The Journal of Medicine and Philosophy, 46: 645–655, 2021
https://doi.org/10.1093/jmp/jhab029

Well-Being and Health

RICHARD KIM*
Loyola University Chicago, Chicago, Illinois, USA

DANIEL M. HAYBRON
Saint Louis University, St. Louis, Missouri, USA

*Address correspondence to: Richard Kim, Department of Philosophy, Loyola University Chicago, 1032 W. Sheridan Road, Chicago, IL 60660-1537, USA. E-mail: rkim7@luc.edu

This introduction to the special issue on well-being and health explores the ways that philosophical inquiry into well-being can play a productive role in understanding health and medicine. We offer an explanation of the concept of well-being, central theories of well-being, and how these key topics, along with other cutting-edge issues such as disability and cross-cultural reflections, can contribute to the discourse on the nature of health and medicine. We also provide brief overviews of the essays in this special issue and highlight the significant philosophical implications they have for understanding both well-being and health.

Keywords: *happiness, health, medicine, welfare, well-being*

I. INTRODUCTION

As we pen this introduction, we are deep into a global pandemic that has ravaged nations physically, mentally, and economically. Social and civil division and unrest loom large, and we live in a politically charged and polarized world. Perhaps our chief consolation has been the inspiring mobilization of the healthcare professions to lead us through this crisis, and the breathtaking international scientific collaboration that has gifted us with vaccines far sooner than many thought possible.

It is one of those moments when the philosopher's brief can appear rather slight. "Trouble breathing, eh? How about I analyze some concepts for you?" It is probably asking too much to expect one's trade to be consequential on the order of alleviating suffering and saving lives. Still, it may not seem the best moment for a special issue on what philosophy, specifically the philosophy of well-being, can do for medicine.

What is the task of philosophers in all this? What can we offer? One thing that philosophers can do well is calling into question unnoticed assumptions and entrenched modes of thinking that may look plain and obvious but, on closer examination, are far less clear and often saddled with dubious baggage. Instead of being locked into a particular perspective or mode of inquiry, philosophers look to see how ideas, concepts, and arguments hang together. Thus, the aim of philosophy offered by Wilfrid Sellars: "to understand how things in the broadest possible sense of the term hang together in the broadest possible sense of the term" (1963, 1).

In matters of well-being, we are talking about values: what sorts of lives are best for us? What is in a person's best interests? Usually, in healthcare contexts, questions of ultimate ends may not be particularly salient: even the Stoic, for whom chest pain is merely an "indifferent," is apt to regard it as a distinctly dispreferred indifferent and take his pills. Yet, things are often less straightforward: choices must be made among different goods, such as longevity and quality of life, or whether a given therapy is worth the money. One's priorities in such matters may not be in good order: human judgment is shot through with predictable forms of irrationality and ignorance, and it is cliché that people frequently exit the crucible burdened with regret, or enlivened by a newfound sense of what matters in life. The customer is often wrong.[1] Accordingly, the examination of priorities is a crucial part of growing up, and ultimately of living well—and this includes living well in one's profession, as a healthcare provider, policymaker, citizen, or what have you.

Especially for those charged with the care of others, it seems desirable to have a mature, worldly grasp of the ideals of living that reflective people have found compelling: what does it mean for a person to do well, to flourish, to thrive? This is not automotive repair, where the terms of success are fairly plain: it is a game whose terms we do not fully understand, though the stakes could hardly be greater. Greater still than one might imagine, if one steps back to consider the healthcare professional's role as citizen and shaper of society and policy. For instance, should government healthcare expenditures be based on life-satisfaction metrics of well-being, as some have argued (Clark et al., 2018)? What if people with certain illnesses and disabilities turn out to be surprisingly happy, and so get lower priority in this scheme than one might expect?

For various reasons, a concern for health should make us attentive to philosophical questions about well-being, all amounting to: if we get our ends wrong, we may in many ways get our health wrong, both through the clinic and through the public arena. Of course, what we do as philosophers tends not to be so ambitious, our talents being better suited to sharpening our ideas, tinkering with the conceptual machinery, than painting grand vistas of the landscape of human life. Mary Midgley once memorably described philosophy as akin to plumbing. Nobody cares much about plumbing during normal times. But once a faulty pipe bursts, we come to immediately realize

its importance. Similarly, when it comes to fundamental concepts like health and well-being, we need to know what we are talking about and ensure that our foundations are sturdy.

To help situate the papers in this issue, we begin with a brief review of philosophical theories of well-being. While the notion of well-being has gotten more philosophical attention than that of health, and indeed has been a central concept in philosophy since at least Plato, it is noteworthy that we lack even a very good term for it. "Well-being" is not a particularly common expression in ordinary language, and when used it seems to take a narrower meaning than it does in academic research—something closer to health, along the lines of "well in body and mind," as one might encounter in a spa advertisement.

In academic contexts, "well-being" refers to a type of value, often referred to as *prudential value*, in contrast to other types of value such as aesthetic or moral or perfectionist value. Well-being has to do with what benefits or harms a person, is good or bad for her, makes her better or worse off, contributes to her self-interest or best interests, or makes her life go well for her. Other commonly used terms for this value include "welfare," "flourishing," or (in one sense of the word) "happiness." There is some dispute about whether these words are strictly equivalent, for instance, whether "welfare" concerns only subjectivist views of well-being favored by utilitarians, or whether "flourishing" only applies to the kind of well-being discussed by Aristotle and other eudaimonists. Yet Greek students of *eudaimonia* and contemporary well-being scholars all seem to be talking about the same thing: what ultimately benefits us, is in our interest, and so forth. Whatever word one prefers, there is an important matter of substance here: for example, what course of treatment for a patient would be in his best interests? Would medication help him to lead a better life despite the side effects, or would he be better off with other therapies, or no treatment at all?

Following Derek Parfit, it is commonplace to divide philosophical theories of well-being into three types: hedonism, desire theories, and objective theories.[2] According to hedonists, well-being consists entirely in pleasure, or a bit more exactly, in a person's balance of pleasant vs. unpleasant experience. Epicurus, Bentham, and Mill espoused classic examples of this view, which remains a major contender in the field. But a minority view: most contemporary philosophers reject hedonism, essentially because it is so hard to shake the conviction that things other than just pleasure ultimately matter in life. Robert Nozick's (1974) famous "experience machine" case is the best-known variant of this complaint: you are asked to imagine a virtual reality machine that can offer any experience of any life you desire. Plugging in, then, offers as pleasant a life as a person could have, and you would have no idea that the experiences are anything other than real. Would you plug in, and spend your life in the machine? Very many people have a decidedly aversive reaction to this suggestion, the standard conclusion

being that pleasure, and experience generally, cannot be all that fundamentally matters for well-being. This conclusion has been disputed on various grounds and hedonism remains a live option, but a majority of theorists have taken one of two alternative routes, and near-relations to them.

One might think that the problem with the experience machine is that one is not *actually* getting what one wants. What matters is succeeding in getting what one desires in life, and most people want actually to accomplish things, to have friends and loving relationships, and so forth. Desire theories of well-being resemble hedonism in basing well-being on the individual's own perspective on his life, but differ in focusing on whether the person's desires are actually fulfilled, and not whether she merely has good experiences. Such views come in various flavors, the most common being informed desire accounts, which identify a person's good with what he *would* want, given adequate information, reflection, etc. This sort of account allows us to say that people can often be mistaken about what is good for them—as of course they can—while still giving them a kind of authority about their own well-being. One's good depends entirely on what one cares about, or would care about if one had the relevant facts.

One might object to experience-machine life on quite different grounds: the problem is not that one is not getting what one wants. For one thing, that may not be the case, say, if all one ultimately cares about is pleasure: the desire theory must allow that some people do thrive, with no loss, in the experience machine. Many people find it natural to suppose that certain things just are good for us, and not simply because we like or want them: friendship, love, understanding, autonomous choice, achievement, and active engagement with the world. That is, certain things are objectively good for us, and it is desirable for a human life to contain them, and something to lament if the individual not only lacks them, but also lacks any desire for them. (Perhaps deprivation has so narrowed a person's horizons that she has no wish to be educated, to pursue a skilled occupation, or to make important choices for herself.)

Objective theories of well-being allow us to say that something is defective about experience-machine life without having to scrutinize the person's desires or feelings: it is lacking in important elements of a full human life. This last way of putting it brings to mind the most influential class of objective theories, nature-fulfillment views such as Aristotle's, which take well-being to consist in the fulfillment of the organism's nature, for instance, leading a characteristically human life of excellent activity.[3] Many objective theories do not have this sort of teleological structure, but simply posit a brute list of intrinsically beneficial items: knowledge, achievement, virtue, pleasure, friendship, etc. Accordingly, such theories are fittingly dubbed "objective list theories" (e.g., Fletcher, 2016).

What have these theories of well-being to do with matters of health and health care?[4] Several authors in this issue take up that question, but a simple

beginning of an answer is: well-being is among the chief reasons to care about health, and among the chief aims of health care. If a treatment does not benefit the patient or anyone else, the question arises, what is the point? It is fair to say that advances in promoting healthier lives have been among our greatest achievements in the betterment of human well-being. Health is bound to be important, given virtually any theory of well-being, at least on plausible assumptions about human life: for the hedonist, by reducing suffering and making life more pleasant; for the desire theorist, by helping us to lead the kinds of lives we want; and for the objective theorist, by alleviating evils such as suffering or at least better enabling us to enjoy the goods of life: friendship, understanding, achievement, autonomy, virtue, etc. Health might even be *part* of well-being on an objective view: while not typically found on such lists, it could be among the objective goods, and it may be necessary for the possession of certain goods. It may be, for instance, that healthy human functioning is a prerequisite for excellent human functioning. This raises a question to which we will return, namely, whether well-being should be defined in terms of health, health in terms of well-being, or neither.

Theories of well-being might not seem to matter very much for practical purposes, since one hardly needs a theory to tell one that heart attacks and anthrax are bad. Now how one thinks about well-being does have practical stakes: if hedonism is the right theory, then Freud may have been mistaken to refuse pain medication so that he could think more clearly (Griffin, 1986). Likewise, the many artists and other individuals who prefer to live with pain, sometimes passing up a more pleasant life, so that they can pursue their passions or carry out their duties more fully. Whereas, if the desire theory is correct, such choices may be in the patient's best interests: making them happier may not in fact benefit them, because it comes at the expense of other things they care about more.

For many objective theories of well-being, a top priority in health care will be helping people to function well, and disability raises particularly interesting questions here (e.g., Becker, 2012; Shea, 2019; Campbell et al., 2021; Graham, 2021). One might think it a benefit of Aristotelian theories of well-being that they naturally support the commonsensical idea that certain disabilities are bad for a person: for instance, that deafness and blindness, or severe intellectual disability, deprive the individual of important elements of a characteristically human life (Kraut, 2007). These relate to objectively valuable aspects of life, and their value does not wholly depend on what the individual wants or enjoys. On the other hand, subjectivist hedonists and desire theorists may think it a feature of their views precisely that they do *not* entail the badness of disability. Perhaps disability is just a different way of being, at least for many disabilities, and if the individual enjoys her life and does well enough on the matters she cares about, then who is to say there is anything bad about it?

Healthcare professionals should have little trouble seeing the practical relevance of these philosophical debates. We hope it is also apparent—or

will be after reading the articles in this issue—that more than one philosophical theory has merit. For instance, perhaps the reader is divided about disabilities—for instance, sharing both the intuition that there is something bad about deafness, or Down Syndrome, even for someone completely satisfied with their situation, and also the intuition that a deaf person, or a person with Down Syndrome, could very well flourish, and indeed be better off than very many of those without disabilities. These questions have lately become especially pressing in light of developments in genetic engineering and reproductive technologies and methods.

Whatever position one takes on these challenging issues, one insight that we can take away from the growing philosophical literature on disabilities is that we need to learn from a broader range of viewpoints and perspectives. Gaining an adequate understanding of the lived experience of those with disabilities and the role that disabilities play in the broader context of culture and society ought to be an important part of the philosophical conversation. Moving along this line of thought, we should also pay closer attention to the different values, norms, and practices that are embodied in non-Western cultures and societies. There is little doubt that the broader currents of cultural values and norms influence what we think about matters of deep ethical significance, including our conceptions of well-being and the good life. For example, in early Confucianism we find a challenge to the modern individualistic conception of the self that in turn leads to an emphasis in a more communally oriented set of prudential values such as family and filial piety that are fundamental for a Confucian account of well-being (Kim, 2020). Moreover, as Ruiping Fan has argued, Confucianism has profoundly influenced medical practice in East Asian societies; for example, by permitting (even encouraging) a family-oriented approach to patient informed consent that contrasts sharply with the individual, autonomy-based patient informed consent we usually find in American medical practice (Fan, 2015). If we are aiming to develop accounts of well-being and medicine that have practical significance, we cannot detach our philosophical reflections from the context of culture and society within which well-being or medical practice ought to be realized. Nor should we be sanguine about the theoretical merits of philosophical accounts that derive universal claims from parochial sentiments that may seem plausible only to a fairly narrowly specified "we."

Theories of well-being are theories about a kind of value, and judgments about well-being are value judgments—and we have just seen how varied our judgments can be in this domain. Some readers may be uneasy about the prospect of making decisions in health care on the basis of value judgments like these, as the ostensible beneficiaries may not share those values. Is it appropriate for a physician, say, to impose her values—her ideals about what is best for a person—on her patients? This is a thorny question to be sure, and there are at least two reasons it may not be. First, no matter what is best for the patient, there can be moral reasons not to impose it on them. As

we learned from *Brave New World*, one has a right to be unhappy if one so chooses. Even if one refrains from imposing one's values on the person, one might still reasonably draw on one's values in thinking about how to proceed, if only to be candid about the daylight between one's view of things and the patient's. At any rate, it hardly seems desirable for practitioners to have no compass of their own.

Second, it may be that principles of respect for persons and antipaternalism counsel us to defer to individuals' own values when deciding what is best for them. Variants of this sort of position are common in political philosophy, for instance in the ideal of liberal neutrality, and recently it has been argued that a stance of "pragmatic subjectivism" is called for in policy contexts (Haybron and Tiberius, 2015): when making decisions on behalf of others, policymakers must as far as possible defer to the values of their beneficiaries when deciding what is good for them, approximating the ideal of self-government to the extent feasible.[5] This kind of subjectivism may hold even if the true theory of well-being is objective, and it might be extended to healthcare contexts as well.

Would this sort of view mean we need not bother to understand the philosophical theories of well-being? No: for the philosophical theories represent a range of equilibrium positions that people tend to converge on, given adequate reflection—the theories are popular because they represent the things people really care about when given a chance to reflect on what matters in life. They give us clues to people's deeper values, and arguably the pragmatic subjectivist should be more concerned with those than with whatever whimsical preferences someone might express off the cuff, or in the checkout line at the supermarket. If patients claim to care only about money and stuff, and the physician has a bit of time for conversation, the discussion might reveal that actually the patients' values aren't so philistine—perhaps their everyday preferences are out of line with their fundamental values. Having read a bit of Aristotle, perhaps the physician can generate an "aha" moment in patients by asking them whether they think it is a good thing for persons to realize their potential. Maybe it will turn out that the money is mostly a proxy for being really good at their trade. Even if one's practice is not founded on a particular view of well-being, one need not—should not—tune out the vast corpus of great works on ideals of human flourishing. Being informed about it may be the best way for a physician to connect with the patients, and what they really care about. (For that matter, it is not a terrible thing if our healthcare providers also have some knowledge of literature, the arts, history, and other works that foster a mature and worldly understanding of the human condition. They are not just technicians but also guides to shepherd us through some of life's most difficult decisions.)

We hope to have made a bit of headway in showing how philosophical reflection on well-being can illuminate important questions that arise in healthcare contexts. As the papers in this issue illustrate, such work need not

focus on the abstract, big questions of which theory of well-being (if any) is true (Hawkins, 2021). Theoretical questions of other sorts arise, such as whether to understand mental health as equivalent to a kind of well-being (Wren-Lewis and Alexandrova, 2021). The philosophy of well-being also takes up very concrete questions, such as whether a disability is necessarily bad for the individual (Campbell et al., 2021), or what might be the interests of individuals showing minimal signs of consciousness (Graham, 2021), or whether children have a significant interest in knowing who their genetic parents are (Groll, 2021). The remainder of this introduction briefly summarizes each of the papers in this issue.

Jennifer Hawkins' paper aims to demonstrate why medicine needs philosophy by showing how a deeper reflection on well-being or what is fundamentally good for us can improve our thinking about medicine. She carries out this task by arguing that philosophical theories about well-being are not particularly useful, but that philosophy still has important contributions to make through what she calls a "theory-without-theories" approach. On this approach, we first underscore certain basic, intuitively plausible elements of welfare (e.g., happiness). Next, we make use of a philosophical framework that will help guide our decisions. More specifically, Hawkins argues for what she calls a "mild objectivity framework" that builds on four assumptions: (1) mild objectivity, (2) epistemic humility, (3) future truth-makers, and (4) death as deprivation. Hawkins illustrates the usefulness of her approach by applying it to some concrete case studies. What results is a nuanced exploration of how philosophical thought can be connected to medical practice in beneficial ways.

While Hawkins' paper attends to the issue of how philosophy can make a positive difference for medicine, the rest of the papers are directed toward specific issues in the philosophy of medicine.

The paper by Sam Wren-Lewis and Anna Alexandrova explores the important topic of mental health by proposing a sophisticated definition of mental health that is appropriately connected to well-being. They do this by first rejecting two possible definitions of mental health that are either too thin and undemanding (mental health as absence of mental illness) or too ambitious and demanding (mental health as the state of general well-being). In the course of arguing against these definitions, they draw attention to several key issues in the philosophy of medicine, including the extent to which definitions of mental health (or health more generally) can be value-neutral, given the normative guidance that such definitions are supposed to provide, and worries about over-medicalization with regard to negative mental states such as unhappiness. Wren-Lewis and Alexandrova offer their own nuanced, positive definition of mental health as "the capacities of each and all of us to feel, think, and act in ways that enable us to value and engage in life."

The next paper, by Stephen M. Campbell, Sven Nyholm, and Jennifer K. Walter, focuses on what is known as the "Disability Paradox," which

highlights the apparent conflict between our intuitive judgment that disabilities diminish well-being and the relatively high life-satisfaction reports of disabled people. Campbell et al. seek to resolve this paradox by examining what they call the "goods of life" (those elements that make our lives go better for us) and determining whether disabilities impede access to the goods of life.

What follows is a careful discussion of how different disabilities—sensory, mobility, intellectual, and social—do or do not impede access to four specific prudential goods of life (happiness, rewarding relationships, knowledge, and achievement). Now, some disabilities do not seem to hamper the achievement of certain goods, for example, the inability to walk does not seem to impede the gaining of knowledge. Other disabilities do appear to diminish the opportunities for fully achieving certain goods. For example, severe cognitive impairment would seem to substantially limit the possibility of knowledge. But, as Campbell et al. argue, there are different forms of knowledge and also different levels of intellectual disability. Appreciating the nuances and distinctions of both disabilities and goods, they argue, will lead to the realization that disabilities are often compatible with a wide range of prudential goods. While they agree that more needs to be said on this topic (including more thorough empirical research), their argument enriches our resources for thinking about the lives of people with disabilities, which may then lead to different policy decisions, for example, resource distribution.

The paper by Mackenzie Graham explores how reflection on well-being can bear on the ethics of treating patients with cognitive motor dissociation (CMD). Graham argues that patients with CMD can have conscious awareness by drawing on empirical support (e.g., the mental imagery task). Touching on themes also raised by Campbell et al., Graham highlights how healthy people can make erroneous judgments about the quality of lives of those with severe health conditions or disabilities. There is reason to believe that similar mistakes may happen when evaluating the well-being of patients with CMD, and, given the evidence of consciousness in some of these patients, we ought to be wary of writing them off as having little to live for. Graham argues that the lives of many CMD patients could be worth preserving because they may enjoy a sufficient level of well-being. In the course of his argument, Graham also develops several important points that have been made by both disability theorists and feminist philosophers like Eva Feder Kittay: (a) the flourishing of people with disabilities and health conditions largely depends on the kind of environment that the society is willing to support, and (b) that the very relation of dependence and care provide human beings with a sense of dignity and worth that often goes unnoticed. Even being simply cared for by another person can make one's life worth living.

The final essay in this issue, by Daniel Groll, turns to another intriguing philosophical issue with practical implications: the prudential significance of genetic knowledge. Given the increasing number of children born through gamete donations, there is growing debate about whether or not the children have the right to know who their donors are. Groll argues that there is good reason to provide children with knowledge about the identity of their genetic parents because children often have a "worthwhile significant subjective interest" in knowing who their biological parents are.

The position Groll develops is nuanced. While he believes that there is prudential value in knowing one's genetic parents, he does not subscribe to what he calls the Profound Prudential Good view defended by David Velleman, claiming that lacking this knowledge constitutes a significant harm to the subject. Instead, Groll argues that the genetic knowledge is based on the empirical data that this knowledge is a "worthwhile significant interest" (in the sense that he carefully lays out) for most people conceived through gamete donation. Parents, Groll argues, have an obligation to take certain steps toward the satisfaction of a child's foreseeable worthwhile significant interests because they have an obligation to look after the child's well-being. So, parents who conceive using gamete donation have a weighty reason to use an identity-release donor. What emerges is a subtle philosophical analysis of how considerations of well-being can play a role in a complex bioethical issue with serious practical implications.

We hope this collection of papers makes it apparent that philosophical work on well-being has a great deal to offer medicine, and health care generally. From the most abstract reaches of high theory to focused analyses of concrete practical questions, the philosophy of well-being has a vital role to play in matters of human health.

NOTES

1. See Graham (2021) for an example regarding people's attitudes toward disability.
2. Parfit (1984). Parfit called the latter "objective list" theories, but only some objective theories take the form of a list. While this taxonomy is not entirely satisfactory and various alternatives have been proposed, it is good enough for our purposes. For recent overviews of the philosophical literature on well-being, see Bradley (2015), Crisp (2013), and Fletcher (2015, 2016).
3. For a recent overview of this broad family of theories, see Haybron (2016).
4. Hawkins (2021) offers an extensive treatment of related questions.
5. Related positions are defended in, for example, Hawkins (2021) and Alexandrova (2017).

ACKNOWLEDGEMENTS

This article and special issue were supported by funding from the John Templeton Foundation and Saint Louis University through the grant Happiness and Well-Being: Integrating Research Across the Disciplines. We also thank our anonymous reviewers for their comments.

REFERENCES

Alexandrova, A. 2017. *A Philosophy for the Science of Well-Being*. New York: Oxford University Press.

Becker, L. C. 2012. *Habilitation, Health, and Agency. A Framework for Basic Justice*. New York: Oxford University Press.

Bradley, B. 2015. *Well-Being*. Malden, MA: Polity Press.

Campbell, S., S. Nyholm, and J. Walter. 2021. Disability and the goods of life. *Journal of Medicine and Philosophy* 46(6):704–28.

Clark, A., S. Flèche, R. Layard, N. Powdthavee, and G. Ward. 2018. *The Origins of Happiness: The Science of Well-Being over the Life Course*. Princeton, NJ: Princeton University Press.

Crisp, R. 2013. Well-being. *Stanford Encyclopedia of Philosophy* [On-line]. Available: http://plato.stanford.edu/entries/well-being/ (accessed July 20, 2021).

Fan, R. 2015. Informed consent: Why family-oriented? In *Family-Oriented Informed Consent: East Asian and American Perspectives*, ed. R. Fan, 3–23. Cham: Springer.

Fletcher, G. 2015. *The Routledge Handbook of Philosophy of Well-Being*. New York: Routledge.

———. 2016. *The Philosophy of Well-Being: An Introduction*. New York: Routledge.

Graham, M. 2021. Residual cognitive capacities in patients with cognitive motor dissociation, and their implications for suffering. *Journal of Medicine and Philosophy* 46(6):729–57.

Griffin, J. 1986. *Well-Being: Its Meaning, Measurement, and Moral Importance*. Oxford, United Kingdom: Clarendon Press.

Groll, D. 2021. Well-being, gamete donation, & genetic knowledge: The significant interest view. *Journal of Medicine and Philosophy* 46(6):758–81.

Hawkins, J. 2021. Theory without theories: Well-being, ethics, and medicine. *Journal of Medicine and Philosophy* 46(6):656–83.

Haybron, D. M., 2016. The philosophical basis of eudaimonic psychology. In *Handbook of Eudaimonic Well-Being*, vol. 1, ed. J. Vittersø, 27–53. New York: Springer.

Haybron, D. M., and V. Tiberius. 2015. Well-being policy: What standard of well-being? *Journal of the American Philosophical Association* 1(4):712–33.

Kim, R. 2020. *Confucianism and the Philosophy of Well-Being*. New York: Routledge.

Kraut, R. 2007. *What Is Good and Why*. Cambridge, MA: Harvard University Press.

Nozick, R. 1974. *Anarchy, State, and Utopia*. New York: Basic Books.

Parfit, D. 1984. *Reasons and Persons*. New York: Oxford.

Sellars, W. 1963. *Science, Perception, and Reality*. London, United Kingdom: Routledge.

Shea, M. 2019. The quality of life is not strained: Disability, human nature, well-being, and relationships. *Kennedy Institute of Ethics Journal* 29(4):333–66.

Wren-Lewis, S., and A. Alexandrova 2021. Mental health without well-being. *Journal of Medicine and Philosophy* 46(6):684–703.