rawlsian standard for the burdens of judgment.[31] Would the linguistic/conceptual argument at pages 40–2 of *Just Health* do the job?

In many passages, it is not clear what Daniels means by "the extreme normative view,"[32] his self-styled polemical target. On the one hand, it is contrasted with the weakly normative view, that is, one featuring both a normative component and an (independent) naturalistic account of normal function(ing). On the other hand, it seems to have a narrower meaning, namely, the view that "a disease is just an unwanted condition,"[33] that is, strong normativism A, according to our definition. But the two polemical targets—views according to which a disease is just an unwanted condition (strong normativism A) and views that are not constrained by a naturalistic account of normal functioning (strong normativism B)—are conceptually distinct. As opposed to what Daniels's analysis presupposes, there are four, not three, distinct categories of definitions at stake:

Naturalism: Disease is a departure from normal functioning (naturalistically defined).
Weak normativism: Disease is a departure from normal functioning (naturalistically defined) that causes harm or reduces the individual's opportunity range.
Strong normativism A: Disease is an unwanted condition.
Strong normativism B: Disease is a departure from normal functioning (normatively defined) or a departure from normal functioning (normatively defined) that causes harm or reduces the individual's opportunity range.

Daniels provides an argument against strong normativism A when it is addressed to all reasonable people; namely, he argues that it is linguistically or conceptually inadequate—it cannot explain why people are comfortable, in practice, with the distinction made by clinicians, healthcare practitioners, and insurance companies between pathological conditions and merely unwanted or undesirable ones.[34] Daniels cites several instances of the recognition of such distinctions: the cases of women who desire a breast enlargement for aesthetic reasons but acknowledge

that small breasts cannot be regarded as a pathology; clauses in insurance contracts requiring that fully subsidized medical treatments address medical needs; and finally, the agreement of a political committee not to regard pregnancy as a pathological state, despite the fact that the members wanted abortions for undesired pregnancies to be fully covered by medical insurance.[35]

Let us concede that the linguistic/conceptual argument against strong normativism A is correct. But strong normative views of kind B are different, because they do not entail that diseases are just unwanted conditions. Let us analyze some examples in detail.

Suppose, for the sake of the argument, that our imaginary biologist and philosopher of medicine, Xoorse, argues that the class of people with homosexual inclinations should be considered a reference class. Suppose she adopts this position out of a concern for the public image of homosexuality. Her reason for the choice of reference classes is a pragmatic, not a scientific, one. Xoorse is fully aware that, strictly speaking, Boorse's categorization of homosexuality as a pathology does not imply that homosexuality deserves clinical attention, nor does it imply any form of discrimination against homosexual persons. Yet she fears that many people would draw the wrong conclusion from calling homosexuality a pathology (as it is common for people to lack logical sophistication). Suppose this is a good enough pragmatic reason to treat homosexuality as a reference class. The choice is dictated by bona fide normative considerations. Xoorse's view is bona fide value-laden and normative all the way down.

Does Daniels's argument against the extreme normative view show that strong normativism B is implausible? To answer this question, let us ask again, what would change in practice if Xoorse's views were accepted? Suppose that her views were adopted by the medical community and society at large. Would this amount to abandoning the distinction between unwanted traits and pathologies? For an answer, consider Xoorse's definition of diseases: a feature x of a part or process of a person's body is a health need if and only if x counts as a deviation from the normal function of that part or process in the human population of the same age, sex, and sexual inclination as the person whose feature it is.

Normative definitions of health needs à la Xoorse can establish the needed boundary between health needs and other kinds of needs or desires. If someone wants to get rid of a large nose, it is not a pathology, according to either Boorse's or Xoorse's definition. Consider a 35-year-old lesbian who would like to get rid of her homosexual inclinations on religious grounds. According to Boorse, this circumstance would be a pathology, but probably not one deserving clinical attention; according to Xoorse, it would be an unwanted condition but not a pathology.

Indeed, within Xoorse's framework, the difference between health needs and other unwanted conditions can be expressed in categorical terms for any possible condition: health needs are *necessarily* deviations from normal human functioning (defined à la Xoorse), whereas bare, unwanted conditions are not.

A similar argument applies to the statistical definition of the normality range. It is tempting to argue that Boorse's concept of normal functioning can *only* be normative, because no biological description of the world fixes the amount of standard deviation from the mean that defines the normal range. The performance of some biological functions (their contribution to survival and reproduction) has a normal (bell curve) distribution. Take IQ, for example. Some people would claim that defining the normal intelligence range as falling so many standard deviations

below the population average is an arbitrary social convention, one that does not carve nature at its joints. The same level of intelligence could be classified as normal or pathological if a different convention were adopted.

Maybe we can establish that such and such a departure from the mean is pathological based on purely naturalistic considerations: I will remain agnostic on this point. But suppose that in actual fact the threshold were only justified by invoking pragmatic considerations, including moral considerations about moral hazard and reciprocity. Imagine a community that wants to protect the opportunities of people with a low IQ, those who appear to have significantly worse opportunities than most. They realize there is a continuum, and any threshold is somewhat arbitrary (is there any significant difference between a score 70 and a score 72?). But they also want to adopt a conceptual framework in which people with IQ around the average cannot demand cognitive enhancements as compensation for their natural disadvantage against a more intelligent competitor. Social equality—they maintain—does not require a *perfect* leveling of the playing field. They set a statistical threshold corresponding to 70 IQ points as a practical guide; because they are aware of the arbitrariness of any cutoff point, they are committed to treat any borderline case with special attention, when the occasion arises.

This not-so-fictional community relies on normative considerations to justify the parameters of the concept of normal functioning. Hence, they also end up with a distinction between health and pathology that is normative all the way down, that lacks a normatively independent naturalistic module. It is true that their conception of health relies on the idea of normal functioning, but the parameters of this idea are normatively specified. They can distinguish all unwanted conditions from pathologies with a degree of precision that it is humanly reasonable to expect for their societal needs. They are fully aware of the conventional nature of the threshold but do not challenge it every day or every year, which enables it to sustain stable expectations. A normative distinction between normal functioning and pathology can be incorporated into medical and legal practices and can avoid the social coordination problems that would arise if the distinction lacked a definition altogether.

To sustain relatively stable expectations, a concept of normal functioning established through public deliberation ought to deliver a framework within which more day-to-day, ordinary deliberations about resource allocation take place. To play this role, deliberation about the nature of normal functioning should be less frequent and more binding than ordinary resource allocation deliberation in healthcare. Perhaps, taking the courts as a model, it ought to involve special procedural rules, such as larger majorities and stricter eligibility conditions for participation. Ideally, deliberation concerning normal functioning relates to deliberation concerning healthcare resources in the same way as deliberation concerning the interpretation of constitutional principles relates to deliberation concerning day-by-day economic policy.

Conclusion

Norman Daniels offers no compelling argument against definitions of health and disease that are normative all the way down, that is, those that avoid naturalistic definitions of normal functioning, functions, or pathology. I concede, for the sake

of argument, that a very simple argument, bypassing technical debates in the philosophy of medicine, shows that the concept of disease is not equivalent to that of an unwanted condition. This is not an argument, however, against conceptions of normal functioning that are normative all the way down. Daniels's framework offers no justification for excluding moral and prudential considerations, as such, from the deliberation that leads to constructing the idea of normal functioning.

Notes

1. Daniels N. *Just Health: Meeting Health Needs Fairly.* Cambridge: Cambridge University Press; 2008, at 37.
2. Daniels N. Normal functioning and the treatment-enhancement distinction. *Cambridge Quarterly of Healthcare Ethics* 2000;9:309–22, at 315.
3. World Health Organization. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 states (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948; 1946; available at http://www.who.int/about/definition/en/print.html (last accessed 24 June 2009).
4. Nordenfelt L. *Health, Science, and Ordinary Language*. Amsterdam: Rodopi; 2001.
5. Engelhardt HT. *The Foundations of Bioethics*. New York: Oxford University Press; 1986.
6. See note 1, Daniels 2008, at 40.
7. See note 1, Daniels 2008, at 40.
8. See note 1, Daniels 2008, at 42, especially the following: "the intuitive distinction underlying the biomedical view can be reformulated into a nonnormative (or naturalistic) distinction."
9. Kingma E. What is it to be healthy? *Analysis* 2007;67(294):128–33.
10. Boorse C. On the distinction between disease and illness. *Philosophy and Public Affairs* 1975; 5(1):49–68.
11. Boorse C. Health as a theoretical concept. *Philosophy of Science* 1977;44(4):542–73.
12. Boorse C. A rebuttal on health. *Biomedical Ethics Reviews* 1997:1–134.
13. Daniels N. *Just Health Care*. Cambridge: Cambridge University Press; 1985, at 28–30.
14. See note 1, Daniels 2008, at 38.
15. Wakefield J. The concept of mental disorder: On the boundary between biological facts and social values. *The American Psychologist* 1992;47(3):373–88, at 381–5.
16. See note 1, Daniels 2008, at 39.
17. See note 11, Boorse 1977, at 562.
18. See also note 12, Boorse 1997, at 7.
19. See note 11, Boorse 1977.
20. See note 9, Kingma 2007, at 130–1. More specifically, Kingma considers three possible interpretations of "a natural class of organism of uniform functional design," namely, a class defined by (1) statistically common characteristics, (2) a high degree of uniformity among class members, and (3) natural design. The first interpretation is unacceptable because some age groups and morphological types (the queen design in the bee, for instance) have very few members. The second must be rejected because many diseases, especially genetic ones, can be remarkably uniform. The third appeals to either a theological or an evolutionary concept of design: the former renounces naturalism, whereas the latter does not fit our intuitions because some pathologies (e.g., sickle cell anemia) result from natural selection.
21. See note 9, Kingma 2007, at 131.
22. See note 10, Boorse 1975, at 63.
23. See note 9, Kingma 2007, at 132.
24. See note 10, Boorse 1975, at 61–2.
25. See also note 12, Boorse 1997, at 11.
26. See note 1, Daniels 2008, at 42.
27. Rawls J. *Political Liberalism*. Expanded ed. New York: Columbia University Press; 1996, at 54–7.
28. See note 1, Daniels 2008, at 40.

29. See note 1, Daniels 2008, at 42.
30. See note 1, Daniels 2008, at 42.
31. See note 27, Rawls 1996, at 223–30.
32. See note 1, Daniels 2008, at 40.
33. See note 1, Daniels 2008, at 40.
34. See note 1, Daniels 2008, at 40.
35. See note 1, Daniels 2008, at 40.