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3. Vulnerability, Childhood, and the Definition of Health

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Abstract This chapter explores the concept of childhood health through the lens of universal vulnerability and relational theory. It argues that these illustrate the highly individualised and idealised nature of definitions of health. Once we see childhood through the lens of universal vulnerability theory, the boundaries between adults and children collapse. We can then see health as communal and inter-relational, a place where mutual vulnerability and lack of capacity can be celebrated.

Keywords vulnerability | autonomy | health | childhood | relationality

3.1 INTRODUCTION

This chapter explores the definition of children's health through the lens of vulnerability. To do so, we need to consider two key questions. First, how is health to be understood? Second, how is childhood to be understood? I will outline some of the key debates that emerge from the literature. I will then look again at these questions in light of two key themes: the universal vulnerability of all people and the significance of relationality. These will give us powerful insights into our understanding of childhood and health, and therefore of children's health.

3.2 DEFINITION OF HEALTH

There is an extensive literature on the definition of health. I will offer a very brief overview of the main perspectives. Later in the chapter I will set out what an alternative vulnerability and relationality-based approach would look like. The standard debates around the definition of health tend to centre around two key models.

3.2.1 The Medical Model

To many, the medical model is the natural way to understand health. You are unhealthy if you have a disease or medical condition; you are healthy if you do not.

Rodolfo Saracci explains, "Health is a condition of well-being free of disease or infirmity and a basic and universal human right."[1] This approach typically involves a list of medical conditions, as recognised by the medical profession. These tend to be diseases that are able to be diagnosed. Where a person is assessed as having no disease, they can then be seen as healthy. Where a person has a disease, they are unhealthy, and medicine is used to cure the disease and return them to full health.[2] Key to this approach is acceptance of a norm (the healthy person), any departure from which can be regarded as unhealthy. We see this in many forms of diagnosis in medicine where a person is tested to see if their results are "normal" and any "abnormalities" are seen as a cause for concern.

Implicitly built within this approach is the understanding that not every departure from a norm will be illness. A person might have longer or shorter hair than is common, but this will not be seen as an illness unless it is seen as causing a harm or disadvantage. Here, hidden judgements may come into play. Baldness might not be seen as an illness for men, but might be so for women. Being overweight will be seen as an illness, but (generally) being underweight will not. And so forth.

More sophisticated versions of this understanding of health have been developed. Norman Sartorius even suggests that "health depend[s] on whether a person has established a state of balance within oneself and with the environment". This means that a person with a disease may be able to establish an "internal equilibrium" so they can "get the most they can from their life despite the presence of the disease".[3] This approach still seems to be based on the understanding of a disease; it is merely open to the idea that a person may be able to overcome the negative impact of their condition and so be able to have health.

3.2.2 The Well-Being Model

An alternative model sees health as a positive state. According to the preamble of the 1946 World Health Organization (WHO) Constitution, health is "a state of complete physical, mental, and social well-being and not merely the absence

1 Rodolfo Saracci, "The World Health Organisation Needs to Reconsider Its Definition of Health," *British Medical Journal*, no. 314 (1997): 1409–1410.

2 This approach is commonly found in the medical model of disability.

3 Norman Sartorius, "The Meanings of Health and Its Promotion," *Croatian Medical Journal*, no. 47 (August 2006): 662.

of disease or infirmity"[4]. Or, as Hiko Tamashiro[5] puts it, "It is not the absence of disease that sets the stage for health but the fullness of life."

The WHO and the United Nations (UN) see the "right to health" as "the right of everyone to the highest attainable standard of physical and mental health".[6] The UN explains that the right to health

> embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[7]

These social determinants of health also include healthy working conditions, reproductive health, and "non-discrimination and equal treatment."[8]

Critics of such broad understandings of health argue that with them the word loses its meaning. All kinds of things might be said to promote "well-being". Why, even high-speed broadband or cheaper ice cream could be argued to do this! It is claimed that the broad definition smuggles controversial social, political and cultural factors into the concept of health. It leaves the concept of well-being undefined, in particular by failing to identify whose understanding of well-being is to be used. Is it enough if the bodily feature is seen as harmful to well-being by the individual themselves? Or must an objective understanding of harm be used? Thana De Campos complains that "the 'well-being conception of health' conflates the distinct ideas of basic and non-basic health needs, as well as those of individual autonomy and freedom." There is a real danger of setting up a goal of "complete well-being" which few if any can reach. As Gillon observes, by that definition "none of us is, has ever been, or is ever likely to be healthy".[9]

In part, the debate between these two approaches to health depends on the purpose to which the word is being used. De Campos is particularly writing in the

4 World Health Organization, *Preamble to the Constitution of World Health Organization* (World Health Organization, 1946).

5 Hiko Tamashiro, "Definition of Health Revisited in the Era of COVID-19," *Japanese Journal of Education and Health Promotion*, vol. 29(4) (2021): 335.

6 International Covenant on Economic, Social and Cultural Rights 1966.

7 Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health* (Art. 12), E/C.12/2000/4 (August 11, 2000), para. 4.14.

8 Thana De Campos, *The Global Health Crisis: Ethical Responsibilities* (Cambridge: Cambridge University Press, 2017).

9 Raanan Gillon, "On Sickness and on Health," *British Medical Journal*, vol. 292 (February 1986), 318.

context of a "right to health", which we might take as the minimum entitlement that a citizen can expect from the state. Such a use is likely to require a narrow definition. She also refers to its use in debates over rationing, where again we seek to distinguish health matters that are entitled to a higher drawdown on resources than "luxury" non-health matters. If, however, we were engaging in a discussion about an aspirational understanding of health – a goal to which we should be striving but will never reach – then the wider definition might be more appropriate.

Later, I will return to this debate and explain how, in fact, I think neither the medical nor the well-being model properly captures our understanding of health.

3.3 CHILDHOOD

We next need to consider childhood. Some of the key perspectives around childhood are as follows.

3.3.1 Childhood as Deficit

For some commentators, childhood should primarily be understood as a means to achieving adulthood. So, a successful childhood is one that leads to a successful adulthood. In other words, children are imperfect adults who need to be helped to overcome this disadvantage and reach adulthood. Aristotle saw children as imperfect, unfinished adults.[10] Todres[11] summarises this popular image of childhood well:

> the dominant view of children today is that they are adults in the making—that is, dependent individuals who are not yet capable of mature and autonomous thought or action and who need to be socialized to conform to the world.

Those taking this approach tend to highlight two particularly common "imperfections" that children need to overcome: vulnerability and a lack of mental capacity.[12] They are seen as lacking the mental abilities to have full mental capacity or to protect themselves from harm. As Hannah[13] claims:

10 Anca Gheaus, "Unfinished Adults and Defective Children: On the Nature and Value of Childhood," *Journal of Ethics and Social Philosophy 1*, vol. 12 (2015).

11 Jonathan Todres, "Independent Children and the Legal Construction of Childhood," *Southern California Interdisciplinary Law Journal*, vol. 23 (2014): 261–304.

12 Patrick Tomlin, "Saplings or Caterpillars? Trying to Understand Children's Wellbeing," *Journal of Applied Philosophy*, vol. 35 (2018): 29.

13 Sarah Hannah, "Why Childhood Is Bad for Children," *Journal of Applied Philosophy*, vol. 35 (2018): 11.

> Children's vulnerability is more profound and asymmetric than the vulnerability associated with most adult relationships. Moreover, children are often unaware of their vulnerability, insensitive to facts about the world and those they are in relationships with.

On this understanding, childhood health will focus on taking steps to overcome these disadvantages. Indeed, childhood might be something we wish a child to speed through as quickly as possible so they can "grow up" and escape these disadvantages.

This "deficit" model of childhood is relevant for health in two ways. First, it gives our understanding of child health a particular goal which is not present for adults. Our focus in terms of health is that the child should develop "normally" and reach adulthood. There is no equivalent goal for adult health.

A second argument is that children's lower mental capabilities impact on our understanding of their health.[14] That is because we cannot rely on their assessment of what counts as "healthy" for them. For adults, the person's own assessment of their condition, and response to it, can play an important role in determining their health. However, children, it is said, lack that ability. To be clear, when people claim that children lack decision-making autonomy, they do not claim that children are unable to make a decision but rather that the decisions that children take are not entitled to the kind of respect due to decisions taken by adults with capacity. Generally speaking, for a decision to be protected by autonomy, the decision must be taken by a person who has an understanding of the relevant facts and is able to apply their own values and reasoning to these facts in order to reach a conclusion. It is commonly said that children lack these abilities in a range of ways. They will not understand the necessary information, or will not be able to exercise their will free from the influence of parents or others, or will lack the foresight and intellectual skills for rational thought, or will not be able to have clear values they have adopted for themselves.[15] There is some debate over the extent to which this is true, but there is no space to discuss it here.

These concerns over autonomy are seen to justify a different approach to medical decision-making for children, as compared with adults. Skelton, Forsberg and Black[16] write, "There is strong reason to believe that a great measure of what makes

14 Andrée-Anne Cormier and Mauro Rossib, "Is Children's Wellbeing Different From Adults' Wellbeing?" *Canadian Journal of Philosophy*, vol. 49 (2019): 1146.

15 Gareth Matthews and Amy Mullin, "The Philosophy of Childhood," in *The Stanford Encyclopaedia of Philosophy*, ed. Edward Zalta (University of Stanford, 2018).

16 Anthony Skelton, Lisa Forsberg, and Isra Black, "Overriding Adolescent Refusals of Treatment," *Journal of Ethics and Social Philosophy*, vol. 20(3) (November 2021): 221.

an adult's life go well depends on what she wants or what she values." So, they argue, whether an adult's life will go well depends much more on these subjective goods, while in relation to childhood the "objective" goods are emphasised because the child has less chance to develop them for themselves. In particular, where issues arise involving children, we should, therefore, postpone decisions until later, when they are able to make the decision. Where decisions must be made, we should make decisions which will not unduly limit the child's options when they reach adulthood.[17] In the meantime, we should ensure that the child receives the training and skill to exercise autonomy.[18]

3.3.2 Special Goods

A second view emphasises that there are very special goods that are distinct for children. Cormier and Rossib[19] suggest the following as examples:

> unstructured play, freedom of experimenting with different selves, sexual innocence, an ability to love and trust without apprehension, purposeless imagination and a sense of being care-free.

The debate is complex, and much depends on precisely what is meant by a good of childhood. As Tomlin[20] notes, we might take four views:

i. Childhood goods are a sub-set of adult goods
ii. Adult goods are a sub-set of childhood goods
iii. Adult and childhood goods overlap
iv. Childhood and adult goods are completely different

Further, we need to consider whether the claim is that these are goods that are particularly beneficial to children or that children are more adept at accessing.[21] So we might value play in childhood, but not recognise it as an activity that is beneficial for adults. Or, we might say that children lack inhibition and so can enjoy free play,

17 John Eekelaar, *Family Law and Personal Life* (Oxford University Press, 2017), chapter 2.
18 John Rawls, *A Theory of Justice* (Oxford University Press, 1971).
19 Andrée-Anne Cormier and Mauro Rossib, "Is Children's Wellbeing Different", 1146.
20 Patrick Tomlin, "Saplings or Caterpillars?", 29.
21 Harry Brighouse and Adam Swift, *Family Values* (Oxford University Press 2014), 65.

which the burdens of adulthood prevent us from enjoying. Anca Gheaus[22] distinguishes childhood goods that are intrinsically beneficial from those which have developmental value. In other words, the distinction is between those goods which are good for children in themselves and those which are good in the way they help a child develop. The right to play might be a good example to use here. We might see play as good in and of itself; or we might see play as beneficial because it helps the child to be healthy and develop social and intellectual skills that will be helpful in adulthood.[23] Cornier and Rossib[24] claim the kinds of good mentioned are just as instrumental to other things, such as pleasure and happiness. If that is correct then health or well-being is the same concept for children and adults, although there may be difference in achieving them.

There is no space to explore these issues further. However, it is clear that if the arguments for such childhood goods are accepted, then this could have quite some significance for our understanding of children's health. It would include, certainly with a more than minimalist definition, that we need to be promoting these goods. So, a child who was not able to access these goods of childhood would not be healthy.[25]

3.4 SUMMARY OF THE MAINSTREAM ARGUMENTS

To summarise the points made thus far, debates around children's health can – over-simplistically, no doubt – be reduced to two core themes. The first is the extent to which health is seen as the absence of a disease or impairment and the extent to which it is seen in positive terms, living a thriving life. For those taking the medical line, a successful childhood is one that is disease-free, where the child has developed in line with normal expectations. Those who see health in positive terms will focus on whether the child has thrived. What that means depends on the second issue. The second is the extent to which childhood is seen as impairment, though it provides an effective route to adulthood, or whether it is seen as a time of unique goods. For those who see childhood as a time of deficit, a successful childhood is one where a child learns the skills they need to reach adulthood and is well placed to succeed as an adult. For those who see

22 Anca Gheaus, "The 'Intrinsic Goods of Childhood' and the Just Society," in *The Nature of Children's Well-Being: Theory and Practice*, ed. Alexander Bagattini and Colin Macleod (Springer, 2014), 35–52.

23 Naomi Lott, *The Right to Play* (Nottingham: University of Nottingham 2020).

24 Andrée-Anne Cormier and Mauro Rossib, "Is Children's Wellbeing Different", 1146.

25 Ibid.

special goods in childhood, health is found in enjoying these special goods. The positive state model is linked with the special goods model. It sees health in positive terms and identifies the goods of childhood such as play, innocence and carefreeness as goods we need to ensure children receive so that they thrive in childhood.

I believe all the models discussed so far are misguided. In particular, they see health in terms of individual attributes rather than being a communal and relational thing. I now seek to unpack that concept.

3.5 RETHINKING HEALTH: THE IMPORTANCE OF VULNERABILITY

Understanding vulnerability to be at the heart of the human condition opens up new ways of thinking about childhood and health. There has been an exciting and fertile increase in the literature on universal vulnerability in recent years. Traditionally, vulnerability has been used to identify particular individuals or groups of people as particularly at risk of being harmed and therefore in need of state protection or services.[26] Children are often included in such groups.[27] There might, therefore, be a natural reticence among child rights advocates to the language of vulnerability for fear that doing so will justify paternalistic interventions against children. Indeed, the vulnerability of children is regularly used to justify restricting children's freedoms. However, those promoting universal vulnerability, most notably Martha Fineman, have argued that vulnerability is an inevitable aspect of the human condition.[28] She writes:

> The vulnerability approach recognizes that individuals are anchored at each end of their lives by dependency and the absence of capacity. Of course, between these ends, loss of capacity and dependence may also occur, temporarily for many and permanently for some as a result of disability or illness. Constant and variable throughout life, individual vulnerability encompasses not only damage that has been done in the past and speculative harms of the distant future, but also the possibility of immediate harm. We are beings who live with the ever-present possibility that our needs and circumstances will

26 Jonathan Herring, "Foreword," *University of New South Wales Law Review*, vol. 41 (2018): 22.

27 Sabine Andresen, "Childhood Vulnerability: Systematic, Structural, and Individual Dimensions," *Child Indicators Research*, vol. 7 (May 2014): 699.

28 Martha Albertson Fineman, "'Elderly' as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility," *The Elder Law Journal*, vol. 20(1) (2012): 86– 87.

> change. On an individual level, the concept of vulnerability (unlike that of liberal autonomy) captures this present potential for each of us to become dependent based upon our persistent susceptibility to misfortune and catastrophe.[29]

Fineman makes it clear that all humans are constantly vulnerable, but we are positioned differently. This can be in terms of our embodiment or in terms of economic, relational and social circumstances. This does not negate the essential vulnerability underlying us all, but can impact on the lived experience of it. This is an issue I will need to return to shortly, but first, more needs to be said about vulnerability as a key feature of humanity.

There is much that universal vulnerability might teach us about legal norms, conceptions of the self and the importance of autonomy.[30] For now I will focus on what it means for health and bring out three particularly relevant themes.

3.5.1 Our Fleshy, Fragile Nature

First, our bodily and fleshy nature makes us vulnerable. Our bodies are frail, naturally wear down, and are "profoundly leaky".[31] It is in their nature to wear down. Inevitably, they are susceptible to sickness, illness and injury. As Fineman 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."[32] Ultimately, our bodies are programmed to die. They are not designed for eternal living. We are in a constantly precarious nature.

As Rogers et al. 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."[33] Indeed, as Leonardi points out, "common experiences in life suggest that a long period free of physical and mental symptoms is highly improbable: scientific evidence shows that the average adult experiences about 4 symptoms in a 14-day period."[34] A normal healthy lifespan will contain times of "illness".

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29 Martha Albertson Fineman, "The Vulnerable Subject: Anchoring Equality in the Human Condition," *Yale Journal of Law and Feminism*, vol. 20(1) (2008): 12.

30 Jonathan Herring, *Law and the Relational Self* (Cambridge: Cambridge University Press, 2019).

31 Margrit Shildrick, *Embodying the Monster: Encounters with the Vulnerable Self* (Sage, 2002).

32 Martha Albertson Fineman, "'Elderly' as Vulnerable", 89.

33 Wendy Rogers, Catriona Mackenzie and Susan Dodds, "Why Bioethics Needs a Concept of Vulnerability," *International Journal of Feminist Approaches to Bioethics,* vol. 5 (2) (2012): 12.

34 Fabio Leonardi, "The Definition of Health: Towards New Perspectives," *International Journal of Health Services* vol. 48(4) (June 2018): 735.

We need an understanding of health that has disease and illness built into it. This is a fundamental flaw at the heart of the medicalised model of health. We should reject the view that there is a "healthy norm" from which ill health is a departure. Dealing with fatigue, disease, infirmity and limitations is a natural part of the human life.

3.5.2 Dynamic

We sometimes imagine our bodies to be static and as providing a barrier to the dangers outside us. 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.[35] As COVID-19 has made so clear, biological material passes easily from one body to another. The truth is our bodies are in constant flux, profoundly leaky, and deeply dependant on other bodies and the broader environment.[36]

Human life is dynamic. There is a real danger of assuming a particular aspect of our life course as our "prime" – typically middle age – and of presenting that as a norm, and that any departure from it is a failure. We see this in the understanding of childhood as a deficit: the idea that there is an "ideal" of adulthood we are reaching for and that if a child fails to achieve the standards then they have "failed". We see it too in how childhood health goals are fixed in terms of what they mean for middle age. Similarly, a successful old age is commonly presented as one where the individual is able to mimic middle age as much as possible.

3.5.3 Care

Given our bodily and emotional vulnerability, our caring relationships are key to our survival and well-being.[37] Dependency is an inevitable facet of human life.[38] It is because of dependency that care is so important. The degree of dependency

35 P.-L. Chau and Jonathan Herring, "My Body, Your Body, Our Bodies," *Medical Law Review*, vol. 15 (2007): 34.

36 Jonathan Herring, "Why We Need a Statute Regime to Regulate Bodily Material," in *Persons, Parts and Property: How Should We Regulate Human Tissue in the 21st Century?*, eds. Imogen Goold, Jonathan Herring, Loane Skene and Kate Greasley (Hart Publishing, 2014), 215–230.

37 Jonathan Herring, *Caring and the Law* (Hart Publishing, 2013), chapter 2.

38 Ibid.

may vary at different points in our lives. But, at all point in our lives, we are dependent on others for care. Feder Kittay 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. … 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.[39]

In relationships of care, our interests become intermingled. A harm to one is a harm to the other. The boundaries between me and you break down. Indeed the categories of carer and cared for break down when the relationship is marked by interdependency. Caring relations often involve a complex interplay of dependencies and vulnerabilities. As Fine and Glendinning 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 caregiver 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.[40]

Ultimately, as Bridgeman puts it, "[h]umans are vulnerable … because we care, love, are intimately connected to others".[41] This leads us to a crucial point about health.

Caring relationships are key to health, and so health can only be understood in a relational context.[42] Robinson Crusoe, living alone on his desert island, might

39 Eva Feder Kittay, *Love's Labor: Essays on Women, Equality and Dependency* (New York University Press 1999), xii.

40 Michael Fine and Caroline Glendinning, "Dependence, Independence or Inter-Dependence? Revisiting the Concepts of Care and Dependency," *Ageing and Society*, vol. 25 (June 2005): 601–621, 616.

41 Jo Bridgeman, "Relational Vulnerability, Care and Dependency," in *Vulnerabilities, Care and Family Law*, eds. Julie Wallbank and Jonathan Herring (Routledge, 2014), 201.

42 Emmanouela Mandalaki and Marianna Fotaki, "The Bodies of the Commons: Towards a Relational Embodied Ethic of the Commons," *Journal of Business Ethics*, vol. 166 (2020): 745.

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. As our identity is found in our relationships, and our selves emerge from those relationships, it is therefore key to health that our relationships and communities are healthy.[43] This is the flaw at the heart of the medicalised model of health. It is not bodies that are unhealthy, but communities and relationships.

So, then, our health is not found in capacity or autonomy or self-sufficiency but rather in our vulnerable, interdependent and relational selves.[44] It is recognising that we are 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.

So, what might these insights provide us when thinking about childhood and children's health? That is the question that will be considered next.

3.6 RETHINKING CHILDHOOD

As already mentioned, one major reason for seeing childhood health as separate from adulthood is that children (i) lack rationality and mental capacity as compared to adults and (ii) are more vulnerable than adults. I think that this is a misguided understanding for two reasons.

First, this view overemphasises the autonomy and rationality of adults. Normally when people argue that children have similar mental capabilities to adults, this is based on the argument that the abilities of children are underestimated. For example, Gopnik writes:

> we used to think that babies and young children were irrational, egocentric, and amoral. Their thinking and experience were concrete, immediate and limited. In fact, psychologists and neuroscientists have discovered that babies not only learn more, but imagine more, care more, and experience more than we would ever have thought possible. In some ways, young children are actually smarter, more imaginative, more caring and even more conscious than adults are.[45]

43 Kenneth Gergen, *Relational Being* (Oxford: Oxford University Press, 2009).

44 Janet Delgado, "Re-Thinking Relational Autonomy: Challenging the Triumph of Autonomy Through Vulnerability," *Bioethics Update*, vol. 5 (2019): 5065.

45 Alison Gopnik, *The Philosophical Baby* (Random House 2009), 5.

I think the argument is better made on the basis that adults' mental capabilities are commonly exaggerated. The reality is that few of us have the capacity to be genuinely autonomous.

To be autonomous, a person must not only understand the information about a decision but also be able to use it. Most adults make decisions with an awareness of few of the relevant facts about the decisions they make. Even if they do know the facts, their rationality is deeply flawed. Levy[46] 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, Conly[47] 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.

The contrast drawn between the autonomous, well-informed, rational adult and the ill-informed, immature, impetuous child is a gross exaggeration. Adults, just like children, fail to understand the necessary facts, are heavily influenced by the views of others, and have not developed their own values. We need to reject the law's assumption that the norm is the autonomous, liberal individual and replace them with the vulnerable person.

Second, as mentioned, childhood is commonly presented as a time of vulnerability, contrasted with the independence and self-sufficiency of adulthood. Hence, it is said, children need resources to be healthy. However, it is the provisions of society around the body that privilege the status and use of some bodies while disadvantaging others. This is true for childhood. In particular, a child's gender, race, (dis)ability and class can hugely impact on the child's experience of young age. The

46 Neil Levy, "Forced to Be Free? Increasing Patient Autonomy by Constraining It," *Journal of Medical Ethics*, vol. 40 (2014): 293–300, 295.

47 Sarah Conly, "Against Autonomy: Justifying Coercive Paternalism in Healthcare," *Journal of Medical Ethics*, vol. 40 (2014): 349.

dialogue around the weakness or frailty of child bodies is in part due to the social structures around it, which privilege some and disadvantage others. The reality is that all of us are vulnerable and dependent on others for assistance for survival.

It is striking that we identify certain conditions as disabilities and offer accommodations for those with certain bodies but overlook the wide range of structures and forms of assistance that 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. As Lindeman[48] notes:

> 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.

So the emphasis on adult independence, by contrast with childhood vulnerability, overlooks the considerable vulnerability that adults face.

3.7 RETHINKING CHILDREN'S HEALTH: BRINGING THE THEMES TOGETHER

So where does that get us with understanding children's health? I offer five points by way of conclusion.

First, there is a real danger in these debates that the concept of health becomes adult-centred – that adults come to set the agenda for a healthy, successful childhood. There are many things wrong with this approach, but a key one is that it assumes we adults have it right, that we need to teach children and children need to be protected. There is no openness to the idea that children might have things to teach adults; that children perform important work in the care of adults; that children can teach, care for and mould adults. We presume that autonomy, capacity

48 Kate Lindemann, "The Ethics of Receiving," *Theoretical Medicine and Bioethics,* vol. 24 (2003): 501–509, 502.

and independence are key to a successful life and that impediments to these are harms. That, however, is misguided.

Second, mainstream arguments about the definition of health seek to find health in the individual. Instead, we should be seeking to find health in our communities and our relationships. Children's health and adults' health cannot be separated. One of the ironies of use of vulnerability as marking the child/adult divide, as described in the previous section, is that it creates vulnerabilities for adults. If adults are expected to look after children, this is particularly so for parents in relation to their children. Parents will go to extraordinary lengths to look after children because "that is what parents do". It is no doubt why new parents are willing to go through the sleeplessness, toils and strains of the early years of parenthood. Yet, that renders parents themselves vulnerable. There has been a growth in recent years of the literature exploring the insecurities of parents. This insecurity felt by parents is influenced by the message reinforced by public bodies, including the government, about the significant impact of decisions of parents on children's welfare. This message that parents are core to their children's welfare and health generates considerable pressure on parents. Where things go wrong, it is parents towards whom the blame is directed. Parents are clearly feeling under pressure to "succeed" as a parent, interpreted as producing well-rounded, well-educated, high-achieving children. This is also reflected in the increased attention to hyper-parenting, where parents go to excessive lengths to make their child the best possible child. Alvin Rosenfeld and Nicole Wise explain: "This is happening because many contemporary parents see a parent's fundamental job as designing a perfect upbringing for their offspring, from conception to college. … That is why the most competitive adult sport is no longer golf. It is parenting."[49]

Bridgeman has written particularly powerfully of the responsibilities parents feel towards their children and how this impacts on their engagements with healthcare professionals. She writes of the power of these caring responsibilities.[50] This itself creates vulnerabilities for parents as they struggle to negotiate the demands of professionals, their grief and children. The pain of the children generates pain, sometimes great pain, in the adults. The vulnerability of the child constitutes vulnerability in the adult. The misdeed of a parent seeking to genetically engineer or hyper-parent their child is not just that the parent is seeking to impose a particular view of what is a good life on their child, although that is wrong. It is the error of

49 Alvin Rosenfeld and Nicole Wise, *The Over-Scheduled Child: Avoiding the Hyper-Parenting Trap* (New York: St. Martin's Press, 2001).

50 Jo Bridgeman, *Parental Responsibility, Young Children and Healthcare Law* (Cambridge: Cambridge University Press, 2007).

failing to be open to change as an adult, failing to learn from children, failing to see that the things you thought were important are, in fact, not. It is failing to find the wonder, fear, loneliness, anxiety, spontaneity, and joy of children, and to refine them for oneself.

Third, an important theme we see in these debates surrounds power. Some commentators are critical of a highly medicalised model of health, which purports to use objective criterion against which to judge people to be healthy or not. Those deemed disabled or ill can be returned to the norm. As this indicates, determining who is healthy or not involves an exercise of power. 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.[51] Indeed, any attempt to deny one is ill is seen as clear proof that one is. As Turner puts it:[52]

> … 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.

Garland Thomson[53] is particularly powerful in terms of disability, where the "able" get to glorify the status of their own bodies and label those with different bodies as disabled or "abnormal". Cassidy et al. wrote that children

> are stifled and excluded from a society formed and defined by adults' interests until they —the children — are trimmed and shaped in a way that allows adults to find children agreeable. This demonstrates the power relation between adult/child quite clearly.[54]

51 Tom Koch, "Disability and Difference: Balancing Social and Physical Constructions," *Journal of Medical Ethics*, vol. 27 (2001): 370–376.

52 Bryan Turner, *Medical Power and Social Knowledge* (Sage, 1995), 35–36.

53 Rosemarie Garland Thomson, "Misfits: A Feminist Materialist Disability Concept," *Hypatia*, vol. 26(3) (2011): 591–609, 592.

54 Claire Cassidy, Sarah-Jane Conrad, Marie-France Daniel, Maria Figueroia-Rego, Walter Kohan, Karin Murris, Xiaoling Wu and Tsena Zhelyazkova, "Being Children: Children's Voices on Childhood," *The International Journal of Children's Rights*, vol. 25 (2017): 698–715, 702.

And this feeds into a debate among vulnerability theorists. Even if we accept that we are all universally vulnerable, is it not true that some people experience different levels of vulnerability? This, it seems, is accepted by vulnerability theorists. Martha Fineman writes:

> There are two relevant forms of individual difference in a vulnerability approach—those that arise because we are embodied beings and those that arise because we are social beings embedded in social institutions and relationships.[55]

I agree there are different levels of vulnerability. But I am not sure I agree with the source of that vulnerability, included embedded differences. Fineman gives an example of different vulnerabilities over the life course:

> In addition to the bodily differences that are manifest across various members of society at any given time, are those differences that evolve within each individual body. These differences reflect the progressive biological and developmental stages within an individual human life. Individual bodies will mature and grow, as well as age and decline. We can think of these differences as occurring along a vertical and temporal dimension of analysis—within the individual over time.

In particular she writes:

> Infancy and childhood should be understood as merely inevitable developmental stages in the life of the vulnerable subject, not as the occasion for the creation of distinct and diminished categories of state responsibility.

Here, I respectfully disagree with her. First, because I think that some of the dependencies of childhood are created by society. It is the way our society is structured that disadvantages children. The perceived particular vulnerabilities of children mask the vulnerability of adults. The dangers posed by children are dangers posed by adults.

Finally, in some vulnerability literature there is an emphasis on resilience. Fineman writes:

55 Martha Albertson Fineman, "Vulnerability and Inevitable Inequality," *Oslo Law Review*, vol. 4(3) (2017): 133–149, 143.

> While a vulnerability analysis begins with a description of universal vulnerability, it is the particularity of the manifestations of vulnerability and the nature of resilience that are of ultimate interest. Resilience is the critical, yet incomplete, solution to our vulnerability. Social resources give us a sense of belonging and community and are provided through the relationships we form within various institutions, including the family, social networks, political parties and labour or trade unions.

However, I am nervous about the language of resilience. It posits vulnerability as something to be overcome rather than rejoiced in. 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. She is not given to sentimentality, but 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.[56]

Vulnerability is to be greatly welcomed. Our mutual vulnerability requires us to reach out to others to offer and receive help from them. The virtues of beneficence and compassion are encouraged and necessary. We have to become open to others and our own and others' needs. A recognition of our mutual vulnerability leads to empathy and understanding. It creates intimacy and trust. It compels us to focus on interactive, cooperative solutions to the issues we face. As Carse puts it: "Our vulnerability is inextricably tied to our capacity to give of ourselves to others, to treasure and aspire, to commit to endeavours, to care about justice and about our own and other's dignity."[57] Our vulnerability requires us to meet out to others to meet their needs and to have our needs met. Our very vulnerability provides us with the seeds for our growth through relationships with others.[58]

In short, health is found not in individuals but in communities and relationships. So there should not be a conception of a healthy child, but rather a healthy network of relationships which include children. It is in building up caring relationships that true health is found. It comes from recognising that bodies and

56 Eva Feder Kittay, "Forever Small: The Strange Case of Ashley X," *Hypatia*, vol. 26 (2011): 610–631, 621.

57 Ann Carse, "Vulnerability, Agency and Human Flourishing," in *Health and Human Flourishing*, eds. Carol Taylor and Alberto Dell'Oro (Georgetown University Press, 2006), 48.

58 Daniel Bedford and Jonathan Herring, *Embracing Vulnerability: The Implications and Challenges for Law* (London: Routledge, 2021).

people come with different strengths and weaknesses that can vary over time, as is human nature. This is true for children and for adults. We need to reject the view that adults "know it all" and acknowledge the vulnerable and incapable nature of adulthood. Our health is found in pooling our vulnerabilities and caring together. Then adults and children can learn from each other, care for each other and find true health.

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