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On Grounds, Anchors, and Diseases: A Reply to Glackin[1]

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0. Abstract

Shane Glackin's 2019 *Philosophical Quarterly* article aims to (a) offer a framework for understanding the philosophical debate about the nature of disease and (b) utilise this framework to reply to several standard objections to normativist (particularly social constructivist) theories of disease. Specifically, Glackin claims his model avoids three central challenges to normativism, which we term the 'Flippancy Problem' (which charges that normativism implies diseases can be cured by adjusting our attitudes towards them), 'Repugnancy Problem' (which charges that normativism implies we must endorse repugnant historical views regarding 'conditions' like Drapetomania as 'genuine diseases in their day'), and the 'Explanatory Problem' (which charges that normativism cannot explain why diseases warrant certain kinds of medical intervention without lapsing into vicious circularity). Although we find Glackin's framework helpful in clarifying the terrain of the debate, we argue these three challenges continue to afflict his preferred construal of the normativist/social constructivist position.

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1. Introduction

The central contribution of Glackin (2019) lies in offering a grounding[2] framework for understanding the stakes in philosophical disputes regarding the nature of the disease. He introduces this in contrast with a supervenience model previously offered by normativists-including himself:

> "It is an objective, natural fact about a person… that they have leukaemia, or a scaphoid fracture… But normativists hold that it is a *contingent* fact about any such state that it is a disease, and does not reflect any intrinsic feature that it possesses; an individual in any of these objective natural states might or might not be properly regarded as diseased, depending upon other background factors… the defining feature of normativism is that it believes at least some of these additional factors to be evaluative." (Glackin 2019: 261)

To spell out this position more precisely,

> SUPERVENIENCE NORMATIVISM – No change in the facts about whether or not a particular person has a disease is possible without a change in *either* some element of their biological/behavioural state *or* a change in some evaluative property associated with that state.

[2] In what follows, we assume the grounding relation is (a) a uni-directional, explanatory relation of metaphysical dependence whereby one relatum obtains **in virtue of** another, and (b) its relata are facts. Glackin mostly speaks in these terms, occasionally describing the relata instead as claims or things. No element of Glackin's argument or our own hangs on the nature of the relata. We take it that the first claim is largely uncontroversial (though see Wilson 2018).

To give a specific example, if somebody is in the biological state characteristic of leukaemia, then they will have a disease unless their biological state changes in a particular way, or some evaluative property associated with that state changes[3].

We will explain in a moment why Glackin (now) rejects this model and endorses an alternative. First, however, we will introduce the proposed alternative. Glackin writes,

> "…the state of *being ill* or *having a disease* is grounded by the patient's underlying biological or behavioural state. And this grounding relation, according to the social constructivist, in turn exists because the background evaluative facts are as they are." (Glackin 2019: 262)

According to Glackin, everyone (normativist and naturalist alike) can and *should* agree on the following: Where B1 abbreviates 'the biological state that amounts to leukaemia',

(1) (X is in B1) grounds **(X has a disease)**[4]

Call the left-side the 'grounding fact' and the right-side the 'grounded fact'. The same is true for a wide range of states (B1, B2, B3…Bn) characteristic of conditions like influenza. This gives us an account of individual diseases. Likewise, a general theory of actual disease on which we can and should all agree (according to Glackin) supposes the grounding fact is disjunctive. That is,

[3] The evaluative property that must change differs between versions of normativism – social constructivists, for instance, take it to be some kind of collective evaluative judgment about the state in question.

[4] For the purposes of this paper, we adopt the convention that **(X)** abbreviates 'the fact that X'.

> **(2) (X is in B1 OR X is in B2 OR X is in B3…OR X is in Bn)** grounds **(X has a disease)**

All of this is just to say individual instances of disease are grounded in individual biological states, and disease in general is grounded in a disjunction of all such individual biological states. For *d* to be a disease is for *d* to be grounded in one of B1…Bn.

This grounding relation holds within a Frame (Glackin: 262); a set of possible worlds, demarcated by a *framing principle*. Framing principles take forms like that of (1) and (2) and are *anchored,* in the terminology of Epstein and Glackin (Epstein 2015: 84, Glackin 2019: 263), by some *further* fact or set of facts. These anchoring facts establish the grounding conditions for relevant grounding and grounded facts; **(X is in B1)** and **(X has a disease)**, for instance, giving rise to the aforementioned frame principles.

So, if philosophers shouldn't disagree about what grounds disease, then what *should* they disagree about, according to Glackin? His answer is the anchoring fact, or facts, *in virtue of which* the grounding relation holds (Glackin: 263). That is, philosophers ask the following question: in virtue of what do states B1…Bn ground the fact that an individual has a disease? What 'set of facts [anchor the] frame principle'? (262)

Many different theories of disease can be captured by Glackin's framework. For Wakefield's (1992) followers, the grounding relation holds in virtue of the fact that states B1…Bn constitute harmful dysfunctions. For Boorse's (1975, 1977), it is that B1…Bn deviate from statistically normal functioning relative to a reference class. And to use Glackin's terminology (2019: 264), for normativists generally, it is that B1…Bn have certain evaluative properties, for constructivists generally, it is that people make certain kinds of judgments about B1…Bn, and for social constructivists it is that people make certain kinds of evaluative judgments about B1…Bn. Thus,

the normativist, constructivist, and social constructivist positions can now be stated relatively precisely as follows,

> GROUND NORMATIVISM – **(X is in one of states B1…Bn)** grounds **(X has a disease)** and this grounding relation holds in virtue of **(states B1…Bn have certain evaluative properties)**.
>
> GROUND CONSTRUCTIVISM – **(X is in one of states B1…Bn)** grounds **(X has a disease)** and this grounding relation holds in virtue of **(people make certain kinds of judgments about states B1…Bn)**.
>
> GROUND SOCIAL CONSTRUCTIVISM – **(X is in one of states B1…Bn)** grounds **(X has a disease)** and this grounding relation holds in virtue of **(people make certain kinds of evaluative judgments about states B1…Bn)**.

We agree with Glackin that this is a helpful framing of the debate. He has provided, for the first time, an apparently neutral metaphysical landscape on which different theories of disease can be modelled. We disagree, however, that this new framework ultimately serves normativism or constructivism. Indeed, we believe Glackin has inadvertently sharpened the issues they face.

As far as we can tell, Glackin vacillates between which of these distinct positions he is expressly defending. This lack of clarity causes problems when he applies the framework to some standard objections, because not all of the objections straightforwardly apply to each of them, and some of his responses are available to only one or two of them.

2. Grounding, Supervenience, and the Flippancy Problem

Glackin states the reason he now rejects SUPERVENIENCE NORMATIVISM is it puts biological/behavioural facts "on all fours with" evaluative facts when determining disease-status (2019: 262). His worry is this entails that changing relevant evaluative properties eliminates the disease as effectively as altering the biological/behavioural state (2019: 262).

This is a general problem for social constructivist theories, since changing the relevant evaluative properties involves a (usually collective) change of attitude towards the biological/behavioural state in question[5]. Thus it seems social constructivists must accept that a person can be "cured", *either* by changing our attitudes towards their condition ('wishing it away'), *or* by improving their biological/behavioural state. Call this the Flippancy Problem (FP). Glackin explicitly identifies the claim that biological/behavioural facts are "on all fours" with the evaluative facts as being the source of FP. He writes,

> "…we want to maintain a principled distinction between changing a patient's underlying clinical condition, and changing how we evaluate it. And that is just what we cannot do if our metaphysical set-up leaves the biological facts and the background evaluative facts *'on all fours'* together." (Glackin 2019: 262, *emphasis added*)

Glackin is right that neither GROUND NORMATIVISM, GROUND CONSTRUCTIVISM, nor GROUND SOCIAL CONSTRUCTIVISM puts biological/behavioural facts "on all fours with" evaluative facts. On these theories, biological/behavioural facts are the *sole* grounds of the disease facts, but the grounding relation itself holds *in virtue of* background evaluative facts. These

[5] Normativist theories generally may or may not face this problem, depending on whether or not it makes sense to suppose relevant evaluative facts could easily change. A normativist who believes that the anchoring evaluative facts are, for instance, objective universal moral facts, *might* not face this worry.

facts perform wholly different roles within the theory[6]. Nevertheless, FP quickly exacts its revenge.

Imagine what happens, on Glackin's model, if the evaluative facts change (as is the situation imagined by those who push the Flippancy Problem). Of course, the grounding facts do *not* thereby also change. But the facts *giving rise to the grounding relation*, in Epstein's terms "the metaphysical reason [the] frame principle is the case" (2015: 82), have changed. This leaves those facing the Flippancy Problem who accept Glackin's model with four options.

Either **1)** the disease-facts (i.e. the grounded facts) no longer hold, **2)** the disease-facts are still grounded by the grounding facts because of some other 'metaphysical reason' (that currently obtains), **3)** the disease-facts are still grounded by the grounding facts because the relevant metaphysical reason *once* obtained *somewhere* (even though it does not now) or **4)** the disease-facts still hold but are groundless.

1, **2**, and **4** are obviously unattractive to constructivists. **1** amounts to biting the bullet against FP. **2** amounts to a straightforward rejection of the defining feature of constructivism, as Glackin understands it (since it requires positing that something other than the altered collective judgments now play the anchoring role). Moreover, adopting **4** would amount to accepting that there was no need to posit a theory of how disease-facts were grounded in the first place, and would therefore be self-defeating.

What of option **3**? Firstly, it openly rejects Epstein's view on the nature of the circumstances in which social facts persist; he writes that this occurs in virtue of our "ongoing" attitudes (2015:

[6] Glackin notes the directionality of grounding gives it intuitive pull over the supervenience model (2019: 262, fn.9). We agree; it seems right to say diseases *depend* on their underlying biological/behavioural states, rather than necessarily co-varying with them. We note, however, that this is not obviously a matter of grounding's directionality. Supervenience is also directional in the most obvious sense; it is not symmetrical. The attractiveness of the grounding relation appears to be found in the strength and detail of the explanation offered; a claim of dependence tells us strictly more about the metaphysics than a claim of supervenience, since if x (fully) grounds y, then y presumably supervenes on x, but not *vice versa*.

81). But besides this, this response to FP should still be unacceptable to the constructivist as it does not solve the problem at hand as much as relocate it.

To see this, consider the following. It would be flippant to say to somebody requesting aid in curing an illness that they should move to a place where people don't evaluate their condition in the relevant way. Yet, even assuming the availability of time travel, it would be flippant, even absurd, to suggest they travel to a time *before* their condition was evaluated in the relevant way. No person seeking a cure for, or relief from, their illness is thereby seeking a change in the attitudes of others around them[7], whether by way of a change in geography *or time*, yet this option commits one to the view that such a change will do nicely.

There might be hope for option 3. Suppose I am ill by the standards of culture *c1* and move to culture *c2* (with different standards). It is plausible that by some mechanism (perhaps internalisation) standards from *c1* 'follow me', and I therefore remain ill. This might be a feature, not a bug, for some normativists. Yet we think this elides the underlying worry of FP; that it should not be so *easy* to count as not-ill. Suppose I were born and raised in *c2*; I would thereby fail to have an illness which, intuitively, I ought to have, but for a change in my place of birth.

Even if this is not convincing to the normativist, it opens them up to a further flippancy-adjacent problem. If a slave time-travels to our time, and judges themselves to have Drapetomania (a historically purported 'psychiatric condition' whereby black slaves attempted to escape their masters) in line with the standards of *their* time, we want to say they are mistaken, not that *these* value judgments have tracked. And time travel is incidental here. The same would apply were there a culture that collectively thought slavery a 'natural condition' and thus running away a

[7] Disabled people who endorse a social model of disability (whereby disability is primarily the result of external social factors, including collective attitudes) are not likely to be exceptions to this rule because disabilities, on this view, are usually not considered diseases (Brisenden 1998: 25). Moreover, it is not just attitudes, but material circumstances, that will need to change in order to provide 'relief' from disability on such accounts. There are some complexities here, but they are beyond the scope of this paper.

'disorder of the mind'. The spectre of such 'conditions' presents another significant challenge to normativism, which Glackin believes his model can meet. We argue it fails to do so.

3. Constructivism and the Repugnancy Problem

Glackin suggests a way out of another standard problem for normativist theories of disease. Consider the history of Drapetomania, a condition once considered a disease (Glackin 2019: 271). Most people's intuition is that doctors of those times were mistaken[8]. Even though many believed Drapetomania was a disease and adopted the same attitudes towards it as they did other diseases, this was an error.

But constructivists struggle to stop there, since precisely these kinds of attitudes are supposed to determine *what it is to be* a disease. Here, constructivists seem to be backed into a counterintuitive corner. Their theory implies the public were not wrong to say that Drapetomania was a disease *at the time*, since the sorts of judgments being made about the condition *at the time* are, by their lights, the hallmarks of a condition counting as a disease. And therefore, so the challenge goes, constructivists cannot preserve the intuition that our ancestors were mistaken (see, e.g., Murphy 2008; 2015; Ereshefsky 2009). We might be wrong *now* to say that Drapetomania is a disease, but are committed to the view that such utterances were *once* true (Glackin 2019: 271).

Glackin's reply to this problem is not satisfying.

> "SOCIAL CONSTRUCTIVISM, along with the grounding analysis I've given here, aims to capture *the nature of judgments about disease*, but in no way commits us to accepting them… most of us don't believe that the sort of moral values I've appealed to in defining

[8] For the sake of setting up this worry, we leave aside the possibility that doctors and wider society knew full well that the relevant behavioural profile did not amount to disease and instead outwardly pretended that they were, merely as a way to justify violent forms of social control.

> the concept are relative. Some societies might treat homosexuality… as [a disease]; but they are wrong to do so in just the same way that some societies are wrong to allow slavery, or liquidate the kulaks…" (Glackin 2019: 273-274, *emphasis added*)

Glackin's claim here is that we need not accept judgments of our ancestors as accurate, and thus need not think that they were ever correct. As long as the disease-facts are as they are in virtue of some evaluative fact that has not changed between then and now (as normativists, though not, we should note, constructivists or social constructivists, are able to claim), we may respond to the repugnancy problem by suggesting that the behavioural profile of Drapetomania *never* grounded the fact that a person had a disease (2019: 273). This is because the relevant evaluation was never true of it (even though our ancestors mistakenly thought it was). This much is an instance of GROUND NORMATIVISM, and avoids the charge of repugnancy (on the extremely plausible assumption that judgment-independent moral facts are not the sort of things that are prone to changing over time).[9]

Is this response available to Glackin though? We think not. He is not simply a normativist about disease, but (avowedly) a social constructivist. If he suggests the relevant anchoring facts are judgment-independent, he abandons constructivism. No version of constructivism has this response available, since the kinds of facts doing the anchoring are strictly judgment-dependent, prone to change and *have in fact changed* over time. Assuming that *this* is the position Glackin wishes to defend, his reply lacks force.

[9] It is not clear why Glackin limits himself to a claim about the nature of disease-judgments (rather than disease *per se*) in order to mount this defence, since a) his paper is explicitly about the nature of disease (see 2019: 262 & 269-70) despite some oddities in phrasing on occasion (see Glackin's statement of Social Constructivism on p.266), b) his defence works without retreating to this claim (for GROUND NORMATIVISM anyway), and c) his preferred framework (from Epstein) is a *theory of social kinds*, not a *theory of judgments about social kinds*.

This conflation of normativism, constructivism, and social constructivism is a persistent problem for Glackin's argument, reaching its peak in his discussion of the final objection, which we dub the Explanatory Problem (EP).

4. Normativism, Constructivism, and the Explanatory Problem

The challenge goes as follows. Our theory of disease should justify the fact that *diseases* are deserving of medical treatment/resource diversion etc, and *non-diseases* are not (Glackin 2019: 272). Specifically, the disease-status of certain states should explain their evaluative significance (see, e.g., Kukla 2014). Various kinds of normativism/constructivism seem to get this backwards; the fact that certain states have such evaluative status (or we judge them to) is what *makes* them diseases in the first place. Therefore, since evaluative status cannot both *explain* disease-status and *be* explained by it, such positions are untenable.

Glackin's solution to this problem is to say the explanation of the evaluative significance of disease is not provided by their disease-status, but by independent moral facts; we are justified in intervening on diseases in the relevant ways because that is 'the right thing to do'. He writes,

> …we can respond to [the explanatory problem] by resisting the claim that anything over and above our *ordinary moral judgments* is required or, indeed, would be adequate here. Even if the disease-concept were entirely value-free, we could not – for familiar Humean reasons – expect to infer from it without challenge normative conclusions about the treatment of patients. So it is no objection to…any…normativist account of disease, that it does not provide us with an expedited route to socially just treatment of patients; no version of the concept is going to do that. (Glackin 2019: 273)

On this picture, it is unreasonable to expect the disease concept itself to do the work of justifying the right kind of treatment of ill people. Rather, we should appeal to moral facts – roughly, treating people with diseases in certain ways is *the right thing to do*.

Now, this response can avoid explanatory circularity, but only if the nature of disease does not do *any* significant work in explaining why these independent moral facts hold. For example, the fact that, say, providing treatment for those with leukaemia is the right thing to do must not be explained, even in part, by the fact that leukaemia is a disease. If it does, then normativists are in trouble again; the fact that leukaemia is a disease both explains and is explained by the fact that treating it in certain ways is the right thing to do.

So, let us assume these facts are independent of each other. We must then explain why the moral and disease facts march in lock-step. Why do the independent moral facts just so happen to imply that all and only *diseases* warrant appropriate medical treatment?

A normativist can, we think, meet this challenge. The moral facts about the treatment of patients and the disease-facts presumably march in lock-step because they *both* depend (albeit in different ways) on other judgment-independent evaluative facts about the conditions in question (e.g. that Leukaemia involves severe and medically-relievable suffering). But this response is not available to a constructivist of any stripe, because it is implausible that our *judgments* about such conditions can determine the moral facts in this way.

This response, however, does highlight something more broadly worrying about Glackin's response to EP. Glackin's solution is to say *no* theory of disease (alone) explains why it is justifiable to assign the sick role (all of the differences in treatment of people that might be warranted in virtue of them having a disease) to all and only people with diseases.This position appears deeply counterintuitive. If someone's disease-status does not explain the appropriateness of assigning the sick-role, we are justified in asking what *could*. Either (A) a descriptive theory of

disease plays at least some *partial* role in justifying the assignment of the sick role or (B) it plays *no* role.

If we adopt B, the fact that someone has a disease becomes entirely incidental to the appropriateness of assigning them the sick role. It seems as if Glackin might endorse this picture when he invokes the spectre of 'Humean reasons' to claim that making inferences about just arrangements for people with diseases on the basis of their having diseases will always involve leaping blithely across the 'is-ought' gap. But we cannot help but think that this claim is much too strong – surely one's having a disease must play *some* role in explaining why one deserves appropriate treatment, care, time off work, and so on?

Even the response we offered above on behalf of the judgment-independent normativist (not constructivists) suffers from this worry. On this proposed picture, the fact that Leukaemia involves severe and medically-relievable suffering (perhaps in concert with other, similar, facts) explains the fact that Leukaemia is a disease (because it is an evaluative fact that anchors the relation in which 'Leukaemia is a disease' is the grounded fact). It *also* explains the fact that assigning the sick-role to those with Leukaemia is the right thing to do. Note, this breaks the explanatory link between disease-status and the independent moral fact completely; the fact that state B1 is a disease *co-varies* with the fact that assigning the sick role to those in B1 is the right thing to do, but it does not explain it (this, of course, is how it avoids EP). Normativists owe sceptics a justification for this result, which is both counter-intuitive and adds significant complexity to what seemed a perfectly reasonable foundational hypothesis; that we are justified in giving people medical treatment because they have an illness.

If we plump for A, however, then EP unavoidably remains; how can a normativist account of disease play *any* role in explaining the appropriateness of the sick role if it presupposes elements of it? In such a situation, appropriate evaluations of the relevant conditions both explain and are explained by their counting as diseases. But this sort of reasoning looks viciously circular.

Unless they adopt our suggestion above (along with its problems) versions of this problem apply as much to the normativist generally, as to the constructivist in particular. If **(x has at least one of B1…Bn)** grounds **(x has a disease)** because of judgment-independent evaluative facts, it is hard to see how we can go about explaining those judgment-independent evaluative facts by way of **(x has a disease).** Those judgment-independent evaluative facts are *already* part of the explanation of why **(x has a disease)**, given that **x has at least one of B1…Bn**. The same risk of circularity applies if **(x has at least one of B1…Bn)** grounds **(x has a disease)** because of some kind of individual or social judgment (evaluative or otherwise). We cannot go about explaining the appropriateness of these judgments at all in terms of the fact **(x has a disease),** because those judgments are already part of the explanation of why **(x has a disease)**, given **(x has at least one of B1…Bn)**.

5. Conclusion

We have shown Glackin's responses to three standard challenges posed to normativist/constructivist theories of disease are insufficient. We have also highlighted the importance of distinguishing the claims of normativism, constructivism, and social constructivism when evaluating the force of these standard objections (and the value of replies to them). Normativists who claim that judgment-independent evaluative facts anchor the relevant grounding relations fare much better in some regards, but still struggle to resolve EP in a satisfying way.

Undoubtedly, refining and improving all philosophical theories of disease is a task Glackin's preferred meta-philosophical framework aids us with enormously. Nevertheless, it offers no immediate advantage for normativist theories.

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