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Insidious Illness: A Criticism of Medical Reductionism

Cody Hatfield-Myers

University of Michigan-Flint

ABSTRACT

What is the best way to understand 'illness'? One step toward answering this question is to first establish which ways one must not understand 'illness.' The paramount target for criticism is the reductionist account of illness. In this paper, I will first address conceptions of illness and disease as articulated by Christopher Boorse; K. Danner Clouser, Charles M. Culver, and Bernard Gert; and Roberto Mordacci and Richard Sobel. I will then offer my criticism of the reductionist account of illness, arguing that such an account strips the ill individual of their autonomy, thereby rendering their experience of illness meaningless, and subjecting them to stigmatization from both medical experts and the public. I then address the social implications such an account entails, the legitimization of the institution of medicine, and the delegitimization of the individual's perception of social injustice. I conclude by opting instead for a holistic account of health, disease, and illness.

KEYWORDS

Boorse, Clouser, Culver, Gert, Mordacci and Sobel, Reductionism, Malady, Disease, Illness, Narrative, Health, Social Model, Medical Model, Normalcy, Stigmatization

Introduction

What is the best way to understand 'illness'? One step toward answering this question is to first establish which ways one must *not* understand 'illness.' The paramount target for criticism is the reductionist account of illness. In this paper, I will first address conceptions of illness and disease as articulated by Christopher Boorse; K. Danner Clouser, Charles M. Culver, and Bernard Gert; and Roberto Mordacci and Richard Sobel. I will then offer my criticism of the reductionist account of illness, arguing that such an account strips the ill individual of their autonomy, thereby rendering their experience of illness meaningless, and subjecting them to stigmatization from both medical experts and the public. I then address the social implications such an account entails, the legitimization of the institution of medicine, and the delegitimization of the individual's perception of social injustice. I conclude by opting instead for a holistic account of health, disease, and illness.

Disease and Illness

In "On the Distinction Between Disease and Illness," Christopher Boorse argues against the idea that the concept of 'disease' involves value-judgments, and argues for the idea that there is an objective and autonomous framework within which 'disease' may be defined. He is therefore wholly against the normativist accounts of disease, both strong and weak.

The strong normativist view regards undesirability and disapproval as being both necessary and sufficient conditions for a given condition being labeled a disease, while the weak normativist view holds that value-judgments are only necessary conditions for a condition being considered a disease. Boorse argues against both, claiming that they both imply the consideration of disease as contrasted to health as an ideal, where this ideal is deified and Platonic, like holiness or virtue, and built into which is the notion that this ideal is intrinsically desirable; however, says Boorse, "[t]here are normative and nonnormative ideals" (Boorse 2004, 80). Health, he argues, is a non-normative ideal. So, he claims, there are two concepts of 'health': one being descriptive, objective and non-normative, with the other being mixed, involving both evaluative presuppositions as well as descriptive content.

Boorse then distinguishes 'disease' and 'illness' by defining the former as a theoretical notion, and the latter as a practical notion. Further, disease

is understood to be the genus of which illness is a species. Disease, and the theoretical conception of its opposite, 'health,' are applicable across species and are free of any normative content or value-judgments. Disease for Boorse is something which is objectively definable by comparison with what is characteristic of the species at large, or what is considered 'normal' for the fulfillment of the functions and goals typical of a given species, as well as of each individual organ or bodily system of a specimen of such a species. According to Boorse, each of these physiological components functions in a certain, 'normal,' way in order to fulfill its end, and collectively these "physiological functions tend to contribute to all manner of activities neutrally" (Boorse 2004, 83). So, health is considered to be that condition of an organism in which each of its organic components are fulfilling their ends, thus allowing for the organism's capacity to meet "higher level goals such as survival and reproduction" (Boorse 2004, 82). That is, health is what is in alignment with an organism's natural function. Diseases are then objectively undesirable insofar as they interfere with this natural function.

Illness and its opposite, 'wellness' are those terms which are both descriptivist and normative.¹ Hence, any species of living thing may be diseased, in that some one of its biological functions is obstructed. But only human beings may be ill or well, as only human beings make value-judgments which conceive a certain disease to be undesirable; and this attitude towards an undesirable disease necessitates the action to cure or remove the illness. An illness, for Boorse, is a disease which

is serious enough to be incapacitating, and therefore is (i) undesirable for its bearer; (ii) a title to special treatment; and (iii) a valid excuse for normally criticizable behavior... (Boorse 2004, 84)

He likens this distinction between disease/illness to concepts like untruthful/dishonest: in certain contexts, the objective condition of being untruthful takes on, or sheds, the connotations that 'dishonest' implies, "as when the Gestapo inquires about the Jews in your attic. Here the untruthful house-holder will not be

1. Boorse uses 'health,' in both a theoretical and practical sense to denote the conceptual opposites of both 'disease' and 'illness,' respectively. I will use 'wellness' as an equivalent for Boorse's 'practical health,' to denote the conceptual opposite of illness, in order to avoid confusion between the two senses of 'health' Boorse defines.

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described as speaking dishonestly” (Boorse 2004, 84). Likewise, diseases may be considered to be either illnesses or simply diseases depending on whether it is more beneficial to conform to the species-design or to deviate from it.

Boorse then turns his attention to mental illness. He grants that even if “mental conditions usually called pathological are in fact unhealthy,” i.e., that these conditions are the result of malfunctioning psychological processes, it is still not the case that these conditions—or diseases—are illnesses as he conceives of illness (Boorse 2004, 84). Against the first criterion, he argues that:

[T]o evaluate the desirability of mental health we can hardly avoid consulting our desires; but in the mental-health context it could be those very desires that are judged unhealthy. (Boorse 2004, 85)

Because one must find the condition undesirable, and because mental illnesses themselves are often distortions of what one desires, it is not possible for a psychopathological condition to meet this criterion of ‘illness’

Against the second criterion, he argues that because it is possible that cultural/environmental circumstances can injure or disease entire societies, it is *possible* for disease to be universal within a society, thus failing to fulfill the illness-criterion that “not everyone can be ill” (Boorse 2004, 86). Boorse argues that it is theoretically possible for an entire population to be affected by environmental factors to such an extent that it’s possible, as a result, for that population to exhibit paranoia, for example, and for that paranoia to be statistically normal, yet remain a disease, as it is the product of environmental causes:

A statistically normal condition, according to our analysis, can be a disease only if it can be blamed on the environment. (Boorse 2004, 86)

Boorse argues, however, that even if empirical research showed this possibility to be manifest within a given population, it would constitute an illness “only by abandoning one of the presuppositions of the illness concept: that not everyone can be ill” (Boorse 2004, 86). Thus, mental illness fail to meet his second illness-criterion.

Against the third criterion, Boorse employs the Aristotelian understanding that, even if unconscious processes are claimed to explain deviancy, those

unconscious processes and desires are still the result of the agent's conscious choices and actions. As says Boorse:

Strictly speaking, mental disorders are disturbances of the personality. It is persons, not personalities, who are held responsible for actions, and one central element in the idea of a person is certainly consciousness. This means that there may be some sense in contrasting responsible persons with their mental disease insofar as these diseases lie outside their conscious personalities...[However,] [u]nconscious ideas and wishes are still *our* ideas and wishes...They may have been conscious at an earlier time or be made conscious in therapy, whereupon it becomes increasingly difficult to disclaim responsibility for them. It seems quite unclear that we are more responsible for many conscious desires and beliefs than for these unconscious ones. (Boorse 2004, 86-87; emphasis in original)

Because the mind is the "very seat of responsibility" (Boorse 2004, 86) for moral behavior, it is not so obvious that mental illnesses account for and excuse one's immoral behavior. One has no agency over the functioning of one's bodily organs or cells, but it seems impossible for one not to have control over the faculty which is responsible for decisions and self-control itself. Therefore, granting that pathological mental conditions are indeed diseases according to Boorse's view, mental illnesses yet fail to fulfill the third of Boorse's criteria and so are not considered to be proper illnesses at all.

Malady

In "Malady: A New Treatment of Disease," Clouser, Culver and Gert set out to define the genus of which 'disease,' 'illness,' and 'injury,' among others, are species. They argue that this genus is 'malady.' According to Clouser et al.:

[a] person has a malady if and only if he or she has a condition, other than a rational belief or desire, such that he or she is suffering, or at increased risk of suffering, an evil (death, pain, disability, loss of freedom or opportunity, or loss of pleasure) in

the absence of a distinct sustaining cause. (Clouser et al. 2004, 101)

That is, a condition would count as a malady so long as the suffering is internal to the person, and is not easily remedied. For example, if one experiences pain as a result of being slapped on the back, one does not have a malady. However, if one experiences pain as a result of arthritic inflammation, then the cause is internal, "biologically integrated...[and]... not easily removable," (Clouser et al. 2004, 96) and so is considered to constitute a malady.

Clouser et al. then claim that what unites the causes of suffering, "evils," is that "no one wants them...Thus, what unites death, pain, and disability is the attitude that people take toward them" (Clouser et al. 2004, 93). Here, 'evil,' one of the key elements of 'malady,' is defined by how people perceive and avoid it. This emphasis on attitude, the role that abnormality, and consequently relativistic value-judgments serve in defining what constitutes 'disability,' 'increased risk,' and 'loss of pleasure/freedom,' seems to undermine the objectivity that Clouser et al. tout for their definition of malady.

With regard to what constitutes 'disability,' 'increased risk,' and 'loss of pleasure/freedom,' Clouser et al. have recourse to abnormality. They define 'disability' as the loss of an ability that is typical of the species during its prime stage of maturity. So, a man aged ninety-nine who no longer can walk is considered disabled since at some point in the past (in his prime) he had the ability to walk, but no longer does (Clouser et al. 2004, 97). 'Increased risk of suffering' is defined as a condition which makes one more likely than a 'normal specimen' of the species to suffer harm.² They again define it in comparison to the species' norm rather than in comparison to that individual's previous state, since it's possible for an Olympic athlete to be less fit than they were previously, and so at greater risk than they were before; but in comparison to the rest of the population, they still have above-average health and so are not considered to be at increased risk. 'Loss of pleasure/freedom,' is defined as the restriction of one's choices which is not a result of external, sustaining circumstances/causes. So, a prisoner is not suffering loss of freedom due to a malady, but due to distinct sustaining causes. However, one who is unable to eat peanuts, unable to touch cats, or one who

2. Examples of this would include high blood pressure, high cholesterol, and other such conditions.

is disfigured and so cannot participate in certain activities, is subject to loss of freedom/pleasure as a result of their condition.

The authors claim that this definition is universal and objective, yet which allows for a certain degree of cultural relativity/value-judgment with regard to certain understandings of the components of the definition, in that it relegates abnormality to an indirect role in determining what a malady is, since it is used in deciding what constitutes disability or an increase in the risk of suffering, but not 'malady' directly and as a whole (Clouser et al. 2004, 101). However, if abnormality is used to determine the nature of each class of evils, it remains to be seen how this definition is as objective as Clouser et al. claim.

Another issue with 'malady' is that it requires that one's suffering must be due to a condition which is not a rational belief or desire (Clouser et al. 2004, 94). That is, anybody will avoid all evils, "unless they have some reason not to avoid them" (Clouser et al. 2004, 94). So, if one has a reason to endure pain or death (to save a loved one's life, for example), one is not considered to have a malady in this sense. A question prompted by this conception of malady is: what is considered 'rational'? This term seems to betray another aspect of this definition which is dependent upon, or at least vulnerable to, a value-judgment regarding what constitutes a reason or rational belief.

Let's recall the proposed definition:

[a] person has a malady if and only if he or she has a condition, other than a rational belief or desire, such that he or she is suffering, or at increased risk of suffering, an evil (death, pain, disability, loss of freedom or opportunity, or loss of pleasure) in the absence of a distinct sustaining cause. (Clouser et al. 2004, 101)

If what constitutes a rational belief/desire is subject to value-judgment; if being "at increased risk of suffering an evil" is determined with reference to the concept of abnormality; and if the very nature of all the "evils" elucidated by Clouser et al. are all determined by the agreement of attitudes of "all rational persons," (Clouser et al. 2004, 101) with 'rational' being under dispute: then it seems clear that this definition is either normative, or at least intersubjective. In either case, it appears not to be as objective as its authors would hope.

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Criticism aside, this new genus (malady) of 'disease' and 'illness' encompasses a wider scope than did Boorse's notion of 'disease,' while still attempting to allow for objective definition of what constitutes a disease, illness, injury, etc. With all of these terms contained within a single genus, with the result that disease and illness are distinct and independent from one another, although they may overlap. Boorse disagrees with this concept of malady since "its basic elements, concepts, principles, and arguments are the same when applied to mental maladies as to physical ones" (Clouser et al. 2004, 102). That is, 'malady' allows for mental and physical diseases, illnesses, etc., all to exist on the same plane, whereas Boorse questioned "whether current applications of the health vocabulary to mental conditions have any justification at all" (Boorse 2004, 78).

Health and Meaning

In "Health: A Comprehensive Concept," Mordacci and Sobel claim that health is something which is unable to be defined wholly in descriptive terms, but must instead encompass the values attached to it. This is necessary, they claim, because health is something desired and valued, so the definition of health must account for why it is valued. The authors seek to avoid both strictly descriptivist as well as strong normativist accounts of health, opting instead for an account which includes both descriptivist, biopsychological understandings of health and disease, and also which provides the necessary tools for the patient to make sense of their condition. Mordacci and Sobel argue that

[t]he existential, moral, and symbolic dimensions of the experience of illness must be addressed as challenges the patient is required to face with his cultural, personal, and religious resources. (Moradacci and Sobel 2004, 106)

A person's sense of the meaningfulness of their health, disease, or illness is vital to sustain the will to live, in conjunction with scientific treatment.

They cite as an example of the importance of a holistic view of health a terminally ill patient who seemed (biologically) the same the day he died as the day before he died, stating that at each point the patient had been in the same condition descriptively, with the only difference being that, on the day he died, he had lost his will to live (Mordacci and Sobel 2004, 106-107). From this they argue that *attitude* plays an equally important role in somebody's health as physiological

treatment. Here again is the inclusion of attitude as being a decisive factor in determining the nature of health, disease and illness. Yet, in this case it is not an indirect, but a direct and explicit contributing factor in the state of human health. Where Clouser et al. conceived of attitude as the principle uniting the “evils” which then played a part in defining maladies—and by extension diseases and illnesses—Mordacci and Sobel stress its status as an independent factor of health, *alongside* physiological factors, rather than as a necessary condition for defining them.

The conception of health from the perspective of the Medical model views health as an end in itself. However, Mordacci and Sobel argue that health is not only an end, but a means to achieving the ultimate end of plenitude (Mordacci and Sobel 2004, 105-106). Therefore, they argue, health is not only the quiet functioning of organs, but is the possession of the will to live and to make sense of one’s life. This they call a “life narrative” (Mordacci and Sobel 2004, 105-106).

Health, then, is the “possibility of blossoming” (Mordacci and Sobel 2004, 105). It is something which is never separate from the person and which has a dynamic nature: a past, a present and a future. It is important for medical professionals to at least be aware of our desire for health, in order to help the patient. Mordacci and Sobel claim that technical answers are only part of the solution, and that an ability to face the existential dread of illness and to make sense of one’s life, health, and illness, is equally important for any biological treatment. Doctors who are unable to do this (mostly in the West) are unable to truly help a person. They then recapitulate the commonly held notion that health is the “silent functioning of organs” (Mordacci and Sobel 2004, 106) and that it is something not directly experienced, but is rather the absence of malady. ‘Malady’ they use to cover both illness and disease (Mordacci and Sobel 2004, 106).³ Malady, they claim, is not incompatible with health, as the two coexist almost all of the time. Mordacci and Sobel thus reject the genus-species relationship that Boorse posits between disease and illness: “One can be ill without being diseased, diseased without feeling ill, or both ill and diseased” (Mordacci and Sobel 2004, 106). A person can be ill (depressed, anxious) and yet be biologically and theoretically healthy, or physically diseased, yet happy and contented.

3. ‘Illness’ for Mordacci and Sobel refers to “first-person” suffering, whereas ‘disease’ refers to the “third-person” ability to codify and diagnose the cause of the suffering (Mordacci and Sobel 2004, 106).

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Illness, then, is something which causes us to lose trust in the idea of plenitude, or the good life (Mordacci and Sobel 2004, 107). The sick person loses the feeling of coherence and thus the ability to act freely; and it is this “confidence that things will work out” that contributes to one’s health and sense of well-being (Mordacci and Sobel 2004, 108). Not only physiological, but cultural, personal, social, etc. factors contribute or detract from this sense of coherence and meaningfulness. They therefore posit the existence of pathogens and salutogens, the former being things which cause or worsen maladies, the latter being things which promote health. Each is not strictly biological but encompasses both biological/psychological factors as well as everyday-experience factors, such as having a good living arrangement, not drinking to excess, etc. These conceptual categories (pathogens/salutogens) thus increase dramatically the scope of factors which contribute to or deteriorate the health of an individual.

Where Clouser et al. posited ‘malady’ as the genus to encompass Boorse’s ‘disease’ and ‘illness,’ Mordacci and Sobel now posit pathogens to encompass all those things which

may cause or worsen maladies or may affect health independently of any influence on malady... (Mordacci and Sobel 2004, 107; emphasis added)

For Boorse, illness is a species of disease; for Clouser et al., illness and disease (as well as all other terms such as ‘injury’ or ‘lesion’) are overlapping species of maladies; for Mordacci and Sobel, illness, disease, and health all coexist and are not subordinate to one another, but constitute a plurality across physical, mental, social, personal, etc. planes, the appropriate balance of which is the achievement of health.

Implications of a Reductionist Conception of Illness

Disease, for Boorse, is the body’s deviation from the functioning normal and characteristic for the species at large. Illness is a disease severe enough as to be so undesirable that it is sought to be cured and over which the sufferer has no direct control. Disease and illness, for Clouser et. al, are maladies which *may* manifest themselves, in the first case, as discoverable entities with physical etiologies but without any symptoms (although they lead to symptoms), and in the second case, as symptoms only. Illness for Mordacci and Sobel is that poverty

of meaning which deteriorates the patient's will to live, and which is not reducible to a physical condition like Boorse's 'disease.' Boorse's conception of illness and disease, from the viewpoint of both Clouser et. al and Moradacci and Sobel, appears to ignore the fact that correlation does not imply causation: an illness and disease may overlap, but the presence of disease is not a necessary condition for the presence of illness.

What then is the best way to understand 'illness'? One step toward answering this question is to first establish which ways one must not understand 'illness.' The reductionist account of illness seems to me to be an important target for criticism.

If illness is only a subclass of disease, then symptoms, the first-person experience of being ill, are characteristics of that disease, not the person. If one has a terminal illness and so suffers depression because of how this affects one's life, a reductionist account would mean that that depression—a symptom—is directly caused by the disease, and that in fact that whole experience of the terminally ill is only the expression of disease. So, the reductionist would seek to eliminate this disease and by extension the illness, thereby restoring the patient to their former selves.

This means that the treatment and the problem will always be physiological, with all symptoms serving only as indicators of a disease presence. This seems to imply that the ill person is not themselves until having been cured, consequently discrediting their reports of suffering. Symptoms, then, are not only reduced to manifestations of some more ontologically robust disease-entity, but are thereby seen as somewhat unreliable. If the symptoms a patient reports are not to be trusted because they are 'not themselves,' then it seems that doctors can, or even should, ignore such reports of suffering, taking them to be nothing more than a sign that something must be wrong. This not only reduces illness to disease, but reduces the experience of persons to expressions of malfunctioning organisms. There is then a loss of self. An ill individual, on the reductionist model, seems not to be anyone at all. They are thereby dehumanized and reified as expressions of disease or abnormality.

The dehumanization of patients, and their being reduced to expressions of disease or illness, has at least two important implications for the patient: [1] it renders the patient powerless, and [2] it perpetuates stigmatization.

[1] When a patient is ill, they often do have some sort of biological malfunctioning which serves to cause pain or at least discomfort, and over this malfunctioning they do not have direct control. However, this is not to concede to Boorse's reduction of illness to disease. A patient, when ill, has lost control of their body—or, rather, their body has lost the ability to control itself. But this need not imply that the patient has lost control of themselves. The self and the body are not one and the same, though a reductionist account would imply as much. When a doctor only treats the disease, disregarding symptom-reports only as signs *that* something's wrong, rather than as reports of what the patient is experiencing, they strip the patient of their sense of self. When a patient loses their ability to say anything meaningful, because of their perceived displacement caused by the disease, they are indirectly encouraged to surrender to that perception, and by extension, to surrender themselves to the disease.

This surrender opens up a further problem. When the patient has lost their autonomy, there is no reason for them to do anything apart from what they are told by the medical experts. If they are unreliable and diseased, they cannot trust themselves to make the right decisions in regard to their pursuit of recovery. But this raises the question: if a patient does not follow the medical advice they are prescribed, is this decision made by the person or an error caused by the disease? It would seem to be the latter, if the person is stripped of their autonomy; but it often happens that patients are chastised for their failure to follow the doctors' orders. But if a patient is not themselves, and is victim to the expressions of their disease, chastisement is unnecessary and inappropriate. If autonomy is stripped, it seems impossible to expect the patient to choose to follow medical advice.

However, the alternative seems to be complete control of the patient by medical professionals, whether that is coerced surgery, pharmaceutical treatment, or hospitalization. In these cases, the method of treatment seems to fit the supposed loss of patient autonomy: 'they can't control themselves because they are diseased; therefore, we will control them until we cure the disease and restore them to their old selves.' The logic is now consistent with reductionist accounts of illness. However, this grants sovereignty of the medical profession over the patient and all those it deems diseased. It also trusts the medical experts to recognize when the patient is back to their old self again. Because symptoms may be used as *signs that* indicate something's wrong, rather than as *reports of* what the patient experiences, it's not clear that the remedy of physiological malfunction

will, in the professional's eyes, strictly correlate with the restoration of the patient's 'old self.' Therefore, the medical experts may not have any gauge with which to determine whether the patient is indeed cured and restored to autonomy.

The power the medical profession gains through such control of the patient also poses the problem of expertise: if the medical profession has a monopoly on the knowledge which defines 'disease' and 'illness,' and if all 'ill' patients are subject to such modes of treatment as mandatory hospitalization, coerced surgery, pharmaceutical treatment, etc., then theoretically the medical profession can deem any sort of behavior or person as 'ill' and thereby exercise its sovereignty to control them. This sort of power, as Peter Conrad says, serves to legitimize the "depoliticization of deviant behavior," as well as to

[divert] our attention...from seriously entertaining the idea that the 'problem' could be in the structure of the social system.
(Conrad 2004, 160)

If the medical profession has the authority to define all medical diseases, and if all illnesses are disease, they thereby have authority to define all sorts of illnesses. And because illnesses are those diseases which are so severe as to impinge upon the conscious experience of the patient, the medical profession thereby has authority to determine what experiences anybody should or should not have. And if one has experiences deemed unhealthy, then one will be subject to coerced 'treatment.'

[2] Such dehumanization of the ill patient, coupled with the power-monopoly of the medical profession, inevitably contributes to and perpetuates the stigmatization of all ill and diseased individuals. If the ill patient is no more than the expression of the disease they carry, and if illnesses are by definition those diseases which are so undesirable that all measures must be taken to eliminate them, it's clear to see the types of attitudes that will be taken toward anybody who is deemed as ill. The ill patient, reduced to disease and stripped of autonomy, is seen as an affliction on society, avoided by all who are not ill. This avoidance, and the attitudes the ill patient is met with, all constitute the stigmatization of the state of illness.

If the patient is seen as 'not themselves,' they are, in a sense, objectified through their being reduced to the state of their disease. In this case, they may be pitied or patronized, but almost always largely ignored and avoided. There is a

sense that the ill person is contagious in all circumstances, regardless of whether their disease really is so. Because the symptoms of the ill patient are seen as signs of something wrong, it seems that there's the idea that everything the ill patient says has the potential to contaminate 'healthy' persons. Nobody wants to hear the complaints of the ill, because they are the ramblings of a diseased, effectively self-less individual. When symptoms are no longer words, but treated as *signs* of disease, just as swelling or fever are signs of infection, there is projected this strange aversion to the reports of the ill as though they are contagious. In reducing the patient's illness to disease, and by being stripped of their autonomy, their words now mean nothing to themselves—and to everyone else, they mean only 'stay away.'

But the stigmatization reaches further than this. Because of the disconnect between the general public and the medical professionals, and because of the monopoly of knowledge the latter holds, most are unaware of how the patient is perceived in the medical community. Most, for example, would not know that the patient is seen, in the eyes of the medical professionals, as the expression of a disease, no longer their old self. Most would certainly not know that this perception effectively renders the patient powerless, and encourages them to see themselves as invalid. So, it is not uncommon for ill individuals to be 'chastised' for their incompilance with medical orders, as was discussed earlier. Because most see the ill individual as still possessing autonomy, the latter is often confronted as being 'lazy,' 'irresponsible,' or 'rebellious' by those who do not see them only as their illness. So, often the ill individual is either chastised or ignored: in both cases they are stigmatized.

The implications of a reductionist account of illness are apparent. In reducing an ill person to their functional abnormalities, medical professionals indirectly encourage the patient to surrender their identity to the disease, consequently muting their sense of self, which may negatively impact their will to live. In addition, this mentality inculcated within the ill patient undermines any credibility their illness has within the eyes of others, and any meaning they derive from their own experiences. Their words carry no meaning for themselves, and hardly any meaning for others. They are turned into walking diseases which others actively avoid. The patient is wholly reliant on the medical professional to 'fix' them. This mentality generally contributes to the conferring of immense amounts of power to the medical profession, thereby delegitimizing any dissatisfaction

an individual may have with its structures' or institutions' methods, policies, or organizations. Anyone who sees injustice in the way a society is run may be deemed 'ill' and forcibly subjected to 'treatment,' effectively granting the medical profession full control over a society's inhabitants.

Conclusion

It is clear then why a reductionist conception of illness, and by extension, health, is insufficient for, and even dangerous to, a society whose denizens value freedom, autonomy, and meaningfulness. A better alternative account, I think, would be one in accordance with Mordacci's and Sobel's, one which embraces the plurality of factors which contribute to a well-lived life, conceiving them to be holistic elements rather than as ranked in a hierarchy. Meaningfulness is vital to well-being, and cannot be eliminated or reduced to what it is not without harmful consequences.

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