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MEANING, ETHICS, AND IDENTITY

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For Megumi

Thank you for your love and
sacrifice these many years.

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INTRODUCTION

This dissertation reflects critically on the culture of modern medicine, specifically, as a good for us as human beings. Culture is not a neutral space; it is instead a moral space. Even as we shape it, it shapes and has shaped us. As its inhabitants, we cannot but deliberate and act in that space—as creatures who are always already shaped by it. Or as Richard Miller puts it, culture is "the total of the inherited beliefs, values, knowledge, and material products that habituate a people, constitute the shared bases of individual and collective identity and action, and provide the milieu in which persons relate to historical and natural events."[1] The ethical question in such a space is not merely about what one must do to resolve this conflict, respect that person, or fulfill those obligations. Such questions are important, but a deeper question persists: what does it mean for us to inhabit this cultural space—modern medicine—well, such that it is experienced as a human good?

This question is inescapable; it cannot be willed away. It persists because it arises from a basic human longing for happiness, for meaning in our lives. In contemporary moral philosophy, as Charles Taylor writes, we tend to "focus on what it is right to do rather than on what it is good to be, on defining the content of obligation rather than the nature of the good life."[2] This is no less the case for modern medicine and its ethics, preoccupied as it is with the clinical and policy questions of what should or should not be done and why. The question of what it is to inhabit the modern medical space well is instead ethical in an older sense; it is oriented to human flourishing, or what the ancient Greeks called *eudaimonia*. Or in Harry Frankfurt's words, the question gets at

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[1] Richard B. Miller, *Friends and Other Strangers: Studies in Religion, Ethics, and Culture* (New York: Columbia University Press, 2016), 41.

[2] Charles Taylor, *Sources of the Self: The Making of the Modern Identity* (Cambridge, MA: Harvard University Press, 1989), 3.

an ethical concern not so much "to make people good" but "to make their lives meaningful, and thus to help make their lives in that way good for them to live."[3]

As a matter of ethics, moreover, this question invites a two-fold inquiry into the moral space of modern medicine: a critical concern for what that space should be such that it can be inhabited as a human good as well as a self-critical concern for how those of us in that space—as patients, communities, professionals, or policymakers—should inhabit it. These two concerns are distinct, and yet, they are also inseparable. There is a basic unity between them insofar as the critical question of what the moral space ought to be is always already a self-critical question of its good for us as human beings. Likewise, the self-critical question of how to inhabit or conduct oneself within that space is always already a question of what that moral space is or aspires to be. Indeed, the tendency in modern medicine to separate these concerns as isolable points of inquiry is part of the basic problem to which I propose to attend in this dissertation.

In modern medicine, there is a troubling inarticulacy concerning this question of its good for us, of what it means to inhabit its space well. Consider the rather inchoate but nonetheless persistent and widely felt sense of malaise within its ranks today. Patients have long and too often experienced its space as alienating—as though they were merely a problem to be managed by its technocratic, capitalistic, or otherwise impersonal systems. But even clinicians are now expressing their disquiet in major journals and books, speaking out on a similar sense of alienation, of lost meaning and disenchantment.[4] Yet, the predominant response of the medical community has

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[3] Harry G. Frankfurt, *The Reasons of Love* (Princeton, NJ: Princeton University Press, 2004), 99.

[4] See e.g., Lydia Dugdale, "Re-enchanting Medicine," *JAMA Internal Medicine* 177 (2017): 1075-6; David Rosenthal and Abraham Verghese, "Meaning and the Nature of Physicians' Work," *New England Journal of Medicine* 375 (2016): 1813-5; Sandeep Jauhar, *Doctored: The Disillusionment of an American Physician* (New York: Farrar, Straus & Giroux, 2014); Carl Elliott, "Disillusioned Doctors," in *Lost Virtue: Professional Character Development in Medical Education*, ed. Nuala Kenny and Wayne Shelton (Oxford: Elsevier, 2006), 87-97; Pamela Hartzband and Jerome Groopman, "The New Language of Medicine," *New England Journal of Medicine* 365 (2011): 1372-3.

been to manage the issue as that of burnout, a job-related syndrome.[5] The strategy has been to push systems changes to lower clinicians' job demands and increase job resources. Yoga and other individualized wellness programs have also been tried. Such strategies, however, have failed to resonate with clinicians' actual experience, seeming only to obscure something of its depth.[6]

This inarticulacy mirrors the two-fold nature of the inquiry at stake. One has to do with what the meaning of modern medicine is or ought to be. The clinician-ethicist Leon Kass speaks of a confusion as to the moral ends of medical practice, while others like Carl Elliott describe a growing misalignment between the business realities of everyday practice and the traditional ideals of clinicians.[7] Jeffrey Bishop similarly decries a pervasive "metaphysics of efficiency" in modern medicine that estranges us from our "capacities, histories, projects, and purposes."[8] The difficulty on this score is to name what has been lost so as to rediscover it. The other inarticulacy, however, concerns the sense in which the alleged confusion, misalignment, or metaphysics is a problem for modern medicine. Its practices, after all, work; its technical prowess has improved health outcomes dramatically over many decades. So, why expect anything more of medicine? Is the malaise in this space warranted or is it a nostalgia that its inhabitants do well to get over?

More precisely, the difficulty is not that modern medicine is utterly inarticulate on this question. The question of its good for us as human beings indeed arises in this space, and persistently so. But as its inhabitants, we only ever seem to be able to articulate it in terms of its

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[5] National Academy of Medicine, *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being* (Washington, DC: National Academies Press, 2019).

[6] See, e.g., Thomas Schwenk and Katherine Gold, "Physician Burnout—A Serious Symptom, But of What?" *Journal of the American Medical Association* 320 (2018): 1109-1110; Wendy Dean, Simon Talbot, and Austin Dean, "Reframing Clinician Distress: Moral Injury Not Burnout," *Federal Practitioner* 36 (2019): 400-402; Philip J. Candilis, Daniel T. Kim, and Lois Snyder Sulmasy, for the ACP Ethics, Professionalism and Human Rights Committee, "Physician Impairment and Rehabilitation: Reintegration into Medical Practice while Ensuring Patient Safety: A Position Paper from the American College of Physicians," *Annals of Internal Medicine* 170 (2019): 871-879.

[7] Leon Kass, "Regarding the End of Medicine and the Pursuit of Health," *The Public Interest* 40 (1975): 11-42; Elliott 95.

[8] Jeffrey Bishop, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame, IN: University of Notre Dame Press, 2011), 309.

instrumental importance. This, after all, is how we tend to treat questions of meaning in modern medicine. We commonly understand people's sense of meaning in terms of personal beliefs or self-reported variables that need to be accommodated in order to deliver care that patients and communities find satisfying or culturally appropriate. Alternatively, we understand them as sources of our particular biases or idiosyncrasies that ought to be bracketed so as to focus on curing the disease. In other words, we tend to treat our various meanings only as variables to be managed so that the technical work of modern medicine can carry on.

But such instrumental rationalizations of our meaning questions lack any of the depth or resonance that we feel should be there—or so I want to argue. This is not how we human beings ordinarily experience our meanings; we do not simply choose them on some instrumental basis, say, of preference or convenience. Yet, this is where modern medicine's articulacy tends to end. Beyond such rationalizations, it is incoherent as to the *constitutive* significance that our meanings often have for us. Meanings in fact orient us; they give our lives a shape, a narrative, an identity. As Viktor Frankl writes in his great book *Man's Search for Meaning*, one's "search for meaning is the primary motivation in his life and not a 'secondary rationalization' of instinctual drives." One does not live or die for one's rationalizations; however, one "is able to live and even to die for the sake of his ideals and values!"[9] Conversely, as Taylor notes, "to begin to lose one's orientation is to be in crisis, and to lose it utterly is to break down and enter a zone of extreme pathology."[10]

In this dissertation, I will show that modern medicine's inarticulacy as to the good of its moral space for us is symptomatic of a deeper obscurity concerning the self's ontology. The self, here, refers to the "me" who inhabits a world; at stake is how the self relates to it. More and more, we inhabit the modern medical space in ways that alienate us from the good of its practices—or

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[9] Viktor E. Frankl, *Man's Search for Meaning* (Boston, MA: Beacon Press, 2006 [1959]), 99.
[10] Charles Taylor, "Reply to Commentators," *Philosophy and Phenomenological Research* 54 (1994): 203-213, 209.

even the need to ask about that good in the first place. That is, we experience ourselves as what Taylor calls "disengaged" from the world; we see ourselves—our beliefs, feelings, or values—as being "within" us while the world is "without." Our dignity, on this view, consists in a within-the-self freedom to choose a life unencumbered by that world from which we are—or feel that we should be—disengaged.[11] This self-image indeed underwrites and is underwritten by our empirical modes of knowing and being in modern medicine. Increasingly, we seem not only to know the world in these empirical terms but also to experience our very selves in them.

My constructive thesis is thus centrally concerned with our moral anthropology. I argue that we must inhabit modern medicine not as disengaged but as hermeneutical selves if we are to experience it as a good for us as human beings. The "hermeneutical self" clarifies our experience of knowing and being as that of creatures who inhabit our moral space—our world of meanings and the claims of others on us—as "self-interpreters."[12] Contrary to the disengaged self, we do not engage this space primarily on instrumental terms. We inhabit it as beings who are always already constituted by it; the moral space precedes the self. It is as creatures of a particular space that we interpret the world and ourselves in it. We do so, specifically, as "strong-evaluators"—in terms of what Taylor describes as our basic "inner craving … to be rightly placed in relation to the good."[13] We aspire, as inhabitants of that space, to be in a state of "fullness"—a place in which we envision our life to be "fuller, … more admirable, more what it should be," a place where we feel moved to act with "integrity or generosity."[14]

Reflecting again the two-part nature of the inquiry at stake, this thesis rests on the validity of a two-part claim: the hermeneutical self is an inescapable *source* and *condition* of medicine's

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[11] Taylor, *Sources*, 111-112.
[12] Charles Taylor, "Self-Interpreting Animals," in Human Agency and Language: Philosophical Papers 1 (Cambridge: Cambridge University Press, 1985), 45-76, 45.
[13] Taylor, *Sources*, 44.
[14] Charles Taylor, *A Secular Age* (Cambridge, MA: Belknap Press, 2007), 5.

good. The hermeneutical self is the good *for* which the moral space and its practices exist—the source of their meaningfulness. The practice matters to us not for its own sake but for the sake of those who inhabit it. This is not, to be sure, the only reason why one might find the practice meaningful. There are any number of reasons, such as the simple satisfaction of being treated or achieving a certain job status, skill, or ideal. But whatever other goods may condition the practice for a person, the hermeneutical self is necessarily one. This is so insofar as such a self is the one *by* whom modern medicine is engaged—by whom the question of its good is asked in the first place. The question would not otherwise arise.

The point, in this way, is to help humanize modern medicine by clarifying the good of what it always already is—a space for and by hermeneutical selves. Despite all of its individual, relational, and institutional complexities, modern medicine is at bottom carried on for and by human beings, and this is as obvious a point as it is inescapable. The project thus starts here. It does not aim to construct some a priori ideal to which we must then conform, nor does it describe the empirical observations of the social sciences. At stake is neither what modern medicine should be in some ideal world nor what its current or historical experience looks like. Such would be the primary concerns of a disengaged self. The hermeneutical aim instead is to clarify the moral space of modern medicine for what it always already is—a question of its good for us. As hermeneutical selves, this is how we in fact inhabit this space; we cannot but do so. The ethical task is therefore to sustain this way of being so as not to alienate ourselves from it—from the very possibility of experiencing modern medicine as a good for us as human beings.

Methodology

This ethical task is no small thing. Modern medicine's overwhelming propensity is to obscure the hermeneutical constitution of our ontology; it is to see ourselves as disengaged. The burden of proof therefore is on the side of the hermeneutical self. Now, a hermeneutical ontology is not something that can be proved in terms of a disengaged self, that is, on empirical grounds. If my thesis holds, then the proof itself must be shown on hermeneutical terms. To do otherwise, would be to give credence to the disengaged self from the start. In other words, the hermeneutical self is not an object out there that can be empirically described from the standpoint of a disengaged observer. Instead, the subject of inquiry is us, our experience of ourselves. The need is to clarify that experience hermeneutically as that of the hermeneutical self so as to achieve a progressively better grasp of ourselves as hermeneutical.

The methodological challenge is thus inseparable from what it is to be a hermeneutical self. As mentioned, to say that we are hermeneutical selves is to say that we engage the world hermeneutically, as self-interpreters. We interpret our world as beings who are always already constituted by it—that is, in terms of who we are or aspire to be within it. Hermeneutics is thus a science of interpretation that seeks to make sense of an object, including the self, without the illusion of disengaging from it. Its key feature is the "hermeneutical circle," the idea that there is no interpretation without presupposition. A shared reading of any object necessarily presumes a shared language and recognition of the same problem and solution. While an empiricist looks to verifiable sense-data in an effort to escape the circle, the hermeneut accepts uncertainty as "an ineradicable part of our epistemological predicament."[15] The danger otherwise is that we block out important aspects of our lived experience—the sense in which that experience is *ours*.

The hermeneutical approach must therefore be comparative rather than empirical; its goal is progressive clarification, not certainty. This dissertation applies what Taylor calls the "BA principle."[16] The "BA" refers to "best account." The hermeneutical insight is that there can be no

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[15] Charles Taylor, "Interpretation and the Sciences of Man," in *Philosophy and the Human Sciences: Philosophical Papers 2* (Cambridge: Cambridge University Press, 1985), 15-57, 18.

[16] Taylor, *Sources*, 58.

absolute, third-person knowledge of human lived experience—insofar as that experience is always already ours and is constituted by a significance as such. So the limit of what can be achieved is the "best sense" that we can make of it. Rather than looking to sense-data, the idea is to move comparatively across the competing accounts of that experience. The goal is to proceed by way of "error-reducing" moves that resolve a contradiction or confusion or that identify an important consideration that was previously obscure. The proof at each step consists in showing what can be gained with respect to our grasp of that experience, especially relative to the analyses of the disengaged self.

The validity of a "best account" is necessarily provisional. It is valid "unless and until" it can be replaced with "more clairvoyant substitutes."[17] As Taylor puts it, the approach is akin to a biographical narrative. We transition from one account to another in an experience of "moral growth," and it is this sense of growth or "resonance" that grounds our confidence in the account we come to embrace. The growth, to be sure, may be false or illusory. But the argument over its validity is necessarily resolved not by appeal to some absolute criterion but in terms of the best interpretation of the life we are living.[18]

Hermeneutics, then, is an epistemology, one that is inseparable from our ontology as knowers. The method thus presumes the argument concerning the nature of the self even as that argument justifies the method. But crucially, this circle is productive rather than vicious. The idea is to interrogate critically our modes of being and knowing in order to progressively clarify a best account of the self's experience in modern medicine. The dissertation, in this way, looks to sustain a hermeneutical ontology of the self over against our propensities to do otherwise, that is, to give credence to the disengaged self. It attends to the lived experience of illness and disease and the

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[17] Ibid.

[18] Ibid. 72.

giving and receiving of care so as not to be alienated from it. This constitutes moral growth, and the truth of the dissertation hinges on demonstrating it.

Organization

The potential areas of modern medical experience to which this dissertation might attend are as diverse as the experiences themselves. With respect to the analysis of the self, moreover, this dissertation construes "modern medicine" broadly. It can refer not only to clinical care but also to public or global health. There are of course important differences between these modern medical fields. In contrast to the others, for example, clinical care attends primarily to individuals rather than populations or communities, and it stresses the tools of clinical diagnosis and prognosis rather than epidemiology. Different sets of ethics rules and standards can also be emphasized or may apply. But that said, there is also significant overlap between them, in particular, with respect to the propensity to perceive the moral space of caregiving as that of the disengaged self.

Within the limits of a single dissertation, however, I propose to limit the analysis to just five areas of the modern medical experience: that of the problem at stake in this dissertation, that of our social ontology, that of our moral goods, that of clinician distress, and that of health justice. Each area corresponds to a chapter. The first motivates the project by way of modern medicine's malaise, while the second and third clarify crucial features of the hermeneutical self. The fourth returns to the malaise by which the problem of the self was clarified in the first, and it does so as a policy issue. It intervenes on the matter hermeneutically and thereby closes that loop. The fifth intervenes on an important limit case for hermeneutical analysis insofar as distributive justice is typically defined by an aspiration to disengaged impartiality. Moreover, the issue is central to how our institution-based obligations to others are conceived in modern medicine, and in that way, helps demonstrate the hermeneutical possibilities for concerns beyond the clinical.

In addition, each chapter proceeds hermeneutically in terms of the BA principle. The analyses move across a range of accounts and insights from interdisciplinary sources, including clinical, public, and global health theories and studies, medical anthropology, critical and feminist theory, applied and hermeneutic philosophy, and theological studies. The chapters draw on these resources dialogically and eclectically, and in that way, engage, reflect, and contribute to the interdisciplinary discourses and concerns that have long characterized the bioethics field.

By way of clarifying the problem at stake in this dissertation, chapter one poses the question of meaning and its significance in the context of medicine's malaise. Taking clinician malaise as a symptom of a deeper problem of the self, it problematizes the propensity in modern medicine to imagine the self and its values in terms of the disengaged self. The chapter moves in a step-wise manner across three major approaches to malaise in modern medicine—that of the medical profession, natural law, and critical theory. It analyzes each account on its own terms before evaluating the adequacy of the self-perception underlying it. Each thus builds on the one prior in order to clarify the need for a hermeneutical ontology of the self.

Chapters two and three explicate two crucial features of the hermeneutical self. Chapter two focuses on the experience of the self as a social being, as always already inhabiting a cultural space. Certain cultural values, which Taylor calls "inter-subjective" and "common meanings," condition the practices that constitute the self's identity.[19] A particular view of autonomy, for example, must already hold in medicine if one is to understand certain acts of assent as informed consent and judge them to be worthy of one's dignity. There can be no self, in other words, apart from these larger meanings that we each inhabit and rely on to constitute our good. The chapter clarifies this hermeneutical social ontology by building progressively on accounts of the social self in clinical care, population health, and medical anthropology.

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[19] Taylor, "Interpretation," 39.

Chapter three clarifies the hermeneutical self in terms of its experience of moral goods. Looking to Harry Frankfurt, Taylor, and Augustine, the chapter argues that the moral space of the self is constituted not only by social meanings but also by the claims of just love. Building on Frankfurt's moral psychology of care and its importance, I look to Taylor's notions of "strong evaluation" and "fullness." We do not interpret the world and ourselves in it only "weakly," in terms of convenience or satisfaction. We also do so "strongly," in terms of its qualitative worth as noble or base, good or bad, that is, as more or less proximate to a longed-for state of fullness. But I also go beyond Taylor to Augustine, for whom this hermeneutical experience or aspiration is dependent not only on our interpretive meanings but also on a relational peace with oneself, others, and the divine.

The last two chapters further demonstrate the task of sustaining a hermeneutical ontology of the self in medicine by engaging its applied concerns. Chapter four returns to clinician malaise not so much as a symptom of a deeper problem of the self but as a policy issue. Moving across the accounts of burnout and moral distress in the medical and nursing literature, I turn to Bernard Williams's notion of agent-regret and an Augustinian moral grief to show that a hermeneutical perception offers a more coherent grasp of the experience than is otherwise possible. The policy implications are also considered. Chapter five extends the same pattern of analysis to a modern, principlist account of health justice. I reframe that approach hermeneutically, moving across theory-based and social scientific critiques of principlism, a feminist ethics of care, and an Aristotelian life of virtue. The analysis also extends to implications for pedagogy in this area.

In these ways, each chapter illustrates a constructive interdisciplinary dialectic between the hermeneutical self and its varieties of expression in modern medicine. The goal thereby is to critically affirm, so as to inhabit, that moral space as a good for and by human beings.

CHAPTER ONE

Is Medicine Ailing? Malaise and the Self as a Problem

In October 1960, *Harper's Magazine* published a special issue entitled, "The Crisis in American Medicine." One article noted that "millions of people" were "bitterly dissatisfied" with their medical care,[1] while another lamented a "crisis in human relations."[2] Rapid developments in medical knowledge and technologies had given rise to a culture of care that was fragmented, bureaucratized, and impersonal. Over sixty years later, a sense of malaise, if not crisis, persists. More than ever, modern medicine is an immense system involving myriad stakeholders and competing interests. The complexities of care delivery have only multiplied, and the concomitant imperatives of quality control and cost efficiency seem more relentless than ever.

Within modern medicine's impersonal modes of care, the patient's sense of alienation—of being disregarded as a human presence[3]—has likewise intensified. Even clinicians now express their malaise in major journals. One speaks of medicine's "disenchantment," noting the irony that "this most human of activities—care of the sick—hardly requires human contact."[4] Others lament a loss of meaning as their distance from the "embodied identity" of patients and colleagues grows.[5] Still others observe a "new language of medicine," which describes patients as "customers" or "consumers," clinicians as "providers," and their interactions as commercial transactions. The

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[1] Marion Sanders, "The Crisis in American Medicine," *Harper's Magazine* 221 (1960): 121–168, 123.

[2] Greenberg, Selig, "The Decline of the Healing Art," *Harper's Magazine* 221 (1960): 132–137, 132.

[3] Nancy Anderson, "Exclusion: A Study of Depersonalization in Health Care," *Journal of Humanistic Psychology* 21 (1981): 67-78.

[4] Lydia Dugdale, "Re-enchanting Medicine," *JAMA Internal Medicine* 177 (2017): 1075-1076. See also Sandeep Jauhar, *Doctored: The Disillusionment of an American Physician* (New York: Farrar, Straus & Giroux, 2014).

[5] David Rosenthal and Abraham Verghese, "Meaning and the Nature of Physicians' Work," *New England Journal of Medicine* 375 (2016): 1813-1815.

language, it is argued, signals a culture in which clinicians are seen as “interchangeable” and care is treated as “a prepackaged commodity on a shelf.”[6]

What sense can be made of this experience? At one level, malaise is a symptom linked to a growing sense that we inhabit a medicine that is no longer what it ought to be or claims to be. Leon Kass, writing in 1975, observes that “people both in and out of medicine have begun to wonder out loud whether and to what extent medicine is doing good.”[7] Medicine, he argues, is ailing from a confusion as to its moral purpose. More recently, Carl Elliott speaks of a problem of misalignment between physicians’ “internal” self-understanding as engaged in a humanitarian practice and an “external” perception that their practice is essentially a business.[8] Jeffrey Bishop similarly takes modern medicine to task for its inattention to “final” causes. It fixates, he argues, on “the empirical realm of matter, effects, and the rational working out of their causes” at the expense of any purpose beyond “finding ways to control the material of bodies.”[9]

But there is an additional level to the malaise that is often missed, namely, the *significance* of what has been lost. To experience malaise is not just to be confused, misaligned, or inattentive in a cognitive sense but, in a deeper sense, to feel alienated and disenchanted, to grieve a loss. This is because we inhabit the cultural space of modern medicine not so much on cognitive terms but on moral ones. It is a moral space in which, as Richard Miller might put it, “persons identify themselves and find meaning and moral direction.”[10] At stake in the experience of malaise, in

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[6] Pamela Hartzband and Jerome Groopman, “The New Language of Medicine,” *New England Journal of Medicine* 365 (2011): 1372-1373.

[7] Leon Kass, “Regarding the End of Medicine and the Pursuit of Health,” *The Public Interest* 40 (1975): 11-42, 12. Kass, Elliott, and Bishop are each physician-ethicists; I expand on their diagnoses in the course of this chapter.

[8] Carl Elliott, “Disillusioned Doctors,” in *Lost Virtue: Professional Character Development in Medical Education*, ed. Nuala Kenny and Wayne Shelton (Oxford: Elsevier, 2006), 87-97.

[9] Jeffrey Bishop, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame, IN: University of Notre Dame Press, 2011), 20.

[10] Richard Miller, *Friends and Other Strangers: Studies in Religion, Ethics, and Culture* (New York: Columbia University Press, 2016), 41. I share Miller’s understanding of culture as “the total of the inherited beliefs, values, knowledge, and material products that habituate a people, constitute the shared bases of individual and collective identity and action, and provide the milieu in which persons relate to historical and natural events” (ibid.).

other words, is a question of meaning—what we take medicine to be in its moral significance for us.[11] The nature of medicine is not a value-neutral object to be described. To ask about its meaning is to ask about the *good* in virtue of which its practices are meaningful for us—that good which matters to us and the loss of which rightly grieves or distresses us.[12] The question thus implicates us as subjects of value for whom the good matters.

As a matter of grief, however, one might ask whether medicine's malaise is but a personal as opposed to a moral problem. Might malaise not be an ill-advised nostalgia for a bygone era? Perhaps, as some suggest, the solution is not to criticize modern medicine but to better manage individual expectations of what the good of medicine is or ought to be.[13] The system, one might say, "works." Health care outcomes have improved over the years—dramatically in many cases—and every expectation is that with sustained effort, they will continue to improve. Indeed, recent news of advances in Alzheimer's and cancer treatments and in genetics and precision medicine suggest that exciting breakthroughs are just over the horizon; the possibilities seem limitless. Even medicine's many policy issues around access and cost seem, in principle, manageable. It is far from clear to many that medicine is in fact ailing.

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[11] My use of the term "moral" refers to experiences or practices that implicate questions of good or bad, right or wrong. Ethicists typically distinguish "ethics" as a mode of critical, rational reflection on a person's or community's morals—their mores, norms, or practices. This is not to say that these morals do not have their own reasons; but ethics is the second-order reflection on those reasons. In that sense, this chapter—indeed, this dissertation—is an exercise in ethics. It reflects critically on our moral experiences.

[12] Recent publications are increasingly aware of what has been called "moral distress" in clinicians' experience of malaise. The concept has been familiar in the nursing literature since 1984 but is now starting to gain traction among physicians as well. See, e.g., Elizabeth Dzeng and Robert Wachter, "Ethics in Conflict: Moral Distress as a Root Cause of Burnout," *Journal of General Internal Medicine* 35 (2020): 409-411; National Academy of Medicine, *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being* (Washington, DC: The National Academies Press, 2019). I will have more to say about this literature in chapter four when I address malaise more directly as a policy concern.

[13] See, e.g., Elliott, "Disillusioned Doctors"; Stephen Swensen, Gregg Meyer, Eugene Nelson, et al., "Cottage Industry to Postindustrial Care—the Revolution in Health Care Delivery," *New England Journal of Medicine* 362 (2010): e12.

The question of modern medicine's malaise, therefore, is not only *what* its good is or ought to be but also *why* its loss should matter to us in the first place. This chapter is an effort to make sense of medicine's good in this dual aspect. I argue that the difficulty of seeing its malaise for what it is—as a moral experience of grief—is rooted in an inadequate picture of the self. That is, the experience of malaise is a symptom of a deeper problem of our self-understanding—the self's alienation from itself. Herein is the focus of this chapter. I will return to the symptom in a later chapter, but here, I want to articulate the self as an underlying problem. It is only in seeing the self as a problem that we can even begin to make sense of the symptom.

In order to clarify the self as a problem, then, I examine the three prominent accounts of modern medicine's malaise and its good, which draw on approaches in the medical profession, natural law, and critical theory. Examining each in turn, I argue that they fail because they each presume an understanding of the self as "disengaged," as an agent for whom such goods have but an instrumental significance. Far from resolving the malaise, they are apt to perpetuate it. Instead, drawing on Charles Taylor, I contend that a hermeneutical understanding of the self, as an agent for whom meanings have a constitutive significance, is a necessary condition for experiencing the moral space of medicine as a human good—the loss of which we rightly grieve. Such a self, to that extent, is also a necessary source of medicine's meaning.

Modern Medicine and its Subject

Medicine has long placed the patient at the center of its self-identity as a meaningful practice, arguably from its very origins. In the Hippocratic Oath, the physician pledges by the gods to "help the sick according to my ability and judgment, but never with a view to injury and wrongdoing."[14] This basic idea animates the solemn declarations of all the major physician associations today, and has been claimed as an aspiration of the health care system more broadly. In an influential 2001 report, the Institute of Medicine (IOM) identifies "patient-centered" care—alongside safe, effective, timely, efficient, and equitable care—as a vital goal for the future of US health care. The idea is "to customize care to the specific needs and circumstances of each individual, that is, to modify the care to respond to the person, not the person to the care."[15]

The patient on this account is laudably normative, but in modern usage, the patient is also typically interpreted in a particular way. The IOM, for example, states that medicine in the 21st century should be "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions."[16] This conceives the patient as an articulate source of identifiable values, needs, and preferences that are, in part, to govern and constitute the very definition of quality care. Within the bounds set by the other vital goals of US health care, it matters less what those values, needs, and preferences are than whose they are.

This picture of the patient thus tends to conceive meaning as a question of personal value or satisfaction. This is likewise at play in the medical community's understanding of physician malaise, which it accounts in terms of self-reported wellbeing. Large studies have shown that over half of medical trainees report being burned out and depressed, and that non-trainee physicians are faring little better.[17] Alarmed, the two largest physician groups in the US have each launched

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[14] Hippocrates, "The Oath," in *Hippocrates, Volume 1*, translated by W.H.S. Jones, Loeb Classical Library 147 (Cambridge, MA: Harvard University Press, 1923), 298-301, 299.

[15] Institute of Medicine Committee on Quality of Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academy Press, 2001), ch. 2.

[16] Ibid.

[17] See, e.g., Liselotte Dyrbye, Colin West, Daniel Satele, et al., "Burnout among U.S. Medical Students, Residents, and Early Career Physicians Relative to the General U.S. Population," *Academic Medicine* 89 (2014): 443-451; Tait Shanafelt, Omar Hasan, Lotte Dyrbye, et al., "Changes in Burnout and Satisfaction with Work-Life Balance in Physicians and the General US Working Population between 2011 and 2014," *Mayo Clinic Proceedings* 90 (2015): 1600-1613.

new initiatives citing concerns about the effects of burnout on turnover and care quality. By focusing their policy efforts on "identifying, promoting, and disseminating approaches to improve the practice environment," their goal is to help physicians experience greater individual fulfillment.[18] The approach, of course, is itself premised on physician self-reports of wanting to provide high-quality care and being more satisfied when they do.[19]

Indeed, this image of the individual as source of value underwrites and is underwritten by medicine's predominantly empirical modes of knowing and care delivery. Patient satisfaction and perception are widely surveyed to assess everything from service delivery and communication dynamics to risk-benefit assessments in clinical decision making.[20] There is now also a push to incorporate patient perspectives as a baseline consideration in more research so as to improve their clinical relevance and evidence uptake.[21] Patient satisfaction has become a routine part of hospital performance evaluations. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, for example, is used at 4,100 hospitals across the country, is validated and publicly reported by the Center for Medicare and Medicaid Services (CMS), and partially determines CMS hospital incentive payments.[22]

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[18] The two physician groups are the American Medical Association (AMA) and the American College of Physicians (ACP). The quote is from ACP's "Statement of Commitment" for its initiative on Physician Well-being and Professional Satisfaction (https://www.acponline.org/practice-resources/physician-well-being-and-professional-satisfaction). The AMA's StepsForward initiative has similar aims (https://www.stepsforward.org/).

[19] Mark Friedberg, Peggy Chen, Kristin Van Busum, et al., for the American Medical Association, *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy*, RAND Corporation Research Report Series (2013), accessed at https://www.rand.org/pubs/research_reports/RR439.html on 16 September 2018.

[20] See, e.g., Tammy Hoffmann and Chris Del Mar, "Patients' Expectations of the Benefits and Harms of Treatments, Screening, and Tests: A Systematic Review," *JAMA Internal Medicine* 175 (2015): 274-286, and the related commentary, Deborah Korenstein, "Patient Perception of Benefits and Harms: The Achilles Heel of High-Value Care," *JAMA Internal Medicine* 175 (2015): 287-288.

[21] This was the intent, for example, of $3 billion in recent funding from the Patient-Centered Outcomes Research Institute (PCORI), which was established as part of the Affordable Care Act in 2010 (Lori Frank, Ethan Basch, Joe Selby, et al., "The PCORI Perspective on Patient-Centered Outcomes Research," *Journal of the American Medical Association* 312 (2014): 1513-1514).

[22] Lemeneh Tefera, William Lehrman, Patrick Conway, "Measurement of the Patient Experience: Clarifying Facts, Myths, and Approaches," *Journal of the American Medical Association* 315 (2016): 2167-2168; CMS, *Hospital Value*

Roots in Baconian Philosophy

Modern medicine thus tends to empiricize values, needs, and preferences in terms of individual self-reports and imagines the patient as their final source. The prevailing sense, moreover, is that this way of conceiving values is value-neutral, which in turn is often well-regarded in a modern societal context of diverse values. But this value-neutrality unfortunately does not hold. The empiricization of values itself constitutes a moral philosophy—a stance by which one engages the world. It has a history and is justified on certain warrants and in rejection of others, and as such, is open to critical scrutiny. To make sense of this claim, we do well to turn to a seminal articulator of this move, Francis Bacon. As the historian Stephen Gaukroger puts it, it was Bacon who "inaugurated the transformation of philosophy into science, and philosophers into scientists."[23]

One of Bacon's fundamental moves was to contrast his empiricism to philosophies in which knowledge turns on what he calls "speculation," that is, mere "hard thinking and perpetual working and exercise of the mind." Knowledge, he argues, should be sought not on the basis of "the mental operation which follows the act of sense" but on that of "simple sensuous perception," with a mind free of bias so that it may not "take its own course."[24] The work of understanding is to be "done as if by machinery," methodically attending to the particulars and inductively "rising by a gradual and unbroken ascent, so that it arrives at the most general axioms last of all."[25] He

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Based Purchasing (2017), accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf on 9 August 2018.

[23] Stephen Gaukroger, *Francis Bacon and the Transformation of Early-Modern Philosophy* (Cambridge: Cambridge University Press, 2001), 221.

[24] Francis Bacon, "Novum Organum," in *The Works of Francis Bacon*, vol. 4, ed. James Spedding, Robert Leslie Ellis, Douglas Denon Heath (London: Longman and Co., et al., 1860), preface. I rely on this later work by Bacon throughout my explication of him; he presents his seminal philosophy here with particular clarity, simplicity, and profundity. As Meyer Isenberg notes, such is the great virtue of the classics; secondary works that build on the classics present seminal ideas often less clearly and almost always with greater complexity (M.W. Isenberg, "The Classics and Humanities Curriculums," *Journal of General Education* 10 (1956): 49-54).

[25] Bacon, *Nov Org*, I.14.

distinguishes, in this way, between knowledge as "anticipations of nature"—which are prone to the subjective biases of speculation—and knowledge as meticulous "interpretations of nature."[26]

The warrant for the latter is a crucial feature of Bacon's philosophy. It builds on the ordinary biases and limitations to which the human understanding is prone, which he categorizes into four "idols of the mind."[27] The first set is the "idols of the tribe," so called because these idols are part of the human condition. We are all prone to presume, for instance, more "order and regularity in the world" than there actually is; to select evidence that confirm prior opinions and to ignore those that do not; to erroneously extrapolate from things that we happen to find striking; to restlessly speculate explanations ad infinitum; to believe as true that which we want to be true; to overlook the "deceptions of the senses"; and to resolve nature into abstractions instead of attending to the details.[28]

The "idols of the cave" are the second set of the mind's limitations that Bacon identifies. These have to do with "the peculiar constitution, mental or bodily, of each individual" and their "education, habit, and accident."[29] The third set, "the idols of the market-place," are rooted in language as the medium of discourse and association. Bacon surmises that words are not only governed by our reasoning but also affect it. The problem is that words are typically "framed and applied according to the capacity of the vulgar understanding," are thus inadequate to the truth, and resist later correction by acuter minds.[30] A fourth set, the "idols of the theatre," arises from the dogmas of speculative philosophy.[31]

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[26] Ibid. I.26.

[27] According to Gaukroger, Bacon's doctrine of idols, to which I now turn, is distinct from Descartes's starting point of radical skepticism in the *Meditations on First Philosophy* (1641). The former is not speculative in the way that the latter is, and to that extent, historically proves to be more compelling because the deficiencies of our faculties are plainly evident to all in our daily lives (Gaukroger 222-223).

[28] Bacon, *Nov Org*, I.45-51.

[29] Ibid. I.53-58.

[30] Ibid. I.59-60.

[31] Ibid. I.61 ff.

The idols are thus many, and any knowledge based on our anticipations cannot be trusted. True knowledge, for Bacon, can only be guaranteed by an empirical interpretation of nature that "leaves but little to individual excellence" and "performs everything by the surest rules and demonstrations."[32] To attain it is to grasp a "true model of the world," the truth of which in turn is assured by Truth itself—it bears the "creator's own stamp."[33] Moreover, by the same token, the purpose of truth is moral. It is "to produce worthy effects, and to endow the life of man with infinite commodities."[34] Bacon writes that once the human mind is emancipated of its idols, "there cannot but follow an improvement in man's estate, and an enlargement of his power over nature."[35] Though humans fell from our original state of innocence and dominion, we can restore both to some extent—the former by religion and the latter by the sciences.

Modern medicine, to be sure, is not beholden to Bacon's empiricist philosophy; its normative commitments are not exhausted by it. But medicine is nonetheless indebted to Bacon as a foundational source of its self-understanding. Bacon's ideas, for example, were decisive to the founding of the Royal Society in 1660, and his place is honored with an image on the frontispiece of a major apologia of the Society written by Thomas Sprat in 1667.[36] The Royal Society went on to play a pivotal role in the institutionalization of science in the West, eventually claiming as its fellows all the "leading scientific lights of the past four centuries."[37] In this connection, Bacon's

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[32] Ibid. I.122.

[33] Ibid. I.124.

[34] Francis Bacon, *In Praise of Knowledge*, in *The Works of Francis Bacon*, ed. James Spedding, Robert Leslie Ellis, Douglas Denon Heath (London: Longman and Co., et al., 1858), 123.

[35] Bacon, *Nov Org*, II.52.

[36] Thomas Sprat, *The History of the Royal Society of London, for the Improving of Natural Knowledge* (London: Printers of the Royal Society, 1667). See also Joseph E. Davis, "Reductionist Medicine and its Cultural Authority," in *To Fix or to Heal: Patient Care, Public Health, and the Limits of Biomedicine* (New York: New York University Press, 2016), 33-62, 38.

[37] The Royal Society, "History of the Royal Society," accessed at https://royalsociety.org/about-us/history/ on 9 August 2018.

arguments help clarify some key empiricist commitments of modern medicine that are otherwise taken for granted, specifically, in terms of purpose and warrant.

Bacon paints a grand vision of empiricism's purpose, namely, dominion over nature. He conceives science as a power by which to achieve a divine mandate. Although the mandate is not an intrinsic feature of the method itself, it frames science as a moral enterprise. "Let the human race," Bacon argues, "recover that right over nature which belongs to it by divine bequest, and let power be given it; the exercise thereof will be governed by sound reason and true religion."[38] The method is seen as accountable to a divine order; it is to be deployed in order to bend nature in the service of peace and plenty, not hubris. Thus, longevity was an ambition that preoccupied Bacon, who assiduously detailed in two of his later writings the causes of aging and how aging might be slowed or even stopped by scientific means.[39]

Of course, modern medicine does not invoke a divine mandate in the same way. But it is not that people no longer construe medicine on religious terms; many still do.[40] Rather, religious construals are now largely conceived in terms of personal beliefs as opposed to a public framing of ends. The shift reflects what Taylor observes is a defining condition of modern life: ours is an age in which belief in God is no longer unchallenged or unproblematic but is "one option among others, and frequently not the easiest to embrace."[41] This broader shift seems apparent in the IOM's commitment to patient-centered care: instead of respect for a divine mandate, its moral

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[38] Bacon, *Nov Org*, I.129. This quote is Bacon's response to those who worry about "the debasement of arts and sciences to purposes of wickedness, luxury, and the like." The same divine-moral link is echoed by others who followed. Sprat, who wrote the early historical apologia of the Royal Society, argues that the new science is to be marked by "humility and innocence," such that "it is defign'd not to brave the Creator of all things, but to admire him the more," so as to be "the utmost perfection of the humane Nature" (Sprat 111).

[39] The two writings are *De Vijs Mortis* (1610s) and *Historia Vitae et Mortis* (1620s) (Gaukroger 95-96).

[40] See e.g., Tyler VanderWeele, Tracy Balboni, Howard Ko, "Health and Spirituality," *Journal of the American Medical Association* 318 (2017): 519-520; Daniel Sulmasy, *The Rebirth of the Clinic: An Introduction to Spirituality in Health Care* (Washington, DC: Georgetown University Press, 2006); William F. May, *The Patient's Ordeal* (Bloomington: Indiana University Press, 1991).

[41] Charles Taylor, *A Secular Age* (Cambridge, MA: Belknap Press, 2007), 3.

orientation is to the personal values, needs, and preferences of each patient. The same goes for the physician wellbeing initiatives, which seek to provide physicians the space to achieve greater individual fulfillment.

Bacon also helps illuminate the warrant for empiricism, namely, the failure of speculative thought as overly prone to subjective bias, the idols of the mind. The methodical study of nature is presumed to offer a reliable objectivity that Bacon claims is not otherwise possible. What is more, in setting up empiricism as a foil to what he terms "speculation," Bacon not only indicates how to attain true knowledge but also defines what in fact counts as true knowledge. Modern medicine takes this warrant for granted, and likewise elevates the validity of empirical realities at the expense of others. Although it sets aside the Baconian belief that the truth of empiricism is assured by the "creator's own stamp" on nature, it readily embraces the utility and emancipatory potential of such knowledge.

This perception of what counts as knowledge thus helps explain the strain in the medical literature to understand the causes, nature, and effects of medicine's malaise in objective terms. Relevant experiences are pooled into statistically adequate samples, which are defined in terms of measures that effectively nullify the significance of individual variation and biases. Patients are thus asked whether their needs, values, and preferences have been respected, yes or no. Physician wellbeing is screened as a construct of self-reported burnout or dissatisfaction. Even when studies venture to connect wellbeing to concepts laden with deeper cultural or religious meanings, such as a calling or vocation, the term is empiricized as a personal belief.[42] But by seeking objectivity through self-reports in this way, modern medicine unfortunately reinforces the idea that malaise

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[42] For example, a recent study showing that burned out physicians are less likely than their counterparts to identify medicine as a "calling" defines that notion in terms of a commitment to something that is "personally meaningful." It measures that commitment using six true-false survey items (Andrew Jager, Michael Tutty, Audiey Kao, "Association between Physician Burnout and Identification with Medicine as a Calling," *Mayo Clinic Proceedings* 92 (2017): 415-422).

is an individual-subjective experience. The move obscures the seemingly moral, as opposed to the merely personal, nature of that experience.

The Problem of Disengaged Selves

Medicine's image of the individualized subject as the normative source of value, need, and preference is characteristic of a ubiquitous modern self-understanding that Taylor describes as the "disengaged self." This picture is so part of our sense of self and lived experience—both within and outside medicine—that it has "come to *feel* fixed and unchallengeable."[43] As moderns, he writes, "we think of our thoughts, ideas, or feelings as being 'within' us, while the objects in the world which these mental states bear on are 'without'."[44] The metaphor is spatial. We see our basic dignity as consisting in a disengaged freedom—the freedom to define our own life-plans, make choices, and realize them free of outside inhibitions. This place within is thus nowhere in particular; the self is instead defined in terms of a rightful capacity or power to make and remake one's world. It is such a self, unencumbered by bias, that Bacon's empiricism presupposes.

The problem, however, is that a disengaged self does not allow us to make sense of a reality or good beyond the self so conceived. From within this self, all that is outside is an object of one's instrumental reasoning, an object to be used as a means to achieve one's self-defined ends. According to Taylor, disengagement is prone to a "buffered" identity that is "lived as a limit, even a prison, making us blind or insensitive to whatever lies beyond this ordered human world and its instrumental-rational projects."[45] We are unable, in other words, to conceive a meaning that is not always already self-defined, as anything more than a personal project or means to it. As

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[43] Charles Taylor, *Sources of the Self* (Cambridge, MA: Harvard University Press, 1989), 112.
[44] Ibid. 111.
[45] Taylor*, A Secular Age*, 302.

a result, "our actions, goals, achievements, and the like, have a lack of weight, gravity, thickness, substance … a deeper resonance … which we feel should be there."[46]

A disengaged self, for example, cannot give a coherent response to those who argue that the problem of medicine's malaise is rooted not in its technocratic or commercial imperatives but in what individuals expect health care to be. The physician-ethicist Carl Elliott, for example, observes that the happiest physicians in his experience are those who entered medicine without any illusions about what it would be like. They chose the profession because "they found disease interesting," "had a talent for science," "enjoyed doing technical procedures," or simply liked the "day-to-day business of doctoring." They were not looking for some higher meaning; for them, medicine was "never anything more than a job."[47] The physicians who are disillusioned, by contrast, are those who expected otherwise.

Elliott thus sees the problem of medicine's disillusionment as a kind of disappointment: as medicine becomes ever more "technocratic, impersonal, and bureaucratic, driven by the demands of economics, it loses its magic."[48] Whatever the gains in efficiency or health outcomes, the work becomes decidedly less fulfilling because most doctors "do not want to imagine their jobs as anything like those of accountants or middle managers."[49] That is not what they signed up for. The result is an increasing misalignment, in other words, between physicians' internal perceptions of themselves as engaged in an essentially humanitarian enterprise and an external perception of medicine as a business.[50] As the sociological realities of medicine increasingly reflect and validate the external perception, the disillusionment grows.

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[46] Ibid. 307.

[47] Elliott 96-97 (see fn. 8 for full citation).

[48] Ibid. 94; Or as others have put it, medicine becomes "disenchanted" or loses sight of its meaning or sense of identity (see, e.g., the Dugdale (2017) and Rosenthal (2016) articles cited in the introduction to this chapter).

[49] Ibid. 93.

[50] The potential for this type of disjunction in meaning perceptions to cause disillusionment can be backed up by empirical evidence. A recent study based on 50 in-depth interviews with clinicians providing emergency-only

Insofar as the structures of medical practice now treat physicians "as skilled technicians trading services in the marketplace," Elliott argues, the solution may not be to insist ever more stridently on high-minded professional ideals or ethical theories.[51] In fact, doing so is likely only to deepen the disillusionment. Perhaps, he concludes, it would be better if physicians did not feel obliged to "put on a mask of idealism,"[52] if they adjusted their expectations. To be sure, Elliott is not decisive in this conclusion; he comes across as almost agnostic. But this is also my point. On my reading, Elliott is working with the same disengaged picture of the self: he conceives the question of meaning in terms of individual perception, of personal belief or opinion. He thus lacks a basis for making a normative judgment as to what the meaning of medicine ought to be.

It is tempting to dismiss Elliott's conclusion as mere cynicism. But he illustrates the basic incoherence of the self-image that underlies much of medicine today. Medicine understands itself to be a practice that is oriented to the patient as its good, specifically, to a disengaged subject of values, needs, and preferences. But this orientation paradoxically also undermines the very coherence of medicine's commitment to the patient in the first place. The commitment can be dismissed as just another opinion or nostalgic belief about what medicine's meaning ought to be. It leaves medicine bereft of a clear rationale for its stance against the impersonal workings of the health care system. Or worse, it fails to dispel a lingering suspicion that physicians' appeal to patient-centeredness may in fact be self-interested.[53]

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hemodialysis to undocumented immigrants, for example, found that "feeling compelled to perpetrate injustice and provide inferior care due to a nonmedical factor (immigration status)" is an important driver of clinician moral distress and burnout (Lilia Cervantes, Sara Richardson, Rajeev Raghavan, et al., "Clinicians' Perspectives on Providing Emergency-Only Hemodialysis to Undocumented Immigrants: A Qualitative Study," *Annals of Internal Medicine* 169 (2018): 78-86.

[51] Elliott 96.

[52] Ibid. 89.

[53] This general suspicion reflects the politicization of physicians' professional authority in the latter half of the 20th century with the growth of a popular distrust of that authority and the rise of bioethics to counter it (see Jonathan Imber, *Trusting Doctors: The Decline of Moral Authority in American Medicine* (Princeton: Princeton University Press, 2008). The historian Albert Jonsen helpfully notes a moral paradox that, "like a geographical fault, penetrates the terrain of medicine," namely, between self-interest and altruism. Physicians experience their

What is more, this lack of coherence constrains medicine to treat malaise not as a moral problem but as that of burnout, a "syndrome" linked to one's "sense of reduced personal accomplishment."[54] Great urgency now surrounds individual-focused and structural interventions to prevent and reduce burnout. Mindfulness training, stress management, small group discussions, and institutional policies like limits on duty hours have all shown measurable results.[55] But for all that, one feels that these efforts may in fact be missing the point, namely, malaise. Indeed, a recent medical commentary raises this precise point, noting the dearth of any real understanding about the origins or root causes of burnout.[56] Critiquing the present rush to treat the issue as a "national crisis," the commentary rightly calls for further introspection as to the deeper roots of physician misery.

Objective Meaning and its Subject

In a seminal 1975 article, "Regarding the End of Medicine and the Pursuit of Health,"[57] Leon Kass proposes a conceptual gain on the individual-subjective conception of meaning that currently prevails in medicine. Anticipating my critique above, Kass rejects the modern medical paradigm as lacking the necessary grounds on which to see and address what ails it. Within its scientific perception, he writes, questions about the good have "no cognitive status and are not subject to

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responsibilities as divided between using their skills for self-satisfaction or support and responding to others' needs ("Watching the Doctor," *New England Journal of Medicine* 308 (1983): 1531-1535). Influential histories of US health care have indeed explored the ways in which physicians have long leveraged their professional authority to serve not only the sick but also their own economic power (see, e.g., Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), 21-28; Jeffrey L. Berlant, *Profession and Monopoly: A Study of Medicine in the United States and Great Britain* (University of California Press, 1975), 64-127).

[54] See, e.g., Colin West, Liselotte Dyrbye, Patricia Erwin, and Tait Shanafelt, "Interventions to Prevent and Reduce Physician Burnout: A Systematic Review and Meta-analysis," *Lancet* 388 (2016): 2272-2281.

[55] Ibid.

[56] Thomas Schwenk and Katherine Gold, "Physician Burnout—A Serious Symptom, But of What?" *Journal of the American Medical Association* 320 (2018): 1109-1110.

rational inquiry—they are, as we are fond of saying, values, and therefore, merely subjective."[58] He instead defines medicine's end in terms of health as nature's telos, the good of which is objective, that is, independent of any subjective valuation. Only as such, he claims, can health orient a medicine that warrants our trust. He offers what might be termed a natural law approach.

Kass argues that the source of medicine's malaise is a fundamental confusion as to its purpose. Few doubt that health is medicine's end, but the problem is that we are unclear as to what health is exactly. Even as technology has broadened the scope of what medicine is able to do, people are no longer "simply charmed by the profession's diagnostic and therapeutic wizardry." Technology has instead blurred the lines of what medicine can do or should do, and it is no longer possible to take for granted the good of what medicine does. Kass fears that without clarity about this good, modern medicine risks being reduced to "a set of powerful means" and the physician to "a scalpel for hire, selling his services upon demand."[59]

Kass observes that medicine is often tempted in its confusion to take an expansive concept of happiness as its goal. This happiness is understood in terms of "gratifying or satisfying patient desires" or achieving the World Health Organization's "state of complete physical, mental, and social wellbeing." Alternatively, medicine tries to prevent crime, promote moral character, tackle poverty and discrimination, enhance human capacities, perfect the species through eugenics, or even prevent death. But all such goals, he argues, are "false goals"; they are "perversions" of the medical art. They either exceed the bounds of medical reason and what it can deliver or are only tangentially related to its proper goal, namely, health.[60]

What then is health? Kass cannot define health on medical terms or capacities since that only begs the question. If medicine must be identified with reference to health as its end, then

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[58] Leon Kass, *Toward a More Natural Science: Biology and Human Affairs* (New York: The Free Press, 1985), 7.
[59] Kass, "End of Medicine," 12.
[60] Ibid. 13-18.

health must be defined on its own terms. Kass thus conceives health as "a natural standard or norm." It is a natural "well-working of the organism as a whole," and "reveals itself in activity as a standard of bodily excellence or fitness."[61] This definition denies that health is a purely relative, social construct. It takes seriously the fact that one can experience health independently of one's ability to define it and that for all the variations in care across cultures, "some form of medicine is everywhere practiced."[62] Positively, the definition identifies health as a determinate state of being: it is seen as a bodily condition that is recognizable—even if not always definable—and more or less attainable. While Kass acknowledges the "soul" as relevant for how health is valued, he sets it aside for the purposes of defining what health is as an end.[63]

Health therefore always already exists in nature and is in principle objectively knowable. Specifically, the human body shows itself to be "naturally teleological" and to have its own determinate well-working wholeness. Kass claims that "medicine knows, but [the science of] biology denies, that nature in living bodies is not neutral to the difference between health and disease."[64] The body is made up of parts with distinct functions contributing to the whole and matures irresistibly into an adult body. When organs and tissues become damaged, they display a remarkable ability to heal themselves, to restore wholeness.[65] Likewise, the human body is never static; its functions show themselves to have a dynamic range between excess and deficiency, even if our definition of the "normal" may be arbitrary to some extent.[66]

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[61] Ibid. 28-29.
[62] Ibid. 24.
[63] Ibid. 19.
[64] Kass, *A More Natural Science*, 12-13. Indeed, for Kass, all of nature is "hierarchic and tends, at least in part, toward the emergence and growth of higher powers of freedom, awareness, and self-awareness, now culminating in man." For more on this, see the chapter "Teleology, Darwinism, and the Place of Man: Beyond Chance and Necessity?" (Ibid. 249-275).
[65] Kass, "End of Medicine," 26.
[66] Ibid. 27.

It is precisely as this natural norm that health is something about which a physician can be said to be an "expert." Kass argues that physicians must be knowers who in principle know "how our bodies work and how they should work." Without this presumption, the very act of medicine would make little sense. How else could physicians justify doing harm—prescribing unpleasant medicines or surgically mutilating a body part?[67] To be sure, health is dependent to a large extent on "our whole way of life," including our temperament, character, and habits.[68] Our agency can often blur the lines between want and need, and complicate the physician's clinical obligations.[69] But in the final analysis, Kass insists, the physician's loyalty is to the well-working wholeness of the patient's body, not to the patient per se. The idea is to recognize "what a wonderful and awe-inspiring—not to say sacred—thing the healthy living human body is."[70]

Why Nature's Teleology?

Kass's description of health in terms of a natural teleology contrasts with empirical presumptions of nature's purposelessness. Far from being value-neutral, our bodies exhibit an intentionality toward a well-working wholeness that medicine is bound to respect. This is why he imagines the physician as a "minister" of health—someone who aids the ill body in cooperation with not only the patient but also nature itself.[71] Kass, in other words, sees health as an objective, pre-political end of medicine: it is a good not because medicine happens to aspire to it, but medicine aspires to it because it is a good already.

The question is whether Kass succeeds in showing that health is indeed a good to which medicine rightly aspires. Granting for the sake of argument that nature is teleological, why should

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[67] Ibid. 21.

[68] Ibid. 30.

[69] Kass, *A More Natural Science*, 196-197.

[70] Ibid. 198.

[71] Ibid. 198, 200.

its intentionality, in itself, warrant a physician's uncompromising loyalty? That is, given the technologies at our disposal, such as for enhancing our bodies, capacities, or reproductive outcomes, why should our intentions and aspirations not override that of nature? Kass is unclear on this question insofar as he relies on the same disengaged picture of the self that underlies much of modern medicine.

Kass confronts this question when he discusses the growing pressures in medicine to treat its care as a service to be "provided" and "consumed." He rejects in particular the "notion that a person has a[n unlimited] right over his body," and instead, argues that the physician's normative end is the healthy body, not the patient's wishes. But why should that be the case? The reason, tellingly, is not nature's teleology. Kass instead appeals to the fact that health is *already* valued by medicine as a basic good. He notes that the profession's "very foundation presupposes … the precariousness of human life and the dependence of all good things on a well-working body."[72]

The problem with this appeal, however, is that Kass cannot have it both ways. The normativity of health cannot be grounded in both nature's teleology and the fact that it is already valued by medicine. The point of the former is to establish health as a self-evident good capable of directing medicine and not being directed by it. The latter, however, suggests that the good of health is dependent on medicine's prior valuation of it. In other words, Kass's appeal to the latter begs the question. If health as well-working wholeness is a good because medicine already values it as a good, then why should this health define modern medicine in the first place? The move forgets the very thing Kass set out to establish. The initial question reemerges: why should the false goals he identifies be seen as "perversions" of the medical art? He answers that it is because they fall outside the domain of health as he understands it, but if that health is delimited by

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[72] Ibid. 198.

medicine's valuation, then the answer only returns to why medicine should orient itself to that health, and so on in a circle.

This circularity means that Kass fails to establish health as a pre-political norm—the type of norm that he suggests is necessary to orient modern medicine and clarify its meaning. This is the case barring an explanation for why a natural teleology should inspire our awe and necessarily override our aspirations to use our bodies as we deem fit. This, I noted, Kass fails to do, and the basis of his insistence that his definition of health be normative is consequently unclear. For one, it is unclear that bodily well-working wholeness, in itself, *is* actually what inspires physicians' awe or is capable of reliably doing so. But more importantly, it is unclear why this health, in itself, *ought* to inspire medicine's respect as its end. Even Kass at the end acknowledges that "it is not mere life, or even a healthy life, but rather a good and worthy life for which we must aim."[73] So then why should mere health be our end in modern medicine?

In other words, Kass seems unable to explain why a bodily well-working wholeness should be medicine's end without presupposing that medicine values it already or is competent with respect to it. My claim is that this inability is rooted in the untenable picture of the subject that underlies Kass's conceptualization of the problem. Kass criticizes the scientific paradigm for sidelining the larger human questions as matters of personal value. But for all that, the same concern to avoid the "problem" of subjectivity—the Baconian idols of the mind—seems to drive his search for an objective end of medicine. In both, the presumption is that the knowing subject must be disengaged from that which is known if she is to know it as truth. But the problem for Kass is that a disengaged self cannot conceive a good beyond the self; it cannot make sense of his claim that health, as he defines it, is the good to which medicine must aim.

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[73] Kass, "End of Medicine," 42.

The Regime and its Subject

The above critique of Kass does not establish that an objective end of medicine cannot succeed in principle, but it suggests that any such account must make sense of its goodness for us as subjects of meaning. This subjectivity, moreover, must be more than that of a disengaged subject. In more recent years, an alternative Foucauldian line of inquiry into medicine's malaise seeks to offer this richer analysis of our nature as subjects, specifically, with how it comes to be constituted.[74] This marks a potential gain on our self-understanding as subjects of value. Our subjectivity, on this view, is determined by the power exercised by particular "regimes of truth," including that of medicine. The individual subject is not the ground of value but always already constituted by a value-defining regime, or what Foucault calls "the gaze." This gaze, more specifically, is that of the corpse. But in my view, this critical theoretical perception of the self also falls short.

The gaze of the medical regime, according to Foucault in *The Birth of the Clinic*, is made possible within the space of the hospital clinic of nineteenth century France. This clinic orders medical science on "the exercise and decisions of the gaze,"[75] and is the organizational context in which the gaze comes to constitute the modern medical experience. The clinic sustains the gaze as not just that of any observer but "that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and intervention." It authorizes the doctor not only to grasp a body's surface but to probe and penetrate it in search of "the deviant," and to do so in a stance not of passivity but of calculation, weighing chance and risk.[76] The clinic, in other

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[74] Jeffrey Bishop represents perhaps the most thoroughgoing example of this approach (*The Anticipatory Corpse* (2011); see fn. 9 for full citation). He explores how the Foucauldian gaze of death has come to structure modern medicine, which now "comes to construct for us our care of the dying" (8). My analysis in this section focuses on Foucault's original "archaeology" of the clinic and its gaze given its unmatched profundity and conceptual power, but I will return to Bishop's insights afterwards.

[75] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, translated by A.M. Sheridan Smith (New York: Vintage Books, 1994), 89.

[76] Ibid.

words, organizes a particular mode of medical knowledge or method that is "bound up with the emergence of the doctor's gaze."[77]

The clinic organizes the gaze but does not define it; the gaze is constituted by its own structure and discourse. In the preface to his work, Foucault contrasts the doctor-patient discourses exemplified by Pomme in 1769 and Bayle in 1825. In the former, the doctor asks, "What is the matter with you?" whereas in the latter, the question is, "Where does it hurt?"[78] Foucault sees in this change a decisive shift in the "spatialization" and "verbalization" of the medical gaze. In 1769, doctors are observers who must *listen* and *be told*, whereas by 1825, they presume to *see* and *say* the source of the hurt. There is a shift of *depth* in the structure of their knowledge, a change in the very rules of how knowledge is formed.[79] Doctors now probe below the body's surface into "what had previously been below and beyond their domain."[80]

This shift is made possible by a fortuitous development, a new way of opening up corpses at the turn of the eighteenth century, what Foucault calls "the age of Bichat."[81] Prior to Bichat, death was "the end of life and, if it was in its nature to be fatal, it was also the end of the disease; … in death, disease reached the end of its course, fell silent, and became a thing of memory."[82] But this presumption is questioned when the clinic enables corpses to be opened up *immediately*. The

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[77] Ibid. 91.

[78] Ibid. xviii.

[79] Ibid. 137.

[80] Ibid. xii.

[81] It is not the case that corpses were previously banned from being opened, as though "the need to know the dead must already have existed when the concern to understand the living appeared" (ibid. 126). Foucault argues that the common narrative that "with the coming of the Enlightenment, death, too, was entitled to the clear light of reason, and became for the philosophical mind an object and source of knowledge" is historically false; it was perpetuated in the history of medicine as "retrospective justification." The clinical gaze, in other words, was not a realization of some eternal truth going back to Hippocrates, which was somehow unjustly repressed by "an anatomical church militant."

[82] Ibid. 140.

development collapses the gap between "pathological time and the first stage of cadaveric time," such that disease now reveals itself even in death.[83]

With Bichat, then, knowledge of disease and life finds its touchstone in death, which in freezing time, allows an objective "grasp on the truth of life and the nature of its illness."[84] From here, Foucault claims, it is only a small step to Broussais, who soon inaugurates a medicine of pathological reactions in which the gaze is directed "upon a space filled with the forms of composition of the organs."[85] This gaze dominates the task of medicine thereafter: through the nineteenth and twentieth centuries, its primary task is to identify which organ is sick, explain how it became sick, and eliminate the cause and its symptoms. Broussais, in Foucault's telling, finally constitutes "the historical and concrete a priori of the modern medical gaze."[86]

The modern medical gaze is thus a way of *seeing* deeper. But not only that, it is also a way of *saying*, of defining truth. As the new spatialization of the gaze makes the invisible visible, a rational discourse of the clinic develops to grasp the previously unseen. Language is opened to "a certain qualitative, ever more concrete, more individualized, more modelled refinement."[87] In describing what is seen, moreover, medicine simultaneously comes to know, for "by saying what one sees, one integrates it spontaneously into knowledge."[88] The gaze is thus "a speaking eye" that masters and teaches, and through "repetitions and convergence," reserves knowledge for those who have been initiated or are deemed worthy to be so: "this speaking eye would be the servant of

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[83] Ibid. 141.
[84] Ibid. 144.
[85] Ibid. 190-191.
[86] Ibid. 192.
[87] Ibid. 169.
[88] Ibid. 114.

things and the master of truth."[89] In this way, it places the patient "in parentheses"[90]; the patient experience is seen as irrelevant to that which the gaze must see and say.

The medical gaze is thus sovereign, and this is a crucial point in Foucault's analysis of the medical experience. The gaze does not merely override the patient's perspective on her pain or suffering but dictates the very truth of her experience. In passing over the body, around it, and into it, the gaze brings to the seen "nothing more than its own light"; the gaze is not just a light in the darkness, but "flickers around solid objects and, in so doing, establishes their place and form."[91] This sovereignty rests on the postulate that in principle "all that is *visible* is *expressible*, and that it is *wholly visible* because it is *wholly expressible*."[92] The gaze presumes to signify the signified without remainder. But regardless of the validity of this premise, Foucault contends, the gaze thereby constitutes a "regime of truth" that defines and organizes modern medicine.

The sovereignty of this clinical gaze is such that it has come to constitute us in our wider political existence as well. What this gaze sees and states defines for us our self-understanding: we now see ourselves as objects of our own scientific knowledge and discourse, as essentially finite.[93] In *The History of Sexuality, Vol. 1*, Foucault calls ours an era of "bio-power." The sovereign power over death is conceived as a power over life. States deploy a disciplinary power of an "anatomo-politics of the human body" as well as a "biopolitics of the population."[94] Through precise and comprehensive regulatory controls, it "endeavors to administer, optimize, and multiply" life for the purposes of production.[95] Our subjection to the scientific gaze is thus seemingly complete

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[89] Ibid. 115.
[90] Ibid. 8.
[91] Ibid. xiv.
[92] Ibid. 115.
[93] Ibid. 197.
[94] Michel Foucault, *History of Sexuality, Vol. 1: An Introduction*, translated by Robert Hurley (New York: Pantheon Books, 1978), 139.
[95] Ibid. 137.

with few places for us to turn. Death constitutes not only the a priori of our medical experience but also that of our politics.

But how does this gaze come to constitute us as subjects, dictating our perceptions in this way? Foucault's answer has to do with his understanding of power. The truth of the gaze "induces regular effects of power," a "general politics" of truth. This power is not just a sovereign or legal power to prohibit, but is productive: "it induces pleasure, forms knowledge, produces discourse."[96] It controls our discourses, techniques, and procedures of truth and the social status of its purveyors. Such power, Foucault observes, is not possessed by a particular individual, institution, or class; it is instead diffuse and its coherence can only be read in terms of strategy and effect. Individuals and institutions, on this view, are operating only a "microphysics of power" and are not its source or mastermind.[97]

In other words, we are all subjects of a power that precedes us. Far from being its author, we cannot but inhabit the regime's mechanisms of power and perpetuate them. In *Discipline and Punish*, Foucault describes the workings of this power as both absolute and "absolutely discreet." First, we are observed: the hospital, for example, is organized to monitor patients so as to optimize their treatment and environment.[98] Second, by establishing programs, regulations, and everyday processes like the duration of a task, we are normalized into certain judgments about expectations, values, and the conformity to be achieved.[99] Third, we are examined on the basis of these observations and judgments; we are documented and fixed as cases, and in this way, held

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[96] Michel Foucault, "Truth and Power," in *The Foucault Reader, edited by Paul Rabinow* (New York: Vintage Books, 2010), 51-75, 61.
[97] Michel Foucault, *Discipline and Punish: The Birth of the Prison*, translated by Alan Sheridan (New York: Vintage Books, 1995), 23-24.
[98] Ibid. 172.
[99] Ibid. 183.

fast in the regime's "mechanism of objectification."[100] These, then, are the basic microphysics of power by which we participate in our own subjection to the objectifying gaze.

Drawing heavily on these Foucauldian ideas, Jeffrey Bishop argues that medicine has yet to escape the clinic's objectifying normativity of death. Both the physiological and statistical branches of today's medicine "deploy a metaphysics of control, of efficient causation, where efficiency is their highest value."[101] It thereby imposes a dehumanizing coldness that "alienates the bodies of patients from their capacities, histories, projects, and purposes, which are molded in communities."[102] The patient-physician relationship is thus nothing but an object-subject relation in which the patient is questioned in "much the same way that the corpse is questioned."[103] The significance of patients as particulars fails to register, and medicine instead strives to define and fix the patient with its normalizing social-scientific gaze.

If anything, Bishop claims, the probing of the sovereign medical team has only intensified with new instruments of assessment that purport to see and say not only the bodies of patients but also the social, psychological, and spiritual aspects of their lives. Even as medicine in recent decades has "acknowledged that humans are not mere concatenations of biologically functioning parts," its efforts have only perpetuated its regime of efficient causality. The psychological or social sciences likewise attempt only to say in order to "discipline" the patient within its own categories of knowledge. "What," for example, "could be more damning than to be pronounced depressed, as distinct from suffering depression, when one refuses to be categorized as such?" The regime thus remains sovereign in Bishop's view and the way forward unclear.[104]

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[100] Ibid. 187.
[101] Bishop 89.
[102] Ibid. 309.
[103] Ibid. 91.
[104] Ibid. 92-94.

Alternative Regimes?

Foucault unmasks our predicament in the clinic by excavating the conditions that operate beneath our consciousness and define our "conceptual possibilities" and "boundaries of thought."[105] This is indeed the basic goal of his archaeological method, which he deploys across his many projects, including on the perceptions of madness, the prison, sexuality, knowledge, etc. This is necessary, as Bishop puts it, because "we so inhabit our dogmas … that to question our beliefs—those things that our time and our society have taught us to be true and good, and indeed beautiful—threatens who we are."[106] Given our subjection to the medical regime of truth, we are unable or unwilling to see the problem of meaning for what it is: a problem.

The critical point here is that truth is not independent of our world, the regime that constitutes us.[107] The truths we perceive as subjects are the result of a disciplinary power that is induced by a regime of truth that precedes us. For Foucault, the supposed freedom of the disengaged subject that I said modern medicine tends to presuppose is in fact an illusion. Rather, "we are forced to produce the truth of power that our society demands, of which it has need, in order to function; we *must* speak the truth; we are constrained or condemned to confess or to discover the truth. Power never ceases its interrogation, its inquisition, its registration of truth; it institutionalises, professionalises and rewards its pursuit."[108] Thus, through the absolutely discreet workings of its power, the gaze is sovereign, not the self.

But where does this leave us? Having defined the problem of malaise in terms of our subjection to the medical gaze, Bishop for his part hesitates to offer any easy answers. After all,

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[105] Gary Gutting and Johanna Oksala, "Michel Foucault," *The Stanford Encyclopedia of Philosophy* (Summer 2018 Edition), accessed at https://plato.stanford.edu/archives/sum2018/entries/foucault on 22 August 2018.

[106] Ibid. 94.

[107] Foucault, "Truth and Power," 72-73.

[108] Michel Foucault, "Two Lectures," in *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*, edited by Colin Gordon (New York: Pantheon Books, 1980), 93; emphasis in original.

there are no ready ways of overcoming our subjection, and the danger is that any proposed fix will only repeat the errors of the current regime. But tentatively, he calls for the need to talk more about "living and dying" rather than "life and death."[109] While we may never know the suffering of the other in their full integrity, that is not to say that we cannot respond at all. He ventures that medicine can learn to respond better.[110] Specifically, it must learn from alternative regimes in which a different truth and way of being and knowing might be possible. He alludes, in particular, to religious or other "living traditions" that aspire to be present to the suffering of others.[111] "It just might be," he concludes, "that the practices of religious communities marginalized in modernity and laughed at as unscientific are the source of a humane medicine.... Might it not be that only theology can save medicine?"[112]

Indeed, Gerald McKenny, in his notable work *To Relieve the Human Condition*, reaches a similar conclusion. He identifies a bioethics of "technological utopianism" that lacks any sense of the moral significance of the body, any sense of how to direct and guide the vast powers of medical technology. He thus carefully evaluates a series of proposed solutions, ends his analysis with Foucault, and finally commends a set of Christian attitudes and practices as an alternative regime within which to make sense of the body's moral significance for bioethics.[113] Like Bishop, McKenny is compelled to make this move because there otherwise is no criterion within the sovereignty of medicine's empirical regime, or even within Foucault's archaeological method, by which to evaluate or judge its truth or goodness.

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[109] Bishop 292.
[110] Ibid. 305.
[111] Ibid. 307.
[112] Ibid. 313.
[113] Gerald McKenny, *To Relieve the Human Condition: Bioethics, Technology, and the Body* (Albany: State University of New York Press, 1997), ch. 8.

To be sure, Foucault is not without his own proposed solution. In an interview, he clarifies that the issue is "not that everything is bad, but that everything is dangerous." Our moral response to our subjection should not be "apathy" but a "hyper- and pessimistic activism."[114] The point is constantly to "create ourselves as a work of art,"[115] to define ourselves over against a regime that threatens our original creative act. But McKenny rejects this move, arguing that it is incoherent. Even if one were to define oneself over against every danger, one is still created by the dangers one perceives, which is different from creating oneself per se. No such self-creation seems in principle possible. What is more, Foucault fundamentally lacks any basis for affirming self-creation as a good in the first place. McKenny concludes that to see the normative failings of a given regime at all, an alternative standpoint must be presumed.[116]

However, in my view, any appeal to an alternative regime is not without difficulty; it exposes itself to the very critique on which it establishes itself. That is, if there can be no rational basis for Foucault's identification of self-creation as a fundamental good, then there likewise cannot be a coherent reason for adopting any other standpoint, including a theological one. A theological regime can make no claim on the modern medical experience. While it can bear witness to its own way of life, it cannot provide any shared reasons for why medicine needs saving or why medicine should adopt its standpoint in order to be saved. This is why—self-creation notwithstanding—Foucault denies any interest in finding a "better" regime: "you can't find the solution of a problem in the solution of another problem raised at another moment by other people."[117] While Bishop, for example, suggests that a theological regime would render medicine less alienating, this only defers the bind that Foucault puts him in. It is unclear that a Christian

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[114] Michel Foucault, "On the Genealogy of Ethics: An Overview of Work in Progress," in *The Foucault Reader*, *edited by Paul Rabinow* (New York: Vintage Books, 2010), 340-372, 343.
[115] Ibid. 351.
[116] McKenny 208.
[117] Foucault, "Genealogy of Ethics," 343.

medical regime, for example, would not be alienating to its own "moral strangers"—a Muslim, a Buddhist, an atheist, and so on.

Regimes and the Possibility of Moral Judgment

Foucault's reading of power and truth, therefore, leaves us in a rational impasse. It posits self-enclosed regimes from which we cannot realistically escape and leaves us with no way to discern whether the regime is good or bad, better or worse. But this feels like an odd place to be. It makes a mockery of what Kass notes is a basic human longing for meaning, to know "which way of life or form of regime is better or best and why"; it "relegates to oblivion human inwardness, purposiveness, and consciousness."[118] Kass's target here, of course, is not Foucault but the ways in which science crowds out the rationality of our subjectivity and our need to know what is better or best. But Foucault's account shares the same incapacity, and this, I now show, is suggestive of a common source of incoherence, namely, the disengaged self.

Our inability to make sense of our moral judgments regarding the regime in Foucault reflects the picture of the knowing self that is built into his archaeological method. In excavating the conditions of modern medical experience, Foucault presumes a scientific view from nowhere. In effect, he fails to escape the sovereign gaze of the regime which he seeks to dissect. The result distorts our ordinary experience of subjectivity and its orientation to truth. As Taylor puts it, the account "leaves out—or better, it blocks out—the possibility of a change of life-form which can be understood as a move towards greater acceptance of truth."[119] In other words, the problem with Foucault's approach is that there is in fact no view from nowhere; he is merely perpetuating the

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[118] Kass, *a More Natural Science*, 4-6.

[119] Charles Taylor, "Foucault on Freedom and Truth," in *Philosophy and the Human Sciences: Philosophical Papers 2* (Cambridge: Cambridge University Press, 1985), 152-184, 180.

gaze, as it were, gazing upon the gaze. The result is a false picture of our medical experience; he fixes us in yet another objectifying gaze, namely, as creatures of a regime.

In truth, we are constantly navigating the claims of this or that regime, and we do so in light of our sense of being a particular subject. We experience our identity as a normative point of reference that we cannot avoid. Taylor explicates this idea by using two examples. One is a common biographical experience. When, after a long struggle, I come to realize that I really do love this person, I experience that as a gain in truth. I do so, not because I received a revelation from outside myself, but because "I see this change as a discovery of what I am, of what really matters to me."[120] Truth, in this sense, is tied to my sense of self. The same applies for collective, societal identity. Taylor points as examples to American revolutionaries who rose up against King George III "in the name of the liberties which defined their way of life."[121] In each case, we experience change as a gain—or loss—in truth, and this is tied not to some gaze or regime to which we are subjected but to our self-understanding as a person or people.

The same holds for the problem of medicine's meaning, its regime. Having unmasked the clinical gaze, the question cannot be, to which of the alternative regimes should medicine subject itself? This would entail a radical act of choice that ignores the choosing agent's sense of self, as though that were even possible. Regimes are complex and ever-evolving, and our judgments about them are inescapable. They are not as hermetically self-enclosed as Foucault suggests, for that makes nonsense of our restless need for truth—to know what is better or best. In other words, to determine medicine's meaning is to struggle over its interpretation in light of our self-interpretation, our own sense of self as particular human beings. The struggle is not just over the

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[120] Ibid.
[121] Ibid. 181.

truth of this or that regime but over nothing less than what matters to us and who we are or aspire to be.

The Hermeneutical Self and its Meanings

The significance of our self-identity to what matters and what is known brings this chapter to the hermeneutical self. In order to explicate this crucial picture of the self, I now turn to Taylor. I do so as a conceptual gain on the disengaged self, the presupposition of which I have argued is the basic error of the accounts considered above. A disengaged subject is interested in the question of *what* medicine's meaning is or ought to be, as though it were merely one object among others. Its self-image occludes the importance of asking *why* a given meaning—whether a patient as value-source, nature's telos, or a particular regime—is or should be judged as a good. Why, after all, should we care about its occlusion or loss? In order to make sense of *both* the what and the why of this sense of loss, I propose, a hermeneutical self-understanding is necessary.

Hermeneutics is a mode of interpretation that seeks to make sense of, or make coherent, an object that is otherwise confused, incomplete, contradictory, or unclear in some other way. It deals in this way with meanings, the sense an object has for us.[122] A key feature of hermeneutics, moreover, is its embrace of the "hermeneutical circle," the idea that there is no interpretation without presupposition. A shared reading of an object presumes a shared vocabulary and recognition of the same problem and solution. The uncertainty—or Baconian bias—inherent in this mode of knowing is regarded as "an ineradicable part of our epistemological predicament."[123] An empiricist like Bacon looks to sense-data to escape the circle and discover verifiable objective

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[122] Charles Taylor, "Interpretation and the Sciences of Man," in *Philosophy and the Human Sciences: Philosophical Papers 2* (Cambridge: Cambridge University Press, 1985), 15-57, 15.

[123] Ibid. 18.

knowledge. But to do so is to miss important dimensions of human understanding, in particular, the significance that any such understanding has for us.[124]

The idea of the hermeneutical self presumes that any act of making sense by a person necessarily involves not just an object but also a subject for whom the object matters. Without such a subject, as Taylor puts it, "the choice of criteria of sameness and difference, the choice among the different forms of coherence which can be identified in a given pattern, among the different conceptual fields in which it can be seen, is arbitrary."[125] An object's meaning is in fact always already "for or by a subject"; it is inescapably bound up with our sense of self. In other words, we do not reflect on an object's meaning as disengaged subjects; rather, who we are or aspire to be is constitutive of the very coherence of that object. Otherwise, why would it even occur to us to ask what it is?

Taylor illustrates this point with the phenomenon of shame. A person could not feel shame at his shrill voice, for example, if he did not already aspire to be a person of a certain sort. Rightly or wrongly, he must already ascribe an import or meaning to his shrill voice such that he knows it to be shame-worthy and feels shame about it.[126] Likewise, if I did not already aspire to be an independent person who is respected as such by others, then the norm of autonomy would not be important to me. I would have no reason to subscribe to it or say that it is true or false.[127] Any shame one may feel in each case is thus what Taylor calls "subject referring." Unless the self is seen as hermeneutical in this sense—as self-interpreting in its interpretive relation to the world—the ordinary experience of emotions like shame would cease to make any sense.

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[124] Ibid. 21.
[125] Ibid. 16.
[126] Charles Taylor, "Self-Interpreting Animals," in Human Agency and Language: Philosophical Papers 1 (Cambridge: Cambridge University Press, 1985), 45-76, 53.
[127] Ibid. 60.

The experience of shame further clarifies two important features of our hermeneutical ontology: as self-evaluative beings, we (1) inhabit a field of social meanings and (2) do so in relation to certain strongly valued goods. I will explore each feature at greater length in chapters two and three of this dissertation, respectively, but I introduce them here briefly in order to indicate what the hermeneutical self entails with respect to the problem of meaning and its experience in modern medicine.

The first insight is that we do not aspire to be a certain kind of person in isolation. Taylor observes that the meanings things have for us always exceed the individual. They depend on "the distinctions and categories marked by the language people speak," that is, "with the level and type of culture" inhabited by the subject for and by whom the meaning is.[128] There is no simple correlation between what an individual says and a thing's meaning as such. An empiricist might say that the word "shame" fully describes a feeling that is already objectively shameful or that thinking something as shameful can make it so.[129] But in fact, Taylor finds that language not only allows us to represent an emotion in a more sophisticated manner but also enriches the very experience of it.[130] We can and often do express our meanings in more than one way. This is not because we are predetermined to do so or choose a thing's meaning from nowhere, but because we always already interpret as inhabitants of a field of meanings, a culture.

This field of meanings, moreover, is not just "a converging set of subjective reactions," as it might be for an empiricist.[131] That is, the objects of meaning are not value-neutral entities on which we then each project our individual-subjective meanings. What counts as shameful is not a

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[128] Taylor, "Interpretation," 25.

[129] Foucault, for example, observes that the empirical gaze is premised on the postulate that the visible is expressible, the expressed is known, and that in principle "it is wholly visible because it is wholly expressible" (see fn. 91 for reference).

[130] Taylor, "Interpretation," 26.

[131] Ibid. 40.

matter merely of a person's personal opinion. Many social meanings in fact precede us as individuals; they are "out there" and constitute the practices that condition our modes of social relation. Taylor specifies two types of such realities: "inter-subjective meanings" and "common meanings." The first set pertains to the distinctions and vocabulary that constitute particular social practices. Without "a distinction in men's self-interpretations between autonomy and forced choice," for example, no amount of marking and counting pieces of paper would constitute voting.[132] The second set of meanings applies to ideas of significance that constitute a common reference world, such as the idea of democracy. These are the bases of our debates and public life and define our society for what it is.[133]

The second, concomitant insight of the hermeneutical self is that experiences like shame presuppose a certain orientation to the goods that constitute our sense of self. We inhabit our meanings on evaluative terms that are self-constitutive as opposed to merely instrumental. To make this point plain, Taylor distinguishes between "strong" and "weak" evaluations.[134] In the latter, we evaluate in terms of such simple criteria as convenience, satisfaction, or efficacy. But Taylor claims that we often do much more than that. We also evaluate the "qualitative worth" of different choices, characterizing them as good or bad, admirable or base, courageous or cowardly, worthy or trivial, and so on.[135] In so doing, we "speak in terms of the kind of quality of life which it [our choice or desire] expresses and sustains" or to which we aspire.[136] We presuppose a sense of self that is already oriented to strongly valued goods, those by reference to which we grasp our

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[132] Ibid. 35.
[133] Ibid. 39.
[134] Charles Taylor, "What is Human Agency?" in *Human Agency and Language: Philosophical Papers 1* (Cambridge: Cambridge University Press, 1985), 15-44, 15.
[135] Ibid. 16.
[136] Ibid. 25.

lives. Those who lack any such orientation would not only be incapable of feeling shame but also be deeply incoherent as to who they are or aspire to be.

Conceptual Gains on Malaise

The hermeneutical self stands in sharp contrast to the empirical conception of the knowing subject as essentially disengaged. But in articulating it, I am not suggesting that empirical knowledge is undesirable. Empirical surveys of self-reported malaise can indeed be done and often to important effect and insight. My point, rather, is that the hermeneutical standpoint relativizes this knowledge within a space of deeper questions about the meaning of malaise as a human experience. The temptation in modern medicine is to incorporate the moral experience of malaise into its favored empiricist mode of perception. But doing so blinds us to this space of questions; it denies our ordinary ontology as self-evaluative creatures. Attending to this ontology, therefore, clarifies important features of malaise that are otherwise missed.

First, the hermeneutical self explains the sense in which malaise is experienced as a loss of a good that is at once both deeply personal and larger than the self. Malaise in medicine is not an issue merely of personal belief or nostalgia. We exist in a space of meaning-laden social realities, among which is the good of medicine, its source of meaning. The occlusion of that meaning is thus a social loss. But this loss is also that of a self-constituting good. The meaning of medicine does not exist simply as an objective end or regime that is out there and to which one may or may not choose to subscribe. Instead, as strong evaluators, we depend on such meanings or goods to make sense of who we are or aspire to be. The problem of malaise is not that we lack the resilience to experience medicine as meaningful, but that we no longer seem capable of making sense of the significance of the larger meanings in and through which we must orient ourselves as participants in a meaningful practice.

Second, the hermeneutical self clarifies the basic unity in the twofold question with which this chapter began: *what* medicine's meaning ought to be and *why* it should matter to us. The hermeneutical self presents itself as both the source and condition of medicine's meaning. That is, the question of the nature of medicine's good makes no sense without a subject for whom it matters, and indeed, few things are more important to the hermeneutical self than its questions of meaning. By the same token, medicine must respect and foster this hermeneutical self as a necessary good, that is, as a condition of its own possibility. Medicine otherwise cannot make sense of its malaise, much less sustain itself as a meaningful practice.

Sustaining the good of medicine, therefore, is a matter of it being what it always already is. Whatever else might be said of modern medical practice, it is inescapably carried on for and by hermeneutical selves. This is true not only of medicine as a clinical practice but also as a public or global health practice. Regardless of the technical means, medicine is a meaning-filled activity that responds to conditions of health and illness that are themselves implicated in deeply felt webs of meanings. Only by honoring our hermeneutical ontology, I propose, can we experience medicine as a human good. It is unsurprising that a medical culture that so often occludes or blinds us to our hermeneutical nature is increasingly experienced as alienating. This alienation, on my view, is not just a "depersonalization" of a particular person but symptomatic of a deeper "dehumanization" in which we are increasingly incoherent as to why the good of medicine matters to us human beings in the first place.

Conclusion

Medicine's malaise is a symptom of a deeper moral problem of meaning. Yet, I have argued that we cannot make sense of the problem as such without an adequate picture of the self. For all the discourse around medicine's malaise and its source of meaning—its good—the disengaged self that underlies it does not allow us to make sense of the problem as anything more than a personal problem. If we are to sustain medicine as a meaning-filled practice, then we need a conception of the self-interpreting subject for whom the meaning of medicine has a self-constitutive as opposed to a merely instrumental import. Such a self clarifies why the meaning of medicine is not an option but an inescapable question of its practice. In this respect, then, the hermeneutical self is the condition of possibility of a meaningful medicine, and moreover, must be respected and fostered as such, as a good of medicine or its source of meaning.

To be sure, much more remains to be said about the experience of malaise itself, which I regard as a symptom of the deeper problem that this chapter has articulated, namely, that of the self. An adequate grasp of the self is a basic condition for talking coherently about the moral dynamics of clinicians' experience of malaise, but this insight does not exhaust the complexities of the phenomenon itself. I will therefore return to this issue in chapter four in order to further explicate the experience of grief involved and what a proper response to it might look like. The explication, moreover, will be important in two respects: it will not only strengthen the validity of the hermeneutical self by demonstrating the usefulness of its perception but also constitute, in itself, an intervention on the problem of malaise.

That said, if this chapter's articulation of the self as a problem is on target, the malaise in question is also not a delimited, isolable issue. It implicates a pervasive self-understanding that underwrites medical practice and ethics in a global sense. On this score, the antidote is unlikely to consist in insisting upon, identifying, or resisting a particular individual-subjective source of value, objective end, or regime. Rather, on my view, a more constructive way forward may be to further clarify our nature as hermeneutical selves and what it means to engage in medicine as such. Given my critique in this chapter of the persistent presumptions to the contrary, I take this to be no small thing. The burden of proof is on my side of the argument.

A further elucidation of the hermeneutical self and its conceptual gains, then, is the overarching task of the remaining chapters. I begin in the next two by articulating this self as a theoretical question, namely, the sense in which we are constituted by our social meanings as strongly valued goods. This will set the stage in later chapters for more granular analyses of the hermeneutical self and its perceptions in different domains of applied or practical concern in medicine, such as malaise and justice as policy issues.

CHAPTER TWO

A Meaning-Laden Social Ontology of the Self

I argued in the last chapter for the importance of recognizing ourselves as hermeneutical. We are creatures for whom meanings matter, often intensely and always inescapably. That is, we inhabit a field of social meanings that precedes us, and what is more, we do so as creatures oriented by our strong evaluations about them. To miss these two claims about ourselves, as so often happens, is to be incoherent as to medicine's good, much less to care to inquire about it. I want to defend each of the two claims more precisely by clarifying their conceptual gains. I take up the first claim in this chapter before turning to the second in the next. The second claim will thus build on the first in order to clarify an account of what I am calling the hermeneutical self.

What is it to inhabit a field of social meanings in modern medicine? One way to answer is empirically, as a series of observations or self-reports about the effects of social meanings on our behavior or the ways in which we affect those meanings. This would credit what Taylor calls "an atomist view" of their significance, which rests on a Lockean view that the human good is attained essentially alone—as that of a disengaged self. The view conceives social realities in value-neutral, instrumental terms: "what men derive from association in realizing the good are a set of aids only contingently, even if almost unfailingly, linked to this association."[1] This idea, I show, underwrites the prevailing assumptions about the social self in clinical and population medicine today.

By contrast, I will argue for what Taylor calls "a social animal view." This is an Aristotelian view that sees society as constitutive of the individual's good. Here, "a community of language

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[1] Charles Taylor, "The Nature and Scope of Distributive Justice," in *Philosophy and the Human Sciences: Philosophical Papers 2* (Cambridge: Cambridge University Press, 1985), 289-317, 292.

and mutual discourse about the good and bad, just and unjust" is understood to be the condition of possibility for realizing one's good *qua* social animal.[2] Here, the social features that condition our good as selves are conceived as always already value-laden. This contention, by its nature, cannot be proved on empirical grounds. If we exist as hermeneutical selves, as I have argued, it makes no sense to approach such questions of meaning as though from nowhere. Rather, I aim to clarify the matter by appeal to our experiences of disease, illness, and the giving and receiving of care. The idea will be to achieve step-wise gains in coherence across the key accounts of our social ontology as they pertain to these experiences.

I begin in the first two sections with widely accepted accounts of the social self in clinical (biopsychosocial model) and population medicine (social epidemiology). These stand as leading critiques of the dominant biomedical model, specifically, its reductionism and dualism regarding disease causation and the self's experience. I contend, however, that the assumption underwriting both accounts is the disengaged self, and they consequently miss the self-constitutive features of our illness experience as social beings. I instead move toward a hermeneutical ontology of the social self in the third section by building on Arthur Kleinman's medical anthropology. His account of symbolic reality in our illness and care experiences marks a crucial conceptual gain. But pressing beyond him, I ask about his evaluative criterion for inhabiting that reality, and argue with Taylor that a question of orientation to moral goods represents another conceptual gain.

The Biopsychosocial Patient

Is the patient's social experience of disease and illness relevant to clinical care, and if so, what is the nature of its significance? This is the question that the biopsychosocial model, classically articulated by George Engel in 1977, puts to clinical medicine's biomedical presumptions. The

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[2] Ibid.

model is now a standard point of appeal for those seeking to account for the social dimensions of illness. However, as valuable as the model is, I believe it distorts our understanding of the person by presuming that we relate to our social conditions as disengaged selves. To see this point, we do well to consider Engel's critique of biomedicine and his solution in the context of the mid-twentieth century debate about psychiatry's identity. The question was, given the inherent social dynamics of psychiatric conditions, should psychiatry be regarded as a medical discipline?

In 1960, Thomas Szasz published a seminal article, "The Myth of Mental Illness,"[3] which proved to be the basis of his decades-long influence as a leading critic of the medical model of psychiatry.[4] "Illness," he argues, is a medical term that seeks to explain our problems as a "deviation from some clearly defined norm." Yet, the "disorders of thinking and behavior" to which the term "mental illness" refers do not typically have an identifiable anatomical or physiological cause, such as a defect in the brain or nervous system. Neither is there reason to think that research will eventually show otherwise. In the absence of such causes, he asserts, psychiatrists are engaged in a futile effort to fit in with the medical model and have ended up only with such abstractions as "a deformity of the personality."[5]

Szasz in effect contends that mental illness is an artificial construct that perpetuates a convenient illusion, namely, that our social interactions and lives are "inherently harmonious" and that the problem lies in some defect of the "mentally ill" individual. The construct obscures the real problem and functions as a "social tranquilizer," much as religious myths did in the past.[6] It falsely medicalizes what are in fact perennial "problems in living" rooted in "the everyday fact that life for most people is a continuous struggle, not for biological survival, but for a 'place in the

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[3] Thomas S. Szasz, "The Myth of Mental Illness," *The American Psychologist* 15 (1960): 113-118. See also Thomas S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Dell Publishing, 1961).

[4] Jeffrey A. Schaler (ed.), *Szasz Under Fire: The Psychiatric Abolitionist Faces His Critics* (Chicago: Open Court, 2004).

[5] Szasz, "The Myth," 114.

[6] Ibid. 118.

sun,' 'peace of mind,' or some other human value." The real deviation, for Szasz, is not from a biological norm but from psychosocial, ethical, and legal ones. In imposing a medical remedy to such problems, psychiatry misconstrues what mental illness in fact is and perpetuates society's convenient illusions about its own norms.[7]

In response to critics like Szasz, others like Arnold Ludwig argued that psychiatry's concerns should be more clearly delimited so as to ensure its fit within the biomedical domain. Writing in 1975, Ludwig laments that psychiatry "has become a hodgepodge of unscientific propaganda, and politicking for 'mental health' and other esoteric goals."[8] Nonetheless, he insists that "islands of sound, responsible psychiatric practice" can be found—those based on the biomedical model. In this sense, for Ludwig, what critics like Szasz attack is not psychiatry at all but the unfortunate deviations in modern-day practice that can and should be regulated.

Despite the difference in their visions for the field, however, Ludwig shares with Szasz the same basic definition of biomedicine. Ludwig understands the medical model as a distinct "philosophical orientation" toward the symptoms and signs of patients—one in which "sufficient deviation from normal represents *disease*, … the disease is due to known or unknown *natural causes*, and … elimination of these causes will result in *cure* or improvement in individual patients."[9] He departs from Szasz only in arguing that while psychiatric diagnosis may work with lower thresholds of evidence, its practices are not qualitatively different from those of other medical fields. Instead of excluding all mental conditions from the medical model, Ludwig proposes to limit psychiatric concerns to cognitive-affective behavior disorders that are due

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[7] Ibid. 114. From this, Szasz in later writings emphasizes the importance of an individual's freedom to deviate from psychosocial or ethical norms. He argued that just as people are free to partake in religious myths, people should be free to engage or not to engage a psychiatrist or psychotherapist. He was thus an advocate against the institutionalization of psychiatric patients or psychiatric efforts to classify homosexuality as a disease.
[8] Arnold M. Ludwig, "The Psychiatrist as Physician," *Journal of the American Medical Association* 234 (1975): 603-604.
[9] Ibid. 603.

primarily to a “brain dysfunction, either biochemical or neurophysiological.” Conversely, he excludes from psychiatry’s domain mental disorders due to “metaphysiological, interpersonal, or societal causes,” including “problems of living.”[10]

The classic 1977 article by George Engel, “The Need for a New Medical Model: A Challenge for Biomedicine,” steps into this debate about psychiatry’s identity.[11] He does so by turning the debate around into a critique of medicine’s biomedical identity. Biomedicine, to be sure, had been a source of envy for psychiatry: it seemed to have “a firm base in the biological sciences, enormous technologic resources at its command, and a record of astonishing achievement in elucidating mechanisms of disease and devising new treatments.”[12] Yet, Engel argues, its approach fails to account for the psychological, behavioral, and social conditions that impinge not only on psychiatric illness but also on classic biomedical ones.

Engel in this way proposes to dissolve the dilemma over psychiatry’s identity by critiquing the medical model itself as philosophically “reductive” and “dualistic.” Its problem, to be sure, is not the “scientific method.” Engel affirms that diagnosis of disease rightly “progresses from symptoms, to clusters of symptoms, to syndromes, and finally to diseases with specific pathogenesis and pathology.” The merits of this scientific approach to elucidating and classifying disease, as far as he is concerned, “needs no argument.”[13] The issue instead lies in the causal factors for which the model accounts. Engel’s target is the model’s reductive assumption that “complex phenomena are ultimately derived from a single primary principle” and that this principle is “physicalistic,” which presupposes a mind-body dualism.[14]

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[10] Ibid. 604.

[11] George L. Engel, “The Need for a New Medical Model: A Challenge for Biomedicine,” *Science* 196 (1977): 129-136. Engel cites both Szasz and Ludwig as proponents of the two positions on psychiatry to which he is responding.

[12] Ibid. 130.

[13] Ibid. 131.

[14] Ibid. 130.

In reality, according to Engel, a biochemical defect is "a necessary but not a sufficient condition for the occurrence" of even the most obvious medical conditions, like diabetes. It is "but one factor among many, the complex interaction of which ultimately may culminate in active disease or manifest illness."[15] Regardless of the characteristics of a biochemical defect, its experience as an illness is determined in large part by a person's psychological and social conditions of living. This is something that diabetes and schizophrenia have in common. Psychosocial factors affect whether and when the person comes to interpret himself as ill and even his susceptibility to disease and its time of onset, severity, and disease course.[16]

The biomedical model, Engel claims, is in fact a historical anomaly. "In all societies, ancient and modern, preliterate and literate, the major criteria for identification of disease have always been behavioral, psychological, and social in nature."[17] The biomedical model deviates from this tradition because medical scientists devised it for research, not for patient care. The model goes wrong when physicians and other caregivers, in virtue of the model's preponderance in their professional training, fail to distinguish its original purpose from that of clinical care. They instead help perpetuate it as a cultural imperative,[18] distorting our experience of disease and impeding truly scientific care.

The biomedical model in fact defies the plain facts of how a person experiences disease. The model's enviable status, Engel explains, is rooted not in its scientific validity for clinical care but in its utility as a social device. Disease is often puzzling and disturbing, and because our experience of disease is so often characterized by uncertainty and discomfort, it is undesired, if not feared. This in turn gives rise to a need for corrective action against the disease, and the

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[15] Ibid. 131.
[16] Ibid. 132.
[17] Ibid. 130.
[18] Ibid.

model's unprecedented success in that regard has over time elevated it to the status of present-day "dogma." We consequently strain to force even discrepant clinical data to fit the model instead of rethinking the model in light of the discrepant data; failing that, we exclude the data as irrelevant. Ludwig attempts the former by delimiting the scope of psychiatry to fit the dogma so as to secure its social legitimacy. Szasz, for all his differences, also fails to question the dogma; the only difference is that he opts for the latter, excluding psychiatry from medicine.

But at the heart of Engel's critique of this dogma is an underlying claim about the nature of the person. He rejects biomedicine's propensity to reduce the person to the body, instead proposing to see the person as a biopsychosocial entity. In an article on the clinical application of his model, Engel describes the person in terms of a "systems level approach" whereby the patient is regarded as a component part of a systems hierarchy. She stands at "the highest level of the organismic hierarchy," constituted in descending order by a nervous system, organs and organ systems, tissues, cells, organelles, molecules, atoms, and subatomic particles. Simultaneously, she is "the lowest unit of the social hierarchy," constituted in ascending order by two persons, family, community, culture-subculture, society-nation, and biosphere. Each level of the hierarchy exists independently and interdependently: each has its distinct dynamic but none exists in isolation since each is influenced by the configuration of the system as a whole.[19]

The physician's task then is to be a "systems-oriented scientist." While bench scientists may isolate and concentrate on one part of the system, a physician cannot. She otherwise risks the "neglect of, if not injury to, the object of study, the patient."[20] Her responsibility is instead twofold. Each component of the system must be "identified and characterized in detail and with precision," and biomedicine's factor-analytic approach—which holds all factors constant except

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[19] George L. Engel, "The Clinical Application of the Biopsychosocial Model," *American Journal of Psychiatry* 137 (1980): 535-544, 536-537.

[20] Ibid. 536.

the one under study—has proven apt. But she also must not rely exclusively on this method, lest she lose sight of "the rules and forces responsible for the collective order of a system."[21]

In fact, much of the data necessary for diagnosing and caring for patients, Engel argues, "appear in behavioral and psychological forms, namely, how the patient behaves and what he reports about himself and his life." These are necessarily "gathered within the framework of an ongoing human relationship" between the physician and patient.[22] Good patient care therefore depends as much on high-level interview skills and knowledge of the psychosocial determinants of patient experience as on technical procedures and laboratory results. The idea is to understand the psychological and social processes that influence the course of an illness, instead of seeking only "the simplest explanation, preferably the diagnosis of a single disease," and regarding all else as irrelevant to the physician's task.[23]

A Value-Neutral System

To be sure, the biopsychosocial model's influence on medicine, while significant, is far from dominant. The model continues to encounter resistance from the biomedical mainstream, which some contend has limited the model's influence through "encapsulation," as though it were an infection.[24] Nonetheless, the model has arguably made "a new way of thinking about medicine widely available."[25] It has advanced attention to the social dimensions of patient care in ways that the biomedical model could not, and is widely invoked for that purpose. It has indeed seeded major curricular reforms and new fields of medical practice like psychoneuroimmunology,

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[21] Ibid. 537-538.
[22] Ibid. 536.
[23] Ibid. 538.
[24] Richard M. Frankel, Timothy E. Quill, and Susan H. McDaniel, "The Future of the Biopsychosocial Approach," in *The Biopsychosocial Approach: Past, Present, Future*, edited by Richard M. Frankel, Timothy E. Quill, and Susan H. McDaniel, 255-267 (Rochester, NY: University of Rochester Press, 2003), 259.
[25] Ibid. 257-258.

psychosomatic medicine, and social and community medicine. But in my view, it nonetheless misconceives our nature as selves and thus falls short of its stated goal.

Engel writes that "the crippling flaw of the [biomedical] model is that it does not include the patient and his attributes as a person, a human being."[26] A key question, which I answer in the negative, is whether Engel himself succeeds in making sense of the patient as a human being. To be sure, Engel's physician-scientist has a broader scope of concern with respect to the causal factors affecting the patient than the biomedical one. But each factor is value-neutral and bears little relation to the others except in terms of causal effects. The cause-effect relations do not seem qualitatively different from, say, the causal effects of biochemical factors in the biomedical model. The psychosocial dimensions seem only to be additional data points to be accounted for. While the effects of various levels on the patient can "appear in behavioral or psychological forms," these are but the signs of the underlying effect.

In other words, in terms of the non-causal significance that any given factor has for the patient, one scientist is equally in the dark as the other. The person within the hierarchy is in principle simply one object or level among others. She is no different in kind from, say, the subatomic particles at one end of the hierarchy or the biosphere at the other. Although the person may hold a particular significance for the systems-oriented physician, that significance derives not from the intrinsic quality of the patient but from what the physician takes her task to be. According to Engel, the physician's "prime object of study" is the patient but that need not be the case for other scientists, and in fact, it is not. The fact that the patient is the physician's focus is contingent only on the physician's aim in studying the patient as a biopsychosocial entity.

The problem I want to identify here is not necessarily the legitimacy of a physician's aim to fix a biopsychosocial defect. My point instead is that Engel's model misses something essential

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[26] Engel, "Clinical Application," 536.

to what it means to be a human being, namely, a self. It betrays a disengaged self-image that fails to account for the patient as a subject of value for whom things have a meaning beyond the instrumental. Consistent with what Taylor calls "an atomist view," the patient is perceived either to affect social factors or to be affected by them. But the model is blind to the ways in which patients relate to those factors in terms of moral meanings, as good or bad, right or wrong. Any such significance is seen to be determined by an individual's psychological makeup, and knowable only as self-reported data to be factored in with the other levels of the systems hierarchy.

In trying to recover a richer sense of the patient, Engel sees his model as a corrective to the ways in which biomedicine distorts the "boundaries of professional responsibility" and the physician's "attitudes toward and behavior with patients."[27] The patient, he believes, should not be treated reductively, and he strives to do justice to the patient as a more multifaceted entity than the biomedical model allows. However, in viewing the physician's task as a fundamentally scientific one, his model—its aspirations notwithstanding—fails to make sense of the patient as a human being, as something more than one object among others. Engel's picture of the self thus remains reductive. It makes sense of neither why our social world and its meanings exert the influence that they do—beyond the subjective inner workings of an individual's psychology—nor why or whether they should.

The Individual of Populations

If the biopsychosocial model represents a widely invoked clinical image of the individual's relation to the social, we do well also to cover the population perspective, namely, medicine's social image of the individual. I want to show that medicine, given its prevailing epistemology, broadly lacks an adequate vision of the social self even where social concerns take precedence

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[27] Engel, "New Medical Model," 129.

over the individual. Clinical care has traditionally dominated medical concerns, but in recent decades, population approaches to prevention and the structural causes of disease have gained significant traction.[28] It has in the process relativized clinical care as but one social determinant of health among others.[29]

This dynamic is evident, for example, with respect to obesity as a health issue. A growing number of medical associations now regard obesity as a disease—not just a risk factor for other chronic conditions—with pathophysiological causes that require clinical management.[30] But it is equally clear that obesity implicates social factors that reach beyond the clinic or laboratory. It is a rising global pandemic precisely because of causes like increased availability and marketing of energy-dense foods.[31] So even as articles in top medical journals contend with obesity's clinical and surgical management, they all recognize the limits of the physician's ability to manage all its causal pathways.[32] They inevitably regard the clinical approach as but one aspect of a broader campaign to create the social conditions of healthy living.

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[28] The growing national attention on the population perspective is being driven in part by the knowledge that clinical care accounts for comparably little in terms of a people's health. Despite enormous investments in clinical care, Americans are not particularly healthy relative to other nations, as measured by life expectancy and infant mortality. See, e.g., Institute of Medicine, *For the Public's Health: The Role of Measurement in Action and Accountability* (Washington, DC: The National Academies Press, 2011), Introduction.

[29] For a noteworthy example of this sort of reconceptualization, see Robert G. Evans and Gregory L. Stoddart, "Producing Health, Consuming Health Care," *Social Science and Medicine* 31 (1990): 1347-1363.

[30] The American Medical Association, for example, adopted policy in 2013 stating that "Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention" (Policy H-440.842 searchable at https://www.ama-assn.org/form/policy-finder). See also Theodore K. Kyle, Emily J. Dhurandhar, and David B. Allison, "Regarding Obesity as a Disease: Evolving Policies and Their Implications," *Endocrinology and Metabolism Clinics of North America* 45 (2016): 511-520.

[31] The GBD 2015 Obesity Collaborators, "Health Effects of Overweight and Obesity in 195 Countries over 25 Years," *New England Journal of Medicine* 377 (2017): 13-27.

[32] Steven B. Heymsfield and Thomas A. Wadden, "Mechanisms, Pathophysiology, and Management of Obesity," *New England Journal of Medicine* 376 (2017): 254-266, 264. See also Caroline M. Apovian, "The Obesity Epidemic—Understanding the Disease and the Treatment," *New England Journal of Medicine* 374 (2016): 177-179; Edward H. Livingston, "Reimagining Obesity in 2018: A *JAMA* Theme Issue on Obesity," *Journal of the American Medical Association* 319 (2018): 238-240.

In its 2003 report on *The Future of the Public Health in the 21st Century*, the National Academy of Medicine (NAM; formerly the Institute of Medicine) states that "among the greatest advances in understanding the factors that shape population health over the last two decades … has been the identification of social and behavioral conditions that influence morbidity, mortality, and functioning."[33] The report specifically identifies five key determinants as being backed by substantial evidence: socioeconomic position, race and ethnicity, social networks and social support, work conditions, and ecological factors like economic inequality and social capital. The NAM has since published a series of major follow-up reports to address these social and other determinants of population health in terms of measurement, law, and funding.[34]

The research basis for much of this broad interest in social determinants is rooted in social epidemiology, a subfield of epidemiology.[35] The subfield defines itself against traditional epidemiological approaches that regard causal factors in individual and biophysiological terms. Classic case-control and cohort studies establishing smoking as a risk factor for lung cancer, or serum cholesterol and smoking as risk factors for coronary heart disease, were of this sort.[36] Imagining the population as merely an aggregate of individuals, these studies focused on decontextualized measures of individual behavioral or biophysiological risk factors and disease incidence. To the extent social factors were addressed, they were factors to be adjusted for in

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[33] Institute of Medicine, *The Future of the Public's Health in the 21st Century* (Washington, DC: National Academies Press, 2002), ch. 2.

[34] Institute of Medicine, *For the Public's Health: The Role of Measurement in Action and Accountability* (Washington, DC: The National Academies Press, 2011); *For the Public's Health: Revitalizing Law and Policy to Meet New Challenges* (Washington, DC: The National Academies Press, 2011); *For the Public's Health: Investing in a Healthier Future* (Washington, DC: The National Academies Press, 2012).

[35] See, e.g., Lisa F. Berkman, "Social Epidemiology: Social Determinants of Health in the United States: Are We Losing Ground? *Annual Review of Public Health* 30 (2009): 27-41.

[36] This form of epidemiology, for instance, characterized what Mervyn and Ezra Susser have called "the era of chronic disease epidemiology" ("Choosing a Future for Epidemiology: I. Eras and Paradigms," *American Journal of Public Health* 86 (1996): 668-673).

order to isolate the individual behavioral or biophysiological cause. Particularly favored were the biophysiological causes amenable to intervention through the health care system.[37]

By contrast, a central feature of a social determinants view is that it takes the population as its unit of analysis. The classic articulation of this belongs to the epidemiologist Geoffrey Rose.[38] Unlike the clinical approach, the focus is not on screening and treating individuals who are sick or at high risk for a condition. The aim instead is "to shift the whole population's distribution of the risk variable."[39] Rather than trying to manage the high-risk variable of a small minority, it calls for a "mass strategy" that can change the societal characteristics conditioning the low-risk variable of an entire population. The idea is thereby to prevent more cases overall. It accepts what Rose termed "the prevention paradox": "a measure that brings large benefits to the community offers little to each participating individual."[40]

This central paradox involves two basic premises. The first is that disease and risk factors in a population exist along a continuum as opposed to dichotomously. Alzheimer's disease, for example, is only the end result of a series of natural changes that move imperceptibly into increasing dementia. The question is not so much "has he got it?" but "how much of it has he got, and why?"[41] The same can be said for hypertension, obesity, cancer, or infectious diseases. A dichotomy between disease and non-disease states serves clinical convention and management, Rose notes, but it is not found in nature. While a low level of disease severity may not be treatable, it can nonetheless be prevented.[42] The same logic applies for risk factors like blood

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[37] Neil Pearce, "Traditional Epidemiology, Modern Epidemiology, and Public Health," American Journal of Public Health 86 (1996): 678-683; Nancy Krieger, "Epidemiology and the Web of Causation: Has Anyone Seen the Spider?" *Social Science and Medicine* 39 (1994): 887-903.

[38] Geoffrey Rose, "Strategy of Prevention: Lessons from Cardiovascular Disease," *British Medical Journal* 282 (1981): 1847-1851. See also IOM, *Future of the Public's Health*, ch. 2.

[39] Rose, "Strategy of Prevention," 1851.

[40] Ibid. 1850.

[41] Geoffrey Rose, *Rose's Strategy of Preventive Medicine* (Oxford: Oxford University Press, 2008 [1992]), 43-44.

[42] Ibid. 46.

pressure or BMI. It makes little sense, Rose argues, to focus on one side of a dichotomy while neglecting the continuum of factors that preceded it.[43]

A second premise of the approach involves a stark distinction between "sick individuals" and "sick populations."[44] In terms of disease etiology, the approach sets aside the former. The etiologic question is not, for example, "why do some individuals have hypertension?" as in the clinical view, but rather, "why do some populations have much hypertension, whilst in others it is rare?" The two questions, according to Rose, "require different kinds of study, and they have different answers,"[45] and as noted, entail different prevention strategies. The traditional high-risk and population-based mass strategies are not mutually exclusive, and realistically, both are necessary. But in principle, Rose insists, the former is "an interim expedient." The latter strategy is more "radical" in its attempt to remove underlying causes, and if successful, "individual susceptibility ceases to matter."[46]

However, despite its focus on the population as the unit of analysis, the approach is not without an underlying image of the individual. It hypothesizes that distributions of disease, their scale and pattern, "reflect the way that people live and their social, economic, and environmental circumstances."[47] We are presumed to be social beings in this sense, and this image is built into the population method itself. As Rose puts it, "society is not merely a collection of individuals but is also a collectivity, and the behaviour and health of its individual members are profoundly influenced by its collective characteristics and social norms."[48] Indeed, Rose explains even the evolution of individual variations in a population—whether due to genetic or social factors—in

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[43] Ibid. 41.

[44] Rose makes this distinction in a classic paper, "Sick Individuals and Sick Populations," *International Journal of Epidemiology* 14 (1985): 32-38, 33.

[45] Ibid. 33.

[46] Ibid. 37, 38.

[47] Rose, *Rose's Strategy*, 35.

[48] Ibid. 96.

terms of its benefits for the population.[49] This image of persons as socially conditioned is what ultimately drives the attention to social circumstances in Rose's approach and to his belief that most diseases in theory can thereby be prevented.[50]

Value-Neutral Social Individuals

Despite the importance of this social image of the individual for making sense of the population approach, however, it is unclear that it moves us beyond Engel's systems level understanding of the person. There is a shift in perspective—from the individual to the population—but there is no substantive change in how persons are envisioned. The social determinants view seems to be built on the same image of the person, that is, as one value-neutral object among others. There is still too little room for conceiving the individual as a self—a subject of value for whom objects in the social world are not only of instrumental but also of constitutive value. What is more, the epistemology of the population approach makes this an intractable problem.

The image of the person in the population approach seems to have common roots with Engel's biopsychosocial model. In making the social-biological connection in 1977, Engel was drawing on the epidemiological literature of his day. The term "social epidemiology" had already been coined by Albert Yankauer Jr. in 1949,[51] and Engel shows familiarity with the related literature. In particular, he cites John Cassel's seminal 1964 article, "Social Science Theory as a Source of Hypotheses in Epidemiological Research,"[52] which was helping to set the field's future

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[49] Ibid. 88 ff.

[50] Ibid. 35. Or as Rose says elsewhere, "if [population] causes can be removed, [individual] susceptibility ceases to matter" (Rose, "Sick Individuals," 38).

[51] Albert Yankauer, Jr., first used the term in a 1949 talk that was later published as "The Relationship of Fetal and Infant Mortality to Residential Segregation: An Inquiry into Social Epidemiology," *American Sociological Review* 15 (1950): 644-648.

[52] John Cassel, "Social Science Theory as a Source of Hypotheses in Epidemiological Research," *American Journal of Public Health* 54 (1964): 1482-1488.

intellectual agenda.[53] In that article, Cassel had critiqued the single-agent germ theory of disease etiology for failing to explain variabilities in disease incidence relative to exposure and for foreclosing research into other potential causes, namely, factors like rapid social change.[54]

Like Engel, population medicine also imagines the individual as part of an interactive system. Only the arrangements are more sophisticated. The "web of causation" model replaces the germ theory's single-agent view with a web of "multiple causations." The idea is to intervene on those factors that are closest to the desired outcome rather than being limited to a unilinear hierarchy. The web-based model first appeared in an epidemiological textbook in 1960,[55] and is now a taken-for-granted feature of the field's reasoning.[56] More recent proposals have also sought to integrate ecological concerns, reimagining the web in ever more complex and broad terms. One example is the "Chinese boxes" model that envisions a series of self-contained but interactive systems—ranging from the molecular and genetic to ecological—that exist as "a conjurer's nest of boxes, each containing a succession of smaller ones."[57]

For all their sophistication, however, these models remain reductive about the nature of the individual or population and their relation to social or ecological worlds. Each system within a system or web is a value-neutral object of the epidemiologist's disengaged observation. Just as in the case of the patient in Engel's model, the population or individual is not so much a subject for which social or cultural realities matter as good or bad, right or wrong, but merely one object or system among others. The models thus still seem to miss something essential in our ordinary

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[53] See, e.g., Lisa F. Berkman and Ichiro Kawachi, "A Historical Framework for Social Epidemiology," in *Social Epidemiology*, 3-12 (Oxford: Oxford University Press, 2000). Another important often cited article by Cassel is "The Contribution of the Social Environment to Host Resistance," *American Journal of Epidemiology* 104 (1976): 107-123.

[54] Cassel, "Social Science Theory," 1483, 1486.

[55] Brian MacMahon, Thomas F. Pugh, and Johannes Ipsen, *Epidemiologic Methods* (Boston, MA: Little Brown, 1960).

[56] Krieger, 889-890.

[57] Mervyn Susser and Ezra Susser, "Choosing a Future for Epidemiology: II. From Black Box to Chinese Boxes and Eco-Epidemiology," *American Journal of Public Health* 86 (1996): 674-677.

experience of how our social and ecological worlds are evaluated and mediated in our experiences of and behaviors regarding disease.

A Missing Link

As was the case with Engel's model, my concern is that value-neutral systems, no matter how dynamic, cannot but obscure our relation to an already value-laden, morally significant social world. In a similar vein, the epidemiologist Nancy Krieger observes that social epidemiologic models tend to neglect "translating societal conditions into population patterns of health, disease, and well-being."[58] She in particular argues that the models are "biologically opaque," and instead proposes an "ecosocial model" that attends to "embodiment." She calls on epidemiologists to consider the ways in which "we literally embody, biologically, our lived experience, in societal and ecologic context, thereby creating population patterns of health and disease."[59] The body, on this view, is the missing explanatory link. Determinants like social and economic deprivation, inadequate health care, environmental hazards, social trauma, targeted marketing, and degraded ecosystems affect populations by changing people's biological characteristics.[60]

For Krieger, bodily change is a dynamic process; the "pathways of embodiment" are "diverse, concurrent, and interacting." She uses the term "embodiment" as a "verb-like noun" in order to capture "our bodily engagement (soma and psyche combined), individually and collectively, with the biophysical world and each other." The idea is to incorporate cognitive and neuroscientific research on how our bodily engagements with the world shape our cognitive and behavioral developments, as well as sociological and anthropological findings on the bodily

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[58] Nancy Krieger, *Epidemiology and the People's Health: Theory and Context* (Oxford: Oxford University Press, 2011), 213; see also Krieger, "Web of Causation," 895-896.
[59] Krieger, *People's Health*, 215.
[60] Ibid. 214.

implications of our cultural practices and beliefs. In this way, embodiment “conceptually stands as a deliberate corrective to dominant disembodied and decontextualized accounts of ‘genes,’ ‘behaviors,’ and mechanisms of disease causation.”[61]

Krieger’s concept of embodiment is tantalizing. It helpfully foregrounds the ways in which social determinants are mediated by our bodies, and in so doing, she creates the possibility of considering the richer role of our lived experience within the dynamics of population health and epidemiological research. She even highlights, for example, the need to consider cultural practices and beliefs surrounding “diet and cuisine, religion, family formation, sexuality, and social identities.”[62] However, she does not delve into this prospect. She in fact neglects even to address the tall challenge of doing so within epidemiology’s epistemological constraints. Can an empirical worldview make sense of Krieger’s account of embodiment without distorting it?

The Intractable Problem of Brute Data

There is reason to be skeptical of Krieger’s proposal to integrate the dynamics of embodiment into social epidemiology. The problem is the field’s epistemological grounding in what Taylor has called “brute data.” This is “data whose validity cannot be questioned by offering another interpretation or reading, data whose credibility cannot be founded or undetermined by further reasoning.”[63] The epistemological appeal of brute data thus presumes a fundamental distinction between data and our inferences about them. The aspiration is to build knowledge on “a unit of information … which has by definition no element in it of reading or interpretation.”[64] It rests on the illusion, according to Taylor, that we can escape the hermeneutical circle. It is thought to

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[61] Ibid. 222.

[62] Ibid.

[63] Charles Taylor, “Interpretation and the Sciences of Man,” in Philosophy and the Human Sciences: Philosophical Papers 2 (Cambridge: Cambridge University Press, 1985), 15-57, 19.

[64] Ibid.

provide epistemic certainty, a way to circumvent our subjective biases, or what Francis Bacon called the "idols of the mind."

Brute data is currently the reigning ideal of verification in the social and health sciences. Rather than allowing our lived experiences and behaviors to speak for themselves, the tendency is to conform them into the rubrics of brute data. Taylor, for instance, cites the study of political behavior in modern political science. Since human actions are "usually described by the purpose or end-state realized," political science tends to focus only on those behavioral end states that are brute data identifiable. In the epidemiological studies of obesity, eating high-density foods or exercising may be measurable actions of this sort. These are self-reported or observed behaviors that "can be identified beyond fear of interpretative dispute,"[65] those that can hope to meet the requirements of brute data verification.

Brute data epistemology likewise constrains the account of human agency within the social sciences—the question of why people behave the way they do. Because the scope of possible reasons must be limited to those that are brute data identifiable, social scientists are relegated to "facts about the agent, his beliefs, his affective reactions, his 'values', as the term is frequently used."[66] Sure enough, in the case of obesity studies, data about people's reactions or values are usually collected through surveys or qualitative interviews. The prevalence of obesity-related stigma in a population or its effects on health behavior, for instance, might be assessed in this way. This is because self-reports, as Taylor notes, can be thought of as brute data verifiable. There is no need to interpret whether or not a respondent says she agrees with a proposition or expresses a particular belief or reaction to certain events.[67]

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[65] Ibid. 28-29.

[66] Ibid. 29.

[67] Ibid.

Likewise, to the extent that something like social stigma makes sense as a population characteristic, the brute data view must regard it as a widely held belief or opinion. A complex social meaning is thereby reduced to a set of personal values belonging to an aggregate of disengaged selves. Rose, for example, affirms population characteristics like societal depression, hostility, aggression, or fitness level, but he predictably proposes to assess them through population surveys that allot a score to each individual.[68] However, on Taylor's account, such an approach necessarily distorts important aspects of our social reality and the ways in which we relate to them. A brute data view precludes any perception of the matrix of collective meanings or norms by which we each make sense of our lives and identities as social beings.

For Taylor, inter-subjective and common meanings exist in society regardless of whether they are shared by the individuals in it. Inter-subjective meanings constitute our diverse social practices for what they are. The meaningfulness of patient autonomy and clinical judgment, for example, give the patient-physician relationship its distinctive quality as a social practice. Common meanings, in turn, constitute the shared reference world within which we necessarily make sense of all our social practices. The idea of the good of health, broadly construed, may be one such reference. We may parse its meaning and pitch bitter political battles over it, but it is nonetheless a major point of reference for our self-understanding as a society, for our sense of common aspiration, celebration, or even shame.[69]

To say that these societal meanings exist as independent social realities is also to say that no single individual is their source. Each individual is instead born into them and inhabits them prior to any choice. Far from originating in the private minds of disengaged entities, they are constitutive of who we are as particular persons; they are integral to "our ordinary consciousness

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[68] Rose, *Rose's Strategy*, 97-98.

[69] For an extended discussion of intersubjective and common meanings, see Taylor, "Interpretation," 32-40.

and hence speech about our actions."[70] We cannot choose to escape or embrace these meanings because our social existence is necessarily conditioned by them. To that extent, Taylor argues, these meanings cannot in principle be assessed by surveys or other forms of brute data analysis. A social epidemiology or population medicine that is beholden to its brute data epistemology cannot but miss essential aspects of who we are as social beings and our experience as such of illness or health.

Toward a Hermeneutical Social Self

A more adequate perception of the social self than what clinical or population medicine tends to dictate is required. But the challenge is not necessarily to incorporate an alternative perception of the self into medicine's existing epistemological models. Rather, the existing models need to be relativized within a qualitatively different perception of the human. Significant strides in this regard are evident in medical anthropology, in particular, in the pioneering work of Arthur Kleinman. In contrast to the above medical models, his work foregrounds the symbolic character of social reality and effectively clarifies our relation to it as subjects of value. While I ultimately find that Kleinman understates the normative orientation of human agency, we do well first to attend to his rich description of our illness experience on its own terms.

Writing in 1994, anthropologist Byron Good observed that medical anthropology had come of age. In the 1960s, the fledgling field was primarily applied, oriented to being useful to health development efforts around the world. But by the 1990s, it had seen an "explosion" of intellectual interest, moving ever closer to the center of the anthropological discipline and gaining traction in the social sciences and humanities.[71] Social theory, moreover, was no longer

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[70] Taylor, "Interpretation," 23.

[71] Byron J. Good, *Medicine, Rationality, and Experience: An Anthropological Perspective* (Cambridge: Cambridge University Press, 1994), 4.

peripheral to the field. No longer beholden to an empiricist paradigm of the medical domains it sought to serve, according to Good, the field was now engaged in a critical examination of its own epistemology lest it "reproduce … conventional knowledge in an unexamined fashion."[72]

Good credits Kleinman's work in particular for catalyzing this situation with "a new approach to medical anthropology as a systematic and theoretically grounded field of inquiry" in its own right.[73] He established, starting in the 1970s, what Good calls a "meaning-centered" or interpretive tradition in medical anthropology. The field had always regarded culture—a system of beliefs and practices—as a central feature of our response to illness. But according to Good, Kleinman departed from two noteworthy pitfalls of previous conceptions. Against the empiricist tradition, he relativized all cultures, rejecting the assumption that biomedical representations of disease were normative—that disease was a part of nature rather than culture.[74] He similarly departed from conceptions of culture that reduced meaning to cognition or knowledge.[75]

For Kleinman, medicine everywhere is a set of "socially organized responses to disease that constitute a special cultural system: the *health care system*."[76] The biomedical system of care is no exception. Its empirical epistemology is not so much to be denied but relativized as one cultural system among others. Health care systems are like a religion or language; they constitute "symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions." They consist in distinctive "patterns of belief about the causes of

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[72] Ibid. 6.

[73] Ibid. 52.

[74] For Good's extended treatment of the empiricist tradition, see 37-47.

[75] For an extended treatment of cognitive models, see Good 48-52.

[76] Arthur Kleinman, *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry* (Berkeley: University of California Press, 1980), 24. Kleinman earlier articulated his theoretical model in various academic articles, but this is his first book-length treatment of it, and one in which he fruitfully applies the framework in a cross-cultural study of Taiwan's health care system. For an earlier articulation, see, e.g., "Concepts and a Model for the Comparison of Medical Systems as Cultural Systems," *Social Science and Medicine* 12 (1978): 85-93.

illness; norms governing choice and evaluation of treatment; socially-legitimated statuses, roles, power relationships, interaction settings, and institutions."[77]

The challenge is to understand the components of the system and their interrelation, in particular, how people within it think about health care, act in it, and use its components. For Kleinman, we do so not only cognitively or instrumentally but also symbolically. "Symbolic reality" links a person's psychological and biological reality with her social and cultural world (i.e., "social reality," of which the health care system is a domain).[78] The system in this sense is not a value-neutral reality that we navigate as disengaged subjects but, according to Kleinman, a system of symbolic meanings that conditions and shapes our very experience of disease and care.[79]

This picture of our experience, moreover, rests on the premise that while "disease" and "illness" are distinguishable, they are inseparable. Kleinman sees disease as "a malfunctioning of biological and/or psychological processes" and illness as a response to disease that is at once both personal and social, involving "processes of attention, perception, affective response, cognition, and valuation." Disease is thus always already experienced as illness; it is culturally shaped within local systems of meanings and relationships. It is only in illness that disease is given a "meaningful form and explanation as well as control."[80]

The self in Kleinman's account experiences disease and illness as a hermeneutical agent inhabiting particular systems of social meaning; we are not merely passively shaped. In his early work, Kleinman conceives this in terms of a plurality of "explanatory models" (EMs) that patients and their families must navigate. Each health care system formally consists in three overlapping

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[77] Kleinman, *Patients and Healers*, 24.

[78] Ibid. 41. Kleinman defines psychological reality as "the inner-world of the individual," biological reality as "the infra-structure of organisms, including man," and physical reality as "the material structures and spaces making up the non-human environment." Each of these are distinct from social reality.

[79] Ibid. 42.

[80] Ibid. 72-73.

parts: "the popular, professional, and folk sectors."[81] Each overlaps with the others to varying degrees, but it is the people who pass between them that connects these sectors and gives them a larger coherence.[82] As hermeneutical agents, patients and their families translate the language of one EM's set of meanings, norms, and power into another, and this process in turn dictates their clinical interactions and illness experience.[83]

Kleinman recounts, for example, the case of a young man in Taiwan with a chronic anxiety neurosis and physiological symptoms related to peptic ulcer disease.[84] A psychiatrist diagnoses the condition as a "sexual neurosis" common among young men in Taiwan and predicts that the somatic ulcer will also resolve with psychiatric treatment.[85] But this diagnosis is only one EM among several. Other Western-style doctors name it "neurasthenia," while Chinese-style doctors diagnose a kind of "kidney weakness."[86] A local spirit medium (*Tâng-ki*) meanwhile prescribes charms and the burning of spirit money, explaining that the illness was caused by the ghost of a girl who died unmarried and is now pursuing him.[87] The mother, for her part, sees her son's problems as one in a series that began at the age of seven when he was hit on the head with a hammer by his older brother, and blames the present issues on "dreaming too much and frequent nocturnal emissions ... since the semen loss causes him to lose *yang* (male principle) and thus produces weakness, fatigue, and lack of energy."[88] Finally, the patient himself fears he is losing too much "seminal essence (*ching*)" due to frequent masturbation, and thus feels guilt, frustration, and condemned to suffer his symptoms.[89]

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[81] Ibid. 50.
[82] Ibid. 60.
[83] Ibid. 53.
[84] Ibid. 123.
[85] Ibid. 124.
[86] Ibid. 123.
[87] Ibid. 121.
[88] Ibid. 122.
[89] Ibid. 124.

The plurality of EMs fundamentally shapes this young man's experience of illness and role as a sick person. In the popular sector, his sick role is a "legitimated mechanism for managing personal and interpersonal problems." It gives him "release from the obligation to work, the right to stay at home, to be passive, and to seek help from family members, and legitimation of failure in examinations, work, and interpersonal transactions."[90] But as he moves out of the family and into the various professional sectors, he takes on a patient role, and in the folk sector, a client role. His role in each dictates the kind of explanation he receives and the symptoms and troubles he chooses to share. The mother and son therefore view themselves as the locus of responsibility for his care, and accordingly, exhibit "varying degrees of commitment to the different EMs," evaluating each cultural sector in terms of its particular efficacy.[91]

In his later writings, Kleinman both deepens and broadens this conception of our social subjectivity. In a deepening move, he blurs the line between the self and society with a focus on "somatization." In a 1986 study of the neurasthenia-depression-somatization complex in China, for example, he shows that the body—not just the mind—"can be a vehicle for experiencing, interpreting, and communicating about emotion and social issues … that in some nontrivial sense the body feels and expresses social problems."[92] In directly connecting the symbol system to the body in this way, Kleinman more strongly rejects biomedicine's materialist epistemology, arguing that its value neutral idea of nature is not only cross-culturally peculiar but connotes a mind-body dualism that defies our lived experience.[93]

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[90] Ibid. 125.

[91] Ibid. 125-126.

[92] Arthur Kleinman, *Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China* (New Haven: Yale University Press, 1986), 194.

[93] Arthur Kleinman, *Writing at the Margin: Discourse Between Anthropology and Medicine* (Berkeley: University of California Press, 1995), 29-30.

Kleinman also progressively broadens the scope of symbol systems that shape our illness experience. Illness is rooted in political realities as much as in the popular or clinical realities of health care systems.[94] In the same 1986 study, for instance, Kleinman finds that the survivors of China's Cultural Revolution experienced their social trauma as bodily symptoms of exhaustion, dizziness, and pain. The survivors shared these somatic symptoms because of their common politico-cultural circumstance.[95] In a 1995 rereading of his own work, Kleinman sees this as an important step in his move away from tendencies to naturalize or formalize particular EMs or notions of culture.[96]

However, Kleinman soon comes to view even this deepened and broadened grasp of culture and our relation to it as too constraining to fully capture the narratives of his patients. His 1988 book, *The Illness Narratives*, was the consequence.[97] "I felt a deep compulsion," he writes, to retell the "stories of sickness much as they had been told to me."[98] The stories are thus told not as clinical histories or cultural analyses but "as moral tales of remorse and regret, as social dilemmas, as cultural ironies, as the imperative stuff of myth and tragedy." Here, he reflects, "I had more or less found my subject, or it had found me."[99]

The Question of Orientation

Kleinman's influential life-long work can be read as a search for ever greater clarity about the hermeneutical self's illness experience. The deepening and broadening moves in his later writings

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[94] For an interdisciplinary elaboration of what he terms "social suffering," see Arthur Kleinman, Veena Das, and Margaret Lock (eds.), *Social Suffering* (Berkley: University of California Press, 1997).

[95] For Kleinman's analysis of the cases he uses to make this claim, see *Social Origins*, ch. 6.

[96] Kleinman, *Writing at the Margin*, 7.

[97] Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York: Basic Books, 1988).

[98] Kleinman, *Writing at the Margins*, 14.

[99] Ibid.

helpfully extend his insight into our social dependence and nature as self-interpreting narrative creatures. But at the same time, these moves seem to make less and less clear the basis on which Kleinman can make sense of the human experience of disease and illness. The emphasis seems to shift inexorably to the mere retelling of personal narratives. In other words, the fact that we are conditioned by symbolic social realities is ever clearer, but on what basis are we to make sense of how we evaluate and navigate those realities? The adequacy of Kleinman's presumption in this regard warrants critical examination.

Across his many works, Kleinman presumes that "efficacy" is the primary criterion by which we navigate our response to illness and health. As early as his first book, he focuses on "the way people *act* in [the health care system] and *use* its components." Envisioning the system as a "nexus of adaptive responses to the human problems created by sickness," he notes that "the issue of 'efficacy' is central to it."[100] In later writings, he cites William James and John Dewey to describe our experience of living as marked by "an orientation of overwhelming practicality."[101] While the self orders and narrates its experience as a being conditioned by society and culture, it ultimately does so with a view primarily to practical application and efficacy.

The centrality of this orientation of the self can be plainly seen in Kleinman's distinction between the moral and the ethical. "Experience is *moral*," he writes, not ethical. The ethical deals in abstractions and debates over codified values or principles. It emphasizes "cognition (more precisely, in today's jargon, rational choice) over affect or behavior and coherence over the sense of incompleteness and unknowability and uncontrollability that is so prevalent in ordinary life."[102]

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[100] Kleinman, *Patient and Healer*, 26-27.

[101] Kleinman, "Moral Modes," 360.

[102] Arthur Kleinman, "Experience and Its Moral Modes: Culture, Human Conditions, and Disorder" (The Tanner Lectures on Human Values, Stanford University, Stanford, CA, April 13-16, 1998), 355-420, 362-363. See also Arthur Kleinman, *What Really Matters: Living a Moral Life amidst Uncertainty and Danger* (Oxford: Oxford University Press, 2006), 1-3.

The moral, in contrast, is marked by that orientation to practicality. Simply put, "what so thoroughly absorbs the attention of participants in a local world is that certain things matter, matter greatly, even desperately."[103]

In other words, we care in various, complex, and often unpredictable ways, and act accordingly. Culture is not a monolithic set of "shared canonical meanings that are distributed equally throughout a community." They are instead "lived meanings." Kleinman argues that we contest them across any number of differences, including gender or politics, and actualize them "differently in everyday social transactions so that they exert a partial, uncertain effect."[104] His metaphors are also telling. The "tidal stream" is a favored image. Like a tidal stream, he writes, experience "washes in among the feelings of inner life and rushes out among values, norms, and relationships." Just as "fresh water and salt water intermingle but also maintain their own forms in a tidal stream," the same holds for the intermingling of our subjectivity with the social.[105]

On Kleinman's view, then, ethics is but one of the contingent things that moral beings care about. It is not that ethics is irrelevant, but that it is instrumental. In problematizing the over medicalization of certain forms of bereavement as depression, for example, he notes that "ethical discourse can play a potentially useful role of reflexive awareness."[106] The moral, medical, and political in such cases may have intersected in ways that can be considered unethical. But the task of ethics is not to critique it from a disengaged point of view. It should be just a part of a broader moral reflection on how professionals and institutions come to "transform the recalcitrance of a moral problem into the corrigibility of a medical one."[107]

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[103] Kleinman, "Moral Modes," 360.
[104] Kleinman, *Writing at the Margin*, 58.
[105] Kleinman, "Moral Modes," 378.
[106] Ibid. 396.
[107] Ibid. 395-396.

The universalizing tendencies of moral philosophy are thus anathema to Kleinman, and this is the point on which, in his Tanner Lectures, he takes issue with Taylor. Kleinman allows that he has some considerable affinities for Taylor's views on the moral self. Citing Taylor, Kleinman affirms the shared view that "we are selves only in that certain issues matter for us" and that our identities come to be "through historically situated narrative forms."[108] But he departs from Taylor's crucial position that we have "an inner craving which is ineradicable from human life. *We have to be rightly placed in relation to the good*."[109] Taylor's claim of "a single, universal human nature," Kleinman argues, is unconvincing given the contingent nature of our subjectivity and its moral existence.

However, Kleinman's position against Taylor undercuts his own assumption that we navigate our local contexts with "an orientation to overwhelming practicality." He shares with Taylor a basic understanding that all human beings, by nature, are creatures for whom things matter. Their difference, more accurately, seems to consist in the sense in which things matter, that is, in the distinction between "practicality" and "the good." On this score, Kleinman seems to understate the ways in which things not only matter to us but also matter to us as good or bad, right or wrong. The good is not just one among many objects of value to which we are contingently or pragmatically attached. For Taylor, certain notions of the good constitute us as a fundamental orientation in reference to which we always already evaluate other goods.

Moral Goods and Their Conceptual Gains

Kleinman misses the force of an important Taylorian insight into our hermeneutical ontology. As I noted in the first chapter, Taylor distinguishes between "weak" and "strong" evaluations of our

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[108] As quoted in Ibid. 398.

[109] As quoted in Ibid. 399; emphasis is Kleinman's.

first-order desires. Kleinman perceives only the former, whereby we assess our desires in terms primarily of convenience or satisfaction. On this score, we are no different from other animals for whom things also matter. But Taylor argues that there is more to us; we are hermeneutical also in the sense that we evaluate the desirability of our desires on the basis of constitutive goods—an ineradicable craving to be rightly placed in relation to them. Taylor calls these strong evaluations, which are based on distinctions of the "qualitative worth of different desires" as higher or lower, noble or base, good or bad.[110]

In *Sources of the Self*, Taylor refers to these goods—in reference to which we evaluate strongly—in terms of the spiritual. The good is spiritual in the sense that it stands independently of "our own desires, inclinations, or choices."[111] It pertains to questions not only of justice or respect for others but also of "what makes our lives meaningful or fulfilling."[112] The good is that by which we measure the worth of our lives; it is integral to our ability to make sense of our lives, to situate it within some framework, to narrate its story. To be sure, what we take any such goods to be can vary by person and even more so by culture. But the fact that we must be oriented to some good is an inescapable feature of human agency and experience. To lack this orientation is "to fall into a life which is spiritually senseless," that is, meaningless.[113] It is not to know who one is or to be able to answer for oneself.

In the earlier case study of the young man in Taiwan, for example, Kleinman infers that the mother's health seeking actions were "an entirely pragmatic hunt for a treatment." This was the case even when she and her son considered psychiatric treatment. Despite the stigma

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[110] Charles Taylor, "What is Human Agency?" in *Human Agency and Language: Philosophical Papers 1* (Cambridge: Cambridge University Press, 1985), 15-44, 15-16.

[111] Charles Taylor, Sources of the Self: The Making of the Modern Identity (Cambridge, MA: Harvard University Press, 1989), 4.

[112] Ibid.

[113] Ibid. 18; see also, Ibid. 31.

attached to mental illness in Chinese culture, they considered it because other options had failed.[114] However, one might reread the decision through Taylor's insight. On this view, the inference is not self-evident. Deeper moral considerations that Kleinman duly notes, such as the young man's guilt and feelings of being condemned or the mother's move to contextualize her son's present woes within a larger arc of his life of similar woes, are underexplored. Questions of guilt or fate are suggestive of goods at stake that cannot be reduced to concerns of expediency or even the desire to appear good before others.[115] But on Kleinman's picture of how we inhabit the social or orient ourselves within it, these are largely overlooked.

Consider a further example. In *The Illness Narratives*, in a chapter entitled, "Aspiration and Victory: Coping with Chronic Illness," Kleinman tells the story of Patrick ("Paddy") Esposito. Paddy had long suffered from a progressive inflammatory disease that attacked the smooth muscle of his heart and eventually led to his death. But Kleinman in particular marvels at Paddy's sense of peace and wisdom in the face of his suffering. A Buddhist, Paddy aspired to "small human blessings: friendship, inner peace, the joy of helping others, courage, the search for meanings one could live by."[116] He notes that "people, not commodities, were his life." When Paddy died, it was noted that his final years were a "luminous example of the moral life." Unsure of what else to make of it, Kleinman simply states, "I'm convinced that Paddy Esposito's response to his illness represents the best that is in us."[117]

But rather than appreciating this story for what it is, Kleinman goes on to reinterpret Paddy's aspiration in pragmatic terms, as an exemplary means of "coping." While Kleinman

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[114] Kleinman, *Patients and Healers*, 125, 127.

[115] As Taylor might observe, this last inference about stigma seems to be all too common among the social sciences since it can be readily explained by the well-known psychological issues of "ego" and "image" (see *Sources of the Self*, 33).

[116] Kleinman, *Illness Narratives*, 142.

[117] Ibid. 143.

worries that "few of us are likely to have the qualities and discipline" to carry out Paddy's "strategy,"[118] he affirms that people have coped in similar, even if more modest, ways. But with this rereading, Kleinman seems to minimize the very aspiration for the good that made Paddy's story so inspiring in the first place. In fact, as soon as he describes Paddy's aspiration as a "coping" strategy, he acknowledges that the label is "trivializing."[119] But the problem is not just the label; it is also the analysis. In presuming that we are oriented to practicality, Kleinman seems incoherent as to the significance of Paddy's aspiration for the good as a basic driver of or point of reference for his illness experience.

The problem with Kleinman's failure to grasp Taylor's insight into our nature as strong evaluators, however, is not only that it curtails our awareness of certain aspects of our illness experience. It also impedes recognition of the normative significance of his own descriptive approach to caregiving. Kleinman calls for an "ethnographic model" of caregiving. Like ethnographers, he asks that physicians and other caregivers solicit and attend to the sufferer's story and cultivate the skills to grasp what matters to people in their everyday lives.[120] But he is unclear as to why we ought to do so; that is, why should medicine orient itself to our existence as hermeneutical as opposed to disengaged selves. After all, this is not an easy ask given the trends in modern practice that run counter to it. Kleinman finally appeals to our "moral-emotional capacity … to engage the other,"[121] but this is hardly a reason for why that engagement should necessarily be ethnographic.

Taylor's account of the self as a strong evaluator helps make sense of what Kleinman cannot. It helps explain the constitutive and not just the instrumental importance of Kleinman's

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[118] Ibid. 144.

[119] Ibid.

[120] Kleinman, "Moral Modes," 416; see also Kleinman, *Illness Narratives*, 230 ff.

[121] Kleinman, "Moral Modes," 412.

critique of biomedicine's epistemology, proposed alternative, and the rather strong, universalizing terms of that critique. In other words, Kleinman too exhibits a fundamental need to be oriented to some constitutive good. That good seems to be a version of what Taylor describes as a "sense of the importance of the everyday in human life, along with its corollary about the importance of suffering."[122] This ideal has a particularly powerful resonance in the modern West, which may explain why Kleinman presumes it rather than reflecting critically on it. Its pervasiveness helps illustrate the importance of our orientation to a good for making sense of our everyday moral judgments, both large and small. But Kleinman unfortunately seems blind to the workings of this powerful point.

Conclusion

Medicine is a meaning-filled social practice—one that is for and by hermeneutical selves who are always already oriented to some good. The challenge is to make sense of this practice for what it is. I have tried to clarify in this chapter our ontology as socially constituted selves—how it is that we inhabit our social worlds. Kleinman's analysis of our illness experience as subjects embedded in local worlds of symbolic reality was crucial. Grounded in ethnographic studies, he effectively moves beyond my critique of the confusions in clinical and population medicine—namely, their construal of our relation to the social in value-neutral, disengaged terms. But it is ultimately Taylor's notion of strong evaluations that illuminates an important aspect of our illness and care experience that Kleinman's account obscures.

The validity of this hermeneutical social ontology is not grounded in empirical facts. The point is not to discover, within what Kleinman describes as the "tidal streams" of human experience and history, our ontology as an empirical fact of nature. That would be exceedingly

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[122] Taylor, *Sources of the Self*, 14.

difficult, and indeed, illusory given that there can be no knowing without presupposition. The point instead is to reason about ontology in order to explain our sense that the social practice of medicine is and should be meaning-filled. Neither our experience of illness nor our attention to another's need is a question merely of usefulness, efficacy, or expediency. Some notion of the good and our orientation to it is a constitutive feature of any such experience. The point is to be able to see this against the confusions. We alienate ourselves from these goods at great peril of collective incoherence and disorientation.[123]

However, much more needs to be said in defense of this notion of moral goods, which Taylor characterizes as in some sense "higher." This is a crucial feature of his moral thought and what it means to have a socially constituted identity by which we inhabit our worlds, and in terms of which we realize our good. I now turn to a clarification of this feature of the hermeneutical self in the next chapter.

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[123] For Taylor's articulation of this basic point, see Ibid. 8.

CHAPTER THREE

Moral Goods and a Self Claimed by Love

Our identity as selves is intimately bound up with the social worlds in which we have our being. As I argued in the previous chapter, the social is not merely instrumental to our self-realization, but deeper than that, it is constitutive of it. We inhabit our worlds in terms not only of efficacy but also of goods that we take to be in some sense higher—as constituting who we are or aspire to be. Per Taylor, an ineradicable "craving … to be rightly placed in relation to the good" is fundamental to what it means to be human.[1] We thus experience social realities on strongly evaluative terms, as always already laden with meaning prior to any projections on our part. But this claim requires elaboration and defense, and herein, I address the second of the two claims I specified in the last chapter. Why, after all, perceive our self-identity in strongly evaluative terms? What would such a claim imply about what it means to be a self?

In the last chapter, I indicated that seeing the self as inhabiting its social ontology in strongly evaluative terms, as opposed to pragmatic ones, clarifies certain features of our illness and caregiving experiences that are otherwise obscure. But this observation still leaves open a hermeneutical question of why clarifying matters in this way should matter to us. What, in other words, is the significance of perceiving our social ontology as meaning-laden, as goods? The question in effect mirrors that of malaise posed in the first chapter, namely, the why of medicine's meaning. The answer, I suggest in this chapter, entails interrogating the constitutive features of the self as a subject of meaning and its basic longings.

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[1] Charles Taylor, *Sources of the Self: The Making of the Modern Identity* (Cambridge, MA: Harvard University Press, 1989), 44.

The inquiry at this point must go beyond the third-person observations of clinical, epidemiological, or anthropological perceptions. It requires a deeper, hermeneutical reflection on our moral psychology and agency—one that develops comparatively on the basis of its conceptual gains. With this in mind, I offer in the first section a reading of Taylor on the notions of strong evaluations and fullness, and I do so in relation to Harry Frankfurt's moral psychology. The analysis leads in the second section to the problem of diverse moral goods—of how to inhabit our differences—as a basic feature of our self-identity. In particular, I critique Taylor's account of the self's identity—its moral space—as overly solipsistic. While the self inhabits a field of meanings in the presence of others, the significance of those others is unclear.

I instead claim that the self's identity is oriented to its goods—its sources of meaning—as a creature always already constituted by the claims of the other, of love. In largely neglecting this feature of our moral space, Taylor understates an attendant problem of rightly ordered relations in the midst of diverse moral goods, namely, what Augustine calls the *libido dominandi*. This is the shadow side of our craving for the good, which I contend must be accounted for lest we despair of reaching a place of what Taylor calls fullness and Augustine calls rest. At stake, ultimately, is to articulate an account of the self that can help make sense of the deeper importance of the goods, including transcendent goods, of our moral experience.

Desires, Strong Evaluations, and Fullness

Taylor's articulation of moral goods is tied to his account of strong evaluations as a basic feature of human agency and the possibility of what he calls "fullness." Knowing the good is not a matter of metaphysics; the good is emphatically not Platonist. In response to a confusion about his work on this score, Taylor notes that “Platonism is dead.”[2] The good is not a question of a disengaged knower, an object of no particular significance to the knower. But neither is it merely subjective, dependent only on individual or collective projections. Rather, the good for Taylor is a matter of a kind of Kantian postulate; it is inferred from our sense of self as a being with an identity.[3] The idea is that without positing certain goods as identity-orienting, we are incoherent as to crucial aspects of our moral experience, which is what ultimately is at stake.

The moral experience in question relates to strong evaluations, which Taylor articulates on a crucial Frankfurtian emphasis on “the importance of what we care about.”[4] A modern temptation, according to Frankfurt, is to see personhood on materialist terms, as a marker of a species of animal. This distinguishes us from other animals on the basis of some psychological or material property, such as consciousness or some bodily characteristic. The challenge then is to define the essential mind-body relation that is said to constitute personhood. This is the typical materialist approach, but as Frankfurt argues, it misses the depth of what our use of the term “persons” ordinarily captures.[5] The term in fact gets at “our most humane concern with ourselves and the source of what we regard as most important and most problematical in our lives.”[6]

For Frankfurt, then, to ask about personhood is to ask about our agency—its freedom and responsibility—not as an empirically identifiable characteristic but as something about which we *care* intimately as human beings. This is what drives the inquiry in the first place. We cannot

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[2] Charles Taylor, “Reply to Commentators,” *Philosophy and Phenomenological Research* 54 (1994): 203-213, 210. Taylor here is replying to a critique by Frederick A. Olafson, “Comments on Sources of the Self by Charles Taylor,” *Philosophy and Phenomenological Research* 54 (1994): 191-196.

[3] Ibid. 209. See also Charles Taylor, “The Validity of Transcendental Arguments,” *Proceedings of the Aristotelian Society* 79 (1979): 151-165.

[4] See Harry Frankfurt’s book of that title, *The Importance of What We Care About* (Cambridge: Cambridge University Press, 1998). Specifically, as I articulate later in this chapter, Taylor’s idea of strong evaluations builds on Frankfurt’s crucial distinction between first- and second-order desires, which makes sense of the importance in question (Charles Taylor, “What is Human Agency?” in *Human Agency and Language: Philosophical Papers 1* (Cambridge: Cambridge University Press, 1985), 15-44).

[5] Harry Frankfurt, “Freedom of the Will and the Concept of a Person,” *Journal of Philosophy* 68 (1971): 5-20, 5-6.

[6] Ibid. 6.

make sense of the idea of personhood apart from its significance for us. This, then, is the ambit of concern that animates Taylor's understanding of our experience of the good and its sources, and as I later show, Augustine's as well. The question of moral goods for each of these thinkers is tied to an age-old question of what it means to be a person and to be fulfilled as such. In developing this inquiry, we do well to begin with Frankfurt.

Desiring Selves

Frankfurt defines "first-order desires," which we share with other animals, as the desire simply "to do or not to do one thing or another."[7] "Second-order desires" by contrast are distinctive to us as persons. These apply when a person either "wants simply to have a certain desire or when he wants a certain desire to be his will."[8] The key here is a person's self-reflective will, not reason. The structure of the will, to be sure, presupposes rationality since critical assessment of the desire to be willed would otherwise be impossible. But rationality alone is insufficient. Whether or not one is rational, to be without volition is to be what Frankfurt calls a "wanton." It is to act without a care as to the inclinations one follows; like other animals, one is simply moved by the desire that happens to be strongest.[9]

Frankfurt's claim of a higher order desire rests on its power to explain a feature of our agency that is otherwise puzzling. We typically associate freedom with being able to do what one feels like doing.[10] But the problem is that animals too can do things freely in this sense. This typical view fails to account for the sense of moral distinctiveness that the term "personhood" in

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[7] Ibid. 7.

[8] Ibid. 10.

[9] Ibid. 10-11.

[10] For example, the biomedical ethics principle of autonomy as articulated by Tom Beauchamp and James Childress conceives freedom in this way, that is, being "free from both controlling interference by others and limitations that prevent meaningful choice, such as inadequate understanding" (*Principles of Biomedical Ethics*, 7th ed. (New York: Oxford University Press, 2013), 101).

fact articulates. Thus, by positing a second order to our desires, Frankfurt makes sense of the fact that we experience our willing as self-reflexive. We care that the desires that move us be our own, regardless of whether or not we are able actually to act on them. We intuit, for example, that a person addicted to drugs, who feels compelled to take them despite a contrary desire, is not in fact free.[11] The addicted person is a non-agent, a "passive bystander" to his desires, because the desire that moves him is not willed as his own.[12]

We indeed enjoy a self-evident satisfaction when we experience our desires as our own. Conversely, "ambivalence, conflict, and self-deception" regarding those desires is a central human problem. Frankfurt argues that an inability to identify with one's desires and to be responsible for them diminishes one's humanity. It means that the person has no preference as to her desires, and at its limit, the condition paralyzes her from acting at all or estranges her from herself altogether. This is a state of human misery. To resolve the conflict, a person needs to commit to a higher-order desire as one's own. But the problem is that there is no limit to the series of desires to which one could defer commitment. When one cannot stop deferring to an ever-higher order of desire, one is less than human, caught up instead in a kind of "humanization run wild."[13]

In order to experience freedom, therefore, a person must identify *decisively* with her desires. She must identify with a higher-order desire in such a way as to put an end to all further questions over her desires. Frankfurt distinguishes elsewhere between "caring" and "loving." To care is to desire self-reflexively, in the mode of second-order desires, and to love is to care decisively. When we care about something, we do so instrumentally, as a means to something else we care about. But when we love, we care about that thing as an end in itself; there can be no

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[11] Frankfurt, "Freedom," 15.
[12] Ibid. 17, 20.
[13] Ibid. 16.

higher-order object of desire than that which is loved.[14] The significance of love thus consists in bringing an end to the potentially endless regress in the ordering of our cares. It is the condition for attaining the good of what Frankfurt calls "wholeheartedness," a state of volitional unity that gives our practical lives coherence.[15]

What kind of love, then, can be adequate to a wholehearted existence? Given its role in our moral psychology, according to Frankfurt, love is fundamentally disinterested; its concern must be for the flourishing of what is loved for its own sake. In loving, one wills the practical good of the beloved, not one's belief or feeling toward the beloved. Love thus opposes all forms of "infatuation, lust, obsession, possessiveness, and dependency," which instrumentalize the other for one's own satisfaction. For this same reason, love also entails an identification with the interests of the beloved not as a member of a class but as an irreducibly particular object. A person, for example, cannot be loved for the sake of a class such as "humanity" or "the poor." Finally, love must be involuntary so as to be free from all ulterior motives or rationalizations; one cannot help but love.[16]

What meets these criteria in the most "unequivocal and unalloyed" manner, Frankfurt argues, is self-love.[17] This is why he finds that to be wholehearted simply "*is* to love oneself"; it is to will to be oneself, to love what one already loves.[18] Self-love presupposes a robust identity of the lover and the beloved. In loving oneself, one readily identifies with the interests of the beloved as a particular individual and does so without ulterior motives. Other loves are rarely so thoroughly disinterested: they are "nearly always mixed up with, if not actually grounded in, a hope to be loved in return or to acquire certain other goods that are distinct from the well-being of the

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[14] Harry Frankfurt, *The Reasons of Love* (Princeton: Princeton University Press, 2004), 42.
[15] Ibid. 95.
[16] Ibid. 42 ff.
[17] Ibid. 80.
[18] Ibid. 95.

beloved."[19] While the love of parents for their children may approach the unconditional character of self-love, even this identity of interests remains uncertain, especially as the child grows older and goes her own way.[20]

Strong Evaluations

This Frankfurtian moral psychology is the basis for Taylor's account of strong evaluations. Taylor distinguishes between "strong" and "weak" evaluations at the level of Frankfurt's second-order desires. The move, notably, helps make sense of the importance in our moral experience of what Taylor calls "quality of life" considerations, which he describes in such terms as being nobler, more integrated, or in some other way higher. This indeed is a feature of moral agency to which Frankfurt is blind. For Frankfurt, the evaluations characteristic of persons is really a question not of moral judgment but contingent preference. One's choice of a higher-order desire may be capricious or irresponsible; there may be no basis for the preference at all.[21] This is because the reasons do not matter as far as wholeheartedness is concerned. The point, as he writes, is not to "make people good" but to "help make their lives … good for them to live."[22]

However, to say with Frankfurt that self-willing is a matter of preference rather than the weighing of any deeper reasons is to say that love is a-rational. Love, as he states, "is itself, for the lover, a source of reasons. It creates the reasons by which his acts of loving concern and devotion are inspired."[23] Our loves are what they are. They are determined not by reason but by "biological and other natural conditions, concerning which we have nothing much to say."[24] In fact, any effort

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[19] Ibid. 83.
[20] Ibid.
[21] Frankfurt, "Freedom," fn. 6.
[22] Frankfurt, *Reasons*, 99.
[23] Ibid. 37.
[24] Ibid. 46.

to determine what we *ought* to care about, Frankfurt argues, always presupposes the criterion of importance that we already care about.[25] The seemingly rational is in fact personal and doomed to a self-referential circularity. Even our decisive act to will certain desires to be our own—so as to be responsible for them[26]—is inevitably determined by what our prior preferences happen to be.

The problem with this Frankfurtian conclusion is that it belies the fact that we often experience our loving as rational, and care that it be so. We commonly feel a need to account for *why* we love what or who we love, and in so doing, we willingly open ourselves to others' and our own judgments about that love. This is so much the case that we typically regard a person who does not care at all about anyone's moral judgments as pathological, or at least immature. This is not to say that love cannot be a source of reasons. I may happily, and appropriately, do good for someone simply because I love that person. But this does not preclude someone else from asking why I love the person in the first place and expecting to hear warranted reasons for that love.[27] To this extent, Frankfurt's claim about the a-rationality of love is too strong.

For example, philosophers Kate Abramson and Adam Leite make a powerful case for seeing love as what they call a "reactive emotion." Love is not only a source of reasons as Frankfurt would have it, but also "an appropriate reaction to reasons, to certain virtuous traits of character manifested in interactions with the lover."[28] This is particularly true in the context of loving friendships or romantic relationships. "Nothing could be more familiar," they note, "than the ways in which starry-eyed lovers extol their beloved's good qualities. Likewise, a familiar

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[25] Ibid. 26.

[26] Frankfurt holds that we are morally responsible only for those acts that we perform for reasons that we willed to be our own. This is so regardless of any available alternative action, even when we are apparently forced to act in a given way. Responsibility hinges on the willing of the act (Harry G. Frankfurt, "What We are Morally Responsible for," in *The Importance of What We Care About* (Cambridge: Cambridge University Press, 1998), 95-103, 95).

[27] This argument is from Kate Abramson and Adam Leite, "Love as a Reactive Emotion," *Philosophical Quarterly* 61 (2011): 673-699, 684-685.

[28] Ibid. 684.

refrain at the demise of a relationship is that the former beloved was not worth it, did not deserve the love, because the ex was a jerk, or a creep, or a selfish, self-involved, inconsiderate good-for-nothing."[29] We ordinarily regard such moral traits as appropriate reasons for love, as warrants for seeing one's love for another as wise rather than impetuous.

Taylor helps make further sense of Abramson and Leite's observations about such reactive experiences of love. He shows that reducing our judgments to preferences, as Frankfurt does, dooms us to a certain "shallowness" of moral experience, to an inarticulacy as to its sense of depth. That is, it rules out strong consideration of "the kind of beings we are or want to be,"[30] despite the fact that this is something we commonly care deeply about. On Taylor's terms, a person in Frankfurt's account exists in a realm of weak evaluations, whereby her choice between two desired objects turns only on what she prefers at that moment. She sets aside the alternative simply because it happens to be incompatible with the other object chosen. The choice may be as innocuous as whether or not to eat an éclair at a party or as consequential as whether to marry a person one loves. In either case, Frankfurt seems to leave no recourse for the decision beyond contingent preference.

An often favored, and still weakly evaluative, way of adjudicating the superiority of one preference over another, Taylor observes, is utilitarian. I should choose a dessert, for example, on the basis of calorie counts. Eating the éclair may increase my cholesterol and weight more than if I eat no dessert at all. So, given the negative consequences to my health, which may affect my ability to satisfy my various other desires, I should decide that a pastry is not worth it. The issue here is not the quality of life, or sense of identity, that eating or not eating the dessert implicates but its consequences. The utilitarian perception sidelines strongly evaluative judgments, such as that an

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[29] Ibid. 674.

[30] Taylor, "Human Agency," 26.

overly impulsive eater is not an admirable person. It invalidates, as a sound ground for reasoning, any yearning one may feel "to be the kind of person whose mere bodily appetites respond to his higher aspirations."[31]

To be sure, perhaps this is a good thing. After all, the utilitarian may want to discount our strong-evaluative yearnings because of their dangers. Associating weight gain with being a certain kind of person may stigmatize those who are overweight. Indeed, seeing my weight issues in terms of calorie count may give me a distance from the problem that helps me manage it more effectively. However, this sort of objection does not defeat Taylor's claim about the inescapability of strong evaluations. To say that one should take a utilitarian stance, he might note, is to say that the stance is in some sense morally *better*. The utilitarian in this sense already presupposes a qualitative distinction: "they admire the mode of life in which one calculates consciously and clairvoyantly as something higher than the life of self-indulgent illusion, and do not simply elect it as more satisfying."[32] A thoroughgoing utilitarian perception thus masks the strong notions of qualitative worth that underlie even its own moral experience.

Taylor's point is not that a utilitarian analysis of our moral agency is incorrect in some objective, absolute sense. Rather, seeing ourselves as strong evaluators is "error-reducing"; it constitutes an epistemic gain.[33] It takes us beyond an image of the self as a simple weigher of consequences or, in Frankfurt's case, of preferences.[34] The strong evaluator has a rich vocabulary of

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[31] Ibid. 21-22.

[32] Ibid. 23. This can also be considered in terms of "the priority of the right over the good" to which utilitarianism and various Kant-derived theories subscribe. Taylor offers an extended critique of the dominance of this idea in moral philosophy today in *Sources of the Self*. He argues that such theories have "cramped" our moral thinking. They tend to reduce our moral considerations to modes of procedural reasoning and obligations, and elide such aspects of moral thinking as our "aspirations to perfection, heroism, supererogation, and the like" (88 ff.).

[33] Taylor, *Sources of the Self*, 72.

[34] This insight is one of Taylor's major philosophical contributions. It arguably has been the catalyst for "the gradual displacement of the belief-desire model as the dominant paradigm in the philosophy of action" (see Daniel M. Weinstock, "The Political Theory of Strong Evaluations," in *Philosophy in an Age of Pluralism: The Philosophy of Charles Taylor in Question*, edited by James Tully, 171-193 (Cambridge: Cambridge University Press, 1994), 171).

contrastive characterizations—courageous-cowardly, good-bad, admirable-base, worthy-trivial, etc.—that a weak evaluator does not. This vocabulary, moreover, enables us not only to articulate the superiority of a given desire over another but also to go deeper, to speak of the moral quality of life to which we aspire.[35] It validates, for instance, my sense of wanting not to act in a cowardly manner because I want to be a courageous person and, conversely, explains the shame I predictably feel at being otherwise. Such emotions, as Taylor points out, are "subject-referring," possible only for those who already aspire to a certain sense of identity or self.[36]

Fullness

By articulating a dimension of moral life that is inchoate in Frankfurt's account of agency, Taylor also reframes the Frankfurtian aspiration to wholeheartedness. For Taylor, wholeheartedness cannot be a matter merely of decisive identification with oneself—the decisive willing of what one happens to love. This is because the beloved is not value-neutral, an object whose meaning is dependent entirely on one's subjective or contingent preference for it. Rather, being at one with oneself presupposes a strong evaluation of the prior goodness of what one loves. The moral quality of the beloved does not collapse into a decisive identity with the loving subject's interests, as it does in Frankfurt. Taylor instead offers a picture in which we are oriented to a good whose goodness persists quite apart from one's preference for it.

Taylor speaks not of wholeheartedness but of "fullness." In *A Secular Age*, he describes this experience in terms of being "placed" in relation to certain goods. The space in which we are placed has a moral or spiritual shape; we find our life there to be "fuller, richer, deeper, more

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[35] Taylor, "Human Agency," 24.

[36] See Charles Taylor, "Self-Interpreting Animals," in *Human Agency and Language: Philosophical Papers 1* (Cambridge: Cambridge University Press, 1985), 45-76, 59 ff. Other subject-referring emotions include our sense "of dignity, of guilt, or pride, our feelings of admiration and contempt, or moral obligation, of remorse, of unworthiness and self-hatred, and (less frequently) of self-acceptance, certain of our joys and anxieties."

worthwhile, more admirable, more what it should be." We aspire to be in that place. Moreover, it is "a place of power" in which we feel deeply moved to act with "integrity or generosity or abandonment or self-forgetfulness." To this point, both thinkers affirm our longing for a sense of unity of self that empowers us to act. Akin to Frankfurt's wholeheartedness, Taylor describes fullness as a place of "joy and fulfillment, where we feel ourselves there."[37] But they differ in how they conceive the goods that constitute that state. For Taylor, they are goods because we deem them to be worthy of our love already, not because we happen to love them.

Taylor, unlike Frankfurt, is a moral realist. We each exist in an inescapable space of questions regarding what we presume to be independent goods, and rightly so. These goods may be variously located within this space, but the idea is to be placed in right relation to them.[38] For religious believers, fullness is generally envisioned as a given; it comes to them from the outside. A Christian, for example, feels a need to be "opened up, transformed, brought out of self" by divine grace. Those who are not religious may instead imagine the good as found within the self, such as in the self's rationality. Or Romantics who are critical of rationalism may look to nature, our inner depths, or both. Lest they despair, Taylor notes, even those who deny any such center resort to some ideal or good to empower their mode of life, such as "the sense of our courage and greatness in being able to face the irremediable, and carry on nonetheless."[39]

Empowering ideals, Taylor argues, extend beyond the self in this way. They clarify an enduring human experience that belies a modern culture that has been described as "the triumph of the therapeutic."[40] In elevating self-realization as the ultimate good, this cultural turn reduces all sense of the good, the true, and the beautiful to "values" that are subjective. It denies the fact

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[37] Charles Taylor, *A Secular Age* (Cambridge, MA: Belknap Press, 2007), 5.

[38] Ibid. 50.

[39] Ibid. 8-10; existentialists may be examples of this last view.

[40] Taylor, *Sources of the Self*, 507. Taylor here cites Philip Rieff, *The Triumph of the Therapeutic* (New York: Norton, 1966).

that certain independent goods or purposes provide the significance that our lives need, even as we experience their significance all the time in our everyday dilemmas over competing goods. Many near divorcing couples, for instance, may be seen as inhabiting a place of intense tensions between self-fulfillment and other deeply self-orienting goods.[41] Indeed, if realized, a therapeutic world devoid of meaning beyond self-fulfillment would collapse into emptiness for nothing would matter, "nothing would count as a fulfillment."[42] Taylor's point is not that self-fulfillment is not a good but that it necessarily presupposes other goods that already constitute the self; in order to make sense as a good, self-fulfillment must be experienced as one of a package of goods.

Taylor's picture of being placed in a given orientation to certain goods, or in a space of questions about them, accounts for two other related experiences worth noting. First, fullness involves not a decisive yes or no to the self, as in Frankfurt's wholeheartedness, but a sense of greater or lesser proximity. A person may at times feel closer to the place of fullness or at other times distant, even exiled, from it. It is also possible to feel that one has forgotten that place and to suffer the misery of loss or absence. Indeed, most people most of the time live in or aspire to what Taylor calls a "stabilized middle condition." Here, we are doing things "which contribute to our ordinary happiness, or which are fulfilling in various ways, or which contribute to what we conceive of as the good."[43] We try to keep our sense of exile at bay in this way, through regular everyday contact with the place of fullness.

Second, related to the first, the metaphor of a moral space implies a picture of our lives as a narrative. This, Taylor notes, is a necessary condition of any effort to make sense of our lives as a whole. What I am in the present, specifically in relation to the good, can only be grasped in terms of what I have become and where I am going. The same applies to collective identity, our sense of

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[41] Ibid. 511.
[42] Ibid. 507.
[43] Taylor*, A Secular Age*, 7.

who we are as a group or a people. We are beings always on the move, always changing and becoming more or less proximate to the good. Taylor cites here Heidegger's *Being and Time*, noting "the inescapable temporal structure of being in the world": "from my sense of where I am relative to it [the good], and among the different possibilities, I project the direction of my life in relation to it."[44] One would indeed be hard pressed to deliberate at all about one's longed-for future without some sense of who one is and has become.

Diverse Moral Goods

Within Taylor's moral psychology—structured by the agency of desiring selves, strong evaluations, and orientation to fullness—the goods that constitute the self's identity are multiple. This is not to deny the unity of a person's identity, but Taylor speaks of that identity in terms of an "inescapable framework" or "moral space." Each is constituted by the "background assumptions to our moral reactions" and the "contexts in which these actions have sense."[45] No human being can do without a framework, for to lack it is to lack an identity. We may, to be sure, feel at times that we have lost or are confused about our framework, but the point is that we would regard such a condition as problematic. As Taylor notes, "to begin to lose one's orientation is to be in crisis, and to lose it utterly is to break down and enter a zone of extreme pathology."[46]

The questions in one's moral space implicate a complex web of rights to be done, goods to be pursued, and the direction to give one's life. A framework is comprised of a whole set of strong evaluations.[47] One level of the goods that our qualitative distinctions define are what Taylor calls

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[44] Taylor, *Sources of the Self*, 47.

[45] Ibid. 78.

[46] Taylor, "Reply to Commentators," 209.

[47] Taylor speaks of "having an identity which is defined in terms of certain essential evaluations which provide the horizon or foundation for the other evaluations one makes" (see, e.g., Taylor, "Human Agency," 39).

"life goods," for they are "facets or components of a good life."[48] These are distinct from the objects of weak evaluation, those of "ordinary" desire, such as wealth, health, sex, food, or dominance.[49] Life goods instead pertain to certain qualities that define a life as well lived, such as benevolence, justice, autonomy, self-responsible reason, the pursuit of happiness, and family life.[50] But such goods are not all; they do not stand alone. Rather, their significance as goods for us rests on deeper sources that Taylor calls "constitutive goods."

Constitutive goods are certain moral realities that are good in a "fuller sense." They may be inchoate or hidden, needing to be articulated, but they preside in all moral frameworks. In Plato's ethics, the Idea of the Good as the principle of the order of being is that good in virtue of which this but not that action or aspiration is a life good. For theists, various understandings of God are the sources that define all life goods for us. Even humanistic frameworks that are non-theistic or metaphysical, Taylor insists, rest on some reality that explains certain life goods and not others as goods. In Kantian ethics, for instance, the constitutive good is the autonomous agent acting solely out of respect for the moral law. Or in Albert Camus's *The Plague*, the moral source is embodied in the hero Dr. Rieux, who demonstrates "a dogged unshakeable commitment to relieve human suffering" in the midst of a disenchanted world.[51]

In addition to explaining life goods as goods, constitutive goods also empower us. They move us to act or aspire for those goods. They are "moral sources" in this deeper sense: "it is a something the love of which empowers us to do and be good."[52] The moral life for Taylor, that is,

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[48] Taylor, *Sources of the Self*, 93.

[49] Charles Taylor, "The Diversity of Goods," *Philosophy and the Human Sciences: Philosophical Papers 2* (New York: Cambridge University Press, 1985), 230-247, 241-242. See also Charles Taylor, "Ethics and Ontology," *The Journal of Philosophy* 100 (2003): 305-320, 309.

[50] These are examples Taylor explores in *Sources of the Self*; see e.g., pages 93, 341, 308.

[51] Taylor, *Sources of the Self*, 92-93, 411. See also Taylor, "Iris Murdoch and Moral Philosophy," in *Iris Murdoch and the Search for Human Goodness*, edited by Maria Antonaccio and William Schweiker (Chicago: University of Chicago Press, 1996), 3-28, 13. For a more detailed secondary discussion of constitutive goods, see Ruth Abbey, *Charles Taylor* (Princeton: Princeton University Press, 2000), 47-52.

[52] Taylor, *Sources of the Self*, 93.

being a good person, is a matter not only of doing what is right or exhibiting good qualities but also of loving what is good. In the very first page of *Sources of the Self*, he critiques contemporary moral philosophy for its "focus on what it is right to do" at the expense of any concern for "what it is good to be," thus obscuring any "notion of the good as the object of our love or allegiance or … as the privileged focus of attention or will."[53] In positing constitutive goods, therefore, Taylor deepens our perception of the moral domain so that it reflects how we ordinarily live our moral lives rather than how it tends to be theorized.

Lastly, Taylor also speaks of certain life and constitutive goods as "hypergoods." Not everyone necessarily lives with a hypergood or is aware of doing so,[54] but it meets a basic need one has to weigh, organize, and rank one's many goods. For many of us, some goods "not only are incomparably more important than others but provide the standpoint from which these must be weighed, judged, decided about."[55] A person, for example, may subscribe to the goods of "self-expression, of justice, of family life, of the worship of God, of ordinary decency, of sensitivity, and a host of others," but "consider one of these—perhaps their relation to God, or perhaps justice—as of overriding importance."[56] One draws close to a hypergood by articulation, and this is typically experienced as "a step to a higher moral consciousness."[57] But even those who are not single-mindedly committed to a hypergood recognize its powerful role.[58]

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[53] Ibid. 3.

[54] There is some debate in the literature over whether all moral frameworks have a hypergood or just some. Several thinkers, like Daniel Weinstock or Richard Rorty, have assumed the former. However, I am persuaded by Ruth Abbey's more considered reading on this score. She argues that only some people's frameworks have hypergoods: "if hypergoods were experienced by all, the challenges of pluralism would not be as piquant as Taylor frequently suggests they are. His attempt to provide a phenomenology of moral life is also significant here, for many people do live their lives devoid of any sense of such a preponderant good" (Abbey 37).

[55] Taylor, *Sources of the Self*, 63.

[56] Ibid. 62.

[57] Ibid. 64.

[58] Ibid. 63, 92.

Charted in this way, the diversity of moral goods in modern life is evident at two levels: history and experience. At the level of history, Taylor rejects any simplistic telling of the story of modern identity as one of either ascendance or decline. To be sure, hypergoods are often a source of conflict; they tend to be exclusive. Such moral sources, when widely adhered to, often arise through "a historical supersession of earlier, less adequate views."[59] Platonism superseding a Homeric honor ethic and Judeo-Christian revelations superseding various forms of what they perceived as idolatries are examples. More recently, the principle of universal and equal respect has largely replaced earlier hierarchical conceptions of society.[60] Supersession indeed is part of the story that Taylor so powerfully tells in *Sources of the Self* and in *A Secular Age*.

But supersession is neither the only nor even the primary story. Taylor narrates how the older moral sources persist and remain as sources of criticism of present practices and beliefs. It is true that we moderns largely share a commitment to universal justice and beneficence, equality, freedom and self-rule, and the avoidance of death and suffering. But the sources underlying this general agreement are in fact more conflictual and complex than is typically grasped.[61] In *Sources of the Self*, for example, Taylor narrates the development of three facets of this identity: "the sense of ourselves as beings with inner depths, and the connected notion that we are 'selves'," "the affirmation of ordinary life," and "the expressivist notion of nature as an inner moral source."[62] These draw variously from three larger domains—theism, naturalism, and expressivism—which themselves influence and problematize each other.[63] Far from a neat chronological development, Taylor offers a picture of complex crisscrossing influences and multiple modernities.[64]

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[59] Ibid. 64.
[60] Ibid. 64-65.
[61] Ibid. 495.
[62] Ibid. x.
[63] Ibid. 496.
[64] Taylor expands on this basic idea in a later work, *Modern Social Imaginaries* (Durham, NC: Duke University Press, 2004). There, he examines more closely the practices and socio-historical processes of society. Invoking the term

This history means that no single framework now reigns supreme. None can be taken for granted as an unquestioned fact. At the level of experience, then, some of us react by "holding a definite traditionally defined view with the self-conscious sense of standing against a major part of one's compatriots." Others of us feel that our framework is merely one among others: "right for us but not necessarily binding on them." Still others of us see ourselves as on a quest, holding to a framework tentatively; we are aware of our own uncertainties, unable to "recognize a definitive formulation with ultimate confidence."[65] Taylor's massive project, *A Secular Age*, can thus be read as an articulation of the conditions that explain an instance of this circumstance—that belief in God is but "one option among others, and frequently not the easiest to embrace."[66]

Inhabiting Difference

This modern situation poses a familiar problem of diverse goods, namely, how to inhabit our differences. Our diverse moral outlooks coexist in tension, and are often sources of acute moral dilemmas. What is entailed in living with our differences as strong evaluators? Taylor's answer to this question involves achieving a cognitive coherence regarding the conflicting goods in our lives. However, as I will go on to argue, the answer falls short of his ontological turn, his search for an account of the self that best makes sense of our lived experience. This critique will also be my point of departure for moving on to Augustine in order to clarify what is at stake in this problem.

With respect to difference, specifically with respect to conflicting hypergoods, Taylor charts a strategy between two extremes. He rejects, on one side, what he calls the "revisionist"

"social imaginaries," he seeks to get broader and deeper into "the ways people imagine their social existence, how they fit together with others, how things go on between them and their fellows, the expectations that are normally met, and the deeper normative notions and images that underlie these expectations"(23). Though his focus in the book is on Western modernity, his larger claim is that today's multiple modernities need to be understood in terms of the multiple social imaginaries involved.

[65] Taylor, *Sources of the Self*, 17.

[66] Taylor, *A Secular Age*, 3.

stance. This option embraces a single hypergood in rejection of all others. Taylor notes as an example the guardians in Plato's *Republic*, who are denied the goods of family and property for the sake of social harmony. On the other side is the Aristotelian move of affirming all goods; Taylor calls this the "comprehending" strategy. While one good, such as contemplation, may rank above the others, it does not altogether deny those others. The parts instead are held together within a greater whole, the good life as a whole is conceived as supreme. But according to Taylor, both strategies succeed only in avoiding the dilemma. The first denies all other goods in the worship of one, while the second uncritically affirms all goods as consistent within a larger whole.[67]

Is critical judgment among competing goods possible? The empiricist temptation is to accept that it is not. One version simply dismisses hypergoods, or values in general, as our subjective projections onto a neutral world. But even if this first version is rejected in favor of seeing our values as having a reality beyond the individual, the tendency is to adopt a stance of cultural relativism. Although more sophisticated, this second version only shifts the reductionism of value. Any "truth" in a value or meaning is tied inextricably to a certain mode of life, and is necessarily judged within it. "To the extent to which these goods appear not to be so from the standpoint of another way of living, or even appear sometimes to be wrong or evil," Taylor writes, "there is no way of adjudicating the dispute."[68] The reductionism imposes an "in-principle limit" on the possibility of intercultural critique.

But the problem with the empiricist positions, for Taylor, is that of making sense. Theories of the first sort, which reduce our values to individual projections, cannot make sense of our strong evaluations or orientation to moral fullness. This is problematic because the very act of espousing, deliberating, and making judgments about values and their motivations presupposes qualitative

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[67] Taylor, *Sources of the Self*, 65-66.

[68] Ibid. 67.

distinctions.[69] Likewise, theories of the second sort, which reduce to cultural relativism, fail to account for our persistent unease that at least some of the many goods that people espouse but are objectionable or even abhorrent to us must be wrong, if not illusory.[70] Strong evaluations of this sort cannot simply be ignored, and any adequate stance or strategy regarding our differences must account for our experience of such evaluations.

Taylor thus proposes an alternative third option against the revisionist and comprehending strategies, namely, what he calls the "BA principle." The search here is for the "best account" of our lived experience, to "make the best sense of our lives."[71] The "best" here is the limit of what can be achieved insofar as there can be no absolute standpoint from which to assess an account of our lives. The principle rejects explanations that rely on the terms of a third-person observer since its standpoint is of "no use to the agent in making sense of his own thinking, feeling, and acting." The observer might claim to explain people's behavior without resort to strongly evaluative terms like "dignity," but the move thereby risks imposing terms that, in effect, "change the subject." It is apt to miss an array of experiences in which we cannot do without that term, in which that term underwrites our most clairvoyant explanations to date.[72]

Instead, the BA principle's approach to difference entails proceeding comparatively by way of "error-reducing" moves, by showing that one account is superior to another. This may involve resolving a contradiction or confusion or identifying an important consideration that was previously obscure. This mode of argument is akin to a biographical narrative. The idea is that I thereby transition from one account to another in an experience of "moral growth," and it is this sense of growth that grounds my confidence in the account I come to embrace. The growth, to be

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[69] Ibid. 59.
[70] Ibid. 71.
[71] Ibid. 58.
[72] Ibid. 57.

sure, may be false or illusory. But the argument over its validity would be resolved not by appeal to some absolute criterion but in terms of the best interpretation of the life I am living.[73]

Toward a Self Claimed by Love

Taylor's BA principle is well and good as far as it goes. But it is presented as primarily a cognitive exercise of an individual strong evaluator—as a person's drive for conceptual coherence. Largely missing in the approach is a robust accounting of the intersubjective dimensions of our experience of moral growth. While attending to the coherence of cognition, it neglects an ontological question of the coherence of being. Is a person's moral space constituted only by the self and the self's moral meanings, or does it consist in something more? The question, put differently, is whether a person is accountable to anyone other than the self with respect to the truth of one's moral growth. For Taylor, as William Schweiker surmises, "it is with respect to the self's act of radical evaluation that the moral space is defined as such since the self alone can endorse a normative standard for orienting life."[74] By contrast, I want to argue that our strong evaluations are indexed to the self not merely as a self alone but as a self-in-relationship.

To be sure, as I have been describing, Taylor is well aware that a person's identity is constituted by social worlds. But the awareness of those worlds is primarily sociological. For example, in one noteworthy work, Taylor traces the history of Western modernity in terms of "social imaginaries." His interest is in "the way we collectively imagine, even pretheoretically, our social life."[75] The model identifies as relevant not only "the ways people imagine their social existence" but also "how things go on between them and their fellows."[76] But for all that, Taylor's

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[73] Ibid. 72.

[74] William Schweiker, "The Good and Moral Identity: A Theological Ethical Response to Charles Taylor's *Sources of the Self*," *Journal of Religion* 72 (1992): 560-572, 568.

[75] Taylor, *Social Imaginaries*, 50.

[76] Ibid. 23.

primary object of study are the imaginaries that condition the self's identity, which are indeed richly complex and nuanced. But the picture of the self oriented within the imaginaries is of one who, though culturally encumbered, ultimately answers for oneself. We seem to inhabit those imaginaries only as "selves among other selves."[77]

A similar sociological concern drives Taylor's other major works *Sources of the Self* and *A Secular Age*. In the former, the sources of our modern identity and its complex development are at issue. In the latter, at stake are the historical changes in the conditions of belief in God. Taylor even deploys a Durkheimian description of belief conditions to trace the shifts. Believers in the West between 1500 and 2000 are pictured as inhabiting paleo-, neo-, and post-Durkheimian cultural milieus.[78] These describe different dispensations for relating the social and sacred, which range from the two being inseparably intertwined, to sacred life expressing a larger social identity, and finally, to an uncoupling of the two altogether. The complex movements and contestations of these ideal types, in turn, are shown to affect how we think about and participate in religious life.[79] But again, though richly imagined, Taylor is unclear as to how a strong evaluator inhabits these sociological conditions, other than in terms of conceptual coherence.

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[77] The turn of phrase here is Schweiker's (568), which he deploys in his review of another of Taylor's works, *Sources of the Self*.

[78] In the paleo-Durkheimian dispensation, the social and the sacred are one. The paleo societies, such as the Ancien Régime, presumed the state's dependence on God and higher time—a sense that a "higher" reality, such as "eternity," gathers, assembles, reorders, punctuates "profane, ordinary" time (Taylor, *Secular Age*, 54). In neo dispensations, such as in 19th century American "civil religion," "God is present because it is his Design around which society is organized." The Design allows for a freedom that lends itself to denominational structures that coexist within a state "under God" (459). In a post-Durkheimian milieu, "the 'sacred,' either religious or 'laïque,' has become uncoupled from our political allegiance" (487).

[79] For example, in a paleo-Durkheimian milieu, "people could easily feel that they had to obey the command to abandon their own religious instincts, because these being at variance with orthodoxy must be heretical or at least inferior." In a neo-Durkheimian world, by contrast, "joining a church you don't believe in seems not just wrong, but absurd, contradictory." Finally, in a post-Durkheimian age, "many people are uncomprehending in the face of the demand to conform … the idea of adhering to a spirituality which doesn't present itself as your path, the one which moves and inspires you" (Taylor, *Secular Age*, 489).

The self's formation, or moral growth, is accountable to and dependent on the conditions, sources, or imaginaries that constitute the self. The BA principle entails that the self comparatively resolve their conceptual contradictions, confusions, or obscurities. This much is clear in Taylor's account, but beyond that, there seems to be an important omission. What strikes me about the problem of difference is not only the possibility of conceptual clarity but also our all-too-common and willful rejection of the claims of the other. This human propensity, what Augustine calls our lust to dominate, is evident throughout the history of modern identity. As Schweiker notes, this propensity indeed underlies an abiding concern in Western thought for "conscience" or "a law of love." This has long been a way to make sense of "the categorical character of moral norms" and to guard against "the fallenness or inauthenticity of life."[80] In this sense, even as we have long denied the claims of love, they nonetheless "resonate" in us as deeply as any demand of coherence.

To see the force of my concern and the problem it poses for Taylor, consider his analysis of the "ethics of authenticity" as a dominant ideal within Western modernity. Taylor departs from critics who repudiate the ethic wholesale as narcissistic, hedonistic, or self-indulgent.[81] Their disavowal, he argues, is too quick; they miss the ways in which we experience the question of authenticity not so much as self-indulgence but as a "moral ideal." Its quintessential articulation—that "each of us has an original way of being human"—may be Herder's, but it is now a part of our consciousness. We moderns indeed feel "called upon" to live authentically in this way: the sense is that "if I am not, I miss the point of my life, I miss what being human is for *me*."[82]

Taylor instead recommends engaging the ethic by helping to realize authenticity in its "higher and fuller modes" as against its "flatter and shallower forms."[83] The task is neither to

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[80] Schweiker, 568.

[81] Taylor has in mind critics Allan Bloom in *The Closing of the American Mind*, Daniel Bell in *The Cultural Contradictions of Capitalism*, and Christopher Lasch in *The Culture of Narcissism* and *The Minimal Self*.

[82] Charles Taylor, *The Ethics of Authenticity* (Cambridge, MA: Harvard University Press, 1991), 28-29.

[83] Ibid. 94.

wholly reject or embrace the ethic as it is lived but to deny its erroneous expressions. Such errors include appeals that elevate "choice as itself a good to be maximized," that instrumentalize all relationships to self-fulfillment, or that ignore "whatever transcends the self: for rejecting our past as irrelevant, or denying the demands of citizenship, or the duties of solidarity, or the needs of the natural environment."[84] Such deviations are ultimately incoherent; they reduce moral life to a relativism that is self-defeating—that undercuts even the very source of modern subjectivism that powers it.[85] "Far from being a reason to reject the moral ideal of authenticity," he writes, such errors should in fact "be rejected in its name."[86]

Consistent with the BA principle, Taylor here argues against deviant modes of authenticity by appeal to their conceptual errors, their incoherence. But by the same token, he misses the deeper, even if incoherent, *appeal* that deviant expressions of authenticity in modernity have on us. What Taylor calls deviant modes of authenticity in fact seem to be increasingly live options today, as though these too were moral ideals: many of us consciously aspire to exult in asserting one's authenticity in ways that recognize few, if any, limits. Of course, the importance of attending to the confusions that drive such options should not be denied. But by itself, the response feels inadequate; it seems to miss a deeper root of the problem. In order to make sense of this, then, we do well to further clarify the self as relationally constituted.

A Moral Space Constituted by Love's Claims

In order to clarify this crucial relational gap in Taylor's account of the self, I now propose to turn to Augustine. Of course, attention to the relational dimensions of moral life is not new. But turning to Augustine is apt for two reasons. First, he attends to our relationality from a self-referring,

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[84] Ibid. 22.
[85] Ibid. 17, 21.
[86] Ibid. 22.

hermeneutical concern. In the first lines of his great work the *Confessions*, he writes, "You stir us so that praising you may bring us joy, because you have made us and drawn us to yourself, and our heart is unquiet until it rests in you."[87] We are by nature "unquiet," or "restless" in other translations. Far from self-sufficient, we are fundamentally incomplete or impermanent, and this sense of lack drives our desire for the good. Anticipating Frankfurt, Augustine sees love as "nothing other than to desire something for its own sake,"[88] for it is in possessing our final end that we are happy. Where Frankfurt speaks of wholeheartedness and Taylor of fullness, Augustine posits a longing for rest.

Second, Taylor himself attributes to Augustine a central role in the making of modern identity, as bequeathing to Western moral tradition what Taylor calls a "radical reflexivity." This self-referential stance is not just about self-concern. It is one thing to say—with the modern sciences—that the world is known or experienced by self-concerned agents. It is another to adopt a stance in which "what matters to us is the adoption of the first-person standpoint,"[89] in which self-reflection itself is the object of one's concern. "Do not go outward," Augustine cautions, "return within yourself. In the inward man dwells truth."[90] The Augustinian insight, Taylor notes, is that by attending to the self's self-awareness, "reason recognizes that there is a truth which is criterial for it, i.e., a standard on which it regulates itself, which is not its own making, but beyond it and common to all."[91]

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[87] *Conf* I.1; all citations to *Conf* are from Augustine, *The Confessions*, 2nd ed., trans. Maria Boulding (Hyde Park, NY: New City Press, 2012).

[88] See, e.g., Augustine, "Eighty-Three Different Questions," in *The Fathers of the Church, vol. 70: A New Translation*, trans. David Mosher (Catholic University of America Press, 1982), 35.1.

[89] Taylor, *Sources of the Self*, 130.

[90] Ibid. 129. The original Latin that Taylor translates is, "noli foras ire, in teipsum redi; in interiore homine habitat veritas."

[91] Ibid. 132. Augustine's move does not end in the self, whereby "the vantage point of the 'I think' is somehow outside the world of things we experience" (131), that is, an empiricist's "view from nowhere." Taylor suggests this is an aberration that is attributable more to the legacy of Descartes.

Now, on Taylor's reading, Augustine's concern is with the truth of the self's reasoning. Even as we are fully present to ourselves, we can be mistaken about ourselves: "we can search to know ourselves; and yet we wouldn't know where to begin looking or be aware that we had found ourselves unless we already had some understanding of ourselves."[92] But unlike Plato's theory of Ideas, the standards of reason—which we experience as given or discovered as opposed to invented by us—is to be found in God, who in turn is found "at the very foundations of the person."[93] We are not taught the principles of right judgment so much as we "remember" the God within, and this is the sense in which, for Augustine, God is "closer to me than I am myself, while being infinitely above me."[94] Thus, in radical self-awareness, Taylor takes Augustine to be saying, we discover the very condition of our self-knowledge; we realize our necessary dependence on something higher, a truth that makes sense of the self in the first place.

Along these lines, Taylor further argues that for Augustine, moral evil consists not in reflexivity per se but in a reflexivity that is "enclosed on itself." This is because knowledge exists in a complex relation with the will: "the will is as much the independent variable, determining what we can know, as it is the dependent one, shaped by what we see."[95] The problem is that we experience the will as deeply divided between a desire for the good and the base—the "higher and immaterial" versus the "lower and sensible." We often do not desire the good that we see, or see the good that we should.[96] Instead of seeing and loving the condition of our existence as we ought, we love the self as that condition and seek to dominate and possess all things to ourselves. Thus, on Taylor's telling, the Augustinian road to healing is through a radical self-reflexivity that

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[92] Ibid. 134.
[93] Ibid. 134.
[94] Ibid. 136.
[95] Ibid. 138.
[96] Taylor here notes that the causality is circular, not linear. This differs from "the simpler 'Socratic' model according to which we always act for the good we see" (Ibid. 138).

recognizes its dependence on the higher: "healing comes when it is broken open, not in order to be abandoned, but in order to acknowledge its dependence on God."[97]

However, this reading understates a crucial relational dimension in Augustine's moral thought. This is perhaps unsurprising given Taylor's neglect of the same in his own account of the self's moral space—his concern to chart the sources of a self whose strong evaluations alone orient one's life. In my view, the fundamental dynamic for Augustine is not merely between the self and the divine as the condition of one's truthful self-presence. The moral space is constituted by more than that; there is a third, the neighbor. The moral problem that God illumines is not just the restlessness of a solipsistic self-presence but of a self who always already exists in relations of love, who inhabits a matrix of love's claims. At stake for Augustine is the happiness of a self who is essentially not only dependent on a higher truth but also beholden to the neighbor.

Augustine argues that the divided will—our restlessness—is a problem of sin, which is fundamentally relational in nature. This is why a solution like that of Frankfurt's—a decisive will to self-love, to love what one happens to love—does not work. Such a move only deepens the problem by understating the possibility of self-deception. The divided will is a prideful turning of the self into oneself, into the nothingness out of which one was created as a being in relation to the creator. Here, it is not the self which is evil, for that is created by God and is good, but rather, the "the defection of the will itself which is evil."[98] In defecting into oneself, "the soul cuts itself off from the very Source to which it should keep close and somehow makes itself and becomes an end

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[97] Ibid. 139. In other words, Taylor notes, the condition of radical reflexivity is what "dissipates" the will's perversity, even as that dissipation is a condition of any such radical reflexivity.

[98] *CD* XII.8; all citations to *CD* are from Augustine, *The City of God against the Pagans*, translated by R.W. Dyson (Cambridge: Cambridge University Press, 1998).

to itself."[99] In seeking to be one's own master, one lives a lie: "man does indeed wish to be happy; but he lives in such a way that it is not possible for him to be so."[100]

Crucially, however, this cutting off of oneself involves a deception concerning not only the divine but also, in the very same move, the self's relation to neighbor. This is the point that Taylor seems to neglect in his reading. For Augustine, the neighbor is an essential third in the dynamics of love's order. "There is a sense," he writes, "in which these [love of God and neighbor] either rise together to fullness and perfection, or, while the love of God is first in beginning, the love of our neighbor is first in coming to perfection."[101] To be sure, the two loves are not identical; there is an important distinction in this unity. We are to love God in the mode of "enjoyment" (*frui*), as an end in itself, while we are to love the neighbor in the mode of "use" (*uti*).[102] I will return to this oft-misunderstood distinction in the subsection below. But suffice to say, the basic point here still holds: we cannot love the one without the other.

Thus, even as we experience sin as a personal "bondage" that begins with a perverted will that then becomes a necessity by becoming a habit,[103] sin insinuates itself in our social relations in the form of injuries, suspicions, hostilities, and war. Augustine laments that we cannot rest secure from evils even in our own households, noting that the troubles only increase as one moves into ever larger spheres of social relations, including the city.[104] In the city, self-deception implicates social-deception. Rulers knowingly and systematically spread falsehoods "in order to bind men

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[99] *CD* XIV.13.

[100] *CD* XIV.4.

[101] *Mor* XXVI; all citations to *Mor* are from Augustine, "The Morals of the Catholic Church," in *Basic Writings of Saint Augustine*, ed. Withney J. Oates, vol. 1 (Grand Rapids, MI: Baker Book House, 1948), 318-357.

[102] *DDC* I.XXII.20-21; all citations to *DDC* are from Augustine, *On Christian Teaching*, trans. R.P.H. Green (Oxford: Oxford University Press, 1997).

[103] In a memorable line in the *Confessions*, Augustine writes, "For my will was perverse and lust had grown from it, and when I gave in to lust habit was born, and when I did not resist the habit it became a necessity. These were the links which together formed what I have called my chain, and it held me fast in the duress of servitude" (VIII.5).

[104] *CD* XIX.5.

more tightly, as it were, in civil society, so that they might likewise possess them as subjects."[105] Pride reigns in the social realm, and entire peoples are inevitably deceived in this way.

Likewise, healing from the bondage of sin involves reorienting a relational self. It entails not only a recognition of one's being conditioned by a higher reality, per Taylor's reading, but also a training of the heart in acts of love.[106] Love, Augustine notes, "is never perfect as soon as it is born. It is born that it may be perfected. Born it is nourished: nourished, it is strengthened: strengthened, it is made perfect."[107] Our obligation, he exhorts, is to make a beginning, "if you are not yet capable of dying for your brother, show now your capacity to give him of your goods."[108] We can preserve and restore the neighbor's bodily health by means of medicine, food and drink, clothing and shelter, etc. with compassion and prudent benevolence, as well as help to discipline their mind through restraint and instruction.[109] After all, we ourselves typically desire no less. We are, in these ways, daily to "cherish [love] so that it be not stifled."[110] At stake is not just a duty born of recognition but a becoming, a healing of the relational bonds that constitute the self.

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[105] *CD* IV.32.

[106] There is a major point that might be made here about grace and free will in Augustine's moral thought, but it likely takes us too far astray. My primary point here concerns the relational nature of sin and our healing from it. The precise role of grace in actualizing the self's progress in love need not detain us. Suffice to say, as Taylor notes (see above), the will in Augustine is as much shaped by what we see as it shapes what we are able to see. Grace thus constitutes a necessary in-breaking that both reveals and enables us to do and be good. But in so doing, grace need not mock our free will. As Aquinas might put it, grace does not "destroy nature" or set it aside but "perfects it." In his treatise on "Grace and Free Will," Augustine too writes, "in beginning [God] works in us that we may have the will, and in perfecting works with us when we have the will … He co-operates with us" (XXXIII). A long history of Christian thought has held that "human will is so depraved by the Fall that humans require grace even to make a decent attempt at and perhaps even properly to discern the natural good, let alone to go beyond it." But Taylor calls such interpretations radical, or "hyper-Augustinian" (*Sources of the Self*, 246). I am inclined to agree.

[107] *IoEp* 5.4; all citations to *IoEp* are from Augustine, "Ten Homilies on the First Epistle General of St. John," in *Augustine: Later Works*, trans. and ed. John Burnaby (Philadelphia: Westminster Press, 1955).

[108] *IoEp* 5.12.

[109] *Mor* XXVII, XXVIII.

[110] *IoEp* 5.7.

Loving Rightly

On my reading of Augustine, the moral problem deepens beyond a Taylorian concern for right recognition of our sources, conditions, or imaginaries. Herein lies the appeal of untrammeled self-authenticity. It is rooted in a willful failure to orient ourselves rightly in our moral space in terms of the claims of others on us. While error-reducing coherence remains crucial, the issue more fundamentally involves what it means to inhabit our loves rightly and to be formed in such loves. This, Augustine suggests, is at the heart of our restlessness as hermeneutical selves. On this picture, to be at rest—to be fully coherent as a self—is to be oriented ethically toward the other. Given what Schweiker notes is our perennial concern for conscience or a law of love in the West, I take this Augustinian recognition to be an important epistemic gain.

The moral space in Augustine is an order of love. Being rightly oriented within it entails, as a first prerequisite, seeing what we ought to love. Happiness can be either true happiness, that for which we were created, or false happiness. It turns not only on whether we possess the desired object but also on the nature of the desired object. Augustine notes that we suffer when we do not possess what we love, or do not love what we ought to possess, or possess what is in fact harmful. He reasons that true happiness is achieved only when "that which is man's chief good is both loved and possessed."[111] What is more, if that good is to quiet a restlessness born of our impermanence as finite beings, then it cannot be a good of equal impermanence; it "must be something that we cannot lose against our will."[112] Only God, as the eternal source of all that is, meets that criterion. The divine thus makes sense of our deepest longing for happiness, without which only a perverse despair would remain.

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[111] *Mor* III.

[112] *Mor* VI.

But again, Augustine reasons about God as a response to the restlessness not of a self who stands alone but of a self who is relationally constituted. The chief good, in this sense, is a common object of love—that to which we are all beholden. Indeed, it underwrites the goodness of all that is simply in that they exist. Augustine affirms the many goods of life as valid objects of love, including persons. In virtue of our createdness, we all participate in the goodness of our creator. All that *is* is good, Augustine writes, "God has made all things *exceedingly good*,"[113] and again, "there is no wholesomeness for those who find fault with anything you have created."[114] This is why, conversely, evil is understood as a privation, a destruction that ends in nonexistence: "evil ... cannot be a substance, because if it were, it would be good."[115] Insofar as we exist, our goodness is ontologically inescapable.

This is a theological claim, to be sure, but also at stake is the very possibility of relational equality between persons. The divine makes sense of an aspect of moral experience that we all care about, namely, just relations. Given the nature of sin—a curving in of the self that indexes all else to the self—Augustine's affirmation of goodness conceives the neighbor as constitutive of the self as an other to be respected rather than to be possessed. The worth of the other is determined not by what one prefers or projects on to the other but by our common status as creatures of a chief good. Augustine's favored phrase is "in God." In God, the neighbor, like all mutable goods, takes on what Richard Miller calls "iconicity." The neighbor points beyond herself "to enduring principles that secure temporal reality's objectivity and alterity, making that reality available to us independently of our desire to grasp it for confidence and control."[116]

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[113] *Conf* VII.18.

[114] *Conf* VII.20.

[115] *Conf* VII.18.

[116] Richard B. Miller, "Evil, Friendship, and Iconic Realism in Augustine's *Confessions*," in *Friends and Other Strangers: Studies in Religion, Ethics, and Culture* (New York: Columbia University Press, 2016), 173-197, 178.

Seeing the neighbor for what she is, an icon in this sense, is therefore crucial to being rightly oriented in one's moral space. This also leads to a second prerequisite, which is the corresponding need to love in the correct mode. This brings me back to the distinction between *uti* and *frui*. Augustine argues that all created things are to be loved in the mode of "use" while only the creator is to be loved in the mode of "enjoyment": when I use something, I do so with reference to some other end, while when I enjoy something, I do so as an end in itself. For Augustine, material goods are the most unambiguous objects of human use. But persons too are to be loved in the form of use, in reference to God. One is to love oneself in the same way.[117] The point is to order our loves so as to love mutable goods in a manner commensurate with their created nature—to love changeable goods for what they are, icons.

This *uti-frui* distinction is easily misunderstood. Modern readers have critiqued Augustine for treating persons as means rather than as ends. Hannah Arendt, for instance, reads Augustine as "using" the neighbor for a still higher, radically distinct, good instead of attending to her in any genuine way.[118] But on my reading, the *uti-frui* distinction opposes precisely what such critics accuse Augustine of advising. In *On Christian Teaching*, immediately following his conclusion about the "use" of persons, Augustine reasons as follows: "for if something is to be loved on its own account, it is made to constitute the happy life, even if it is not as yet the reality but the hope of it

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[117] *DDC* I.XXII.20-21.

[118] Hannah Arendt has been influential on this point. She writes that because Augustinian love is ordered in light of an "absolute future" as its end, "the love of my neighbor is at best a secondary consideration for a desire whose aim transcends mankind and the world, both of which have justifiable existence only to the extent that they can be 'used' for the sake of something that is radically different and separated from them" (Hannah Arendt, *Love and Saint Augustine*, ed. J.V. Scott and J.C. Stark (Chicago: University of Chicago Press, 1996), 41.) This particular interpretation, however, depends on the adequacy of her interpretation of "absolute future" and her asserted discontinuity between finite existence and absolute future in Augustine's thought. Her understanding of that future, however, does not comport with what I consider to be Augustine's communal picture of our eternal "participation" in the Trinity, which itself is a unity in plurality, and in "fellowship" with the saints; and we do so as bodied beings (*CD* IX.15; *CD* XIII.20; *CD* XIV.28). But this issue need not detain us here.

which consoles us at this time."[119] The critics thus miss a crucial insight: it is precisely in loving the other as the final end that one paradoxically uses the other to quiet one's own restlessness. Such love both overstates, with respect to finitude, and understates, with respect to equality, the other's significance in relation to the self.

Augustine indeed demonstrates a deep concern for the ways in which we seek to possess others for our own ends, even under the noble guise of love. "All men," he writes, "desire to have peace with their own people, whom they wish to see living according to their will. For they wish to make even those against whom they wage wars their own if they can, and to subdue them by imposing upon them the laws of their own peace."[120] Therefore, the only way not to exhaust the meaning of others by viewing them in terms of their capacity to satisfy one's own desire, Augustine suggests, is to love them in God, as creatures like oneself.[121] People, he cautions, "are not to be loved as things to be consumed, but in the manner of friendship and goodwill,"[122] that is, as equals. We are to seek peace with all, which is to say, we "harm no one" and we "do good to all" so far as we can.[123]

The contrast in the quality of love in Augustine can be described, as Miller does, in terms of "narcissism" and "heterology." Miller reads in the *Confessions* a striking contrast in "onlook," or stance, toward the death of loved ones before and after Augustine's conversion.[124] Before, in book

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[119] *DDC* I.XXII.20; see also *DDC* I.XXIII.23. In other words, as Rowan Williams explains, "the language of uti is designed to warn against an attitude towards any finite person or object that terminates their meaning in their capacity to satisfy my desire, that treats them as the end of desire, conceiving my meaning in terms of them and theirs in terms of me" ("Language, Reality and Desire in Augustine's *De Doctrina*," *Journal of Literature & Theology* 3 (1989): 138-150, 140).

[120] *CD* XIX.12.

[121] As Oliver O'Donovan puts it, for Augustine, right relation to God "is the only purpose that the subject can conceive for the object [of love] which he can be absolutely sure is not willful imposition" (*The Problem of Self-Love in St. Augustine* (New Haven: Yale University Press, 1980), 35).

[122] *IoEp* 8.5.

[123] *CD* XIX.14.

[124] In using the term "onlook," Miller cites Donald Evans. An onlook is a stance or attitude. Miller notes that one's onlook involves more than merely having a "perspective" on something. "Onlooks rather involve us by way of feeling, posture, commitment, vision, and intentionality." It involves the particularities that matter to me, "to our

IV, Augustine recalls mourning the death of a dear friend to whom he "had been like another self." At his death, he experienced a "black grief," "a hideous anguish" and hatred toward "all things because they held him not."[125] Death "had taken him from me," he writes, and "I hated it as a hideous enemy, and feared it." Tellingly, even as he "wept very bitterly," he found repose in it: "miserable as I was, I held even this miserable life dearer than my friend."[126] "A species of *cupiditas*," Miller notes, "Augustine's grief had himself as its object." The attachment had been idolatrous, seeing the friend as more than he was, and driven by a possessive narcissism.[127]

But after his conversion, in recounting the death of his mother Monica, Augustine aspires to an onlook that triangulates *caritas*, iconicity, and heterology. In loving her in God, he regards her iconically. He describes, for instance, a shared time before her death in which they journey inward and upward, transcending for a moment to "*That Which Is*."[128] Moreover, upon her death, he speaks not of "one soul in two bodies" as with his friend, but of a shared life "woven out of mine and hers."[129] He speaks not of a self-indulgent "repose" but of "woe" at his own grief. Comfort is instead found "in weeping before you [God] about her and for her, about myself and for myself."[130] The sadness, far from possessive, moves as a prayer for her good, a prayer for divine mercy and forgiveness.[131] An iconic vision, Miller argues, makes possible *caritas*, a love that respects the "alterity of the other and, with that, its independent goodness."[132]

Augustine's reflections on the nature of right loving therefore marks an epistemic gain with respect to our moral experience of difference. Over against Taylor's account, Augustine's

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basic normative commitments—commitments that involve us at the very root of our identity and our nonneutral stance toward others and the world" (Miller, 4-5; see also 179).

[125] *Conf* IV.9.

[126] *Conf* IV.11.

[127] Miller, 181.

[128] *Conf* IX.23-24.

[129] *Conf* IX.30.

[130] *Conf* IX.31, 33.

[131] *Conf* IX.35.

[132] Miller, 179.

makes sense of our abiding worries about self-indulgent human desires that seek to dominate or possess others and all things to oneself—to deny others' claims of love. For Frankfurt too, it is precisely because of the need for love to be disinterested, as opposed to infatuated or possessive, that he argues for self-love as love's surest expression. But of course, for Augustine, such a prescription is self-defeating. The other is not an obligation for a self who is fundamentally alone—one who is self-sufficiently wholehearted. The Augustinian concern for loving others rightly speaks to the very constitution of the self's moral identity as a self-in-relationship and what it means for such a self to find rest, to be wholehearted, or to be in a place of fullness.

A Question of Transcendence

There is a potential objection to be addressed at this point. Does, as Augustine would have it, a rightly ordered relational moral space require reference to God, a reality beyond the self and neighbor? That is, does human flourishing entail an aspiration to a good that transcends it? This is an open question today. As Taylor argues, we now live in an age in which "a purely self-sufficient humanism" is "a widely available option."[133] We inhabit significant "cross pressures," and hence a choice, between two responses: "we can either see the transcendent as a threat, a dangerous temptation, a distraction, or an obstacle to our greatest good. Or we can read it as answering to our deepest craving, need, fulfillment of the good."[134] Augustine falls into the latter, but on what basis can we weigh one way or the other?

To be sure, modern life is conditioned by what Taylor calls "an immanent frame." The frame is made up of "the buffered identity of the disciplined individual," a self who is closed off

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[133] Taylor, *A Secular Age*, 18.

[134] Ibid. 548; later, he also characterizes the cross pressure as between "orthodox religion" and "materialist atheism." There are many middle positions in between, but they define themselves in comparison or contrast with other positions, among which are the extremes. "In this sense, the cross pressure defines the whole culture" (598).

from and invulnerable to the world of spirits and powers, and thus capable of a disengaged, self-controlled rationality. In this social space, "instrumental rationality is a key value, and time is pervasively secular." We are conscious of time primarily in our ordinary sense of chronology, and have lost sight of older notions of "higher time"—of which eternity is one—that "gathered, assembled, reordered, punctuated" ordinary time.[135] The immanent order, which is common to all in the West, is in these ways characteristically "natural" as opposed to "supernatural." Crucially, however, this frame does not constitute a "closed world structure." It permits closing off all possibility of transcendence, but it equally permits the opposite.[136]

The temptations toward closure, Taylor observes, are based not on any strength of argument but on moral appeals that "spin" the frame in its direction. An important facet of closure, for example, is the notion of the "death of God." This is said to be underwritten by science, which is said to prove that we are material beings moved only by physical relations and causes. Religious claims are thus myths. But according to Taylor, the argument is philosophically weak. What in fact draws so many to it are the moral ideals that surround it, such as the courage to face a cold and meaningless world for what it is and to let go of our comforting illusions about it.[137] This similarly applies to other facets of closure that have become axiomatic: "the narrative of subtraction," "the rise of modern political-moral spaces," and "the authorization of values by the autonomous self." Together, these tell an inspiring tale of moral growth that then confirms our original perceptions and, in a positive loop, spins us toward closure.[138]

But other facets of human experience have long resisted this spin. Against materialism, for instance, Taylor points to three: the sense that "we aren't just determined, that we are active,

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[135] Ibid. 542. For a discussion of the buffered self, see 38-39; for more on time, see 54-59.
[136] Ibid. 550-551.
[137] Ibid. 560, 566.
[138] Ibid. 590.

building, creating, shaping agents"; that "we have higher ethical/spiritual motives"; and that "art, nature moves us; we have a deeper sense of meaning; we can't see our 'aesthetic' responses as just another form of pleasurable reaction."[139] The issue is not that materialism ignores these experiences altogether but that its explanations have seemed implausible to many. A materialist account of moral motivation, for instance, fails to account for strong evaluations. Or, as Taylor also rhetorically asks, can our deepest responses to Rembrandt really be captured by how colors trigger certain reactions in the brain?[140]

There can be no absolute argument one way or the other—at least not one that avoids "a leap of faith" based on hunches.[141] Instead, per Taylor, the struggle over transcendence finally comes down to the account that makes best sense of our moral experience: namely, in what does fullness consist and what is our ethical predicament?[142] The idea is to avoid despair, to make sense of the possibility of fullness. Taylor, for his part, posits a transcendence that answers the longings of a self constituted by its strong evaluations. Building critically on this insight, I further argued that Augustine clarifies a self who is defined also by just relations, the claims of which we are prone to deny. On this view, affirming a transcendent reality of which the neighbor is an icon makes crucial sense of the possibility of rest as relational creatures. This amounts to an epistemic gain in terms of our self-understanding.

On this question of fullness—in an echo of Arendt's critique of Augustine—humanists have long worried that transcendence tempts us to escape the human condition altogether, which

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[139] Ibid. 596.
[140] Ibid. 597.
[141] Ibid. 550. By "leap of faith," Taylor refers to the way in which "our over-all sense of things anticipates or leaps ahead of the reasons we can muster for it. It is something in the nature of a hunch; perhaps we might better speak here of 'anticipatory confidence.'" On this view, "spin" is "a way of convincing oneself that one's reading is obvious, compelling, allowing of no cavil or demurral." It is a deceptive lack of lucidity about what is in fact the case (551).
[142] Ibid. 602.

would be to our detriment. Martha Nussbaum, for example, argues that "human limits structure the human excellences, and give excellent action its significance," such that to transcend those limits would be self-defeating.[143] Any such happiness would not be recognizably human. She also contends elsewhere that Christian modes of transcendence, in their effort to overcome original sin, have too often denigrated and induced disgust toward ordinary human desires. This is a stronger claim about the ways in which transcendence can actually harm, and not just defeat, the prospects of human flourishing.[144] These concerns, I believe, are well taken.

However, these concerns do not amount to jettisoning transcendence altogether. In fact, Nussbaum herself calls for an "internal" transcendence, for "delving more deeply into oneself and one's humanity, and becoming deeper and more spacious as a result."[145] The idea thereby is to be empowered to attend to ordinary human needs, to overcome one's propensity for laziness, inattention, and shallowness of feeling.[146] The problem, however, is that it is unclear how helpful this internal-external distinction is. As Taylor notes, many have and continue to experience external transcendence in terms of a return that renews and sustains the ordinary; Augustine's seems to be of this sort. While an external move can certainly tempt one to escape the ordinary altogether, a similar danger exists in Nussbaum's internal move as well. She indeed acknowledges this danger.[147] Nussbaum's move also struggles to identify what counts as external and therefore

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[143] Martha Nussbaum, "Transcending Humanity," in *Love's Knowledge: Essays on Philosophy and Literature* (Oxford University Press, 1990), 365-391, 378. She illustrates this point in the story of Odysseus, who upon being offered immortality with Calypso, declines and chooses to return to the vagaries of his mortal life. She notes that while we may not be able to fully explain the why, the decision is nonetheless intelligible, even admirable. We rightly feel uneasy about the idea of immortality, for it would not be a human life as we know it, and something of the very meaning or goodness of being human would be lost (365-367).

[144] Martha Nussbaum, "Narrative Emotions: Beckett's Genealogy of Love," in *Love's Knowledge*, 286-313, 306-307.

[145] Nussbaum, "Transcending Humanity," 379.

[146] Ibid. 378.

[147] Ibid. 380.

forbidden. For example, as Taylor notes, it would be odd to forbid an aspiration to universal love even though it transcends—in an externalizing move—the particularity of erotic love.[148]

My point here is not that Nussbaum is necessarily wrong. Indeed, granting her humanist concerns, a transcendence that is wholly independent of the self is difficult to imagine as viable. Even those sources that exist outside the self, Taylor might say, now need to be grasped in modes that "resonate" within the self, as "an order which is inseparably indexed to a personal vision."[149] But beyond this point, the question of transcendence does not lend itself to a final determination. I am with Taylor only in not foreclosing its possibility. Transcendence comes in various religious and non-religious modes. But as Augustine shows, its possibility is critical to making sense of and sustaining our moral experience—for orienting the self in a moral space that is constituted not only by strong evaluations but also by the claims of love. At the very least, the burden of argument now seems to rest with those who think otherwise.

Conclusion

The goal of this chapter has been to clarify what constitutes our moral space—our basic identity as human beings. I did so by reflecting on the nature of our agency and longing for some notion of wholeheartedness, fullness, or rest. The argument moved comparatively from Frankfurt to Taylor to Augustine, building on and clarifying the conceptual gains at each step. In sum, I have tried to clarify a picture of the hermeneutical self as one who is constituted by and accountable to not only the social meanings that one inhabits (see also chapter two) but also the claims of the other to which one is beholden. This indeed is what it means to be human and to flourish as such. This, moreover, is where the question of transcendence arises as of great significance for us.

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[148] Taylor, *A Secular Age*, 629-630.

[149] Taylor, *Sources of the Self*, 510; see also 428.

What does all this mean with respect to modern medicine? I have been arguing that in order to sustain medicine as a meaning-filled practice—as what it inescapably is—we need to get clearer about the hermeneutical self. I have sought to do just that in this chapter and the last. I first did so in reference to clinical, epidemiological, and anthropological accounts of the self, and then, in terms of the self-reflective moral theories of Frankfurt, Taylor, and Augustine. But this does not exhaust the task. In the various applied domains of medical practice, the confusions regarding the self can evolve in particular ways and be of different sorts. To demonstrate this point, I will engage two such domains in greater depth in the remaining chapters so as to further clarify the epistemic gains of the hermeneutical self in those domains. I begin with a return to the problem of malaise, but this time, with a focus on malaise as an applied problem.

CHAPTER FOUR

Burnout, Moral Distress, and Agent-Regret

In light of the hermeneutical self articulated in chapters two and three, this chapter revisits the question identified in chapter one, “Is Medicine Ailing?” I argued there that the answer is yes but that in order to make sense of why, a hermeneutical self must be presumed. Conceiving caregiver malaise as a personal or clinical matter, a confusion as to its ends, or a dehumanizing regime fails to make adequate sense of the moral dimensions of that experience—the grief over the loss of a good. That said, how is malaise to be understood and responded to as a practical matter? It is one thing to argue that a hermeneutical self must be presumed in order to make sense of the problem. It is quite another to clarify what a hermeneutical standpoint actually has to say about the malaise. This is now my constructive task.

It is important to note, however, that the implications of a hermeneutical self for caregiver malaise is not the only contention at stake. This argument will itself be hermeneutical, and in that sense, constitute a further test of our hermeneutical ontology—that is, its plausibility. As in previous chapters, my argument will proceed by way of error-reducing moves regarding the phenomenon of moral distress. The procedure will be comparative rather than empirical; each error-reducing move will represent a conceptual gain. I will thereby argue that a hermeneutical perception yields a more coherent grasp of the ordinary experience of clinician malaise and our response to it than is otherwise possible. The success of this argument in itself will constitute a further mutually reinforcing argument for the hermeneutical self.

I begin with a consensus report on clinician burnout that the National Academy of Medicine (NAM) published in December 2019.[1] The report advances a “systems approach” to clinician well-being, and at 300 plus pages, represents a comprehensive statement on the problem by the medical community. I show that while it seeks to capture the moral nature of burnout by acknowledging a related notion of moral distress, it ultimately fails to fully grasp the significance of that distress and, for that reason, does not yield a plausible response to the problem. I instead join calls to reconceive the problem in terms not of burnout but of moral distress, a construct that takes the clinician’s moral agency more seriously. I engage this promising construct in the second section, describing its crucial insights and conceptual difficulties. These in turn comprise the points of departure for clarifying the conceptual gains of a hermeneutical self.

In the third section, then, I argue that a hermeneutical perception clarifies crucial aspects of moral distress as it has been developed in the clinical literature. The perception heightens what is morally at stake in the experience, explains its cumulative effects within the narrative structure of the self, and integrates its disparate instances in self-referring terms. Specifically, I propose to refocus the experience with respect to various circumstances of moral luck and its concomitant feelings of agent-regret. In so doing, in the fourth and final section, I sharpen and broaden the policy implications. I argue for the need not only to reform institutional systems but also to make sense of agent-regret as a constitutive feature of what it means to be a virtuous clinician. I propose, in particular, an Augustinian virtue of moral grief as an apt response to moral distress that clinicians do well to foster as a moral community.

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[1] National Academy of Medicine, *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being* (Washington, DC: The National Academies Press, 2019).

A Systems Approach to Burnout

Burnout is the leading construct for talking about clinician malaise in the medical community, and the most comprehensive statement on the phenomenon to date is the report *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being*. The report is the latest in NAM's Quality Chasm Series, which began with landmark reports that led to major reforms in health systems: *To Err Is Human: Building a Safer Health System* (2000) and *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001). This latest report on clinician burnout is likewise cast as a response to an "alarming" problem requiring "immediate action." Burnout, the report notes, is "detrimental to quality of care," "costly for organizations experiencing workforce shortages," and makes for "poor teachers and role models for students and trainees."[2] Preventing burnout is therefore critical if our health systems are to reach their "maximum potential."[3]

The report defines burnout as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment."[4] The definition follows the work of Christina Maslach, a social psychologist, and is the basis for her widely used measure of burnout, the Maslach Burnout Inventory. The World Health Organization also restates these symptoms in its definition: "(1) feelings of energy depletion or exhaustion; (2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and (3) reduced professional efficacy."[5] On this standard definition, the emphasis is on work-related stressors that affect professional, as opposed to personal, attitudes and behaviors. The condition, in this sense, differs from depression or other mental health diagnoses.

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[2] Ibid. xiv.

[3] Ibid. 38.

[4] Ibid. 39.

[5] As quoted in Ibid. 40.

Clinician burnout is a “complex multi-factorial problem that is not easily solved.”[6] Its causes are many, and they are mediated by such individual differences as personality traits, cognitive abilities, or decision styles. It manifests differently in different individuals, and much like hypertension, presents in degrees of severity as opposed to dichotomously. Nonetheless, according to the NAM report, studies have identified several structural factors associated with burnout that might be managed. Some factors are related to “job demands,” such as excessive workload and administrative burden, unmanageable workflow and time pressures, and poor technology usability.[7] Other factors implicate problems of “job resources,” such as weaknesses in organizational culture, professional autonomy and flexibility, or collegial support.[8]

The question, however, is in what sense these associated factors are rightly seen as moral issues as opposed to that of optimizing clinician productivity. Viewed skeptically, claims that job demands are too high or that job resources are too low can be read as the self-interested demands of professionals who are by many measures relatively privileged. It is unclear that clinicians deal with more such burdens than others. Who wouldn’t benefit from more flexibility at work or fewer administrative burdens? In other words, is not burnout merely a management problem to be solved? Perhaps the issue is little more than a matter of political or economic negotiation. Is there really more at stake here than how much clinician turnover the public or our health institutions are willing to tolerate and what they can in fact afford?

For its part, the NAM report locates the moral nature of the problem in a troubling “imbalance” between job demands and moral resources. Most clinicians enter their profession with the moral aspirations that animate its oaths, values, and dedication to the well-being of the patient. These ideals of professionalism are goods—sources of meaning and identity—that have

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[6] Ibid. xiv.

[7] Ibid. 83 ff.

[8] Ibid. 97 ff.

long sustained the best of our clinicians and are not so readily dismissed for administrative priorities like cost efficiency.[9] Thus, when job demands persistently impede one's ability to live out such ideals, the stress can be intense and eventually lead to burnout.[10] This is why, according to the report, job demands that limit clinicians' time with patients, organizational values that prioritize business needs, and problems of patient access to care are not just managerial issues. They also endanger the professional ideals that have long structured clinical practice.[11]

A Problem of Moral Experience

Beyond observing an association, however, the report does little to make sense of why or how this inability leads to burnout or even stress. That is, in what ways do clinicians live with or respond to the dissonance of values—in what ways do they experience it? The neglect in this regard may be a consequence of the report's systems approach, which focuses on the systems-level conditions of clinician practice. But this systems perception, I argue, risks missing the problem of burnout for what it is, and thereby the appropriate remedy. More specifically, the report risks understating the moral nature of the problem. It is one thing to treat dissonance as a self-reported inability or risk factor that can be managed with improvements in the practice environment. It is quite another to make sense of the dissonance as a moral experience that involves a clinician's sense of agency in complex, human ways.

The closest that the report comes to capturing the moral experience of clinicians is in the construct "moral distress." First characterized in 1984 by Andrew Jameton, a philosopher of

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[9] Consider the long history of public pledges by clinicians in this regard. These date back to the Hippocratic Oath and the Nightingale Pledge, and continue to find expression in the professional codes of most, if not all, clinician associations, such as the World Medical Association's Declaration of Geneva (2017).

[10] NAM 52-55; on this connection, see also the report's discussion of "Meaning and Purpose in Work" (97f.) and "Alignment of Values and Expectations" (100f.).

[11] Ibid. 52 ff.

nursing ethics, moral distress was widely studied in the nursing literature before gaining traction in a range of other medical fields in more recent years.[12] The original definition is narrowly focused: “moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.”[13] The attention is on institutional constraints against one’s sense of right—on the effects of being complicit in hospital care that can often be morally contradictory. The construct articulates, for example, the experience of an oncology nurse who is required to “perform a painful test on a child. The child is dying, and the nurse believes that the test is irrelevant to the child’s welfare.”[14] It names the sense of anguish that she may feel at being compelled to cooperate in acts she deems to be wrong.

The NAM report broadens this definition: in addition to situations of institutional duress or constraint, it defines moral distress to include participation in situations that are “morally undesirable.”[15] These fraught situations may involve patients, their surrogates, or clinical teams, and include, for example, “providing potentially harmful or futile treatment, providing care that prolongs dying, or witnessing clinicians who give false hope to patients or family members.” On this view, issues like poor communication or lack of input on clinical decisions can be further contributing factors.[16] Whether mild or intense, according to the report, if such experiences of

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[12] The term was first invoked in Andrew Jameton, *Nursing Practice: The Ethical Issues* (New Jersey: Prentice-Hall, 1984). Jameton notes in 2017 that his informal search of PubMed showed that “more articles about moral distress were published in the last three years ending 2016 than in the prior three decades.” This, he suggests, may reflect the growing frequency, intensity, and extent of distress among health professionals (Andrew Jameton, “What Moral Distress in Nursing History Could Suggest about the Future of Health Care,” *AMA Journal of Ethics* 19 (2017): 617-628, 619). On the growing interest in moral distress, see also Giulia Lamiani, Lidia Borghi, and Piergiorgio Argentero, “When Healthcare Professionals Cannot Do the Right Thing: A Systematic Review of Moral Distress and Its Correlates,” *Journal of Health Psychology* 22 (2017): 51-67.

[13] Jameton, *Nursing Practice*, 6.

[14] Ibid. 283.

[15] NAM 94-95.

[16] Ibid. 95.

distress are repeated and persistent, they can have a cumulative effect and lead to "feelings of depletion, disillusionment, despair, and moral residue," and eventually burnout.[17]

Understood in this way, the report acknowledges the deeper feelings of distress that appear to be at stake for clinicians in a variety of morally compromising circumstances. However, it does so inadequately; it understates its significance. The report conceives moral distress only as one risk factor for burnout among others. The construct is lumped with other factors related to "job demands," such as "excessive workload, unmanageable work schedules, and inadequate staffing," "workflow, interruptions, and distractions," and "inadequate technology usability." In effect, the report reduces moral distress to a data point, stripping the idea of any resonance with the complex moral experience to which it alludes. The self-reported empirical fact of distress is acknowledged, but its moral significance is not clearly grasped.

Put differently, the NAM report conceives moral distress and burnout as two independent constructs. The distinction between them, to be sure, follows several studies that have done the same and shown the two constructs to be associated.[18] But these studies belie a certain artificiality in the distinction. The distinction isolates the moral dimensions of the clinician's experience within the moral distress construct, as something separate from burnout. It thereby implies that burnout is not itself a moral experience. In this way, the moral anguish is reduced to a risk factor—to a variable that is instrumental to burnout, the primary phenomenon of interest. Burnout instead is an amoral "syndrome." The effect, again, is that the report obscures the

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[17] Ibid. 96; the report defines "moral residue" as "the lingering feeling of moral distress that, over time, can accumulate and can be detrimental to personal well-being and professional effectiveness" (Ibid., fn. 2).

[18] See, e.g., Patricia A. Rodney, "What We Know About Moral Distress," *American Journal of Nursing* 117 (2017): S7-S10; Leah Johnson-Coyle, Dawn Opgenorth, Mandy Bellows, et al., "Moral Distress and Burnout Among Cardiovascular Surgery Intensive Care Unit Healthcare Professionals: A Prospective Cross-Sectional Survey," *Canadian Journal of Critical Care Nursing* 27 (2016): 27-36; Renata Rego Lins Fumis, Gustavo Adolpho Junqueira Amarante, Andréia de Fátima Nascimento, and José Mauro Vieira Junior, "Moral Distress and Its Contribution to the Development of Burnout Syndrome Among Critical Care Providers," *Annals of Intensive Care* 7 (2017): 71.

significance of clinician burnout *qua* moral experience, and thereby risks missing the very experience that it seeks to address.

The inadequacy of burnout as a construct by which to understand the clinician's malaise can be seen in its failure to resonate with that experience; it fails the plausibility test. A number of clinician critics like Thomas Schwenk, Wendy Dean, and Elizabeth Dzeng, among others, have made this point, calling for reframing their experience in terms not of burnout but of moral distress or injury.[19] As Dean and her colleagues note, for example, "many clinicians have resisted being characterized as burned out, citing a subtle, elusive disconnect between what they have experienced and what burnout encapsulates."[20] Indeed, the burnout construct is inconsistently understood even in the literature, with studies finding wide variances in self-reported prevalence. A recent high-quality systematic review of 182 studies conducted among physicians between 1991 and 2018, for example, reported a range of 0% to 80.5%.[21]

The lack of plausibility is also reflected in the failures of interventions into the problem, so defined. When burnout is regarded as a syndrome, the turn to yoga, mindfulness, or wellness retreats makes sense. But to many clinicians, such interventions can seem "absurd." In particular, they resist the implication that the problem resides in individual clinicians, that they are in some way psychologically deficient, that is, lacking the resilience to cope with the necessary demands of the job.[22] The NAM report, to be sure, focuses on the systems-level conditions of burnout and not

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[19] See, e.g., Thomas Schwenk and Katherine Gold, "Physician Burnout—A Serious Symptom, But of What?" *Journal of the American Medical Association* 320 (2018): 1109-1110; Wendy Dean, Simon G. Talbot, and Arthur Caplan, "Clarifying the Language of Clinician Distress," *Journal of the American Medical Association* 323 (2020): 923-924; Simon Talbot and Wendy Dean, "Physicians Aren't 'Burning Out.' They're Suffering from Moral Injury," *STAT*, July 26, 2018; Wendy Dean, Simon Talbot, and Austin Dean, "Reframing Clinician Distress: Moral Injury Not Burnout," *Federal Practitioner* 36 (2019): 400-402; Elizabeth Dzeng and Robert Wachter, "Ethics in Conflict: Moral Distress as a Root Cause of Burnout," *Journal of General Internal Medicine* 35 (2020): 409-411.

[20] Dean et al., "Reframing," 400.

[21] Lisa S. Rotenstein, Matthew Torre, Marco A. Ramos, et al., "Prevalence of Burnout Among Physicians: A Systematic Review," *Journal of the American Medical Association* 320 (2018): 1131-1150.

[22] Dean et al., "Reframing," 401; see also Philip J. Candilis, Daniel T. Kim, and Lois Snyder Sulmasy, for the ACP Ethics, Professionalism and Human Rights Committee, "Physician Impairment and Rehabilitation: Reintegration

the resilience of clinicians. But here too, effective interventions have been elusive, and NAM cites this fact in declining to specify any recommendations on system-level interventions. It instead calls for more work on such interventions and rigorous evaluations of them.[23] But after more than a decade of ineffective efforts in this area, I am inclined to agree with the critics of the burnout construct: it is time to look beyond "mechanistic explanations" and to revisit the problem more squarely in terms of the clinicians' moral experience and agency.[24]

Moral Distress

In order to better grasp the clinician's experience of malaise, then, we do well to further clarify moral distress as an alternative approach. Some critics of burnout have invoked "moral injury" instead in order to leverage the work done on the concept in relation to combat veterans.[25] But "moral distress" does similar work and is the dominant construct in the clinical literature. It is also what the NAM report cites, so I follow that lead. Now, the pressing question is whether moral distress in fact offers a more adequate grasp of the experience in question. What is entailed in the experience of moral distress? Why do clinicians experience it—what are its causes? I want to address these questions in terms of the existing literature in this section. I can then turn in the next to how a perception of the hermeneutical self offers a further depth of explanation that may be crucial to an adequate policy response.

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into Medical Practice while Ensuring Patient Safety: A Position Paper from the American College of Physicians," *Annals of Internal Medicine* 170 (2019): 871-879, 877.

[23] NAM xv. See also Maria Panagioti, Efharis Panagopoulou, Peter Bower, et al., "Controlled Interventions to Reduce Burnout in Physicians: A Systematic Review and Meta-analysis," *JAMA Internal Medicine* 177 (2017): 195-205. The authors of this systematic study report that "treatment effects were significant but small" and that "at present, the low quality of the research evidence does not allow firm practical recommendations."

[24] See, e.g., Dzeng and Wachter 409.

[25] See fn. 19.

When Jameton first characterized moral distress in 1984, it was to capture "the emotional side of moral problems" and not just their cognitive moral reasoning.[26] He distinguishes moral distress from two other types of ethical problems that nurses routinely confront, namely, "moral uncertainty" and "moral dilemmas." The former "arises when one is unsure what moral principles or values apply," and the latter holds "when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action."[27] The ethical, he argues, is "professional"; it speaks in terms of codes and is directed at "inquiry," to "the systematic study of principles and values." Morals, by contrast, tend to be "personal," something to which one is "committed" so as to "follow and defend in daily life."[28] While the two overlap extensively in the daily experience of clinicians, he suggests, they can be roughly distinguished in this way.

For Jameton, the power of moral distress as a construct thus consists in attending to the emotion-laden nature of moral experience, something that standard modes of bioethics tend to obscure. The issue of overtreating the dying, for instance, is not just a problem of ethics in the abstract. In defining moral distress, he names the deeper anguish that nurses often express in such situations. Physicians write the orders, but nurses manage the consequent suffering. Unlike for physicians who "enter a patient's room and write orders, only to depart quickly and leave," for bedside nurses, the unnecessary pain can feel like "abuse of patients"—a suffering they cannot justify inflicting.[29] Their sense of complicity in such situations—or inability to do otherwise due to institutional constraints—induces feelings of distress. Jameton speaks of these feelings in terms of "guilt" in his original formulation, but later talks also of "frustration, anger, and anxiety."[30]

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[26] Jameton, "What Moral Distress," 618; see also Andrew Jameton, "A Reflection on Moral Distress in Nursing Together with a Current Application of the Concept," *Bioethical Inquiry* 10 (2013): 297-308.

[27] Jameton, *Nursing Practice*, 6.

[28] Jameton, *Nursing Practice*, 4-5.

[29] Jameton, "A Reflection," 299.

[30] Jameton, *Nursing Practice*, 283; Andrew Jameton, "Dilemmas of Moral Distress: Moral Responsibility and Nursing Practice," *AWHONN's Clinical Issues in Perinatal and Women's Health Nursing* 4 (1993): 542-551, 544.

This sort of distress, Jameton argues, can be devastating. To make sense of this, he later distinguishes between "initial" and "reactive distress." One can experience acute distress initially, during the situation itself. But one can also be distressed reactively after the initial situation has passed, especially if it is left unaddressed.[31] In a widely cited article, Elizabeth Epstein and Ann Hamric subsequently model this distinction in terms of a "crescendo effect." The initial distress, which can range from the mild to life altering, represents a "first crescendo." It may subside, but it also may not; the initial feelings can reactively linger, leaving a "moral residue" that then establishes "a new baseline." Then, as a clinician experiences repeated crescendos—a second, a third, and so on—the baseline rises and creates ever higher crescendos: "new situations evoke stronger reactions as a clinician is reminded of earlier distressing situations."[32]

The devastating nature of moral distress is also often explained as a threat to one's integrity.[33] More than mere "psychological distress," moral distress undermines one's "core values and duties." In recalling a death, for instance, a person may feel sadness or grief as a psychological response. But moral distress identifies an additional sense of "powerlessness" or constraint with respect to one's moral agency.[34] The following recounting of clinicians in a neonatal intensive care unit (NICU) are illustrative, the first by a nurse and the second by a physician:[35]

> My grief comes from walking in the unit and seeing a baby suffering for weeks and weeks and weeks on end—knowing in your mind, knowing what's going on and knowing that that child's not going to survive, so why is this happening?

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[31] Jameton, "Dilemmas," 544.

[32] Elizabeth G. Epstein and Ann B. Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect," *Journal of Clinical Ethics* 20 (2009): 330-342, 333. Epstein and Hamric support their claims based largely on qualitative studies on moral distress.

[33] In addition to Epstein and Hamric, see Joan McCarthy and Chris Gastmans, "Moral Distress: A Review of the Argument-based Nursing Ethics Literature," *Nursing Ethics* 22 (2015): 131-152, 145.

[34] Epstein and Hamric 331-332.

[35] As quoted in Epstein and Hamric 334, 335.

> We do a lot of things to keep these kids alive and I think a lot of it, in my heart of hearts, I think a lot of it is probably inappropriate and is harming the child and that bothers me a lot. But when you think that you're fighting against the whole expectation of medicine … of what we'll do for children and, you know, these interventions create a life of their own.

Questioning the Causes of Distress

In more recent years, moral distress has come under constructive scrutiny, and much of it has centered on its causes, its circumstances. In particular, some have questioned Jameton's early move to distinguish moral distress from moral uncertainty and moral dilemma. Why focus on the distress of being institutionally constrained but not of being unable to act for other reasons? If the interest is in the experience of distress, the exclusions seem to make little sense. The logic of that experience, for example, could be applied equally well to legal constraints or that of societal or cultural norms. Jameton himself seems to move in this direction by 2013, for example, when he notes the distress bioethicists can feel when confronted by the social—and not just institutional—forces that constrain action against climate change in healthcare.[36]

But more pointedly, as Stephen Campbell and others argue, some constraints can be personal rather than external. In a situation of moral uncertainty, for instance, one may do what seems right, all things considered, but be distressed in the suspicion that one might have done otherwise.[37] Imagine, for instance, a palliative care physician who struggles over whether to euthanize a patient. The patient requests the service competently and the practice happens to be

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[36] Jameton, "A Reflection," 301.

[37] Stephen Campbell, Connie Ulrich, and Christine Grady, "A Broader Understanding of Moral Distress," *American Journal of Bioethics* 16, no. 12 (2016): 2-9, 3; see also Daniel W. Tigard, "Rethinking Moral Distress: Conceptual Demands for a Troubling Phenomenon Affecting Health Care Professionals," *Medicine, Health Care and Philosophy* 21 (2018): 479-488.

legal, but the physician personally believes that it is unethical. Still, after much effort, the patient ultimately persuades her of the merits of his case and she euthanizes him. The physician in this case is not facing any external constraints, but she must wrestle with her conscience and may struggle afterwards to shake a deep unease that she perhaps did a grave wrong.[38] A similar distress might hold when a clinician is caught in a moral dilemma in which she must choose the lesser of two evils. She may know that she acted rightly but still feel distressed by the wrong that unavoidably resulted.[39]

Moral luck has also been proposed in this literature as a potential source of distress. A person may act rightly, or at least not wrongly, but because of "factors beyond their control," those actions may "turn out to have morally undesirable consequences."[40] The suggestion seems to be that this differs from situations of uncertainty or dilemma insofar as the results are due to luck as opposed to circumstances for which one can account in an act of decision. In the latter situations, I am responsible for my decision within the limits of its non-ideal circumstances. The question in the case of moral luck, however, is whether I can be held responsible for something that occurs for reasons beyond my control. I will question this distinction later in this chapter. But here, the limited point is that we often do feel responsible—rightly or wrongly—for things that are outside our control in ways that can induce feelings of distress.

But the move to broaden the construct also has critics. Elizabeth Epstein and colleagues, for example, fear that it "undermines the original distinctiveness" of the construct. It reframes moral distress "away from situations in which persons feel forced to violate their moral integrity

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[38] This case example paraphrases Tigard's in "Rethinking" 481.

[39] Campbell et al. 5; see also Carina Fourie, "Moral Distress and Moral Conflict in Clinical Ethics," *Bioethics* 29 (2015): 91-97.

[40] Campbell et al. 5; see also Daniel W. Tigard, "Moral Distress as a Symptom of Dirty Hands," *Res Publica* 25 (2019): 353-371.

to situations that they perceive as merely morally undesirable."[41] It is one thing to say that difficult choices due to uncertainty or dilemma or unfortunate outcomes due to luck can give rise to negative feelings. But if the choices pertain to ethical issues or the inherent risks of patient care, the negative feelings are not necessarily undesirable. No "true moral compromise" is involved.[42] As such, one might say, moral distress in these situations is an irrational response. What is more, according to critics, redefining the construct would set back decades of research and policy that have built on the narrower definition.[43] A broadened construct would replace it with a vaguer and less useful agenda.

I agree that the condition "morally undesirable" is vague. It seems to allow for almost every conceivable situation of "distress" and risks rendering the construct meaningless. But even if the causes are specified in terms of moral uncertainty, dilemma, or luck, critics of the broadening move can question whether such circumstances are in fact rational causes of distress. As Epstein et al. point out, while nonideal compromises "might generate undesirable feelings, … they are not necessarily morally undesirable outcomes." No true moral compromise is involved.[44] This indeed is a problem. An irrational distress can be an emotion for which a person might be consoled or helped to rethink,[45] but it can hardly be the basis for organizing institutional practices. That said, however, the opposite danger here is to preemptively exclude situations that seem to be widely experienced by clinicians as causes of distress. Thus, rather than excluding these experiences, I

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[41] Elizabeth G. Epstein, Ashley R. Hurst, Dea Mahanes, et al., "Is Broader Better?" *American Journal of Bioethics* 16 (2016): 15-17; see also Joan McCarthy and Settimio Monteverde, "The Standard Account of Moral Distress and Why We Should Keep It," *HEC Forum* 30 (2018): 319-328, 324.

[42] Epstein et al. 16.

[43] Ibid. 17; McCarthy and Monteverde 325.

[44] Epstein et al. 16.

[45] Daniel Tigard suggests "consolation" as an appropriate response to cases of moral distress due specifically to moral luck given that no wrongdoing is implicated; see his article, "Moral Distress as a Symptom."

propose that their rationality must be further explained. I will make good on this point in terms of moral luck and agent-regret later in this chapter.

As for the critics' caution that broadening the construct could damage research and policy goals, proponents have sought to propose clearer taxonomies of moral distress, including by type of cause, their effects, and the degree of one's participation.[46] They contend that a broadening move, if it is attentive to distinctions, need not lead to a vaguer research or policy agenda. This seems correct; such development could conceivably lead to more comprehensive policy solutions without necessarily neglecting the details. But in addition, I believe a prior critical question needs to be asked. Namely, in reference to what should the construct be restricted—or for that matter, broadened—and why? Simply excluding additional causes per the critics does not resolve this question, and neither does simply enumerating more cases of an ill-defined "distress." Such moves only beg the question of the actual nature of the experience.

In failing to ask this question, the tendency is to approach moral distress as primarily a policy or research concern. However, the move to restrict the construct from such a standpoint, as the critics suggest, seems to put the cart before the horse. The approach may be expedient, helping to address the narrower range of readily managed issues caused by external constraints. But the risk is that we thereby miss other vital dimensions of the problem, or worse, misconstrue the very nature of the problem. This, I suggested above, is what NAM does in its systems approach to burnout. It lacks plausibility as a result and has prompted calls to reframe the problem. Restricting moral distress to situations of external constraint risks making the same mistake. It hobbles attention to the very agency that is constitutive of the experience.

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[46] Campbell et al. 8; Tessy Thomas and Laurence McCullough, "A Philosophical Taxonomy of Ethically Significant Moral Distress," *Journal of Medicine and Philosophy* 40 (2015): 102-120.

Moral Distress as a Hermeneutical Experience

Moral distress is an experience of a moral agent before it is a policy problem, and this entails grasping the experience in terms of that agency. That agency, moreover, is that of a hermeneutical self, and this has been my argument throughout this dissertation. Now, the point here is not that a hermeneutical self would add another piece to the puzzle, another piece of observation to what is already known. The task is more fundamental; it is to reimagine the experience in terms of that agency and to show what is thereby gained. The literature, as I described above, clarifies some key issues: it distinguishes moral distress from psychological distress, identifies the crescendo effect, and associates an inability to do the right with feelings of distress. But in each instance, there is a lingering question: *why* should that be? The hermeneutical self, I argue, helps to explain and in that way sharpen these observations and to clarify what is at stake.

To say that we are hermeneutical creatures is to say that we inhabit our moral space—a world of meanings and the claims of others on us—as self-interpreters. As I argued in chapters two and three, we do not engage this space merely as though it were an instrument of our desires. Rather, we always already inhabit it and cannot but engage it as inhabitants. That is to say, certain meanings—what Charles Taylor calls "intersubjective" and "common meanings"—exist prior to the self, as do the claims of love others have on one. They constitute the self not as a matter of the self's wishful projection but as goods to be interpreted in light of who one has become or aspires to be. We do so, more specifically, as strong-evaluators—in light of our judgments about the qualitative worth of our desires as higher or lower, good or bad.[47] This evaluation, moreover, is

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[47] Taylor distinguishes between "strong" and "weak" evaluations. In the latter, we evaluate in terms of such simple criteria as convenience, satisfaction, or efficacy. But Taylor claims that we often do much more than that. We also evaluate the "qualitative worth" of different choices, characterizing them as good or bad, admirable or base, courageous or cowardly, worthy or trivial, and so on. In so doing, we "speak in terms of the kind of quality of life which it [our choice or desire] expresses and sustains" or to which we aspire (Charles Taylor, "What is Human Agency?" in *Human Agency and Language: Philosophical Papers 1* (Cambridge: Cambridge University Press, 1985), 15-44, 15-16, 25; see also my longer discussion of this in chapter three).

rooted in an ineradicable feature of what it is to be human, that is, "an inner craving … to be rightly placed in relation to the good"[48]—to be in a place of "fullness."[49] This longing or sense of movement toward a longed-for state then gives our identity its narrative structure.[50]

First, this account of the self helps explain the significance of the distinction between psychological and moral distress. The former, according to Epstein and Hamric, "describes emotional reactions to situations, but does not necessarily involve violation of core values and duties."[51] Administrative constraints, such as understaffing issues, can be psychologically stressful but do not necessarily violate one's core values. But the question is, what counts as a core value? The literature tends to link core values to one's sense of "integrity," but the move only defers an explanation. What, after all, is integrity? Here too, the explanations are typically unhelpful. In a recent book that explores integrity as an "anchor" for responding effectively to distress, Cynda Rushton writes, "viewed as a state of balance, harmony, or solidarity, or being undiminished, integrity is a necessary element of human flourishing."[52] As is typical of the literature, she re-describes integrity using other abstract terms, but fails to explain the notion.

A hermeneutical self, by contrast, explains our core values in terms of the moral goods by which we orient our lives. The good of patient care, for example, is a source of common and intersubjective meanings that all clinicians inhabit—to which they profess a solemn oath and by which they are defined. An integrity understood in this way is not merely personal but also social;

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[48] Charles Taylor, *Sources of the Self: The Making of the Modern Identity* (Cambridge, MA: Harvard University Press, 1989), 44.

[49] In a place of fullness, Taylor notes, we find our life to be "fuller, richer, deeper, more worthwhile, more admirable, more what it should be." We ineradicably aspire to be in that place. Moreover, it is "a place of power" in which we feel deeply moved to act with "integrity or generosity or abandonment or self-forgetfulness" (Charles Taylor, *A Secular Age* (Cambridge, MA: Belknap Press, 2007), 5).

[50] For more on the narrative structure of our lives, see chapter three of this dissertation. Taylor posits this feature in *Sources of the Self*, 47-48.

[51] Epstein and Hamric 331.

[52] Cynda Hylton Rushton, "Integrity: The Anchor for Moral Resilience," in *Moral Resilience: Transforming Moral Suffering in Healthcare*, edited by Cynda Hylton Rushton, 77-103 (Oxford University Press, 2018), 78.

the personal is in fact constituted by social meanings, such as the ethical ideals of clinical practice. In addition, one's integrity is constituted by the claims of love. A clinician's integrity depends not only on sustaining the coherence of a norm like patient autonomy but also on the right ordering of one's relation to the patient, the patient's family, and others in the care team. The distress, in other words, is a matter not merely of violating self-defining values. It just as deeply implicates a sense of having failed the people by whom one's identity is also constituted.

The upshot is that the stakes are raised. The core values and obligations are not a matter of choice. A clinician cannot simply choose to or be institutionally compelled to ignore, adjust, or replace their moral goods at will. That would risk a crisis of orientation in their moral space and, at its limit, a despair of reaching fullness within it. As Taylor notes, "to begin to lose one's orientation is to be in crisis, and to lose it utterly is to break down and enter a zone of extreme pathology."[53] Moreover, integrity cannot be just one value to be weighed against other values. It makes little sense to balance my integrity against, for example, my concern to provide cost-effective care. Doing so would undermine the very space in which the value of cost-effective care is meaningful to me in the first place. Integrity instead is foundational to the self's moral space and the possibility of enjoying the fullness to which we all are ineradicably oriented.

Second, a hermeneutical perception of moral distress better explains the crescendo effects of initial and reactive distress described by Epstein and Hamric. On their picture, distressful events are discrete incidents; each adds to a "baseline" that increases with every new event. But it is unclear why or how each occurrence can "evoke stronger reactions as a clinician is reminded of earlier distressing situations." What, after all, connects the discrete situations such that they build on one another? The authors' use of the words "evoke" and "reminded" suggests that they are presuming a self with a history and agency—one who can conceivably mediate the discrete

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[53] Charles Taylor, "Reply to Commentators," *Philosophy and Phenomenological Research* 54 (1994): 203-213, 209.

events. But little is said about this crucial point. Instead, the language of their model, such as "baseline" or "buildup of moral residue," conflicts with that picture. The self in the model seems disengaged from its residue. The residue builds up in one like fuel in a tank, as something that happens to one or as an object in the world to be instrumentally managed.

A hermeneutical account instead looks decisively to a self who is "reminded" of old distresses and in whom a new situation can "evoke" a heightened distress. It explains this not in terms of baselines, buildups, or crescendos but of the narrative structure of one's life. Through narrative, I make sense of the experience within a whole, in terms not only of what I am in the present but of what I have become and where I am going. We are fundamentally moved by our longing for what we take to be a place of fullness and evaluate our life experiences accordingly.[54] On this view, a clinician experiences every distressful situation as an agent constituted by a self-narrative, within a sense of the very meaning of her life. The narrative integrates each recurrence with all the previous ones, and with each conflict, the coherence of that self-narrative becomes more and more difficult to sustain. The threat is that of living a lie, and in time, the clinician will need to either change her self-narrative or try to save it by leaving her practice.

Third, a hermeneutical account helps clarify the nature of the emotions involved in the experience of moral distress. Jameton is unclear on this score and merely invokes a range of distress-related feelings, such as frustration, anxiety, anger, and guilt. The literature mentions others like shame or self-blame, but there is otherwise little critical analysis of these feelings. Further analysis, however, is warranted. As I noted above, there are ongoing concerns about the causes of moral distress. Even as some want to include situations of uncertainty, dilemma, and luck as important causes, others want to exclude them on the basis of policy expedience or their seeming irrationality. The lack of clarity on the emotions involved reflects this debate. After all,

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[54] See fn. 49.

the causal circumstances are the context in which particular emotions must be judged as apt or not. Clarifying these emotions thus also requires an extended analysis of the circumstances involved; the two go hand-in-hand.

I turn to this analysis next. In taking a hermeneutical perception, the analysis takes the question of identity as an ineradicable point of reference. Moral distress, on this view, involves self-interpretation. To know is to interpret, and interpretation is an act of self-reference. That is, we judge morally in terms of the good of who we are or aspire to be, not just what it is right to do. With this in mind, I propose to consider what Richard Miller calls "concomitant feelings." These are "connected to eventualities that lie outside the agent's will"; they "accompany events that one causes but does not intend, sometimes in response to injustices imposed from without."[55] Crucial here is Bernard Williams's concept of "moral luck." By explicating this notion and its concomitant feeling, I want to make sharper sense of the causal circumstances of clinician distress and the rationality of the emotion involved.

Moral Luck and Agent-Regret

By way of contrast, consider a recent hypothesis on physician burnout by Lawrence Blum.[56] He draws on his psychiatric practice in that population to identify guilt—"a feeling of having committed wrong or failed in an obligation"—as a widespread driver of what ails them. Instead of addressing this feeling honestly, physicians bury it and compensate by doing good and worrying about their patients. Such worries, Blum notes, "help to direct attention away from guilt and keep it out of awareness, assuage guilt by providing evidence of conscientiousness, and diminish guilt

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[55] Richard B. Miller, "Augustine, Moral Luck, and the Ethics of Regret and Shame," *Journal of Religion* 100 (2020): 361-385, 364. I am also grateful to Prof. Miller for catalyzing this line of thought in my thinking about clinician burnout during an informal conversation in his office in 2018.

[56] Lawrence Blum, "Physicians' Goodness and Guilt—Emotional Challenges of Practicing Medicine," *JAMA Internal Medicine* 179 (2019): 607-608.

by providing some punishment for it."[57] But guilt thereby festers. Moreover, much of this guilt is "irrational." It often arises in situations where the physician is not at fault, such as "circumstances in which no good outcome is possible, inevitable errors in clinical judgment, torturous if often preposterous malpractice suits, and endless bureaucratic criticism and interference."[58]

Blum's analysis thus raises a critical question: is clinician distress a pathology? After all, he is not alone in finding that situations of clinician distress typically do not involve wrongdoing. The drive I described above to broaden Jameton's original definition to include situations of luck, uncertainty, or dilemma is getting at the same observation. Jameton's scenario, to be sure, involves feeling institutionally constrained to carry out a perceived wrong, and he describes it in terms of guilt. I will soon question this characterization, but even if it is granted for the sake of argument, why should clinicians find these other situations to be distressing in the same way, in terms of guilt? Once the construct is broadened, as it should be, in what sense is moral distress not a pathology? This, then, is where moral luck and the concomitant feeling of agent-regret can help to redescribe and thus clarify matters.

Williams contrasts "agent-regret" with "regret" and "remorse."[59] Regret characterizes the standpoint of a "spectator." For example, if a lorry driver, "through no fault of his own, runs over a child," then a bystander appropriately feels regret at what occurred. But her regret would be over a state of affairs; she rightly would experience no sense of personal responsibility for it. The lorry driver, however, is not a spectator; he is a "participant." His is the standpoint of agent-regret; it is self-referring in a way that regret is not. Unlike the spectator, the focus of the driver's agent-regret is his own actions: given the possibility that he might have done otherwise, he wishes that he

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[57] Ibid. 607.

[58] Ibid. 607.

[59] Bernard Williams, "Moral Luck," *Proceedings of the Aristotelian Society, Supplementary Volumes* 50 (1976): 115-135, 126.

had.[60] Indeed, he feels a personal burden to make amends for what happened, or if that is not possible, to signify in some way his desire to that effect.[61] An insurance payout on the child's life from a third-party, for example, would not satisfy his agent-regret.

The lorry driver's agent-regret thus moves the domain of the moral beyond questions of intent—what one voluntarily does or fails to do. It is unlike remorse in this sense—or what Blum calls guilt. We do well, at this point, to move past the language of guilt. It would be odd, after all, for anyone to expect the lorry driver to feel remorse or guilt over an accident caused by factors outside his control. Yet, as Williams notes, it would be equally odd if he absolved himself of any role in what transpired by moving "too blandly or readily" to a spectator's position. In that case, we would judge him to be morally callous. The lorry driver's agent-regret seems fitting, as does any desire he feels to make amends, even if only to express his sorrow. This is why we feel sorry for him; we feel that "there is something special about his relation to this happening, something which cannot merely be eliminated by the consideration that it was not his fault."[62]

This lorry case is akin to what proponents of broadening the construct of moral distress seem to mean by situations of "moral luck." Campbell et al., for example, consider a situation in which a psychiatrist works hard to persuade a reluctant patient to take a prescribed medication to help with his depression, but two weeks later, the patient overdoses on that very medication and dies.[63] Like the lorry case, this incident is a result of brute luck. The psychiatrist did no wrong, and yet, due to unforeseeable and unintended factors, the patient dies. In both, guilt does not fit as an appropriate response, but agent-regret does. If the psychiatrist too easily moved into a

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[60] Ibid. 123-124.

[61] Ibid. 124. The appropriate degree of these feelings will vary from case to case, and one should guard against "irrational and self-punitive excess" (Ibid. 125). But as Williams notes, it would also be "a kind of insanity never to experience sentiments of this kind."

[62] Ibid. 124.

[63] Campbell et al. 5.

spectator position on the patient's death, we would judge him to be morally callous given his role in the patient taking the medication. We would instead expect him to feel "terrible" to some extent and to feel a need to express that sentiment.

But agent-regret is not limited to situations of brute luck, that is, to purely involuntary acts. It applies just as well to voluntary ones, such as those of uncertainty. Williams imagines a semi-fictional case of the artist Gauguin, who leaves his family behind to live a life devoted to his art in Tahiti.[64] He believes this will enable him to realize his gifts as a painter. But is he right to do so, that is, can he justify his decision? His judgment on this score, Williams argues, comes down to considerations of luck. It can only be determined retrospectively based on whether he succeeds, and this is highly contingent. Moral theories offer no certainty of rectitude either. Applying a moral principle such as "one can neglect family obligations if one is a great artist" only begs the question. How can Gauguin say with any certainty whether or not he will be a great artist if he goes to Tahiti? Utilitarian assessments of benefits and harms also fail given the uncertainty of outcomes involved.[65]

Whether Gauguin succeeds—whether he can justify his decision—depends on two types of luck: those "intrinsic" to the project and those "extrinsic" to it. The former has to do with whether he is "a genuinely gifted painter who can succeed in doing genuinely valuable work." In this case, the locus of luck lies within Gauguin—whether he has the talent and proves capable of discovering and realizing it. But his success also depends on external good fortune, say, of not suffering an injury that disables him from painting ever again. Bad luck with the former would mean that *he* failed whereas bad luck with the latter would mean only that the project failed.[66] The nature of the luck can thus nuance Gauguin's self-evaluation but both types are ultimately

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[64] Williams 117.
[65] Ibid. 119-120.
[66] Ibid. 120-122.

inescapable. Luck is constitutive of any justification he can offer for why he was right to leave his family in order to pursue his art, or conversely, the agent-regret he feels otherwise.

In addition to situations of brute luck and uncertainty, Williams notes that agent-regret can be felt in cases of dilemma. These are "cases of conflict between two courses of action each of which is morally required, where either course of action, even if it is judged to be for the best, leaves [agent-]regrets."[67] The lesser of two evils must be chosen. A physician, for instance, who decides to save Jane and not John with the last remaining ventilator because Jane is more likely to recover may act rightly but nonetheless regrettably. The decision is to let one or the other die. What the physician feels is agent-regret; we expect the emotion to be that of a participant and not a spectator. But here, unlike in the case of the lorry driver or Gauguin, there is no "wish, all things taken together, to have acted otherwise." One can know the decision to have been acceptable, and yet agent-regret what one had to do.

The luck involved in this third case is different from that of the other two cases. To make this plain, Miller draws a helpful distinction between "luck-as-chance" and "luck-as-fate." In luck-as-chance, the cause is utterly random; it is akin to "a lottery."[68] The lorry driver's accident is of this type, as are the external fortunes that may determine Gauguin's success. In luck-as-fate, the cause is akin to "a horoscope"; it "refers to reliable patterns in experience that are more or less intractable to human planning."[69] Matters of this sort are foreseeable but nonetheless beyond one's control. John's death in the ventilator case and the innate talent that Gauguin may or may not possess pertain to luck of this sort. Here, one feels "the weight of agent-regret" not only

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[67] Ibid. 127.
[68] Miller 370.
[69] Ibid. 371.

retrospectively—as in luck-as-chance—but also prospectively or concurrently of one's action.[70] In both sorts, luck is the cause of eventualities that far exceed the intent of the agents involved.

Finally, does agent-regret explain the distress in the standard scenario that Jameton first proposed as involving institutional constraints? As I noted, he describes that distress as a feeling of guilt at being constrained to do a perceived wrong. But if granted, any such scenario would not be a case of agent-regret and would imply a separate category of distress than the luck-related cases I have been describing. I claim, then, that it need not be granted. Consider his example of a nurse who is anguished at having to administer a physician-ordered treatment to a dying patient in what she takes to be a case of overtreatment.[71] The nurse feels unable to do otherwise given the hierarchy involved but believes she is causing unnecessary suffering to the patient. Or consider another case I quoted earlier in which a NICU physician thinks in his "heart of hearts" that much of what he does is "probably inappropriate and is harming the child." But he goes on intervening because within "the whole expectation of medicine" the interventions tend to "create a life of their own."[72] These are not, to be sure, situations that involve choosing the lesser of two evils, as in a dilemma. Neither are they about random misfortunes or the uncertainties surrounding a decision. But these are, I propose, luck-related cases of what one might call "moral constraint."

Describing the constraint in terms of guilt, per Jameton, presumes that the wrongness of the act that it compels is clear. But this oversimplifies. If it were clear, the situation would be that of doing one's duty to report or change the constraint. The apt response would be frustration or anger at one's inability to fix an unjust constraint. Jameton has indeed invoked such emotions as well elsewhere,[73] but the problem is that they fail to capture the self-referring nature of the actual

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[70] Ibid. 372.

[71] Jameton, "A Reflection," 299.

[72] As quoted in Epstein and Hamric 335.

[73] Guilt is how Jameton characterizes distress in his original formulation (*Nursing Practice*, 283). But in a later 1993 publication, he also speaks of nurses feeling "frustrated, angry, and guilty" ("Dilemmas," 543).

emotion—one in which a person's basic self-narrative is threatened. In fact, in my view, the perceived wrongness in these cases is not as clear as Jameton presumes. It is not difficult to imagine potential countervailing goods, such as a life not lost or a patient's decision respected. Nor should clinical practice be dictated by personal moralities alone. The issue of what constitutes futile care, for example, requires a degree of professional consensus that in itself is also a countervailing good about which clinicians do well to care.

In other words, describing the clinician's distress as guilt or frustration in these cases risks understating their inherently tragic aspect. The distress does not arise only from the clinician's inability to do otherwise than what he takes to be wrong; it implicates also the necessity of the constraint itself. That is, institutional constraints have a luck-as-fate quality that is to some extent outside the control of any individual clinician. In this sense, agent-regret better acknowledges the rock-and-a-hard-place situation in which clinicians so often find themselves in modern care—a space in which institutional imperatives so often compete with those of patient care. Even in the absence of actual wrongdoing, clinicians can feel the agent-regret that what they must do so often involves foreseeable harms or compromises. Such distress can thoroughly haunt the clinician's self-narrative because the agent-regret involved is prospective, concurrent, and retrospective.

Intrapsychic Luck

The circumstances of moral luck examined above pertain primarily to factors that are external to a self's moral agency. In situations of brute luck, uncertainty, dilemma, or constraint, one's volition is intact as one's own, even if the evaluation of that agency is dependent on factors that may or may not eventuate. Moral luck here, as Miller puts it, concerns "the extrapsychic hazards of happenstance or destiny."[74] But in Augustine, Miller identifies yet another sort of luck, which he calls "intrapsychic luck." It pertains to a divided will within the moral agent—an "intrapsychic alterity" of desire that "can recruit the will to act against itself."[75] In Augustine's moral psychology, such desires can be particularly devastating to a person's moral life, and we do well to consider it as we reimagine moral distress in terms of agent-regret.

Intrapsychic luck refers to an "anarchic desire" within the self that, according to Miller, "threatens to undermine the agent's self-control, his or her capacity to be an agent at all." In this way, it threatens a "diminishment and self-loss" that "bears on the question of 'who I am' rather than only 'what I've done.'"[76] It is thus "radically self-referring,"[77] and its moral hazards are correspondingly greater than those of extrapsychic luck. Even though Williams speaks of intrinsic luck in Gauguin's case—that is, his innate talent as an artist—it presents as an epistemological problem. It is a point of uncertainty with respect to whether Gauguin will succeed in Tahiti. If his project were to fail because of intrinsic luck, it would represent his failure to know himself—to evaluate his talent properly. Intrapsychic luck, however, marks a categorically deeper, ontological threat of "internal alienation," a fundamental division in one's self-constitution.[78]

Augustine accounts for Miller's notion of extrapsychic hazards in relation to the conduct of war given its inevitable bloodshed and slaughter. The focus is on the doing, on the disposition with which one conducts oneself. Even just wars, he contends, must involve a sense of what Miller calls "justice-with-regret."[79] Augustine writes, "let everyone … who reflects with pain upon such great evils, upon such horror and cruelty, acknowledge that this is misery. And if anyone either

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[74] Miller 385.
[75] Ibid. 381.
[76] Ibid. 379.
[77] Ibid. 384.
[78] Ibid. 380.
[79] Ibid. 361 ff.

endures them or thinks of them without anguish of soul, his condition is still more miserable: for he thinks himself happy only because he has lost all human feeling."[80] In other words, on Williams's terms, we expect a person who wages war to feel agent-regret about its necessities—to regret not as a spectator but as a participant. We otherwise would likely judge him to be morally callous, and indeed, to be an unhappy sort of person deep down.

By contrast, intrapsychic luck implicates a deeper alienation of cause and intent within the self. Augustine articulates this in the context of sexual lust and a concomitant feeling of shame. "It is right," he writes, "to be greatly ashamed of lust, and … the members which it moves or fails to move by its own right, so to speak, and not completely in accord with our will."[81] Lust, as anarchic desire, tends to master the self rather than the other way around, and the shamefulness of that self-diminishment, he argues, resonates with our experience. He sees this in our common desire for privacy when engaging in intercourse or to cover our genitals in public.[82] He likewise critiques the Cynics' belief that "since the sexual act is lawful as between husband and wife, no one should be ashamed to perform it in the presence of others, and to have marital intercourse in any street or square." Such an idea is so contrary to our natural sensibilities, he notes, that even the Cynics do not dare to act on it: they would otherwise "be overwhelmed, I do not say with a hail of stones, but certainly with a shower of saliva by the disgusted onlookers."[83]

Shame, to be sure, is distinct from agent-regret. Shame involves a wrongdoing and sense of guilt that the latter does not. Miller in fact critiques Augustine's move to shame "sexual arousal

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[80] *CD* XIX.7; all citations to *CD* are from Augustine, *The City of God against the Pagans*, translated by R.W. Dyson (Cambridge: Cambridge University Press, 1998).

[81] Ibid. XIV.17. Consider, Augustine notes elsewhere, that sex involves "a bodily pleasure so great that, at that moment of time when he achieves his climax, the alertness and, so to speak, vigilance of a man's mind is almost entirely overwhelmed" (XIV.16).

[82] He marvels, for instance, at "certain barbarians" who "keep their coverings on while they wash" in baths and at Indian gymnosophists who practice philosophy naked but "nevertheless have coverings on their genitals" (XIV.17).

[83] Ibid. XIV.20.

simpliciter," to regard it as "inherently shameful." A couple's need for privacy, he argues, is better seen not as an effort to hide their act but as "the necessary context in which their pleasures can be properly expressed and exultantly shared." Shame should instead attach only to "feelings of self-diminishment in response to desires that prompt unjustified actions."[84] In the absence of actual guilt, then, shame is not an apt emotion. But intrapsychic luck need not be tied to shame. A basic Augustinian insight concerning such luck stands regardless of wrongdoing: as Miller puts it, "we are to account for our urges despite their nonvoluntary status. Such accounting would presuppose that we should take ownership of them given their intimate connection to human agency and interpersonal relationships."[85]

Intrapsychic luck, I argue, constitutes a new hermeneutical insight in the context of moral distress. This Augustinian concern need not be limited to matters of sexual arousal. In the lives of many clinicians, for instance, an everyday desire like self-interest may be experienced as anarchic given their professional ideals to the contrary. Insofar as such desires can involve negative—but not necessarily wrong—eventualities, they can be persistent and self-defining sources of agent-regret. As experience shows, moreover, such desires are not always easily contained, and in arising from within one's agency, they can be self-alienating in a more radical way than extrapsychic sources of moral luck. In this sense, moral distress cannot merely be an issue of assuaging distress as though clinicians were passive sufferers of external constraints or misfortunes. Nor is it enough to mitigate the hazards of clinical decision in contexts of uncertainty or dilemma. It requires, in addition, self-vigilance about the unruly urges that constitute one's very agency.

Consider further the unruly desire of self-interest. According to Albert Jonsen, this desire sits in historical tension with altruism, and this tension, "like a geographical fault, penetrates the

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[84] Miller 385.
[85] Ibid.

terrain of medicine."[86] It has long cut through not only the institution of medicine but also the agency of clinicians themselves. Picking up on this idea, Edmund Pellegrino and David Thomasma argue that the tension is in fact central to "the most crucial dilemmas" of medicine even today. These include "whether to disclose one's HIV-positive status, having an economic interest in an MRI unit to which one refers a patients, whether there is a duty to treat all patients who request care, the problem of healthcare for the poor and one's obligations in this regard, the reform of the health care system, conflicts about requests or public policy for physician-assisted suicide, integrity in scientific research, the medical-industrial complex, physicians' incentives as gatekeepers to keep costs down, and many others."[87]

The intrapsychic luck of self-interest is thus an example of a pervasive danger. None of the listed issues can be isolated from it, and the nature of the challenge is perhaps no more obvious than in terms of money. William F. May observes that money is deeply intertwined in medicine. Its influence is inescapable, and the norms of its exchange seem to constitute a necessity all their own. But money's influence is not straightforward; it sits in tension with the traditional ideals that have long animated clinicians' aspirations to fullness. On one hand, money is necessary "as it feeds, motivates, energizes, and mobilizes talent, and, in part, as it distributes goods."[88] But on the other hand, it can "vulgarize," "distract," and "corrupt,"[89] and crucially, it does so not by force

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[86] Albert Jonsen, "Watching the Doctor," *New England Journal of Medicine* 308 (1983): 1531-1535. Influential histories of US health care have explored the ways in which physicians have leveraged their professional authority to serve not only the sick but also their own economic power (see, e.g., Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), 21-28; Jeffrey L. Berlant, *Profession and Monopoly: A Study of Medicine in the United States and Great Britain* (University of California Press, 1975), 64-127).

[87] Edmund Pellegrino and David Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), 31.

[88] William F. May, *Beleaguered Rulers: The Public Obligation of the Professional* (Louisville: Westminster John Knox Press, 2001), 50.

[89] Ibid. 28 ff.

but by appeal to our self-interest. Such a desire, then, demands self-vigilance lest we be mastered from within. As May writes, “money is a useful but unruly servant and a vicious master.”[90]

Rationality of Agent-Regret

Having rearticulated moral distress in terms of moral luck and the concomitant feeling of agent-regret, I now return to a question that I have so far under-argued: in what sense is agent-regret rational? It is one thing to say that agent-regret is widely experienced. It is another to explain *why* it is. Williams, for example, argues that “it would be a kind of insanity never to experience sentiments of this kind [agent-regret] towards anyone, and it would be an insane concept of rationality which insisted that a rational person never would.”[91] The question is in what sense is it “insane” not to experience the sentiment? This question adds further significance to my claim that agent-regret is an experience of hermeneutical selves.

Whether agent-regret is rational or not depends in part on the rationality of its foil—the idea that our moral lives can be “rendered immune to luck.” The aspiration, according to Williams, runs deep. It is a version of an ancient idea that “identified the end of life as happiness, happiness as reflective tranquility, and tranquility as the product of self-sufficiency.”[92] On this view, contingency is the enemy of tranquility and thus an enemy of the self. Though the idea has “rarely prevailed” in the history of thought, Williams notes, a strand of it persists powerfully to this day: we widely assume that our moral acts and judgments are so immune. Kantian ethics—namely, the categorical imperative—is a foremost instance of this idea. It persists, Williams argues, because it promises “solace to a sense of the world’s unfairness.”[93] The thinking is that

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[90] Ibid. 50.
[91] Williams 125.
[92] Ibid. 115.
[93] Ibid. 115-116.

insofar as the rational will is free of such contingencies as those of birth or upbringing, it is possessed by all in equal measure. Our moral equality, to that extent, is assured.

This solace, however, is an illusion. The aspiration to a tranquil moral self-sufficiency is not in fact a possibility, even if it were desirable. This is what Williams's case examples of moral luck show, not to mention the persistence of situations of clinician distress that I highlight above. No such ideal seems possible in clinical practice, at least not as a perpetual reality. Luck inevitably impinges on our moral lives, and with it comes agent-regret. Like moral luck, agent-regret cannot be simply willed away or ignored. It haunts us, and no less for our rejection of it. We feel sorrow in some way when we participate in circumstances of moral luck that have negative eventualities, and we widely pity those who do not feel this sorrow as morally callous. To be sure, this does not prove in any empirical sense that agent-regret is rational. But it does suggest that contingency is ineliminable from the moral life. To that extent, our agency indeed seems to be what Williams sees as "a web": "anything that is the product of the will is surrounded and held up and partly formed by things that are not."[94]

Put differently, the measure of rationality is not some illusory ideal of a luck-free life but our lived ontology; any solace we might find is found here. In particular, from the standpoint of a hermeneutical self, this is necessarily so. We cannot grasp the rationality of our self-referring emotions in any other way. This is true even of the rationality of guilt, not just agent-regret. Any such emotion is not an object out there that can simply be observed from a spectator perspective. These are self-referring emotions that *I* experience. At this point, an empiricist might turn to my self-report as an objective datum, but that would not help. A survey might show that I, along with others, expressed feeling some such emotion in a given circumstance, but it would explain very little about its rationality. Its rationality cannot in principle be proved in this way. Rather, the

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[94] Ibid. 126.

hermeneutical point is to accept that making sense of the emotion is inseparable from the agent's self-ontology. There is no escaping this epistemological predicament, and to try is to arrive at overly narrow insights that fail to resonate with what Williams calls the "actual."[95]

Responding to Moral Distress

Moral distress, then, is best described in terms not of guilt but of agent-regret, which arises in a range of circumstances of moral luck in which clinicians daily find themselves as participants. No clear wrong need be involved. If justified guilt is involved, shame would be the apt concomitant reaction, but if no fault is involved, the emotion would be irrational. This is not to say that shame is not distressful in some way for clinicians; it is only to say that the feeling makes sense only if they are in fact guilty of wrongdoing.[96] Shame is morally distinct from agent-regret, and we do well not to confuse the two emotions. Per my analysis above, circumstances of moral distress in the literature do not involve instances of wrongdoing, such that a clinician's actions ought to be censured. Policy responses should instead be directed at the clinician's agent-regret.

Seeing moral distress in terms of agent-regret not only sharpens the issue at stake but also broadens the policy agenda. To begin, it affirms the importance of the systems approach outlined in the NAM report. Regulatory and institutional policies, payer systems, and technologies that prioritize business imperatives constitute justice-as-fate sources of agent-regret for clinicians. In

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[95] Ibid. 126; see also chapter two for more on the hermeneutical circle and the intractable problem of brute data.

[96] William Bynum, IV, and colleagues have begun to study the experience of shame among medical trainees in the context of failures in patient care, failures in exams, etc. (see William Bynum IV, Anthony Artino Jr, Sebastian Uijtdehaage, et al. "Sentinel Emotional Events: The Nature, Triggers, and Effects of Shame Experiences in Medical Residents," *Academic Medicine* 94 (2019): 85-93; William Bynum IV and Anthony R. Artino Jr, "Who Am I, and Who Do I Strive to Be? Applying a Theory of Self-Conscious Emotions to Medical Education," *Academic Medicine* 93 (2018): 874-880). However, the focus of their work is to shift feelings of shame into guilt—from a feeling of "I am bad" to "I did a bad thing." The idea is to help trainees psychologically manage the feeling of shame. The problem is that they thereby ignore the question of whether the guilt or shame is in fact justified. In effect, if shame is justified, they are too easily ignoring the rationality of the shame involved. Or if the shame is not justified, then guilt would be a misdiagnosis since no wrongdoing is involved.

the face of institutional constraints, clinicians feel powerless. Being compelled to provide care that one feels is cruel or unnecessary, as in Jameton's classic scenario, can cause intense feelings of justified agent-regret—of wishing one might have acted otherwise. In that sense, policies that better align "job demands" with clinicians' "job resources," technologies that improve rather than impede workflow, and work environments that empower clinicians to speak up are all justifiable and plausible means of mitigating instances of agent-regret.[97]

However, as a self-referring emotion, agent-regret implicates matters of identity that top-down, systems-based policies alone cannot sustain. That is, professional identities are constituted by meanings and relationships that clinicians themselves must also constantly reaffirm from the bottom-up. As a hermeneutical standpoint makes clear, these meanings and relationships are not primarily determined by the individual clinician. Individuals instead inhabit what largely precedes them. This means that inhabiting these meanings and relationships well—that is, navigating the extrapsychic and intrapsychic hazards of moral luck in one's daily practice—presupposes a moral space, or community, that constitutes each clinician.[98] Each necessarily relies on that community to make sense of their experiences of not only constraint but also misfortune, uncertainty, dilemma, and conflicting desires. It is only in such community that a clinician can do so in terms of their basic aspiration to fullness as clinicians.

To be sure, a moral community is increasingly difficult for clinicians to sustain. In the case of physicians, the common bases of knowledge and ethics that grounded them in the past have

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[97] For a full list of NAM's systems-based recommendations, see pages 285-296 of their report; see also Panagioti et al. (fn. 23); Victor Dzau, Darrell Kirch, and Thomas Nasca, "To Care Is Human—Collectively Confronting the Clinician-Burnout Crisis," *New England Journal of Medicine* 378 (2018): 312-314; Lois Sulmasy, Ana María López, Carrie Horwitch, for the ACP Ethics, Professionalism and Human Rights Committee, "Ethical Implications of the Electronic Health Record: In the Service of the Patient," *Journal of General Internal Medicine* 32 (2017): 935-939.

[98] I have in mind a notion of a clinician community akin to that of the "moral community" articulated by Edmund Pellegrino. Such a community not only is one in which members "share a covenantal relationship with each other and with society" but also is one that has "a certain life independent of who its leaders or members might be" and is "something more than" their simple addition ("The Medical Profession as a Moral Community," *Bulletin of the New York Academy of Medicine* 66 (1990): 221-232, 225-226).

steadily eroded. Medical knowledge is ever more specialized and profit motives are increasingly the norm. Physicians are also taking on a variety of often conflicting roles, further undermining a coherent sense of professional identity: they are not only caregiver but also “businessperson, scientist, proletarian, corporate executive.”[99] In their daily practice, moreover, physicians now spend much of their time at their computers, while doctors’ lounges have largely ceased to serve as places to socialize.[100] Still, efforts will need to be made; there are no easy answers. As David Rosenthal and Abraham Verghese put it, clinicians need to find ways to spend more time together and with patients, “restoring some rituals that are meaningful to both us and the people we care for and eliminating those that are not.”[101]

With respect to moral distress, in particular, programs like Schwartz Rounds may be crucial inter-professional spaces in which clinicians can reflect on and share their practice-related social, emotional, and ethical challenges. The Rounds are open to both clinical and nonclinical staff, and are organized as regular, perpetual sessions as opposed to one-off events. Facilitators avoid directing discussions toward problem solving or decision making, and instead aim to create a safe space for sharing and reflection. In this way, the idea is to help sustain clinicians’ relational connections with colleagues and patients.[102] The intent is to be “a ‘counter-cultural’ space that differs from the protocol-driven, outcomes-oriented healthcare environment that values emotional stoicism.”[103] As of 2018, the program is being run at 430 medical institutions in the US

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[99] Pellegrino and Thomasma 35.

[100] David Rosenthal and Abraham Verghese, “Meaning and the Nature of Physicians’ Work,” *New England Journal of Medicine* 375 (2016): 1813-1815, 1813.

[101] Ibid. 1814-1815.

[102] Cath Taylor, Andreas Xyrichis, Mary Leamy, et al., “Can Schwartz Center Rounds Support Healthcare Staff with Emotional Challenges at Work, and How Do They Compare with Other Interventions Aimed at Providing Similar Support? A Systematic Review and Scoping Reviews,” *British Medical Journal Open* 8 (2018): e024254, 2.

[103] Ibid. 14.

and at over 170 in the UK.[104] While the evidence base for this and other similar programs remains weak, there appears to be little reason not to embrace their potential.

A Response of Virtue

Schwartz Rounds thus offer a critical space in which clinicians can approach problems like moral distress in terms not of urgent action and decision but of self-reflection and relational connection. However, more is required. For a hermeneutical self, the final point of inhabiting a moral space cannot simply be to share one's agent-regret as a matter of sorrow. Doing so may bring a measure of psychological relief, but it ignores the moral nature of the experience. It misses the fact that the clinician's longing is not merely to make herself feel better or, worse, to deceive herself into it. A space like Schwartz Rounds, I suggest, cannot be neutral to this worry. It is inescapably a moral space in which the clinician navigates her deeper aspiration to make sense of herself as really a good clinician—or in Taylor's words, "to be rightly placed in relation to the good." Such spaces should account for the fact that while the good may be variously imagined, it is always already conditioned by a prior self-constituting space of meanings and relations.

In other words, for a hermeneutical self, part of the challenge of moral distress is that of moral formation—of sustaining a self-narrative oriented to some good. The task is not to deploy cognitive strategies to mitigate or manage agent-regret as an unjustified psychological pain, nor to use ethical analyses to retrospectively convince oneself of the propriety of one's actions—to dismiss the agent-regret as irrational. Instead, I want to argue that just as the problem is moral, the response must be moral; the challenge is for the clinician to make sense of agent-regret as part of her life of virtue.

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[104] Ibid. 2.

Here, I have in mind an Aristotelian definition of virtue: an "excellence" or "characteristic" of a person that "makes him a good man, and which causes him to perform his own function well."[105] This life of virtue, as Aristotle argues, is conditioned by a moral community, for it is by the "speech" of that community that one comes to know the just and the unjust.[106] And it is by such a life of virtue that a happiness proper to us is constituted.[107] On this view, acquiring the virtues is thus constitutive of a complete life of happiness—one that can be described as "a kind of good life and well-being" and an end for which we seek all other goods.[108] This comports with what I articulated as a fundamental aspiration of the hermeneutical self—what Taylor calls a place of fullness. There, in proximity to it, we find fulfillment and feel empowered to act with "integrity or generosity or abandonment or self-forgetfulness."[109] Such a place can be variously imagined, but it is constituted by some notion of what it means to be good. This aspiration is ineradicable for it orients us as the basis of our identity and of our strong judgments about the qualitative worth of our lives. Our lives would otherwise lack a coherent narrative.

Now, with respect to an emotion like agent-regret, virtue entails that we experience it "at the right time, toward the right objects, toward the right people, for the right reason, and in the right manner."[110] Put differently, to experience agent-regret as an expression of a life of virtue is to do so truthfully. It is a concomitant emotion that one *should* feel given the often high-stakes but messy realities of medical practice—its ineliminable contingencies of moral luck. So the crucial question is, what does it look like to experience agent-regret as a good clinician would? A policy

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[105] *NE* 1106a.22-24; all citations to *NE* are from Aristotle, *Nicomachean Ethics*, translated by Martin Ostwald, Library of Liberal Arts (Englewood Cliffs, NJ: Prentice Hall, 1962).

[106] Aristotle, *Politics*, translated by Carnes Lord, 2nd ed. (Chicago: University of Chicago Press, 2013), 1253a14-19.

[107] *NE* 1099b.26-27.

[108] Ibid. 1098b.21; 1097a.28 ff. As Aristotle goes on to note, happiness "requires completeness in virtue as well as a complete lifetime. Many changes and all kinds of contingencies befall a man in the course of his life, and it is possible that the most prosperous man will encounter great misfortune in his old age…. When a man has met a fate such as his and has come to a wretched end, no one calls him happy" (Ibid. 1100a.4-9).

[109] Charles Taylor, *A Secular Age* (Cambridge, MA: Belknap Press, 2007), 5.

[110] *NE* 1106b.20-24.

response to moral distress that ignores this question does so at the peril of missing the problem for what it is—an experience of hermeneutical selves.

With this question in mind, then, I want to touch on what Mark Wilson articulates as a virtue of "moral grief." He does so as a response to the problem of moral injury in the context of war, but as I will soon show, it is also apt as a response to moral distress. The virtue in question is Augustinian; it derives from a passage in Augustine that I also quoted above: "let everyone … who reflects with pain upon such great evils [of just wars], upon such horror and cruelty, acknowledge that this [the conduct of war] is misery. And if anyone either endures them or thinks of them without anguish of soul, his condition is still more miserable."[111] The anguish of soul—what Wilson frames as moral grief—is conceived by Augustine as an imperative. This is so, Wilson notes, because the failure to experience such anguish would be "contrary to human nature and right reason, a pitiable and pitiful condition."[112] In Augustine's mind, one who refuses or fails to be anguished is self-deceived: he "thinks himself happy only because he has lost all human feeling."[113]

This moral grief, as Wilson articulates it, is fundamentally a "virtue of self-knowledge, … a lamentation seeking understanding."[114] The imperative is to be disposed to reflect well on one's participation in the realities of war, and to do so soberly and without self-deception. The question is, "Who am I who has participated in this [tragic circumstance]?"[115] The virtue consists in getting this self-reflection right, in being a person who habitually responds to conditions of moral luck with the right "mean between unchecked self-loathing and unthinking apathy."[116] Wilson specifies this further in terms of three "cooperative virtues," namely, "humility," "fidelity," and

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[111] *CD* XIX.7.
[112] Mark A. Wilson, "Moral Grief and Reflective Virtue," in *Virtue and the Moral Life: Theological and Philosophical Perspectives*, edited by William Werpehowski and Kathryn Getek Soltis, 57-73 (Lexington Books, 2014), 64.
[113] *CD* XIX.7.
[114] Wilson 66.
[115] Ibid.
[116] Ibid. 67.

"availability." The first "facilitates an accurate assessment of one's agency and the limits thereof." It grasps the limits of one's control in situations of moral luck, and guards against falsely assuming guilt.[117] In addition, humility acknowledges "the opacity of the self to the self," the self's mystery to itself. It thus enjoins a "rigorous honesty in the interpretation of memory, and a realism with regard to the limits of self-awareness and the traps of self-deception."[118]

Fidelity "connotes a faithfulness to one's self through time and a commitment to the integration of one's past." It entails revisiting one's distressing memories so as to reintegrate them into one's self-narrative. The temptation is to dissociate from one's painful memories, even to use drug or cognitive therapies to do so. But this would entail an alienation from oneself, from some of the core experiences that make up the self. Fidelity instead enjoins openness to the redemptive possibilities in those experiences, no matter how painful.[119] Finally, the third cooperative virtue of availability "indicates a willingness to be shaped and to be called into response." The past is neither simply rejected nor reified, that is, allowed to become "an albatross that curses the future." Rather, in being available, one engages the past responsibly, in "the hope for an integrated self, a self re-collected into an intelligible unity."[120]

Again, Wilson develops this account of moral grief in the context of moral injury among combat veterans. But my claim is that this virtue applies just as well to the often tragic, luck-related moral contingencies of clinical practice and the distress those situations can involve. Moral injury, as Wilson defines it, is the "psycho-emotional pain directed to the tragic effects of one's agency." It "entails feelings of responsibility for bad states of affairs and a sense of moral compromise and/or conflict," regardless of "whether the acts are omissions or commissions,

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[117] Ibid. 67-68.
[118] Ibid. 68.
[119] Ibid. 69.
[120] Ibid. 70.

intended or accidental."[121] Its "constitutive feature," he further remarks, is "Williams's account of agent-regret."[122] Thus, if what I have said about clinicians' experience of moral distress likewise holds, then we do well to consider the virtues that Wilson articulates in the clinical context as well. The point would be to recognize not only the moral depth of the distress involved for clinicians but also the moral depth of our response to it.

It is important to note at this juncture that fostering the disposition to experience agent-regret well is not optional. Agent-regret is a fact of clinical life; it is not entirely eliminable for it is marked by not only institutional constraints but also misfortune, uncertainty, dilemma, and desires. While it is often asked whether the virtues can be taught, this is the wrong question to ask. As inhabitants of a moral community, clinicians are always already shaped by or help to shape either virtue or vice. For trainees, for instance, this may happen explicitly with classroom content or implicitly through what is often called "the hidden curriculum."[123] But in either case, the modeling of virtue or vice is inescapable. The same applies for the virtue of moral grief. Character education, as Pellegrino and Thomasma put it, is "a *de facto* reality. Whether the faculty wishes it or not, they do teach virtue or vice in everything they say or do."[124]

The only question, then, is what the virtuous clinician looks like. This, of course, is not a simple question. Other ethicists have already enumerated many important virtues that clinicians do well to inhabit, such as fidelity, compassion, fortitude, temperance, integrity, and phronesis.[125] It has also been observed that a focus on the ideals of virtue detracts neither from the importance

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[121] Ibid. 63.
[122] Ibid. 61.
[123] See e.g., Lisa Lehmann, Lois Sulmasy, Sanjay Desai, for the ACP Ethics, Professionalism and Human Rights Committee, "Hidden Curricula, Ethics, and Professionalism: Optimizing Clinical Learning Environments in Becoming and Being a Physician: A Position Paper of the American College of Physicians," *Annals of Internal Medicine* 168 (2018): 506-508.
[124] Pellegrino and Thomasma 176.
[125] Pellegrino and Thomasma, chs. 5-12; see also Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 8th ed. (New York: Oxford University Press, 2019), ch. 2.

of principles or rules nor from the need for institutional reforms.[126] Indeed, just as systems reforms are incomplete without attention to the virtues, the virtues would be difficult to sustain without mutually supportive systems. But that said, it is beyond the scope of this chapter to consider the many virtues of clinicians and their nature in detail. My limited point is that moral distress constitutes an often misrecognized but ineliminable problem of clinician virtue. Wilson's articulation of moral grief offers a helpful answer to the everyday challenge of navigating well the extrapsychic and intrapsychic hazards of clinical practice.

Conclusion

An adequate response to moral distress, I have argued, must account for the agency of clinicians who actually experience it. As important as mitigating the systems-based conditions of moral distress—or as NAM conceives it, burnout—may be, it is not enough. It casts clinicians as a series of objects among others, as though they were molded merely in a passive manner. It obscures the true nature of moral distress as a human experience, and its description of the problem fails the plausibility test. The moral distress construct that emerged from the nursing literature, starting with Jameton, is a promising way to think about the distress in terms of our moral agency, but I have argued that it too falls short. It misses the fact that our agency is of a hermeneutical self. My claim is that moral distress is best understood in terms of our hermeneutical agency—that is, in terms of a basic longing to be a good, virtuous clinician.

My claim stands or falls on the truth of the nature of our agency. That truth, however, does not rest on an objective, empirical proof. As I have argued throughout this dissertation, the very fact of our hermeneutical nature discounts that possibility. There can be no knowing without presupposition. Any knowledge of our agency presupposes our ontology as hermeneutical selves.

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[126] May 271-272; see also Pellegrino and Thomasma, ch. 2.

As in previous chapters, this has been my presumption here. The argument has thus consisted in showing step-wise gains in coherence across the different accounts of moral distress—gains that better resonate with our lived experience of it.

Specifically, I have shown that articulating moral distress in terms of a hermeneutical self constitutes a cognitive gain in two mutually reinforcing respects. First, it clarifies the experience of moral distress in crucial ways. It further explains the nature of the integrity involved as well as the narrative structure of the self for whom distress has cumulative effects. It also explains how seeing moral distress in terms of agent-regret—a feeling concomitant of various circumstances of moral luck—brings coherence to the disparate instances of that experience in the literature. In this way, agent-regret sharpens our grasp of moral distress and broadens its policy implications, in particular, with respect to making sense of agent-regret as part of a clinician's longing for fullness, for a life of virtue. Second, by demonstrating another instance of conceptual gains in this way, this chapter follows the previous ones in this dissertation: it adds to the larger argument for humanizing modern medicine by way of the hermeneutical self.

CHAPTER FIVE

Health Justice and the Just and Caring Self

Making sense of our experience of modern medicine, I have been arguing, entails a fundamental shift in the terms of our understanding—from that of a disengaged self to that of a hermeneutical self. In attending to our ontology in this way, the idea is to sustain the conditions for experiencing the practice as being for and by human beings—to humanize it. As I noted at the end of chapter one, this is no small task given that much of our experience in medicine today is conditioned by our self-perception as disengaged. I explored an instance of this in the context of clinical practice in chapter four, and I now want to turn to its instance in our discourses on health justice, which tends to focus on distributive concerns. In what sense is our approach to health justice conditioned by the disengaged self? Why should this imperative be clarified in terms of the hermeneutical self, and what would it mean to do so?

The just distribution of health-related goods is a large topic entailing varied traditions of thought and numerous modern theories—utilitarian, egalitarian, capabilities-based, and so on. I cannot cover them all in a chapter, much less assess the merits of any one theory over another. I instead propose to focus on a particular *approach* to health justice that I take to be characteristic of the field of bioethics. Often associated with principlism, the approach presumes a neutral, agnostic attitude toward the various theories of justice, which it then deploys to resolve concrete problems. This tendency is well noted as far back as 1990. K. Danner Clouser and Bernard Gert, for example, lament that “almost all anthologies of medical ethics” start with summaries of the ethical theories and their inadequacies, which are then left unquestioned. The practical issues are seemingly “dealt with on an *ad hoc* basis, or the student is told to apply whatever inadequate theory he thinks is most useful in dealing with the problem at hand.”[1]

Not much has changed in this regard, and the basic approach has extended to recent anthologies of public and global health ethics. They standardly open with descriptions of the major theories or connected principles and then turn to apply them to various practical concerns.[2] The point is not to evaluate the theories or principles but to present them as resources for the analysis of issues. This is also the case in the newest moves to “reimagine” the field. For example, in an effort to “resocialize” global health toward biosocial perceptions, Paul Farmer and colleagues merely present the major theories in terms of their role in framing debates and in motivating an ideal of equity. Here too, only the pros and cons are presented; no critical analysis is offered.[3] The characteristic concern is not so much with the validity of any given theory but with its usefulness for helping resolve policy dilemmas or other practical challenges.

It can be tempting to caricature this approach as a mechanical, uncritical application of various ethical norms to a practical context or issue. But in my view, matters are not so simple; it need not be the case. In this regard, I want to build on a reading of the principlism that Clouser and Gert critique as the source of this particular ill in bioethics. That principlism, of course, is that of Tom Beauchamp and James Childress (henceforth, B&C) as articulated in their seminal text *Principles of Biomedical Ethics* (henceforth, *PBE*). *PBE* is currently in its eighth edition and has been a dominant point of reference for the field ever since its first publication in 1979. It has

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[1] K. Danner Clouser and Bernard Gert, “A Critique of Principlism,” *Journal of Medicine and Philosophy* 15 (1990): 219-236, 231. A similar description of the prevailing approach is offered by Ronald M. Green, “Method in Bioethics: A Troubled Assessment,” *Journal of Medicine and Philosophy* 15 (1990): 179-197, 187-188.

[2] See, e.g., Ronald Bayer, Lawrence O. Gostin, Bruce Jennings, and Bonnie Steinbock, eds., *Public Health Ethics: Theory, Policy, and Practice* (Oxford: Oxford University Press, 2007); Stephen Holland, *Public Health Ethics*, 2nd ed. (Malden, MA: Polity Press, 2015); Andrew D. Pinto and Ross E.G. Upshur, eds., *An Introduction to Global Health Ethics* (Abingdon, UK: Routledge, 2013); Henk A.M.J. ten Have and Bert Gordijn, *Handbook of Global Bioethics* (Dordrecht: Springer, 2014).

[3] Paul Farmer, Jim Yong Kim, Arthur Kleinman, and Matthew Basilico, *Reimagining Global Health: An Introduction* (Berkley, CA: University of California Press, 2013), ch. 9.

set the terms of debate on many of the field's core issues, including justice. But crucially, it has also been an ever-developing account, one that has adapted itself well to critics like Clouser and Gert by way of clarification and addition. It does not lend itself to easy caricature.

In this chapter, then, I grant that some version of what might be called a pluralist approach to distributive health justice is likely unavoidable. I will make this case in the first section by describing B&C's principlist approach and putting it in dialogue with Clouser and Gert. Like B&C, my concern is not to argue for any one theory of health justice as the best but to clarify what it would mean to engage in a critical version of a pluralist approach. B&C offer a highly nuanced version that entails a disciplined specification, balancing, and coherence. It marks an important gain on any ad hoc approach, and Clouser and Gert's counter proposal of a more comprehensive theory fares little better. Indeed, I hold that there is reason to prefer B&C's more flexible approach, and I do so by drawing on Michael Walzer's account of distributive goods.

B&C's promising approach to health justice, however, falls short in terms of a critical hermeneutical insight—our self-reflexivity. This is the case I will make in the second section. The difficulty is raised by social scientific concerns that challenge the universal nature of B&C's principles, including justice. The worry is that B&C's claim on this point obscures the fact that their action-guides actually rest on parochial grounds. A version of this critique takes aim at the existence of a common morality, but I propose to deepen the critique in terms of the problem of self-reflexivity. I argue that in neglecting the self-reflexivity of moral life, including their own, B&C miss the actual force of two other criticisms of their approach over which they recently expressed abiding puzzlement: that autonomy is their dominant principle and that they downplay the virtues. This worry over self-reflexivity thus serves as my point of departure in later sections for reframing B&C's approach to health justice.

Specifically, then, I argue in this chapter for reframing B&C's principlist approach to justice within a larger account of the hermeneutical self. My mode of argument throughout, as in previous chapters, is the BA principle; the search is for the best account of our experience of that task by way of error reducing gains. In addition to the moves for this argument in the first two sections, I make two further moves in the remaining sections.

In the third section, I build on B&C's account of the virtues—a potential resource for self-reflexivity—and what they claim is the "central virtue" of health care, namely, care. I critique their move to privatize that virtue, and look to the feminist political theorist Joan Tronto to help clarify care's centrality in the moral life, both private and public. Justice, on this view, is a constraint against the caring self. I take this to be a gain over the way in which B&C bifurcate the virtues and principles, and in turn, obscure our lived experience of them. Yet, against Tronto, I further argue that we are selves with a longing to be not only caring but also just persons.

In the fourth and final section, then, I propose to better integrate the norms of health justice within a life of virtue, within a self who is both caring and just. I turn in particular to Aristotle's account of the virtuous life as consonant with the hermeneutical self. The point is to integrate justice and care within a coherent self-ontology so as to locate health justice not only as a question of the instrumental distribution of goods but also, more fundamentally, as a question of our highest aspirations to self-flourishing. Lastly, to illustrate what this perception might entail as a way forward, I conclude this section by turning to its implications for health justice pedagogy and, returning to a point I made above, the anthologies used in that space.

B&C's Principlist Approach

Health justice, for B&C, is one of four prima facie principles—alongside autonomy, beneficence, and nonmaleficence—that constitute a "framework of general norms … that form a suitable starting point for reflection on moral problems in biomedical ethics."[4] As is the case for much of the current literature, B&C understand justice as a distributive principle, and their concern is to guard against "capricious" and "unfair" allocations of health-related social burdens and benefits. This has been their worry ever since the first publication of *PBE* in 1979, and indeed, it predates and perhaps helped set the subsequent agenda for the health justice literature. The first major theoretical work devoted to health justice, for example, is Norman Daniels's *Just Health Care* in 1985, which imagines health care as an institutional system that significantly determines "the level and distribution of our welfare" and should be governed by general principles of justice.[5]

In other words, the basic question of health justice for B&C is a formal one of distribution, which they attribute to Aristotle: "equals must be treated equally, and unequals must be treated unequally."[6] I later move to recontextualize this invocation in the final section, but B&C see in this principle the common basis of all theories of justice. The problem for them is that it "lacks all substance." As a formal principle, it offers nothing in terms of the criteria by which equals are to be regarded as equals and unequals as unequals. It thus needs to be specified with respect to the material goods to be distributed, that is, in terms of the "material principles" of justice, and these in turn are as diverse as the goods in question. As they note, in any given society, the criteria for distributing health resources (e.g., individual need or societal utility) will often differ from those for jobs (e.g., market competition) or basic education (e.g., equally to all).[7]

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[4] Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 8th ed. (Oxford: Oxford University Press, 2019), 13.

[5] Norman Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985), ix. In a later edition, Daniels defines health justice as entailing three fundamental questions: "is health … of special moral importance?" "when are health inequalities unjust?" and "how can we meet health needs fairly under resource constraints?" (*Just Health: Meeting Health Needs Fairly* (Cambridge: Cambridge University Press, 2008), 11).

[6] B&C, *PBE* 8th ed., 268.

[7] Ibid. 268-271; the distinction between formal and material principles of justice has persisted since the first edition of *PBE*; see Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 1st ed. (Oxford: Oxford University Press, 1979), 171 ff.

Health justice thus poses an epistemological problem: our persistent disagreements about what the obligation entails—about what material principle should determine the distribution of health-related goods. Efforts to systematize a given material principle, B&C contend, have led to several justice theories that are fundamentally distinct. By the eighth edition of *PBE*, they describe six. Utilitarians seek "rules and actions that maximize social utility," and libertarians look to maximize the "liberty and property resulting from the exercise of liberty rights and participation in fair free-market exchanges." Communitarians rely on "conceptions of the good developed in moral communities," while egalitarians provide for "an equal measure of liberty and equal access to the goods in life that every rational person values." Finally, capability theories assure to each "the means necessary for the exercise of capabilities essential for a flourishing life," and well-being theories provide for each person's "realization of core elements of well-being."[8]

B&C's principlist framework takes this plurality to be our predicament and makes no effort to assess or rank the various theories.[9] B&C recognize that the theories are constructed as competitive approaches, but venture that no single theory is adequate by itself. Each succeeds "only partially in bringing coherence and comprehensiveness to our multilayered and sometimes fragmented conceptions of social justice." There is, after all, no social consensus around any one material principle. In practice, while many countries want to assure equal access to health for all its citizens, they also rely on free-market principles to do so. "It is likely," B&C argue, "that there has never been a political state or a world order fashioned *entirely* on one and only one of the six theories of justice."[10] Thus, the basic, perhaps pragmatic, challenge is not to select any one theory for all our questions of justice but to specify and balance the several that are available.[11]

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[8] B&C, *PBE* 8th ed., 271.

[9] Ibid. 267; this problematic has framed B&C's discussion of justice from the very first edition of *PBE* (1st ed., 168).

[10] B&C, *PBE* 8th ed. 281.

[11] Ibid. 268.

B&C thus deploy all six theories as viable sources of norms for tackling practical issues of justice in health care. They accept that tragic choices must be made in conditions of scarcity. Material principles that are otherwise valid may appropriately be compromised or infringed when specifying or balancing their weight vis-à-vis other norms. In specifying, an agent extends a given norm by narrowing its scope; she articulates the concrete circumstances and means by which an action is to be done or avoided.[12] Specification thereby provides the action-guide implied in the principle. Balancing comes into play when two or more norms conflict. It involves reasoning about the norms that should prevail in a particular circumstance, and thus, also guards against proliferating specific rules for every conceivable circumstance.[13]

For example, on the issue of health disparities, B&C begin with the "fair-opportunity rule" drawn from Rawls's fair equality of opportunity principle. There is injustice when health-related social benefits are distributed in accord with properties that are undeserved, that is, are matters of life's lottery. These include race, ethnicity, gender, and social status. Justice requires that everyone have the health benefits needed to reach a "suitable level of function and have a fair opportunity in life."[14] But the fair-opportunity rule is not absolute. In reducing disparities in the distribution of kidney transplants, for example, the imperative must be balanced against medical utility. To what extent should a system prioritize human lymphocyte antigen (HLA) matching? An HLA match enhances the kidney's longevity, but because HLA phenotypes vary by race and most donors are

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[12] Ibid. 20. Specifically, a norm's scope is narrowed by "spelling out where, when, why, how, by what means, to whom, or by whom the action is to be done or avoided" (Ibid. 17; B&C here quote Henry S. Richardson, "Specifying, Balancing, and Interpreting Bioethical Principles," *Journal of Medicine and Philosophy* 25 (2000): 285-310, 289).

[13] Ibid. 20 ff.

[14] Ibid. 282.

white, prioritizing it leads to racial disparities in terms of wait times.[15] Policy here, B&C suggest, must balance equity concerns against medical utility.

Questions of a right to health are similarly occasions for specifying and balancing the principle of justice. B&C affirm a right to health care on the basis of reciprocity and, again, the fair-opportunity rule. On the norm of reciprocity, a society can expect a return on its investments in physician education, research funding, etc. But investments are specific; helping to fund the discovery of a treatment may not necessarily entail a right to its distribution. Thus, B&C suggest, this imperative should be buttressed by another, namely, that of mitigating opportunity-limiting conditions. A right to health can be traced to the obligations of social institutions to "counteract lack of opportunity caused by unpredictable misfortune." When injuries, diseases, or disabilities disadvantage and reduce a person's capacity to function, society is obliged to use its resources to mitigate their effects and give them a fair chance in life.[16]

Justifying a right to health care, however, is only part of the challenge. This right must be further specified in terms of "the entitlements the right requires us to recognize." A meaningful right to care must include a right to obtain that care. On one hand, libertarians oppose using public funds to provide for such care, which is contrary to the considered judgments expressed in the other justice theories. On the other hand, however, a right of equal access to all health-related goods for everyone would be overly demanding. It is utopian given that public resources are not limitless.[17] B&C thus settle on a "right to a decent minimum of health care" with a two-tiered

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[15] Ibid. 285 f. B&C note that the United Network of Organ Sharing rightly changed its kidney allocation criteria in 2003 by eliminating HLA-B matching, a subset of HLA phenotypes. This targeted move was justified not only on grounds of improving equity but also not sacrificing medical utility.

[16] Ibid. 291-292.

[17] Ibid. 292. This concern for limited resources comports also with B&C's discussion of the principle of beneficence. They distinguish between "obligatory beneficence" and "ideal beneficence." They argue that "virtually everyone agrees that the common morality does not contain a principle of beneficence that requires severe sacrifice and extreme altruism" (Ibid. 218).

arrangement: "enforced social coverage for basic and catastrophic health needs (tier 1), together with voluntary private coverage for other health needs and desires (tier 2)." Tier 1 covers "public health protections and preventive care, primary care, acute care, and special social services for those with disabilities." Other services like "luxury hospital rooms and optional, cosmetic dental work" are then be covered by private insurance available for purchase.[18]

Beyond recognizing resource limits, for B&C, it is significant that a decent minimum standard represents a compromise among the various theories of justice. For egalitarians, the standard assures equality in terms of a fair opportunity principle. For utilitarians, the standard "serves to minimize public dissatisfaction, to promote social utility, and to permit allocation decisions based on cost-effectiveness analysis." Similarly, libertarians can appreciate the space for free-market principles in tier 2, while advocates of capability and well-being theories can expect increases in people's capability to access care and achievements of better health. In this way, on the particular issue of access, a decent minimum standard balances the competing theories by specifying premises that they variously stress or find acceptable.[19]

The same logic of specification and balancing applies all the way through to the more granular issues of allocating, setting priorities, and rationing health care goods and services. B&C, for example, recognize the legitimacy of cost-effectiveness analyses that are utilitarian, but they also caution that relying on them exclusively treats health care on "unjustifiably narrow terms."[20] They argue that such tools need to be constrained by other justice considerations, such as the need not to undermine or ignore the health needs of disadvantaged populations.[21] In certain contexts, such as public health emergencies, the norms of public trust, support, and engagement

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[18] Ibid. 293.
[19] Ibid.
[20] Ibid. 252.
[21] Ibid. 304.

may also be indispensable.[22] The point, consistently, is that there is no set of universal criteria applicable in all situations. Doing justice entails attention to the particular circumstances in which any given good or service must be allocated and rationed.

Finally, extending the principle of justice to global health, B&C add that while the "*circumstances* of justice" may be always local, "the *reasons why* rules of justice are needed" are global. The right to a decent minimum is thus a global ethic. The distinction between citizen and foreigner is as arbitrary as race, class, or gender. If the goal is to assure fair opportunities for all, including the worst off, then there is no reason to limit the principle's scope to a given nation-state.[23] Indeed, in our interconnected global order, such limits would only exacerbate existing disparities.[24] In the many local circumstances of global health, moreover, B&C affirm the need to think in terms of a decent-minimum of "health" rather than "health care." Just as poor access to health care affects health, poor health affects access; just as lack of education or poverty harms health, poor health exacerbates education and poverty; and so on. In global health, no one issue can be addressed in isolation from the others.[25]

In sum, rooted in the formal idea that equals be treated equally and unequals unequally, the primary questions of justice in *PBE* have to do with the right distribution of health-related goods. The challenge is to clarify what we owe to each other, that is, the scope and limits of the claims we have on one another. However, unlike the various theories that meet the challenge in terms of a particular material principle, B&C offer a framework in which to analyze the norm's meaning, weight, and implications in practical cases. The approach is neither systematic nor comprehensive, and this is both its great strength and weakness. As is evident in the examples I

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[22] Ibid. 313.
[23] Ibid. 298.
[24] Ibid. 299.
[25] Ibid. 300.

have rehearsed here, it is highly pluralistic and tolerant of conflicts and tradeoffs, and sensitive not only to competing principles but also to practical exigencies. That said, these very strengths also raise the question of whether the approach goes too far, whether its resolutions finally rest merely on ad hoc intuitions.

An Ad Hoc Approach?

The objection that principlism ultimately relies on ad hoc intuitions is forcefully stated by Clouser and Gert in their 1990 article, "A Critique of Principlism."[26] They protest that a principlist approach like that of B&C is merely formal and offers no action-guiding content. Classically, a principle "embodies the moral theory (or part thereof) that spawned it; it is used by itself to enunciate a meaningful directive for action."[27] For example, the principle "do that act which creates the greatest good for the greatest number" is a clear directive that embodies the utilitarian theory. This principle may be variously interpreted in particular situations, but it is not set in conflict with others such that an agent must choose between them.[28] This is the case even when a theory articulates two or more principles like in Rawls's theory of justice; the relationship between its directives is clear. But this is not the case with B&C's principles.

At best, Clouser and Gert argue, B&C's principles "operate primarily as checklists naming issues worth remembering when considering a biomedical moral issue."[29] Though each purports to be a prima facie principle, each incorporates multiple norms and considerations that are only

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[26] See fn. 1 above for the full reference to this article. Clouser and Gert were not the only ones with this critique at the time, but theirs was the most sustained and received the greatest attention in B&C's subsequent response to the criticism in their fourth edition. The other critics B&C cite on this score are Ronald Green's "Method in Bioethics: A Troubled Assessment" (again, see fn. 1 above) and Stephen Toulmin, "The Tyranny of Principles," *Hastings Center Report* 11 no. 6 (1981): 31-39.

[27] Clouser and Gert 221.

[28] Ibid. 222.

[29] Ibid. 220.

"superficially interrelated." The principle of justice, they argue, is particularly egregious in this regard. Its chapter reviews various competing accounts of justice but offers no clear action-guide. The principle instead functions as a "hook on which to hang elaborate discussions of various topics."[30] In other words, each principle is merely a point of view. When competing principles are "applied" to a case, "this actually amounts simply to thinking about the case from diverse and conflicting points of view."[31] Such an "eclectic and unsystematic use of moral theory," Clouser and Gert argue, risks obscuring and confusing moral reasoning.[32]

Specifying, Balancing, and Coherence

John Arras memorably describes principlism as "The Borg of bioethics." He has in mind the "cybernetically enhanced humanoids" in *Star Trek* who "explore the universe in search of interesting new cultures and technologies, which they promptly conquer and incorporate into their neural network en route to their goal of ultimate perfection." Likewise, many a would-be crippling critique of *PBE* over the years has been "welcomed with open arms, trimmed of its perceived excesses, and incorporated into the ever-expanding synthesis of the next edition."[33] B&C's response to Clouser and Gert's critique is an example of this phenomenon.

B&C respond in the fourth edition of *PBE*. They reaffirm that "untidiness, complexity, and conflicts" are pervasive, unfortunate features of the moral life. They are skeptical that a unified, comprehensive foundation for ethics can ever be discovered, and thus reject any move to present their principles as anything more than a framework.[34] Anticipating this point from the very first

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[30] Ibid. 227.

[31] Ibid. 223.

[32] Ibid. 220.

[33] John Arras, *Methods in Bioethics: The Way We Reason Now*, ed. James Childress and Matthew Adams (New York: Oxford University Press, 2017), 2.

[34] Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 4th ed. (Oxford: Oxford University Press, 1994), 106-107. Clouser and Gert target the second edition of B&C's text; the third edition was published in 1989,

edition, B&C note that our principles and rules cannot be absolute. Conceiving them on overly rigid terms "undermines the freedom and discretion of moral agents." To be sure, some rules may be close to absolute, such as prohibitions against murder or lying. But even here, much depends on how the rule is defined or qualified: its application "may hinge on different understandings of the relevant moral terms ... as well as on their weight and stringency." Whether a murder or lie is wrong would, for instance, depend on how one specifies unjustified killing or lying.[35]

However, B&C also guard against intuitionism. They insist that their principles are not mere "rules of thumb" that can be applied piecemeal in a given situation.[36] They are instead prima facie norms. Following W. D. Ross, B&C posit that certain duties are "on all occasions binding *unless* they are in conflict with stronger duties." Duties like beneficence or promise-keeping are not absolute in that "they can be overridden under some conditions." But they also are not mere rules of thumb; "they constitute strong moral reasons for performing the acts in question."[37] One might say that the burden of proof is on the side of overriding the norm. For example, killing a person is commonly prohibited, but it can be overridden for reasons of self-defense. The same can apply to lying, where it may be justified if it can benefit another, say, by saving their life. As a result, B&C add, overriding a prima facie duty leaves what Robert Nozick calls "moral traces," an experience of "regret and, perhaps, even remorse at having to neglect or violate this duty."[38]

In the third and fourth editions of *PBE*, B&C expand on this idea by spelling out the conditions under which a prima facie norm may be infringed or balanced against other norms. Starting with the fourth edition, following Clouser and Gert's critique, they do so under a new

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just a year prior to Clouser and Gert's critique was published in 1990. But there is little change between the second and third editions on the points that Clouser and Gert criticize. Thus, the fourth edition is the first occasion on which B&C could have responded with substantial changes to their account.

[35] B&C, *PBE* 1st ed., 43-44.

[36] Ibid. 42-43.

[37] Ibid. 45.

[38] Ibid. 47.

section on “Specifying and Balancing Principles.”[39] This remains true through the eighth edition, which only adds to the conditions for balancing principles. The process of balancing, as I noted earlier, involves resolving two or more conflicting norms. B&C identify six conditions for when prima facie norms may be overridden: “good reasons” for infringement are offered; the prospect of achieving the purpose of infringement is “realistic”; no “preferable alternative” is available; the least infringing option is selected; all negative effects are minimized; and all affected parties are “treated impartially.”[40] Balancing, to this extent, entails deliberation and not just intuition.

The fourth edition is also where B&C clarify the process of specification as a formal, explicit strategy in their method. One can sometimes “apply” norms straightforwardly to simpler cases, but “in managing new, complex, or problematic cases,” specification is the first line of approach. Specification entails a careful narrowing of the norm’s scope by identifying the where, when, why, how, and who of the decision or act in question. Citing Henry Richardson, B&C thereby see it as a critical means of determining what counts as an instance of a principle and of “gradually reducing the dilemmas and circumstances of conflict that the abstract principle has insufficient content to resolve.” The point is to conceptually and normatively develop a principle that is otherwise abstract so as to connect it to concrete action-guides and judgments.[41]

Again in the fourth edition, B&C clarify yet another important condition for moral reasoning: a coherence rooted in “the common morality.” The common morality is a subset of “the morality shared in common by the members of a society—that is, unphilosophical common sense and tradition.”[42] It is not to be equated with “customary morality,” nor is it merely a

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[39] B&C, *PBE* 4th ed., 28-37; B&C begin to articulate these conditions under their discussion of “The Place of Rules and Principles” in the third edition (*Principles of Biomedical Ethics*, 3rd ed. (Oxford: Oxford University Press, 1989), 53). There, they articulate four conditions, expanding to five in the fourth edition.

[40] B&C, *PBE* 8th ed., 23.

[41] B&C, *PBE* 4th ed., 28-29; see Henry S. Richardson, “Specifying Norms as a Way to Resolve Concrete Ethical Problems,” *Philosophy and Public Affairs* 19 (1990): 279-310.

[42] B&C, *PBE* 4th ed., 100.

"summation" of that morality. Rather, common morality norms embody a "moral point of view that transcends merely local customs and attitudes."[43] Clarifying these ideas in later editions, B&C mention as examples such action-guides as "do not kill" or "do not cause pain or suffering to others" and such virtues as "nonmalevolence" or "trustworthiness." In contrast to the norms particular to different cultures or institutions, such common morality norms exist in *all* cultures; they are believed universally by all "morally committed persons." Moreover, they are not ahistorical or a priori but are learned and transmitted in history.[44]

The common morality, then, ensures that coherence, as a justifying condition of moral reasoning, is grounded in substantive norms. After all, not any coherence will do; a pirate's code may be coherent, but it is unethical.[45] For B&C, a justified coherence instead depends on a Rawlsian "reflective equilibrium." The process begins with "considered judgments," which are the moral judgments that are "least likely to be affected by conflicts of interest and other distorting influences and therefore appear at least provisionally acceptable on their own without argumentative support."[46] These judgments therefore anchor our reflections on our moral beliefs, norms, and theories. The reflection, however, aims not necessarily for an alignment with the considered judgments but for an equilibrium with them. Where there is conflict, we must revise either our beliefs, norms, and theories or our considered judgments. The latter is much less likely but is in principle always a possibility.[47]

On this picture, the four principles for B&C are the main considered judgments of biomedical ethics. They are the starting point of its moral reflection. They are, moreover, drawn from the common morality and are thus universal, that is, applicable to all. The four principles do

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[43] Ibid. 100-101.
[44] B&C, *PBE* 8th ed., 3-4. These points about the common morality are clearest from the 6th edition onward.
[45] B&C, *PBE* 8th ed., 443.
[46] Ibid. 440.
[47] Ibid. 440-441.

not exhaust the common morality; they are selected from it for being particularly suitable for the biomedical sphere. The truth of this last claim, however, can only be demonstrated in application, that is, in the defense of "the vital role of each principle in biomedical ethics."[48] That, ultimately, is what B&C seek to do in much of their book, including in the chapter on justice.

In making these moves, B&C also defend against the critique that principlism reduces moral reasoning to a set of formal principles to be mechanically applied to particular cases. Their coherence model contrasts with the type of "top-down" deductive reasoning that critics, including Clouser and Gert, often seem to have in mind.[49] Top-down reasoning involves "applying a general norm … to a clear case falling under the norm." The norms—rules, principles, or theories—are prior and "always universal in their logical form"; they serve to justify particular judgments.[50] But B&C's contrary point is that such norms must be specified and balanced in particular cases, and this entails complex considerations of contingent facts, cultural expectations, uncertain outcomes, and precedents.[51] Far from being reducible to deductive reasoning, the process entails being open to inductive conclusions calling the starting principles into question.[52] Such reasoning

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[48] Ibid. 13.

[49] To be fair to Clouser and Gert, among other critics, the first three editions of B&C's text carried a diagram of a hierarchy of moral justification that moved from "particular judgments and actions" at the bottom to "rules," "principles," and then "ethical theories" at the top. The justificatory movements were illustrated by unidirectional arrows pointing upward (see B&C, *PBE* 1st ed., 5; *PBE* 3rd ed., 6; *Principles of Biomedical Ethics*, 2nd ed. (Oxford: Oxford University Press, 1983), 5). This gave the impression that B&C's approach moved in a unidirectional application of theories to principles to rules to cases. B&C arguably clarify (as opposed correct) a more nuanced relationship characterized by an equilibrium in later editions, as I have pointed out (see also Arras 11).

[50] B&C, *PBE* 8th ed., 426-427.

[51] Ibid. 427-428.

[52] In this sense, B&C also call their mode of justification "an integrated model." It incorporates not only deductive reasoning but also inductive reasoning, or what they call "bottom-up" reasoning. In inductive moral reasoning, principles are not prior but derivative. They are justified by precedent cases or practices or by exemplary lives and narratives. Casuistry as articulated by Albert Jonsen and Stephen Toulmin is a prime example bottom-up reasoning, and one that B&C critique. They note that cases are not self-justifying in the way that Jonsen and Toulmin present. Rather, the validity and applicability of a paradigm case are subject to evaluation, and this entails recourse to an external reference, namely, principles (Ibid. 438). The point is that neither top-down nor bottom-up reasoning is sufficient on its own—one needs the other—and hence the reflective equilibrium. This is another example of B&C being what Arras called them: the Borg of bioethics. For Jonsen and Toulmin's full account, see their *The Abuse of Casuistry: A History of Moral Reasoning* (Berkeley: University of California Press, 1988).

demands a constant, reflexive back-and-forth between our general norms and practical decisions in a process of reflective equilibrium.

Specifying, balancing, and coherence, then, are the basis of B&C's claim that their use of the six theories of justice as resources is a matter of deliberation, not mere intuition. It does not fall prey to what they argue against: "the tragically piecemeal approach" to justice that is all too common in how health systems are set up.[53]

Against a Singular Theory

The question remains, is B&C's response to Clouser and Gert enough? This is difficult to say in any definitive way. After all, enough for what? But by way of comparison, we do well to consider Clouser and Gert's own counter proposal. Rather than a set of loosely interrelated principles, they argue, bioethics needs a moral theory that can justify acts on "a single clear, coherent, and comprehensive decision procedure for arriving at answers." They conceive morality as "a public system that applies to all rational persons." In particular, the system entails ten moral rules that all such persons accept—such as "don't kill," "don't deceive," "do your duty"—a set of ideals to which all such persons can aspire, and a decision procedure for "estimating" when a moral rule can be violated.[54] The procedure would determine the morally relevant facts of a case and then estimate the consequences in order to arrive at an acceptable policy.[55]

It is unclear, however, that any single decision procedure, including Clouser and Gert's, can be comprehensive enough. When Clouser and Gert apply their theory to health justice, for example, they stress a government's duty to "lessen the amount of harm suffered by its citizens."

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[53] B&C, *PBE* 8th ed., 313.

[54] Clouser and Gert, 234. I use the term "estimating"—as opposed to "determining"—because that is what Gert elsewhere says the procedure entails (see Bernard Gert, *Common Morality: Deciding What to Do* (Oxford: Oxford University Press, 2004), 74-75).

[55] The procedure usually involves a range of acceptable estimates, leading to a range of acceptable policies (Ibid.).

But beyond that, they concede that there is too much disagreement, including around the competing imperatives of cost and the ranking of the harms and benefits involved.[56] On one hand, this concession is reasonable, even predictable, given the complexities involved. But on the other hand, it also undermines their claim that their ethical theory improves on what they claim is B&C's ad hoc approach. As B&C note, Clouser and Gert's "criticism that our principles lack directive moral substance … applies to their [system of] rules in a near-identical way."[57] It does not seem possible to avoid intuitive judgments altogether in connecting norms to practice.

Moreover, in my view, even if a comprehensive theory were in principle possible, there may be good reasons not to aspire to it. B&C's observation that no single theory of justice has ever prevailed in a society is compelling.[58] To be sure, they do not so much argue the point as assert it. But Michael Walzer does, and he does so powerfully. In *Spheres of Justice*, he notes not only that there has never been a "single criterion" of distribution—per B&C—but also that there has never been a "universal medium of exchange" or "a single set of agents." Not even money has ever been so powerful a medium as to render all other mediums of exchange moot. Likewise, no agent of state has ever regulated or had the capacity to regulate all distributive patterns in a society. One only has to think of the abiding role of familial, political, or religious networks and agents in any given society to see this point.[59]

But Walzer's crucial insight here is that this plurality is not because of some failure to agree on a universal principle. The reason instead is that the goods we distribute always already have distinct meanings for us in a given society. It is not only that we do not or cannot distribute all goods on a single criterion but that we *should* not. Theories of justice, Walzer writes, tend to

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[56] Bernard Gert, Charles M. Culver, and K. Danner Clouser, *Bioethics: A Systematic Approach*, 2nd ed. (Oxford: Oxford University Press, 2006), 63.
[57] B&C, *Principles*, 8th ed., 429-430.
[58] Ibid. 271, 281.
[59] Michael Walzer, *Spheres of Justice: A Defense of Pluralism and Equality* (New York: Basic Books, 1983), 3-4.

assume only that "people distribute goods to (other) people." But in fact, "people conceive and create goods, which they then distribute among themselves."[60] In other words, what we distribute are not neutral objects that simply appear in our hands. Rather, the goods are social; they have "shared meanings because conception and creation are social processes." Far from determining how goods are to be distributed, the distributive principles are determined by the prior "shared conceptions of what the goods are and what they are for."[61]

On this view, the diversity of principles and theories on matters of distributive justice is expected: "different social goods ought to be distributed for different reasons, in accordance with different procedures, by different agents."[62] To be sure, Walzer thinks of medical care as a distinct distributive sphere of justice. He proposes the criterion of "need," as opposed to "free exchange," as most appropriate for the distribution of medical care.[63] But in my view, matters in this sphere are more complex than Walzer recognizes. Health-related goods are highly diverse, including not only material resources like drugs and devices but also services and larger structural and social determinants of health. These goods, moreover, intersect in myriad ways with other spheres of social life, including politics, markets, education, and so on.[64] Even if one could delimit a medical sphere, no single criterion, agent, or procedure of distribution would therefore seem to be apt. To that extent, it is doubtful that any such standard can or should in principle succeed.

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[60] Ibid. 6.

[61] Ibid. 7.

[62] Ibid. 6.

[63] Ibid. 86-91.

[64] Indeed, more recent conceptions of health justice tend to argue for a pluralism of goods of which health is an interrelated part. In their wellbeing theory of justice, for example, Madison Powers and Ruth Faden characterize wellbeing in terms of six "essential dimensions": health, personal security, reasoning, respect, attachment, and self-determination. They argue that justice within public health and health policy entails attention to each of these dimensions, not just that of health (*Social Justice: The Moral Foundations of Public Health and Health Policy* (Oxford: Oxford University Press, 2006). Similar points on the inescapable multiplicity of intersecting goods are made in extensions of capabilities theories into the health sphere as well as that of Rawlsian theory (see, e.g., Sridhar Venkatapuram, *Health Justice* (Malden, MA: Polity Press, 2011); Jennifer Prah Ruger, *Health and Social Justice* (Oxford: Oxford University Press, 2009); Daniels, *Just Health* (2008)).

A Problem of Self-Reflexivity

B&C's response to Clouser and Gert's objection marks a conceptual gain in avoiding problems on either of its sides, that is, ad hoc intuitionism on one and over-systematization on the other. It is worth noting, however, that this middle ground is not an abstraction—an absolute ideal "out there" that exists external to the self. Rather, it is the subject of a self's ongoing negotiation—of a self's judgments on the specification and balancing of norms in particular situations. B&C are not blind to this fact, but the question is whether they do full justice to it. I argue in this section that they do not. They fall short in terms of a critical hermeneutical insight, our self-reflexivity. This point will be important to establish so as to motivate the need in later sections to reframe B&C's approach to health justice in terms of the hermeneutical self.

One articulation of this concern hangs on B&C's reliance on the common morality as a basis for the universality of their principles. In an oft-cited article, Leigh Turner argues that B&C do not show that there is in fact a universal common morality to which all societies hold.[65] The burden of proof, he notes, rests with B&C because the preponderance of historical and anthropological evidence shows the opposite: "the plasticity of understanding of morality across cultures and through time."[66] Some cultures are hierarchical and others more egalitarian; in some, gender determines access to jobs and other resources, and in others, less so; some promote an ethos of nonviolence and others of warfare; even within a single society, notions of justice can be

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[65] Leigh Turner, "Zones of Consensus and Zones of Conflict: Questioning the 'Common Morality' Presumption in Bioethics," *Kennedy Institute of Ethics Journal* 13 (2003): 193-218, 197. Many others make related arguments: see, e.g., David DeGrazia, "Common Morality, Coherence, and the Principles of Biomedical Ethics," *Kennedy Institute of Ethics Journal* 13 (2003): 219-230, 222; Anna E. Westra, Dick L. Willems, and Bert J. Smit, "Communicating with Muslim Parents: 'The Four Principles' are not as Culturally Neutral as Suggested," *European Journal of Pediatrics* 168 (2009): 1383-1387; Donald C. Ainslie, "Bioethics and the Problem of Pluralism," *Social Philosophy & Policy* 19 (2002): 1-28, 3-4; Patricia Marshall and Barbara Koenig, "Accounting for Culture in a Globalized Bioethics," *Journal of Law, Medicine & Ethics* 32 (2004): 252-266, 256-257; Barry Hoffmaster, "Can Ethnography Save the Life of Medical Ethics?" *Social Science & Medicine* 35 (1992): 1421-1431, 1422-1423.

[66] Turner 197.

drawn from the ancient Greeks at one time or liberal democratic thought at another.[67] There are thus grounds for initial skepticism about B&C's claims.

B&C's failure to ground their claim in empirical evidence, Turner contends, instead shows that their principles are actually "ahistorical, acultural." B&C look to a cross-cultural convergence on the common morality, but when societies diverge, they are dismissed as exceptions resulting from "indoctrination" by those who are not "morally committed." B&C thereby ensure that any empirical evidence to the contrary cannot in principle disprove their claim. In this way, Turner concludes, they "dress" their claim as empirically valid, but they are in fact "working with a priori moral concepts that exist independently of culture and time. It is only with such concepts in place that it is possible to confidently label individuals and entire societies as 'amoral' or 'immoral.'"[68]

Turner's worry captures a version of what I am calling a problem of self-reflexivity. That is, in Turner's view, B&C's common morality claim obscures the actual "degree of normative conflict in US society." It blinds us "to the political processes by which particular understandings of morality come to power, or are squeezed from positions of public authority."[69] His contention is that ethics is political, including B&C's principles. What is called for is a book not on the *Ethics of* but on a *Politics of Biomedical Ethics.* "Such a work," Turner predicts, would "be less confident of the existence of an a priori, transhistorical, universal common morality, and more cognizant of how local, temporal, normative civic cultures are built through much struggle over the passage of time."[70] Given what I have said in earlier chapters and will say later in this one about the ethics of the hermeneutical self, I do not agree that ethics is political all the way down. But Turner's worry about the historical situatedness of B&C's principles is well taken.

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[67] Ibid. 194-195.
[68] Ibid. 204.
[69] Ibid. 215.
[70] Ibid. 216.

B&C respond to Turner in the sixth edition of *PBE* by maintaining the possibility of an empirical justification for the common morality.[71] They grant that there is no positive empirical evidence for the common morality, but they also note that there is no evidence to the contrary. They insist that the contrary evidence to which Turner and others point only capture differences in the particular moralities of various cultures. They show the diversity in the "interpretation, specification, and balancing of moral norms, but they do not study or show that cultures accept, ignore, abandon, or reject the standards of the common morality."[72] To use one of Turner's examples, B&C might say that the fact that libertarians and egalitarians in the US favor different health policies does not show that either group ignores the common morality norm of justice or autonomy. For both, the same norms still frame the debate—which is all that the principles are intended to do[73]—and their differences in conclusion can be expected.

In addition, while B&C do not conduct an actual study, they outline a design for one that they believe could show that all people who are "committed to morality" hold their hypothesized common morality norms. The key is not to limit the included subjects to those "who already have the commitments and beliefs the investigator is testing for" or to include subjects regardless of "whether or not they are committed to moral norms." Doing one or the other would beg the question, per Turner's worry, by biasing the study either for or against the hypothesis. B&C thus propose using a commitment to nonmaleficence, for example, as a minimal inclusion criterion. "It is unimaginable," they argue, "that any morally committed person would reject this general

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[71] Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 6th ed. (New York: Oxford University Press, 2009), 4; Turner and others on this score are cited under ref. 7 of that page.

[72] B&C, *PBE* 8th ed., 450; italics removed from original.

[73] The principles, they write, function "as an analytical framework of general norms derived from the common morality that form a suitable starting point for reflection on moral problems in biomedical ethics" (Ibid. 13).

principle." The strategy could then capture the larger set of common norms in morally committed persons without predetermining those norms.[74]

In response to Turner, therefore, B&C insist that the common morality is universal but that it is also historical. Far from deploying a priori constructs, they seek an ever-evolving equilibrium that is lived in history. This is so much the case that even the common morality can in principle change, at least in its contents if not its universality. In the seventh and eighth editions, B&C write, "to the extent we can envisage circumstances in which human society is better served by substantively changing or abandoning a norm in the common morality, change could occur and could conceivably be justified."[75] To be sure, this has never happened and is not presently happening, but that is not to say that it never can. Moreover, B&C's claim that some of us are amoral, immoral, or selectively moral does not seem to invalidate this historicity. The point, after all, is to critique our particular moralities within and across cultures, and this is what in part fuels the very change and diversity that critics like Turner observe in history.

Deepening the Critique

B&C respond effectively to Turner's focus on the historicity of the common morality. But in my view, the critique can be deepened. For all the insistence on their principles' historicity, it is unclear that B&C come to terms with its self-reflexive implications. That is, B&C understate their

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[74] Ibid. 450-451. It is worth noting that B&C also offer normative and conceptual justifications for the common morality. But these are not relevant to my discussion here. In brief, B&C argue that "normative justifications" are possible insofar as ethical theories can be used to justify certain norms of the common morality. Utilitarian, Kantian, rights, and virtue theories are examples (Ibid. 452-453). B&C also endorse "conceptual justifications," such as that of Philippa Foot: "certain norms are essential to the concept of morality and are starting-points, fixed by the concept, that state what is objectively correct" (Ibid. 454). Specific norms, in other words, are definitional of the very notion of morality such that it could not otherwise be conceived.

[75] Ibid. 446; see also Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 7th ed. (New York: Oxford University Press, 2013), 413. B&C recognize that there have been momentous changes in the scope of the common morality, such as to whom justice applies, but that is different from saying that one or more of its norms have ever been, say, abandoned.

own historical or cultural situatedness. To make this plain, I want to focus on two criticisms over which B&C have expressed abiding puzzlement. In a 2019 article marking the fortieth anniversary of *PBE*, B&C refer to these criticisms as "common misunderstandings" of their approach. One is that principlism "enshrines the principle of respect for autonomy as the dominant moral principle, overriding all other moral principles." Another is that their approach "neglects or downplays the virtues."[76] I argue, however, that these may not be misunderstandings. Rather, B&C appear to miss the force of the critiques because of their inattention to self-reflexivity—the very issue that I argue the two critiques raise.

Against the critique alleging the preeminence of autonomy, B&C insist that their four principles are not ranked a priori. Each is a prima facie principle of equal moral standing. B&C point to the many examples in their text where autonomy is indeed outweighed, such as by "threats to public health that require the restriction of liberty through forcible isolation or quarantine" or by threats to a third-party that entail breaching a patient's confidentiality.[77] But this critique may be deeper than B&C appreciate. The issue is not that autonomy cannot be outweighed through specification and balancing but that its individualizing emphasis underlies how each of the other principles are also *defined*. B&C tend to treat each principle as a discrete norm that is independent of the others, and they understate the ways in which the principles may inform each other at the level of interpretation. Little, in fact, is said in any of their texts about how principles might be interpreted critically.

B&C are indeed uncritical of the individualist bias underlying their own definitions of the principles. Daniel Callahan, for example, notes that "the driving force of principlism in practice is autonomy." Nonmaleficence for B&C "is simply a derivative principle from that of respect for

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[76] Tom Beauchamp and James Childress, "*Principles of Biomedical Ethics*: Marking Its Fortieth Anniversary," *American Journal of Bioethics* 19 no. 11 (2019): 9-12; B&C do not cite the specific sources of the critique.
[77] Ibid. 11.

persons and their bodily sovereignty." Beneficence entails advancing the good of another or society, but here too, "there are many possible goods and it is up to individuals to choose their own." Similarly, the principle of justice is reduced to assuring that "individuals have equal opportunity to pursue their autonomous life goals without an unfair lack of access to good health care."[78] Callahan's worry is that a certain individualism underlies how B&C define their principles, and this biases their analysis of issues from the outset.

Echoing this critique, Søren Holm takes particular issue with the fourth of B&C's five conditions for obligatory—as opposed to supererogatory—beneficence. Namely, person X has a duty of beneficence only if, among other conditions, "X's action would not present significant risks, costs, or burdens to X."[79] This condition, Holm contends, heavily circumscribes the duty in a way that betrays the fact that while B&C invoke four principles, "only one or two (i.e., autonomy and non-maleficence) are really important." Likewise, for instance, he notes that their emphasis on autonomy also excuses our obligations of justice insofar as carrying it out is often difficult and imposes burdens that are heavier than many of us are willing to carry.[80] B&C, in other words, define their principles parochially in a mirror of their American bioethical ethos—one that, as Renée Fox observes, gives "paramount status to the value-complex of individualism."[81]

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[78] Daniel Callahan, "The Social Sciences and the Task of Bioethics," *Daedalus* 128 (1999): 275-294, 283.

[79] Søren Holm, "Not Just Autonomy—The Principles of American Biomedical Ethics," *Journal of Medical Ethics* 21 (1995): 332-338, 334. Holm finds this condition in the fourth edition, but B&C maintain it through their eighth as well; see B&C, *PBE* 8th ed., 207.

[80] Holm 335-336.

[81] Renée C. Fox, "The Evolution of American Bioethics: A Sociological Perspective," in *Social Science Perspectives on Medical Ethics*, edited by George Weisz (Dordrecht: Springer, 1990), 201-217, 206. The value-complex underscores "the principles of individual rights, autonomy, self-determination, and their legal expression in the jurisprudential notion of privacy." Its paramount status, Fox argues, is evident in the field's preoccupations, which include a negative reaction to paternalism; the notion of contract in mediating relationships; veracity and truth-telling to assure informed decisions by individuals; justice as the distribution of material resources in relation to cost containment; a beneficence circumscribed by a deference to individual rights, interests, and autonomy; and a stress on minimizing harm over maximizing the good (Ibid. 206-207).

The force of the critique here is not simply that the principles and the common morality from which they are drawn are interpreted, weighed, or specified variously in practice. In that case, B&C can respond that for all the particular differences, the principles are still operative across cultures in framing the issues. Instead, at stake is the *depth* to which one's articulation of the principles is culturally situated. If Callahan and Holm are correct, we not only apply and think with the principles as situated beings but also formulate their very definitions as such. B&C do not escape this fact. Autonomy, as the direct expression of their American ethos, does not only bias the weight they give to it at the level of balancing but also conditions how they define each of the other principles. More to the point, B&C neither acknowledge this self-reflexive concern nor offer much to mitigate it. They simply assume that the principles are self-contained, unmediated concepts that are equal in relation to one another.

But in what sense is this critique an actual problem for B&C? Could they not say that how the principles are defined are also particular to a culture, and move on? One problem is that the move would seem to accept that people across cultures do not in fact talk about the same thing when they refer to the word "justice," or to any other principle. In that case, universal principles would be meaningless. They would be as thin in content as they are universal in scope, that is, infinitely so. The worry, as Holm suggests, is that the principles turn out to be purely formal, lacking in any substance; and as such, they can provide no real guidance.[82] Another related implication would be that the principles are culturally relative all the way down. This, again, is a conclusion that B&C cannot accept for it defeats their common morality aspirations.

It is unclear how B&C would respond; they do not consider the possibility that their principles may be parochial all the way down. But in my view, this critique also tends toward an abstraction that risks missing what is actually at stake. The fact is that B&C's principles have

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[82] Holm 337.

already been taken up as a framework for bioethical debate in a variety of cultures. *PBE* has been translated into numerous languages and has "a readership all over the world,"[83] and according to Callahan, this was increasingly true even in 1999.[84] To that extent, whether the principles lack substance or are culturally relative all the way down may be a moot point. Now, one could question whether the resonance is due to cultural imperialism as opposed to an authentic elaboration from within each culture.[85] But this debate too risks missing what is already at stake practically, again, the resonance that already exists across cultures. Thus, instead of debating the universality of principlism, a better question may be whether B&C have critical resources for constraining the biases inherent to their approach.

A Turn to the Virtues

This last question brings me to the second of the criticisms that I noted at the top of the previous subsection, namely, the charge that B&C downplay the virtues. The moral virtues are a promising resource that not only are a part of the common morality in their approach but also could help attend to the concerns about self-reflexivity.

In resisting this criticism, B&C rightly note that they have featured a chapter on "Ideals, Virtues, and Integrity" from the very first edition of *PBE*. They have consistently rejected any efforts to make the virtues primary, but they have also always rejected any idea of separating duty and virtue, act and agent.[86] If anything, their emphasis on virtue has increased with time. In the

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[83] B&C, "Marking Its Fortieth Anniversary," 11.

[84] Callahan 283.

[85] The term "elaboration" is from Michael Walzer, *Thick and Thin: Moral Argument at Home and Abroad* (Notre Dame, IN: University of Notre Dame Press, 1994), 4. Though Walzer is not fully satisfied with the term, he intends to capture the idea that "morality is thick from the beginning, culturally integrated, fully resonant, and it reveals itself thinly only on special occasions, when moral language is turned to specific purposes." One might imagine that bioethical dilemmas may be one such category of purposes.

[86] See, e.g., B&C, *PBE* 1st ed., 234.

fifth edition, they expand the theme and make it more prominent by moving it to chapter two, which they title "Moral Character" and locate between crucial chapters on "Moral Norms" and "Moral Status."[87] By the eighth edition, B&C also better demonstrate how the virtues and principles "work together in practical situations," such as when "delaying or staging" the disclosure of bad news to patients "in the context of both caring for and respecting the autonomy of those patients."[88] As they write elsewhere, "How physicians and nurses balance different moral considerations often involves sympathetic insight, humane responsiveness, and the practical wisdom of discerning a particular patient's circumstances and needs."[89]

Finally, in another self-reflexive move in the eighth edition, B&C look to the virtues to address the issue of bias in the selection of their principles. In discussing the four principles as considered judgments on which a reflective equilibrium can be secured, they ask, "On what basis can we be confident that our considered judgments are sufficiently free of bias and constitute acceptable starting points?"[90] Their response is to delineate the "epistemic and moral qualities" of those who evaluate, so as to select or endorse, the considered judgments: "evaluators must exhibit absence of prejudice, relevant knowledge, and honesty, as well as attitudes of sympathy and compassion for the welfare of others. Evaluators must also display these attitudes in a consistent and sustained way." In other words, "convergence reached by individuals *qualified*" in this way is "the essential condition" for assuring that the selection—or defining—of principles is free of bias, including cultural bias.[91]

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[87] Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 5th ed. (Oxford: Oxford University Press, 2001), ix-x.

[88] B&C, "Marking Its Fortieth Anniversary," 11; see B&C, *PBE* 8th ed., 329-334.

[89] B&C, *PBE* 8th ed., 22.

[90] Ibid. 440.

[91] Ibid. 440.

But as with the criticism around autonomy, B&C seem to miss the force of the criticism about downplaying the virtues. The issue, in my view, is not that B&C do not talk about the virtues but that they do not fully integrate the virtues into their principlism. To be sure, as I just described, B&C do better in this regard in the eighth edition of *PBE*. But the question still is whether they do enough. That is, do they grasp the implications of the self-reflexive dimensions of their principlism and, for my purposes, what that might mean for health justice? I argue that they do not. But clarifying this point requires a more sustained analysis of what B&C actually say about the virtues and of the conceptual gap that persists between their virtues and principles. I thus do so in the next section.

Justice and Care

The conceptual gap in B&C between the virtues on the one hand and the principles on the other is well conceived as a gap between care and justice. Care is the virtue that B&C regard as central in the context of health care, but as I will show, they relegate it to the private sphere. The gap in their account between care and justice thus reflects that between the private and public, the interested and disinterested. But more to the point, I now propose to clarify this gap in terms of its ontological depth, in terms of the hermeneutical and disengaged self. The norms of care and justice would otherwise remain abstractions, as would their integration. That is, to not clarify in this way would again obscure the hard-earned insight into the significance of our self-reflexivity. The goal, to the contrary, must be to show the gains in making sense of care and justice as vital norms of self-reflexive creatures.

B&C's move to deepen their reliance on the virtues is a welcome hermeneutical one. I have argued throughout this dissertation for a basic unity of epistemology and ontology. Hermeneutics is an epistemology that is inseparable from our ontology as knowers. My entire approach, the

Taylorian BA principle, has been a search for the "best account" of our lived experience of modern medicine, and that presupposes our nature as hermeneutical selves. As I argued in chapters two and three, to say that we are hermeneutical selves is to say that we are creatures who inhabit a world of meanings and the claims of others on us as self-interpreters, as self-reflexive creatures. We engage the world as beings who are always already constituted by that world—that is, in terms of who we always already are or aspire to be.[92]

Our ontology as self-interpreting, hermeneutical selves stands in contrast to that of disengaged selves. For the latter, the task of justice is conceived as what B&C describe as a top-down model of applying its norm to particular cases. The cases are neutral, amoral spaces that must be analyzed and ordered in light of an a priori principle. To be clear, B&C do not necessarily presume a disengaged self, especially in the later editions of *PBE*. As I described above, following Clouser and Gert's critique on this score, B&C nuance and clarify their account in terms of a reflective equilibrium—one that stresses a back-and-forth movement between deductive and inductive reasoning to achieve a coherence of our considered and particular judgments. The equilibrium is, one might say, B&C's version of a best-account principle. Moreover, a disengaged self is unlikely to endorse the virtues as B&C have consistently done.

However, neither do they necessarily presume a hermeneutical self. In one indication of this, B&C insist on "the moral point of view" as an ideal of those who are "committed to morality." Recall that all such persons accept the norms of the common morality. In outlining an empirical

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[92] See chapters two and three for my fuller discussion of these ideas. In brief, Charles Taylor argues that to be a self is to be a question to oneself—to engage in "strong evaluations" and not just "weak evaluations" of convenience or satisfaction. That is, we ask about the qualitative worth of our values, as noble or base, good or bad, and we do so in reference to who we are or aspire to be ("What is Human Agency?" in *Human Agency and Language: Philosophical Papers 1* (Cambridge: Cambridge University Press, 1985), 15-44, 16). What is more, that identity is itself constituted by the social meanings that the self inhabits—what Taylor calls "intersubjective" and "common meanings" (Charles Taylor, "Interpretation and the Sciences of Man," in *Philosophy and the Human Sciences: Philosophical Papers 2* (Cambridge: Cambridge University Press, 1985), 15-57, 35 ff).

study to prove this hypothesis, B&C identify two criteria of morally committed persons: their beliefs should include at least one identified considered judgment, such as nonmaleficence, and they should be "determined to take the moral point of view."[93] This moral point of view is defined as "an ideal of moral judgment; the core of the idea is that the moral point of view is the one that would be taken by impartial, dispassionate, and disinterested judges."[94] Achieving this stance is rare, but it is nonetheless an "excellence" to which B&C suggest one can strive as a "morally beautiful adornment."[95]

There is, then, a seemingly unresolved tension in B&C between the two: between the partial and impartial, the passionate and dispassionate, the interested and disinterested. They want to affirm both sides, but they seem unable to integrate them into a coherent account of the moral agent. This tension also conditions B&C's framing of the virtues. If the principles represent a moral point of view, then the virtues are by definition possessed by particular selves. They are a question of moral character, of "the *agent* who performs actions."[96] They thus admit a degree of partiality, passion, and interest in a way that principles do not. B&C define the moral virtues as "a dispositional trait of character that is morally valuable and reliably present."[97] The very idea is to capture the fact that when making moral judgments, we care about the agent's motives and not just that they mechanically followed the rules.

Consider that, for B&C, the central virtue for our "relationships, practices, and actions in health care" is care, which is constituted by a family of "traits valued in intimate personal relationships."[98] Especially important to its development and expression are "five focal virtues":

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[93] B&C, *PBE* 8th ed., 450.
[94] Ibid. 450, fn. 60; B&C cite Kurt Baier, *The Moral Point of View* (Ithaca, NY: Cornell University Press, 1958) as the most detailed work on the subject.
[95] B&C, *PBE* 8th ed., 92.
[96] Ibid. 31.
[97] Ibid. 32.
[98] Ibid. 35-36.

compassion, discernment, trustworthiness, integrity, and conscientiousness.[99] Each is integral to the professional lives of clinicians because each helps sustain an “emotional commitment to, and willingness to act on behalf of persons with whom one has a significant relationship.”[100] In such contexts, B&C write, “moral judgment involves moral skills beyond those of specifying and balancing general principles.” Care thus “liberates” clinicians from “the narrow conceptions of role responsibilities” that their ethics codes typically delineate.[101] The virtues thus concern moral character, “a dispositional trait of character that is morally valuable and reliably present.”[102]

In defining the care-related virtues in this way, however, B&C also relegate them to the private sphere. B&C in effect perpetuate a care-justice distinction that Carol Gilligan observes in her seminal work, *In a Different Voice*. She identifies care and justice as two modes of thinking that can be described in terms of “attachment” and “separation.” The latter is justified by an ethic of rights. It is “predicated on equality and centered on the understanding of fairness,” and is “a manifestation of equal respect, balancing the claims of other and self.” It celebrates separation in the sense of autonomy and individuation. The former by contrast is justified by an ethic of care. It is a manifestation of “the concept of equity, the recognition of differences in need,” and a sense of responsibility for the other.[103] The primary concern is not how to exercise one’s rights without infringing another’s, but how to live a life of attachment, of “obligations to myself and my family and people in general.”[104] As an empirical matter, according to Gilligan, the justice ethic tends to predominate in men and the care ethic in women.[105]

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[99] Ibid. 38 ff.
[100] Ibid. 35.
[101] Ibid. 37.
[102] Ibid. 32.
[103] Carol Gilligan, *In a Different Voice: Psychological Theory and Women’s Development* (Cambridge, MA: Harvard University Press, 1993 [1982]), 164-165.
[104] Ibid. 21.
[105] Ibid. 2.

Referencing Gilligan, B&C build on the distinction uncritically. They circumscribe the virtues within relationships of trust, intimacy, and dependence—where "principles or rules … may … be intrusions rather than essential elements."[106] Among strangers, the virtues are less relevant. Before a patient-physician relationship is established, for example, the clinician does well to rely on rules and principles when obtaining consent, proposing do-not-resuscitate orders, etc. In other words, for B&C, the principles and virtues are distinct but complementary.[107] The principle of respect for autonomy has a corresponding virtue of respectfulness for the same, nonmaleficence corresponds to nonmalevolence, beneficence to benevolence, and justice to a virtue of justice. Not all virtues have a corresponding principle or are always relevant, but they all have a role in the various spheres and circumstances of morality.[108]

Care as a Public Concept

The question is whether the virtues can be circumscribed in this way, and I argue that they cannot be. B&C overstate the care-justice distinction because of what I have said is a deeper ontological tension in their account. But ultimately, even they cannot relegate the virtues entirely to the private. The evidence is in what I said earlier about B&C's recent move to rely on certain qualities of persons to constrain the selection of the four principles as the considered judgments of their reflective equilibrium. At stake in those qualities is not just an intimate other but an entire field; the virtues are crucial to assuring the reliability of a public intellectual task. Those who evaluate the validity of the considered judgments need to possess a reliable absence of prejudice, relevant knowledge, honesty, sympathy, and compassion,[109] and these are well covered

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[106] B&C, *PBE* 8th ed., 415.

[107] Gilligan seems more or less to share this view: she notes that care and justice constitute two "views of morality which are complementary rather than sequential or opposed" (33).

[108] B&C, *PBE* 8th ed., 414, 415.

[109] Ibid. 440.

by B&C's care-related virtues: compassion, discernment, trustworthiness, integrity, and conscientiousness.[110] These virtues, in this case, are not in fact private.

In nonetheless articulating the virtues as private, B&C run afoul of a problem that feminist political theorists have long identified. B&C perpetuate the ways in which, as Seyla Benhabib puts it, "universalistic, contractarian theories … lead to a privatization of women's experience and to the exclusion of its consideration from a moral point of view."[111] As an explanation of the problematic persistence of this bifurcation between care and justice, private and public, Joan Tronto's conception of "moral boundaries" is particularly incisive. I turn to her account now. But in doing so, it should be noted that Tronto does not think of care as a virtue in the way that B&C do. This is an important point of contention, and I will return to it in the next section. For now, I want to focus on the gains of de-privatizing care.

The divide between care and justice, Tronto argues, persists because of the social *context* in which its arguments hold relevance. That context consists in three interrelated moral boundaries. The first divides morality and politics. Politics in Western thought is typically assumed to be "the realm in which resources are allocated, public order is maintained, and disputes about how these activities should occur are resolved."[112] The question on this view is

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[110] According to B&C's definition of each care-related virtue, evaluators would be asked to act as follows: in compassion, demonstrate an "active regard for another's welfare"; in discernment, "reach decisions without being unduly influenced by extraneous considerations, fears, personal attachments, and the like"; in trustworthiness, reliably act "with the right motives and feelings and … moral norms"; in integrity, be objective, impartial, and faithful in their "adherence to moral norms"; and in conscientiousness, adhere to "an internal sanction that comes into play through critical reflection" (Ibid. 38-43).

[111] Seyla Benhabib, *Situating the self: Gender, Community, and Postmodernism in Contemporary Ethics* (New York: Routledge, 1992), 152. Even feminists who endorse such justice theories have questioned the stark public-private distinction. Susan Moller Okin, for example, pushes back on such theorists as Michael Sandel, who assume that an appeal to fairness in families is rightly "pre-empted by a spirit of generosity in which I am rarely inclined to claim my fair share." Her point is that such generosity too often fails in families, and indeed, reigning social realities mean that women have to decline their fair share more often than men. Instead, justice need not exclude care. It should reign in families as much as in the public for families are "where we first learn to develop a sense of justice" (*Justice, Gender, and the Family* (Basic Books, 1989), 31).

[112] Joan C. Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 6.

whether morality or politics is primary: is politics accountable to morality or should morality align with politics? The latter, exemplified by Machiavelli, tends to render morality irrelevant, and most theorists today focus on the moral principles by which to order our politics. But either way, Tronto concludes, morality and politics are seen as essentially distinct, such that moralities of care are readily dismissed as too naïve for application to politics.[113]

The second boundary separates the lived world of emotions and the "moral point of view"—a standpoint of an autonomous, disengaged moral agent. Starting with Kant, a proper moral judgment is taken to entail only the latter—to "arise not out of the concrete circumstances of any given society, but out of the requirements of reason."[114] According to Tronto, several implications follow: morality excludes emotions; morality is universal, transcending local customs or habits; any local variations are lesser than the ideal; and what matters is the nature of moral thought rather than how it is lived.[115] The moral point of view thus excludes a care ethic that stresses relationships, responsibility, and meeting the needs of others. The third, finally, is the private-public boundary to which I have already alluded, whereby women—along with their care-oriented concerns—are so often excluded from the public and relegated to the private spheres of family and friends.[116]

The point, for Tronto, is not to abolish these boundaries. That would be disorienting and risk the very basis of feminist thought and its struggle for freedom. The idea instead is to "redraw" the boundaries—which she identifies as social constructs—so as to recognize care as not only a private, moral concept but always already a public, political one. In other words, there is a need to *revalue* care in our political and social institutions for what it is: far from only a private, women's

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[113] Ibid. 7-8.
[114] Ibid. 9.
[115] Ibid.
[116] Ibid. 10.

domain, care is revalued as a "central concern of human life."[117] Here, Tronto defines care as a "species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible."[118] Care is not merely a principle or emotion; it is in fact a socio-political *practice*. It is basic to the capacity of "democratic citizens to live together well in a pluralistic society," and conversely, it is only in such a society that care can flourish.[119]

The redrawing of the moral boundaries marks important conceptual gains. According to Tronto, it extends care's concern beyond private goods to public ones by blurring the line between them. Caregiving for an ill loved one or securing day care for one's child, for example, would be seen not just as a private concern but also a social responsibility.[120] It would secure communal support for care-related acts that experience suggests are not so private. The move would also clarify certain assumptions about human nature. We are not so much autonomous as we are interdependent: we grow up dependent and remain so, and are always claimed by others for our care. A justice ethic that is underwritten by autonomy ignores this lived reality.[121] Care, moreover, would shift the locus of our claims on one another from individualistic "interests" to intersubjective "needs."[122] On this picture, we would assume a stance of "engagement" with the particulars of one another's needs rather than a "detachment" from them.[123]

Lastly, revaluing care as a public practice in this way challenges the "false dichotomy" between care and justice. This is another conceptual gain. The easy assumption is that "care is particular, justice universal; that care draws out of compassion, justice out of rationality."[124] The

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[117] Ibid. 180; see also Ibid. 111.
[118] Ibid. 103.
[119] Ibid. 161-162.
[120] Ibid. 165.
[121] Ibid. 162-163.
[122] Ibid. 164.
[123] Ibid.
[124] Ibid. 166.

divide is thought to be rooted in mutually exclusive metaethical positions. On the one hand, deontological or utilitarian universalists seek a moral point of view—a morality that stands above context, above the contingencies of political life.[125] Or as Bernard Williams might say, they seek "solace" against "the world's unfairness," seeing in morality—the rational will—a basic equality that is immune from the vicissitudes of birth and upbringing.[126] But on the other hand, there are others like Williams who argue that morality cannot be rendered immune in this way.[127]

Now, Tronto's point is that this distinction cannot be resolved at the level of metaethics, of "philosophical discussion itself."[128] Any effort to do so presumes the moral point of view and pre-decides the question in favor of justice. On that view, "care will always be a type of moral fill-in."[129] In revaluing care, Tronto instead makes what I see as a hermeneutical move. She makes an ontological turn to the lived practices of care. She builds on the hermeneutical insight that "the kind of metaethical theory that we find convincing reveals a great deal about who we are, what moral problems we think are significant, and how we view the world."[130] In other words, again, epistemology is inseparable from ontology, and this is the critical point that our universalizing theories of justice tend to reject. They generally obscure rather than engage our lived experience because their basic appeal consists in disengaging from its vicissitudes.[131]

To be clear, Tronto is not implying that justice should be displaced. Rather, as care is revalued as a public practice, justice likewise is revalued. Instead of imagining justice as care's metaethical foil, Tronto reincorporates it as a check on care's moral dangers. Tronto highlights

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[125] Ibid. 148.
[126] Bernard Williams, "Moral Luck," *Proceedings of the Aristotelian Society, Supplementary Volumes* 50 (1976): 115-135, 115; see my discussion of Williams on this point in chapter four, under "Rationality of Agent-Regret."
[127] Williams here is joined by, as Tronto notes, "Thomists, eudaemonists, pragmatists, those who would call themselves advocates of character or virtue ethics, and other assorted Aristotelians" (Tronto 149).
[128] Tronto, *Moral Boundaries*, 149.
[129] Ibid. 148.
[130] Ibid. 149.
[131] Ibid. 148.

two dangers in particular as intrinsic to care: paternalism and parochialism. The ethic presupposes the vulnerability of those receiving care relative to those who provide it. Caregivers can thus easily slip into a paternalism that assumes they can assess needs better than the receivers themselves, "especially when the care-givers' sense of importance, duty, career, etc. are tied to their caring role."[132] Relatedly, parochialism arises when caregivers and receivers become overly partial to their own particular cares. At its extreme, such care can devolve into saying that "everyone should cultivate one's own garden, and let others take care of themselves, too."[133]

Against these dangers, Tronto insists, "care needs to be connected to a theory of justice and to be relentlessly democratic in its disposition."[134] Such a theory would help clarify what needs care should meet and look to assure equity between caregivers and recipients. Needs are complex: they are culturally determined and "vary not only from one person to another, they also vary over a life."[135] To be sure, care has internal resources: it entails "attentiveness" to the needs of others so as to address those needs, "competence" to meet the identified need for which one takes responsibility, and "responsiveness" to the other's standpoint so as to guard against abusing the vulnerability of those receiving care.[136] But these elements of care, Tronto seems to suggest, are not enough. She notes that determining the significance or priority of a need relative to other competing needs requires recourse to a theory or principle. Tronto is not committed to any one theory but highlights the capabilities approach as particularly promising.[137]

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[132] Ibid. 170.
[133] Ibid. 171.
[134] Ibid. 171; this, more or less, is a widely held view. Gilligan holds this view, noting that the two views of morality—justice and care—are "complementary rather than sequential or opposed" (Gilligan 33). B&C speak of the correspondence of the virtues and their principles (*PBE* 8th ed. 414), and as I describe above, argue that the virtues attend to moral motives in ways principles do not, just as the principles help to constrain the virtues.
[135] Tronto, *Moral Boundaries*, 171.
[136] Ibid. 127-137.
[137] Ibid. 140.

Justice as an External Principle

Tronto's account of care helpfully reframes the metaethical debate over justice and care as an issue of the latter's lived ontology. However, she never quite integrates justice into that ontology of care except as a constraint against care's excesses. Justice is revalued vis-à-vis care but remains only as a rational construct that is external to the self; it is but an instrument of one's prior cares. I worry that this picture underwrites a moral psychology that is Frankfurtian.[138] Per my critique in chapter three, for Harry Frankfurt, love—a species of care that is the reason for our many cares—is self-justifying. There can be no reason for why we love what we love other than that we happen to do so. But if so, the concern is why one should care to be imposed upon by a principle of justice. Why should I care not to be paternalistic or parochial in my practices of care?

Tronto is silent on this question, but to start, certain instrumental reasons might be given. For example, if justice is the basis of a well-ordered society, and we need to associate in order to secure our wants, then we have an interest in living by the rules of justice. Or as John Locke might say, "the great and *chief end* … of men's uniting into common-wealths, and putting themselves under government, *is the preservation of their property*," that is, "their lives, liberties, and estates."[139] On a view like this, justice is an instrumental good that helps secure those things in which we happen to have mutual interests, such as security or prosperity, and for that reason we have good cause to care about it.

But from a hermeneutical standpoint, the issue with such reasoning is that its validity depends on the self-conception of the person with whom it resonates. It resonates best with an inadequate self-ontology—what Taylor describes as a Lockean "atomist view" of the human good,

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[138] This is not to say that Tronto would in fact work with a Frankfurtian picture of the moral structure of our cares and loves. Such an imputation would require a closer analysis of the works of Tronto and other care ethicists than I can engage in this chapter. It is sufficient for my purposes here that the seeming externalization of justice in the life of care in principle raises this possibility.

[139] John Locke, *Second Treatise of Government* (Indianapolis, IN: Hackett Publishing Co., 1980 [1690]), IX.123-124.

where that good is an attainment of a self who stands fundamentally alone. My flourishing as a human being is not essentially tied to society; instead, my association with others offers "a set of aids only contingently, even if almost unfailingly, linked to this association." This contrasts with the Aristotelian "social animal view," which I defended in chapter two as the social ontology of the hermeneutical self. Here, the association is an essential condition for realizing my good as a person inhabiting it; the association is the source of the meanings that always already constitute who I am, by which I can even begin to conceive my flourishing as a particular person.[140]

From this latter standpoint, any instrumental rationalizations of justice are wanting. They are not necessarily incorrect, but they confine us to a realm of "weak evaluations" that come down to our contingent preferences for convenience or satisfaction. Such reasons do not speak to our deeper longing for identity—to flourish as a certain kind of person with a certain "quality of life." That is, as Taylor notes, we are beings who evaluate not only weakly but also strongly, in terms of whether an act is good or bad, admirable or base, worthy or trivial, and so on.[141] We care deeply in this way about "the kind of beings we are or want to be,"[142] and long to be rightly placed in relation to the goods that we take to be constitutive of such a being's "fullness."[143] Those for whom justice is only an external construct—as is the case with Tronto—are blind to this deeper need we have to flourish as social animals, that is, to be not only a caring but also a just person.

Justice, Care, and a Life of Virtue

In this final section, I want to consider the need to better integrate not only care but also justice within a larger account of the moral life, that is, of the hermeneutical self. Tronto's account of a

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[140] Charles Taylor, "The Nature and Scope of Distributive Justice," in *Philosophy and the Human Sciences: Philosophical Papers 2* (Cambridge: Cambridge University Press, 1985), 289-317, 292.
[141] Taylor, "What is Human Agency?" 16.
[142] Ibid. 26.
[143] Charles Taylor, *A Secular Age* (Cambridge, MA: Belknap Press, 2007), 5.

life of care falls short in this respect insofar as it externalizes justice relative to the caring self. I instead propose to locate justice more firmly within a life of virtue. The point in this way is to reframe, rather than reject, B&C's approach to health justice. It is to clarify the hermeneutical self as its inescapable condition so as to recognize more fully the moral task and dangers involved in our practices of health justice. But first, this aim raises the question of whether care should also be regarded as a virtue. In speaking of care thus far, I have largely followed B&C uncritically in interpreting it as a virtue.[144] I agree with B&C on this view, but it warrants critical argument.

Tronto is not explicit about whether care is a virtue in *Moral Boundaries*, though she stresses that care is both a disposition and practice so as not to over sentimentalize it as an individual's concern.[145] However, she is clearer in a later book, arguing that "the problem with all theories of care-as-virtue is that they are not relational." They seek the ethical perfection not of "relationships and meeting needs" but of the virtuous individual.[146] Other political theorists of care ethics have made the same point in rejecting the idea that care is a virtue.[147] Nel Noddings, for example, quotes Martin Buber—"in the beginning is the relation"[148]—to drive home the basic commitment of care ethics to the fact of our relationality. Care ethics is relational in grasping not only our interdependence but also that "in every moral decision, there is *another* besides the moral agent whether that other is actually present or just somehow affected by what we do."[149] These theorists thus dismiss the virtues for not being relational enough.

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[144] B&C, *PBE* 8th ed., 35; they do not make an explicit case for their interpretation.

[145] Tronto, *Moral Boundaries*, 118-119.

[146] Joan C. Tronto, *Caring Democracy: Markets, Equality, and Justice* (New York, NY: New York University Press, 2013), 36.

[147] See, e.g., Nel Noddings, "Care Ethics and Virtue Ethics," in *The Routledge Companion to Virtue Ethics*, edited by Lorraine Besser-Jones and Michael Slote (London: Routledge, 2015), 401-414, 402; Virginia Held, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 19-20.

[148] For the actual quote, see Martin Buber, *I and Thou*, trans. by Walter Kaufmann (New York, NY: Simon & Schuster, 1970), 69.

[149] Noddings 401-402.

Tronto's critique of the virtues, however, is not entirely fair. I share Tronto's concern for the relational self. This is why in chapter three, I turned to Augustine for a conceptual gain on Taylor's account of the self. I critiqued Taylor for conceiving the self's moral space in overly solipsistic terms, as constituted by a self who seemingly inhabits the field of social meanings alone. A Taylorian self does not seem to be accountable ultimately to anyone other than the self with respect to the truth of one's strong evaluations and moral growth. In contrast, I argued, an Augustinian account of our loves helps clarify the ways in which our moral space is constituted not only by our social meanings but also by the claims of others on us. From his account of the nature of sin to the right ordering of our loves, at stake for Augustine is the rest, or fullness, of a self who is always already beholden to another. My account of the hermeneutical self, in this sense, is likewise fundamentally relational.

My point, contra Tronto, is that a relational commitment does not preclude a conceptual move to a life of virtue. In fact, doing so offers a conceptual gain for that very commitment. As was the case in chapter four, I again have in mind an Aristotelian virtue. Aristotle defines it as an "excellence" or "characteristic" of a person that "makes him a good man, and which causes him to perform his own function well."[150] The attention is on the individual, but it is not what Taylor calls an atomist self or one that care theorists rightly worry about. Instead, the individual is a social animal. For Aristotle, a life of virtue is conditioned by a community for it is by the "speech" of that community that one comes to know the just and the unjust.[151] It is only in conformity with that virtue that one can be happy.[152] Our flourishing as human beings—that for the sake of which we seek all other goods—is inseparable from the justness of the community of which we are a part.

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[150] *NE* 1106a.22-24; all citations to *NE* are from Aristotle, *Nicomachean Ethics*, translated by Martin Ostwald, Library of Liberal Arts (Englewood Cliffs, NJ: Prentice Hall, 1962).
[151] Aristotle, *Politics*, translated by Carnes Lord, 2nd ed. (Chicago: University of Chicago Press, 2013), 1253a14-19.
[152] *NE* 1099b.26-27.

Indeed, according to Aristotle, "the highest of all virtues" is fundamentally relational for "he who possesses it can make use of his virtue not only by himself but also in his relations with his fellow men."[153] That virtue is justice. As he notes, we generally regard as just a person who is "law-abiding" and "fair." The fair neither take "more than one's share of the good" nor take "less than one's share of the bad." To be law abiding is to obey that which aims to "secure either the common good of all or of the best … or on some other basis of this sort." Just acts are therefore those that "produce and preserve happiness for the social and political community,"[154] and in that sense, justice is a "complete virtue." Aristotelian virtue thus affirms our relationality as its highest calling: "the best man is not one who practices virtue toward himself, but who practices it toward others, for that is a hard thing to achieve."[155]

But what is to be gained by conceiving care as part of an Aristotelian account of virtue? An important gain is in better integrating care within a coherent self-ontology. As I argued, seeing care as a virtue sustains the importance of human relationality. But in addition, doing so clarifies the sense in which care is not just a practice to be done but also a practice into which one must be habituated. Care, in other words, is grasped as an Aristotelian mean.[156] Like any virtue, care is concerned with "emotions and actions," and as such, it is prone to "excess, deficiency, and the median." One can care too much or too little, say, in terms of parochialism or paternalism on one hand and apathy on the other. The moral task is thus to experience our emotions and acts "at the right time, toward the right objects, toward the right people, for the right reason, and in the right manner—that is the median and the best course, the course that is a mark of virtue."[157] Caring

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[153] *NE* 1129b.27-33.

[154] *NE* 1129b.10-19.

[155] *NE* 1130a.7-8.

[156] For related arguments along these lines, see Raja Halwani, "Care Ethics and Virtue Ethics," *Hypatia* 18 (2003): 161-192.

[157] *NE* 1106b.15-23.

well in this way is difficult, or as Tronto might put it, it entails "attentiveness," "responsibility," "competence," and "responsiveness."[158] Like any virtue, therefore, it requires habituation: "men become just [or caring] by performing just [or caring] actions."[159]

In another crucial gain, seeing care as an Aristotelian virtue integrates care with justice within that same coherent self-ontology. Instead of seeing justice as an external, instrumental check on the life of care as Tronto does, both care and justice can be understood as vital aspects of our highest aspirations to fullness—to be the best of ourselves both as individuals and as a society. As Taylor describes it, in that place of fullness, we find our life to be "fuller, richer, deeper, more worthwhile, more admirable, more what it should be." We ineradicably aspire to be in that place, but not necessarily selfishly. Fullness is instead "a place of power" in which we feel deeply moved to act with "integrity or generosity or abandonment or self-forgetfulness."[160] This longing, in other words, answers the question of why one should care to be just and not only caring, and it does so in a way that no instrumental rationalization can.

To be sure, justice in a life of virtue can still be spoken of as a rational, distributive principle. I earlier described Aristotle's treatment of justice in the "complete" sense, but he also speaks of justice in the "partial" sense. Complete and partial justice are of the same "genus" in that both pertain to "our relations with others." But where one covers everything that concerns the moral life, the whole of virtue, the other deals with partial goods of distribution or rectification, such as material goods, honor, and the like.[161] Health-related goods would thus fall under partial justice. For Aristotle, justice as fairness in distribution is proportionate. The distributed shares should be proportionate to the equality or inequality of the persons to whom they are given: "to

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[158] Tronto, *Moral Boundaries*, 127 ff.

[159] *NE* 1105a.17-18.

[160] Taylor, *A Secular Age*, 5; see chapter three for my fuller discussion of this idea.

[161] *NE* 1130a.33-1130b.5.

each according to his deserts."[162] This of course returns to the formal principle of justice in B&C at the top of this chapter. Moreover, as I argued with Walzer, the specification and application of that principle will depend on not only the equality of recipients but also the medium and agents of exchange and the particular meaning of the goods in question.

All these issues of a principlist approach to health justice thus remain pressing in a life of virtue. What is different is that they are always already a question of the emotions and activities of particular persons—one that involves all of that person's self-reflexive biases and aspirations to care and justice. "Now that they [the just and unjust] have been differentiated from one another," Aristotle writes, "it is clear that just action is median between acting unjustly and suffering unjustly: the one is having too much and the other is having too little." The differentiation, in other words, is in service of making sense of who we are—of what it is to act and suffer justly. A principle of justice is "that quality in terms of which we can say of a just man that he practices by choice what is just."[163] The principle is inseparable from a life of virtue that aspires to both justice and care, among other related virtues.

A Gain on What is at Stake

Having reframed B&C's approach to health justice in terms of the hermeneutical self, I now want to clarify a further gain for our grasp of the moral task and dangers at stake, specifically, in health justice pedagogy. This important area of practice unfortunately tends to focus only on its rich theories. It reflects, in this way, a broader literature that also does little more than presuppose that we care. Questions of our motivations and responsiveness to the other, as well as their moral dangers, are rarely examined. As I noted at the top of this chapter, modern anthologies of public

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[162] *NE* 1131a.25.

[163] *NE* 1133b.30-1134a.3.

and global health ethics tend to follow a tradition of medical ethics in emphasizing summaries of the major theories and the conflicts that they generate. But from a hermeneutical standpoint, such approaches are inadequate. They obscure the ways in which our acts to define, interpret, specify, and balance our theories and principles are conditioned by the self.

In other words, they neglect the fact that health justice is always already animated by our moral motivations and aspirations to be caring and just. There are some promising developments in this regard, specifically, in terms of solidarity as an expression of our moral motives and other regard. In their review of best pedagogical practices in health justice, for example, Christy Rentmeester and colleagues talk about the need to "narrow the gap between conceptual and affective learning" and to cultivate solidarity as a core moral value by which to motivate collective action.[164] Solomon Benatar and colleagues similarly argue for solidarity as "the most important" value in global health ethics. Without it, they write, "it is inevitable that we shall ignore" many of the field's central concerns, including "distant indignities, violations of human rights, inequities, deprivation of freedom, undemocratic regimes, and damage to the environment."[165]

From a hermeneutical standpoint, the attention to solidarity in the space of health justice discourses is highly consonant. The hermeneutical self would attend, in particular, to solidarity's self-reflexive dimensions. A crucial step in cultivating a just solidarity, for instance, may entail something like what the educational philosopher Paulo Freire calls "critical consciousness."[166] The notion builds on the insight that "men relate to their world in a critical way. They apprehend the

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[164] Christy A. Rentmeester, Helen S. Chapple, Amy M. Haddad, and John R. Stone, "Teaching and Learning Health Justice: Best Practices and Recommendations for Innovation," *International Journal of Teaching and Learning in Higher Education* 28 (2016): 440-450.

[165] Solomon R. Benatar, Abdallah S. Daar, and Peter A. Singer, "Global Health Ethics: A Rationale for Mutual Caring," *International Affairs* 79 (2003): 107-138, 117; see also Solomon Benatar and Ross Upshur, "Virtue in Medicine Reconsidered: Individual Health and Global Health," *Perspectives in Biology and Medicine* 56 (2013): 126-147, 138.

[166] For this suggestion in the context of health justice, see Rentmeester et al. 442.

objective data of their reality … through reflection—not by reflex, as do animals.” It is in one’s act of critical perception that one acquires “the capacity to adapt oneself to reality plus the critical capacity to make choices and to transform that reality.”[167] Critical consciousness, in other words, is an essential condition for authentic freedom, for being a subject. It “unveils” the world through a dialogic “critical analysis” of its problematic realities.[168]

The problematic realities in health injustice are of course complex; they are, as has been amply pointed out, not only individual but also biosocial. Paul Farmer and others have argued that global health, for example, is fundamentally the latter—that its issues are “without exception, biosocial problems.” In critiquing the prevailing biomedical perceptions, Farmer and colleagues therefore look to integrate the “resocializing disciplines,” such as anthropology, sociology, history, political economy.[169] The same need extends to justice discourses in bioethics. Thinkers like those I cited above—Leigh Turner, Renée Fox, Daniel Callahan, Barry Hoffmaster—have long criticized how a bioethics rooted in universalizing, reductive modes of reasoning cannot but marginalize the social sciences. Bioethics thereby risks neglecting the complex realities of decision making.

All this is indeed well and good. From a hermeneutical perception, the social sciences are essential to our capacity for health justice and care—to the possibility of being attentive to the needs of others and competent to meet those needs. But again, the challenge for a hermeneutical self goes much deeper. There is no escaping the *moral* nature of the problematic realities in question. As I argued in chapter two, the temptation in modern medicine is to forget that the social realities we inhabit are always already value-laden. But as the “social animal view” makes

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[167] Paulo Freire, *Education for Critical Consciousness*, trans. by Myra Bergman Ramos (London: Continuum, 2005 [1974]), 3-4.

[168] Paulo Freire, *Pedagogy of the Oppressed*, 30th anniversary ed., trans. by Myra Bergman Ramos (New York, NY: Continuum, 2005 [1970]), 168-169.

[169] Farmer et al. xiv, 3; see also my discussion of Arthur Kleinman and the insights of medical anthropology in chapter two of this dissertation.

clear, we engage the world as a good for us—a good that always already constitutes our aspired-for goods. Hence, the social scientific question is likewise always already a question of the good for us, of our flourishing. What is more, per chapter three, that good is fundamentally relational. The hermeneutical need, in other words, is to distribute health resources and determinants not only effectively and fairly but also within an ontology of rightly ordered relations.

In a final self-reflexive turn, then, a hermeneutical self attends to what Augustine calls the right ordering of our loves. Just solidarity entails respect for the other's identity within the ambit of relationship. That is, as Freire puts it, "it is always you as an other who constitutes me as an I as long as I, like the you of the other person, constitute that person as an I." This interpersonal differentiation is valid. The difficulty arises in that "we have a strong tendency to affirm that what is different from us is inferior. We start from the belief that our way of being is not only good but better than that of others who are different from us. This is intolerance."[170] Or as Tronto terms it, parochialism and paternalism. Or better, in the Augustinian language I used in chapter three, the challenge is our *libido dominandi*—our lust to dominate. I will not revisit that analysis here, but suffice it to say, our education in health justice should not neglect vigilance on this point.

Conclusion

Too often, health justice is conceived as merely the right distribution of health-related resources or determinants. The focus is on what Aristotle calls "partial justice"; it is on getting right the proportionality of the distribution. As I have argued, this is B&C's basic agenda and one that seems to animate much of the current literature in this area. I do not dispute the importance of this line of inquiry and have defended B&C's concern to specify and balance their justice principle

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[170] Paulo Freire, *Teachers as Cultural Workers: Letters to Those Who Dare Teach*, expanded ed., trans. by Donaldo Macedo, Dale Koike, Alexandre Oliveira (Boulder, CO: Westview Press, 2005), 127-128.

well in particular circumstances. Instead, I have critiqued the tendency in their agenda to obscure the critical significance of the self who is engaged in that task—the self for whom the task matters in the first place. I did so, specifically, by problematizing B&C's inattention to self-reflexivity and their move to privatize a promising resource against it, namely, the virtue of care.

Instead, looking constructively to Tronto, I argued for revaluing care as a public practice, one with gains for redrawing the boundaries between private and public, care and justice. Her account, however, fails to revalue justice as anything more than an external, instrumental good of the caring self. In a final step, therefore, I argued for revaluing health justice, along with care, within a larger account of an Aristotelian life of virtue.

I have sought, in other words, to reframe B&C's "partial justice" approach as that of "complete justice." Doing so marks important gains for connecting our health justice practices to a coherent self-ontology. It helps make sense of health justice as part of our highest aspirations to be just and caring persons—to be in a place of fullness in which we feel deeply moved to act with integrity and generosity. It also clarifies, finally, the pedagogical need to tutor and be critically vigilant about those aspirations.

As with previous chapters, my claim here stands or falls on the truth of our ontology as hermeneutical selves. I have argued that to see our approach to health justice as a question of the hermeneutical self is to better reflect our actual experience of that work. It is to recognize the task for what it is—to clarify how the typical ways of applying health justice principles or theories in modern medicine risks obscuring important dimensions of our lived experience. This experience, again, is not a matter of some objective, empirically observable state of affairs. It is always already lived and is always already a question of a good for us. Its truth must instead be recognized by clarifying the obscurities in our typical modes of knowing. This, then, is what I have sought to do in this chapter by building on B&C, their critics, Tronto, and Aristotle.

I hope, in this way, to have added another constructive chapter to the dissertation's larger goal of clarifying—indeed, humanizing—our experience of modern medicine in terms of the hermeneutical self. The point, as always, is to make sense of that experience for what it always already is so as not to be alienated from it.

CONCLUSION

This dissertation has been a sustained argument for humanizing modern medicine by offering an account of the hermeneutical self. The point has not been to construct some alternative, ideal vision of what modern medicine should be but is not. Nor has it been merely to critique its seemingly inexorable trends toward impersonal modes of knowing and being. The point instead has been to *clarify* the moral space of modern medicine for what it always already is—a space for and by hermeneutical selves. The idea is to better grasp this actuality so as not to be alienated from it, that is, from our actual everyday experiences of modern medicine. At stake in this ethical task, I have argued, is the very possibility of inhabiting and experiencing modern medicine as a human good.

In one sense, the argument is nothing new. It is one in a long history of efforts to protect the basic humanizing impulse of modern medicine. Such efforts are readily recognizable. The classic distinction between the "art" and "science" of medicine, for example, is ever present, and it is not uncommon to hear exhortations to preserve both. The Hippocratic Oath has also served as a bulwark for generations of physicians professing to "use treatment to help the sick" and "never with a view to injury and wrong-doing."[1] To this day, in a prominent modern update of the Oath, physicians "solemnly pledge to dedicate my life to the service of humanity."[2] Recent decades have also seen ethics and humanities programs gain footholds in schools of medicine and public health as a way to fill perceived gaps in their otherwise science-dominated curricula.

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[1] Hippocrates, "The Oath," in *Hippocrates, Volume 1*, translated by W.H.S. Jones, Loeb Classical Library 147 (Cambridge, MA: Harvard University Press, 1923), 298-301, 299.

[2] Ramin Walter Parsa-Parsi, "The Revised Declaration of Geneva: A Modern-Day Physician's Pledge," *Journal of the American Medical Association* 318 (2017): 1971-1972, 1971.

In another sense, however, the dissertation's argument goes beyond just another call to attend to modern medicine's humanizing traditions and developments. The point rather has been to *deepen* the significance of doing so. It is not enough to understand these humanizing moves as answering a traditional exhortation, reinforcing a motivational bulwark, or rounding out an otherwise empirical practice. Any such rationalization only instrumentalizes the significance of the humanizing moves. The moves may be seen as a way to enhance the public's trust in modern medicine, to reduce clinician burnout, or to optimize the effectiveness of its interventions. But any such rationalization is weak. No necessity attaches to it insofar as there are sure to be other ways to enhance public trust, reduce burnout, or optimize effectiveness, including some that are likely to prove more efficient, measurable, and reliable.

I argued in chapter one that we cannot begin to appreciate the deeper significance of this humanizing impulse without clarifying the nature of the self for whom it matters. The problem is that more and more, we inhabit the moral space of modern medicine in terms of the disengaged self—a self that underwrites and is underwritten by our empirical modes of knowing and being in modern medicine. Its hold on us in modern medicine is so pervasive that we not only strive to know on its terms but also think of ourselves in them. It obscures the importance of even asking what it means to inhabit its moral space as a good for us. What, in fact, is the good of modern medicine? In what sense is it a good for us, such that we rightly grieve its loss? In building on the three prominent responses to this sense of loss, I concluded that mainstream approaches to modern medicine are incoherent as to an adequate answer—as to the persistent and growing malaise within its ranks.

The hermeneutical self, then, is the condition of possibility for experiencing modern medicine as a good for us, and in that sense, is also its source. This is who we in fact are and there is no escaping this ontological predicament or our fundamental longing as such. I argued in chapter two that we are bound up with the world in which we have our being, including that of modern medicine. We do not project or choose the meanings by which to constitute the self as though we were disengaged selves. Rather, the self's identity is always already constituted by the meanings that we inhabit as social animals. Moreover, in chapter three, I clarified that as hermeneutical selves, we are constituted also by a basic longing for fullness—per Taylor, a place in which we find our lives to be "fuller, … more what it should be," a place where we are moved to act with "integrity or generosity."[3] That is, we interpret and engage the moral space of modern medicine—its meanings and relationships—in inescapable reference to it.

In other words, the significance of the humanizing impulse consists in who we always already are—hermeneutical selves. The wellspring of that impulse is our ineradicable, deep-seated longing for fullness—for meaning and identity as inhabitants of modern medicine's moral space. It cannot be willed away; the longing persists, as does our malaise over its loss. Rationalizing the humanizing impulse on instrumental grounds thus only underwrites the idea of a disengaged self—the very self-concept that obscures a basic truth of our experience. Instead, the very possibility of experiencing modern medicine as a human good rests on seeing its practices for what they always already are—practices carried on for and by hermeneutical selves.

This dissertation, finally, has sought not only to make this claim but to demonstrate it. The truth of our experience as hermeneutical selves cannot be ascertained by empirical means. I instead proceeded hermeneutically, that is, comparatively by way of error-reducing moves. In each chapter, I relied on Taylor's BA principle, seeking out conceptual gains in order to articulate a "best account" of each experience. The move to clarify the problem of this dissertation in chapter one and to articulate the nature of the hermeneutical self in chapters two and three were no exceptions. The same pattern of analysis applied in chapters four and five. Moreover, in those

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[3] Charles Taylor, *A Secular Age* (Cambridge, MA: Belknap Press, 2007), 5.

last two chapters, I engaged two applied issues in modern medical practice—clinician distress and a principlist approach to health justice. They each illustrated what policies in its respective area have to gain with respect to the hermeneutical self-perception. Each thus not only clarified an area of practice as hermeneutical but also amounted to yet another argument for the truth of our experience as hermeneutical selves.

This ethical work of clarifying the modern medical experience as that of the hermeneutical self, however, is not complete. The task is indeed open-ended. The need for clarification is as pervasive as the actual experiences of disengaged selves in modern medicine. A single dissertation cannot treat them all. But in making a beginning herein, I hope to have made a strong case not only for what is at stake in the work but also for what might be gained thereby.

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