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PHILOSOPHY OF MEDICINE AND OTHER HUMANITIES: TOWARD A WHOLISTIC VIEW

ABSTRACT. A less analytic and more wholistic approach to philosophy, described as 'best overall fit' or 'seeing how things all hang together,' is defended in recent works by John Rawls and Richard Rorty and can usefully be applied to problems in philosophy of medicine. Looking at sickness and its impact upon the person as a central problem for philosophy of medicine, this approach discourages a search for necessary and sufficient conditions for being sick, and instead encourages a listing of "true and interesting observations" about sickness which reflect the convergence of a number of different viewpoints. Among the relevant viewpoints are other humanities disciplines besides philosophy and the social sciences. Literature, in particular, provides insights into the meaning and the uniqueness of episodes of sickness in a way that philosophers may otherwise fail to grasp.

Key words: Philosophy of medicine; Reflective equilibrium; Biopsychosocial model; Self-respect; Literature.

INTRODUCTION

Physicians – at least those sensitive to trends reflected in the current literature – have learned to be self-conscious about identifying patients with phrases like 'the gall bladder in 1306.' There is in medicine a renewed commitment not to let fascination with science and technology obscure the individual who suffers from the sickness; a renewed interest in a medicine that views the individual patient as the primary focus of concern, and not merely as the incidental receptacle which temporarily houses a disease. There is an anecdote, dating from the era before antibiotics, about a young physician who asks the wise old practitioner how one should treat scarlet fever, and who receives the reply, 'It depends on what is the matter with the patient.' The anecdote is old; the interest in applying its message to clinical medicine is new. And philosophers who have begun to work in clinical settings as 'medical ethicists' may in part have contributed to these trends.

If the 'medical ethicists' are at the forefront of these positive trends, the 'philosophers of medicine' are, I think, lagging somewhat behind (despite the fact that the two classes often consist of the same members). Reviewing the literature on concepts of health and disease over the past ten years, one not infrequently encounters statements and arguments which are the philosophical equivalent of 'the Disease in 918' or 'the Illness in 1234.' In the approach that seems favored by most writers on the subject, Health, Disease, and Illness are of most interest when they float free like Platonic forms; the individual people

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who are healthy, ill or diseased are of almost no consequence, and any differences among those individuals are trivial to an adequate philosophical understanding of the subject.

I wish to suggest in this paper that this approach is unsatisfactory, and that philosophy of medicine will advance in the coming decades primarily by finding new approaches which recapture some sense of individual sick people and their particularities – at least insofar as discussions of concepts like 'health,' 'disease,' and 'illness' remain central to the field. I will argue that there are strong methodological justifications for these approaches. And I will suggest that these approaches may bring philosophy of medicine closer to the other medical humanities, including literature and history, in a mutually stimulating and illuminating manner.[1]

The literature in medical ethics has been enhanced recently by a good deal of explicit concern over methodology. Criticism has been leveled especially against the "applied ethics" model, which suggests that medical ethics simply takes all-purpose ethical principles derived from general ethical theory, applies them to scientific medical sitautions, and deduces the right answer (Caplan 1983). These criticisms, and the proposal of alternative models, should in the end benefit ethical theory generally every bit as much as they benefit medical ethics. But I have seen much less explicit methodological discussion in the literature on philosophy of medicine. Instead there is the implicit assumption that one approaches a medical issue in exactly the same way as one would approach any philosophical question. If one is a phenomenologist or an existentialist, one applies one's pet school of thought to the medical issue at hand, paying little heed to how one's approach might complement or fail to complement the work of someone taking a different approach. If one is looking at issues in psychiatry, one reflexively turns to the standard approaches of philosophy of mind; for other issues, one turns to philosophy of science, or epistemology, and so on. In modern academic, analytic philosophy, these different subdisciplines tend to occupy watertight compartments; and so lack of "leakage" among these lines of investigation, when applied to medicine, may well be perceived as a virtue.

The medical ethicists have often been stimulated toward methodological criticism by so-called 'real world' experiences – Caplan (1983) was led to question the applied ethics model by experiences on the hospital wards, while Toulmin (1981) was led to similar reflections while working with a Federal commission. Most philosophers have been willing to accept "real-world" relevance as a criterion of success in medical ethics, but not in philosophy of medicine more generally. However, outside of philosophy of medicine, philosophers of stature have been attacking traditional analytic philosophy on similar grounds – that analytic philosophy expresses concerns and approaches that are increasingly removed from real-life problems, partly because (it is argued) analytic philosophy

has bought wholesale the agenda of the Enlightenment and has treated this agenda as the only way to carry out philosophical business, not as a historically limited agenda that will naturally be replaced by more up-to-date concerns once it has run its natural course. I think that the criticisms of these philosophers provide a methodological justification for a more wholistic approach to philosophy of medicine, that seeks and thrives on 'leakage' instead of trying to confine issues to tidy pigeon-holes.[2] Now, if a wholistic approach such as I describe leads to interesting and original observations about medical issues, it could be considered self-justifying, and these methodological arguments would be unnecessary. And yet I think they are useful for the larger agenda, not merely of doing philosophy of medicine in an interesting and creative manner, but instead of doing philosophy of medicine in such a way that what we learn rebounds to the benefit of philosophy as an entire discipline.

CONTRIBUTIONS FROM RAWLS, RORTY, AND MACINTYRE

I will now briefly sketch some of these methodological arguments, with special emphasis on their utility in clarifying the concept of sickness.[3] As a most general method, I am impressed with Rawls' (1971, 1980) notion of wide reflective equilibrium. In this basically wholistic approach, a philosophical construct or theory is judged according to how well it fits within an interlocking pattern of the largest possible number of related elements; and particularistic judgments about specific real-world occurrences, including individual cases, are included among the elements for which the overall fit is sought. In wide reflective equilibrium, an otherwise promising and elegant theory may be rejected if it fails to do justice to a class of specific cases; and newly discovered 'tough' cases of the sort that frequently emerge in clinical medicine must be fed back into the system and may force us to revise our theories. Rawls proposes wide reflective equilibrium as a viewpoint for choosing principles of justice; and with some modifications it can be used to elicit some principles of morality. It must be viewed as a very general framework, and tinkered with somewhat freely, before it can be employed as an approach to philosophy of medicine. And yet, even if one adheres more closely to the elements that Rawls specifies, certain benefits remain for medical inquiry. One is more likely to be reminded of the moral concerns within medicine, and of the fact that medicine exists as a social enterprise within a particular social context that may more or less resemble our ideal of a just, well-ordered society. This approach reinforces the point raised by other philosophers of medicine that medicine is fundamentally and irreducibly a moral and social activity (Pellegrino and Thomasma 1981).

Further support for a wholistic approach is provided by Rorty's (1979, 1982)

attack on traditional analytic philosophy. Rorty criticizes the pretensions of the Descartes-Locke-Kant tradition, which holds up philosophy as the ultimate arbiter of any claims to knowledge put forth by any other discipline. Presumably philosophy is to occupy this exalted station because it possesses a 'theory of knowledge' which can deal with necessary and timeless truths, and can act as an eternal, culturally neutral observation platform from which one can rise above the accidental, historical, and cultural biases to which one would otherwise be subject.

Rorty argues against the existence of any such observation platform, using to good advantage cracks in the edifice of analytic philosophy that have been discovered by the analysts themselves – doubts over the validity of the subjective-objective distinction, and doubts as to whether any empirical knowledge of the world can be simply 'given' in a noninferential manner, for example. He is unabashedly pragmatic and relativistic in his thinking, although he is careful to point out that pragmatism and relativism need not have the negative connotations with which they are typically associated by philosophers who have bought wholesale the Descartes-Locke-Kant program (cf. Bernstein 1980). According to Rorty's much more modest view of the role of the philosopher, understanding medicine would not consist of using some general theory of knowledge to decide upon the nature and validity of knowledge-claims made by medical scientists and practitioners. Instead, philosophy of medicine would pay much more attention to the real-life activity of medicine, and to the history of how it evolved as a coherent unity, and might then proceed to assess medical concepts according to the role that they play in that ongoing activity. This does not mean that philosophers would automatically approve of any aspect of medical activity they witness; for example, if medical scientists are engaged in committing basic logical fallacies in interpreting their data, the philosophers will not hesitate to criticize them on that score. And philosophers, being thoroughly read in the great works of philosophers of the past, can be expected to be very good at picking out certain sorts of fallacies and unproductive patterns of thought. But in the final analysis the conclusions reached about medicine by the philosopher will reflect less the specific subject matter and methodology of philosophy than they will an all-purpose, utility-infielder sort of intellectual scrutiny. The work of the philosopher, the medical historian, and the literary critic may well end up overlapping and blurring in important and productive ways.

Other criticisms of post-Enlightenment philosophy, this time its ethics specifically, come from MacIntyre (1981). MacIntyre and Rorty both seem to agree that we should not view the post-Enlightenment agenda as the only or even as the most fruitful way of doing philosophy, and that we might benefit from recalling the way that earlier philosophers like Aristotle went about their business. However, Rorty and MacIntyre seem to disagree markedly about just what

Aristotle was really up to; and MacIntyre would reject Rorty's relativism and pragmatism as symptoms pathognomonic of the modern philosophical disease. Further, MacIntyre rejects Rawls along with all other social thinkers of the liberal Enlightenment tradition.[4] Despite these differences, elements of MacIntyre's argument can stand alongside of the considerations derived above from Rawls and Rorty without internal contradiction. One such element is the notion of a practice. MacIntyre's emphasis on the centrality of virtues in a coherent theory of ethics leads him to focus on certain complex types of human activity, the appreciation of which requires recognition of standards of excellence that are internal to the activity itself instead of residing in the outcomes or the products of carrying out the activity. He calls such complex activities practices, and views as ethically incoherent any society which has forgotten the importance of goods internal to practices and can instead see as a good only the outcome, the proverbial 'bottom line.' By his definition, medicine is of course a practice; much of what physicians do to treat sickness is a practice; and some of the ways in which patients might alter their lives in response to sickness are practices also.[5]

Another point from MacIntyre that can beneficially be employed is the concept of the narrative form of a human life. MacIntyre asserts that from an ethical standpoint, human lives must be seen as connected wholes whose internal structure takes the form of narrative. This concept of a narrative life form is irreducibly linked with three related concepts – personal responsibility, personal identity, and the intelligibility of one's actions. That is, when addressing issues that have to do with personal identity or personal responsibility, the viewpoint one adopts ought to be that of the biographer, interested in making sense of an entire life, and interested secondarily in making sense of particular actions within the overall context of that complete life. MacIntyre's approach thus differs from much of the contemporary philosophical literature, which seeks to analyze personal identity in terms of time-slices, and ethical responsibility in terms of discrete decisions and actions viewed apart from an enduring moral character. MacIntyre's approach further supposes a social and cultural context for human life – a starting point and a backdrop for the narrative, as it were. If life must be seen as a narrative, then sickness can be analyzed in terms of what it might do to the flow of the narrative. And if the notion of personal identity is inextricably linked to the narrative form of life, then issues about the extent to which one is the 'same person' whether sick or well, and the extent to which severe sickness makes one into a "different person," could be elaborated in similar terms.

TRUE AND INTERESTING THINGS ABOUT SICKNESS

What happens when one reviews the philosophical literature on concepts of sickness, with these sorts of methodological considerations in mind? I believe

that one can accumulate a number of true and interesting things about what it means to be sick; and these things then begin to sort themselves out as philosophical markers upon the medical landscape. These observations primarily represent important concepts seen from a number of viewpoints, several of which are not generally regarded as "philosophical"; and their value lies in their representing multiple possible vantage points from which to approach the notion of sickness. To the analytic philosopher, 'true and interesting things about sickness' might seem a totally trivial preoccupation. One ought instead to seek something of proper philosophical weight, such as 'necessary and sufficient conditions for being sick.' But the literature tends to suggest that the search for "necessary and sufficient conditions" easily leads to a concept of sickness that is so abstract as to be drained of any meaningful, particular content. On the other hand, the more modest pursuit of 'true and interesting things,' in keeping with the more modest philosophical program proposed by Rorty, holds promise for maintaining contact with those features that make individual instances of sickness in individual persons unique.

Each of the following 'true and interesting things' requires considerable explication and defense. I will be able here to provide only very cursory sketches.

1. To be sick is to experience an unpleasant sense of disruption of the unity of self and body, and an assault on one's sense of self and personhood. This observation derives from philosophers and physicians who attempt to capture the quality of sickness as it is immediately experienced by the sufferer, before the sufferer has the chance to attempt any degree of analysis of the phenomenon (Gadow 1980, Cassell 1982, Bergsma and Thomasma 1982). A phenomenological method may be the philosophical approach employed in such an inquiry (Gadow 1980). The very basic way in which sickness impacts on one's personhood and personal unity has been usefully labeled "ontological assault" (Pellegrino 1979). This observation prepares the investigator to view sickness as an event closely linked with very basic concepts of self and personhood, which is disvalued in itself quite apart from any of its consequences. Furthermore, while sickness may give rise to a fear of death, which in turn represents the ultimate dissolution of personhood and the body-self unity, this observation nonetheless reminds us that sickness itself, quite apart from the possibility of a fatal outcome, constitutes an ontological assault. That is, one may discourse learnedly on humankind's mortality and finitude, and upon fear and avoidance of death, and yet still not exhaust the philosophical content of the notion of sickness.[6]

2. To be sick is to have the sort of thing that physicians customarily treat. This observation is deliberately stated in a form that produces worry about circular definitions. If we define sickness as what physicians treat, and determine what physicians are supposed to treat by looking for the presence or absence of sickness, then of course a vicious circularity has resulted. But it is worth asking

what sort of account could flesh out this framework while avoiding vicious circularity. And the account would have to include a historical dimension; it would have to show that medical therapeutic activity is not arbitrary and ad hoc, but instead partakes of a coherent unity as a result of its gradual development based both on scientific understanding of the human organism and the accumulation of empirical experience. Due to this coherent unity resulting from gradual evolution, medicine is fully a practice in the sense described by MacIntyre. As a practice, it has evolved its own internal standards. Faced with problematic cases (such as alcoholism and homosexuality, for example) physicians will answer the question, 'Is this a sickness?' in part by asking whether the sort of activity that might usefully be applied to that problem coheres meaningfully with their existing armamentarium of therapeutic practices. Thus medical activity, as it has evolved historically, helps to define what is to count as sickness, in a noncircular fashion. Philosophers approaching the concept of disease support this point to the extent that they are willing to grant that the concept of therapy plays a crucial role in elaborating the concept of disease (Pellegrino and Thomasma 1981, Engelhardt 1984).

3. To be sick is to have something wrong with oneself – that is, to be suffering or at risk of suffering an evil due to a cause that is located within oneself. This observation is in fact derived from a definition stated in terms of necessary and sufficient conditions; but the conditions are stated not for sickness, disease, or illness, but for the more general term 'malady' (Clouser, Culver and Gert 1981). 'Malady' is used to designate the generic term, which represents what a group of specific terms – sickness, disease, illness, deformity, injury, disability, etc. – all have in common. As a very general term, 'malady' does deviate somewhat from the methodological suggestions above; it clearly tends to blur important distinctions between individual cases. And yet the observation clearly has utility. For one thing, it illustrates the duality of sickness, which has some aspects of factual, biological judgments about organisms made with reference to species norms, and also some aspects of value judgments to the effect that certain states of the organism are dysvalued and undesired. Thus the account shows both why a philosopher like Boorse (1975) is incorrect in arguing for a value-free concept of disease, and also why an account like Boorse's has an undeniable appeal.

The definition of 'malady' is also useful for correcting problems with other formal definitions that have been offered for 'disease.' On the one hand, by insisting on the basic notion of having something wrong with oneself, in the absence of a distinct sustaining cause, the definition eliminates things such as unemployment from the purview of sickness, while overly inclusive definitions like the WHO definition of health might have included them. On the other hand, by speaking in terms of the self and causes located within the self, the

definition avoids the problems that Pellegrino and Thomasma (1981) have in trying to define the concerns of medicine solely in terms of bodily dysfunction, and then explaining why psychiatry should be seen as a part of medicine at all. Finally, the definition reveals that all cases of sickness, however important the differences among them, do in fact have something pertinent and specifiable in common. This represents a meaningful alternative to the view that instances of sickness vary so markedly among themselves that they can be linked only by a family resemblance, and not by any sort of formal definition (cf. Engelhardt 1975).

4. To be sick is to participate in a disruption of an integrated hierarchy of natural systems, including one's biological subsystems, oneself as a discrete psychological entity, and the social systems of which one is a part. This observation derives from the application to medicine of concepts from systems theory and cybernetics, in a form that has come to be widely known as the "biopsychosocial model" (Engel 1977). This view of sickness has arisen almost entirely from within medicine and medical science, as a frankly reformist attack on the reductionistic tendencies of much of medical thinking of the early and middle twentieth century. Philosophers have generally been much less interested in such offshoots of systems theory, which appear too grandiose and vague for one schooled in analytic philosophy and particularly in the logical-positivist tradition of philosophy of science. But as this tradition in philosophy of science increasingly falls under attack, for the reasons listed by Rorty, the biopsychosocial model may come to be seen as the sort of wholistic construction consistent with the philosophical enterprise as described by Sellars (1963) – the question of how things, in the broadest sense of the term, hang together, in the broadest sense of the term.

The biopsychosocial model can serve as an integrating model – a sort of roadmap to a wide reflective equilibrium of medicine – by lending order and pointing out pertinent linkages between the various bodies of knowledge and disciplinary research methods which all converge upon sickness from many different starting points. The model suggests that claims about sickness made by the biological, behavioral, and social sciences are complementary rather than competing views of reality. It demolishes the reductionism that would hold up only certain levels of the hierarchy of systems, the biophysical and biochemical levels, as being 'real' and as counting as 'hard knowledge.' And it lends its support to the first observation listed above, in claiming that a Cartesian mind-body dualism must be dispensed with before a satisfactory and sophisticated understanding of sickness can be sought.

5. To be sick is to experience an alteration of one's social roles and of one's relationships with others, in ways that will be influenced by cultural belief systems and that will vary depending upon many dimensions of the particular

sickness episode. This observation derives primarily from medical sociology and anthropology, and hence depends upon the previous observation to lend it credence by reminding us that the social sciences constitute a valid way of examining the reality of sickness. Philosophers have been quite ready to accept this view and have been eager to incorporate lessons from medical social science into their analyses of sickness – the primary example being the philosophical popularity enjoyed by Parsons' (1951) concept of the 'sick role.' Unfortunately, the popularity of this concept is more understandable when one recalls that Parsons could be accused of the same sin I have attributed to many philosophers of medicine – constructing abstract general models of sickness as if the differences among particular instances of sickness are of no great importance and can be dismissed.

In this vein, the Parsons model has been criticized by other medical sociologists as working nicely for some cases of sickness (primarily serious and acute sickness) but as describing very poorly many other types of sickness (notably chronic disease) (Freidson 1970, Levine and Kozloff 1978). It is simply not the case, as Parsons seemed to suggest, that all instances of sickness involve relieving the sufferer of any moral responsibility for his plight, or relieving the sufferer of his usual social role responsibilities. Many cases of sickness do have these qualities; but the exceptions are equally important and equally suggestive. If these sociological critics of Parsons are correct, the popularity of the Parsons sick-role model among philosophers may indeed be due to the fact that Parsons was engaged more in doing philosophy of medicine than in doing medical sociology.

One can recapture a sense of the individual, particularistic illness experience by focusing, not on the meaning attributed to illness by the entire society, but instead on the meaning attributed by the specific subculture of which the patient is a member, or even more, of the individual patient himself based on idiosyncratic beliefs and personal past history (Kleinman, Eisenberg and Good 1978). This approach highlights the particularity and uniqueness of sickness events while still reminding us that sickness has an irreducibly social dimension. What it means to be sick can be understood only in part by reference to the notion of ontological assault and disruption of body-self unity; there is a remainder that needs explicitly social constructs in terms of roles and relationships for a full understanding.

SELF – RESPECT AND STORIES OF SICKNESS

These five true and interesting observations about sickness illustrate both the strengths and the limitations of standard philosophical approaches. On the one

hand, features of sickness have been usefully highlighted for further study – for example, how sickness affects one's relationships with others in a social network, and how sickness may in part be defined and determined by the practices of medical therapeutics. On the other hand, these observations, taken in conjunction with the methodological considerations previously mentioned, strongly suggest that our understanding will proceed only with a considerably fleshed-out picture of individual cases of sickness. And the notion of the narrative form of life further encourages us to turn to works of literature or drama for useful insights and case examples. Sophocles in *Philoctetes*, Thomas Mann in *The Magic Mountain*, Alexander Solzhenitsyn in *The Cancer Ward*, were all interested in describing in considerable detail how the life narratives of individual persons might be modified by sickness and by cure. Indeed, the latter two authors constructed fascinating literary laboratories for the study of sickness – the first in the form of a tuberculosis sanatorium on the eve of World War I, the second in the form of a Soviet cancer hospital in the era of de-Stalinization. The philosopher seems to say, 'Let me tell you how sickness affects persons, their personal identity, and their personal autonomy.' The novelist says, 'Let me show you a dozen people, all suffering from the same illness, and we can see a dozen different ways of responding to the illness. Then let's go back into the life stories of each, to see if we can make sense of why each person responds to sickness the way he does. And through all this I will remind you of the important events and forces shaping the society in the background, and we will see if we cannot locate ripples of these larger social forces, as well, in the manner in which our characters respond to sickness.'

The philosopher may talk usefully of ontological assault, of a disrupted relationship between self and body, as the manner in which sickness is immediately experienced by the sufferer. Essayists as diverse as John Donne, Charles Lamb, and Virginia Woolf, each writing autobiographically about a single episode of illness, can describe in much more striking terms how differently the world appears, how one's sense of self and time narrows and contorts, when one is sick. For example, a medical sociologist may describe a variety of ways in which one's social fellows may respond to one's malady (almost all of which are, incidentally, captured at various points in Kafka's story, 'The Metamorphosis'). But these essayists describe in a much more profound manner how, social roles and social relationships aside, solitude may be the most acceptable and most desired state of the sick individual.

A wholistic approach to sickness would require not that we ignore the philosophers in order to glory in the depth and richness of literary creations. Instead we are challenged to turn to philosophy to learn the more useful questions to ask of our literary texts, to discover which veins of ore are most worth mining and refining. Here, the various methodological considerations and observations

about sickness reviewed above can be helpful. One further construct seems to me to offer special benefits for this inquiry – Rawls' (1971) notion of self-respect. Asking what sickness does to one's self-respect brings together several of the most important themes alluded to above – one's life viewed as narrative; one's relations with one's close associates; and one's sense of responsibility for one's actions. This is because, for Rawls, self-respect entails having a rational plan of life which offers a good fit with one's natural talents and proclivities, which is esteemed by one's close associates, and which one feels that one is reasonably on the way to carrying out. Sickness can threaten self-respect in a variety of ways. It can prove a simple impediment to the carrying out of one's projects. It can alter one's baseline talents and abilities, so that what used to be a realistic life plan is no longer sensible. And it can drive a wedge between oneself and the social network to which one used to look for affirmation of the worth of one's life plan. And yet, in cases of chronic sickness at least, the appropriate modification of one's life plan can often lead to a return to a rebust sense of self-respect, even though the process may be a long and painful one. With this in mind, we can then ask how sickness has impacted upon the life plans of an individual; what this has done to the individual's sense of self-respect; how the individual proceeds to recapture a sense of self-respect; and the role that the individual's close associates play in this process.

In conclusion, there may be many questions in philosophy of medicine, particularly those of an epistemological nature, where a straightforward analytic approach will be the most fruitful. I have attempted to argue here that the concept of sickness is in many ways a central question, if not the single central question, in a philosophical understanding of medicine; and that the most useful methodologies for addressing this problem involve a willingness to cross over perceived boundaries between philosophy and the other humanities disciplines.

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NOTES

[1] The comments in this paper represent a considerable condensation of a book-length manuscript, 'Sickness and Self-Respect,' currently submitted for publication. In the complete manuscript I defend at greater length assertions which appear in this paper with only cursory support – for example, that there exists a more or less accepted way of doing 'philosophy of medicine'; that sickness is at least a central, if not the central problem for philosophy of medicine; and that the search for "true and interesting things" about

sickness is better than searching for necessary and sufficient conditions for being sick. For an extremely useful anthology, see (Caplan, Engelhardt and McCartney 1981).

[2] What I mean here by 'wholism' is what Rorty calls the belief "that it would be good to hook up our views about democracy, mathematics, physics, God, and everything else, into a coherent story about how everything hangs together. Getting such a synoptic view often does require us to change radically our views on particular subjects. But this holistic process of readjustment is just muddling through on a large scale" (Rorty 1982, p.168).

[3] The term 'sickness' is used deliberately. I wish to avoid for present purposes entering into the distinction or distinctions between 'disease' and 'illness,' even though those distinctions can be useful so long as they are used more carefully than they have generally been. I use the term 'sickness' as one that can encompass features of both 'disease' and 'illness.' In addition, partly because of sociological constructs such as the 'sick role', the notion of 'sickness' suggests an inherent social dimension which the other two terms may lack.

[4] In my manuscript referred to in Note 1 above, I defend Rawls at some length from MacIntyre's criticisms and show that Rawls' scheme of Kantian contructivism (Rawls 1980) can successfully meet all of MacIntyre's (apparent) criteria for a coherent ethical theory.

[5] The idea of a 'practice' of being sick may seem strange at first glance. But sociologists can speak comfortably of a 'sick role,' which assumes that one can carry out a set of role responsibilities in a more or less satisfactory manner. A good deal of Thomas Mann's *The Magic Mountain* can be read as a catalogue of 'practices' for adapting oneself to life with tuberculosis in a pre-World-War-I sanatorium in the Alps.

[6] In this regard it is useful to contrast John Donne's 'Devotions' with Charles Lamb's "The Convalescent" and Virginia Woolf's 'On Being Ill.' The first of these three accounts of an episode of illness (or 'pathographies': Hawkins 1984) makes sense only by viewing fear of death and readiness for the hereafter as the central theme. The latter two are just as clearly accounts of an anticipated nonfatal illness, in which the reaction to illness is almost totally uninfluenced by thoughts of death. This example further highlights the value of literary sources in understanding the concept of sickness.

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