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

It may seem somewhat odd to feature a special issue on philosophy of medicine in a journal that effectively has philosophy of medicine in its title. However, a review of the contents of this journal and similar ones such as *Journal of Medicine and Philosophy* will quickly reveal such an issue's purpose. The dominant content of most issues of these journals tends to draw on certain fairly specific philosophical areas: medical ethics in all it forms and, to a lesser degree, philosophy of mind in the context of philosophy of psychiatry. Philosophy of medicine, as it is represented at the Roundtable, seeks to broaden the range of philosophical questions that are asked about medicine, and to encompass the whole range of kinds of philosophical questions that might be asked about medicine. In particular, approaches from philosophy beyond ethics, such as the philosophy of science, metaphysics, epistemology and methodology are strongly represented at the roundtable. As one of us is also an editor of this journal, we know that the dominance of biomedical ethics and philosophy of psychiatry is not due to any antipathy on the part of the journals to philosophy of medicine. Rather, the explanation may be that philosophy of medicine has not been generating the volume of philosophical

work and debate that it could fruitfully sustain, nor a volume of work comparable to that in bioethics.

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

Of course, this special issue only presents a limited selection of the papers presented at the roundtable. We believe, however, that the papers published here well represent both the quality and range of the papers that were presented. Other papers from the roundtable have been published or are forthcoming in *Journal of Medicine and*

Philosophy [11], *Philosophy of Science* [12] and *Journal of Evaluation in Clinical Practice* [13].

The issue begins with two papers concerned with some traditional issues in philosophy of science: causal methodology and progress. In "Placebo Orthodoxy and the Double Standard of Care in Multinational Clinical Research," Maya Goldenberg revisits a well-known set of ethically controversial placebo-controlled clinical trials that took place in the developing world in the mid 1990's, whose purpose was to test short-term vs. full course AZT as a treatment to reduce maternal-fetal transmission of HIV. While there has been much discussion in bioethics about the problem that such trials revealed a morally dubious "double standard" (such trials would not have been accepted in the developed world), she takes up instead what she says is a neglected line of thought, one that relies on an analysis of methodology and the philosophy of science. In particular, she claims that an unjustified assumption of the necessity of placebo controls led to inappropriate judgments about the trial design, resulting in the unnecessary loss of many lives.

She first criticizes the arguments—such as that they are more efficient and will allow us to gain more reliable results more quickly—that placebo controls are methodologically superior to active-control equivalency trials across the board. She then takes up and challenges the argument that there were particular reasons why placebo-controls were necessary in this particular set of trials. Important here is the matter of exactly what question needed to be answered by the trial, and within this she argues that a subgroup analysis of the original ACTG 076 data suggests that it was already known that

the short course treatment would work better than a placebo, but that this was not taken seriously at the time.

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

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

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

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

They motivate their analysis by addressing in detail a dilemma that Kingma has shown exists for Boorse's account—that it cannot simultaneously handle two significant sorts of counterexamples having to do with specificity: the situation-specificity of many normal functions (such as digestion, which only performs its function at particular

appropriate times) and the situation-specificity of many diseases (such as mountain sickness, involving a temporary set of symptoms brought on by high altitude). They follow Hausman in rejecting an analysis relying on statistical typicality, and they emphasize that health must be conceived as an intrinsic property of the organism. In particular, they say that health is an organism's homeostatic disposition to maintain its designed functions. They then demonstrate how this definition sheds light on the various aspects of situation-specificity, and how it accounts for the intuitions that have played a role as counterexamples to previous analyses.

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

This special issue serves as a reminder that philosophy of medicine is a vital part of the discipline of philosophy, and as a call for yet more work in the field. It also illustrates, we hope, the potential for the philosophy of medicine to contribute usefully to the medical professions. We hope that the papers will provide readers with a sense of the

excitement and invigorating discussion the attendees of the Roundtable experienced and will inspire future work, both at the Roundtable and throughout the philosophical community.

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