

HEALTH AS VULNERABILITY; INTERDEPENDENCE AND RELATIONALITY

Jonathan Herring

Exeter College, University of Oxford

Abstract

This article challenges the assumptions that underpin many discussions about health. In particular the view that healthy people are autonomous, self-sufficient and contained. It will argue that in our nature humans are, and should be, vulnerable, interdependent and caring. Health must be understood in a way which recognises that. We should not hide from the precarious, leaky, relational aspect of our bodies, but rejoice in them.

Key words

Health, Bodies, Autonomy, Vulnerability, Care, Relationality

Introduction

“How are you?” is a standard opening pleasantry in many a conversation. It’s not normally a query expecting a serious answer. Yet lurking behind this innocuous question is a more profound one. What is it to be well? How are we to understand the notion of health?

That is not simply a question of interest to philologists. There is a growing claim to a “right to health”. But if such a right exists, what is health? Most Governments seek to promote health and will have a Department for Health (or some such body). What is it, precisely, that these organs of government are seeking to achieve? And whether one relies on a National Health Service or Health Insurance we need to know what it is these are expected to provide. Not surprisingly such questions have produced a burgeoning literature on the definition of health (e.g. Foster and Herring 2014).

This paper argues that the academic debates over the meaning of health in the West are typically premised on assumptions about what a good human body is like or what a good life will be. It is assumed that our normal status is to be free of illness and impairment, whereas the reality is that impairment and vulnerability are part of the essence of being human. It is assumed that wellness involves being independent and self-sufficient, whereas being interdependent is inevitable and necessary for human flourishing. It is assumed that health is an individual characteristic, whereas our wellness is found in our relationship with others.

Standard definitions of health

The old-fashioned western definition of health is that it is the absence of a disease or illness. Such an approach tends to adopt a highly medicalised approach, with a list of conditions which are recognised by the medical profession. Diseases are observable and capable of objective assessment (Balog 1981). The absence of these means one is healthy. The role of medicine is to

cure the disease and restore a patient to health. The same approach is found in terms of defining disability, where the traditional model identifies the disabled as people whose bodies lack the ability to do certain particular tasks and where the role of medicine is to restore the disabled person to normal functioning.

That traditional model has lost favour in recent years. It fails to look at the whole person and their wellbeing. It views health as the absence of something, rather than being a positive virtue. Its list of approved diseases is contentious. What counts as a sickness or disability varies hugely from time to time and culture to culture. Look at what was considered “unhealthy” in the past: it included everything from the wish of a slave to be free, to sexual desire in women (Hamilton 2010). This indicates that at least a significant of what constitutes an illness is the attitude of society towards the behaviour, rather than it being an objective statement of scientific fact.

Most commentators now favour a definition that defines health in a positive way. The most influential is the World Health Organisation (1947)’s infamous definition:

‘Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.’

One clear benefit of this definition is that it covers mental health as well as physical health. It also takes the concept of health well beyond the standard textbook definitions of illness. However, the explanation for its longevity (it has been around since 1947) may lie in its ambiguous nature. In short, health under the WHO definition can mean whatever you want it to mean.

want it to mean (Callahan 2012). It appears to merge the questions of what is health and what is a good life. As a result, issues which might properly be regarded as political or social matters, become medical questions. For example, one might say that the WHO definition would be produced by providing more high speed broadband. It means that medicine becomes the primary response to a wide range of social, political and cultural problems. As a result, there is a danger that medicine and morality become merged. Bad behaviour is seen as an illness and to be healthy means to be virtuous.

The WHO definition offers little by way of explanation of whose conception of well-being is used. A major issue is the extent to which an individual's assessment of wellbeing is relevant or whether an objective one is to be used. A further ambiguity is that there is no indication in the definition of whether all departures from complete well-being amount to a lack of health. For example, are baldness or bushy eyebrows, if disliked by the individual a lack of health?

A further concern is that taken literally "complete wellbeing" sets a standard, in which case few, if any, can hope to reach. I doubt many readers can compare the level of fitness of a Paula Radcliffe or a Usain Bolt. It seems, then, that the WHO definition is idealistic. As Raamon Gillon (1986: 381) observes by that definition "none of us is, has ever been, or is ever likely to be healthy".

It is important at this point to emphasize the power that can be exercised in determining who is healthy or who is ill; who is disabled and who is able bodied. The questions of what is health and how one should live one's life become closely linked. If one is 'ill' one needs the state's

protection and therapy; if one is disabled one's body needs to be corrected to return it to the norm (Koch 2001). Any attempt to deny one's illness is further evidence that one is ill. Bryan Turner (1995: 35-6) writes:

... the doctor has replaced the priest as the custodian of social values: the panoply of ecclesiastical institutions of regulation (the ritual order of sacraments, the places of vocational training, the hospice for pilgrims, places of worship and sanctuary) have been transferred through the evolution of scientific medicine to a panoptic collection of localised agencies of surveillance and control. Furthermore, the rise of preventive medicine, social medicine and community medicine has extended these agencies and regulation deeper and deeper into social life.

This article is designed not so much to propose an alternative definition but cause us to think further about the assumptions that tend to underpin the discussions of what we mean by health. Writings on health and ability preserve and validate a certain image of what makes a beautiful, fit, competent, intelligent body. This provides power to those who have these attributes and alienates those who do not. Rosemarie Garland Thomson (2011: 592) writes:

The disability system excludes the kinds of bodily forms, functions, impairments, changes, or ambiguities that call into question our cultural fantasy of the body as a neutral, compliant instrument of some transcendent will.

Rather than rely on an idealised version of the body we should recognise the wide diversity that the human form takes, with different versions carrying different advantages and disadvantages. We need not mould everyone to fit the one stereotype and require homogeneity. Although the standard discussions draw a sharp distinction between illness and health, it will be a theme of this paper that to be ill is to be healthy. The categories of health and illness do not break down into sharp mutually exclusive divisions (Sadegh-Zadeh 2000).

I suggest that many people's conceptions of health and disability are motivated by fear. The ideal vision of health is of a person being free from disease or impairment; being self-sufficient; and interdependent. Autonomy and the freedom to act as you wish is elevated to being the essential essence of the self. This causes people to assume that where there is a lack of independence, self-sufficiency or autonomy there is sickness. Those who need assistance are disabled; those whose rational thought is impaired suffer a mental illness; and those not self-sufficient cannot be able bodied. So we, the healthy, keep our distance from these others. As will be argued in this article the truth is we are all far from the ideal, but we cannot face that reality. Perhaps this explains the desire to "correct" the disabled body. The disabled body shows too openly the vulnerability and interdependence of all of us. Illness is too powerful a reminder of our finality and precarious nature. We must "other" these things. We are not these things. We are the healthy.

Susan Wendell (1989: 107) captures this fear well:

Suffering caused by the body, and the inability to control the body, are despised, pitied, and above all, feared. This fear, experienced individually, is also deeply embedded in our culture. Our real human bodies are exceedingly diverse—in size, shape, colour, texture, structure, function, range and habits of movements, and development—and they are constantly changing. Yet we do not absorb or reflect this simple fact in our culture. Instead, we idealize the human body. Our physical ideals change from time to time, but we always have ideals. These ideals are not just about appearance; they are also ideals of strength and energy and proper control of the body. We are perpetually bombarded with images of these ideals, demands for them, and offers of consumer products and services to help us achieve them. Idealizing the body prevents everyone, able-bodied and disabled, from identifying with and loving her/his real body.

The rest of this chapter calls for greater honesty. We need to acknowledge, and indeed rejoice, in the fact all people are vulnerable; utterly dependent on each other; and that health is found in our relationships, not our selves.

Vulnerability as health

I will argue in this section that vulnerability is an inherent part of being human (Butler 2004) and therefore to health. To some this is a shocking claim. Many people like to emphasise our capacity, independence, and autonomy. But they kid themselves.

Martha Fineman (2013) argues:

Throughout our lives we may be subject to external and internal negative, potentially devastating, events over which we have little control—disease, pandemics, environmental and climate deterioration, terrorism and crime, crumbling infrastructure, failing institutions, recession, corruption, decay, and decline. We are situated beings who live with the ever-present possibility of changing needs and circumstances in our individual and collective lives. We are also accumulative beings and have different qualities and quantities of resources with which to meet these needs of circumstances, both over the course of our lifetime and as measured at the time of crisis or opportunity.

This vulnerability comes from three primary sources. The first is that our bodily fleshy natures makes us vulnerable. Second, our incapacities to make autonomous decisions make us vulnerable and third, our emotional state is not, and should not be, stable.

The body

We are in our nature corporeal beings. And it is in the nature of human bodies that they are susceptible to sickness, illness and injury. As Fineman (2013) puts it: ‘we are born, live, and die within a fragile materiality that renders all of us constantly susceptible to destructive external forces and internal disintegration.’ Ultimately our bodies are programmed to die. They are not designed for eternal living.

Further, our bodies are ‘profoundly leaky’ (Shildrick 1997). People tend to imagine their bodies as static, immutable and a barrier against the world. In fact our bodies are constantly changing with new material being added to them and old material being discarded. By the end of each day we have lost a whole host of cells and grown new ones. By our deaths there is little of us that is biologically the same as when we were born. Further, our bodies are not all human. Inside they are dependent on a wide range of non-human organisms to survive. Outside they are constantly interacting with the environment (Chau and Herring 2007). Viruses are passed from one person to another. Pollution can have devastating impacts on bodies. It is well known that a broad range of socio-economic factors impact on life expectancy (MacInnes et al 2013). The truth is our bodies are in constant flux; profoundly leaky; deeply dependant on other bodies and the broader environment (Herring 2014).

Autonomy

The ideal person against which the ill or disabled are typically measured is the autonomous person. Often, people like to think they make their own decisions on issues and act in a rational way. Impairments in rational thought are deemed mental disorders or learning difficulties. But, few of us have the capacity to be genuinely autonomous. To be autonomous a person must not only understand the information about a decision, they must be able to use it. Most people make decisions with an awareness of few of the relevant facts about the decisions they make. Even if they do know the facts, Jennifer Drobac and Oliver Goodenough (2015) in their analysis of the psychology of decision making list the following requirements for rational use of information:

- (i) parties with stable, well ordered preferences,
- (ii) choices that are fully voluntary and unconstrained;
- (iii) relatively equal, and ideally complete, information;
- (iv) relatively equal bargaining power and experience;
- (v) sufficient cognitive capacity to evaluate the transaction and to exercise voluntary control over the conflicting factors and emotions involved;
- (vi) the absence of monopoly power or other distortions of the market,
- (vii) the presence of good faith and absence of fraud in both parties; and
- (viii) a level of consequence for a mistake that is not disastrous to the party.

The authors, after examining the latest neuroscience and psychology, suggest that few people have these capacities. They are not alone in their analysis. Neil Levy (2014: 295) refers to a wide range of psychological studies which reveal ‘fallibilities of human reasoning’ (including ‘myopia for the future’, ‘motivated reasoning’ and ‘biases’ in ‘assessing probabilities ... exacerbated ... under cognitive load’). He concludes that ‘Human beings are, under a variety of conditions, systematically bad reasoners, and many of their reasoning faults can be expected to affect the kind of judgements that they make when they are called upon to give informed consent’. To similar effect Sarah Conly (2014: 349) writes:

‘As has by now been discussed convincingly and exhaustively (notably by Nobel Prize-winning Daniel Kahneman and Amos Tversky), we suffer from common, apparently ineradicable tendencies to ‘cognitive bias,’ which means that in many common situations, our decision-making goes askew. These biases are many and

varied, but they have in common that they interfere with our appreciation of even quite simple facts, and lead us to choose ineffective means to our ends.’

Susan Dodds (2007: 507) also argues that we need a legal and social system which is premised not on individualistic conceptions of autonomy but an acceptance of our vulnerability:

A vulnerability-centered view of the self and of persons is better able to capture many of our moral motivations and intuitions than can be captured by an autonomy-focused approach. We are all vulnerable to the exigencies of our embodied, social and relational existence and, in recognizing this inherent human vulnerability, we can see the ways in which a range of social institutions and structures protect us against some vulnerabilities, while others expose us to risk. We do not have to view our obligations towards those who lack the capacity to develop or retain autonomy as having a different source from our obligations towards those whose autonomy is made vulnerable due to a degree of dependency. It may be easier to recognize the social value of provision of care if it is viewed as something on which we all have been dependent and on which we are all likely to be dependent at different points in our lives, rather than altruistic behaviour extended to those who lack ‘full personhood.’

Emotional instability

We assume that health is tied to a happy state of mind. But happiness is not always commensurate with wellbeing. There are times when it is right to be sad. Grief may be an unhappy emotion, but it is not an illness, indeed not experiencing grief at the loss of a loved one is more likely to be indicative of a problem.

The importance of our emotional state depends upon the support of others and this creates vulnerability. Mary Neal (2012: 185) puts it this way:

even the least vulnerable human being is still fundamentally, and inescapably, vulnerable in the negative sense, since none of us can meet her basic needs and satisfy her core desires without the co-operation of others; and even the most capable adult is vulnerable to hurt and harm, both physical and emotional.

She goes on (at 196) to explore how striking a balance between positive and negative emotions is part of having dignity:

Take the example of a bereaved relative at a funeral, or in court during the trial of someone accused of her loved one's murder. She bears herself with restraint and self-control, and is moderate in her utterances. She may even express forgiveness, call on her community not to retaliate, or request mercy for the perpetrator. All of this impresses us because we assume her to be suffering great pain and distress, and to be conducting herself in this way despite the way she is feeling. In other words, her vulnerability is a necessary and integral part of what we value when we value her dignified conduct.

To conclude, the human nature is to be vulnerable: constantly open to bodily, emotional and social harms. We are in a constantly precarious nature. As Rogers, Mackenzie and Dodds (2012: 11) claim ‘... all human life is conditioned by vulnerability, as a result of our embodied, finite, and socially contingent existence. Vulnerability is thus an ontological condition of our humanity.’ To be healthy, therefore, is to be vulnerable.

Health as interdependence

We are all profoundly dependant on others for our physical and psychological well-being. In this section I argue that to imagine our health as being simply a matter of the state of our bodies or minds is profoundly mistaken. Our society has built up a wide range of structures and forms of assistance which disguise our mutual dependence. Indeed we are forced by a wide range of societal pressures to disguise or mitigate our vulnerability so that we can behave in an acceptable way in the public realm. In a powerful article Kate Lindemann (2003: 517) contrasts the emphasis on “accommodations” made to assist disabled people, with the lack of appreciation of how much accommodation there is for the able bodied:

Colleagues, professional staff members, and other adults are unconscious of the numerous accommodations that society provides to make their work and life style possible. ATM’s, extended hours in banks, shopping centres and medical offices, EZpass, newspaper kiosks, and elevators are all accommodations that make contemporary working life possible. There are entire industries devoted to accommodating the needs of adult working people. Fast food, office lunch delivery, day time child care, respite care,

car washing, personal care attendants, interpreters, house cleaning, and yard and lawn services are all occupations that provide services that make it possible for adults to hold full time jobs.

As that quote indicates, much is made of the assistance given to help the disabled and indeed the fact they need this assistance is seen to define their disability. Yet the reality is we are all dependent on a huge range of resources. The able bodied need the provision of stairs to get to the first floor as much as the wheel chair user needs the lift. Yes it is the provision of the lift for which we pat ourselves on the back for making such excellent provision for the disabled. In fact, we all depend on a wide range of social provisions to live in our society, from sewerage to supermarkets; from banks to buses. Our self-sufficiency is a myth (Herring 2012).

I want to explore a little further the way that health is not simply a personal matter, simply a determination of what our bodies can do. Rather it inevitably involves a consideration of the social context. I will explore that in two particular examples. The first is the nature of disability and the second is the importance of care.

Disability

The traditional view is that disability reflects a flaw with someone's body. John Harris (2000: 99), a highly influential bioethicist, has argued that a disability is a "harmed condition". He is aware of the potential dangers with this claim and emphasises that a disabled person can live a

good life and he is also absolutely clear that he sees a disabled life as being as valuable as any other life. However, he sees those statements as not inconsistent with a claim that a disabled person would have improved chances of a better life if he or she were not disabled. The example he uses is the deaf person, who by virtue of their deafness is denied the opportunity of hearing beautiful music or the voices of loved ones, were they not deaf. That he suggests must be a harmed condition and hence a disability.

I suggest two reasons why I believe that view to be misguided or at least over-simplistic. First, many of those writing from a disability perspective have demonstrated that the social environment in which the disabled person has to live makes a physical difference a disadvantage (e.g. Silvers 1998). The Union of the Physically Impaired Against Segregation explains:

In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society. To understand this it is necessary to grasp the distinction between the physical impairment and the social situation, called “disability”, of people with such impairment. Thus we define impairment as lacking all or part of a limb, or having a defective limb, organism or mechanism of the body and disability as the disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities. Physical disability is therefore a particular form of social oppression. (3–4)

Many supporters of the social model of disability accept there is a distinction between impairment and disability. An impairment is something which limits the function of the individual, but disability is the limitation of opportunities to engage in social activities, due to barriers (social or physical) which society itself has imposed. But typically the argument is that the impairment would have only a limited impact on a persons' wellbeing and it is the disability that disadvantages. As Oliver (1996: 32), puts it "it is not individual limitations, of whatever kind, which are the cause of the problem but society's failure to provide appropriate services and adequately ensure [that] the needs of disabled people are fully taken into account in its social organization".

The social model of disability demonstrates that it wrong to assume that the root cause of disadvantages flows from a particular body and that the solution is to correct the "misfit" body. The root cause may be in the way society has chosen to position and allocate its resources. Liz Crow (1996: 56) tells us:

[The] social model of disability..., gave me an understanding of my life ...what I had always known, deep down, was confirmedIt wasn't my body that was responsible for all my difficulties, it was external factors, the barriers constructed by the society in which I live.'

The terminology of “disabled people” is therefore appropriate: they are disabled by the fact that social spaces, services and provisions are modelled around certain kinds of bodies to their privilege, to the disadvantage of others (Morris 2001).

There is a complex and interesting debate over the extent to which disability is entirely a matter of social responses and whether there is room for acknowledging the impact of a bodily impairment. For this article, the precise details of that debate do not matter. For what it worth I do accept that even with all the institutional and attitudinal changes imaginable some impairments will still confer a disadvantage. However, I suspect those tend to be exaggerated and they may not be disadvantages that impact on the welling to any great extent and in any event must be weighed against the benefits that can be gained from disability. My point for now is that the extent of a person’s disability is to a large extent determined by social provision (or lack thereof), and only to a limited extent lies in the body itself.

The second issue is that Harris makes assumptions about what makes a good life. Let us take the view that to be disabled is to hinder or limited flourishing (Wilkinson 2010). It is commonly assumed that a disability is disadvantage because one cannot partake in certain activities and so one flourishes less. It is said the deaf person cannot hear the soothing beauty of Bach’s suites for unaccompanied cello or the glories of John Taverner’s The Lamb; the unsighted cannot enjoy the wit of the films of Woody Allen, or the delicacy of a Rembrandt portrait. This kind of argument has several problems. The first is that the selected list of joys is notable: only a minority of people in fact do enjoy Bach’s suites or Rembrandt’s portraits. It is true, of course, that while a deaf person cannot enjoy these things, while many others could in theory hear the music, they

simply choose not to. But, it may, then, be questioned whether they are “missing out” or at least “missing out” to any extent that is notable. Macklem and Gardner (2014) make the point that there many valuable activities which people cannot partake in. They give the example of Sumo wrestling which may be a valuable activity, but one needs certain physical potentials and a cultural context to undertake that. Yet we do not regard non-Sumo wrestlers as disabled. Society has selected certain abilities as privileged and therefore lacking them a disability (e.g. the ability to walk) not labelled others as a disability (e.g. an ability to run a marathon). There are dangers here of ability privilege, that is “the advantages enjoyed by those who exhibit certain abilities and the unwillingness of these individuals to relinquish the advantage linked to the abilities especially with the reason that these are earned or birth given (natural) abilities” (Wolbring 2014: 119). It may also reflect the reluctance, mentioned earlier, to acknowledge the limitations we all have.

Second, Harris’s approach does not put into the equation the benefits that may come from, a disability. In Andrew Solomon (2012)’s remarkable book, *Far From the Tree*, the author looks at families raising disabled children and describes the mixed pictures of disability. In candid discussions disabled people explain the challenges, as well as the joys, that disability can bring. For example, on deafness he writes (2012: 62):

Most hearing people assume that to be deaf is to lack hearing. Many deaf people experience deafness not as an absence, but as a presence. Deafness is a culture and a life, a language and an aesthetic, a physicality and an intimacy different from all others. This culture inhabits a narrower mind-body split than the one that constrains the rest of us,

because language is enmeshed with the major muscle groups not just the limited architecture of the tongue and larynx.

So I am not convinced that we should agree with Janet Radcliffe Richards (2002: 413)'s claim that:

It is hard to doubt that most people must regard disability as having negative value. However strong their all-things-considered commitment to any or all existing disabled people, however willing they are to do all they can to make life as good as possible for them, and even though they would not change their existing disabled child or spouse or colleague for any able-bodied person in the world, the fact remains that most people would think it better for themselves if their disabled friends and relations and employees were not disabled.

Andrew Solomon's book discusses many example of disabled people who could be "treated or cured" and yet prefer their lives with the disability. Often, it is the social interactions and community ties which are important in those decisions. His book also contains examples of disabled people who would readily choose to be cured, but the picture is far more complex than Radcliffe Richards suggests. Perhaps it is notable that Solomon's book is the result of years talking to and spending time with disabled people, whereas Radcliffe Richards cites what she believes to be common sense.

As Soloman's book shows it is the lack of able bodied imagination that things could be done otherwise, that assumes a disability is a harm. For example, Harris assumes the loss of hearing a loved one's voice is a harm, but if hearing a loved one is just one developing a relationship with another, and there other ways of establishing intimacy that may be just as good, there is no reason to see the loss of that method as being a harm (Edwards 2014). There is no evidence that deaf people have less close relationships because they cannot hear.

This discussion of disability, therefore, shows that one cannot understand disability as simply a matter of the state of a person's body. Os much depends on the cultural, social and relational context.

Care

Dependency is an inevitable facet of human life (Herring 2013). And because we are dependent we need care. True, there will be times during our lives when our dependency on others is more obvious. In early years and in times of sickness, perhaps particularly towards the end of life, we will need overt care. However, at all times in our life we need the care of others to meet our practical and emotional needs. Indeed the care we provide for others is an important part of our wellbeing too. Eva Feder Kittay (1999: xii) wrote of our interdependence:

My point is that this interdependence begins with dependence. It begins with the dependency of an infant, and often ends with the dependency of a very ill or frail person close to dying. The infant may develop into a person who can

reciprocate, an individual upon whom another can be dependent and whose continuing needs make her interdependent with others. The frail elderly person . . . may herself have been involved in a series of interdependent relations. But at some point there is a dependency that is not yet or no longer an interdependency. By excluding *this* dependency from social and political concerns, we have been able to fashion the pretense that we are *independent* – that the cooperation between persons that some insist is *interdependence* is simply the mutual (often voluntary) cooperation between essentially independent persons.

In relationships of caring and dependency our interests become intermingled (Herring 2013). We do not break down into ‘me’ and ‘you.’ To harm a caregiver is to harm the person cared-for; to harm the person-cared for is to harm the caregiver. Indeed, it is simplistic to imagine we can identify in a caring relationship who is the caregiver and who is the cared-for; their relationship is marked by interdependency. The ‘cared-for’ provides the ‘caregiver’ with gratitude, love, acknowledgement and emotional support, which will be of great emotional value to him. Indeed, often a ‘caregiver’ will be the ‘cared-for’ in another relationship. Caring relations often involve a complex interplay of dependencies and vulnerabilities. Michael Fine and Caroline Glendinning (2005: 616) have argued:

Recent studies of care suggest that qualities of reciprocal dependence underlie much of what is termed ‘care’. Rather than being a unidirectional activity in

which an active care-giver does something to a passive and dependent recipient, these accounts suggest that care is best understood as the product or outcome of the relationship between two or more people.

Caring relationships are at the heart of most people's lives. We cannot escape them and we do not want to. But that shows, again, why an individualised model of health based on an assessment of one person's body is an overly narrow of health. That feeds into the third point I want to make.

Relational health

In this section, I argue that health can only be understood in a relational context. Robinson Crusoe, living alone on his desert island, might have the most wonderful physique and a BMI to die for, but loneliness and lack of human interaction meant he was healthy in only the narrowest sense. Human identity is found in relationship with others, from our beginning to our end and beyond – in the memories we have and other legacies we leave. As already mentioned in these caring relationships the division between “you” and “me” becomes lost. The vulnerability of the one becomes the vulnerability of the other; the disability of the one becomes the disability of the other (Whitney 2011).

People understand themselves in terms of how they relate to and are understood by others. It is only in response to others that people's lives have meaning. From our beginnings we in relationship. Pregnancy is the most intimate relationship between two beings. From birth the

child comes to interpret themselves and the world through their interactions with their parents. That is why neglect of children is a serious wrong. It is not just that the child does not develop, it is that the child has no sense of self. Babies are taught a sense of self through relationships with parents and carers. They then develop their understanding of self and their goals in terms of relationships with others. The language people use; the way we look at the world; and the sense of self in the world is generated through these early relationships and develops and changes through subsequent relationships. This understanding of the self means we are constant danger of our self being challenged by others rejecting us; not accepting us as members of a group; not providing the support we expect; or using our relationships to harm us.

In a radical sense our relationships constitute our selves and our identity (Gergen (2009). That is why relationships must be at the heart of an understanding of health. There is great wisdom in the National Aboriginal Health Strategy Working Party (quoted Boddington and Raisanen 2009):

Aboriginal health is not just the physical wellbeing of an individual but is the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.

The claim that people are relational in their being is complex and requires much more argumentation than is possible here (see Herring 2013). But, if people are constituted through

their relationships with others, then we are dependent on others and our trust is given to them. These relationships must be central to our understanding of health.

Conclusion

Dr Alexander Burgess (quoted Ahmed, Kolker and Coelh, 2011) once said: “A healthy person is someone who has been inadequately studied.” As this somewhat tongue in cheek remark implies many understandings of health seem to suggest an impossible ideal which we are doomed to meet. This chapter has pushed that claim further. It notes that much writing on health starts with an assumption about “normal health”. The typically “normal” person will be able-bodied, autonomous, rational, adult and, very often, male (Bondi and Burman 2001). It is interested to record the views of young people in Scotland on health:

‘Males tended to think of health as to do with body building, muscles and obtaining a ‘six-pack and weight gain whereas females tended to look upon health as beauty, eating disorders, weight loss and contraception.’ (Health Scotland 2012: 3)

Here we see laid bare the assumptions that typically underpin even academic discussions of health. Yet there is good reason to doubt that the norms of ability, autonomy, rationality, and self-sufficiency are either realistic or desirable.

Eva Feder Kittay's daughter, Sesha, has cerebral palsy. She is profoundly cognitively and physically impaired. She will always be dependent on others for life's basics. Eva Feder Kittay (2011: 621) is not given to sentimentality, still she writes:

Sometimes I wonder if Sesha is a special being sent to us from elsewhere, for there is an impossible to - articulate sweetness, graciousness, and emotional openness about her—qualities we rarely find in others. On any conventional definition of health, Sesha would be found unhealthy, but does not her sweetness, graciousness and openness demonstrate a rare health. We elevate the capacity for logic, rational thought and autonomy over the capacity for wonder, gentleness and warmth, but perhaps the first set of qualities make for a better person than the other.

This chapter has argued that essential to the nature of human beings, and therefore to the concept of health is that we are vulnerable, interdependent and relational beings. The image of the capacious, autonomous, self-sufficient adult is not, in fact the image most people either aspire to or want, even if they were capable of achieving it. The characteristics most people seek out in friends are not marked by such characteristics: they look for gentleness, openness, fun, a sense of the ridiculous. Characteristics as often found in those labelled ill or disabled, as much at the healthy. It is recognising that we in our nature vulnerable; that caring relationships are core to our being human; and that we need each other; that we might begin to find true health. We must never seek to hide from or be embarrassed by our precarious, leaky, interdependent bodies. True health is found not in the scalpel of the surgeon or the pill of the pharmacist; but in the touch of a lover; the smile of a child; and the wind in the hair.

Reference List

- Ahmed, P., Kolker, A. and Coelh, G. 2011. "Towards a New Definition of Health". In: P. Ahmed ed. *Toward a New Definition of Health*. Amsterdam: Springer. pp 12-32.
- Balog, J. 1981. "The Concept of Health and the Role of Health Education" *The Journal of School Health*, 9: 462-464.
- Boddington, P. and Raisanen, U. 2009. "Theoretical and Practical Issues in the Definition of Health: Insights from Aboriginal Australia." *Journal of Medicine and Philosophy* 34: 49.
- Bondi, L. and Burman, E. 2001. "Women and Mental Health: A Feminist Review." *Feminist Review* 68: 6.
- Butler, J. 2004. *Precarious Life*. London, Verso.
- Callahan, D. 2012. "The WHO Definition of Health." In: D. Callahan ed. *The Roots of Bioethics* New York: Oxford University Press.
- Chau, P-L. and Herring, J. 2014. "My Body, Your Body, Our Bodies." *Medical Law Review* 15: 34-62.
- Conly, S. 2014. "Against Paternalism" *Journal of Medical Ethics* 40: 349-352.
- Crow, L. 1996. "Including All of Our Lives: Renewing the Social Model of Disability." In: C. Barnes and G. Mercer eds. *Exploring the Divide: Illness and Disability*. Leeds, Disability Press.
- Dodds, S. 2007. "Depending On Care: Recognition of Vulnerability and the Social Contribution of Care Provision." *Bioethics* 21: 500-512.

- Drobac, J. and Goodenough, O. 2015. 'Exposing the Myth of Consent' *Indiana Health Law Review*, Research Paper No. 2015-3.
- Edwards, S. 2014. "Harris, Disability and the Good Life." *Cambridge Quarterly of Healthcare Ethics* 23: 48-62.
- Feder Kittay, E. 2011. "Forever Small: The Strange Case of Ashley X." *Hypatia* 26: 610-632.
- Feder Kittay, E. 1999. *Love's Labor: Essays on Women, Equality and Dependency*. New York University Press.
- Garland Thomson, G. 2011. "Misfits: A Feminist Materialist Disability Concept." *Hypatia* 26: 591-609
- Fine, M. and Glendinning, C. 2005. "Dependence, Independence or Inter-dependence? Revisiting the Concepts of Care and Dependency." *Ageing and Society* 25: 601-622.
- Fineman, M. 2013. "Feminism, Masculinities and Multiple Identities." *Nevada Law Review* 13: 619-674.
- Foster, C. and Herring, J. "What is Health?" In: M. Freeman, B. Hawkes and B. Bennett eds. *Law and Global Health* Oxford: Oxford University Press.
- Gergen, K. 2009. *Relational Being*. New York: Oxford University Press.
- Gillon, R. 1986. "On Sickness and on Health." *British Medical Journal* 292: 318-321.
- Hamilton, R. 2010 "The Concept of Health: Beyond Normativism and Naturalism." *Journal of Evaluation in Clinical Practice* 16: 323-331.
- Harris, J. 2000. "Is there a Coherent Social Conception of Disability?" *Journal of Medical Ethics* 26: 95-100.
- Health Scotland, 2012. *Young People, Health and the Internet*. Edinburgh, Health Scotland.

- Herring, J. 2012. "Vulnerability, Children and the Law." In M. Freeman ed. *Law and Childhood Studies*. Oxford, Oxford University Press.
- Herring, J. 2013. *Caring and the Law* Oxford, Hart.
- Herring, J. 2014. "Why we Need a Statute Regime to Regulate Bodily Material." In: I. Goold, J. Herring, L. Skene, and K. Greasley eds. *Persons, Parts and Property: How Should We Regulate Human Tissue in the 21st Century?* Oxford, Hart Publishing.
- Koch, T. 2001. "Disability and Difference: Balancing Social and Physical Constructions." *Journal of Medical Ethics* 27: 370-6.
- Morris, J. 2001. "Impairment and Disability: Constructing an Ethics of Care That Promotes Human Rights." *Hypatia* 16: 1-14.
- Levy, N. "Forced to be Free? Increasing Patient Autonomy by Constraining It." *Journal of Medical Ethics* 40: 293-304.
- Lindemann, K. 2003. "The Ethics of Receiving." *Theoretical Medicine and Bioethics* 24: 501.
- MacInnes, T. 2013. *Monitoring Poverty and Social Exclusion*. York: Joseph Rowntree Foundation.
- Macklem, T. and Gardner, J. 2014. "Human Disability." *King's Law Journal*, 25: 60-78.
- Neale, M. " 'Not Gods but Animals': Human Dignity and Vulnerable Subjecthood." *Liverpool Law Review* 33: 177-201.
- Oliver, M. 1996 *Understanding Disability: From Theory to Practice* Basingstoke: Palgrave.
- Radcliffe Richards, J. 2002. "How not to End Disability." *San Diego Law Review* 39: 393-713.
- Rogers, W. Mackenzie, C. and Dodds, S. (2012) "Why Bioethics Needs a Concept of Vulnerability." *International Journal of Feminist Approaches to Bioethics* 5: 11-23.

- Sadegh-Zadeh, K. (2000) "Fuzzy Health, Illness and Disease." *Journal of Medicine and Philosophy* 25: 605-638
- Shildrick, M. 1997. *Leaky Bodies and Boundaries*. London: Routledge.
- Silvers, A. 1998. "Reprising Women's Disability: Feminist Identity Strategy and Disability Rights." *Berkeley Women's Law Journal* 13: 81-121.
- Solomon, A. 2012. *Far From the Tree*. London: Vintage.
- Turner, B. 1995. *Medical Power and Social Knowledge*. London, Sage.
- Wendell, S. 1989. "Towards a Feminist Theory of Disability." *Hypatia* 4: 104-129.
- Whitney, S. 2011. "Dependency Relations: Corporeal Vulnerability and Norms of Personhood in Hobbes and Kittay." *Hypatia* 26: 544-561.
- Wilkinson, S. (2011) *Choosing Tomorrow's Children; The Ethics of Selective Reproduction*. Oxford: Oxford University Press.
- Wolbring, G. 2014. "Ability Privilege: A Needed Addition to Privilege Studies." *Journal for Critical Animal Studies* 12: 118-131.
- World Health Organization, 1947. *The Constitution of the World Health Organization*. Geneva, WHO.