The human right to health & its intersection with multiculturalism

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**NANYANG
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**THE HUMAN RIGHT TO HEALTH & ITS
INTERSECTION WITH MULTICULTURALISM**

**KATHRYN LYNN MUYSKENS
SCHOOL OF HUMANITIES
2019**

The Human Right to Health & Its Intersection with Multiculturalism

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School of Humanities

A thesis submitted to the Nanyang Technological University in
partial fulfilment of the requirement for the degree of Doctorate
in Philosophy

2019

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I certify that all work submitted for this thesis is my original work. I declare that no other person's work has been used without due acknowledgement. Except where it is clearly stated that I have used some of this material elsewhere, this work has not been presented by me for assessment in any other institution or University. I certify that the data collected for this project are authentic and the investigations were conducted in accordance with the ethics policies and integrity standards of Nanyang Technological University and that the research data are presented honestly and without prejudice.

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Associate Professor Andres Carlos Luco

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This thesis **does not** contain any materials from papers published in peer-reviewed journals in which I am listed as an author.

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Kathryn Lynn Muyskens

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SUMMARY

Human rights have been a popular topic in political philosophical literature. Recently, the human right to health has garnered increasing attention. Yet, the philosophical community has not adequately investigated the meaning of health and medicine, or explored how different interpretations may interact in multicultural contexts. How we define these key terms will have significant impact on how the human right to health is interpreted and how it will interact with other rights both within liberal democratic nations and in the international political realm. In this thesis, I will argue for a pluralistic definition of health and medicine. Though I argue that there is more than one valid conception of both health and medicine, there will still be some versions judged unacceptable or inadequate, thus constraining the possible acceptable expressions of health and medicine. As a whole, the thesis examines the relationships between health, culture, and political institutions. While other scholars have defended the inclusion of health in the list of human rights, the operant conception of health was under-defined. Human rights have a complicated relationship with international relations and have sometimes been accused of unjustly assuming Western values to be universal. In my thesis, I take the view that health is a universal good, but also a culturally laden concept, and thus there is a need to articulate how political bodies can respect the human right to health without perpetuating ethnocentric bias. This new understanding of health and healthcare will inevitably influence how the human *right* to health will be understood, and thus the later chapters of this thesis are devoted to exploring how cultural variations in health and medicine play out in domestic and international policy. I hope the arguments I make here will be useful for healthcare policy makers, humanitarian health organizations, and medical practitioners, as well as informative for academics and lay people as to the value that health has for human well-being and its relationship with culture and identity.

INTRODUCTION

Human rights are meant to be universal, but it is sometimes asserted that, in fact, they represent a decidedly Western world view or are even tools for Western political agendas. This argument, sometimes referred to as the “parochialism” argument, is sometimes levied against human rights by ethical relativists. The argument for ethical relativism centres on the incommensurability of certain values from culture to culture. Without some common ground, there is no reason to think that we can have universal human rights. If we accept the relativist position that one culture has no basis on which to judge the practices of another, human rights may become utterly impotent against injustice. There have been various attempts to answer this accusation by offering a foundation for human rights that is convincingly universal. But, like Allen Buchanan (2013) has noted, most of the various philosophers’ arguments have been conceptually imperialistic, assuming “that there is only one concept of human rights (namely, theirs)” (“Preface”). Fortunately, there seems to be a middle path available – the pluralistic approach.

As James W. Nickel (2007) has argued, it is possible that there can be widespread acceptance of the existence of human rights without agreement on the philosophical grounding of those rights. In other words, we can come to agreement about human rights without advocating any imposition of Western values on the rest of the world. This pluralistic view avoids the downfalls of relativism without endorsing Western values as necessarily culturally superior. Further, there may be additional value in a pluralistic justification for human rights in itself, in that it allows for diversity and flexibility in a way that other views cannot.

When not contesting their grounding, much of the debate around human rights, and the human right to health in particular, centres on how we define the relevant terms. Jonathan Wolff’s article, “The Content of the Human Right to Health,” sets out to define what the human right

to health would and would not entail, when it could be considered violated and by whom, and how it could be feasibly fulfilled. Others, like Gopal Sreenivasan (2012), have introduced scepticism about what it could mean to have a right to health at all. In his article he takes the position that having a right to health places demands on the state that are at once too much and too little.

Yet, both Wolff and Sreenivasan take the meaning of both health and healthcare as given. While conflicts between local cultural practices and scientific objectivity have been analysed in the abstract, their intersection with politics, health, and medicine, despite being vital, has been undertheorized. Likewise, the implications of multiculturalism in the realm of healthcare policy and humanitarian health interventions across cultural boundaries has been neglected in the field of political philosophy and bioethics. This project will mend these gaps in understanding.

Many in the Western biomedical field and in the field of political philosophy generally take it for granted that health is a universally recognizable term. However, health is in fact a culturally laden concept. Culture shapes our behaviour and perceptions. It affects when we perceive ourselves to be unwell and why, and what actions we take in order to get better. There are many aspects of health which are culturally relative, and while this does not mean that there is no *real* state of health, ignoring cultural variation in the way it is conceived can perpetuate serious ethnocentric bias.

Additional complications arise in cases where the state in question is unable to meet the health or healthcare needs of its people. In such cases, International Non-Governmental Organization (INGOs) and humanitarian health organizations may step in to help. Yet, often these organizations face significant challenges in navigating the cultural divide. Despite having benevolent intentions, the communities these organizations serve are vulnerable, and special

care must be taken to avoid culturally imperialistic pressure. Health is valuable, but so is cultural identity and heritage. Unfortunately, in situations of crisis, the worst off may be forced to pick between the two. This can happen because of imbalances in power between the communities giving and receiving aid, such that those doing the giving may (even unintentionally) make coercive offers to those they wish to benefit.

From a political angle, philosophers like Anne Phillips (2007), as well as Will Kymlicka and Baogang He (2005) have argued convincingly that states ought to embrace multiculturalism. But this debate has not yet been explored in the context of how it affects public health, or healthcare policy. This urgently needs to be explored – especially in areas where health is under threat, and where multiple cultural conceptions of health and medicine intersect.

Almost every culture has developed its own unique tradition of medicine – and most of these pre-date the scientific method. However, parts of the medical world (including anthropologists, physicians, and ethicists) are sharply divided in their opinions about how to regard these practices. For historians and anthropologists (Good 2008, Winkelman 2009, Burri 2010), it can seem of obvious and urgent importance to document these traditions, because many are in danger of being wiped out as the globe continues to modernize and, as a consequence, homogenize as well.

On the other hand, some Western doctors have come to see other styles of medicine as a threat – as part of an anti-intellectual, anti-scientific trend, or simply as ineffective and potentially harmful snake oil peddled by charlatans (Offit 2015, Pigliucci and Boudry 2013). Ignoring medicine's relationship with culture and social structures leads to ethnocentric discrimination. This is problematic because it can lead to the medical contributions of less powerful groups being unjustly discounted, to the detriment of everyone. However, simply

disregarding scientific investigation of medicines fails to respect the real value of human health – which transcends cultural boundaries.

To bridge this gap, it is necessary to explore a few simultaneous research questions – first, concerning the *nature* of health and medicine, second, the question of how medical efficacy can be determined non-ethnocentrically, and third, an examination of how politics, cultural identity, and medicine relate to one another.

Over the course of five chapters, I attempt to address these questions. First, by laying the case for believing that there is a human right to health, and how this can be articulated in a multicultural fashion. Following that, I provide my own explicitly political account of health (Chapter Two) and medicine (Chapter Three). Ultimately, I argue that the health that is defended in the human right to health is comprised of four components (biological, psychological, social and environmental) and that medicine, as applied science and social institution, is characterised best as a relationship with several necessary parts (patient, practitioner, treatment, and theoretical framework). The last two chapters examine the implications these conceptions of health and medicine have in the domestic policy of liberal multicultural states (in Chapter Four), and in the international sphere (Chapter Five).

CHAPTER SUMMARIES:

Chapter One: The Case for a Multicultural Human Right to Health

Though human rights have gained increasing acceptance in the international discourse, there is still much disagreement over what it means to claim that something is a human right. Within the philosophical literature, debate continues as to what could provide adequate grounding, whether they are best thought of as moral or legal in nature, and which rights deserve the status of a human right. At the same time, there is still resistance by some groups against accepting the fact that human rights exist at all. The objections I engage with come from two popular fronts, either the cynical accusation that human rights are merely political excuses for Western countries to justify intervening in the affairs of other states that do not share the same values, or relativistic worries that it is neither true nor fair to claim that *one* set of cultural values is superior to another, and therefore no universal standard is possible or justified. The human right to health is often one of the rights called into question, since it belongs to the so-called “second generation” rights, also known as “social and cultural rights.” These rights (like a right to education, etc.), are not accepted by some theorists because they are thought to be “positive rights” or rights to goods and services, rather than “negative rights” which are rights to be free from interference from others (like a right not to be tortured).

In this chapter I discuss some possible answers to the question of what could ground the existence of a human right to health. But first, I address the need for this right to be formulated in a way that allows for cultural differences, and how this can be accomplished. Ultimately, I conclude that a political conception of human rights, grounded in an interest-based account of the minimally decent human life, is best equipped to avoid these problems,

and that this foundation makes clear the need for a right to health to be included in the list of human rights.

Chapter Two: A Human Right to What Kind of Health?

Ideally, the human right to health ought to defend people against standard threats to the level of health needed for a minimally decent human life. It is important for universal human rights to avoid being culturally parochial – both to gain acceptance globally and to aid effectiveness in creating positive change. Thus, it is important that not only the *right* to health avoid parochialism, but also its operating conception of *health*. Until now, it has mostly been assumed that the kind of health the right to health is concerned with is clearly understood and universal. Few have questioned what the nature of *health* is in this context. In this chapter, I argue that the health that is protected in the human right ought to be understood to be pluralistic.

After reviewing the philosophical literature on the nature of health, and the advantages and disadvantages of four main camps (naturalist, constructivist, instrumentalist and phenomenological), I argue for what is ultimately a hybrid view. Inspired by what is known as the biopsychosocial model in clinical medicine and psychiatry, I have broken down health into sub-parts: the biological, psychological, social and environmental. Separating health into four components helps us to understand the nature of the standard threats to health. Each component of health points to one of the areas of human experience required for the good life as well as a particular front on which threats to health can arise.

Chapter Three: A Human Right to What Kind of Healthcare?

The human right to health is typically thought to include the right for people to have fair access to adequate healthcare. However, before we can have useful discussions about the

details of meeting people's right to healthcare, we ought to first clarify what *healthcare* is. This paper attempts to define what the nature of healthcare is in this context. We ought to avoid both parochialism and excessive permissiveness in the answer to this question. To begin, we need to acknowledge that there is more than one valid and relevant sense in which a person can be healthy or ill, and more than one acceptable way to be cured. At the same time, a right to healthcare that is not also explicitly the right to effective healthcare rapidly loses meaning.

In attempting to define healthcare, I draw inspiration from a parallel discussion in the philosophy of science: the demarcation problem. Ultimately, I argue that medicine has a dual nature as both an applied science and a social institution, and is characterized by the presence of four necessary elements: patient, practitioner, theoretical framework and treatment. To further refine my account, I distinguish between four categories: medicine, non-medicine, bad medicine and pseudo-medicine. Finally, I discuss the criteria for determining medical efficacy and acceptable medicines in a way that avoids ethnocentric bias.

Chapter Four: From Liberal Multiculturalism to Medical Pluralism

If a liberal state is committed to protecting its people's right to health, and its people belong to diverse cultural backgrounds, how does this effect the way the state goes about meeting its people's right to healthcare? Culture, health, and medicine intersect in many different ways – and not always without friction. In this chapter, I ask how the state ought to interact with communities with different health related or medical beliefs and practices. Answering this question will require the discussion of some controversial areas in the philosophical literature: the debate around whether or not to embrace multiculturalism, the existence of group-differentiated rights, and the question of whether we ought to embrace medical pluralism. I will argue that liberal democratic states with multicultural societies ought to embrace medical

pluralism. To lay out my argument I will first address why liberalism and multiculturalism are compatible and how some group-differentiated rights are consistent with liberal democratic principles. Then, I will attempt to provide some guidance for how the state ought to interact with various medical communities in a way that both promotes health and respects cultural differences.

We don't want the state to be play the role of dictating every choice we make about our own health and bodies, but we also don't want the state to be in the role of promoting pseudo-science. It is difficult, but possible to articulate a way in which a liberal democratic state can respect cultural difference in matters of health and medicine while still protecting its people from charlatanry and medical malpractice. Liberal democratic states with multicultural populations ought to recognise medical pluralism, as a matter not only of respecting group-differentiated and individual rights, but also as a human rights issue.

Chapter Five: Intervening on Behalf of Health

In this chapter, I attempt to deal with the ethical issues that arise in cross-cultural attempts to meet the human right to health and respond to its violation. In these contexts, there are a few key dimensions to examine. First, we should assess whether the right to health has been met or violated. Then, if the right has been violated, we must determine the best response. Reasons for failing to meet the right come in two kinds: (1) a state may be unable to meet its citizens' human right to health, or (2) it may be unwilling to do so. Each kind of failure requires different a kind of response, and each kind of response comes with its own complications and limits. Care must be taken to avoid the appearance of ethnocentric bias when claiming that a human rights violation has occurred, to avoid reinforcing the narrative that human rights are merely justifications for Western imperial impositions.

Threats to health do not stop at political boundaries, and thus a commitment to protecting health (and the duty to respond) must extend beyond national borders as well. These facts, combined with its status as a positive right, means that in addition to responding to outright violations, intervention can also be both obligated and justified on the behalf of unmet minimum standards.

When the primary duty holders are unable to meet those minimum standards, the obligation diffuses to other capable bodies, which can include humanitarian organizations and INGOs. This unique dynamic necessitates additional ethical strategies to guide the actions of such organizations when acting in lieu of the primary duty holders.

CHAPTER ONE: THE CASE FOR A MULTICULTURAL HUMAN RIGHT TO HEALTH

Human rights are nothing if not controversial. Though they have gained increasing acceptance in the international discourse, there is still much disagreement over what it means to claim that something is a human right. Within the philosophical literature, debate continues as to what grounds human rights, whether they are best thought of as moral or legal rights, and which rights deserve the status of a human right. At the same time, there is still resistance by some groups against accepting the fact that human rights exist at all. Though there are many possible critiques of human rights, in this chapter I will address the objections that come from two prominent camps (1) the cynical accusation that human rights are merely political excuses for Western countries to justify intervening in the affairs of other states that do not share the same values, and (2) relativistic worries that it is neither true nor fair to claim that *one* set of cultural values is superior to another, and therefore no universal standard is possible or justified.

The human right to health is often one of the rights called into question, since it belongs to the so-called “second generation” rights, also known as “social and cultural rights.” These rights (like a right to education, etc.), are not accepted by some theorists because they are thought to be “positive rights” or rights to goods and services, rather than “negative rights” which are rights to be free from interference from others (like a right not to be tortured) (O’Neill 2015).

In this chapter, I will discuss some possible answers to the question of what could ground the existence of a human right to health. But first, I address the need for this right to be formulated in a way that allows for cultural differences, and how this can be accomplished. Ultimately, I will conclude that a political conception of human rights, grounded in an interest-based account of the minimally decent human life, is best equipped to avoid these

problems, and that this foundation makes clear the need for a right to health to be included in the list of human rights.

1.1 BETWEEN THE ROCK & THE HARD PLACE: PAROCHIALISM & RELATIVISM

I will argue that human rights (including a human right to health) should be understood as political instruments which derive their moral legitimacy from human interests and the minimally decent life. As political instruments, however, they can be undermined in two important ways: first, by undermining the claim to universality by appealing to a kind of cultural relativism, and second, by accusing human rights of unjustifiably imposing values that are not actually universal. Both objections focus on the claim to universality of human rights, the first arguing that there can be no such thing, and the second arguing that human rights, as stated or practiced, have missed the mark. Successfully avoiding these accusations is like navigating through Scylla and Charybdis. As political instruments, universal applicability is essential to both the legitimacy and efficacy of human rights. In this section, I will demonstrate why human rights (the human right to health included) ought to strive to avoid these problems.

As will be demonstrated in the later sections of this chapter, an account of human rights grounded in human interests avoids some problems that accounts based in will or personhood cannot. One of the issues an interest-based account avoids is a lack of acceptance, that is, just because a person or culture does not accept the idea of human rights does not mean that they do not possess human rights. This is rooted in the belief that there are certain ways of treating a human being that are wrong, regardless of whether any individual or group believes that it is wrong. I will explain this further in the following section, but first, it is important to establish what sense of universality is important. Human rights, as their name implies, are meant to

apply to all people by virtue of their humanity alone. This is what many have in mind when they think of the universal application of human rights – which they apply to everyone. But some others hold a stronger claim to universality which is that human rights belong to all people *at all times*.

From a historical perspective, human rights discourse did not emerge until very recent history. Thus, for the historical or anthropological perspectives it may initially seem strange to claim that in the distant past people's human rights were violated by a lack of clean water in a time before anyone had heard of germ theory. If medieval Europeans had said their right to health was violated during the Black Death it would have been meaningless because no institution at the time could have prevented or treated the affliction, nor was any institution capable of punishing anyone for causing it, let alone identifying the plague's origin. However, this kind of universality seems less strange if we shift the focus away from how certain events may be categorized as violations of a right to health or not depending on when they occurred, to the enduring importance of health to a decent human life.

As Jonathan Wolff (2012) describes in his book, *The Human Right to Health*, “Human rights is not a static concept. Our understanding of human rights is constantly evolving as we come to know more about the human condition” (22). As civilizations advance and societies become ever more capable of defending human health, it is natural for it to become less justifiable not to do so. The political conception of human rights requires that there are political bodies to which people can address their complaints, and which can act in response. Meaning, the emergence of political institutions capable of protecting people from a plague like the Black Death carries with it the obligation to exercise those capabilities. The more control we attain over the things which influence health, the more likely injuries to health will stem from some human actions, and thus, the likelihood that injuries to health will also be violations of the right to health increases. It is this sense of universality that human rights can

justifiably claim. Now, I will turn my attention to the twin problems of parochialism and relativism.

The Perils of Parochialism

Why is it important to avoid cultural parochialism in human rights? Those who doubt that parochialism is a problem at all might wonder: if one culture hits upon something that is truly good, what could be wrong about exporting that to other cultures? After all, isn't that what happens with almost everything we enjoy? Do we want to claim that it was wrong for the first people that discovered mathematics to teach it to their neighbours? Certainly not.

It's a very human trait to mimic what we like in others and recreate it for ourselves. Good ideas (and sometimes even bad ones) are contagious. Those who reject the legitimacy of human rights because of perceived parochialism are not upset because the ideas have an origin in one place as opposed to another, but because they perceive something coercive is at work.

The playing field of international politics is not equal. There are significant power differentials between what is commonly known as the developed world and the developing world. While the days of the old colonial empires are largely gone, the globe is still dealing with the aftermath. This continuing power imbalance makes coercion possible, even in situations where it is not intended. As Thomas Pogge (2002) explains in, "Responsibilities for Poverty Related Ill-Health," "[t]he better-off impose a shared institutional order on the worse-off" (367). This is morally problematic because not only is there a "feasible alternative institutional order under which radical inequality would not persist," but because this imposition "harms the poor in the interest thwarting sense of the term, [and] the interests thwarted ... are basic needs" (Pogge 2002, 367).

Given the persistent imbalance of power in the global order, the burden to refrain from making unjust impositions falls upon those in power. When this power imbalance gives over to an infringement on the agency of the less powerful group, it becomes imperialism. While the colonial era that gave imperialism such prevalence in the past is largely behind us, many thinkers continue to raise worries about its more subtle forms, i.e. cultural imperialism. For example, the political philosopher Lisa Fuller (2012), who argues that cultural imperialism is still a pressing problem in cross-cultural interactions. While colonial era imperial practices were carried out with the belief that one culture was superior to another, and involved coercive pressures to intentionally alter the beliefs and practices of the so-called “inferiors,” Fuller defines this new form of imperialism (cultural imperialism) by its coercive dynamics alone (Fuller 2012). I will pick up on her arguments again in Chapter 5, but for now it is enough to say that parochialism in human rights, and the related potential for cultural imperialism, is problematic – not because of the content of the beliefs it may privilege, but because of the injury done to the agency of less powerful societies.

Interfering with the agency of other communities is not only morally suspect, but it also undermines the ability of human rights to be effective political instruments against injustice. Ignoring cultural difference is a political non-starter. It makes it harder to convince other societies not already predisposed to believe in the claims of human rights of their importance or legitimacy. This, in turn, undermines the ability of human rights to be an effective political instrument for the people who could benefit the most.

An Archimedean point is not always attainable. Ideas have origins, but it’s a bad idea to go down the path of rejecting or adopting ideas based on their origins – we should respond to ideas based on their truth and merit. The real question is how can we be sure we are making the best efforts to avoid ethnocentric bias in our ethical evaluations? We have two options to answer this. We could say, “To each his own” – but this is essentially giving up on the idea

that different human societies can cooperate successfully. We are all worse off if we simply resign from trying to find common ground and go our separate ways.

So, what is the alternative? The more we practice intellectual humility and commit to continuing dialogue and the representation of different perspectives, the more reason we have to trust that the ideas that eventually rise to the top actually do so through merit rather than parochial bias. We can have reason to trust some ideas more than others, and we can feel justified in our preferences when we have taken measures to combat various biases.

Responding to the Relativists

Cultural relativism (the belief that moral standards exist if and only if a cultural group holds them to exist, and that these standards apply only within that group) has found popularity in certain disciplines, and notably within anthropology. The trend of Boasian anthropology, named after its founder Franz Boas, emphasizes the need to understand cultures in their own terms, which is indeed important. In part, the appeal of this trend may be attributable to a pushback against the era of colonialism and ethnocentrism that produced so much suffering around the world. This is an understandable reaction. Yet, we should not uncritically accept the premise that we must side with the relativists to avoid accusations of ethnocentrism.

The American Anthropological Association (AAA) released two statements in response to the Universal Declaration of Human Rights, one in 1947 and one in 1999. The first statement reflected the widely held belief at the time that human rights and cultural tolerance were somehow at odds. The idea was that the acceptance of conflicting cultural norms and values entailed a rejection of human rights' norms (Engle 2001).

The second statement in 1999 was initially seen as a turnaround from the earlier position, as the AAA seemed to back down on the argument that human rights and cultural tolerance were

necessarily opposed. Yet, both statements strongly advocate for the protection of culture, necessitating the continued tension between tolerance and judgment (Engle 2001).

While it is indeed important to be tolerant of cultural differences, the cultural relativists are vulnerable to two serious problems. On one hand, the rhetoric of cultural relativism can be used as an excuse for otherwise inexcusable behaviour (Farmer 1996).

Cultural relativists claim that “a moral judgment is true just because it describes what a society really stands for” (Shafer-Landau 2014, 300). As Russ Shafer-Landau describes in his book, *The Fundamentals of Ethics*, this argument reduces moral claims to “veiled reports of cultural commitments” (Shafer-Landau 2014, 301). The implication is then that wherever cultural norms have permitted slavery, genocide, or honour killing, the perpetrators’ hands are clean as long as their society backed these actions at the time.

Another political philosopher, William Talbott (2005), has made stronger claims against cultural relativism as it relates to human rights. Talbott imagines and then debunks several possible defences of cultural relativism. I will discuss two of them here, (1) the “incommensurability thesis,” and (2) the “claim of distorting bias” (Talbott 2005, 45-47).

The “incommensurability thesis” claims that different culture’s moral outlooks are fundamentally irreconcilable. Yet, Talbott points out, if the values of other cultures were truly incommensurable, their internal norms would necessarily be opaque to us. Talbott gives the example of Hindu cultural norms as seen by a Westerner. The cultural relativist would claim that Westerner’s cannot criticize Hindu customs, but then goes into great depth about how the internal norms of Hindu society function. Talbott argues that if these norms can be successfully explained to an outsider, then they are not opaque, and thus not incommensurable.

Next, the “claim of distorting bias” argues that we are incapable of separating ourselves from our own cultural contexts and biases and that this prevents us from being impartial in any evaluation of cultures not our own. To this argument, Talbott cedes some ground. Indeed, he says, this is sometimes true – as with the Spanish conquistadors in the Americas (Talbott 2005, 47). Yet, just because it is hard to separate ourselves from our own cultural biases, this does not mean it is impossible. In fact, sometimes an outsider’s perspective is necessary to gain clarity about the morality of a culture’s internal moral norms.

In addition to these problems with cultural relativism, in a somewhat paradoxical turn, appreciation of cultural difference can lead to a dangerous kind of cultural essentialism which can be just as disempowering to people as imperialistic oversteps (Farmer 1996).

To develop a system of international human rights, we cannot get very far if we accept that morality is relative. However, it isn’t necessary to accept the claim that to argue for moral realism we must privilege one society or culture over others. To argue for universal human rights is simply to argue that it is possible to be wrong about what is moral, not to a claim that any person or society actually is moral (or more moral than the rest). It’s perfectly possible that we’re all wrong. We don’t need to be relativists to avoid imperialistic harms, but we do need to admit the possibility that our perspective is limited and fallible. Avoiding parochialism requires practicing the virtue of epistemic humility.

Empowering disadvantaged people will change their cultures, but this kind of change is not the same as culture loss induced by cultural imperialism. A healthy culture is able to respond to change. Just as a species must adapt to survive, so must societies. As H.L.A. Hart said, “societies survive changes in basic moral views [and it would be] absurd to suppose that when such a change occurs, [that] one society has disintegrated and been succeeded by another” (“Hart-Devlin Debate”).

Human rights are meant to apply globally, and in doing so they must impose some standard on all the societies in the world, and this will require some to change. It is important for this standard to avoid perpetuating the unjust power imbalances that currently exist and to give a real and effective tool to the disadvantaged to improve their situations. To do this effectively and justly it matters what we think grounds these rights.

1.2 WHAT GROUNDS *RIGHTS*?

Whatever else they may be, human rights are a kind of right. So, in beginning the grounding discussion, it is useful to say a little about the various arguments about the nature of rights in general before settling on what kind of interpretation might make sense to ground human rights, and the human right to health specifically.

There are several schools of thought regarding the nature of rights. Rights can be either legal or moral. Legal rights are rights that states grant their citizens through law or custom. In contrast, moral rights are not dependent on the state's recognition. Moral rights, sometimes also called natural rights, are thought to be grounded in human nature or sometimes argued to be endowed by divine law. Some thinkers, like Jeremy Bentham, have argued that rights can only be understood as legal rights. Other thinkers, like Thomas Aquinas, came to the opposite conclusion, arguing that if legal rights did not have their roots in prior natural law, they were merely a façade.

However, the debate between legal and moral interpretations of rights is not the only fault line in the philosophical discussion. Theories of what grounds rights typically break down into two camps: the *will theory* and the *interest theory* (Kramer 2013). Under the will theory, rights protect the choices of the right holder and preserve the person's ability to make choices. A good example is the practice of informed consent in medicine, which protects the patient's right to decide what treatments he or she will accept or reject. On the interest account, rights

protect the interests of the right holder (interests being what furthers the subject's well-being), regardless of the individual's ability to make choices. For example, if someone pulls me out of the way of an oncoming car they are acting in my interests, regardless of whether I gave consent to being grabbed. In most scenarios these two theories converge, because people tend to choose what is in their interests.

A right not to be assaulted both protects the person's well-being and ability to make choices. But the will theory gives some decidedly counterintuitive answers in other cases. For instance, under the will theory of rights, anyone with diminished reasoning capacity, like the very elderly, disabled, or even children might be excluded from the community of rights-holders since they do not have the same ability to reason and make choices. The interest theory is more inclusive, but presents another problem. How can we demarcate the community of right holders? Anything that is alive can be said to have interests in this way: animals have an interest in not being hunted, grass has an interest in not being cut. But how can we decide which interests should be protected with rights? The will theory is clearly too narrow, but the interest theory may be too broad. Ultimately, I think the truth is somewhere in between these two views. Rights serve to protect us against coercion and enshrine respect for the choices we make, but this protection ought also to extend to our interests (regardless of whether they align with conscious choice).

Why should we worry about rights at all? Whether we think they are legal or moral in nature, or grounded in will or interests, rights have a particular function in societies. There are some situations where we never think to invoke them, and others where invoking rights could even make those involved worse off. We don't typically say a husband has a right to his wife's affection, even if ideally, we hope that affection would be present (and mutual) in a marriage. If this isn't sufficient to explain the foundation of rights, this at least hints at their purpose. Even if we might disagree about their fundamental nature, we use rights-based discourse

primarily (although perhaps not exclusively) in the *political* realm, to defend the individual from the powers of the society and state. We don't usually invoke our rights in intimate relationships, or when our interests are thwarted by natural phenomena.

It's for these reasons that I find political conceptions of rights (human and otherwise) more plausible. A political conception allows us to remain agnostic about the prior moral grounding, while rejecting moral skepticism. Instead, those in the political camp seek to provide sound arguments for the content, normativity, and roles of human rights in the international political sphere.

As Wolff puts it, “a rights-based moral discourse presupposes a society of conflict and disagreement ... It is only necessary to claim a right if there is a potential or actual dispute” (2012, 21). But whether we like it or not, the world that we live in is one in which there is some significant dispute, and therefore there is a need for this rights-based discourse. Rights have a social and political function, in that “[r]ights give permanence and power [and we] are all better off and more secure with rights to government action rather than hoping for the government's continued goodwill” (Wolff 2012, 16).

It is not possible to address all of the interesting things that can be said about rights in this chapter. So, for now, it must suffice to merely gesture to these controversies as we home in on the discussion of one particular breed of rights: human rights.

1.3 WHAT GROUNDS *HUMAN RIGHTS*?

In the philosophical conversation of the grounding of human rights, there are echoes of many of the same divides: moral vs. legal, will vs interest, etc. Though I believe that rights, and human rights included, are best thought of as political instruments, many people think that human rights still need further justification from the moral realm. Legal rights are contracts

between governments and citizens, but there is no one government which has authority over all humans.

Some political philosophers, like James Griffin (2008), strongly defend the formulation of human rights as moral rights. In a similar vein as the will theorists mentioned earlier, he grounds his notion of human rights in human autonomy and personhood. John Tasioulas (2010), on the other hand, defends the idea that human rights are grounded in human interests (the things which contribute to human flourishing). Both Griffin and Tasioulas agree that human rights are meant to defend the ability of people to pursue a worthwhile life, but they emphasize different parts of the equation – mirroring the divide between will and interests described earlier. Tasioulas' argument points to another common theme in the discussion of human rights – the concept of human dignity. The idea of human dignity means that there are certain ways of acting that fail to respect a person's humanity, or demonstrate disrespect for the kind of creature that we are. Human dignity implies that there are some ways that we should not treat people, regardless of whether the individual consents and regardless of whether the individual suffers.

However, agency and interests are not the only options put forth in the philosophical debate. Another popular view is the political interpretation of human rights. Largely inspired by John Rawls' view (1999) the political conception of human rights defines them by their function in connection with political legitimacy and by their role in justifying international (sometimes military) intervention in cases of their violation. Within the political camp there are further divisions of opinion. In addition to agentic and interest based accounts, there are constructivist, anti-foundationalist, and political conceptions of human rights. Not all of the theorists in these camps seem to recognize that both parochialism and relativism are problems.

Some constructivists, like Benjamin Gregg (2010), see the problem of parochialism but not the drawbacks of relativism. He argues for a bottom-up formulation, arguing that local communities decide for themselves what rights they believe are human rights. This allows less powerful societies to exercise their autonomy, but it does little to provide grounds for intervention on behalf of possible minorities in those societies whose interests may be harmed.

Another theorist, Joseph Raz (2010), has taken a different strategy, focusing on their political function in justifying intervention when a state violates the rights of its people. Raz argues that we ought to look at the way human rights rhetoric is used in order to determine their nature, and is sceptical regarding other arguments for their grounding. Raz argues that human rights exist when and where political institutions exist to implement and uphold them. But this perspective seems to ignore the potential harms of parochialism. Without a convincing account of their foundation in universal moral principles, human rights really are just justifications for the powerful to interfere with those with whom they disagree.

Building on Rawls' view, Charles Beitz (2009) focuses on human rights as they have developed in contemporary international practice. He argues that instead of becoming preoccupied with what human rights are at a deep philosophical level, we ought to focus on human rights in practice. Beitz's view is helpful in avoiding the problems of parochialism and relativism as he highlights that we don't need to agree on the foundation of human rights in order to accept and use them. Beitz' view allows us to move on beyond the grounding question to other questions about which rights are human rights and how we ought to use human rights as political tools.

Without tackling the grounding question, however, it's hard to argue that which rights make it onto the list of human rights is not arbitrary. The justification for these rights cannot simply

rest on institutions because this does not seem to accurately track how we think about morality and law in any context, not just regarding human rights. Even ordinary laws have a basis in something other than arbitrary power. We don't think murder is wrong, because it is illegal, we make it illegal because we think it is wrong. Even in most hunter-gatherer societies with no institutions in place to articulate or enforce laws, people still possess a concept analogous to "murder is wrong." This has been supported by anthropological research by Christopher Boehm (2012), who found that all hunter-gatherer societies in a sample of 10 such cultures had a prohibition against murder. Additionally, in his book, *Human Universals* (1991), the anthropologist Donald E. Brown found that *all* cultures on record have a prohibition against murder. Thus, some account of this prior grounding for laws and rights seems necessary.

To bridge the divide between moral and legal visions of human rights, Tasioulas argues that human rights need prior moral grounding in human interests, but other factors must come in to transform that moral right into a political human right. He stresses the importance of the moral ground, since this prevents us from being forced to say that human rights are merely whatever the law says they are (which is often vague and subject to change).

Human rights have their origin in the moral realm, but we have reasons to make only some of them legal. As Wolff writes, "the point of establishing rights is to try to rebalance the power relationship, and to produce long-term, reliable structures that will remove the need for humanitarian concern in the future" (2012, 15-16). We might think it is a vital interest for people to have loving social connections, but just like the marriage example I mentioned earlier – invoking rights in order to make friendships strikes most of us as not only unpleasant but nonsensical. Still, some human rights are best served by being codified in law – which enables them to be appealed to and defended in a concrete way. Once embodied in law, these

rights can defend people against what are often called “standard threats,” a kind of urgent but predictable danger to which people are vulnerable in the modern world.

In the words of Jonathan Wolff, “Essentially human rights have a double role. On the one hand, they provide a statement of the minimum moral obligations owed to human beings simply by virtue of their existence as human beings. On the other, they generate a mechanism of accountability beyond the nation-state” (Wolff 2012, 16). For the purposes of human rights, both moral and legal grounds for human rights are necessary since they are political instruments which have an important role in defending human interests. Now we must address further questions: what are those grounding interests? And what makes them worthy of being embodied in international law?

1.4 WHAT GROUNDS A HUMAN RIGHT TO *HEALTH*?

Human rights are moral rights that protect our ability to pursue a meaningful life and that have been transformed into legal and political instruments. Two things are necessary before something can be said to be a human right – (1) it must be a vital part of a meaningful, or at least minimally decent, human life, and (2) it must be the kind of thing that both can and, morally speaking, ought to be defended from standard threats by political institutions. Thus, if there is such a thing as a human right to health, it must mean that health is an essential component of the minimally decent life, and that health is endangered by standard threats which can be protected against by political institutions. How we define the minimally decent life (and what role health plays in it) will shape the kinds of actions and interventions a human right to health could justify.

In the following chapter, I will examine the question of what health means and how it relates to culture, but for now, I will argue that, however we might define health, we ought to

recognize that it is part of a minimally decent human life, and that it needs and deserves protection.

The Minimally Decent Life

At its base, a minimally decent life involves more than what is needed to survive or simply subsist. For life to be decent, it must be *worth* living, not merely possible to endure. A minimally decent life for a person must include the basic ingredients for the person to survive in a condition preferable to death, but also the basic ingredients for a life that is characteristically human. Beyond this basic definition, however, there is much discussion about the details of what enables a minimally decent life, and what governments ought to provide or at least protect so that their citizens can have the chance to pursue it. Many thinkers argue that societies ought to work to provide their members with some minimal conditions, but there is disagreement over what form that minimum should take.

Common answers fall into roughly three categories: welfare, resource, and capabilities. The welfare view, building on the foundation laid by Jeremy Bentham (1789), argues that a life worth living is one that contains generally more pleasure than pain. The other camps, myself included, would argue that this is too simplistic. More is required to make a human life good than a little more pleasure than pain.

The welfare view is also too vague to provide any instruction for action. Many things can make us happy, and many things can cause us to suffer. Some kinds of suffering are worse than others, and some kinds of happiness more meaningful, but to articulate this, we need to appeal to other criteria beyond pleasure and pain.

A more recent development in the welfare view attempts to measure how well off someone is in terms of desire-satisfaction instead of the net pleasure he or she may experience. But even

in this case, the view runs into trouble. The desire-satisfaction view faces two significant problems. First of all, it is not obvious that the amount of desires met or frequency of desires met is what makes a life worth living. Many desires are trivial, and it seems wrong to treat all desire satisfaction as equal. The second problem is that of “adaptive preferences.” Our desires are often shaped by what we perceive as possible or attainable, and people living in worse-off communities will often end up with fewer or less ambitious desires. They adjust to their circumstances. Even if those circumstances are unjust, brutal, or oppressive, as long as the people have adapted to their situation, the welfare view based on desire-satisfaction will fail to motivate change or improvement.

The resource and capabilities views offer more specific answers to what makes a minimally decent life. The resource view, defended by Ronald Dworkin (2000), argues that what people need to have a reasonable chance at a minimally decent life is access to the *means* of attaining it. The capabilities approach, made famous by Amartya Sen (1992) and Martha Nussbaum (2000), argues that a minimally decent human life involves engaging in a variety of essentially human activities. Sen argues that the resource view is too “fetishistic” – forcing us to focus too much on things like income and wealth without paying attention to how those can be used or what they enable people to do. In laying out the capabilities approach, Sen defines the relevant ingredients of a person’s well-being “as being adequately nourished, being in good health, avoiding escapable morbidity and premature mortality, etc., to more complex achievements such as being happy, having self-respect, taking part in the life of the community, and so on” (1992, 39). Nussbaum (2000), laid out her account of what “activities characteristically performed by human beings are so central that they seem constitutive of a life that is truly human” (39). Nussbaum includes ten capabilities in her list: (1) physical survival, (2) bodily health, (3) bodily integrity, (4) the exercise of imagination, (5) emotional response and exploration, (6) practical reason, (7) love and friendship, (8) connection with

nature and other species; (9) play, (10) the exercise of control over environment, including political control (Nussbaum 2000, 40-41).

But the capabilities approach has drawbacks as well. Determining what an appropriate minimum for any of these capabilities is still a nagging question. Without a clear articulation of the minimum, the capabilities approach runs the risk of being too vague to be helpful in advising action. Others worry that more specificity may make the capabilities approach too *sectarian*, providing too narrow and culturally specific of a vision of the minimally decent life.

The resource view can in some ways avoid the problem of disagreement between cultures about what constitutes a minimally good life. It can acknowledge that reasonable people may come to different conclusions about what gives life value and meaning, but that everyone can agree that some level of means is required to pursue any of the different possible options.

What do the welfare, resource, and capabilities accounts of the minimally decent life say about the role of health? Health alone might not be enough to make someone happy, but it is certainly necessary to have health to avoid many kinds of suffering. Health would also seem to increase one's capabilities to pursue other sources of meaning. Thus naturally, health features prominently in Nussbaum and Sen's account. The resource view would have to take a more roundabout defence of health. Defenders of this view could still argue that health is important for the minimally decent life, but would have to say that what is important is not so much health as it is the means to achieve or maintain it.

Endorsing one or another of these theories has implications for how human rights can be used in practice. Whether what is important to defend about health is the means to achieve it, or the capabilities it affords a person, or the happiness it enables, these would each demand and justify different responses to ensure that people can attain the necessary level of health for a

minimally decent life. If all a government needs to do is provide resources – then perhaps paternalistic measures which prohibit people from taking actions which injure health will be harder to justify. If all that matters is people’s happiness, then just because illness might make someone suffer, it would not necessarily mean that curing the illness is the action demanded. If there were cheaper ways to increase happiness to whatever the requisite level, then perhaps that would be a more appealing option to a government rather than ensuring good nutrition or providing medical care. In different situations it may make sense to invoke one or another account of the minimally decent life, but whichever position one takes, health is clearly fundamental to a minimally good life.

Standard Threats to Health

Health is clearly an important part of a minimally decent life, but that is only part of what is necessary to make a case for health as a human right. Some philosophers have doubted whether there could be a right to health for various reasons, from claiming it is too vague, too demanding, or that the only kind of rights that are real are “negative rights” (O’Neill 2015, Sreenivasan 2012, Nozick 1974). This chapter cannot address all of these worries with the attention they deserve, but I will give a few reasons why we should think that despite these other questions, there is a human right to health.

Human rights are often thought to defend against standard threats, meaning predictable, but urgent kinds of threats to a minimally decent life. So, if there is a human right to health, there must be certain predictable threats to health that would meet this criteria.

Claiming that there is a right to health is complicated by many things, including the fact that many things that affect health are not injustices as we usually think of them. Often, when people are ill or in pain, they are the unlucky victims to forces beyond human control – contagious or genetic diseases, accidents, natural disasters, or even their own ill-advised

actions. What injustice, then, is a human right to health supposed to redress? Are the standard threats to health of the kind that a political instrument like a human right could ameliorate?

James Wilson (2014) gives a helpful clarification in his paper “Global Health Inequalities and Inequities” saying,

It is important to draw a distinction between health inequalities, that is, 'differences, variations, and disparities in the health achievements of individuals and groups,' ... and health inequities, that is health inequalities that are all things considered, unjust [i.e.] differences in health which are 'unnecessary and avoidable but, in addition are also considered unfair and unjust' (4).

Many negative health outcomes are unnecessary, avoidable, unfair and thereby unjust. To illustrate, I will describe two scenarios. First, imagine someone who dies because they needed a kidney transplant and there was no matching kidney available, despite the fact that the person had the ability to pay and qualified doctors were available. Though this death is unfortunate, we don't think this is unjust. In contrast, if someone is having a heart attack and goes to the nearest hospital which is capable of providing lifesaving care, but they deny him service based on his ethnicity, we think this is egregiously unjust. These are two cases most people would find uncontroversial. But there are harder cases in the middle that are not always immediately clear.

Two factors are relevant for making something a violation of the person's right to health in the second case – (1) the lack of a justifiable reason for denial of care, and (2) the real possibility of a different outcome if those responsible had acted differently. Scarce resources are a justifiable reason for lack of care, but discrimination based on race is not. That, plus the fact that getting treated in a timely manner for a heart attack carries with it a high likelihood that the patient could recover and go on living. With both an unjust reason and an alternate

scenario that could have led to such a different health outcome makes such a scenario a violation of a person's human right to health.

The difference between inequities and inequalities can be further explained by the discussion of health "inputs" and health "outputs." Inputs would be anything which contributes to health, like nutrition, sanitation, etc. In contrast, health outputs would be the experience or state of the person being healthy or ill. Some might argue that only distribution of health inputs matters (something those in the resource camp regarding the social minimum would likely agree with), and that inequalities in health outputs are only morally objectionable when they result from an unfair distribution of health inputs (Wilson 2014, 5). Health outputs can be the result of not only the availability or quality of various inputs, but also chance. Even the best nutrition and exercise cannot prevent death from an unfortunate accident, and even the best medical care sometimes fails to win against the most intractable cancers. For this reason, health outputs are difficult to guarantee, and therefore a bad measure for whether justice has been served.

Health inputs are another matter. Not all ill health is merely a question of fate. In fact, many illnesses and premature deaths are not due to faulty genes or other such misfortunes, but the direct result of the inequalities created by the social systems in which we live. A quick look at the site *Gapminder.org* reveals that there is a great discrepancy in the average life expectancy that a person could enjoy depending on whether he or she was born in the Congo (where the average life expectancy is a mere 50 years) or in Japan (where the average life expectancy is 83 years). Not only do differences in lifespan exist from one country to another, but more egregiously they exist within countries from one socio-economic or ethnic group to another. For example, "[i]n the United States, in 1988, life expectancy at birth was 75.5 years for whites and 69.5 years for blacks" (Farmer 1996, 276).

Why is there such a close correlation between income and lifespan of people in various communities? Longevity disparities between countries do not by themselves indicate injustice at work, but these statistics hint at factors other than chance or genetics at work. If the differences in life expectancy between the different racial groups turns out to be the result of racial bias determining the way that health inputs are distributed, and there was an alternative way that the inputs could have been distributed that would not have resulted in such a gap in life expectancy, then this would be a violation of the human right to health. The situation becomes not merely tragic but unjust since we can identify that there is some human activity that is preventing a more equitable distribution of the resources for health. For this reason, it is clear that human health needs the kind of protection a human right could offer.

Another facet for consideration is the role of luck. Many scholars working in the field have distinguished two ways luck can play out in the realm of health justice. Our health can be influenced by both “brute luck” and “option luck,” where “brute luck” refers to the unequal distribution of health in the natural order (i.e. we are not all born with genes that afford us the same opportunities, risks, advantages, or disadvantages) and “option luck” refers to the outcomes of conscious actions (which can still be influenced by chance) (Denier 2010).

Whether health conditions are conceived to be the result of misfortune, the actions or inactions of other agents, or the result of the sufferer’s own choices has wide-ranging policy implications. The luck egalitarian view is by no means without criticism; the bioethicist Norman Daniels (2007) has argued that it results in policies that would be both too narrow (denying treatment to the imprudent, like smokers contracting lung disease) and too wide (urging treatment for “brute” conditions that are unfortunate or disadvantageous but minor or frivolous, like shyness or ugliness) for a just and fair distribution of healthcare resources. But others, like Shlomi Segall (2010) have defended the view, arguing that the luck egalitarian view need not entail denying basic care to “imprudent” individuals, and that there is no

obvious reason why treating minor disadvantages like ugliness should invalidate the approach.

However, the points raised by luck egalitarians are relevant for the present discussion of what could be said to ground a human right to health. Usefully, a cosmopolitan luck egalitarian view would argue that moral agents have duties to mitigate the brute luck of others, regardless of national boundaries, which has obvious implications for the realm of global health. We need not think that the ill health of others must be the result of human action before it is a matter of concern for global justice. The fact that others suffer through no fault of their own, and the presence of a feasible alternative is sufficient.

1.5 CONCLUSION

As the ancient Greek philosopher Herophilus once said, "When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied." Clearly, health is vital for so many activities which give meaning and pleasure to human lives. Health and medicine both need the protection of a human right, since there are many human activities which affect them negatively and which political interventions could prevent.

The human right to health, like all human rights, is left with a very fine line to walk if it is to be both culturally sensitive and combat the structural violence embodied in the global order.

But with continued dialogue on these issues, we can hope to walk that line successfully.

Where conflicts arise between culture and justice, justice must be tempered in culturally sensitive ways, but this is not to say that culture trumps justice. I have hardly solved every controversy surrounding human rights and of course, there remain many other problems in need of solving, but my mission here has never been to solve them all. This chapter has found that a political interpretation of the human right to health, grounded in human interests and the

minimally decent life, can allow for culturally flexible interpretations while still giving a rubric to help us judge what falls below an acceptable line. The human right to health cannot guarantee specific health outcomes in life, but can and ought to be a weapon against the structural violence that forces so many of the world's poorest people into illness and premature death. Empowering people in this way is the opposite of imperialism.

CHAPTER TWO: A HUMAN RIGHT TO WHAT KIND OF HEALTH?

As I discussed in the first chapter of this thesis, I will be looking at the human right to health in a primarily political light as an instrument intended to effect positive change in the lives of people in the world. The human right to health, therefore, ought to be conceived in such a way as to defend against standard threats to the level of health needed for a minimally decent human life. As I discussed earlier, it is also important for universal human rights to avoid being culturally parochial – both to help the rights gain acceptance globally and to aid in their effectiveness in creating positive changes to the lives of people everywhere.

Thus, it is important that not only the *right* to health and its grounding avoid parochialism, but also the conception of what *health* means. Until now it has mostly been assumed that the kind of health the right to health is concerned with is clearly understood and universal. Many thinkers have devoted their time to discussing whether the *right* to health is feasible or real. But few have questioned what the nature of *health* is in this context. This is an important question, which this chapter will attempt to answer. I will argue that the health that is protected in the human right to health is a specific kind of pluralistic health. The human right to health is understood as both a right to a minimally decent standard of health (including access to basic health inputs like clean water and food) and a right to fair access to healthcare (“General Comment 14”). Health and healthcare are closely tied together, but each demands and deserves its own treatment, so in this chapter I will focus only on the meaning of health. The following chapter will examine medicine and healthcare in the context of the human right to health.

2.1 WHAT KIND OF THEORY?

How we think, and how we need to think, about the nature of health in the context of human rights is distinct from how we might think of health in scientific, medical, or lay contexts. For

the sake of the human right to health, we are less interested in what might be considered *ideal* health than someone studying health for other purposes. Though in everyday language the boundaries of health and general well-being are often blurred, we also need to make clear that these terms, while related, are not interchangeable for this context. Health is important for well-being, but is not identical with it. In my account, I take well-being to be a state that includes health, but also other elements of experience that go above and beyond mere health. For example, self-esteem, happiness, and fulfilment are all aspects of well-being, but not the object of the kind of health protected in the human right to health. My account of health, for the purposes of the human right to health, is meant to indicate a state above a minimum threshold, whereas well-being is more aspirational.

Though it is important to have a good general theory of health, the goal of this chapter is ultimately to find a theory that can be an effective instrument in answering important political questions about health. Further, we need something that helps us identify when health has been unjustly injured and what kinds of variations are acceptable or cause for alarm. The human right to health needs a functional but minimal conception, a thin and flexible conception rather than a thick and cumbersome conception of this key term: health.

Philosophically as well as politically, individual health and public health have been dealt with quite differently. But when it comes to the human right to health, we understand that both individuals and populations hold that right (as discussed in Chapter One). We would consider the human right to health to be violated in both kinds of cases – whether it was a group or an individual that was systematically and wrongfully being deprived of health. Therefore, in an appropriate theory of health for human rights, we need something that helps us at both the individual and population levels.

Ideally, a good theory of health for use in the political human rights sphere will be recognizable to ordinary people from a variety of cultures, and would be useful for healthcare professionals, human rights activists, and policy makers. This is because we need the human right to health to be accepted by people from a variety of different backgrounds, and we need it to be the kind of theory that gives a clear idea of what kind of action is demanded from us when the right is violated.

Importantly, and perhaps unexpectedly, a political conception of health needs to deal effectively with beliefs about health that may or may not be true. At times, a political conception of health will be in tension with common belief. Since beliefs about health can be bound up with many other beliefs, values, cultural practices, and perspectives, it may be both too ambitious and unjustifiably intrusive for a human right to health to interfere with these beliefs when they are not directly responsible for harm. Individuals are often wrong about health, but being wrong doesn't always violate the right, and therefore correcting them isn't always warranted in the name of a human right to health. Yet, as I will discuss later in this chapter (in 2.5), when beliefs about health are harmful, the human right to health must be provide grounds to intervene in some manner. Sometimes the human right to health will conflict with other rights. Sometimes this will mean it is necessary to specify when cultural or religious beliefs have gotten something wrong about health. This relationship between the right to health and other rights, however, will be a topic for later discussion in Chapter Four.

What counts as a conception of health? For this discussion, conceptions of health include ideas about what is or should be the natural, normal, and/or ideal state of human life. Usually, these concepts also include ideas about what constitutes an injury to health or the absence of health (disease, disability, etc.). I have separated out the ideas about what restores lost health into my discussion of medicine, which follows later.

As discussed in Chapter One, the language of *The Universal Declaration of Human Rights* (Article 25.1) states that everyone has the right to an “adequate standard of living,” and Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) describes the right to health as the right to “the highest attainable standard of physical and mental health,” while at the same time “General Comment 14” states that the right to health is *not* the right to be healthy. These can be reconciled by recognizing that health exists on a continuum. Each document is discussing the same concept, but the ICESCR expresses an ideal state and the others a minimally acceptable point on the spectrum. The right that people have to health is a right to a minimal level, the health that would be available to them when unjust obstacles to health are removed. This minimal health is also meant to be aspirational and adaptable, meaning the bar can be raised as human societies progress and change.

Health is often discussed in partnership with disease, giving rise to the question of whether health is a positive state or merely the absence of illness. I think we have good reason to treat it as a positive concept, as does the World Health Organization (WHO) in their constitution. They define it as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 1948). As mentioned in 2.1, I am using the term well-being in a slightly different way than the WHO, whose definition of health may imply that health is made up of having many aspects of well-being rather than the other way around (my use of the terms is inverted). Where I agree with the WHO, however, is that health is not merely defined by the absence of certain conditions. Health has features of its own that do not need to be contrasted with disease to be articulated.

One worry presented by such a lofty definition, however, is that it is not possible to provide this equally to all people. As I discussed in more detail in Chapter One, many people doubt that there is a human right to health for this very reason. Health seems to be by nature unevenly distributed. One person might have a genetic predisposition to several severe

illnesses, and another lucky enough to never have to worry about serious illness in their lives, and this can all happen by chance with no violation of anyone's rights. This is all the more reason why we need a separate political conception of health to understand what the human right to health ought to mean and how it can be feasible. The account I will be arguing for later in this chapter attempts to define this kind of health: a kind which is one part of the minimally decent life which all the human rights are aimed at defending (something covered in more depth in Chapter One). But first I will examine the philosophical literature to see which parts may be useful to that end and which parts may be limiting.

Deciding whether the relevant conception of health for use in human rights should be positive or negative is closely linked with what the purpose and foundation of that right is (as discussed in Chapter One). It would be easier in some senses to go with a negative definition of health, since diseases and injuries to health are often easier to identify. But as I will discuss further later in this chapter (in 2.3), there are some important benefits to having a positive conception of health. Namely, a positive conception gives us a firmer grasp of why health is important to defend, how health relates to other human goods, and a better understanding of certain standard threats to health which do not fall into the category of diseases.

2.2 EXISTING PHILOSOPHICAL CONCEPTIONS OF HEALTH

There are many conceptions of health in the world, within and across various cultures. Not all of these conceptions allow for an articulable or enforceable right. Here I will discuss briefly several philosophical accounts of the nature of health, and call attention to some of the helpful insights they have to offer.

Philosophical theories of health can have a variety of different goals in terms of what they want to explain or capture within the theory. Theories of health might try to explain what health is, why we want it, what it is good for, or help us understand what to do in its absence.

A theory might try to closely match lay views of health to explain health's role and value in everyday life. Or, a theory may take a more clinical approach to make itself useful for physicians and doctors (if medicine's goal is to restore health, physicians clearly need a working theory of what the end goal should look like) but this might be very different from how we think of our own health in non-clinical settings.

Culturally, conceptions of health may be well-developed, or may appear as a kind of afterthought within other kinds of beliefs about what constitutes "the good life." But generally, lay uses of health tend to fall within one or a mix of the following four philosophical frameworks. Within the philosophical literature, there are four main theoretical camps: naturalist, constructivist, instrumentalist, and phenomenological.

Thanks largely to the works of Christopher Boorse (1975, 1976, 1977, 1997), naturalism has risen to prominence in recent thought on health. Naturalism sees health as defined by the functions of the body and its various parts. Illness is, therefore, any harmful malfunction of any of these body parts and this can be determined objectively through observation of those parts. In this account, disease is understood as any malfunction detrimental to human functioning. This account makes determining whether a person is healthy something that does not rest on the person's subjective sense of healthiness. In this way, naturalism seems able to accurately explain our understanding of heart disease as a failure of the heart to perform its normal function.

Naturalism is a very attractive foundation for my conception of health because it lends itself well to universalization based on shared characteristics as a species. Additionally, it seems to capture many of the things we think are true and important and can be useful to physicians in diagnosis. However, this theory may not be as helpful when dealing with the political level. Not all cultures agree that health should be defined in this way, and some cultures do not even

recognize the same sets of organs or assign the same functions to the organs that modern science does. This can be a problem when attempting to persuade various communities to take action in the name of or to abide by the human right to health. There are also some aspects of health that this theory does not capture as well as other theories, particularly the social aspects of health. How can we explain certain psychological disorders (like personality disorders) merely by appealing to the normal species function? These seem easier to explain if we look at health and disease through the constructivist's lens.

In contrast with naturalists, constructivists deny that there is any natural or objective state that we can call health. Human values and social constructs determine what people perceive as healthy or not. Essentially, what is healthy is a judgment based on subjective and often culturally specific understandings of human nature. One thinker in the constructivist camp is Rachel Cooper (2002), who in her article "Disease" argues that to be considered a disease a condition must fulfil three criteria: (1) it must be a bad thing to have, (2) the person is considered unlucky to have it, and (3) the condition can be potentially treated (271). This kind of account brings the assessment of the individual or community to the forefront.

Constructivism is good at acknowledging the role of culture and expectations in determining when we perceive ourselves to be healthy or ill. As in the case of personality disorders, these are often most easily understood by reference to what behaviour is normal given the culture where a person resides.

For another example, constructivism can help explain why obesity is often termed a disease in our culture, leading people to seek treatment for it. Obesity is not necessarily related to any malfunction of the body, but since it carries with it negative social stigma, is associated with other detrimental effects on the body (like joint pain), and can be treated with bariatric surgery, it meets Cooper's criteria for a disease. But this example also brings to light one of

the drawbacks of constructivism – who is the arbiter of what counts as health and disease? Is it the individual or the society? In this account, health and disease become relativistic, which is a problem for any attempt at grounding the human right to health. As I discussed in more detail in Chapter One, it is important for human rights to be understood to have universal application. If we simply embrace constructivist accounts, this would give us little basis for that universal ideal.

Instrumentalists, like Georges Canguilhem (1991, 2012), see health as the ability of a subject to achieve his or her goals. How healthy a person is, then depends on the person's ability to achieve his or her goals. This is related to the idea that a healthy organism is one that can tolerate environmental difficulties and adapt well to new situations. Lennart Nordenfelt (1995, 90) argues that a healthy person is one who can satisfy her "vital goals," which are those that are necessary and sufficient for her to be minimally happy. So far this seems like promising grounds for a political conception of health. However, since the instrumentalist account hinges on health's relationship to goals, it has the strange conclusion that those people with the fewest goals are "healthier" than those with more goals (Richman 2003). This opens up some of the same issues that the constructivist account does, especially regarding who the arbiter of this "minimal happiness" ought to be. The human right to health would run into a lot of feasibility problems if, for instance, someone was able to say that because they are particularly difficult to please that their health is being harmed more than someone who is content with the same basic stuff. That said, the account of health I offer (in 2.4) will still ultimately be a kind of instrumental account with some modifications.

Lastly, the phenomenological approach describes health as a state of feeling at home in one's body. Health, in this sense, is an inner experience, not a biologically observable state. As Havi Carel (2007, 2008) argues, someone who has a particular biological condition (perhaps like dwarfism or deafness) may not experience themselves as unhealthy, because they have

adapted to their condition and do not experience this condition as suffering. This seems like a useful insight on its own, but it is difficult to see how a right could be enforced if health were purely defined by “feeling at home in one’s body.” What kind of action could violate such a right? What kind of action could any political body take to protect or restore something that someone feels privately? It might be true that many people experience health in this way, but this kind of conception isn’t suitable as a grounding definition of health for use in human rights.

All of these accounts get something right about health. Grounding health in a naturalist conception based on our shared species seems initially promising as a way of avoiding overly culturally specific accounts of health, while constructivism gives explanation to the role that those cultures play in an individual’s experience of health. The instrumentalist account of health lines up well with what I see as the instrumental purpose of a human right to health. We need a right to health because some minimal amount of health is necessary for a minimally decent human life. It would make sense to think of health as one kind of instrument to that end. Together, these accounts help us understand health’s importance to human life and why it is important to have a human right that defends it. They also help us understand what various threats to health might look like – failing organs, the inability to function in one’s environment, or suffering.

Yet, on their own, each of these conceptions of health has drawbacks as well, especially when translated into the international political sphere. Health in the phenomenological sense is difficult to measure or enforce. Naturalism gives us reason to believe a universal account of health is possible, based on our shared species, but does not by itself help us understand the political and cultural dimensions of health. Constructivism helps us understand how culture affects health, but makes it difficult to generate a universal standard that would not seem parochial. Instrumentalism is good at explaining why health is important and also why it may

appear different from person to person, but is in danger of being too general. The account of health that I offer in the next section combines some of the best elements of these existing philosophical theories, as well as insight from the biopsychosocial model used in medicine, to articulate a political conception of health that can aid our understanding of the human right to health and the actions it demands.

2.3 COMPONENTS OF HEALTH

As was discussed in more detail in the previous chapter, one popular ground put forth for human rights in general is the concept of human dignity and a minimally decent life. So too, the concept of health finds its roots in a minimally decent existence. Some minimum degree of health is required to enjoy any of the things we commonly think belong in a worthwhile life, and indeed to be able to enjoy most of the other human rights as well. A minimally decent human life includes the ability to form close meaningful relationships and to participate in society. Without at least a minimum level of health, people cannot engage in these positive activities, and without some protections many people may be trapped in states of suffering unjustifiably.

Inspired by what is known as the biopsychosocial model in clinical medicine and psychiatry, I have broken down health into sub-parts and modified the model for use in the realm of human rights. These components help account for the variation in acceptable conceptions of health, but also give some useful boundaries to demarcate what conceptions fail.

The biopsychosocial model in medicine is used to explain the factors that contribute to disease and treatment outcomes. It's a model that has been used to help in the diagnostic process and explain causation in medicine – here I am transporting the basic idea into the political realm where it can help us identify standard threats to health and how we might tackle these issues. I will be arguing that the biological, psychological, social, and

environmental components are all realms of human health that need to be accounted for in any theory of health that could be employed by the human right to health. I argue that these categories each deserve individual recognition, but must be combined in order to produce a state that we can recognize as health. Each category is individually necessary but alone insufficient to describe health.

Dividing health into biological, psychological, social, and environmental components is not intended to imply that these parts are in fact separable in life. On the contrary, these four components of health are enmeshed and inextricable from one another in the human organism. Yet, we benefit from naming and describing these categories because it helps us to better analyse the nature of human health. Psychological disorders may indeed have chemical biological causes, but separating the psychological and biological into different components allows each to be discussed in a more focused way, and this focus can further benefit human health overall.

Separating health into four components helps us to understand the nature of the standard threats to health. Each component of health points to one of the areas of human experience required for the good life. Each component of health also represents a particular front on which a specific class of threats to human health can arise. These categories help us to explain illness, and also to better understand the value of health as it relates to human dignity and well-being.

These categories are natural fault lines within human health. Each component stands on relatively equal footing with the others. Each essentially has a kind of veto power over the health of the individual – meaning that if any one of the categories is left unsatisfied, the individual is not healthy, regardless of the other components otherwise being fulfilled. While

health must always contain some combination of these four components, variation can arise within each category.

The first two components (biological and psychological) will be most relevant when examining an individual's health. They are the primary realms which a doctor or other medical professional would examine to determine an individual's health and to decide what to do about it. The other two components (social and environmental) are of more interest to the group level and may be of more interest to the policy makers and those interested in increasing public health. Despite this, all four components are important for individual health and population health.

Biological

The biological component to health is largely familiar to lay people; most cultural understandings of health and most of the philosophical accounts of health can recognize the existence of the body and its importance for experiencing health.

The health of the body is often assumed to be the primary target for the right to health to protect, but I argue that it is only one part of the equation. Many, but not all, of the things which injure our health do so through attacking the body.

Some cultural groups place more or less importance on the body, yet no reasonable person denies that humans have bodies, or that harm to the body is unconnected with health. Most things we consider vital to a meaningful life require some level of function of the body. The body serves as our primary means of interacting with the physical world, therefore we have at least instrumental reasons for wanting to protect the body for this ability. It is capable of pain, and pain lessens the quality of our lives, and so we have further reason to protect the body from things which may cause this. In naturalistic terms, there is such a thing as proper

functioning of our various organs and capacities, and therefore things which can be said to interfere with the proper function of our bodies can be said to harm health. In this way, whatever philosophical account of health an individual ascribes to, we can come to consensus that the body is indeed a vital part of health and worthy of protection.

Psychological

The mind as much as the body is a part of the self. A fit body without a healthy mind fails to enable the individual to live the minimally decent life that human rights are aimed at protecting. Like bodily health, mental health/illness can be understood from a variety of philosophical grounds. It can be understood naturalistically as improper functioning (either physiologically or chemically in the brain), instrumentally as an inability to achieve one's goals, in terms of constructivism as inability to function according to the cultural and social standards, and even in the phenomenological sense of not feeling at home in one's body.

Though some may argue that psychological states can also be explained by biology, I am separating the two here because measuring and treating psychological health is decidedly different than most other bodily health concerns. Psychological health also involves more than what we typically associate with the health of our body. Distinguishing it as its own component of health helps us understand how our overall health is affected by a separate class of threats to health – things which may not damage our bodies, but which lead to emotional and psychological harm, like psychological abuse, neglect, etc. Assaults on our mind, whether from mental illness or from the injurious activities of others, severely influence our abilities to function, achieve our goals, and to feel at ease or in control of our mental faculties.

It may be surprising to some to include psychological health as part of the human right to health because it is often assumed that mental illnesses do not originate from rights violations in the same way that certain bodily harms can. For instance, it is clear that starving a person

may violate their right to health, but it is not always clear how an outside force could cause schizophrenia. Yet, we don't say we have a right to bodily health merely because it can be threatened in this way. We also recognize that some minimal degree of bodily health is necessary for the minimally decent life, and therefore it is required of us to protect it with a positive (and not merely negative) framing of the right. Similarly, since psychological health is so important to the minimally decent life, that to not provide at least some treatment for psychological disorders would violate the right to health.

Social

The social component of health clearly overlaps with both biological and psychological components, but deserves its own individual recognition for the same reasons. Human health can be heavily influenced by social factors, like culture, education, and relationships to others. It is also important to realize how human health can be injured by the absence of social connections (Brownlee 2012). Because the human right to health needs to address issues of public health as well as individual health, it is important to recognize this realm of the human experience as another vital component of human health.

Social health is another vitally important component. Kimberly Brownlee (2012), in her articles "Social Deprivation and Criminal Justice" and "A Human Right against Social Deprivation," has made a strong case for recognizing the harm of social deprivation. Humans need interaction with others to maintain both psychological and physical health. The ability to make and maintain social connections within one's community should be recognized as a vital part of the health equation.

Clearly, some amount of social connection is vital for our overall health, and lacking any social connection will negatively impact the psychological and biological components. But we only have to look at the behaviour of people to find another reason to think the social

realm is at least equally important for a life that is minimally decent. Even Adam Smith noted the importance of being seen as decent in society (in his day, owning a “linen shirt”) in his book *The Wealth of Nations*. In any case, people have a demonstrated need to be presentable and to be able to participate in their societies. As Jonathan Wolff noted in his speech, “Social Equality and Relative Poverty,” people will often choose to spend their limited resources on socially important items and activities, sometimes even at the cost of feeding themselves or getting adequate sleep. If we frame this in a new way as part of health, the choice does not seem unusual. What’s more, Wolff goes on to say hierarchy itself actually results in shorter lives and more illness for those at the bottom who experience chronic stress and degradation.

Environmental

Here, I am going beyond the bounds of the original biopsychosocial model to add another component of health: the environment. This category is often neglected in discussions of health and medicine, but in terms of global population health, its influence is undeniable. Since the initial biopsychosocial model originated in clinical medicine it is understandable how it neglected to include the environmental component (though, as will be seen in the next chapter, not all medical systems neglect this component), but at the group level (which the human right to health seeks to target) it is necessary to name and account for this component of health.

Again, most philosophical accounts of health can give some grounds for this component – as an environment fitting to the species, an environment in which it is possible to pursue normal human goals, and one that is not a source of suffering. Without a sanitary and safe environment, it isn’t possible for even otherwise healthy people to have a reasonable chance at achieving their goals. It is also easy to imagine how toxic environments can interfere with proper functioning of the organs.

It is increasingly hard to deny that our health is intertwined with our surroundings, both immediate and global. Humans need sanitary environments to avoid infection from a variety of diseases. We also suffer from pollution in the air, food, and water. The environmental component of human health deserves at least the same recognition as the other components because without at least some minimally healthy environment, even full health in the other categories is rendered meaningless.

While these examples illustrate the causal links between social context, environment, and health, they do not yet demonstrate that social and environmental conditions are *constitutive* of health. To argue that these are truly *components* of health and not just related phenomena, it is helpful to refer to the field of disability studies. Within disability studies, there are two dominant models – the medical and the social. The medical model of disability locates the disability in the condition of the individual, whereas the social model claims that the sense in which someone is “disabled” depends not just on the individual but on the wider social and environmental context.

To illustrate, the medical model would look at a deaf patient and explain the condition as a defect in the person’s ears, and possibly recommend a cochlear implant to remedy the problem. In contrast, the social model would examine the difficulties the deaf individual faces in his or her life. Through that lens, it is possible to see that the suffering that deafness causes the individual is not entirely (and perhaps not even mostly) due to defective ears. Rather, the fact that the social environment is not set up to accommodate the hard of hearing is what causes deafness to be a disability. Thus, on this model, remedies to the struggle of deafness can be external to the individual – by making changes to the environment, whether physical or social, the difficulties that deaf face can be alleviated.

As one can see, both models get something right about the condition of deafness (there is a lack of normal functioning in the ear, *and* the world is not set up to accommodate those without hearing) but the models give very different answers to what ought to be done to improve the well-being of the person.

The case of deafness also illustrates the power of community in individual well-being. The deaf community, like so many other communities of “differently abled” people, has developed a strong cultural identity. The cultural ties within the deaf community lead many to choose to forgo a cochlear implant, because once within a community where they are able to get their needs met (able to communicate and navigate the world without hearing), the biological defect seems negligible. While the constitutive role of social context and environment is most obvious in the social model of disability, those who side with the medical model ought to recognise the power of social and environmental conditions in shaping whether particular biological features detract significantly from a person’s wellbeing.

Health as a House with Four Walls

With the four components combined, we can imagine health as a house with four walls. The human right to health, then, is a right to have this metaphorical health. If a person lacks health in any of the categories, he does not have a house and he does not have health overall. If a person has abundance in any or all of these categories, then we can imagine this like a person with an especially nice house. Conversely, if someone has been left without the basic ingredients to build one of the walls, then we know we need to investigate the situation to figure out what is preventing them from reaching that minimal standard.

This framework also helps account for pluralism in the human right to health. Health is not one thing. It is a composite of certain instrumental goods, certain biological states, and relationships to ourselves and others. Two equally healthy people may still appear quite

different from each other. This is especially the case when we talk about health at the minimal level protected by the human right. Having just enough health to have a reasonable chance at a minimally decent life need not be identical for all people because of the pluralistic nature of health itself.

We can also think of the four components like four lenses through which we can look when seeking to improve health, whether at the individual or population level. Thinking of health this way can give us a fuller picture of the things which influence health, whether positive or negative, and empower us to effectively take action. Particularly, it helps us understand what the standard threats to health might be and what constitutes a harm to health. Neglecting or injuring one of the components of health is a harm to health. There may be some kinds of harm which are not relevant to health or which are not violations of rights. For example, a bear attack is a harm to health but not necessarily a violation of one's right, and something like the burning of the library of Alexandria might be said to have been a harm, but was not a harm to health. On the other hand, solitary confinement would be a harm to health that is also a violation of a person's rights.

Among the four components it may seem that biology is king, because the complete absence of biological health is death. However, this is countered by the recognition that the complete absence of any of the other categories is a life not worth living. It is possible to have states worse than death. All of the components of health interact with and depend upon each other.

The way in which they interrelate can be seen clearly if we examine an emblematic case of treating a patient for depression or anxiety. Effective treatment involves more than examining their individual psychological state, or merely attending to their physical condition. A good psychiatrist or psychologist will also attempt to ascertain if their patient's issues are caused by something in their social sphere, or by some other environmental factor. In many cases, the

origins of depression or anxiety may come from all four fronts, and effective treatment will need to address all of the parts. Perhaps the patient needs pharmaceuticals, talk therapy, or perhaps he or she would be better served with a change of career or by escaping a toxic relationship. Perhaps all of the above.

The biopsychosocial model of health (on which my account is based) emphasises the interrelationship between the body, the individual's psychology, and the cultural and social context. It stands in contrast to other models of understanding health and disease, which seem to presuppose a kind of mind-body dualism, in which the mind is a kind of epiphenomenon, not causally related to the biological systems of the person (Bolton and Grant 2019). Yet, we can see from examples (like depression and deafness) that human health cannot meaningfully be separated from either the body, mind, culture, or environment.

Aside from being an accurate account, understanding health in this way opens the door to some new areas of application for the human right to health which have not been discussed before. The human right to health is often invoked to prompt action against epidemics, famine, or significant class, gender, or racial disparities in health within a particular country. But now the case can also be made that certain legal punishments like solitary confinement might violate the right to health of prisoners. It also gives us added reason to promote certain environmental policies, not just for the sake of the planet and the species, but because not doing so endangers many people's health in a way that might now be said to violate their rights.

2.4 CRITERIA FOR INADEQUACY

The components of health I have outlined above allow the human right to health to capture and recognize a wide variety of cultural understandings of health. Recognizing that health can express itself in a variety of ways is valuable. But it is still important to realize that some

conceptions of health will be found to be inadequate. If we believe, as we do, that health is a real thing – then it is possible for some people (as well as whole societies) to have mistaken beliefs about what health is.

Now that I have laid out an account of health that can help us understand the implications of the human right to health, I should explain how this can also help us exclude certain conceptions and combat excuses for failing to uphold or defend the human right to health. It is important for any conception of health used in the human right to health to avoid being unjustifiably culturally specific, but it is also important that it avoids being overly permissive. As mentioned before, the human right to health needs to be able to deal with inaccurate beliefs about health. Universal human rights are meant to have global application, meaning the human right to health exists in all corners of the world regardless of what local beliefs may be. For practicality's sake, however, politically, human rights cannot always be cast in the role of evangelizing one particular conception of health. Some people will be wrong about health, but not every wrong idea leads to a violation of the right to health. In the section that follows, I will outline the ways in which conceptions of health can fail or be found to be inadequate in the realm of universal human rights. There are essentially three ways in which this can happen: harmfulness, deficiency, and impracticability.

Because the human right to health needs to be measurable and enforceable to be politically meaningful, this will necessarily exclude some cultural conceptions of health as inadequate. Conceptions of health might also be simply mistaken or misleading, such that adhering to that conception does not actually produce health, or in the worst cases actually leads to harm. Impractical accounts of health are also inadequate to the task in this case, but not necessarily because they are wrong or harmful. Phenomenological accounts of health are not adequate for the human right to health as I explained earlier in the chapter, but it may still accurately describe health in a way that would suit other realms of discussion or in a way that would

align with the way lay people understand themselves to be healthy. Naturalist accounts of health may be inadequate in another sense, but not wrong, because they are good at explaining causation in disease and medicine, but bad at justifying political action.

Harmful Accounts of Health

Some accounts of health may actually be harmful, either because the beliefs motivate harmful behaviour as a means of attaining health, or because they mistake something as healthy that is not. These are beliefs about health that, when adhered to, cause harm to either the individual who believes it or people around that person. Health and harm are such diametrically opposed concepts it might be difficult to understand how a concept of health could be harmful.

The first way in which accounts of health can fail is by making mistakes about the means necessary to attain it. This mistake could be large or small, from believing pain and suffering will lead to health, to extreme and unbalanced diets and exercise regimes. For example, August Engelhardt (a German man who lived in the late nineteenth and early twentieth century) believed that living on a diet of only coconuts was the path to the good life, enlightenment, and immortality (Martyris 2015). He even tried to found a cult based on this belief in Papua New Guinea (then the Bismark Archipelago) (Martyris 2015). Unsurprisingly, despite managing to convince a handful of people to follow his recommendations, the movement did not last long. No matter how much someone believes that eating only coconuts will make them healthy, they will inevitably wind up with severe nutrient deficiencies and will suffer and die, which was indeed Engelhardt's fate himself (Martyris 2015). Ideas *this* wrong about health are doomed to failure, but there are smaller non-fatal mistakes in health that can persist for generations.

For another example, imagine someone sincerely believes that he is a vampire and requires human blood to sustain himself. Such a person's individual definition of what would be

healthy is not only mistaken, but would incur harm both to himself and others because ingesting human blood is in fact not compatible with health. Further, acquiring a supply of human blood would also likely entail harming another person.

While these examples indicate some wrong and harmful instrumental methods of achieving health, it is also possible, though rarer, for cultures or individuals to mistake an unhealthy state for a healthy one. Examples of such beliefs usually take the form of extreme asceticism, such as the Jains in Nepal and India who practice fasting until death (a religious ritual called Sallekhana) (McCarthy 2015). They believe that such extreme abstinence will wear away their bad karma and help them attain godlike status, but in doing so they wither away and die.

At the level of the individual, severe anorexia nervosa and other similar disorders could fall into this category. Afflicted individuals with anorexia perceive themselves to be overweight and idealise an extremely thin and frail body as the most desirable. This has dire consequences, with anorexia leading many to die of complications each year (Nolen-Hoeksema 2014).

When human societies get something wrong about health, the consequence will be a lower standard of health for the people who cling to that belief. Such conceptions, even when sincerely believed, are not acceptable bases for claiming not to have violated the right to health.

Deficient Accounts of Health

Deficient accounts of health describe health in a truncated fashion, leaving out one or more of the components described earlier. Deficient accounts might get some things right about health, but get other parts wrong, or neglect to address them entirely. One kind of example of a deficient account of health is the kind of health sought by mystics and certain extreme

religious groups. There are cultures which place very low value on the body's physical health, like the ascetic spiritual traditions of Christianity and the Hindu Yogis. Christian monks sometimes practice rituals which deliberately harm the body to help the faithful feel the sufferings of Christ and praise this behaviour as an ideal to strive for. While the human right to health can allow for personal choices of this kind, any imposition of this on others is problematic.

For another more extreme case, Christian Science not only devalues the physical, but denies the physical reality of disease. Believers preach that we already exist in the perfect kingdom of heaven and tell their followers that illness is nothing more than an illusion created by insufficient faith in God.

This is an account of health that works only until someone becomes ill with a disease or injury that their body's natural defences cannot overcome. Christian Science may be able to provide a community that gives meaning to its members, a sense of social belonging and connection. These are healthy and important to human life. Yet, Christian Science ignores and denies the reality of biological threats to health, and disallows its adherents from seeking medical care outside the religious community. These features make it not only a deficient account of health, but also mistaken and even harmful.

Impracticable Accounts of Health

Another way a conception of health can be inadequate for the human right to health is by failing to be the kind of thing that is possible to provide or to enforce with a political right. An inadequate account of health is neither measurable nor enforceable on top of also possibly being mistaken. If a conception is too introspective (like in the phenomenological conception), too specific (e.g., health = eating kale), or too lofty (e.g., health means never suffering), it may be either impossible or unclear how any political body could be called upon

to improve the situation. It is also unclear in such cases who would bear the burden of duty, what that duty would entail, or what would satisfy it.

Overly specific accounts of health can also fail. While it may be healthy to eat kale, it might not be possible to provide it to everyone, it might not be equally beneficial for everyone, and it also ignores the other dimensions to health. On the other hand, if we defined health in a lofty way as the complete absence of suffering, this would be far too lofty a goal for the present time. There currently is no way to prevent all kinds of suffering for all people. If we defined health in this way, everyone's right to health would be in constant violation and nothing could be done about it, which would make the human right to health meaningless.

2.5 CONCLUSION

In order to be a useful mechanism of accountability, the human right to health needs an enforceable minimum standard of health by which to judge situations and to determine if a violation of rights has occurred. With the account of the four components of health that I have provided, it should now be clearer what constitutes that minimum standard. This account allows for variation according to the individual and culture, while not being so permissive as to undermine the existence or force of a universal human right. I hope that this account can be useful to policy makers, activists, and healthcare professionals, and that it captures and reflects the value health has in our lives.

CHAPTER THREE: A HUMAN RIGHT TO WHAT KIND OF HEALTHCARE?

The human right to health's second major feature is the right for people to have fair access to adequate healthcare. Most of the discussion in human rights literature has been concerned with how this healthcare could be *provided* to people fairly and justly, sometimes with scepticism that such a thing is possible (e.g., Sreenivasan 2012). This often descends into complex discussions concerning cost-benefit analysis of various kinds of medical treatments and discussions of the feasibility of providing healthcare to all. Less attention has been devoted to investigating what healthcare and medicine *mean* within the scope of the human right. Before we can have useful discussions about the details of meeting people's right to healthcare, we ought to first clarify what *healthcare* is. As I laid out in Chapter One, we have good reason to think that the right to health entails a right to some medical care.

This chapter outlines attempts to define what the nature of healthcare is in this context. We should seek to avoid both parochialism and excessive permissiveness in the answer to this question. To begin, we need to acknowledge that there is more than one valid and relevant sense in which a person can be healthy or ill, and more than one acceptable way to be cured. At the same time, a right to healthcare that is not also explicitly the right to effective healthcare rapidly loses meaning. The later parts of this chapter will be devoted to unpacking the conditions for acceptably effective healthcare.

3.1 DEMARCATING THE MEDICAL

Why do We Need a New Account of Medicine?

The literature on the philosophy of medicine is abundant, with topics ranging from theories of causation (Gifford et al 2011) to the cultivation of the proper virtues of a physician (Marcum

2017). However, here I will focus on a prior question – what distinguishes medicine from non-medicine? To answer that, I will be drawing inspiration from a parallel discussion in the philosophy of science: the demarcation problem.

Distinguishing science from non-science is important not only for its theoretical contributions but also for its practical value in aiding everyday decisions about what society and individuals ought to give credence (Mahner 2007). Many thinkers have tried to solve the demarcation problem. Perhaps most famously, Karl Popper (1962) proposed that what separated science from pseudoscience was the simple criterion of *falsifiability*. According to Popper, a good scientific theory gives a statement which can be disproven through observable phenomena. This makes something like Popper's falsifiability criterion initially seem promising for defining medicine: we could say, it's medicine if it works, and not medicine if it doesn't. Yet, this is not entirely satisfactory as will soon be clear. Since Popper, other thinkers (notably, Laudan 1983 and Kuhn 1974) have criticized his theory as insufficient, and offered further criteria for demarcation, alternately defining science by its methodology, time, community, puzzle-solving ability, predictive power, or some combination of these. Medicine is often discussed in connection with the demarcation problem (Pigliucci and Boudry 2013). This is not only because medicine is often assumed to be a kind of applied science, but also because the threat of pseudoscience is especially clear in the medical context. If we cannot distinguish genuine medicine from things which falsely claim to be, we will be vulnerable to the predations of charlatans and snake oil salesman. When we are wrong about medicine, people suffer and die.

Demarcating the medical, however, presents different challenges than demarcating science in general. On the surface, it seems like it ought to be an easier puzzle to solve because it is narrower in scope. Medicine is confined to merely one species and its ability to improve that species' health. But unlike the other sciences, medicine is intimately connected to social

systems and cultural values in a way that subjects like physics and chemistry are not. Where the goal of science is knowledge, the goal of medicine is health, and health, as I argued in the previous chapter, is pluralistic. For this reason, in the international political realm, it is not enough to simply say that the medicine that people have a right to is whatever is scientifically deemed best. However, scientific support does matter for determining medical *efficacy* (which I discuss later in this chapter).

Medicine may indeed be a kind of applied science, but this does not give us the full picture. Culture has a relationship with medicine that it doesn't have with theoretical physics. People do not consult their local physicist in the same way that they might consult their local doctor. As is well known in the field of medical anthropology, medicine is just as much a social and cultural institution as it is a science, if not more so (Winkelman 2009). Medicine predates the scientific method. It has likely been around in some form for as long as humans have been getting sick, and there are about as many medical traditions as there are cultures (Winkelman 2009). Because of this, not all medical systems are scientific, but being unscientific alone is not enough to invalidate them as medicine. Medical traditions function like social institutions. Thus, the way they operate in society and the needs they serve are difficult to separate from the religious beliefs, social norms and values specific to the cultural context. This social nature of medicine makes the issue of cultural parochialism something we need to confront in the context of the human right to health.

When we argue that there is a human right to healthcare, we are arguing that people ought to have access to a social institution. So, an appropriate theory of healthcare and medicine in this context needs to account for variation in the way that social institutions function. It would be wrong to assume that meeting everyone's right to healthcare means giving everyone access to the kind of medicine that is conventional to Americans or Europeans, merely because it is conventional in those societies. But it's also wrong to say that people's right to healthcare

would be adequately met by providing people with access to medicine which does not actually work. The cost of defining medicine too inclusively is that we lose the ability to identify and exclude quackery. On the other side, the cost of defining medicine too narrowly is that we risk giving credence to the idea that human rights are merely covert attempts at cultural imperialism by the West. While efficacy is not sufficient to describe the nature of medicine, it is still a necessary part of the evaluation. Together, an account of medicine which captures its social and scientific senses will allow us to accept cultural variation but still provide grounds for finding some versions of medicine inadequate in meeting people's human rights.

Medicine vs. Non-Medicine

Naturally, the task of demarcating medicine must begin with separating medicine from non-medicine. It is easy to find articles in medical and philosophical literature that dismiss alternative medicine by saying that there can be no such thing. There is only medicine, and non-medicine, such articles claim, or medicine and alternatives to medicine (Schneiderman 2000, Louhiala 2010). Yet, in my view this argument is conflating the two senses of the medical (as a science and a social institution) and failing to distinguish between the discussion of the *nature of medicine* and the discussion of *medical efficacy*. Both discussions are worth having, but they must be handled differently.

As it stands, in lay terms, people often use the words medicine and healthcare to refer to a range of phenomena. Medicine is often used as short hand for pharmaceuticals, or any substance someone takes when they are ill (e.g. cough syrup, antibiotics, or herbal remedies). Medicine is also a profession, and can refer to an area of expertise possessed by doctors, as well as the services doctors can provide. The profession of medicine comes in many forms and traditions both within and across various cultures. For example, just within American

culture, there is conventional medicine and a variety of what is termed “complementary and alternative” medicine (CAM), including chiropractic care, homeopathy and naturopathy. On top of that, there are innumerable specialties within each style of medicine (i.e. conventional medicine subdivides into gynaecology, gerontology, or gastroenterology, just to name a few), and other categories of healthcare (like physical therapy and sports medicine). A way of consolidating these various conventional uses of the terms, is to argue that medicine and healthcare are best understood as a kind of relationship with several necessary elements: (1) a patient with a health problem of the appropriate kind, (2) a practitioner with the proper training and who behaves ethically, (3) a theoretical framework that explains the origin of the disease and prescribes a cure, and (4) a treatment which is believed to be effective and safe. What distinguishes the medical from the non-medical is the presence of these necessary elements which stand in a certain relation to one another. Something can only be appropriately described as medical if it has this proper kind of structure.

Non-medicine is understandably a much broader category than medicine, since it includes everything which is unrelated to health, and even some things that are. Being given chicken soup by one’s mother when sick is not medicine, even if it can make the person feel better, because not all of the necessary facets of the medical relationship are present. This means that folk remedies are not a kind of medicine (at least for the purpose of the human right to health). Many injuries to health can be “treated” by things that are non-medicine, like adjustments to city infrastructure to make sure that sanitation is adequate so that people do not drink contaminated water and become sick.

Medicine is just one tool in the kit to deal with ill health, and it’s good that it is. We don’t want to force everything health-related into the medical paradigm. A calculator is a great tool to help solve complex math equations, but no one should ask a calculator for career advice. Similarly, misapplying the medical paradigm only leads to wasted efforts.

3.2 IDENTIFYING INADEQUATE MEDICINES

To further refine this account of medicine, it is helpful to look at how James Ladyman (2013) breaks down his discussion of the demarcation problem in his chapter “Toward a Demarcation of Science from Pseudoscience,” in the edited collection *Philosophy of Pseudoscience*.

Instead of merely two categories (science/pseudoscience) Ladyman differentiates between four: science, non-science, pseudoscience and science fraud, laying out the key features of each category. His accounts of pseudoscience and science fraud are particularly interesting. While other thinkers sometimes lump the two together, the distinction is an important one to make because it makes clearer that genuine science requires not only honest ethical practice, but sincerity. Within the realm of medicine, similar divisions seem logical. In addition to medicine and non-medicine, in this section I will attempt to define two further categories: bad medicine and pseudo-medicine. These categories are defined by the quality, rather than the presence or absence, of the elements of medicine. Breaking the discussion down into more categories enables us to track the multiple different ways medicine can go wrong.

Bad Medicine

Bad medicine is defined by its failure to achieve the alleviation of suffering or improvement in health it is intended to. It differs from non-medicine because it possesses all the necessary elements (patient, practitioner, theoretical framework and treatment), but it either falls short or fails to achieve the goals of medicine.

Any one or combination of the elements of medicine could be responsible for medicine “going bad.” Practitioners can fall into bad medicine if they fail to act ethically or practice medicine without qualifications. When medicine goes bad because of the actions of the practitioner, we call this malpractice. This can arise because medical practitioners fail to do their duty to their patients, or take actions lead to their injury.

Alternatively, sometimes bad medicine is sincerely practiced and well-intentioned, but it fails to produce health because the treatment is inappropriately and ineffectively applied. In this sense, bad medicine is specific to context. Attempting to use acupuncture to mend a broken bone is bad medicine, but not because acupuncture is non-medicine. Similarly, surgery would be bad medicine in response to a common cold.

Medical practitioners can also “go bad” by being insensitive to the evidence of the ineffectiveness of their treatments. Ladyman uses homeopaths as an example of this kind of sincere pseudoscientists. As Ladyman says, homeopaths may firmly believe in their wish to help their patients, and in believing that they have succeeded. In fact, even the patients might believe this. Yet, homeopaths have failed to practice genuine medicine because they have demonstrated an insensitivity to the evidence about the ineffectiveness of their treatments and the incoherence of the theoretical framework.

Bad medicine can include treatments with solid theory to back them up and which we have good epistemic reasons to trust, yet still result in harm or fail to produce cures because not enough is known about the condition in question. As the documentary *Attacking the Devil* recounted, the drug thalidomide was once commonly prescribed to pregnant women for morning sickness. The medicine was thought to be safe and was prescribed by well-meaning doctors, but in tragic fashion the drug carried a horrific side effect – severe birth defects, sometimes resulting in children being born without limbs.

What made this perhaps one of the most emblematic cases of bad medicine, is that the testing and marketing of the drug had been negligent and manipulative. The drug company claimed it was “proven safe for mothers and children” knowingly implying that it was safe for pregnant women, when it had in fact only been tested on nursing mothers (*Attacking the Devil*).

Medicine, like science, is a continually evolving body of knowledge. It needs to evolve not only to respond to new emerging diseases and conditions, but also to weed out theories which prove to be inaccurate in the face of new evidence. Scientists do not reclassify Newtonian physics as non-science because of the development of quantum theory. In the same way, outdated medicine does not cease to be medicine, but it becomes bad to practice it when better versions arise.

In the past, under the humoral theory of medicine, which dominated the European medical tradition since the Ancient Greeks, doctors would prescribe bleeding with the use of leeches for a variety of illnesses. We no longer recognize some of those phenomena as illnesses (like excess blood or “black bile”). Humoral medicine is still a medicine, but it would be bad to rely on it in cases where we have updated and more effective treatments. We need to accept to some extent that this kind of bad medicine will always be with us as part of the growing pains of medicine as a science. The important thing is to learn from the past.

Pseudo-Medicine

Like medicine, pseudo-medicine has all the necessary elements of the medical relationship. Like bad medicine, it fails or falls short of genuine medicine in some important way. Unlike bad medicine, however, pseudo-medicine is not the result of poor information, misapplication or malpractice. Instead, insincerity, motivated reasoning, self-deception and/or interpersonal deception defines the pseudo-medical. Pseudo-medicine shares some characteristics with the features of Ladyman’s categories of pseudoscience and science fraud.

Ladyman draws an analogy between pseudoscience and bullshit (or perhaps more politely, “boloney”), by which he means that there is some common disregard for the truth that both share. In contrast, he says fraudulent science is marked by intentional deception. Frauds differ from charlatans, because at least they know what the truth is, even though they work against

others' ability to find it out. But in the medical context neither frauds nor charlatans can truly be said to be sincerely engaging in medicine. Genuine medicine requires *caring* about the health outcome of the patient. Where bad medicine is sincere but inadequate or wrong, pseudo-medicine is insincere and wrong. Pseudo-medicine masquerades as the real thing, but at best is not capable of producing the positive curative effects it claims, and at worst causes harm to patients.

The TV show host, Dr. Mehmet Oz, is an emblematic example of someone who engages in pseudo-medicine. Despite having a legitimate medical degree and practicing medicine for years, when Dr. Oz got his eponymous show, the line between medicine and pseudo-medicine in his behaviour began to blur. Though he has never been convicted of engaging in malpractice personally, his image was used in numerous weight loss product scams. Other doctors have also called out Dr. Oz for “an egregious lack of integrity by promoting quack treatments and cures in the interest of personal financial gain” (Goldschmidt 2015).

Motivation to make money by promoting particular product or service (especially one that is in fact not able to deliver the results claimed) undermines the ability of the practitioner act ethically in the interest of his patients. It's fair to say someone like Dr. Oz ought to know better.

Avoiding Ethnocentric Bias

Haavi Morreim (2003) in her article “A Dose of Our Own Medicine: Alternative Medicine, Conventional Medicine and the Standards of Science,” observes that opponents of CAM medicine often argue against the legitimacy of CAM medicines as medicine. Morreim compares the practice of conventional medicine with CAM, but concludes that conventional medicine is often guilty of the same things they criticize in CAM. Conventional medicine, she claims, is not always more scientific, more effective, or safer when compared to CAM.

Opponents of CAM would argue that we ought to place traditional medicines like Traditional Chinese Medicine (TCM) into the category of bad medicine or non-medicine because they worry not doing so gives a false sense of equivalence between TCM and “conventional” medicine. They worry people will go to their acupuncturist to get treated for cancer instead of going to an oncologist. Yet, this is analogous to worrying that people will go to their psychiatrist for appendicitis and therefore arguing that we ought to declare psychiatry illegitimate. The real issue is perhaps more accurately described as a problem of the patient’s medical illiteracy. Access to better information about what each kind of medicine is capable of and how to find ethical practitioners is enough to combat it.

Although many Western practitioners are sceptical of TCM, acupuncture and Chinese herbal remedies have been shown to be clinically effective for some conditions. Many studies have been done on the efficacy of TCM for a variety of conditions. TCM was found effective for treatment of chronic pain (Vickers et al 2012) fibromyalgia (Jones et al), migraines (Linde et al), and was able to alleviate joint pain (Manheimer et al), among other things (“Traditional Chinese Medicine: What You Need To Know”).

However, a practitioner of TCM who does not refer a patient with a severe bacterial infection to a doctor capable of treating it, is practicing bad medicine, and if an acupuncturist claims that TCM can treat such infections alone, then he or she is practicing pseudo-medicine. But neither case means that TCM is not a medicine, or that it is not able to be effective for certain ailments when applied properly and ethically. The flaw is in the practitioner, not the medical tradition.

It is important to realize that any tradition of medicine (conventional medicine, TCM, etc.) could contain some elements of bad medicine and pseudo-medicine and not allow ourselves to be deceived by ethnocentric bias into thinking that the problem only exists “out there.” We

need a good account of medicine to help identify and weed out bad and pseudo-medicine to protect people from the potential resulting harm.

3.3 ELEMENTS OF MEDICINE

Defining medicine by its four parts helps us distinguish it from non-medicine. But each of these parts still requires more explication before we have a truly workable account.

Depending on the culture, configurations of the various elements of medicine can look quite different. In fact, there is much debate even in the medical and philosophical communities about what the proper roles and objectives of medicine should be. Two popular contemporary Western theories of medicine are medical humanism and medical empiricism. Medical humanists see the purpose of medicine as the alleviation of human suffering whereas medical empiricists see the purpose of their profession as the eradication of disease (Marcum 2017).

If the human right to health is grounded in the minimally decent life (as I argued in Chapter One), then this can inform us as to the proper goals of medicine. People generally care about what makes life better and/or longer. Or, to phrase it negatively, people want to be protected from things which arbitrarily shorten their lives or make them more miserable. Generally speaking, the other things that people care about within medicine, they care about because they believe they are connected to one or both of these things. Because of this, it is reasonable to side with the medical humanists for the purposes of the human right to health. The medical humanist understanding of the role of medicine also aligns more closely with the pluralistic account of health I laid out in the previous chapter.

That said, the task of defining medicine is still challenging. The influence of culture can be seen at any level, from who is considered an appropriate subject of care, who is qualified to administer care, what that care looks like, what it seeks to address, and the explanations offered. There are many medical traditions in the world, many of them incommensurable with

one another. There are also variations in ethical norms of practice for medical practitioners depending on the culture (autonomy being one of the primary values in medical ethics in the West, and paternalism being more acceptable in other cultures). The subject of care may be an individual or a community. The problem may be a pathogen, injury, or something afflicting a person psychologically or spiritually. The practitioner may be a doctor, nurse, shaman, etc. The process may be any one of the numerous medical traditions with its own diagnostic process and explanations of causation. Within these medical traditions, treatments may range from prayers to herbs to pharmaceuticals. With so much variation, it is helpful to attempt to clarify what features are necessary in each element of medicine in order for it to be considered adequate to meet the human right to health and healthcare.

Patient & Problem

As should be obvious, landscapes, layouts of cities, and societal norms are not proper subjects for medical care. *People* are the proper recipients of medical care, and specifically sick people. The well have no need for a doctor, and so a person without a health problem cannot be a patient. A person needs to have a problem of the appropriate kind before we call the person a patient. But what kind of problems does medicine address? Not all health problems are proper targets for medical care. For instance, we don't treat loneliness as a medical problem, even though social connection is important for health (as explained in Chapter Two). We don't commonly think of environmental problems (like sanitation) or social problems (like isolation) as problems that require healthcare. Normally, we reserve medical responses for problems that fall into the biological and psychological components of health. Problems that are *only* social or environmental are not medical problems (refer back to Chapter Two for further discussion of the components of health).

Both individuals and groups can be the recipients of medical care. Medical interventions like vaccinations are often intended to help populations through creating herd immunity and not merely to help the specific individuals who get the vaccine.

Another criterion for a problem to be properly medical is that it must be treatable (at least in principle). Cancer is a medical problem, even though some cancers in some people are not possible to cure. But that doesn't make cancer in those instances a non-medical problem, because if the cancer was treated early enough or if better medical technologies emerged, the outcome could be different.

Practitioner

The next essential part of the medical relationship is the practitioner. There are many names for medical professionals, doctors, nurses, therapists, healers, etc. The practitioner might be responsible for diagnosing the patient, recommending and/or providing the appropriate care. Practitioners require training, and must be held to an ethical code of conduct.

In recent history, Western medical doctors and medical ethicists have settled on a handful of ethical principles of medicine: benevolence, non-maleficence (or non-harm), and autonomy (Marcum 2017). The principle of benevolence requires that doctors act in the interest of their patient's well-being. Non-maleficence prohibits practitioners from acting in ways which may harm or are likely to harm the patients in their care. The principle of non-harm dates back to the early days of Hippocratic medicine, resulting in what is known as the Hippocratic Oath: first do no harm.

However, the remaining principle of modern medical ethics, autonomy, is a relatively recent addition. Upholding autonomy as a principle of medical ethics involves respecting that the patient has the final say in what actions the doctor may take in order to help them. This

includes ensuring informed consent to medical procedures. Up until recently, paternalism in medicine (meaning deference to the doctor's judgment over the patient's own wishes) was the norm even in societies like the United States. Paternalism continues to be more acceptable in some cultures, which poses an interesting question for the human right to health. Does respecting the human right to health mean protecting patient autonomy? Or is some paternalism permissible?

The human right to health, like other human rights, is grounded in the idea that all people deserve to be treated with equal dignity in virtue of their humanity. Respecting personal autonomy is one way to demonstrate recognition of that fact. However, paternalism does not in every case infringe on human dignity. To build on Tasioulas' point (mentioned in Chapter One), the idea of human dignity entails that there are certain ways of treating a person that fail to respect what it means to be human. This idea does not depend on whether the person consents to such treatment or not. There are some treatments that a person could theoretically consent to, which would nevertheless be an affront to their dignity.

Just as we do not think seatbelt laws are an affront to our dignity as persons, not all paternalistic measures constitute a harm. I would argue that some paternalism in medicine is permissible (on the condition that it protects human dignity), but respect for patient autonomy ought to be preferred.

The idea of informed consent became an important part of medical ethics when certain prominent cases in the past demonstrated the threats (both to wellbeing and dignity) that arose without such regard for patient autonomy. One prominent example was the Tuskegee Study. In the study, a group of researchers set out to research the natural progression of syphilis. The subjects of the study were a group of around 600 impoverished African-American sharecroppers (Brandt 1978). A little over 400 of the participants had contracted syphilis

before the start of the study. None of the men were told that they had the disease, and thus were also never treated for it – although during the course of the study a cure for syphilis was known and available (Brandt 1978). The researchers not only failed to inform the men that they had syphilis, they also failed to provide them with any treatment. This failure to inform the men involved had the further effect of preventing them from seeking treatment elsewhere, and also prevented them from taking precautions against spreading the disease to others. The result was predictable. Many of the men died of the disease, at least 40 of their wives were infected, and 19 children born with congenital syphilis (Brandt 1978). Beyond that, the foundation of trust between the African-American community and the public health system in the United States was eroded. The researchers in the Tuskegee study were not acting out of paternalistic concern for their patients or research subjects, and their actions were also an affront to the dignity of the men involved.

From examples like this, the value of patient autonomy and consent is readily apparent. Yet, there are also cases where paternalism can seem to provide the better outcome. Consider the example of an elderly Chinese woman (80 years old) had stage four lung cancer and was never told about her condition or prognosis (Wang 2016). The custom in China is that doctors do not always tell patients directly what their condition is, especially if the patient is elderly, and especially if the prognosis is bad (Wang 2016). The doctor and family agreed that knowing about her cancer would only cause her to worry, and since the doctor was sure that nothing could be done to stop the progression of the disease, the family agreed not to tell her. Her relatives knew of her condition, and rallied around her to say their farewells (all while she was unaware of her prognosis). In order to accomplish this feat (saying goodbye without letting her know that they believed she was dying) the family had to lie to her about her condition. They believed she would die within three months. In fact, she lived for more than

three years beyond receiving the original diagnosis, never knowing of her condition and never receiving treatment (Wang 2016).

In such a case, it seems that no suffering was inflicted through the paternalistic measures taken by the doctor or family, and it is hard to articulate in what sense the woman's dignity could be said to have been violated. Thus, while this kind of arrangement is uncommon in the American or European context, I see no reason why the Chinese would deserve criticism or condemnation for paternalism of this kind.

Theoretical Framework

There are many styles of medicine in the world. Medicine needs a theoretical framework that allows the practitioner to diagnose and explain the cause of illness and select the appropriate response. As discussed earlier, many forms of medicine predate the scientific method, meaning their theoretical frameworks may not qualify as scientific. However, as David J. Hufford (2010) pithily phrased it while presenting his paper, "Folk Healing Comes of Age," "debunking an explanation does not debunk the remedy." Hufford describes one of the techniques used in TCM to prevent breach births (which happen when the baby is not oriented correctly in the womb for safe birth). The treatment involved burning an herb (moxa) and holding the smoke by an acupuncture point located on the woman's little toe. Through trials, the technique outperformed other methods of treating breach birth as well as the control group. The TCM remedy worked, despite having no satisfying scientific explanation. Medical systems don't have to get the causal explanations right to be useful.

Within TCM and Traditional Indian Medicine (Ayurveda), the causes of illness are conceived very differently than in Western scientific medicine. TCM and Ayurveda define the body differently than Western medicine and also differently from each other. Each respective definition is incommensurable with the others, and yet each tradition can still deserve respect

and recognition within the human right to health. TCM sees *meridians* and *qi*, where Ayurveda sees *doshas* and *chakras*, where in turn Western medicine sees *nerves* and *organs*. The differences are more than merely linguistic. There is some reason to believe the chakras may have been pre-scientific attempts to describe the function of glands within the body, and that TCM's Five Element Theory may be a pre-scientific explanation of the five major organs (Kaptchuk 2000, 44). But there is much more entailed in the idea of the chakras and *qi* than is captured by scientific labels like glands and organs.

These other theoretical frameworks can be worth preserving not just because they are sometimes capable of producing effective treatments or because they are deeply valued cultural traditions. As Ian James Kidd (2013) argues in his paper, "A Pluralistic Challenge to 'Integrative Medicine': Feyerabend and Popper on the Cognitive Value of Alternative Medicine," these alternative theories are valuable and not merely as sources for other techniques. He argues that there is an advantage to preserving medicine's cognitive diversity, especially in promoting innovation in the field. In his words, "Questions of medical efficacy aside, the wide range of theories and practices included within the elastic term 'alternative medicine' can prove valuable to [mainstream] medicine—by providing novel and original concepts, therapeutic and diagnostic modalities, theories of healthcare and healing, and so on" (Kidd 2013, 399).

There are many benefits of approaching medical traditions pluralistically. Any given disease or ailment may have a variety of possible acceptable treatments for patients to select. Additionally, some diseases not recognized by, or poorly understood by Western scientific medicine, may be understood and dealt with effectively through other paradigms. This makes such treatments more than luxury options. For certain people, the availability of such alternative treatments may be the difference between a life of limitations and suffering, and a life of normality.

Treatment

Medical care involves responding to whatever the problem is with something that is meant to alleviate or improve it. Different medical traditions may prescribe different treatments for the same underlying condition.

As Ted Kaptchuk's book, *The Web That has No Weaver*, describes, this can lead to cases where a Western doctor would diagnose six patients with the same malady (a peptic ulcer), where a practitioner of TCM would see six different unique syndromes (Kaptchuk 2000). Naturally, the different concepts of the cause of illness shapes what treatment will be considered appropriate. If the sufferer is diagnosed with an ulcer, the appropriate treatment may be lifestyle changes, like reducing stress or changing the diet, medication, or surgery depending on how severe the case is. If the diagnosis is "Liver Qi Stagnation" the treatment may be herbs, acupuncture, and other lifestyle changes (Kaptchuk 2000).

But what makes for a good treatment? The question hearkens back to another persistent topic of discussion in the medical community: do doctors treat problems or patients? Modern scientific medicine is sometimes accused of reducing patients to bundles of symptoms. Treating a problem will likely be less effective at producing improved health if the practitioner does not take into consideration the whole person and all the components of health that effect a person's life and well-being. For this reason, people's human right to health is best met with holistic approaches.

A final criterion for a treatment to be acceptable is that it be effective. If treatments have no ability to improve the health of the patient, they are not real treatments. However, what it means to have a positive effect requires further analysis.

3.4 DETERMINING EFFICACY

Having defined the boundaries that separate medicine from non-medicine, bad medicine and pseudo-medicine, the second task of this chapter requires that we outline the criteria for determining what it means for a medical practice to be acceptably effective. If the proper goal of medicine is the alleviation of suffering (as the medical humanists claim) and not merely the eradication of disease (as medical empiricists would claim), then the proper conception of medical efficacy will likewise be grounded in the capacity of the medicine in question to reduce suffering. To ensure good standards of care, however, we need a good methodology by which we can recognize and measure this ability.

In order to judge whether a medical practice is effective, it needs to have some observable and measurable positive impact on the health problem it targets and this effect needs to outweigh any potential negative side effects in other areas of the patient's health. Medicines can be effective in different ways. Some affect the physical biological source of illness by shrinking cancer tumours or improving organ function. In another sense, medicines might be said to be effective because they provide instrumental benefits. For example, some psychological treatments might be effective by improving mood, reducing intrusive thoughts, or lessening harmful behaviours. In a physical sense, wheelchairs or crutches can enable people to continue living their lives despite illnesses or injuries which affect their mobility.

No one medical tradition has a monopoly on effective treatments. Western medicine has been proven effective with its powerful contributions in the areas of antibiotics and in surgery.

TCM was found to be effective in boosting the liver health of cancer patients receiving chemotherapy in a study in 2009 (Liu, et al). In China, many TCM treatments and diagnostic methods are combined with Western practices successfully (Bhushan, et al 2005). Herbal remedies from TCM like ginseng, ginkgo, and *ma huang* have found scientific support and

subsequent popularity in Western countries (Bhushan, et al 2005). One study by the National Center for Complementary and Integrative Health (NCCIH) in 2011 found that Ayurvedic remedies for arthritis were at least as effective as conventional treatments (“Ayurvedic Medicine: In Depth”). In addition, Ayurveda’s use of turmeric as an anti-inflammatory for aid in digestive disorders and arthritis has found some scientific support, but more trials are needed to confirm (“Ayurvedic Medicine: In Depth”).

However, when it comes to other conditions, especially pain, we are presented with an interesting dilemma in discerning effectiveness. Pain is sometimes psychosomatic, but this does not make the pain any less real or detrimental. For this kind of suffering, placebos may meet the standard to be called effective. Placebos can be any treatment given to patients that has no “active” ingredient. In the colloquial sense, placebos are often used as short hand for treatments with no effect, but this is not accurate. Medical researchers test new drugs and treatments against placebos to see if the new treatment is more effective. But this is not the same as saying placebos have no effect on the patient. In fact, placebos are capable of quite powerful effects on patients. It is common for placebo groups in trials to report better outcomes than the control group, the difference is thought to be the result of the power of suggestion.

Placebos can be in the form of pills, shots, and even surgeries. Often the reported improvement patients experience coincides with how dramatic, expensive, or elaborate the placebo seems (for example in the case of knee pain, placebo surgeries were reported as more effective than placebo pills). Placebo effects are acceptable bonus improvements to health in this sense. However, they are not acceptable substitutes for medicines with effects that go beyond the mere power of suggestion. Providing a placebo in place of a medicine which does have an effective active ingredient is not a suitable way of meeting people’s right to healthcare, even if the person reports feeling better.

3.5 EVALUATING MEDICAL SYSTEMS

Just like health and illness, there is a range of conceptions of medicine and healthcare that may be considered acceptable and sufficient for the human right to health. Nearly every human culture has produced some kind of traditional medicine. These traditions can vary widely in how they understand the body, what a state of health looks like, what the causes of illness are, and what constitutes an appropriate treatment. Since health and medicine exist in such a wide range of possible expressions, it only makes sense for the human right to health to reflect that plurality. There are several possible categories into which medical systems can fall: (1) effective and non-harmful, (2) dubiously effective but non-harmful, (3) dubiously effective and harmful, and lastly, (4) effective but harmful. Each class deserves different treatment within the human right to health.

Effective and Non-Harmful

This is the kind of medicine to which the human right to health entitles people fair and non-discriminatory access. To fall into the first category, there needs to be good reason to believe in a medical tradition's efficacy. These medicines also need to have some checks in place to protect patients against harm. Ideally, these medical systems continue to conduct research and update their body of disciplinary knowledge with the aim of providing the best care possible. Medical systems in this category should have regulated degree-granting institutions and well established and satisfactory ethical codes. Practitioners must be certified and must pass ethics exams. Preferably, they must also maintain their certifications with continuing education. This kind of regulation helps prevent harm to patients through malpractice.

Dubiously Effective but Non-Harmful

At home in this category are systems of medicine that have not yet accrued evidence to support their efficacy, or which may even have some evidence that suggests they are not effective, but which do not cause harm to their patients. Indications of efficacy may be anecdotal, intermittent, or unsubstantiated, but if patients take emotional comfort or hope from the availability of such options, they should not be prohibited from using them.

In regards to the human right to health, providing people with access to one of these kinds of medicine in place of one of the more proven effective medicines is not acceptable. These are not replacements for quality effective care. States don't have a duty to provide these kinds of medicines, but neither do they have the obligation to prohibit them.

Homeopathy is one such medical practice in this category. It has been met with many accusations of being both pseudoscientific and ineffective. There is little evidence to back up homeopathy's treatments, which are mostly substances so heavily diluted with water that there is no active ingredient remaining. Yet, there is also no direct harm involved from ingesting this water. Any improvements patients feel after homeopathic treatment is likely to be from a placebo effect. But, I see little reason why individuals should be prohibited from using a placebo, as long as it does not do them harm. In the case of homeopathy, like the previous class of medicines, it is a regulated practice. People must study and earn degrees and licenses before they can practice homeopathy, and this helps protect against injuries to patients.

Dubiously Effective and Harmful

In contrast, other possible attempts to cure illness, such as that practiced by the Biamei tribe in Papua New Guinea, would fall into my third category, being both dubiously effective and

harmful (“Eating with Cannibals”). The Biama attribute sickness to the work of sorcery, and attempt to cure these illnesses by hunting down the sorcerer, killing, and then eating the person (“Eating with Cannibals”). This kind of cultural conception of and response to illness would not meet the criteria to be considered valid or acceptable because the prescribed treatment requires harming another person. Needless to say, this practice also lacks evidence of effectiveness. Thus, it would not deserve protection or respect.

The human right to health would require states to protect their citizens from such practices, even if they were deeply valued by the communities that practiced them. This kind of situation will be discussed in more depth in Chapter Four.

Effective but Harmful

If effective healthcare or medicine means it improves health, it is hard to imagine that it could also be harmful. But it is possible that such situations can arise, especially given that health is so multifaceted. A medical treatment can be effective at alleviating one kind of suffering, while causing another. Many pharmaceutical drugs do this in a small degree – like heart medications causing stomach upset. Many trade-offs like this seem minor, and it is clear that a reasonable person would prefer to have a working heart despite the discomfort of an irritable stomach. Another example is the use of chemotherapy, which can kill cancer cells but also can cause heart damage or peripheral neuropathy. Despite the damage incurred from the treatment, most reasonable people choose it over the alternative of death from the cancer. But other trade-offs are more complicated, particularly when they involve more than one individual.

Evaluating this kind of medical practice requires serious cost-benefit analysis. Many things can be said to cause some degree of harm somewhere, but it might be possible that the benefits outweigh the harm. In cases where the harm clearly outweighs the benefit, then such

a practice should not be permitted. But there are some hard cases to consider. What different people find to be harmful can also vary according to culture and beliefs. For example, some conservative Christians believe the use of embryos for research (even if that research could save lives) constitutes a harm. To resolve such issues, we can appeal to the capacity to suffer. Embryos are not conscious so they do not feel pain, therefore the ability to reduce the suffering of those who would benefit from the research ought to be privileged.

3.6 CONCLUSION

While different cultures can have different configurations and traditions of medicine, a pluralistic account of the nature of medicine still provides a basis upon which we can judge the effectiveness of the various medicinal practices. A pluralistic conception of medicine in the human right to health can allow for a range of cultural expressions and configurations of healthcare, but still maintain a line between what is acceptable and what is not. Culture shapes our behaviour and perceptions. It affects when we perceive ourselves to be unwell and why, and what actions we take in order to get better. We have good reasons to want to preserve diversity within health and healthcare. Respecting different configurations of healthcare upholds the central liberal value of autonomy by allowing individuals freedom and flexibility. Honouring and protecting the pluralistic nature of health and healthcare allows for individuals situated in a variety of cultures to have their right to health met without being asked to alter or abandon their identities within these groups or to adopt one single conception of what these terms mean. In this paper, I have tried to provide a clear but broad articulation of the nature of healthcare for this purpose. My account defines medicine by the presence of certain necessary elements (patient, practitioner, theoretical framework, and treatment), and subsequently separates “genuine” medicine from “bad” and “pseudo” medicine through outlining some predictable ways in which medicines can fail. My account is deliberately agnostic beyond that

point about what might constitute genuine medicine. Once the failed medicines have been identified, all that remains is what is genuine, and this will continue to grow and evolve.

CHAPTER FOUR: FROM LIBERAL MULTICULTURALISM TO MEDICAL PLURALISM

Thus far in the dissertation, I have argued that access to the ingredients for health, including access to healthcare, is a human right. I have also argued that in this context we ought to conceive of health and medicine pluralistically. In this chapter, I will turn my attention to the political realm and ask, what does recognising pluralism in health and healthcare look like? For the sake of clarity and focus in this chapter, I will confine the context of discussion to liberal democratic states where the state is already presumed to be committed to certain principles, like respect for autonomy and acceptance of human rights. The following chapter will address other kinds of political contexts. In this chapter, I ask how the state ought to interact with communities with different health related or medical beliefs and practices. Answering this question will require the discussion of some controversial areas in the philosophical literature: the debate around whether or not to embrace multiculturalism, the existence of group-differentiated rights, and the question of whether we ought to embrace medical pluralism.

I will argue that liberal democratic states with multicultural societies ought to embrace medical pluralism. To lay out my argument I will first address why liberalism and multiculturalism are compatible and how some group-differentiated rights are consistent with liberal democratic principles. Then, I will attempt to provide some guidance for how the state ought to interact with various medical communities in a way that both promotes health and respects cultural differences.

4.1 LIBERALISM & MULTICULTURALISM

Multiculturalism seems to be ever more increasing in fact, despite it also being ever more controversial in practice. The trend of increasing migration and increasing diversity in many

countries has brought the topic of multiculturalism to the fore of political philosophy in recent years. Occasional violent clashes of cultures like 9/11 and other events have convinced some that multiculturalism, as a policy, is hopelessly naïve. Additionally, multicultural politics have received derision from association with identity politics and social fragmentation. Thus, it is not uncommon to hear the accusation that multiculturalism is at odds with liberal values, and indeed some defences of multiculturalism are built on illiberal grounds and come hand in hand with criticism of liberalism.

Nevertheless, some philosophers, like Will Kymlicka (1995) and Anne Phillips (2007), defend multiculturalism on liberal foundations. In Phillips' view, which she lays out in her book, *Multiculturalism without Culture*, the argument for embracing multiculturalism begins with recognising that people's cultural identities matter to them. From there, the case can be made that ignoring or disparaging people's cultural identities (especially those of vulnerable minorities) does them harm. She argues that respecting people's cultural identities aligns with liberal values like freedom (the ability to live according to one's own principles), and tolerance (respect for others' choices) (Phillips 2007). This has the implication that in societies with culturally diverse populations, it is not appropriate to expect everyone to adopt the practices and beliefs of the majority or dominant group (Phillips 2007). This in turn has public policy implications. Phillips argues that, since existing policies are likely to be biased in favour of the majority, to be consistent with the liberal principles of equality and fairness, these biases must either be further justified or dismantled so that they do not unfairly disadvantage minorities (Phillips 2007).

Kymlicka, too, argues that liberal principles are consistent with multiculturalism and that this ought to reflect in policy accordingly. In his book, *Multicultural Citizenship: A Liberal Theory of Minority Rights*, he argues that some group rights are not only compatible with liberalism, but actually required by it (Kymlicka 1995). Along the same lines Phillips

described, if the existing systems are set up to privilege the majority or dominant group (intentionally or not), then Kymlicka would argue that some group rights are necessary to ensure the same range of freedoms and opportunities to the minority groups. Rather than being special rights that give minorities privileges that the majority does not enjoy, they are simply a counterbalance to existing inequalities.

Kymlicka identifies three groups that liberal multicultural democracies ought to accommodate – (1) indigenous populations (like Native Canadians), (2) regional minorities (like the Quebecois), and (3) immigrants (Kymlicka 1995). Kymlicka argues for the strongest form of minority rights for indigenous peoples because their situation is unchosen – having been coercively incorporated by a larger state. To remedy this injustice and offset the imposition of the larger state, Kymlicka thinks that indigenous people ought to be allowed some rights of self-governance. He further argues that this is consistent with upholding the liberal value of self-determination, since group affiliation is vital to forming individual identity (Kymlicka 1995).

As for immigrant groups, Kymlicka argues that the state ought to ensure fairer terms of integration into the broader society by granting some exemptions or accommodations of cultural differences (like looser motorcycle helmet laws for Sikhs) (Kymlicka 1995). Since immigrants freely chose to migrate to the new country, the basis for group rights is different than that of indigenous peoples. Kymlicka does not think immigrants should resist integration, but in light of the fact that most of the time new immigrant groups are subject to stigmatization and discrimination, he thinks the state ought to do more to aid the integration process and prevent unjust exclusions. This kind of action, he thinks, is required for the state to fulfil its duties to provide immigrants with the same range of life choices and enable same level of democratic participation afforded to the rest of the population (Kymlicka 1995).

Within liberal democratic states, the idea that individuals have certain rights the state is obligated to respect is generally accepted. What is more contentious is the idea that certain *groups* could also possess rights. On its surface, the idea of group rights may seem to stand in opposition to individual rights, and many thinkers worry that arguing for group rights will lead to the oppression of individuals. That is why Kymlicka is reluctant to allow that the rights of groups can be directed inwardly as restrictions upon the group's own members, rather than outwardly as protections against the state (Kymlicka 1995, 34-48).

Even so, some philosophers doubt the existence of group rights. Ontologically speaking, one may doubt that groups have the capacities necessary to hold rights, like the ability to make choices. If groups are incapable of making decisions or willing things independently of their members, how could they possibly hold rights?

To get around some of the objections to group rights, Kymlicka coined the term “group-differentiated rights” to describe a kind of rights accorded to particular groups within the larger society wherein the group exists. Group-differentiated rights are distinct from other group rights in an important way – group rights in the general sense can belong to the group as an entity, whereas group-differentiated rights are possessed by the individual members of the group in question. Initially, the difference may seem merely semantic, but in fact has very different implications.

Sometimes, group-differentiated rights and group rights do overlap, as is in the case of the right for a group to be self-governing – this is a right that can only belong to the group as a whole, not to the members individually (i.e. the group is entitled to govern itself, but no individual in the group can claim the right alone). In the case of group-differentiated rights, it is individuals who hold the right by virtue of their status as members of the group, as is the

case with members of an indigenous community who possess the right to fish in certain waters (Kymlicka 1995).

This kind of distinction helps clarify the difference between what Kymlicka (2009) has called “good group rights” vs “bad group rights.” Good group rights are those which protect individual members of groups from discrimination or injustice from other groups, and bad group rights are those which defend the group at the expense of its individual members. An example of a good group rights claim would be something like arguing for vegetarian meal options at a school to accommodate the dietary practices of students of a religious minority. On the other hand, a bad group rights claim might argue that a particular religion has the right to kill apostates in the name of preserving or defending the group itself.

Kymlicka and Phillips make convincing cases that multiculturalism and liberalism can be compatible. Still, this does not mean that the relationship will be without tensions. Many people worry that embracing multiculturalism means giving up on the right to criticise particular cultural groups, even when their practices seem decidedly illiberal or oppressive.

Is it demanded by the liberal principle of tolerance to tolerate illiberalism? Both Kymlicka and Phillips respond with a firm “no.” Both thinkers are only interested in multiculturalism to the extent that they think it is demanded by the principles of liberalism, and neither is interested in defending illiberal versions. Kymlicka is careful to say that not all groups can be or should be bases for group-differentiated rights, and group rights ought not to be confused with rights of groups over individuals. Kymlicka’s liberal multiculturalism is founded on individual freedom, equality of life chances, and democratic participation. Liberal states need not recognise group rights claims that do not fit within that framework.

Phillips too rests the support for multiculturalism on the respect for the choices made by reasonably informed adults. For example, to many Western feminists the hijab worn by many

Muslim women seems to be a sign of oppression. But Phillips argues that if the woman is a “reasonably informed adult,” our liberal principles ought to guide us to respect her choices, even if we would not make them ourselves. From Kymlicka and Phillips’ arguments it seems clear that at least some kinds of cultural accommodations are consistent with liberal democratic values, especially since cultural membership is often unchosen.

4.2 DISCERNING RELEVANT GROUPS

One of the first tasks of any argument for group-differentiated rights is the identification of the relevant groups. Drawing the boundaries of groups and deciding which groups are relevant and which aren’t is a fraught process and often arbitrary. Ethnicity or culture are often thought to provide “natural” bases for groups, but even these can be difficult grounds for rights since the boundaries of such groups can be fuzzy at best. Kymlicka justifies his selection of groups based on different liberal values and considerations of justice –autonomy for indigenous people, and equality for immigrants, etc. These divisions make sense in the political realm when the object is to ensure that everyone has the same opportunity to enjoy the same range of freedoms.

In the realm of health and healthcare, the groups that Kymlicka identifies still hold some relevance for how a liberal multicultural state should interact with and meet the needs of its various people groups. But given the nature of medicine, some further categories are necessary to articulate how a liberal multicultural state ought to interact with different communities. For instance, it is probably true that indigenous and immigrant communities have some unique health needs that other populations do not necessarily share, but so do other kinds of groups – race, religion, and gender may also shape individual health in important ways. Complicating the issue further is the diversity of medical traditions, many of which are bound up with different cultural traditions.

For the purposes of this paper, I will divide the discussion of liberal multiculturalism and its intersection with the human right to health into two arenas: (1) meeting the rights of communities with distinct health needs, and (2) respecting the rights of communities with distinct medical traditions.

Minority Groups & Health

Most reasonable people would agree that medicine is more effective when tailored to the individual as much as possible. For example, we agree it is better to have a cholesterol drug that our individual body responds to best rather than the one which fits statistically most cases. We also agree that it is better for patient compliance and comprehension if they can have their condition and the doctor's recommendations explained to them in a language that they understand, and not merely the language that the doctor is most comfortable with.

It is nothing radical to claim that it is unjust for ethnocentric bias or other forms of discrimination to prevent a person from receiving medical care. Doctors should not be able to pick and choose which race, gender, or creed of people they are willing to treat. It is also fairly uncontentious to say that doctors interested in providing the best healthcare for their patients ought to consider the unique risk factors their patients may be exposed to due to their background. Recognising individual people's unique health situation is part of being a good doctor, but not necessarily something in need of policy or legal regulations. For instance, it may be the case that ethnically Ukrainian women have higher instances of thyroid disease, but it is probably not the kind of difference that would justify a group differentiated right to thyroid screenings.

However, for other kinds of groups, like recent immigrants and religious or ethnic minorities, a group-differentiated right to certain accommodations in healthcare may be justified.

Screening for thyroid disease is part of providing effective care for patients which may have

higher risk, but not screening is not necessarily a violation of rights, especially not a group-differentiated right. This is because individuals might have higher risk relative to women of another group, but lower risk in absolute terms, and it would be strange to argue that just because the group is at risk, their individual rights are violated even when individually they do not require that kind of care.

Alternatively, if a Ukrainian immigrant patient who does not speak much or any English is not provided with a translator, this could undermine her ability to consent to medical procedures since without that service she may not fully understand what she is consenting to. Recognising the existence of some group-differentiated rights within a human right to health would not mean that Ukrainian-Americans are entitled to special healthcare compared to other Americans. Rather, it means recognizing that in case of recent immigrants not fluent in English, providing the same standard of healthcare that native English speakers enjoy to Ukrainian-Americans may require providing a medical translator.

It is important to realise that effective administration of medical care across a language barrier can be further complicated by different cultural understandings of health and medicine, as Anne Fadiman's ethnographic book, *The Spirit Catches You and You Fall Down* reveals. The phrase that Fadiman used as her title is a word for word translation of the Hmong term for epilepsy. Even with only the title phrase to go on, it is clear that communicating ideas about the origins of disease and biomedical methods of cure between a Western medical system like in the United States and Hmong immigrant communities is a steep task. Fadiman's book recounts the tragic story of a Hmong family with an epileptic daughter, Lia, and their frustrating encounters with the American healthcare system.

As its name in the Hmong language hints, epilepsy is considered a sign that the individual is a shaman, able to communicate with spirits and destined to serve an important role in the

community (Fadiman 1997). Lia's family loved her very much, but even with translators available, it was difficult to communicate the Western diagnosis into terms the family could understand. The family did not comply with the doctor's prescriptions because they thought that the medication was interfering with Lia's spiritual gifts and actually making her worse. The accumulation of misunderstandings eventually led to Lia being removed from her family's care and placed into a foster home. But this was too little to prevent the next seizure putting Lia in a coma at only four years old, from which she never regained consciousness (Fadiman 1997, 360). Not only did the failures of communication lead to a tragic result for Lia's young life, but it shattered the trust between the Hmong community and the American doctors. Situations like this can be avoided if more attention and resources are provided to aid in cross-cultural communication within the healthcare system.

As a matter of practicality and efficacy, cultural accommodation in healthcare is necessary to meet people's human right to health. Without provisions like medical translators, options for religious accommodations, etc., medical practitioners cannot meet the healthcare needs of their patients. This is already generally accepted in the medical ethics field, and many hospitals already try to accommodate these kinds of differences among their patients. However, there are some even more complex intersections between multiculturalism and the human right to health.

4.3 CULTURE VS HEALTH

For liberal states to be consistent with their own principles it is necessary that they respect people's cultural identities. This presents a problem when the interests of health and cultural identity come apart. As I have articulated in previous chapters, our cultural affiliations can strongly shape what we perceive to be healthy, leading some communities to behave in ways which to outsiders may appear decidedly unhealthy. In such cases, how should a liberal state

go about meeting its people's human right to health while also respecting their autonomy and not discriminating against cultures?

In Chapter Two, I described the differences between acceptable and inadequate accounts of health. Inadequate accounts of health (either deficient, harmful or impractical) are unsuitable to meet people's human right to health. This makes them bad operating definitions for policy makers, but nothing prevents people on the individual and cultural levels holding beliefs about health that would fall into the inadequate categories. If liberal democracies believe in respecting individuals' autonomous choices, sometimes these governments will be in the awkward position of needing to defend its citizens' rights to be wrong about their own health. There are, however, some examples where even liberal states can find justification for infringing on people's free choice, as in the case where the choices of individuals have effects beyond their own person, and especially when these effect children in irreversible ways.

In countries like the United States where freedom of religion is a protected right, religious commitments sometimes come into conflict with the law, including laws concerning health and medicine, as is the case with faith healing, some religious circumcision practices, and religious or other objections to vaccinations. For further clarification of this, it is helpful to examine some real world examples of such conflicts.

Metzitzah in Orthodox Judaism

In a case like the Orthodox Jewish practice of *metzitzah*, a religious ritual has a direct and negative impact on the health of a person. Metzitzah is a traditional style of circumcision sometimes practiced by Orthodox Jews, which involves the rabbi using his mouth to clear the blood from the area of incision (Offit 2015, 69). In New York City in the early 2000s, an Orthodox Jewish community's practice of metzitzah led to a number of infants contracting the herpes virus (Offit 2015, 68). Some of the infected children suffered permanent brain damage,

and others died as a result (Offit 2015, 68). City legislators could have chosen to outlaw the practice in the face of the evidence that it was unequivocally harmful (and especially since it was harmful to children who could not themselves consent to the practice). But New York took the more lenient approach – requiring the rabbis that conducted metzitzah to provide educational pamphlets that explained the risk the practice would pose to children (Offit 2015, 69). Those that did not comply would receive a fine of \$2000 (Offit 2015, 69). The decision in the end made no one happy. Those who worried for the safety of the children likely thought banning the practice would have been a better option. On the other side, Orthodox rabbis felt the fine was excessive, and claimed this was an infringement on their right to practice their faith as they saw fit (Offit 2015, 69). They sued the health department, claiming the regulation was “in violation of their rights to freedom of speech and freedom of religious exercise” (Offit 2015, 69). Later, in 2013, a federal judge ruled against the rabbis (Offit 2015, 71).

In the medical realms, it is common for parents and adult guardians to be allowed to give consent on behalf of their children – even those which have irreversible effects, or which may be risky. Phillips (2007) argues that in the case of children, there ought to be special protections against decisions which have irreversible consequences. Because children are too young to consent for themselves to such practices, anything which has irreversible effects ought to be discouraged or delayed until the child becomes an adult and can exercise their own will in making the decision.

However, I would argue that in a case like metzitzah, where the procedure itself is so risky, it is not entirely a matter of patient consent (whether given by the patient himself or a proxy). Even if it is conceivably morally acceptable for the parents to consent to metzitzah on behalf of their child, it is still a question whether it is morally acceptable for the rabbi to perform it. In the case of metzitzah, New York City attempted to discourage the practice with a fine for

not fully informing parents of the risk. Yet, perhaps the state would have been justified in doing more.

If a practice is so dangerous that a medical practitioner would lose his or her license for doing it, shouldn't the same be said of the rabbis? Defenders of metzitzah would reply that rabbis are not doctors, so they should not be held to the same rigid standards. But religion cannot be a free pass for any kind of behaviour. If a religious cult ritually cut off their left hands the government would be within its rights to prevent them from doing so – even if everyone was a consenting adult. Likewise, the government would also be within its rights not to let the cult members cut off the hands of their children.

There are certain kinds of free choices between consenting adults that the state can still legitimately prohibit. Currently, it is still illegal to assist someone in a suicide, even if both parties consent and are rational adults. The addition of religion in a case like metzitzah complicates the matter, especially in the United States, where the government is committed to protecting its citizens' right to practice the faith they choose. Yet, the fact that the United States has banned the practice of female genital mutilation (FGM) on those under 18, but not yet banned metzitzah, to me points to the fact that this is a matter of political difficulty, not moral difference.

FGM presents a similar risk as metzitzah to the children who are subjected to it, and is carried out with similar cultural and religious justification. According to the United Nations International Children's Emergency Fund (UNICEF), the age of the girls typically varies from weeks after birth to puberty ("Female Genital Mutilation/Cutting"). FGM is a common practice in many parts of the world, notably Somalia, Egypt, and other parts of Africa, and is usually done in the name of religion and keeping girls chaste. FGM has no known health benefits and many complications, both immediate and long-term, and many of them severe.

Just some of the immediate complications include “fatal bleeding, acute urinary retention, urinary infection, wound infection, septicemia and even the potential for the transmission of hepatitis or HIV depending on the instruments used” (“Care of Women with Female Genital Mutilation/Cutting”). Later complications can include strictures in the urinary and genital tracts, and incontinence (“Care of Women with Female Genital Mutilation/Cutting”). There can also be psychological consequences such as depression or post-traumatic stress disorder (“Female Genital Mutilation”). It is a religious and cultural practice, and valued just as much in its respective communities as metzitzah is to Orthodox Jews. Still, given its potential harms and the inability of children to decide for themselves in the matter, the United States saw fit to ban the practice. The ban seems to me to have ample justification, and similar justification exists in the case of metzitzah – though no ban is yet in place.

Anti-vaccination in Christian Science

Culture can influence when we perceive ourselves as healthy or ill and what actions we take to get well. Many of these choices are of the kind that liberalism must respect – the free choices of reasonably informed adults. But some choices individuals make can bring consequences for others without their consent or knowledge, and the refusal to get vaccinated is one such area.

For certain religious minorities, like Christian Scientists, the causes of illness and the appropriate methods of seeking cures are radically different than the mainstream view. Christian Scientists believe that we already live in God’s perfect kingdom, and thus, any pain, suffering or illness is only an illusion. They explain the experience of such things by saying that they are merely the result of insufficient faith, and the cure is simply for the sufferer to acquire firmer belief. Christian Scientist parents are encouraged not to vaccinate their children, since doing so is seen by the faithful as giving in to Satan’s temptation and to doubt

God's perfect world. This has led to tragic results in many cases, with children dying of preventable and treatable illnesses. The children do not have a real ability to choose, and given the high probability of severity and permanence of the consequences, combined with the availability of less harmful alternatives, their parents' actions are not justifiable.

Even in the case of adult Christian Scientists their decisions to go unvaccinated may not be acceptable. This is a trickier issue, since we generally want to respect people's bodily autonomy. Yet, allowing individuals to refuse vaccination for infectious illnesses puts others at risk, including other vulnerable communities – like the immune compromised who cannot get vaccinated themselves, and children too young to receive vaccinations. When dealing with contagious diseases, the actions of an individual or community have the ability to affect others, regardless of membership in the group, and regardless of consent. Because personal choices in this case have effects beyond the individual, even a liberal state would be justified in taking some steps to ensure the safety of the broader community, even if this is at the expense of a few people's individual choice.

Possession & Exorcism in Catholicism

While metzitzah is a religious practice which has negative health impacts, and Christian Science's beliefs lead them to resist medical interventions, religion and health can intersect in another interesting way – as in the case of possession and exorcism. Catholics, as well as some other faiths, believe in the possibility of spirits or demons taking control of people's bodies and/or minds. In such cases, the symptoms of possession can overlap with other known medical conditions, such as schizophrenia, epilepsy, depression or even alcoholism. This can create complications when the individual or community sees a person's poor condition as a spiritual affliction, rather than a physical one.

Although it occurred in West Germany in the 1970s, the death of Anneliese Michel is one such clash. As *The Press-Courier* reported in 1978, Michel was a young West German woman who died of dehydration and starvation during the course of an exorcism conducted by the Catholic Church in 1976 (“Bizarre exorcism draws suspended prison terms”). Her death launched an investigation which concluded that Michel’s life could have been saved if the 10 month exorcism had been stopped even one week before she died. For this reason, the state brought the two priests, Ernst Alt and Arnold Renz, along with Michel’s parents to court for “negligent homicide”. It was argued that she was not possessed by a demon, but was merely an epileptic suffering from depression. The prosecution contended that her condition could have been treated with medication and she could have lived a long and healthy life had it not been for the harsh exorcism. The priests and parents were both prosecuted, and convicted. But, as was allowed under German law, the prosecutors requested they receive no jail time. Instead, the priests were fined and sentenced to three years of probation and the parents were convicted but not punished. The court’s decision made it clear that the law had the final authority, and that the law was against any practice like this that would lead to a premature and avoidable death.

The sentence did not condemn religion as Michel’s killer, but the individual priests’ and parents’ neglect. They failed to act, or in the case of the priests – failed to stop acting. The court had determined that if they had stopped the exorcism process even two weeks prior to her death, Michel could have recovered.

If Michel was not mentally ill, it would seem that she would have had the right to consent to an exorcism. But the case is complicated by the question of her mental state. Even if she were of sound judgment at the time she consented to the exorcism, there is no indication that she understood the degree of risk (including the risk of death) and therefore her consent may not have been fully informed. The death of Michel rightly led to the conviction of those

responsible for negligent homicide. But respect for people's freedom to choose their religion requires that we cannot totally ban the practice of exorcisms.

Exorcisms are an explicitly religious treatment aimed at curing an illness not recognized by non-believers. Even though they may seem irrational to outsiders, respect for autonomy would require us to defer to the choices made by reasonably informed adults about their own lives.

Michel was free to believe that she was possessed, and free to seek an exorcism to treat her condition. But she was not the only actor in the scenario – her parents and the priests (even if they too sincerely believed in the reality of her possession by demonic forces), had other ethical duties towards Michel that they neglected. In their relationship to Michel as caregivers, they had a duty to do her no harm. We have duties as part of the human community to avoid harming each other, but this is especially true in the case of caregivers. Michel's, her parents', and the priests' freedom to believe in possession and the power of exorcism does not excuse them from their duty to avoid doing harm.

4.4 MEDICAL MINORITIES: CAM & LIBERAL MULTICULTURALISM

So far, these examples have centred on the interactions of the healthcare system with various culture groups with differing beliefs or needs. But there is another way that the issues of multiculturalism and the human right to health can intersect in the realm of alternative or traditional forms of medicine. The debate around how societies ought to deal with medical pluralism (whether to embrace or reject it) is not usually framed as a human rights issue. Yet, given the nature of medicine (outlined in Chapter Three), we ought to take seriously the question medical pluralism poses for liberal multicultural societies. Medical traditions are often deeply embedded in their home cultures, inextricably entwined with beliefs about the good life and the shaping of identity. Just as cultural beliefs interact with health and shape

how individuals and groups relate to the healthcare system, they also produce healthcare practices themselves.

In much of the modern world, the dominant medical paradigm is called biomedicine, a term simply meaning that medical knowledge and treatments derive from the science of biology. In states where the mainstream medical practice is biomedicine other medical traditions are often lumped together under the banner: “complementary or alternative medicines” (CAM). As it is now, states are sometimes at fault for stacking the deck against certain valid forms of medicine that belong to minority groups. Giving these minority medicines the moniker “alternative” sends the message that they are not equal or legitimate. Since at least sometimes these medicines are genuine and beneficial, this discriminatory labelling does a disservice to people who otherwise could have benefitted. Denying access to effective medicines just because of ethnocentric bias is a disservice to all of us. However, there is a way that the state can rectify this imbalance and still do so in a way that protects people from bad medicine and pseudo-medicine. Building on the ideas laid out in the previous chapter, here I will be arguing that liberal democratic states with multicultural societies ought to embrace medical pluralism.

A human right to health/healthcare ought to be understood as a right to non-discriminatory access to effective and non-harmful medicine (medicine, as I laid out in Chapter Three, as opposed to non-medicine, bad medicine, or pseudo-medicine). My argument that people have a right to medicine, not to “alternatives to medicine” may seem initially uncontroversial, but the controversy quickly comes into the fore when we try to draw the line of what practices and traditions belong in that category of “genuine medicine”.

As I have argued in Chapter Three, medical traditions sit at the intersection of two realms – the scientific and the social – and it is necessary to recognize that medical traditions are also often bound up with religious belief systems, cultural identities, and the unique histories of

the people who practice them. Some vehemently oppose the legitimization of what they call “alternatives to medicine” (Schneiderman 2000). However, on the account of medicine I laid out in the previous chapter, some of the CAM practices deserve recognition and inclusion.

Just as ensuring an equal playing field for members of minority groups is a matter of justice that requires some measures of protection, ensuring an equal playing field for minority medicines may require some regulations to prevent discrimination. Opponents of complementary and alternative medicines will be resistant to any such suggestion because, with good reason, they think the government should not be in the position of propping up pseudo-science.

I agree that bad and pseudo-medicines should not be given the same status as genuine medicine. Not all complementary and alternative medicines meet the criteria I laid out, and I will not be defending them in this chapter either. But as for the practices which do belong in the category of genuine medicine, like TCM and Ayurveda, I will argue that liberal multicultural states commit an injustice if their people are not allowed access to them. It is ethnocentric and unjustified to assume that genuine medicine simply means biomedicine, and nothing else. Some CAM medicines can and do meet the criteria for inclusion in the category of genuine medicine – and thus, to discriminate against the practices does not respect people’s human right to healthcare, or respect their autonomy in choosing the medicines which they prefer.

Jessica Flanigan (2018) argues in her new book, *Pharmaceutical Freedom*, that there is an asymmetry in how we think of patient choice and paternalism. For an example, she describes two scenarios of a patient with diabetes. In the first case, the doctor tells him he should take insulin to treat his condition, but the patient says he would prefer to try managing his diabetes with diet and exercise. We typically think such choices are up to the patient, and so far

nothing seems amiss. However, Flanigan asks us to think about the inverse as well – what if the doctor recommended diet and exercise, but the patient said he preferred to simply have the medication instead of changing his own lifestyle. Here, the patient cannot access the medicine unless the doctor is willing to prescribe it. Writing from a libertarian perspective, Flanigan thinks this asymmetry is unjustified, saying that if we see the first case as an exercise of patient autonomy, we must also recognize the second as such too. While I do not agree with every point she makes in her book, I think the basic argument is sound. Assuming that both options (medication or diet/exercise) are reasonably effective and non-harmful, if we respect patient's ability to choose what is best for them in one scenario, why not the other?

People against acceptance for CAM medicines often refer to cases like Steve Jobs. Steve Jobs was diagnosed with pancreatic cancer (Elkind 2008). Pancreatic cancer is often difficult to treat, but Jobs was lucky enough to have one of the less severe kinds, and to have caught it early. Yet, he chose to attempt treatment for his condition with acupuncture and a vegan diet instead of following the doctor's recommendations. Many people credit this decision for his eventual death. But again, as I argued in the previous chapter, negative health outcomes of this kind are not the result of something like acupuncture being non-medicine or pseudo-medicine. Instead it is the result of misinformation and malpractice (a.k.a. bad medicine). Acupuncture should remain a reasonable and accessible option of treatment for the kinds of conditions we have evidence that it can treat.

Along with respecting autonomy, comes allowing people to make choices for themselves that may in the end have regrettable outcomes. As I discussed in Chapter Two, people (individuals and whole cultures) are sometimes wrong about health. When reasonably informed adults are wrong, there are few options for liberal governments to intercede while respecting their autonomous choices. However, because medicine is a relationship involving both a patient

and a practitioner, it is not only the patient's autonomy that is at issue, it is also the conduct of the practitioner.

4.5 AUTONOMY & NON-HARM

Kymlicka and Philips have made strong arguments for why liberalism ought to embrace multiculturalism. But their arguments are constructed for the political sphere, not the medical. As a political philosophy, liberalism holds autonomy as the primary value. But when we enter the medical realm, it is necessary to acknowledge some unique constraining factors which necessitate that at least some of the time, autonomy will be subordinated to the principle of non-harm.

Within the field of medical ethics, there are a handful of principles that doctors must commit themselves to: non-harm, beneficence, autonomy, (and more recently, justice) (Marcum 2017). The principle of non-harm is one of the oldest – going back to Hippocrates in Ancient Greece. A commitment to non-harm means not only do doctors commit to not actively doing injury to their patients, but they have a duty to not engage in malpractice, which requires more than merely not intending harm to the patient. Avoiding malpractice includes keeping up-to-date on the best medical knowledge, carrying out their practice to the best of their ability, and behaving ethically.

Unlike non-harm, autonomy is a relative newcomer to the principles of medical ethics. Until very recently, it was the norm in most societies (even the USA), to practice medicine paternalistically. Patients were not always fully informed of their condition – diagnosis included. Cancer patients were often not told their diagnosis for fear this would make them less able to cope with it. Most of us agree today that informed consent and patient autonomy are valuable, and preferable to the paternalism of the old days. But embracing patient autonomy does not mean that autonomy is king among medicine's guiding ethical principles.

Medicine is a relationship – by definition involving more than one person. As such, autonomy and its preservation, cannot be the only operating value. People who assume medical or quasi-medical roles must adhere to the ethical principle of non-harm. This is an institutional duty, not an infringement on their personal autonomy or on the autonomy of their patients.

Returning to the case of Jobs, we can argue that Jobs ought to be allowed to choose what treatment he prefers, but practitioners ought not to be allowed to claim things which are not true. Jobs did nothing wrong, but he might not have made the same choice if he had been better informed. Holding practitioners to higher standards serves patients' autonomy, while also reflecting the value of non-harm. In this way, we can protect patients from bad and pseudo-medicine without limiting their choice or making ethnocentric judgments about what medicines deserve legitimacy.

4.6 PSEUDO-MEDICINE & BAD MEDICINE REVISITED

We don't want the state to be play the role of thought-police, or dictate every choice we make about our own health and bodies, but we also don't want the state to be in the role of promoting pseudo-science. Recognizing medical pluralism need not entail surrender to pseudo-medicine and bad medicine. In fact, protection from bad-medicine and pseudo-medicine is consistent with liberal values. No one mistakes the respect for informed consent on the part of the patient for disregard for the expertise of the doctor. Similarly, requiring regulation for pharmaceuticals, herbs, etc., is not an infringement on autonomy, but actually a defence of it. Obligating the providers of medical care to disclose all the relevant information empowers patients' autonomy.

Not only are pseudo-medicine and bad medicine inadequate to meet people's right to health (as I discussed in Chapter Three), but whether it is the result of medical misinformation or greedy snake oil salesman, bad/pseudo-medicines are guilty of failing to respect informed

consent as well (Shahvisi 2016). There is no injustice done to individuals or groups when pseudo-medicine and bad medicine are prohibited. However, if autonomy is all that matters, it is hard to make that case, which is why the medical principle of non-harm is so vital.

We care about preserving patient autonomy, but we also care about the practitioners of medicine being committed to non-harm. It should be within a person's rights to consent to a pseudo-medical practice, like crystal therapy – but for a practitioner to claim that crystals can cure cancer is unethical, and so the practitioners should not be allowed to do so. This aides in the preservation of the freedom of patients to choose among treatments which are real – not fraudulent.

4.7 CONCLUSION

Liberal democratic states with multicultural populations ought to recognise medical pluralism, as a matter not only of respecting group-differentiated and individual rights, but also as a human rights issue. Medical pluralism and respect for cultural differences in the interpretation and practice of medicine is worth protecting. Medical traditions are often a deeply valued part of cultural history and identity and therefore foster the social component of health. Further, diversity in medicine can be a good worth protecting, since it enables individuals to select the kinds of care they determine to be best for them. A respect for medical pluralism does not necessitate support for bad and pseudo-medicines, or validate the excuses of practices that damage health.

Rights are meant to remedy predictable patterns of injustice. Ignoring cultural differences in health may lead to ineffective care, and this would leave people in minority communities with possible substandard healthcare which would seem to violate their rights. Ignoring differences in medical traditions (provided they meet the criteria laid out in Chapter Three to be medicines at all) is inconsistent with the liberal value of autonomy. Out of respect for

autonomy, we must respect the choices of reasonably informed adults, and this includes respecting the choices shaped by their cultural identities.

CHAPTER FIVE: INTERVENING ON BEHALF OF HEALTH

The previous chapter dealt with the intersection of the human right to health with multiculturalism within developed liberal states which hold both the requisite values and the means to meet their citizens' rights. In this chapter, I will examine other contexts, where the state's values and resources present new problems for the human right to health and its relationship with multiculturalism.

Though acceptance of the normative force of human rights may be lacking in these contexts, the need for health and healthcare remains. In these settings, there are a few key dimensions to examine. First, we should assess whether the right to health has been met or violated. Then, if the right has been violated, we must determine the best response. Reasons for failing to meet the right come in two kinds: (1) a state may be unable to meet its citizens' human right to health, or (2) it may be unwilling to do so. Each kind of failure requires a different kind of response, and each kind of response comes with its own complications and limits. Consistent with the other parts of this thesis, care must be taken to avoid the appearance of ethnocentric bias when claiming that a human rights violation has occurred, to avoid reinforcing the narrative that human rights are merely justifications for Western imperial impositions.

For the purposes of this chapter, I will be relying on the definition of cultural imperialism provided by Lisa Fuller in her 2012 paper "International NGO Health Programs in a Non-Ideal World: Imperialism, Respect, and Procedural Justice." The term cultural imperialism originates from the colonial era, where "Western nations set out to conquer and rule territories in North America, Asia, and Africa for the dual purpose of exploiting their natural resources and 'civilizing' their inhabitants" (Fuller 2012, 217). Fuller describes three key features of this kind of cultural imperialism: "(1) the perpetrators or 'imperialists' *intend* to both dominate and reform the beliefs and practices of people from another culture, (2) they feel they are entitled to do this because they *believe* that Western culture is inherently superior to

so-called “native” or “indigenous” cultures, and (3) they carry out their task *coercively*, with the aid of significant economic and military resources, as well as through political channels such as colonial justice systems” (2012, 217).

She describes the wrongfulness of cultural imperialism is not that it exports values of any particular kind, but rather that it undermines the autonomy and sovereignty of the less powerful group. She acknowledges that “these features do not appear – at first glance anyway – to apply in the context of delivering medical aid in the present day,” in that INGO workers do not aim to dominate or impose on others, nor are they likely to believe in the inherent superiority of Western culture (Fuller 2012). However, Fuller argues that in modern times cultural imperialism need not be intentional, and its perpetrators need not believe they are superior or entitled. The coercive activity alone, and the resultant injury to the sovereignty/autonomy of the recipient groups, in the form of their values being “replaced” or “supplanted,” is sufficient to inflict the harms of cultural imperialism. For these reasons, it seems especially important to try to avoid inflicting cultural imperialism if one’s sincere aim is to make others better off and more empowered.

One common understanding of the political function of human rights is as a trigger for intervention (meaning a loss of sovereignty for the errant state). This political function of human rights is the very thing which has often triggered the backlash against them – saying they are merely tools of Western imperialism. Fuller’s arguments about the risks and wrongfulness of cultural imperialism in the context of medical aid align with these objections, and thus this question poses a challenge for appropriate political intervention on behalf of the human right to health.

Discussion of human rights abuses as justifications for international interventions, the manner and method of those interventions, as well as objections to them are abundant in the philosophical literature (Tasioulas (2009), Viehoff (2013), Peterson (2006), just to name a

few). So too is the literature on global health, public health, and the efficacy and ethics of aid (DeCamp (2005) and Bellamy (2006), among others). However, the idea that the human right to health imposes a duty on charities and INGOs, not just states, has not previously been argued. In this chapter I will argue that because of the unique character of the human right to health, intervention on its behalf can be justified not only in response to outright violation, but also due to unmet needs of populations. That said, the manner and form of interventions on behalf of health will look decidedly different from other human rights interventions.

Fuller and those who would agree with her think that coercive interventions are *always* culturally imperialistic and therefore wrong. But I will argue that in at least some cases coercive interventions are not culturally imperialistic, and that some coercive tactics can be justified. I will argue that human rights health interventions, properly done, do not fit the criteria to be considered culturally imperialistic.

5.1 THE IMPETUS FOR INTERVENTION: VIOLATION & UNMET NEEDS

In the first chapter of this thesis, I argued that the human right to health ought to be understood as a right to protection from standard threats to health. I argue against the concept that only “negative” rights can be real rights, since in fact all rights impose some positive duties on others to be maintained (Wolff 2012). Additionally, I endorse the view that one of the functions of human rights is to justify international political intervention when they are violated.

When a state fails in its duty to respect human rights, it loses legitimacy, and thus other states are allowed to disregard the errant state’s sovereignty to remedy the problem. This, however, is a continuing source of conflict, contributing to the suspicion that some have that human rights are merely excuses for Western imperialistic agendas. Thus, it is important to articulate

guidelines that help identify violations and pair these with appropriate responses in a culturally neutral way.

Cross-Cultural Complications

It is common to assume that health is a universal and uncontroversial good. While I think this is true, as I have argued in previous chapters, health is also a culturally laden concept. This means that cross-cultural judgments about what violates a human right to health can be complicated by the different conceptualizations of health that underpin different societies' health policies (as was discussed in Chapter Two).

In the modern era, most ethical traditions seek to disavow the old crusader/colonial mentality that gave excuse to so much violence in the recent past. As William Sullivan and Will Kymlicka (2007) argue, most ethical traditions endorse what they dub a “two-level” view. These two levels (1) express a belief in the existence of universal minimum standards in ethics and (2) favour the use of voluntary debate instead of forcible conversion (Sullivan and Kymlicka 4). Kymlicka, however, argues that the currently fashionable two-level view is not significantly different from the old colonizing practices. He observes that the old colonial powers did not justify their actions on a supposed right to impose their views on others. Rather, colonizing forces (like the Catholic Spanish) perceived the practices of the societies they colonized (like the Aztecs) as falling below a minimally decent moral standard (Sullivan and Kymlicka 5). To the Spanish, many Aztec practices, like human sacrifice, seemed plainly barbaric. Kymlicka notes that few people would disagree with the Spanish today for suppressing the practice of ritualized murder. Yet, the Spanish also perceived other Aztec practices as falling below the minimal standard which seem less uncontroversial today, like the Aztec convention of tracing matrilineal kinship (Sullivan and Kymlicka 7).

With such examples, Kymlicka seeks to caution modern human rights activists from making similar ethnocentric judgments. While we promote human rights, we are often quick to identify practices we perceive to be barbaric in cultures not our own, but fail to see the way in which our own practices may be conceived to be barbaric by others. For an example of this, Kymlicka draws attention to acceptable forms of criminal punishment: cutting off the hands of a thief in Saudi Arabia may seem barbaric from the outside, but so too does the prolonged solitary confinement commonly employed in US prisons (Sullivan and Kymlicka 2007, 8).

To be clear, these two examples are different in an important sense. In the first case, the Spaniards' dislike of matrilineal kinship was ethnocentric, and misplaced – since in fact, there is nothing essentially wrong with tracing kinship matrilineally. In contrast, cutting off the hands of thieves seems cruel to us, and so does extended solitary confinement. Therefore, to judge the Saudi's use of corporeal punishment as morally wrong is not ethnocentric, so long as the would-be judge is consistent and likewise condemns the similar cruelty of solitary confinement.

Different cultures can validly criticise each other without first being blameless and perfect themselves. However, what is worrying is asymmetry in how these kind of judgments are often applied in practice, i.e. the barbaric and inhumane practices of less powerful cultures are rightfully decried and (hopefully) addressed, while the barbaric and inhumane practices of powerful cultures are ignored and allowed to continue.

Human rights intervention in practice has not always avoided these biases. But at least in the creation of international documents, like the Universal Declaration of Human Rights (UDHR) and ICESCR, despite the political power of the United Kingdom and the United States, “intensive lobbying by Carlos Romulo of the Philippines, Herbert Evatt of Australia, and philosophy professor Charles Malik of the Lebanese Republic, together with several Latin American states, led to concerns of less powerful nations and their peoples coming to the

fore” (Wolff 2012, 3-4). Since the documents themselves were created through cross cultural dialogue, they provide a good basis on which to begin the discussion.

Terminology & Tensions

To better understand and identify what it means for the human right to health to be met or violated, it is helpful to look at how the right has been articulated in international documents like the UDHR and ICESCR. The UDHR states in Article 25.1, “Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services.” Article 12 of ICESCR proclaims the “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” The later addition of General Comment 14 further states that the “right to health is not to be understood as a right to be healthy.” General Comment 14 is also specific in pointing out that the United Nations General Assembly did not adopt the conception of health articulated in the Constitution of the WHO (where health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity). General Comment 14 does, however, insist that the right to health is not merely the right to health care, but also the right to the underlying determinants of health, such as food and nutrition, housing, safe water, sanitation, etc.

General Comment 14 also makes explicit the freedoms and entitlements that a human right to health entails. These freedoms include, “the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation” (“General Comment 14”). The entitlements listed “include the right to a system of health protections which provides equality of opportunity for people to enjoy the highest attainable level of health” (“General Comment 14”).

Recognizing the existence of resource constraints, the ICESCR adopts the view of “progressive realization” rather than “full immediate realization” of the right to health. Yet, the phrase, “progressive realization,” especially when used in combination with another of the human right to health’s key terms, “minimum core obligations,” can be perplexing at best. As Jonathan Wolff (2012) explains “[p]rogressive realization” permits a country’s limited resources to provide a valid excuse for limited progress to full realization, whereas the notion of “minimum core obligations” suggests that there is no excuse for failing to achieve a particular level of health care” (11). These two phrases seem to be in tension.

The source of the tension arises from the idea that ‘ought’ implies ‘can.’ In Chapter One, I argued that two things are necessary for something to be considered a violation of the right to health – (1) the existence of a feasible alternative, and (2) a lack of justifiable cause for that alternative not being taken. Both are predicated on the presence of a political institution capable of acting in the first place.

The human right to health is supposed to protect people from standard threats to health (as discussed in Chapter One), standard threats being urgent, predictable, preventable injuries. On that definition, famines could be a violation of rights, but only if the famines are caused by mismanaged resources and not unpredictable and unpreventable natural disasters.

Similarly, death because of finite health resources (e.g. limited kidneys available for transplant) are not violations of the human right to health. But scarce resources cannot be an excuse to give preferential access to healthcare based on race or gender, since that fails to treat humans with equal dignity. Saying some action violated people’s rights must mean that there is some blameworthy reason why the institution did not meet its obligations. The tragic and the unfortunate are not by themselves violations of rights. However, because of the nature of health and the positive duties imposed by the human right, outright violations of rights are not the only possible failure.

Positive Duties, Unmet Needs

The human right to health's status as a *positive* right (as opposed to a negative right) adds further dimensions for consideration. Unlike a right not to be tortured, which requires only that others abstain from the act, the human right to health imposes a positive duty on political institutions. This is a feature which has led some critics to doubt that there is such a thing as a human right to health, arguing that the only coherent rights are negative rights (O'Neill 2015).

But other thinkers, like Jonathan Wolff (2012), have pointed out that even so-called negative rights impose similar positive burdens on political institutions. A right not to be tortured still requires that the state supply police to enforce the law, and other institutions capable of responding if the right is violated.

Just as we do not blame the government for every crime that occurs in a community, we cannot blame a government for every preventable illness either. However, we would consider it at fault if people were regularly murdered because no police force was in place to prevent it, or no legal system was present to bring murderers to justice. Logically, we could consider the state similarly to blame if its citizens regularly died of easily preventable illnesses because it did not have any infrastructure in place to prevent these deaths. But the culpability of the state in these kinds of scenarios is entirely dependent on the perceived ability of the government to prevent the deaths. If a government can prevent deaths from disease, and yet neglects to make any effort to do so, this would be a violation of its people's human rights.

There is a dis-analogy between a right to health and right not to be tortured. If no one is committing torture, then it is safe to assume there is also no one being tortured. But that is not the case with health – just because no one is actively injuring health does not mean that no one's health is injured. The human right to health is a positive right, meaning violations can occur not just through *commission* but through *omission* as well.

If, as I have argued, political institutions are the parties responsible for upholding human rights, then when a state is unable to meet the minimum health needs of its people, is this a violation? If ought implies can, then no. Indeed, it would seem that neither of the previously mentioned criteria for violation have been met. If a state is unable to provide healthcare or basic health inputs through no choice of its own, the health needs of its citizens go unmet, with no one to blame.

Violations of human rights are thought to provide justification for international intervention. Unmet needs are not violations. But all this leaves underdetermined what ought to be done when states have failed, or when people have been robbed of a state to which they can belong, like refugees. This presents a problem for human rights, which are supposed to apply to all people – not just humans with citizenship of certain kinds.

To remedy this gap, I will argue that in cases where the minimum core standards of health are not met, and the normal institutions are not capable or present, then this too can justify intervention. Stateless people, refugees, and those living in failed states still have the same human rights, including a right to health and healthcare. But who can they appeal to, and what form of intervention is justified?

5.2 AIDING THE UNABLE

The human right to health is in a unique situation as compared to other human rights. Sometimes the institutions responsible for meeting and protecting the right will be absent or incapable. But just because the people are left without an obvious institutional alternative does not mean they do not still hold a right to the freedoms and entitlements included in the human right to health. In lieu of the usual institutions, I will argue, the duty diffuses to the next most capable body, which at least in some cases will be a humanitarian health organization or INGO.

Intervening in such cases carries with it some unique factors that create certain moral risks, like undermining the autonomy of the aid recipients, creating unintentionally coercive offers, and exacerbating systems of dependency.

Diffusion of Duties & the Responsibility to Protect

Peter Singer (1972, 2009) has argued that we have ethical duties to help others regardless of their proximity to us. The suffering of another person and our ability to help them are not diminished by distance. While he does not build his arguments in terms of human rights, many of his points still find application when discussing human rights in connection with the issues of global health.

The nature of health provides several considerations that I will argue give us reason to believe the duties imposed by the human right to health extend beyond the relationship between citizens and states. Many aspects of health simply cannot be adequately managed by any single state in isolation. Infectious illnesses, famines, and other threats to health do not respect arbitrary borders between states.

If such kinds of threats to health emerge in states that are too resource-poor to combat them on their own, wealthier states and/or INGOs have strong reasons to make up the difference, from altruism, solidarity (the recognition that we're all in this fight together), and simple self-interest (Emerson and Singer 2010). To realize the "minimum core obligations" that all people are entitled to under the right may require not only cooperation between states, but sometimes cooperation between aid organizations, INGOs, and states.

When states have failed, humanitarian aid organizations may be the only capable bodies to which people can turn for help meeting their basic needs. However, humanitarian interventions carry with them their own unique kinds of ethical risks. Out of respect for the rights of the aid recipients, any humanitarian intervention should be careful to respect the

autonomy of the recipients, and avoid unintentional coercion, culturally imperialistic bias, and creating or exacerbating cycles of dependency.

States of Emergency & Patient Autonomy

Many altruistic people feel the humanitarian urge to help when others are in need. In that case, they may be acting even when they do not feel that they are *obligated*. But even if acting out of altruism, in helping others one assumes a responsibility not to violate the recipient's rights.

Humanitarian aid is often motivated by warm fuzzy feelings, the desire to help, compassion, empathy, etc. but these are not always the best guides to effective or just methods of aid. A doctor may see a person choking, and rush to help. But because of informed consent, the patient has a right to refuse care, or sign a "Do Not Resuscitate" (DNR). Hypothetically, if a doctor knowingly resuscitated a person who signed a DNR, the doctor would be disrespecting the patient's autonomy. DNRs protect patient's wishes, and override what the doctor might otherwise wish to do or think is right.

In emergency situations, ascertaining the wishes of the person in need can be difficult or impossible, and analogous situations arise during urgent humanitarian interventions as well. For example, in countries like Haiti and Nepal, which have had recent devastating earthquakes that destroyed or disabled large parts of their infrastructure, the people were in obvious need of help, but lacked the ability to set the terms on which the help was given.

The historian Bertrand Taithe (2017), in a lecture given at the European Spring School on History of Science and Popularization, discussed the problems that emerged in the wake of the 2010 earthquake in Haiti. Many of the people who rushed to help after the disaster, while motivated by altruistic intentions, were not actually highly skilled (or skilled at all) in the areas which were needed.

Instead of skilled surgeons, the Haitians were often stuck with retired dentists, or other professionals. Almost any help is preferable to no help at all, but if given the choice, they would of course want effective help. Sadly, in such cases, the recipients of aid are not always given that option. This is one of the areas where things could and should be improved.

When unable to ask the patient about their wishes, the doctors usually make assumptions based on what they imagine a reasonable and informed person would wish. This courtesy should be extended to the recipients of aid, but sometimes it is not.

The old cliché may say that beggars can't be choosers, but beggars still have basic human rights. Good intentions are not enough to ensure good outcomes, and thus those participating in humanitarian health interventions ought to ensure that they have more than just intentions to offer.

Unintentional Coercion and “Unrefusable Offers”

Lisa Fuller (2012) presents several scenarios where well-intentioned health INGOs can nevertheless undermine the recipient community's agency, and unwittingly inflict suffering in the form of cultural imperialism.

Fuller describes the problem of cultural imperialism thusly,

First, there can be no doubt that pressure to abandon, disregard, or violate valued practices and beliefs can cause distress. It can cause feelings of shame or pain or sadness in those who contravene traditional beliefs. It may also cause others in their communities to see those who abandon traditional beliefs as reprehensible or misguided, causing further suffering and difficulties due to social exclusion or criticism.

Experiencing such distress makes people worst off. Second, the coercion associated with imperialism denotes a loss of choice or control over an individual's or a community's actions or way of life. Even when losing the ability to choose does not

have a negative impact on people's welfare (and it often will), it is nevertheless insulting and disrespectful for choices about significant aspects of people's lives ... to be taken out of their hands (2012, 218).

Cultural imperialism is wrong, because it causes suffering, makes people worse off, and undermines the autonomy of individuals and communities. For these reasons, it seems especially important to try to avoid imposing cultural imperialism if one's sincere aim is to make others better off and more empowered, as it is in the context of most health INGOs.

Without special care or forethought, Fuller worries, the unequal power dynamic between an INGO and the recipient community will result in what she calls "unrefusable offers." She describes scenarios where recipient communities may be forced to choose between upholding their values and receiving help, and argues that making such offers is unethical. This presents a dilemma for international interventions on behalf of human rights, for many methods of intervention may produce similar scenarios.

Fuller gives two hypothetical examples in her paper. First, an INGO running a feeding center that, for the sake of cost-effectiveness, wishes to prioritize providing food to children, rather than the elderly in the community first (Fuller 2012, 215). The INGO runs into trouble when the community's values conflict with this order of serving. The community wishes that its elders be given the priority. The INGO's cost-effectiveness will go down if they comply, and in the absence of the INGO's accommodation, the people are left with the choice to either go against their traditions and act in a way they perceive to be disrespectful of their elders, or go hungry (Fuller 2012, 215).

In all likelihood, less people overall will actually come to the feeding center than would have if there was no such value conflict. This amounts to a lose-lose situation. As Fuller says, "as a purely practical matter, many projects simply won't work efficiently – or at all – if they are

designed in a way that conflicts with the dominant cultural beliefs and social conventions of the recipients” (Fuller 2012, 215). In this example, Fuller highlights the importance of cultural sensitivity not only in the name of behaving ethically, but in the name of effectiveness too. Without taking into account the cultural landscape, the INGO will not be able to achieve its goals effectively or efficiently.

In her second example, Fuller describes an INGO wishing to provide antiretrovirals to an HIV afflicted community. In this scenario, the complication arises from the fact that the antiretrovirals are known to negatively interact with local herbal remedies provided by a traditional healer (Fuller 2012, 216). Here, Fuller thinks the INGO has a few options – (1) they can undermine the healer and convince the patients to stop taking the herbal remedies, (2) the INGO could relocate to serve a different community without a similar risk of culture loss, or (3) the INGO could attempt to convince the traditional healers of the negative interaction between the antiretrovirals and traditional remedies (Fuller 2012, 232).

Fuller argues that the first two options are culturally imperialistic, since they send the message that the recipient community must either conform to the INGO’s values or go without help. The third option, which she fleshes out into what she calls an “iterated process of reciprocal negotiation” later in her paper, is the only option which she thinks avoids the imperialistic harm (Fuller 2012, 214). In this process, both parties, through dialogue, work out a set of shared beliefs and values and discuss how to proceed, and importantly, both parties stand on equal footing in the negotiation (Fuller 2012, 230).

In her article, Fuller foresees an objection to her ideas from Susan Moller Okin (Fuller 2012, 234-236). Okin suggests that “interactive” approaches, such as Fuller’s, will fall short in contexts where “oppressed people have internalized their oppression” (Fuller 2012, 234). Fuller responds to this by implying Okin only raises questions about “adaptive preferences” and “false consciousness” when the views in question conflict with her own (which are

distinctly Western), and that such thinking only encourages dismissing the views of the poor and oppressed without taking them seriously (Fuller 2012, 235). She admits her proposed method is not the most efficient available, but continues to assert it is the most ethical (Fuller 2012, 235).

I would argue that in at least some cases, Okin may be right, and relying on something like reciprocal negotiation will not result in the best overall outcome. Despite this, internalized oppression makes for a deeply problematic basis for human rights intervention. It is better to be agnostic about the existence of internalized oppression in a given community, but recognize the imperialistic implications of using this as a basis for interventions, and avoid doing so.

Fuller seems to think that coercive pressures across cultural boundaries will *always* be imperialistic and harmful, and this is where I disagree. In at least some cases, coercive pressure will be less harmful than the alternatives. For instance, applying coercive pressure to stop Muslim women from wearing the headscarf would not be justifiable, since there is no imminent or severe harm incurred merely from a head covering. On the other end, coercive pressure to stop the practice of honour killing, despite the deeply held cultural beliefs that drive it, would be justified in light of the severity of harm to the victim. I will pick up on the topic of what can justify coercive pressures later in this chapter, in 5.4.

Before moving away from this point to other complications of humanitarian intervention, it is worth discussing a real-world case study of how cross-cultural interventions can go poorly, and how the intervention could have been improved. For this, I will draw on the actions of an American doctor depicted in the documentary, *The Vasectomist*. The documentary follows the doctor's campaigns in both the Philippines and Haiti, where he regularly ventures to set up clinics where the locals can come in and receive vasectomies. He not only offers these free of

charge, but offers a financial incentive for men to come in (ostensibly to compensate them in the case that they have to miss work for the operation).

His actions are motivated by his wish to help the poor populations in the respective countries, who often have more children than they can support financially. However, his actions create controversy and anger many of the locals because vasectomies and other methods of contraception are explicitly forbidden by the Catholic Church, to which most of the locals belong. The doctor's actions create just the kind of value conflict Fuller worries about.

If his motive was to minimize the numbers of children growing up in poverty, offering vasectomies was by no means the only method at his disposal. As was pointed out in the documentary, he could have partnered with local family planning clinics, which taught women how to track their cycles and fertility (a method of family planning considered acceptable in Catholicism). While vasectomies are clinically proven to be more effective than cycle tracking at preventing pregnancies, perhaps it would have been better to sacrifice some efficacy and efficiency in the name of lessening cross-cultural frictions.

Instead, his choice to offer vasectomies reflected and projected his own beliefs about what is best for the Haitians and Filipinos, rather than their own assessment of what was best for them. The doctor's actions in this case echoes Fuller's description of an "unrefusable offer".

Even if the individuals who received the vasectomies gave their consent, the structure of the offer, given that the doctor offered a financial incentive for the procedure, could create a conflict of values in the recipients. On one hand they can accept the operation and its monetary incentive, but act against the edicts of their faith, and on the other they can abide by their faith's dogma and do without the much needed money.

The coercive pressure of the offer stems from the financial incentive, rather than from the mere existence of a potential value conflict. Had the doctor not provided a financial incentive, perhaps it would have avoided the unintentional coercive pressure.

It is easy to find ways for cross-cultural interventions to go wrong, and much harder to find examples of ideal cases. But most situations can be improved by better understanding of the values and wishes of the recipient community, and by prioritizing dialogue between aid workers and the communities they serve, so that mutual goals can be identified and worked toward more effectively.

Escaping the Cycle of Dependency

Another concern for humanitarian intervention is that it may become an exacerbating influence. This concern is echoed by people like Dambisa Moyo, who describes in her article, “Why Foreign Aid Is Hurting Africa,” “evidence overwhelmingly demonstrates that aid to Africa has made the poor poorer and the growth slower” (1). She describes how even “benign intervention” like the donation of mosquito nets can have disastrous effects, like putting out of business the locals who make the mosquito nets (Moyo 2001, 3). When the donated nets finally wear out, the people are left in an even worse situation because there is no longer any local source for nets. Further, the stigma that aid culture creates, says Moyo, should not be ignored. It can discourage future investors and actually reinforce the nation’s Third World status. There is also a risk that insincere regimes may use the presence of aid as an excuse not to spend their own resources on health, thus leaving people in a perpetual state of vulnerability.

Moyo argues that foreign aid can be done better, pointing out one way to solve this is to formulate clear duties and regulations that make clear that humanitarian aid can only be provided for short spans of time (Moyo 2001). Regular checks on the state’s development and

commitment to “progressive realization” should also be carried out. It is primarily the state’s duty to uphold its citizens’ human right to health, thus humanitarian aid cannot be a long term solution.

Moyo is right that certain forms of aid end up becoming counterproductive, but it is possible to design aid that is more efficacious and sustainable. Thus, aid can only ever act as an interim remedy, and is insufficient on its own without the state’s commitment to “progressive realization.” Again in the words of Wolff, “the point of establishing rights is to try to rebalance the power relationship, and to produce long-term, reliable structures that will remove the need for humanitarian concern in the future” (Wolff 2012, 15-16). Part of rectifying the situation, and thus part of what aid organizations ought to help accomplish, is building the political structures which will take over in their work.

An Appropriate Ethos for Aid

As I argued in Chapter Three, to be genuinely practicing medicine requires sincerity on the practitioner’s part (meaning, sincere interest in the evidence for the treatments they prescribe, the treatment’s outcome, and in the patient’s well-being). Likewise, to be genuinely engaged in humanitarian efforts requires both sincere interest in the efficacy of one’s own methods and sincere respect for the wishes and well-being of the recipient. Organizations, however charitable or altruistic their stated intentions, practice the equivalent of bad medicine if they fail to respect the autonomy of the recipients, or fail to diligently check whether their efforts have had the desired effect.

If humanitarian aid can be a form of intervention to make up for the unmet minimum core obligations of the right to health, the aid organizations need to prioritize the needs and wishes of the recipients above their own ideas about what help they give and how they give it. Too often the recipients are painted as an abstraction, merely vehicles for better off people to feel

satisfied with themselves about their own charitable natures, and disasters treated merely as stages on which to play the white knight. We would not accept such behaviour from a doctor towards his patient, and neither should we tolerate those attitudes in humanitarian interventions.

5.3 PATTERNS OF VIOLATION

Unmet needs are not the only situations in which intervention on behalf of health are called for. One might hope that health is such an obvious good that even the most totalitarian regimes would see the practical benefits of looking after the health of their people. Unfortunately, violations can and do occur.

When violations do occur, I will argue that the human right to health is constrained in its function as justification for intervention in a way that not all human rights are. If intervention is supposed to be on behalf of people's health, the form of intervention itself must not make those people's health materially worse.

Some human rights abuses (genocide, torture, etc.) indeed justify military interventions – but this will almost never make sense on behalf of the human right to health for several reasons. War, even a just war, will make the health conditions of those people worse. If the point of persuading such a state to meet its population's right to health is to actually improve the health of those people, then starting a war in which many of those people will suffer and die seems decidedly wrongheaded.

Additionally, in cases where abuses to health are egregious enough, other human rights violations are likely to be present as well – and these rights would make better justifications for military intervention. To avoid accusations of hypocrisy and to effectively defend the value of health, any intervention, in all but the most severe of cases, must take every available precaution to ensure that the intervention itself does not actually make the supposed

beneficiaries worse off. Within this constraint, however, there are still some methods of persuasion open to the international community to try to effect change.

What form of interventions seem logical, ethical, and appropriate depends on the manner of violation that has occurred. States can violate the right to health along several patterns, (1) through negligence and mismanagement of resources, (2) through systemic bias that unfairly privileges or disadvantages members of certain groups within the society, (3) through the refusal of aid, and (4) through active persecution. Each of these patterns of injury require a different kind of response from the international community and justify different kinds of interventions, ranging from campaigns of education, to possible military intervention.

Systemic Bias

Systemic bias leads to the failure to treat all people with equal human dignity, whether the bias stems from racism, sexism, or xenophobia. The consequences can include inequalities in access to healthcare and basic resources, which certainly constitute a violation to their right to health.

Bias of this kind can shorten the lives of the stigmatized and disadvantaged. One example of the negative effects of such bias is the way that the AIDS crisis has been handled over the years. During the AIDS crisis in the 1980s in the US, homophobia led the government to delay taking actions that could have helped prevent its spread. Discrimination towards people with AIDS and HIV due to a suspected connection with homosexuality continues to be an obstacle to treatment and prevention in many areas, including Russia and parts of Africa.

Here, heavy handed forms of intervention are likely to aggravate international relations. But other states can and should still communicate their disagreement and displeasure about such activity. That, combined with information campaigns that attempt to dispel the beliefs fuelling the systemic bias, over time, can weaken and eliminate it.

Malicious Negligence

While systemic bias often stems from deeply seated cultural beliefs, there are other possible sources and motives behind violations of the right to health. One of those is what I will call malicious negligence. Negligence on the part of the state and the mismanagement of resources leading to negative health consequences for its population is bad enough to prompt some kind of interventions from humanitarian organizations. However, sometimes this negligence is not born of ignorance, but born of selfishness on the part of those in power – which may be justifications for stronger forms of intervention.

For example, we can look at Libya under Gaddafi and North Korea under the Kim family. This type of regime disproportionately spends its nation's resources on the leader's personal enrichment and on military measures which help maintain the regime's power, at the expense of the basic needs and health of its population.

In this context, we are not necessarily dealing with a difference in beliefs – North Korea doesn't need to be convinced that people need food. However, the regime has made the decision that these basic needs are less important than the Kim family's continued power.

Offering aid to states like this presents an ethical puzzle. On one hand, aid would clearly benefit the people, but on the other hand it could help perpetuate the regime's unjust autocratic rule. Given how the regime treats its own people and the threat that it poses to outsiders, acting in ways that enable the regime to sustain itself seems to have consequences potentially as dire as not acting. If a hypothetical regime keeps its people in a state worse than death, then aid which helps perpetuate that would be worse than no aid at all.

The Unable & Unwilling

While states like North Korea and Gaddafi's Libya may be negligent in their duties toward their people, they still can display a willingness to accept help from outside (as North Korea

accepts aid regularly from China and in the past from other nations as well). But what can be done when the state is both negligent and unwilling to accept aid?

This is the case Venezuela faces. Venezuela lacks the resources to meet its people's fundamental rights to health, but those in power, under Maduro's government, have refused to accept humanitarian aid. Purely on behalf of the Venezuelan people's health, it might be possible to justify disregarding the government's sovereignty, but only in the process of offering aid measures. For example, perhaps it would be possible to air drop food and resources despite the Maduro government's refusal. Such strategies are not without risks, and could lead to escalation of tensions between the regime and other states. But without other kinds of violations present, it would be tough to justify invading a country like Venezuela militarily just on behalf of health.

Persecution

The most severe and unambiguous way that states can violate their people's right to health is through active persecution. Often, as events play out, the most severe violations of the human right to health are accompanied by violations of other rights as well. For one current example, the Rohingya in Myanmar are not only being denied access to healthcare, they are being actively persecuted to a much more severe degree (murdered, chased out of their homes, denied citizenship, etc.). In a case like this, it would seem odd to justify a military intervention on behalf of the Rohingya's right to *health*, when so many other, seemingly more pressing justifications would be available. The nature of the violation in this kind of case – being intentional, urgent, and severe, warrants the strongest form of intervention.

The more severe and imminent the harm, the more justification there is for forceful intervention. But for anything less than outright persecution, whether systemic bias, toxic traditions, or malicious negligence – campaigns of education are close to the only option

ethically available. Other forms of intervention are more likely than not to make the lived situations of the supposed beneficiaries worse, rather than better (at least in the short term).

5.4 BETWEEN CULTURE LOSS & HEALTH GAIN

While I think that most of the time interventions which are culturally sensitive are not only the most ethical but also the most effective methods, there are cases where the two come apart. As I have argued in my previous chapter, while respect for autonomy is important, in the realm of health and medicine, it is at least sometimes outweighed by the commitment to non-harm. Similarly, while I support the idea that cultural sensitivity is important to consider – both for the sake of efficacy and respect for people’s autonomy – it is sometimes superseded by the ethical duty to prevent severe and imminent harms.

Fuller attempts to deal with this issue in the way she defines her terms. She defines culture as “that complex whole that includes knowledge, belief, art, law, custom, and any other institutions, habits, and signifying practices acquired by people as members of particular societies and passed on from generation to generation by means of education, the family and tradition” (Fuller 2012, 216). Further, Fuller goes on to distinguish between two types of belief, factual and moral:

“factual beliefs should be understood as those that relate to whether or not certain medicines and medical treatments are likely to make people better off by curing them, alleviating pain, or extending life... [The] moral and religious beliefs I am concerned with are those that concern right and wrong – that is, which actions are morally prohibited [or] permissible...[including] honor, modesty, and appropriate public and private behavior [and] someone’s assessment of what would improve his or her welfare... what would constitute a benefit for that person” (2012, 219).

Fuller also says, “if a norm or practice has very little or no value...then acting against it will not count as a significant evil” (2012, 223). Here, I think Fuller is hoping that the factual/moral divide will enable the most serious conflicts to be avoided. But in the realm of health, as I have described in previous chapters, the factual and moral can be very difficult, if not impossible, to separate. Thus, when such conflicts do arise, we need to be able to determine which path leads to greater harm.

As I have discussed earlier (in Chapters Two and Three), some cultural conceptions of both health and healthcare fail to meet the minimum standard of the human right to health. When intervening on the behalf of health, states and/or humanitarian organizations may need to confront deeply embedded cultural beliefs about health and medicine that range from wrong, to inadequate, to outright harmful. Considering what Kymlicka and Sullivan, as well as Fuller have argued, attempts to convert people out of these beliefs can be problematic – especially when working across borders and when the power dynamic is imbalanced.

Fuller is concerned that humanitarian interventions are carried out by organizations “harboring a ... Western, liberal agenda and [which are] insufficiently engaged with... the communities they serve” (Fuller 2012, 214). While I agree with her that interventions which fit that description cross into the unethical, it is also true that some traditional beliefs and practices are in reality harmful.

Some cultural practices, such as female genital mutilation (FGM), can severely harm the women subjected to it. FGM has no known health benefits, and many complications, immediate and long-term. Just some of the immediate complications include: fatal bleeding, acute urinary retention, infection, septicaemia and even the risk of hepatitis or HIV depending on the instruments used. Later complications can include strictures in the urinary and genital tracts, and incontinence. There can also be psychological consequences such as depression or post-traumatic stress disorder.

A practice like this clearly goes against the entitlements described in General Comment 14, as “the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation.”

Would it be culturally imperialistic to coerce another group out of such a practice? FGM is not justified on inaccurate factual beliefs. The explicit reasons people give for subjecting their daughters to FGM are intimately tied to the system of beliefs around chastity and sexuality, marriageability and appropriateness in the cultures which practice it. Thus, it seems Fuller would place it in the moral belief category, and yet the facts indicate its detrimental health effects.

Because of the harm involved, I would argue that there is at least some justification for the application of pressure to limit or stop the practice. But depending on the kind of pressure involved and where it comes from, it may fail to be effective. Because of the deep cultural embedding of such a practice, many aggressive forms of intervention to stop FGM have been met with resistance, which only entrenches the practice further.

When pressure is perceived to come from “outsiders,” who do not understand the communities’ ways or values, it can become a flashpoint of cultural conflict. Instead, campaigns of education and information that slowly create a sub-population that does not engage in FGM are likely to be more productive, even if they can feel frustratingly slow. Eventually, once a critical mass is reached, the reasons for holding on to the practice will be gone.

A Rule of Rescue

More extreme cases, like honour killing, reveal cracks in negotiative approaches, like Fuller’s. Whenever an active form of persecution violates people’s right to health, time is of the

essence. Negotiative approaches require time, but time in such cases is not realistically available if people are at risk of immediate and irreparable harm.

Under such pressures, we can appeal to a kind of rule of rescue, which excuses some degree of imposition upon another culture and bypasses negotiation, that could apply in human rights where the loss of a cultural practice would not outweigh the harm of allowing it to continue. In cases where loss of a cultural practice *does* outweigh the potential harm to individuals, reciprocal negotiation may remain the best ethical option.

In the end, coercion and cultural imperialism both constitute a form of harm, but so do some cultural practices. Reciprocal negotiation presents a helpful path to resolving some standoffs between conflicting cultural values. A political equivalent to the rule of rescue is helpful in others. Both have drawbacks and downfalls. However, in the process of chasing the ideal of global justice, often the non-ideal is the only way forward.

5.5 CONCLUSION

Human rights exist to motivate institutions to respond when the fundamental components of what makes life worth living are threatened – and in the case of health, threats can arise from human actions as well as natural forces. Threats to health do not stop at political boundaries, and thus a commitment to protecting health (and the duty to respond) must extend beyond national borders as well. These facts, combined with the status of the human right to health as a positive right, means that in addition to responding to outright violations, intervention can also be both obligated and justified on the behalf of unmet minimum standards.

When the primary duty holders are unable to meet those minimum standards, the obligation diffuses to other capable bodies, which can include humanitarian organizations and INGOs. This unique dynamic necessitates additional ethical strategies to guide the actions of such organizations when acting in lieu of the primary duty holders. With the guidelines I have

provided here, it should be clear that it is both necessary and possible to respond to the issues of global health in a way that respects the autonomy of aid recipients and minimizes the risk of exacerbating cycles of dependency, while still offering relief for unmet health needs. As with other human rights, in situations in which states are unwilling to discharge their duties regarding the human right to health, political pressures from other states are warranted. But these pressures will be constrained by the need to avoid making the actual health conditions worse for the populations in question.

CONCLUSION

The human right to health needs a certain robustness as well as a certain flexibility in order to be meaningful. Human rights need to be conceptually thin enough to be truly universal and not in fact culturally specific. Human rights also need to be conceptually thick enough to be meaningful and to exert a force for positive change. Pluralism within our understanding of the key terms of health, medicine, and human rights leaves room for cultural sensitivity and a variety of expressions, but still allows for the evaluation of those practices and the possibility that some will be found to be inferior and not worth protecting, especially when they conflict with other values. The pluralistic approach does not succumb to relativism as it gives us some basis on which to judge and compare what we believe to be factual, but it is more flexible than an absolutist definition of health or healthcare that may carry with it culturally specific biases that can unintentionally do more harm than good.

In this thesis I have tried to shed new light on the way that culture, health, and human rights intersect. There are, of course, some limitations on the scope of my arguments here. For instance, because I have focussed my attention on addressing the tension between parochialism and relativism in human rights, I have left other critiques (e.g. Marxists views) unaddressed. I also must acknowledge that my arguments are likely to fall on deaf ears in the case of readers who are unconvinced of the value of personal autonomy. Arguments on these points must await a future project. For my purposes in this thesis, I have articulated the reasons that culture must be taken into consideration when considering the human right to health and any international interventions on its behalf. I have provided a flexible and pluralistic account of the nature of health, and demarcated the boundaries of an acceptable conception of medicine for use in a political human rights context. I have argued that because of the nature of health, when states have failed to meet the minimum obligations of the right due to a lack of resources, the duty shifts to the next most capable body, which at least in

some cases will be a humanitarian health organization or INGO. And finally, I have given an account of the kinds of measures open to the international community when the human right to health is violated. Of course, much still remains to be explored.

In the future, further exploration of different cultural approaches to the idea of human rights in general (and rights based discourse more broadly) would be incredibly valuable to the field of political philosophy. It would also be interesting to further examine cross-cultural assessment of human rights violations, and the ethics and efficacy of attempts at moral persuasion across cultural divides. In a different vein of research, there is also much more to be said about what kind of structure in a healthcare system can be said to adequately or ideally meet the right to health – whether single payer, socialized, or privatized.

Beyond that, more could be said about the ethical principles of medicine and how other cultures have conceptualized medical ethics, especially the boundary lines of doctor/patient, and the balance between autonomy, beneficence, non-harm, and justice. In the realm of philosophy of science and medicine it would also be interesting to explore how different medical systems conceptualize disease and how they understand a treatment's efficacy. Whichever path one chooses to take, the intersection of medicine, culture, and politics is bound to be fertile ground for many philosophical projects.

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