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What Counts as a Disease, and Why Does It Matter?

Quill R Kukla

ABSTRACT: I argue that the concept of disease serves such radically different strategic purposes for different kinds of stakeholders that coming up with a unified philosophical definition of disease is hopeless. Instead, I defend a radically pluralist, pragmatist account of when it is appropriate to mobilize the concept of disease. I argue that it is appropriate to categorize a condition as a disease when it serves legitimate strategic goals to at least partially medicalize that condition, and when the condition is pathological from inside the epistemology and metaphysics of medicine. While some conditions, like pancreatic cancer, are legitimate diseases from all stakeholders' points of view and in any context, and while other conditions, like homosexuality, are not diseases from any legitimate point of view, there is a range of interesting, messy cases—including Deafness, autism, pre-hypertension, infertility, and ADHD, for example—whose disease status is irreducibly context-dependent and under contest.

KEYWORDS: Disease, Medicalization, Pragmatism, Medical Epistemology, Philosophy of Medicine, Nosology

Philosophers have devoted substantial energy to defining "disease." Attempts to clarify the concept of disease have fallen into several camps. One group of philosophers, centered around the work of Christopher Boorse (1977), has tried to give a naturalistic, statistical definition of disease. Boorse argued, roughly, that something is a disease if it is a statistical variation from biological normal function. He and others have offered various refinements of and added various epicycles to this core view. Critics charge that such statistical accounts cannot capture what is bad about disease (Spitzer and Endicott 2018; Wakefield 1992; Kingma 2010; Stegenga 2018).[1] Accordingly, a second group of philosophers, including prominently Jerome Wakefield (1992; 2007), argues that the definition of disease must have an irreducibly

[1]Indeed, Boorse himself stresses the "value neutrality" of his account (1977, 543).

normative component. One way or another, having a disease is a bad, harmful thing. However, nailing down what sort of badness is essential to disease has proven difficult (for instance, see Feit 2017). What about asymptomatic diseases? What about diseases that end up giving someone's life meaning, fulfillment, and community? A third group of philosophers steps to the side of the naturalist versus normativist debate and goes radically social constructionist. For instance, Tristram Englehart, Jr. (1974) argued that diseases are literally and definitionally whatever the institution of medicine recognizes as a disease. He is willing to bite the bullet, for instance, and insist that when we treated masturbation as a disease, it literally was one, although it isn't one any longer. This kind of social constructionism has frustrated critics who want to be able to say that medical and social institutions can get disease classifications wrong and be in need of correction. None of these broad approaches have yielded anything like a satisfying consensus as to what "disease" means, and there are ongoing attempts to tweak all of them to make them work.

My goal, in this essay, is not to add another definition of disease to the philosophical pile. Nor will I explain how it is systematically related to other, distinct but intertwined concepts such as health, disability, and illness, because I do not believe that it bears consistent or systematic relations to these concepts (although I will return to the strategic relationship between disability and disease below). Rather, I want to argue that the concept of disease is irreducibly and hopelessly messy. I want to convince you that no one notion of disease captures all of the varied important uses of the concept, each of which has its life within different institutional settings and sets of pragmatic goals, and for different stakeholders. In other words, "disease" is not a stable, univocal concept whose correct definition can be excavated or even precisified through an ameliorative project of conceptual engineering (Haslanger 2000). Instead, the concept shows up in deeply competing projects and is used for deeply different ends, and there is no consistent notion of disease that underlies these or ties them together.

It may help to motivate my view to give a couple of examples of the kinds of puzzles that strike me as putting pressure on any unified conception of disease.

I want to be able to understand how at one and the same time it is perfectly appropriate for Deaf parents to insist that their child's deafness is not a disease but rather an identity and a neutral or even positive variation on human capacities, and for insurance companies to classify it as a disease for purposes of coverage for people who do want treatment for it. My intuition is that it would be distorting to say that one of these groups has it right and the other has it wrong. Nor do they disagree on the empirical facts about what Deafness is or what causes it. Rather, they are drawing, it seems to me, on quite different conceptions of disease, which are serving different purposes.

I also want to be able to account for the fact that the claim that alcoholism is a disease can be used effectively to fight against a bad, damaging ideology according to which alcoholics are simply morally weak or lacking in character, and at the same time, this same claim that alcoholism is a disease can be used to uphold a different, bad ideology, for instance that alcoholism is reducible to biological predispositions that are defined in insidious and contested racialized terms, which in turn are weaponized against racial groups. That is, there are times when we do damage by insisting that alcoholism is a disease, and times when it is clarifying and morally helpful to point this out. My intuition is that we are not lying or mistaken in one case and telling the truth in another. Rather, different conceptions of disease are serving different strategic goals in each case, and some goals are pernicious while others are liberating. Both the claim that alcoholism is a disease and the claim that it isn't can be, it seems to me, appropriate strategic claims to make, depending upon what dimension of the condition and its ties to social justice, epidemiology, and treatment we are trying to bring out.

These are quite different examples and neither of them constitutes an argument for anything yet; they are just intended as intuition pumps, designed to trouble our sanguinity about there being a single conception of disease to be found.

I will argue that there are a messy host of competing strategic reasons to call something a disease, or to refuse to do so. Whether something is best classified as a disease is a contingent, historically dependent, perhaps temporary, socially embedded fact that can vary from context to context. We can only settle whether it makes sense to call something a disease by asking what our purpose is in using the concept in a given strategic context, and whether it will further our ends to classify it in this way. There just isn't, I will try to convince you, any neater story to be told. Indeed, any neater story will occlude some of the legitimately important purposes that categorizing something as a disease may serve, along with the harms and benefits that come with this categorization.[2]

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[2]Note that I do not distinguish, in this essay, between "disease" and "disorder." There is a whole other mess of connections, overlaps, and contrasts between these two terms, which also varies from context to context. Boorse (1977) speaks of "disease" but Wakefield, who takes himself to be responding to and correcting Boorse, speaks instead of "disorder""(1992; 2007). I strongly suspect there is no clean answer to the question of the relationship between these concepts, any more than there is a clean answer to the question of the nature of disease. I will speak in this paper of disease, by which I intend to capture both the discourse of disease and the discourse of disorder. There is a separate literature on the relationship between disease and "illness," where illness is understood as having normative valence missing from a naturalistic conception of disease. This philosophical distinction also originates Boorse, particularly in Boorse (1975). In this paper I avoid the concept of illness altogether. I also think, as I argued in Kukla (2014), that the concept of a "health condition" can be understood as usefully distinct from the concept of disease, and I do not address the topic of health conditions here.

What Are Our Motives for Classifying Something as a Disease?

There are a host of different reasons, growing out of different needs and planted within different institutional settings, why we might care whether something counts as a disease or not. Here are seven examples.

1. From within the institutions of biomedical scientific knowledge production, we might wish to identify productive, unified objects of scientific study. For instance, we might wonder whether something is covered by robust counterfactual generalizations, or whether using it as a category in our statistical analyses will be fruitful. From this perspective, we might contrast a proper disease with a socially unified set of diverse behaviors and habits with no shared natural unity.

2. From within the institutions of clinical medicine, we might be interested in identifying productive, unified targets of treatment. Even if we have no leads on what kind of natural unity or etiology a condition has, we might care that lends itself to being clinically addressed in a unified way, and hence functions as a single disease for clinical purposes. Notice that scientific unity and clinical unity may not co-travel. For example, various cases of depression may respond well to similar treatments even if their underlying causes are quite different. Conversely, the unified mechanism behind diabetes is well-understood, and yet different cases of diabetes may be best treated in quite different ways depending on patients' lifestyle, economic means, habits, and so forth.

3. Our interest may instead be epidemiological: we might want to know how a condition or set of symptoms spreads and is distributed. Classifying something as a disease (or not) shapes our epidemiological imagination and approach. If we think of alcoholism as a disease, we are likely to look for certain kinds of epidemiological patterns, for example genetic patterns. If we resist thinking of it as a disease, we might instead seek patterns of social interaction and situation.

4. So far, our first three strategic reasons to care whether something is a disease have all been situated within medical epistemology. But instead, we might care for purposes of institutional decision-making, quite aside from any desire to build knowledge about the condition. We might care whether something is a disease because we want to know whether insurance should cover it. Or relatedly, we might want to know whether it should be part of the professional standard of care to offer treatment for it at all. For example, we might consider a paucity of viable eggs, leading to infertility, to

be a (treatment-worthy, insurable) disease in a thirty-year-old but not in a sixty-year-old, while we might have vigorous debates over how to count it in a forty-five-year-old. This may be so even though we have no empirical disagreements over what the underlying biology is or over how effective intervention would be, and even though there is no natural physiological age threshold.

5. Our motivations for classifying something as a disease may instead be purely economic. Most obviously, pharmaceutical companies are better positioned to market drugs if they can be framed as treating diseases—this phenomenon is often known as "disease mongering." But also, classifying a condition as a disease can make it easier to engage in fundraising for it, or to establish specialty clinics.[3]

6. Whether something is framed as a disease or not may affect how we think about its role in a just state, and hence it may matter for deliberative democratic purposes. We might be interested in how people with a particular condition ought to be treated, or what policies ought to apply to them. Should they receive workplace accommodations? Should they be guaranteed access to care? Whether we understand something as a disease may shape how we settle such questions. For instance, Normal Daniels (1992; 2007) has argued that short people whose height is a manifestation of a disease deserve access to care, whereas equally short people who are just "naturally short," although their height would respond the same way to "treatment," do not deserve this access.

7. Finally, there are social and ethical values and framings at stake in whether we classify something as a disease. We might want to know how to understand the responsibilities and expectations for people with this condition. To what extent should they be understood as responsible for a behavior? Consider the impact on our moral framing of classifying "oppositional defiant disorder" as a formal diagnosis. Or we might want to know, will it help to legitimize and clarify people's experiences and actions to understand them as suffering from a disease? For the sufferers? For onlookers? Or, conversely, will it obfuscate these things? We might ask whether classifying it as a disease will help to build a supportive social community or sense of personal identity, or whether it will undermine these. We might worry about whether in classifying something as a disease, we are pathologizing behaviors or symptoms that we should instead be working on socially accepting. Classifying something

[3]Joel Lexchin, among others, has done excellent work exploring the pharmaceutical industry's generation of diseases for economic purposes; see for instance Lexchin (2006).

as a disease may both create personal responsibilities (for instance, the responsibility to take care of one's health by treating it) or alleviate personal responsibilities (for instance, by treating behaviors as symptoms rather than choices), and either of these may be positive or negative developments.

Each item in this list captures important goals and questions that matter greatly to different people in different settings. But notice that there is, prima facie, just no reason to think that one unified concept of disease will suit all of these well. Why should we think that the same conditions that are productive unified objects of study are the ones that we want to insure, or to monetize, or to bind up in the complex dynamics of personal responsibility or shared community that come with classifying something as a disease? What systematic relationship should we expect there to be between the epidemiological form of a condition and the question of whether it deserves workplace accommodations? And so forth. The burden of proof seems to be on the philosopher who thinks that one univocal concept can serve all these very different masters simultaneously to say how this is so.

Christopher Boorse already acknowledged a version of this point that the verdicts on these different strategic questions might not align when he put forward his naturalist account of disease; he argued that "the judgment that something is a disease is a theoretical judgment that neither entails nor is entailed by any therapeutic judgment about people's need for medical treatment" (1977, 544). In other words, he takes his account of disease to be suited to the ends of scientific research, but not to the ends of clinical medicine. The difference between him and me here is that he thinks that the "theoretical" uses of the concept are somehow privileged, and show us its real meaning or essence, which I deny. Other scholars, such as Wakefield, stress what they take to be the enormous importance of the different uses of the concept lining up. Wakefield insists that the "credibility and even the coherence of psychiatry as a medical discipline" (2007, 149) rests on there being a single true answer as to what counts as a disease, or a "disorder" in his terminology, that works for the purposes of research, treatment, and social classification. I deny the importance of this unity.

When Do We Call Something a Disease?

My suggestion is that we classify something as a disease, not because there is a single unified truth of the matter as to whether it has the proper essential disease nature, but because it is strategic, from a particular pragmatic and institutional perspective, to do so. But when is it strategic to do this? What tools are we bringing on board by classifying it in this way? I propose the following as a broad, open-ended, pluralist, pragmatist account of the use of the concept and language of disease, where this use will manifest in different and conflicting ways in different contexts:

It is appropriate to classify a condition as a disease if (1) it is strategically helpful, with respect to some legitimate goal, to at least partially medicalize that condition or cluster, and if (2) within the epistemology and metaphysics of medicine, the condition or cluster can qualify as pathological.

Right off the bat, I need to stress two things. First, that this is a pragmatic analysis and not a metaphysical definition. In offering this analysis, I am not claiming to uncover a type of thing in the world. This would be to just add one new philosophical definition of disease to the pile. Rather, I am claiming to give an account of when it is (generally) helpful to classify something as a disease, and insisting that there is no more to be said than this. Because, I have argued, there is no one unifying concept of disease, the job of the philosopher with respect to disease should not be conceptual analysis. Rather, the best role we can have is clarifying the pragmatic and normative conditions under which "disease" is a useful concept that can be mobilized appropriately. Second, this pragmatic analysis will often yield different verdicts on whether a condition is a disease in different contexts. It may well be, and often is, strategically helpful to medicalize a condition for some purposes and not others, and for some groups with some sets of interests and not others. There is also enormous ambiguity as to what counts as a legitimate goal, and different stakeholders will have different conceptions of legitimacy. By a "legitimate goal" I mean, roughly, one that is socially acceptable according to our loosely shared ethical and political norms, but there will not be consensus on which goals meet that standard. My account thus not a traditional definition, then, in the sense that it will not divide the world into diseases and non-diseases. It is rather a kind of definition-schema, which will take on different meanings and give different answers depending on the goals and stakeholders involved.

In my earlier article, "Medicalization, 'normal function', and the definition of health" (Kukla 2014), I attempted to give a similarly normatively structured account of "health conditions," which I distinguished from diseases. I claimed that "A condition or state counts as a health condition if and only if, given our resources and situation, it would be best for our 'collective' wellbeing if it were medicalized. . . . In turn, health is a relative absence of health conditions" (ibid., 526). The form of my current account of disease takes its inspiration from that earlier definition of a health condition, but it functions crucially differently in several ways.

In that earlier paper, I did in fact treat the definition as in effect a metaphysical one, as carving out the category of things that really were health conditions. My account of disease here, in contrast, is supposed to be an account purely of when it is strategic to mobilize the concept. In keeping with this earlier attempt to give a definitional account, with my appeal to our collective well-being, I was explicitly trying to

give a criterion that would yield a unified verdict on whether something counted as a health condition. While I recognized that it might be best to medicalize a condition for some people and not others, I tried to appeal to the notion of overall collective wellbeing to yield a single answer as to whether something was really a health condition. That notion of "collective well-being" has been criticized as overly vague (see Barnes, forthcoming) but here I neither defend against nor concede this charge, since I am not in this context interested in appealing to any unified conception of wellbeing anyhow. My pragmatic account of disease here explicitly highlights that, at least in the case of disease, something can function as a disease for some purposes and groups and not others simultaneously, without there being any unified verdict.

Another critical difference between the earlier definition of health and health conditions and this account of disease is my addition, here, of the second clause, according to which diseases are pathological by the epistemological and metaphysical standards of medicine. I explicitly had no such clause when I defined the concept of a health condition. This was because I intentionally wanted to make room for conditions that created needs for medical services but that were not pathological, such as fertility, which can give rise to the need for contraception and abortion; pregnancy, which can give rise to the need for prenatal and birth care; vulnerability to illness, which can give rise to the need for immunization; and trans identities, which can give rise to the need for gender affirming interventions such as hormone therapies and surgeries. None of these are diseases, and they are also not pathologies—indeed it is quite offensive to frame them as pathological. In the earlier essay, I wanted to make clear how these were health conditions but not diseases. But for something to be classified as a disease is, it seems clear, in part to frame it as pathological.

But I have worded this pathology condition carefully. I am intentionally avoiding giving a general philosophical definition of pathology here (which would, I suspect, be as fruitless as trying to define disease), and I am shifting the burden for defining pathology to medicine. Diseases, I am claiming, are at least potentially seen as pathological from within medical epistemology and metaphysics. That is, once we medicalize a condition, we only count it as a disease if, from the perspective of and using the tools of medicine, it shows up as pathological—although it is important to remember that even within medicine, there may be no consensus about this, since the perspective and tools of medicine are not unified or internally consistent. So Deafness, for instance, does not function as a pathology from inside the Deaf community, nor within the life of someone who proudly identifies as Deaf, but insofar as it is medicalized (which it is strategic to do for some purposes and not others), medicine itself frames and understands it as a pathological dysfunction of the aural system. In this way Deafness is different from fertility, for instance, which even from inside medicine is framed as normal functioning. Conversely, infertility is often counted as a disease for purposes such as setting global priorities, justifying

insurance claims, and founding clinics, and indeed from inside medicine, it is often framed as pathological, even though from a medical point of view it is a physiologically and socially variable phenomenon rather than a unified condition.[4] That diseases are pathological from within the perspective of medicine is the thin sense in which they are definitionally bad. This is consistent with them playing a harmless or even a positive role in many people's lives, since they need not be pathological in some essential, cross-contextual sense. But it does seem to me that if medicine doesn't count a condition as pathological at all, then it is misleading and inappropriate to call that condition a disease.

The specifics of my proposal turn on what I mean by "medicalization." This term has different precise meanings for different scholars (see, for instance, Conrad 1992; Conrad 2010; Halfmann 2012; Parens 2013), but the broad idea is that medicalization is the process of bringing some condition or mode of being under the surveillance, management, and control of medicine. I think it is helpful to think of medicalization as having four dimensions. These are causally and conceptually intertwined but also separable, and a condition may be partially medicalized, subject to medical control and surveillance in some of these ways and not others.

The first and perhaps most characteristic dimension is institutional: Medicalization involves bringing a condition under the practical authority of the institutions of medicine. When a condition is medicalized, medical professionals become the socially recognized experts who set the standards for diagnosis, track the condition, and have authority over its management and its treatment, if treatment is available.

The second dimension is epistemological: medicalizing a condition involves using the tools, methods, and epistemic styles of medicine to understand and track it. The epistemology of medicine is a rich topic in its own right, but roughly, the clinic–a "neutral" space isolated from the uncontrolled social environment, in which one examines the surface and interior of individual bodies–is the privileged epistemic site for medicine. There are a variety of techniques and technologies for perceiving medical facts that make up the epistemological toolbox of medicine, for use within the clinic. Medicalizing a condition, then, involves understanding it as properly tracked and understood in this setting and with these tools.

The third dimension is metaphysical, and this one goes hand in hand with the epistemological. Medicalizing a condition involves taking it as made up of the right sorts of entities and processes to be tracked and understood using the epistemic tools of medicine. It is, for instance, to understand it as a state or feature of an individual body rather than as a relational feature of a social ecology.

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[4]For a detailed examination and critique of the understanding of infertility as a disease, see Kukla (2019).

Fourth and finally, medicalization goes along with a specific ethical framework for thinking about a condition. When we medicalize a condition, for instance, we typically take its symptoms to be morally neutral, rather than as manifestations of bad character (although we may think that it manifests bad character that someone got the condition to start with). We do not think of symptoms as expressions of voluntary choices or unfettered will. But we also think of people with medicalized conditions as owing a certain kind of deference or subservience to medical professionals and institutions, and as having duties of self-discipline, because we view "taking care of one's health" as a moral issue.[5]

Notice that just because something should be medicalized doesn't mean that we can or should treat it. Some conditions that are appropriately medically diagnosed, tracked, and understood have no known treatment, especially when they are first medicalized. Or they might not be good to treat, all things considered (for example if the treatment is more burdensome than the prognosis or if someone considers the condition an important part of their identity and doesn't want to treat it). This holds even for pathological conditions.

For ease of expression, I often refer to the institution of medicine, but notice that, to make matters yet more complex, medicine itself is a pluralist institution, or really many institutions, linked together messily. Different cultures have different medical institutions that fit together only imperfectly and sometimes actively conflict (Jilek and Jilek-Aall 2001). Moreover, these different institutions sometimes classify and count diseases quite differently from one another (see, for example, Choy et al. 2008). Even within one region, it is not at all clear that there is one unified medical institution for the very rich and the very poor, and so forth. Some diseases are medicalized within some medical institutions and not others.[6] Hence medicalizing a condition does not mean inserting it into one unified institution, but into a messy web of institutions.

Medicalization is not good or bad in and of itself. Sometimes medicalizing something is appropriate and has enormous benefits, and other times it is inappropriate and can be damaging. This is a core component of my account: there are often good strategic reasons to medicalize conditions, and these can exist side by side with reasons why medicalization will be damaging or distorting. Some conditions should be medicalized even though they are not; for a long time, depression fell into this category. Some conditions should not be medicalized even though they are; for a long time, homosexuality fell into this category. Which conditions are medicalized is historically variable. ADHD, obesity, and fibromyalgia have all been medicalized

[5]This is known as "healthism" and there are various explorations and critiques of it available. See Metzl and Kirkland (2010) for an excellent overview of healthism and its perils.

[6]Many thanks to Solmu Anttila for making this point and its importance clear to me.

fairly recently. Intersexuality keeps popping in and out of medicalization as different groups debate whether its medicalization is helpful or damaging (Feder and Karkazis 2008; Feder 2009; Davis 2011).

Medicalization comes with a variety of risks and potential benefits, so the question of whether it is strategically helpful to medicalize something is often a complex one. Medicalizing a condition can legitimize it and remove stigma, but it can also pathologize it and enhance stigma. It can give access to insurance benefits and workplace accommodations and various other kinds of institutional support. But it can also turn people into targets for economic exploitation and enhanced surveillance, and it can subject them to norms of bodily self-discipline that may be helpful, oppressive, or a combination of the two. (Consider for instance how the medicalization of obesity has enforced the idea that obese people are responsible for disciplining their body in the name of health, and how that has created a great deal of misery and stigma and new health risks without reducing much obesity at all.) Various parties stand to profit from medicalizing a condition: it creates markets for pharmaceutical companies and opportunities for grant seekers, for instance. The medicalization of chronic conditions is especially profitable. From an epistemological point of view, medicalizing a condition frames it in a way that makes a wide variety of epistemic questions, technologies, tools and methods available: placebo trials, clinical instruments, epidemiological approaches, etc. It opens up questions such as whether there is a virus or a gene at the etiological root of this condition. At the same time, it generally shuts down other lines of inquiry, such as how the set of behaviors and experiences that make up a condition may be essentially embedded in a social ecology or a material environment.

This panoply of risks and benefits is critical to my account of disease. My (partial) list of risks and benefits is complex and heterogeneous enough that it is hopefully clear that medicalizing may be strategically helpful for some ends and for some stakeholders and not for others; there just isn't any reason to expect a unified verdict here. In order to decide whether something should count as a disease, we need to answer questions such as: who exactly is helped and who is harmed by counting this as a disease? What are the social, ethical, and economic risks of bringing the group of people who have this condition under the surveillance and control of medical institutions? Will this classification serve the ends of science? Social justice? Economic justice? Will it stigmatize or destigmatize people with the condition? These are sometimes empirical questions that can be answered using the tools of psychology, economics, and anthropology, as well as biology. They are also often questions that call for normative reflection and reasoning. And the answers to these questions may not all line up the same way. There is just no reason to think that the answer as to what best serves economic justice is also the answer that will best serve science, and so on.

A central point for me here is that whether something should be medicalized, relative to a set of goals or from the point of view of a particular stakeholder, depends on contingent, historically changeable facts about what tools medicine has to offer, and the harms and benefits of medicalizing it right now, in this particular scientific, economic, and social context. Medicalizing Down syndrome in the early twentieth century, for instance, was much more harmful than helpful. There weren't particularly effective therapies available, and medicalization went along with a lack of attention to the social needs and potential of people with the condition, resulting in institutionalization, no productive therapy, and a tragically short lifespan. However, both the therapeutic options and the medical attitudes towards the condition and what it might mean to flourish with it have evolved enormously, and hence the strategic point to medicalizing Down syndrome has shifted.

I am arguing that it is appropriate to classify something as a disease when it is strategically helpful for legitimate purposes to bring it at least partially under the control, management, and surveillance of medicine, with all the social, ethical, and epistemological complexity that this entails, and when it shows up as a pathology when using the epistemic toolbox of medicine. In other words, it is appropriate to classify a condition as a disease when it is appropriately an object of medical concern and control, at least to an extent, and it is pathological from within medicine. But this does not mean that we cede complete control over the condition to medicine; if this were my account, then I would just be allowing medicine to have authority over what it means for something to be a disease, which would undermine my whole point that the concept of disease serves multiple masters. When we allow a condition to be medicalized, the way that it is indexed to the institution of medicine will vary and may be quite thin. It may involve borrowing epistemological framings or moral meanings from medicine, for instance, or allowing medical institutions to keep track of cases. And, importantly, we can medicalize a condition and count it as a disease for some purposes even if it does not count as a disease from within medicine, as long as medicine pathologizes it. Once again, consider the case of infertility, which is not a single disease from inside medicine, but which is categorized as a disease by the World Health Organization and typically by fertility clinics, and often by those who suffer from it.

Philosophers of science have argued for the irresolvably ununified, essence-free character of various scientific concepts. Kenneth Waters (2017) speaks of concepts that lack "general structure" and are not naturally orderly, while Philipp Haueis (2021) argues that many scientific concepts are "patchwork concepts" with no distinctive essence. Lilienfeld and Marino (1995) argued specifically that mental disorder is what they called a "Roschian concept," organized around paradigm cases but with no necessary and sufficient conditions. My account of disease is similar

in spirit to these. There are, however, two ways in which I think my account is even more radically pragmatist than these others. First, these authors are offering messy, fragmented accounts of the semantics of scientific terms, and they are interested in the multiple ways in which the concepts they analyze are used in reasoning. I am not engaged in a semantic project; I am interested in the multiple and incompatible uses to which we put the concept and language of disease, not just in reasoning, but in things like allocating funds and care, creating community, disciplining bodies, assigning responsibilities, and so forth. I think the concept of disease is used in too many different ways for too many different purposes for the question of its semantics to be a well-formed one, and I am instead making a claim about its patchwork pragmatic form. Second, and relatedly, these philosophers of science look at the life of the concepts they study within science itself, whereas it is essential to my point that I am looking at the life of the concept of disease in a wide range of institutions, of which science is only one. I am not only claiming that "disease" has no core meaning, and hence is a patchwork concept in Haueis's sense (although that seems true as well), but also that it has no core use, with its use in scientific reasoning being just one of many.

If "disease" has no essential nature and the concept and language of disease are mobilized in irreconcilably different ways in different contexts, perhaps we should just be eliminativists about the notion. Why, we might wonder, should we hold only such a messy concept?[7] I have two responses to this suggestion. First, it is not clear who "we" who are being asked to eliminate the term are here. Philosophers, according to my account, have no special authority over the concept; a large part of my point is that lots of different institutions and stakeholders need and use the concept for their own purposes. So whatever philosophers think about the uselessness of the concept is in a way beside the point, since it is in fact useful and strategically important to many. Second, there is in fact something that holds the varied uses of "disease" loosely together, I have been arguing, although it is not a shared meaning but a shared, loose institutional use: calling something a disease indexes it somehow or other to the institution of medicine, which, internally, understands it as a pathology. I conclude that nothing in my account motivates eliminativism with respect to the concept of disease.

As I mentioned up front, I have gone out of my way not to say anything about any systematic conceptual relationship between disability and disease. It is a vibrant topic within disability studies whether and how disability should be medicalized (see Shakespeare 2013 and Oliver 2018 for helpful overviews of this debate). There is a lot of well-developed resistance to the medicalization of disability and disabled iden-

[7]Haueis (2021) offers this worry about the patchwork scientific concepts that he discusses (and provides his own response, which I will not take up here). I thank him for raising this worry about my account in private conversation.

tities, and yet some disabilities put one in need of medical care and surveillance, and some are classified as diseases from within medicine. I do not believe that the best definition of disability makes any essential conceptual reference to disease or medical need or dysfunction, although that is a topic for a different essay. But one useful feature of my pluralist, strategic account of disease is that it gives disabled people and communities a tool: It allows them to legitimately mobilize a disease framework when they need access to care, medical accommodations, and the like, without thereby being stuck reducing disability to disease or essentially conceptually suturing them together. By acknowledging that disease is a shifting, pluralist, strategic category that can give access as needed to medical institutions without revealing some underlying "true nature," I hope to provide a tool for clarifying some theoretical and practical debates within disability studies and activism.

The Social Construction of Disease and the Problem of Past Diseases

Is disease "socially constructed" in my view? First of all, note that plenty of particular diseases—pancreatic cancer, say, or cystic fibrosis—are natural kinds, and are in no interesting sense socially constructed (which is not to say that they don't take on social meanings or that their manifestation and course are not affected by social factors). This essay does not offer any kind of account of particular diseases, but it surely seems on the face of it like some are natural kinds and some are social kinds; Ian Hacking and his descendants have argued that various mental disorders, for example, are "looping" kinds that come into being through a complex feedback loop between acts of medical and social categorization and responses to being categorized (Hacking 1986). But my interest is in the category of disease, not in disease categories, and on my account, disease itself is a socially constructed category of a distinctive sort. This is because "disease" is an institutional kind, to use a term that I introduced in Kukla (2014).[8] That is to say, while diseases are fully real, the category of disease is constitutively dependent upon and embedded within a social institution. I have argued that we can only understand what counts as a disease by looking at what it is strategic to medicalize, and this constitutively indexes the concept of disease to medical institutions. Were there no medical institutions, there would be no such thing as medicalization, and hence no such thing as a condition that it is strategic to medicalize. Even stronger, I've argued that what counts as a disease depends on the contingent, historical facts about what medicine has to offer right now,

[8]There I argued that health is an institutional kind, but again, neither then nor now do I define health as the absence of disease.

given our particular goals, and so the concept of disease is constitutively dependent upon the actual, concrete institution of medicine in all its contingent specificity.[9]

In this way, "disease" is a concept like "paycheck" or "prison." Such concepts simply get no grip except as conceptually sutured to an institution—medicine, the wage labor economy, or the criminal justice system, respectively. Just like a locked room that is materially identical to a prison is not a prison if it is not located within a social system in the right way, pancreatic cancer, though a natural kind in its own right, is not a disease if it doesn't bear the right relationship to medical institutions. Diseases, like paychecks and prisons, are decidedly empirically real. Their constitutive dependence on social institutions doesn't make them in any way subjective or capable of being wished away. In all three cases, we ignore their very real material impacts at our peril. The fact that pancreatic cancer is a disease makes all sorts of material difference to the phenomenon–it means that one will have access to certain treatments, patient groups, insurance payments, etc.–just as the fact that a locked room is a prison makes a material difference to what is involved in being locked in it. Moreover, unlike "pure" social constructions, which exist and have the character they have only in virtue of how we socially identify them (like "typical Geminis," perhaps), there are plenty of empirical facts of the matter that help settle objectively whether something should count as a disease, on my account. And yet, we cannot make sense of the idea of disease except by understanding the relationship between diseases and medical institutions. This means, most boldly, that had there never been any medical institutions, there would be no such thing as diseases, though many particular conditions that are, as it turns out, diseases would of course still have existed and caused harm.

It is crucial to distinguish the type of institutional dependence that I am describing here with the straightforward social constructionism of someone like Englehardt (1974). Englehart also argues that the concept of disease is constitutively dependent upon the institutions of medicine, but for him, this dependence is one of direct descriptive determination. As I mentioned at the start, Englehardt argues that a disease is simply whatever medical institutions medicalize and pathologize. Thus he is willing to bite the bullet and insist that, for example, things like masturbation

[9]Sean Aas (private conversation) objects that a condition might be strategic to medicalize *were medicine to exist*, and hence that the concept of disease does not actually depend on the institution of medicine, on my account. But first, this still makes it conceptually dependent on this institution, which would be enough to make my point. More importantly, though, I think this objection treats my account as a metaphysical one, rather than a truly pragmatic one. I am taking about what it is *actually* strategic to do, and there is no point to trying to insert a condition into an institution that doesn't actually exist. If it didn't exist, there would be no contingent, concrete details about what sort of institution it was, and hence no determinate answer to the question of whether it would be a good idea to medicalize it if the institution did exist.

and hysteria, which were medicalized in the past, were at that time actually diseases, though they are not any more, since we have demedicalized them or concluded that they don't exist at all. On this account, there is no room for medical institutions to get their disease classifications wrong. But surely most of us want to be able to say that people were just making a mistake when they classified these things as diseases.

My account understands disease not in terms of what we do medicalize, but in terms of what it is strategically a good idea to medicalize, given a legitimate set of goals, whether or not we do. Hence the relationship between disease and medicalization is constitutive but also normative rather than descriptive. This allows me to offer a fairly rich account of how we can make a mistake in classifying something as a disease. It follows from the pragmatic account I have been giving that there can be at least three different ways in which it is wrong to classify something as a disease.

First, internal to a perspective and a set of strategic goals, it may in fact not advance those goals to medicalize something and allow it to be pathologized. There can be legitimate disagreement within a group of stakeholders who share goals as to whether medicalization is the best strategy. We see such debates within the intersex community, for instance, concerning whether it is strategically helpful to keep the medicalized umbrella label "disorders of sexual development" for intersex conditions. The community shares the goal of getting access to appropriate, unstigmatizing medical care, but disagrees over whether the pathologization that comes with labeling intersex as a "disorder" and putting its management and definition in the hands of medicine is worth the unified access to care and the decoupling of intersex from some sort of gender pathology (Feder 2009; Davis 2011). Notice that, importantly, the debate here over whether intersex is best thought of using disease categories does not in any way rest on empirical disagreements over the etiology or underlying biology of the condition; rather, these are social and ethical disagreements.

Second, different groups of stakeholders with different goals and perspectives may disagree over whether one another's goals are legitimate. Remember that I argued that it is appropriate to categorize something as a disease if doing so serves legitimate strategic ends. But if the legitimacy is missing, so may be the appropriateness. For instance, an identity-based advocacy group may believe that it is simply illegitimate for drug companies to frame their shared condition as a disease for profit-making reasons. Even if medicalizing the condition is in fact strategic from pharmaceutical companies' point of view, given their goals, there is room for social disagreement over whether their goals are legitimate or ethical, and accordingly whether the strategic deployment of a disease framework should receive social uptake at all. This debate is active around the topic of "female sexual dysfunction," for instance, with many people feeling that pharmaceutical companies have opportunistically mobilized a disease framework in order to monetize the normal fluctuations and context-dependence of women's libidos (while other, equally vocal groups

have bemoaned the greater medical attention given to men's sexual function and attributed the difference to the social disvaluing of women's sexual pleasure) (Cacchioni and Tiefer 2012; Kukla 2016). Racist nineteenth century physician Samuel A. Cartwright coined the term "drapetomania," which was the "disease" that slaves had that made them want to escape slavery (Cartwright 1851). However we cash out the details of his goals in medicalizing the desire for freedom, we certainly can all agree now that those goals were simply illegitimate, and that drapetomania was never a legitimate disease for that reason.[10]

The third way in which it can be wrong to classify something as a disease goes back to the pathology requirement.[11] A group or institution may classify something as a disease, and while it may be right that medicalizing it serves its strategic goals, it may be that from within medicine it is not actually a pathology. For example, much of the rhetoric, including patient rhetoric, around cosmetic surgery casts surgeries not just as aesthetic improvements that people might enjoy, but–appropriating uncomfortably from a certain kind of trans narrative–as medical corrections of some sort of disorder in which the "inner self" does not match the "outer self" (see, for instance, Blum 2003; Davis 2003). But a disease narrative does not work here, because, although the medicalization of appearance may be useful for meeting various goals, inside medical metaphysics and epistemology, there is no such thing as an "inner self" that has a particular nose shape or breast size, and there is no pathology that is being corrected or treated with surgery. (Of course, profit-driven cosmetic surgeons also sometimes help themselves to this language of fixing pathology and allowing the inner self to match the outer self, but in doing so they are departing from a narrowly medical framing of the service they are offering.) To return to the example of female sexual dysfunction, which has been cast as a disease by pharmaceutical companies and by some community groups, there is active debate over whether it actually corresponds to any medical pathology. If it doesn't, then it is inappropriate to call it a disease, even if "treatments" increase some people's well-being.

While we can be wrong about whether something should be counted as a disease in any of these three ways, it can seem that the extent to which my account of disease is social constructionist can still cause problems, when it comes to talking about the past of a disease. Surely, the objection goes, there were diseases before there was med-

[10]I used to use homosexuality as my go-to example of a condition that had been wrongly medicalized. But Elizabeth Barnes convinced me that perhaps, there were good strategic reasons at one point to medicalize homosexuality– for example, to neutralize the narrative that it was a kind of moral depravity. Certainly, though, we want to say now that anyone who still medicalizes homosexuality does so for bigoted and illegitimate reasons, and that such medicalization causes enormous harm and should not be done.

[11]Many thanks to Simon Hollnaicher for pointing out this third possibility.

icine, and particular diseases often predate useful medical tools and knowledge for surveilling, understanding, or managing them. Pancreatic cancer predates any kind of medical understanding of or tools for managing it, and indeed it surely predates medicine itself. But it seems bizarre to say that pancreatic cancer was not a disease until there were useful ways of medicalizing it, since after all, it has remained the same condition throughout. Certainly Englehardt's direct social constructionism has this consequence, which he would happily embrace. But the conclusion seems implausible if we are aiming for a more robustly realist account, in which it is a concrete material feature of a condition that it is a disease, and not just a matter of social fashion. Here there are three points to be made.

First, I argued earlier than when we medicalize something, one of the things we typically do is bring medical epistemology to bear as the framework for understanding it and tracking it, and medical metaphysics to bear in understanding its nature. But once we medicalize pancreatic cancer, we thus typically privilege the tools of medicine for understanding what it is and how it works. And from inside the framework of medicine itself, pancreatic cancer has a natural history that stretches well into the past. From inside the perspective of medical epistemology, most things that are diseases now have been diseases for a long time, and predate their own medical management and understanding. Most diseases do not just pop into existence (although some do, of course). Moreover, in deciding that it is strategic to medicalize something, we are buying into a certain amount of deference to medical epistemology. Medicine itself tells us that pancreatic cancer is the kind of thing that is rooted in stable biological processes that predated our understanding of them. And hence, once we do medicalize pancreatic cancer, we can say, using the epistemological and metaphysical framework and tools that we have decided is most appropriate, that pancreatic cancer is not only a disease now, but that it always has been one. This kind of reverse causality may seem tricky, but I don't think it is spooky: using the tools that we deem best now, these tools reveal the condition that we are using them for to have always been a disease. These tools have built-in temporal structure to them. Accepting that the epistemology of medicine governs a condition means accepting a framework in which conditions generally have a stable past and a long natural history. At the same time, had medicine never come along, then it never would have been properly classifiable as a disease, because it never would have been strategic to medicalize it.

Second, once again, my account is not a unified story of what disease really is. I am a radical pluralist about that. According to medical epistemology, diseases are biological conditions of individual bodies with particular kinds of etiologies and epidemiologies. According to pharmaceutical companies they may be something different, and according to patients or policy makers, other things again. When the World Health Organization insists that "infertility is a disease," for instance, they are

making a complex social claim about global health priorities, and not claiming that there is some unified biological condition there (World Health Organization 2020). So the question of whether a condition really truly was a disease in the past misses the point of my account, which is to understand disease as a strategic category with no stable core.

Third, and relatedly, if we keep in mind the point that I am giving an account of when we should count something as a disease and what kinds of things are at stake in that decision, then it really doesn't seem that strange to say that there was no reason to count pancreatic cancer as a disease before we understood anything about the condition or had any medical tools for detecting or addressing it. Why would we have done this? Our past selves had no motivation to medicalize the condition nor even the conceptual resources to do so, and this is the sense in which the condition didn't count as a disease in the past. We literally couldn't so count it. But, from our current perspective, given that pancreatic cancer is now thoroughly medicalized, and its metaphysics and epistemology are in the hands of medicine, we have good reason to say that it is now true that it was always a disease.

Institutional Pluralism

I argued that like "paycheck" and "prison," "disease" is an institutional kind, constitutively sutured to an institution. But the institutional embedding of the concept of disease is far messier than that description reveals. Part of the point that I have been making from the start is that "disease" is a concept that has life in multiple different institutions, playing different strategic roles in different contexts and for different stakeholders. I've analyzed the concept of disease as having a pragmatic constitutive relationship to medicine. But we also saw that the concept has life within the insurance industry, the workplace, various identity-based communities, the market, and more. I am arguing that all these different institutions, when they mobilize the concept of disease, to some extent grant one institution, medicine, certain kinds of power over how a condition will be treated. But they do this for a variety of different purposes, and the concept continues to have different forms of life within these different institutions as well. Indeed, the mobilization of the concept of disease can forge complicated ties between the institution of medicine and the other institutions in which it has life. Thus "disease" is not only an institutional kind but what we might call a pluralist kind as well—one that means different things and is mobilized in different ways for and by different institutions, though always with reference to and some deference to the institution of medicine. This means that while medicine gets some social and conceptual control over the concept of disease, we cannot meaningfully ask whether something counts as a disease without further situating the question in a richer institutional context.

I will spend a bit of time on an analogy: consider the concept of work. Work is also an institutional kind; we understand what counts as work through the lens of an economic system of differentiated wage labor. This is the institutional background against which the concept of work gets a grip. But we don't simply equate work with wage labor. Indeed, the question of what counts as work depends heavily on who is asking and for what purpose. The concept of work has life in many different domains, and what counts as work shifts depending on the domain and the context, although it always remains true that by calling something work we are drawing on the resources of the wage labor economy to understand it and perhaps to manage it. Thus "work," like disease, is a pluralist institutional kind.

Consider the wide range of activities that may or may not count as work, depending on the question we are asking and the goal we are trying to achieve. If we are making money without doing anything, for instance from the stock market, does this count as work? How about the reverse: what if we are doing something like an internship that mimics the activities and form of wage labor but is unpaid? If we are going to a dinner for the purpose of networking, are we working? When does creative thought become work? If we work in a creative field, where is the cutoff between just tossing around ideas in our head or chatting and actual work? Should unpaid domestic labor count as work? How about the use of one's body—for example, surrogacy or gamete donation? What do people mean when they insist that sex work isn't work (for instance, see Watson 2014)?

When we try to settle such questions, we do so with reference to the wage labor system—we are asking whether the activity is best framed using the conceptual and institutional resources of that system. However, we don't just equate work with wage labor. Rather, we situate the question within the institutions and goals within which the notion of work has strategic life, and we give different answers to the above questions depending on this context. So for instance, for tax purposes, unpaid domestic labor is not work, but in settling with your spouse who has done more work lately and is more deserving of a night out, it often is. When you claim that domestic labor is work, and hence that you have worked just as hard this week as your spouse has, you are not demanding wages, but you are using the framework of wage labor–it's way of understanding units of time, value, and productivity, for instance–to make your case. If you want to say that you are "busy with work" and shouldn't be interrupted, creative thought counts as work, but no one will recognize your request that a space be made accessible just because you find yourself thinking about a project while you are there. In contrast, you do get to demand the accessibility of a space where you hold an internship, even it is unpaid. Different countries have decided differently whether things like surrogacy and gamete donation count as work, and can be paid. We also might be engaging in more abstract debates over who counts as

a "productive citizen"[12] or who is involved in reproducing the means of production; here again the relationship between an activity and the wage labor economy is conceptually important but not dispositive.

The point is, there is simply no unified answer to what really counts as work. There is no single essence of work to be uncovered, which will tell us the correct answer to whether creative reflection, unpaid child care, surrogacy, waiting out the stock market, and internships are actually work. The concept of work has different life within the institutions of the family, labor law, taxes, economics, and more.

My suggestion is that disease is like work in these ways. It's not arbitrary or just made up what counts as a disease, or as work, but there is no answer to either question outside of social institutions and projects, and the answer may well change, depending on the purpose for which we are asking and the setting in which we are asking. In neither case is there some true, unified essence to be uncovered; rather, the classification is always strategic. But despite this messiness and diversity, to classify something as a disease, or as work, from within any context, is always to bring a specific institutional apparatus on board: in insisting that something is work, or a disease, I am insisting that the institutional resources and norms, including (and perhaps sometimes only) the conceptual resources and norms, of the wage labor system or the medical system be mobilized.

Settling Whether Something Counts as a Disease

I have argued that whether something counts as a disease is a strategic question, and one that often has life within multiple institutions and projects which may give conflicting answers. Once we classify something as a disease, we give some (perhaps quite limited) authority to medicine to define it, but until we classify it as a disease, the question of whether it is a disease or not is not a narrowly biomedical question. Rather, there is a huge array of strategic and social questions as well as medical questions that we might want to ask. I've drawn out some of these along the way. These include, but are not limited to:

1. Does treating this condition as a unitary phenomenon enable or impede research or treatment, or should it be broken into narrower or more proximate conditions, or widened and linked with other conditions? (Consider the debates over whether Asperger syndrome is a useful diagnostic category, for instance, or whether the old category of "manic depression" should be replaced with "bipolar disorder 1" and "bipolar disorder 2.")

[12] I am not endorsing such debates!

2. How effective are our current medical tools at alleviating suffering? How effective are they at clarifying the phenomenon in question?

3. Will framing this condition as a disease further or impede economic justice?

4. Do we want insurance plans to cover treatment for this condition?

5. Will framing this condition as a disease help those who have it build an empowered shared identity? Or will it undermine a sense of community?

6. Will counting this condition as a disease undergird already-problematic social norms or challenge them? For example, did the introduction and expansion of "erectile function disorder" undergird troubling norms according to which men are supposed to be always ready for sex, regardless of context?

7. Will counting the condition as a disease alleviate or enhance structural inequality and disadvantage?

8. Will a disease label be experienced as a legitimizing relief for those with the condition, or will it pathologize and stigmatize them, or perhaps both?

9. And importantly, but not dispositively, do people with this condition want to be recognized as suffering from a disease? Or do they resent and resist the label? The experiences and preferences of potential patients matter, on my account, not because they get to make up reality, but because their strategic desire for or resistance to being inserted into medical institutions and pathologized is a serious concrete concern.

If I am right then, no amount of biomedical research or philosophical definition-setting on its own will determine what counts as a disease, and hence whether we want to insert a condition into medical institutions, handing over some authority and power over it to them and allowing it to be framed as pathological; it's an inherently messy and multipronged question. There are plenty of conditions where the answer is easy: they line up neatly on the "yes it's a disease" side of each of these considerations, sometimes so obviously that we don't have to ask all of these questions. Pancreatic Cancer is clearly a disease; it passes all of these tests. Just as clearly, some conditions fail all these tests and are clearly not diseases. Homosexuality, at least now, is a clear example. But there are all sorts of conditions where the answers to these questions are hard, and the verdicts are split, and the calculus may change over time as both medical resources and social contexts chance: addiction, Deafness, obesity, infertility, and autism are all examples. Whether the answers to all these questions line up the same way is not settled by natural features of the condition alone; many, indeed most, of these questions are ineliminably social and

depend on institutional, economic, psychological, and other kinds of facts that do not have to do with the isolatable natural features of the body.

Consider a complex condition such as "prehypertension," which involves having statistically higher than average blood pressure that falls short of the cutoff for hypertension. Where we decide to draw the line above which blood pressure counts as "diseased" is not based on a cut-off written into nature, although questions about natural causality and risk are relevant. We need to be asking questions such as: who exactly will this diagnosis bring under the control of medicine and pathologize? Will the diagnostic category disproportionately stigmatize and increase surveillance and control over already-disadvantaged groups? Black people and fat people are more likely to have statistically higher than average blood pressure, for instance (Elliot and Black 2007; Glasser et al. 2011). Turning prehypertension into an official diagnostic disease category may mean that these marginalized groups are going to be disproportionately stigmatized and disciplined, and treated as "out of control" of their health. Will giving them this diagnosis come with sufficient health benefits to offset those costs? Who makes money off of medicalizing pre-hypertension and thus creating a market for treatments? Chronic conditions are, as I mentioned earlier, especially lucrative. Who will find themselves suddenly socially required to cleave to new norms of self-discipline and self-surveillance, and what are the costs of that? Does marking out this condition open up productive new research questions? We cannot decide whether prehypertension is a disease just by studying its biology or even its causal or statistical relationship to hypertension proper. This knowledge alone will not answer these complex questions and settle whether labeling prehypertension as a diagnosable disease is a good idea.

Another rich example is ADHD. Many people are helped by medical treatments for ADHD, and they can use the medicalization of the condition as leverage to get much needed accommodations that help them flourish. At the same time, medicalizing ADHD is profitable. It also pathologizes stereotypical "boy behavior" and directs attention away from ecological factors such as classroom structure that might warrant critique and rethinking. Consider how different our epistemological approach to ADHD is if we are using the tools of medicine or the tools of social anthropology to understand it; each has epistemological advantages and disadvantages. There is no simple answer to how people with the condition feel about the label; some find it pathologizing and burdensome and others find it legitimizing and use it as a springboard for a productive and proud disabled identity. There is no single answer as to whether ADHD counts as a disease as opposed to just a neurodiversity and an alternative way of being in the world; it is strategic for some purposes to count it as one and strategic for others to push back against this framing and the medicalization that goes with it. The disease label has its important uses, but we need to apply it

with subtle and socially responsible critical awareness. And so for many conditions, especially those tangled up in complex social meanings and economic pressures.

But who is the "we" that gets to decide whether something is a disease? Again, once we medicalize a condition we give at least some limited priority to medicine to define and manage the condition (by definition). But this doesn't mean that medicine gets priority in advance for deciding what to medicalize in the first place, nor authority over whether it continues to be a good idea to medicalize something. Nor can philosophers settle the issue a priori. Given the wide variety and interdisciplinarity of the kinds of relevant questions "we" need to ask—which draw on medicine, law, economics, health policy, public health, political science, psychology, sociology, and philosophy, as well as the lived experience of people with a condition—there is literally no one who could possibly have the expertise to be in an authoritative position from which to balance and settle all these various strategic questions.[13] I also don't believe there is any abstract or fixed way of ranking which strategic questions and goals take precedence. Thus whether and when something should count as a disease is essentially a collaborative, multidisciplinary, multiperspectival, messy question. The best we can hope for is consensus when we need it for the purpose of large-scale social decision-making, and even then consensus may be elusive. This is not because there is some truth of the matter we failed to uncover, but because of the pluralist, fundamentally pragmatist nature of the concept of disease.[14]

REFERENCES

Barnes, Elizabeth. Forthcoming. *Health Problems*. Oxford: Oxford University Press.

Blum, Virginia. 2003. *Flesh Wounds.* Berkeley, CA: University of California Press. https://doi.org/10.1525/9780520938731

Boorse, Christopher. 1975. "On the Distinction Between Disease and Illness." *Philosophy and Public Affairs*: 49–68.

Boorse, Christopher. 1977. "Health as a Theoretical Concept." *Philosophy of Science* 44.4: 542–573. https://doi.org/10.1086/288768

[13]Sean Valles (2018) also defends the need for messy interdisciplinary consensus and distributed expertise to settle questions concerning the boundaries of health and disease, although he arrives at the same conclusion in different ways.

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Cacchioni, Thea, and Leonore Tiefer. 2012. "Why Medicalization? Introduction to the Special Issue on the Medicalization of Sex." *Journal of Sex Research* 49.4: 307–210. https://doi.org/10.1080/00224499.2012.690112

Cartwright, Samuel A. 1851. "Diseases and Peculiarities of the Negro Race." *DeBow's Review* XI.

Choy, Yujuan, Franklin R. Schneier, Richard G. Heimberg, et al. 2008. "Features of the Offensive Subtype of Taijin-Kyofu-Sho in US and Korean Patients with DSM-IV Social Anxiety Disorder." *Depression and Anxiety* 25.3: 230–240. https://doi.org/10.1002/da.20295

Conrad, Peter. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18.1: 209–232. https://doi.org/10.1146/annurev.so.18.080192.001233

Conrad, Peter. 2010. *Deviance and Medicalization: From Badness to Sickness*. Philadelphia, PA: Temple University Press.

Daniels, Norman. 1992. "Growth Hormone Therapy for Short Stature: Can We Support the Treatment/Enhancement Distinction?" *Growth: Genetics and Hormones* 8.1: 46–48.

Daniels, Norman. 2007. *Just Health: Meeting Health Needs Fairly*. Cambridge: Cambridge University Press. https://doi.org/10.1017/cbo9780511809514

Davis, Georgiann. 2011. "'DSD is a Perfectly Fine Term': Reasserting Medical Authority Through a Shift in Intersex Terminology." *Sociology of Diagnosis* 12: 155–182. https://doi.org/10.1108/S1057-6290(2011)0000012012

Davis, Kathy. 2003. *Dubious Equalities and Embodied Differences: Cultural Studies on Cosmetic Surgery*. Lanham, MD: Rowman & Littlefield.

Elliott, William J., and Henry R. Black. 2007. "Prehypertension." *Nature Clinical Practice Cardiovascular Medicine* 4.10: 538–548. https://doi.org/10.1038/ncpcardio0989

Engelhardt, Tristram Jr. 1974. "The Disease of Masturbation: Values and the Concept of Disease." *Bulletin of the History of Medicine* 48.2: 234–248.

Feder, Ellen K. 2009. "Imperatives of Normality: From 'Intersex'" to 'Disorders of Sex Development.'" *GLQ: A Journal of Lesbian and Gay Studies* 15.2: 225–247. https://doi.org/10.1215/10642684-2008-135

Feder, Ellen K., and Katrina Karkazis. 2008. "What's in a Name? The Controversy Over 'Disorders of Sex Development.'" *The Hastings Center Report* 38.5: 33–36. https://doi.org/10.1353/hcr.0.0062

Feit, Neil. 2017. "Harm and the Concept of Medical Disorder." *Theoretical Medicine and Bioethics* 38.5: 367–385. https://doi.org/10.1007/s11017-017-9418-8

Glasser, Stephen P., Suzanne Judd, Jan Basile, et al. 2011. "Prehypertension, Racial Prevalence and its Association with Risk Factors: Analysis of the Reasons for Geographic and Racial Differences in Stroke (REGARDS) Study." *American Journal of Hypertension* 24.2: 194–199. https://doi.org/10.1038/ajh.2010.204

Hacking, Ian. 1986. "Making up People." In *The Science Studies Reader*. Edited by Mario Biagioli. London: Psychology Press.

Halfmann, Drew. 2012. "Recognizing Medicalization and Demedicalization: Discourses, Practices, and Identities." *Health* 16.2: 186–207. https://doi.org/10.1177/1363459311403947

Haslanger, Sally. 2000. "Gender and Race: (What) Are They? (What) Do We Want Them To Be?" *Noûs* 34.1: 31–55. https://doi.org/10.1111/0029-4624.00201

Haueis, Philipp. 2021. "A Generalized Patchwork Approach to Scientific Concepts." *British Journal for Philosophy of Science*. https://doi.org/10.1086/716179

Jilek, W. G., and L. Jilek-Aall. 2001. "Culture-specific mental disorders." In *Contemporary Psychiatry*, 965–993. Springer: Berlin, Heidelberg. https://doi.org/10.1007/978-3-642-59519-6_56

Kingma, Elselijn. 2010. "Paracetamol, Poison and Polio: Why Boorse's Account of Function Fails to Distinguish Health and Disease." *British Journal for the Philosophy of Science* 61.2: 241–264. https://doi.org/10.1093/bjps/axp034

Kukla, Rebecca. 2014. "Medicalization, 'Normal Function,' and the Definition of Health." In *The Routledge Companion to Bioethics*, edited by John D. Arras, Elizabeth Fenton, and Rebecca Kukla, 539–554. New York: Routledge. https://doi.org/10.4324/9780203804971

Kukla, Rebecca. 2016. "Failed Medicalization and the Cultural Iconography of Feminine Sexuality." In *Philosophy of Love and Sex: Thinking Through Desire*, edited by S. LaChance-Adams, 185–208. Lanham, MD: Rowman and Littlefield.

Kukla, Rebecca. 2019. "Infertility, Epistemic Risk, and Disease Definitions." *Synthese* 196.11: 4409–4428. https://doi.org/10.1007/s11229-017-1405-0

Lexchin, Joel. 2006. "Bigger and Better: How Pfizer Redefined Erectile Dysfunction." *PLoS Medicine* 3.4: e132. https://doi.org/10.1371/journal.pmed.0030132

Lilienfeld, Scott O., and Lori Marino. 1995. "Mental Disorder as a Roschian Concept: A Critique of Wakefield's 'Harmful Dysfunction' Analysis." *Journal of Abnormal Psychology* 104.3: 411–420. https://doi.org/10.1037/0021-843x.104.3.411

Metzl, Jonathan, and Anna Kirkland, eds. 2010. *Against Health: How Health Became the New Morality.* New York: NYU Press.

Oliver, Michael. 2018. *Understanding Disability: From Theory to Practice.* Macmillan International Higher Education.

Parens, Erik. 2013. "On Good and Bad Forms of Medicalization." *Bioethics* 27.1: 28–35. https://doi.org/10.1111/j.1467-8519.2011.01885.x

Shakespeare, Tom. 2013. Disability Rights and Wrongs Revisited. New York: Routledge. https://doi.org/10.4324/9781315887456

Spitzer, Robert L., and Jean Endicott. 2018. "Medical and Mental Disorder: Proposed Definition and Criteria." In *Annales Médico-Psychologiques, Revue Psychiatrique* 176.7: 656–665. Elsevier Masson. https://doi.org/10.1016/j.amp.2018.07.004

Stegenga, Jacob. 2018. Medical Nihilism. Oxford Scholarship Online. https://doi.org/10.1093/oso/9780198747048.003.0011

Valles, Sean A. 2018. *Philosophy of Population Health: Philosophy for a New Public Health Era*. Routledge. https://doi.org/10.4324/9781315163307

Wakefield, Jerome C. 1992. "The Concept of Mental Disorder: On the Boundary Between Biological Facts and Social Values." *American Psychologist* 47.3: 373–388. https://doi.org/10.1037/0003-066x.47.3.373

Wakefield, Jerome C. 2007. "The Concept of Mental Disorder: Diagnostic Implications of the Harmful Dysfunction Analysis." *World Psychiatry* 6.3: 149–156.

Waters, C. Kenneth. 2017. "No General Structure." *Metaphysics and the Philosophy of Science: New Essays*: 81–108. https://doi.org/10.1093/acprof:oso/9780199363209.003.0005

Watson, Lori. 2014. "Why Sex Work Isn't Work." *Logos: A Journal of Modern Society and Culture* 13.3–4. http://logosjournal.com/2014/watson/.

World Health Organization. 2020. "Infertility." https://www.who.int/news-room/fact-sheets/detail/infertility.