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Beyond bioethics: the 5th International Philosophy of Medicine Roundtable

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We are pleased to once again present to the readers of *Theoretical Medicine and Bioethics* papers from the Philosophy of Medicine Roundtable. Previous issues have followed the 3rd and 4th Roundtables, and the current issue presents a selection from the more than 20 papers presented at the 5th Philosophy of Medicine Roundtable, which took place in New York, at Columbia University, in November 2013. Like its predecessors, held in Birmingham, AL, Rotterdam, and San Sebastian, this Roundtable attracted speakers from around the world. It also featured keynote presentations from Rita Charon of Columbia University and Ross Upshur of the University of Toronto.

It may seem somewhat odd to feature a special issue on philosophy of medicine in a journal that effectively has philosophy of medicine in its title. However, a review of the contents of this journal and similar ones, such as the *Journal of Medicine and Philosophy*, will quickly reveal such an issue's purpose. The dominant content of these journals consists of medical ethics in all it forms and, to a lesser degree, philosophy of mind in the context of philosophy of psychiatry. Philosophy of medicine, as it is represented at the Roundtable, is much less

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frequently featured. Philosophy of medicine broadens the range of philosophical questions that are asked about medicine. In particular, approaches from philosophy beyond ethics, such as the philosophy of science, metaphysics, epistemology, and methodology are strongly represented at the Roundtable. As one of us is also an editor of this journal, we know that the dominance of biomedical ethics and philosophy of psychiatry is not due to any antipathy on the part of the journals to philosophy of medicine. Rather, the explanation may be that philosophy of medicine has not been generating the volume of philosophical work and debate that it could fruitfully sustain, nor a volume of work comparable to that in bioethics.

Nonetheless, there has been substantial progress in the field. Philosophy of medicine in this broader sense has continued to advance in the interval since the last Roundtable. Perhaps the clearest sign of this is that there are currently no fewer than three multi-author textbooks of philosophy of medicine being prepared, each targeting a different audience. There have also been many new books, including volumes by Hillel Braude [1], Alex Broadbent [2], Raffaella Campaner [3], Havi Carel and Rachel Cooper [4], Daniel Hausman [5], Philippe Huneman, Gérard Lambert and Marc Silberstein [6], Phyllis Illari and Federica Russo [7], Robert Perlman [8], Jenny Slatman [9], and Miriam Solomon [10], to consider just the English press. Including French, German, Italian, and Spanish literature would add many more volumes. The Roundtable, too, has progressed. The 2011 Roundtable in San Sebastian was the first Roundtable that was not *ad hoc* but planned under the auspices of the International Philosophy of Medicine Roundtable (philosmed.org). With the 2013 Roundtable, we have seen that there is enough demand, material, structure, and resources to plan for regular Roundtables around the world. The next Roundtable is scheduled for Bristol later this year. Indeed, the emergence of what promises to be a second recurring conference in philosophy of medicine, the International Advanced Seminar in the Philosophy of Medicine (IASPM), shows that there is more than enough demand and support for such conferences.

Of course, this special issue represents only a limited selection of the papers presented at the Roundtable. We believe, however, that the papers published in this issue well represent both the quality and range of the papers that were presented. Other papers from the roundtable have been published or are forthcoming in the *Journal of Medicine and Philosophy* [11], *Philosophy of Science*, [12] and *Journal of Evaluation in Clinical Practice* [13].

The special issue begins with two papers concerned with traditional issues in philosophy of science: causal methodology and progress. In "Placebo Orthodoxy and the Double Standard of Care in Multinational Clinical Research" [14], Maya Goldenberg revisits a well-known set of ethically controversial placebo-controlled clinical trials that took place in the developing world in the mid 1990's, the purpose of which was to test short-term versus full course AZT as a treatment to reduce maternal-fetal transmission of HIV. While there has been much discussion in bioethics about the contention that such trials reveal a morally dubious "double standard" (such trials would not have been accepted in the developed world), Goldenberg takes up what she says is a neglected line of thought, one that relies on an analysis of methodology and the philosophy of science. In particular, she claims

that an unjustified assumption of the necessity of placebo controls led to inappropriate judgments about the trial design, resulting in the unnecessary loss of many lives.

Goldenberg first criticizes the arguments that placebo controls are methodologically superior, in terms of, for example, reliability and efficiency, to active-control equivalency trials across the board. She then challenges the particular reasons given for why placebo-controls were necessary in the particular set of trials in question. Important here is the matter of exactly what question needed to be answered by the trial, and within this, she argues that a subgroup analysis of the original ACTG 076 data suggests that it was already known that the short course treatment would work better than a placebo, but that this was not taken seriously at the time.

William Goodwin's paper, "Revolution and Progress in Medicine" [15], falls squarely within the tradition of history and philosophy of science. Through a consideration of the case of Ignaz Semmelweis, Goodwin seeks to show two ways in which Kuhn's account of science is applicable to medicine. He shows, first, that medicine's theoretical paradigms are similar to those of other sciences and, second, that Kuhn provides tools for understanding even non-revolutionary change in medicine.

Goodwin's foil here is Donald Gillies, who sees Semmelweis as revolutionary in the Kuhnian sense. Gillies's argument, as Goodwin frames it, relies on paradigms in medicine being "composite" and, thus, different from those in other sciences. Regarding Semmelweis, Goodwin argues that he was not a misunderstood revolutionary, but a failed practitioner of normal science. And while Goodwin agrees that medical paradigms are composite in an important sense, he does not understand this in the way that Gillies does. For Goodwin, the paradigm for medicine is composite in that it has three parts: (1) a cluster of commitments regarding the study of disease, (2) commitments to the effectiveness of medical interventions and the ways to measure it, and (3) commitments to the institutions that study and implement medicine. Understood in this way, paradigms can help us understand progress in medicine, or lack thereof, as occurring in any of these three domains. In each of these domains, however, the paradigm can be understood as Kuhnian. The paper closes with a reconsideration of Semmelweis in light of this account.

The next three papers deal with topics tied more specifically to medicine: the nature of diagnoses, disease, and health. Hanna van Loo and Jan-Willem Romeijn, in "Psychiatric Comorbidity: Fact or Artifact?" [16], ask why comorbidity is so high for psychiatric conditions. Often, a depressed patient is also anxious, a schizophrenic patient also depressed. Such comorbidity is much more common than for non-psychiatric medical conditions. This raises interesting questions about the legitimacy of the distinctions that psychiatric classification systems draw between such conditions in the first place. In this paper, van Loo and Romeijn propose a conventionalist answer, in place of more familiar answers in terms of classification choices or causal ties between disorders, and argue that this answer resolves the experimenter's regress and the problem of arbitrariness for psychiatric classification. Their paper contains much of value both in setting out the nature of the problem of psychiatry—in particular, emphasizing the importance of a "zone

of rarity" between symptom clusters in motivating a classification system—and in its originality of contribution.

Antoine Dussault and Anne-Marie Gagne-Julien propose a homeostatic view of health in "Health, Homeostasis, and the Situation-Specificity of Normality" [17]. Their account shares many of the features (and advantages) of Boorse's account of health, being naturalistic and utilizing the concept of design, and by integrating this with the concept of homeostasis, they are able to handle a number of counterexamples.

They motivate their analysis by addressing in detail a dilemma that Kingma has shown exists for Boorse's account—that it cannot simultaneously handle two significant sorts of counterexamples having to do with specificity: the situation-specificity of many normal functions (such as digestion, which only performs its function at particular appropriate times) and the situation-specificity of many diseases (such as mountain sickness, involving a temporary set of symptoms brought on by high altitude). They follow Hausman in rejecting an analysis relying on statistical typicality, and they emphasize that health must be conceived as an intrinsic property of the organism. In particular, they say that health is an organism's homeostatic disposition to maintain its designed functions. They then demonstrate how this definition sheds light on the various aspects of situation-specificity, and how it accounts for the intuitions that have played a role as counterexamples to previous analyses.

Finally, in "Biological Pathology from an Organizational Perspective" [18], Cristian Saborido and Alvaro Moreno explore the concept of biological malfunction, which, they argue, is the core concept in naturalistic accounts of health. They draw on recent developments in the philosophy of biology concerning biological malfunction. Specifically, they seek to apply the "Organizational Approach," appealing to the notions of "adaptive regulation" and "functional presupposition" to offer a novel conceptual framework for thinking about biological malfunction in the context of naturalistic accounts of health. The paper thus represents an attempt to link the debate about naturalism about health and, in particular, the naturalistic position in that debate, to the philosophy of biology, which is surely a worthwhile way to deepen the naturalistic account of health.

This special issue serves as a reminder that philosophy of medicine is a vital part of the discipline of philosophy and as a call for yet more work in the field. It also illustrates, we hope, the potential for philosophy of medicine to contribute usefully to the medical professions. We hope that the papers will provide readers with a sense of the excitement and invigorating discussion the attendees of the Roundtable experienced and inspire more future work, both at the Roundtable and throughout the philosophical community.

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