

Resourcefulness of an empirically informed and thickly normative account of disease

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Educators who start a philosophy of medicine or medical ethics class with a philosophical discussion on the definition of basic concepts in medicine, such as health and disease, might relate to this anecdotal account. Students initially find the topic engaging because of the ubiquity of the concept of disease regulating not only their direct encounter with health-related contexts, for example, when veterans returning to school receive accommodations after being diagnosed with Post Traumatic Stress Disorder (PTSD), but also their social world, say, when they get in an argument with their classmates about whether vaccines cause or prevent diseases, or when they join the campus gym to improve their health. Yet their enthusiasm wanes when they read the seminal naturalist and normative accounts of disease. This happens *not* because such conceptual work does not have any philosophical sophistication and value but because the discussion seldom makes direct contact with the common uses of the disease concept in the medical, social, moral and institutional contexts in which the students are heavily embedded.

As the authors of 'Rethinking 'Disease': A Fresh Diagnosis and a New Philosophical Treatment' argue, the notion of disease central to the naturalist and normativist positions is conceptually insulated from its applications in various institutional settings in healthcare and also from its personal, social and economic contexts. This insularity largely stems from the fact that traditional conceptual analysis in philosophy assumes a lot more than it can show, including the assumption that concepts, such as disease, have necessary and sufficient conditions that exist independently of the world as we encounter it and are accessed through our intuitions. This is a problem, because the concept of disease plays a crucial role in medical epistemology, scientific research, and ethical and policy-related issues; a philosophical

account of disease that does not directly engage with them runs the risk of being deemed irrelevant.

The value of traditional conceptual analysis in philosophy has recently been called into question in larger debates about philosophical methodology.^{1 2} For example, the idea that concepts are universal in nature has been criticised, with researchers showing how different social groups have different intuitions about the application of certain concepts.² 'Rethinking 'Disease': A Fresh Diagnosis and a New Philosophical Treatment' can be situated within this empirical turn in philosophical methodology. As the authors argue, concepts are defined in relation to institutions and are 'shaped by particular pragmatic, epistemic, or ethical goals'. Accordingly, they develop an empirically informed and normatively thick account of disease, one that is useful in these pragmatic, epistemic and ethical contexts.

According to the new hybrid approach defended by Russell Powell and Eric Scarffe in 'Rethinking 'Disease': A Fresh Diagnosis and a New Philosophical Treatment', 'a biomedical state is a disease only if it implicates a biological dysfunction that is, or would be, properly disvalued'. The two objective components of the account, namely biological dysfunction and rational moral justification, make the approach conceptually rich and empirically resourceful. It is responsive to the fast-evolving scientific knowledge of the complexity of diseases while maintaining a thickly normative account that demands the said biomedical state be *properly* disvalued.

Let me use the rest of my commentary to focus on the 'objective moral justification' process which, the authors argue, will allow us to determine whether a biological dysfunction is *properly* disvalued. More specifically, I will use the pragmatic framework defended in the article to re-evaluate the removal of the bereavement exclusion criterion from the diagnostic criteria for major depressive disorder in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5),

allowing the possibility of diagnosing individuals who are grieving the loss of a loved one as having major depression.³

The bereavement exclusion criterion was introduced in the DSM-III to avoid a possible false-positive problem. Because there are significant similarities between the features of grief-related distress and the symptoms and signs of depression, the creators of the DSM were worried that distress associated with grief could yield a misdiagnosis of the grieving individual's condition as depression. Thus, the DSM-III⁴ stated that if the depression-like symptoms of the individual in grief exceeded 1 year, and if suicidal ideation and loss of psychomotor functioning were among the symptoms encountered, a depression diagnosis could be made, and the individual could receive appropriate treatment. In the DSM-IV,⁵ the length of appropriate grieving was reduced to 2 months. In the DSM-5³ the bereavement exclusion was completely removed.

The rationale for removing the bereavement exclusion criterion was that the observable and distressing experiences of grieving individuals and those in depression are similar. As there is no scientific evidence for characterising bereavement-related distress and depression as distinct conditions, the DSM creators said treatment that helps the latter will also help the former.^{6 7} The decision caused much controversy; many scholars criticised the DSM-5 Task Force for medicalising a normal human condition^{8 9} and thereby eroding an intrinsically natural emotion.¹⁰ Nonetheless, the change took place, although with an extended note in the DSM-5 to the effect that examining the similarities and differences between complicated grief and depression is an ongoing area of research. I believe the normative account of disease developed by Powell and Scarffe can provide resources for researchers to re-evaluate whether grief should be properly valued as harmful, that is, whether it is correct to think of it as a disease and fold it into the depression diagnosis.

The first question we should ask the creators of the DSM concerns the biomedical states associated with grief. Can they be properly evaluated as 'biological dysfunction' when the norm of function is taken to be evolutionary? The defenders of the bereavement exclusion argued that the physiological features of grief, for example, the loss of interest in pleasurable activities, sleep disruptions, eating anomalies and so on, are phenomena that deem grief to be indistinct from depression. Other important assessments must

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include the appropriate length of time the grieving individual encounters these phenomena, given their variation across different cultures and communities, as well as the degree to which they encounter them, and whether these experiences are considered evolutionarily adaptive or maladaptive. Research on grief experience in non-human animals would also serve as an important resource for comparative analysis.¹¹

The second question that ought to be answered by the creators of the DSM is whether the biomedical states associated with grief are *properly* disvalued. According to Powell and Scarffe, establishing this hinges on a rational moral justification process. Let me highlight one of the ways this process might be applied to establish whether complicated grief is a disease.

Powell and Scarffe argue the moral justification process is a reason-giving process and ‘appeals to authority, popularity, theological premises or false empirical claims will not suffice’. This raises important points about who should be allowed to participate in the moral justification process, all of which should be considered in the DSM-5 decision-making context, in light of the processes followed in previous editions. Are psychiatrists who are trained in psychopathology the only experts, or will all individuals whose lives are somehow be influenced by the decision that grief is a mental disorder be encouraged to participate in the moral justificatory process? Unfortunately, so far, those in positions of scientific and clinical authority in the context of psychiatry have been the main decision makers in creating the DSM taxonomy of mental disorders. Starting with the first edition of the DSM, the so-called experts have been clinically trained in psychopathology, primarily researchers and clinicians in psychiatry. The community involved in the creation of the DSM has assumed that establishing whether a condition is a disease is *merely* a scientific decision; it is *not* a normative decision that involves a process of moral justification to evaluate whether a biomedical state is properly disvalued. Nonetheless, leaving out the community who has direct encounters with

mental illnesses from the community of decision makers creates a significant number of epistemological and ethical problems.^{10 12 13} The lack of inclusion of those with valuable experience-based expertise (ie, patients diagnosed with mental disorders) in the scientific knowledge production has been especially detrimental to increasing the understanding of mental disorders and the ethical treatment of individuals.¹³ The decision-making process in the DSMs has so far excluded the perspectives of epistemic and moral stakeholders and has not always taken into account the best scientific information through an identification of genuine sources of knowledge.

Expanding the decision-making process to include all stakeholders would, for example, open the door for patients and their families, as well as medical professionals such as social workers who directly work with grieving individuals, to be included in the moral justification process to assess whether grief should be appropriately disvalued as harmful. Including, for example, the first-person phenomenology of patients and taking their lived experiences into account would prompt the decision makers to rethink how certain conditions are (dis)valued. Thus, Powell and Scarffe’s suggestion that moral justification processes should be more participatory and egalitarian would be a welcome addition to the debates about whether grief should be diagnosed as a disease.

Ultimately, ‘Rethinking ‘Disease’: A Fresh Diagnosis and a New Philosophical Treatment’ is an indispensable account of disease for philosophers who want to offer deeper analyses of the scientific, ethical and policy dimensions of diseases, and it provides a resourceful framework for those who actively engage in medical ethics, policy and research. It should be read by philosophers who are dissatisfied with the insularity of traditional conceptual analysis as a methodology and by educators who want their students to have a robust conceptual understanding of the concept of disease and its practical implications.

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