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ARTICLE

# The Soul (Put to Work) in Medicine: A Response to Arthur Kleinman

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## Abstract

In his 2019 essay, Arthur Kleinman laments that medicine has become ever-competent at managing illness, yet caring for those who are ill is increasingly out of practice. He opines that the language of 'the soul' is helpful to those practicing medicine, as it provides an important counterbalance to medicine's technical rationality that avoids the existential and spiritual domains of human life. His accusation that medicine has become soulless merits considering, yet we believe his is the wrong description of contemporary medicine. Where medicine is disciplined by technological and informational rationalities that risk coercing attention away from corporealities and toward an impersonal, digital order, the resulting practices expose medicine to becoming not soulless but *excarnated*. Here we engage Kleinman in conversation with Franco Berardi, Charles Taylor, and others to ask: Have we left behind the body for senseless purposes? Perhaps medicine is not proving itself to be soulless, but rather senseless, bodyless – the any-occupation of excarnated souls. If so, the dissension of excarnation and the recovery of touching purpose seems to us to be an apparent need within the contemporary and increasingly digitally managed and informationally ordered medical milieu.

**Keywords:** data; embodiment; medicine; soul; technology

In his essay in *The Lancet*, Harvard psychiatrist and anthropologist Arthur Kleinman offers readers a commentary on his coming to use the unlikely term 'the soul' in medicine. He believes the language of soul is an important counterbalance to medicine's technical rationality that avoids the existential and spiritual domains of human life. Medicine has become overrun with 'institutional bureaucracies that colonise everyday life' in pursuit of its goal of efficiency, he says, following Max Weber.[1] It delimits and defines the experiences of illness and suffering medically, rationally, for the sake of control and elimination. The humanness or 'soul' of the ill person is ignored.

[1]Arthur Kleinman, 'The Soul in Medicine', *The Lancet*, 24 (2019), 630–1.

Kleinman laments that medicine has become ever-competent at *managing* illness while failing 'to engage the most deeply human experiences that require *care* (emphasis added)'.[2] Yet caring for those who are sickly, infirm, and dying is increasingly out of practice. Instead, preoccupations with categorization and control, and with the corresponding bureaucratization, mechanization, and management of medicine made increasingly efficient through information and communication technologies seem to overly determine the work of doctors and other medical workers, administrators, and academics. Thus, like others who might complain with frequency about global healthcare systems, Kleinman accuses 'medicine and institutional health care' of having become 's*oulless*' (emphasis added).[3] Such a term, he goes on to argue, resonates well with 'what is happening to caregiving in medicine in our times where the health system's goals of efficiency and cost-effectiveness, new technological requirements that absorb the clinician's alertness and attention, and the sheer pressure of insufficient time to listen and explain have a dire effect on providing the best care'.[4]

Kleinman's concerns, of course, are noteworthy. But Kleinman delimits 'the soul' in a rather dualist, albeit familiar, tone, which suggests a soul is 'that innermost existential centre to our being'.[5] It is a center of 'perduring … essence' that becomes threatened in the ways 'the sick experienced illness'.[6] At least, for Kleinman's childhood doctor, a non-religious German-Jewish émigré to New York, this is what 'soul' seemed to mean when invoked. Yet that same physician used 'the soul' to refer also to the corresponding and 'human way physicians treated their patients'.[7] 'The soul' in medicine then designated the essence of both patients and physicianship, of both human beings and clinical practice. Following this childhood doctor, Kleinman has come to think similarly, at the very least in the way that the soul might encourage a more holistic medical caregiving even though it remains a term largely 'never uttered' in the social, natural, and medical sciences.[8]

His perspective merits considering, thoughtfully. Yet his conclusion is not the right description of contemporary medicine. Consider, for example, those new technological requirements that absorb both alertness and attention. Consider also the demands for productivity that conform creativity and constancy to abide by the aims of institutional bureaucracies increasingly committed to dataflows and standardized communications fashioned as necessary by and for the infosphere rather than the goods incumbent to caring practices. Consider, for example, the way the referral pathway is imagined in Figure 1, as exhibited in the Royal College of Physicians *Advancing Medical Professionalism* (AMP) report.[9] The only human person imaged in the expedient graphic, save for the avatars of management in step six, is the physician at the third level of a physical examination. Yet, amusingly, she is not positioned alongside another

[2]Kleinman, p. 631.
[3]Ibid.
[4]Ibid.
[5]Kleinman, p. 630.
[6]Ibid.
[7]Ibid.
[8]Ibid.
[9]Jude Tweedie, Joshua Hordern, and Jane Dacre, 'Advancing Medical Professionalism' (Royal College of Physicians, 2018), p. 93. <https://ora.ox.ac.uk/objects/uuid:6d8e0b22-8c2c-46b1-943a-4669b8847d8f/files/m93e0e59cba9d03ecdcca1e28511b8d38>.

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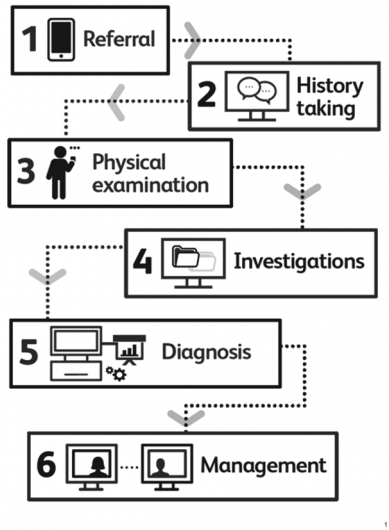


**Figure 1.** Referral pathway. From 'doctor as innovator' in the advancing medical professionalism report (Tweedie, Hordern, and Dacre 2019, 93).

person, i.e., a patient. Rather, she is positioned with a mobile phone, with which we see the familiar ellipses flashing above indicating information is on its way.

'Going to and coming from where?' one might ask.

'Into' and 'out of' a device that is both the receiver and transmitter, the '*infomaton*', of information.[10] Such information includes, of course, data gathered from the verbal dialogue of history-taking, which is also relayed in the AMP graphic, not by the presence of communicating bodies but by the iconography of digital communication, portrayed on a computer screen and speech bubbles, like those we observe on a messaging platform. The message seems clear here: physical presence is needed at neither level of the pathway.

The rhetoric of *soullessness* does not help us to see rightly the corruptions that fail to make doctors as good as possible for their tasks when such digital tools arrange and order the practices or habits of doctoring accordingly. That is to say, the dualism inherent in Kleinman's soul-talk is a recapitulation of the same dualisms that alienate medical workers from that which will give them realistic, vocational purpose – the dualisms he desires to reveal and critique.

During the era of industrial labor, soulless may indeed have been a revealing descriptor of the kind of humanity-denial experienced by workers. The industrial labor economy placed human bodies for long hours in one place, to complete the physically repetitive tasks for which there was not yet a technological substitute, while their minds or souls were free to wander elsewhere. The important thing about such labor was that the body was present, i.e., to push a button or fashion an object on an assembly line. The soul was hardly needed.

[10]Byung-Chul Han, *Non-things: Upheaval in the Lifeworld*, trans. by Daniel Steuer (Cambridge: Polity, 2022), p. 3.

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In our technological age, the important thing about labor is the stuff that technology cannot yet do, such as creativity and conversation in service to information generation (although technologies are quickly catching up). In medicine, information is the currency on which systems operate, and workers are valuable in so far as they generate, manage, and conduct it. It's not so much that the soul is discarded, but the body this time. Another dualism, but in a different direction. The message seems clear that physical presence is not needed for the continuation of medical systems and services. Indeed, a hospital in one author's institution gets by quite easily with telemedicine services in its ICU each night shift. Intensivists are staffed in some far-off location who can monitor large numbers of patients electronically, through the use of 'seeing' computer screens. (Or, one could say, 'looking' but not 'seeing'.) Instructions for patients' medical management can be sent directly to staff on the floor, who implement any necessary changes until physicians return in the morning.

So, we say this: Where medicine is disciplined by technological and informational rationalities that risk coercing attention away from corporealities, like the sensing bodies of patients and physicians, and toward an impersonal, digital order, the resulting practices expose medicine to becoming not soulless but *excarnated*.[11]

Allow us to explain further: The Italian media theorist Franco Berardi's examination of contemporary labor in our increasingly digitized world might help us to see the implications of the 'new technological requirements that absorb the clinician's alertness and attention', for example.[12] A principal argument from Berardi's book, *The Soul at Work*, oscillates around the claim that the soul has been harnessed for the benefit of a contemporary digital marketplace.[13] (And to be sure, the buying, selling, and analyzing of health information for the benefit of clinical research, among other uses, is a massively profitable business). Regardless of such uses and profits, Berardi contends that in our present milieu where digital information tools persist, the mind, language, and emotions (each in the list of euphemisms for the soul) have been exploited, and put to work in pursuit of cognitive capital, and hyper-connected to an idealized world of information while our bodies have been alienated and all but set aside.

The Canadian philosopher Charles Taylor's *excarnation*, introduced above, seems an apt description. By excarnation, or divestment of flesh, Taylor means the objectification of or a grasping after 'matter studied as something quite independent of us, where we don't need to understand it all through our involvement with it.… We should grasp it in a view from nowhere'.[14] Accordingly, the dispassionate gaze, or impersonal order, of judgment about measure and meter, about information, describes the imperative dimension (i.e., the ought). The corresponding indicative dimension (i.e., what one is) is that all we are is a constellation of information to be monitored, mined, and manipulated. The physician, therefore, does not need to *see* a patient; she only needs the data, which can be procured from a distance or from some kind of data-mining tool or schema that gathers the numbers, such as in the case of Tele-ICUs – for it is the data that we've come to trust, and to heed, and to follow, so might say the devout Dataist,

[11]Charles Taylor, *A Secular Age* (Princeton, NJ: Belknap Press, 2007), p. 288.
[12]Kleinman, p. 631.
[13]Franco Berardi, *The Soul at Work: From Alienation to Autonomy,* trans. by Fracesca Cadel and Guiseppina Mecchia (Los Angeles, CA: Semiotext(e), 2009).
[14]Taylor, p. 745.

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as Israeli historian Yuval Harari discusses in his popular history of the future, *Homo Deus*.[15]

Harari describes such devotional Dataism this way: 'Data religion', which seems to be a suitable phrase, 'now says that your every word and action is part of the great dataflow, that algorithms are watching you and they *care* about everything you do and feel (emphasis added)'.[16] Not only might the algorithms care, their processing of our information, of our essential being, is needed because, as Dataism believes, there is no inherent meaning but only that meaning discovered and iterated by the algorithms. Therefore, a 'new motto says: "If you experience something – record it. If you record something – upload it. If you upload something – share it"'.[17] Record, upload, and share, while 'adopting a strictly [data-centered] functional approach to humanity, appraising the value of human experiences according to their function in data-processing mechanisms'.[18] There is a soul in 'data religion', but is there a body?

Irish philosopher Richard Kearney gestures toward the implications of such commitment to excarnation, or the setting aside of bodies, in our digital age when he asks: 'are we losing touch with touch itself?'[19] Whether we are or aren't yet losing touch, Harari might argue that by the rule of data, if touch cannot be turned into 'free-flowing data' it will eventually prove to be meaningless and, therefore, mere fodder for alienation.[20]

The alienating effects of excarnation, however, are a present concern, at least from our perspective. And such alienation is increasingly enabled, if not determined, by a postindustrial and digital marketplace committed to the production and consumption of information. Information has become the essential idea of (non)things and the organization of such information for the purpose of accomplishing practical aims and achievements (and profits) has become a pre-eminent project.[21] But Berardi observingly argues, where information becomes the essential good, one's work life is ordered accordingly whether one has become are aware of it or not. And our work governed by a pursuit of this informational ideal is then caught up into a relationship of production and consumption: 'Each producer of semiotic flows is also a consumer of them, and each user is part of the productive process: all exits are also an entry, and every receiver is also a transmitter'.[22] And Han offers a parallel conclusion: Replacing bodies, 'the digital order *de-reifies* the world by *informatizing* it'.[23]

If these opinions about divestment and dataflows are true, ours is not becoming a *soulless* world, as Kleinman has concluded. Rather, ours is (becoming) a world where only excarnated souls matter. Medical workers, as the soul-bodies practicing medicine, will need to ask themselves questions such as these: Has your soul been put to work for the excarnate consumption and production of information? Have your patients' souls been put to work, too?

[15]Yuval Noah Harari, *Homo Deus: A Brief History of Tomorrow* (New York: Harper, 2017).
[16]Harari, p. 450.
[17]Ibid.
[18]Harari, p. 452.
[19]Richard Kearney, *Touch: Recovering our Most Vital Sense* (New York: Columbia University Press, 2021), p. 2.
[20]Harari, p. 451.
[21]Ashley John Moyse, *The Art of Living in a Technological Age* (Minneapolis: Fortress, 2021).
[22]Berardi, p. 107.
[23]Han, p. 1.

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If you are such a worker, whether a physician or surgeon, for example, you'll need to ask and answer these questions for yourselves. That is, you'll need to ask and answer such questions *if* you're able to look away from those digital tools which orient postures of inattention and blue light gluttony. They are difficult to look away from, of course, because they require that you acquire a constellation of data from the anypatient you don't touch or look at during an annual 'physical examination' or on daily rounds in the hospital. This data you must record in an EMR where all business might be formalized and shared at the speed of thought[24] – not to mention bought, traded, and sold by various firms and agencies to leverage the consumption of medical products that won't resolve the crisis of caregiving, which motivated Kleinman's essay in the first place, for example.

Of course, you might not have the time to answer such questions, since your attention is often diverted to those Epic mobile apps, among others, which keep you *connected* to your patients, your practice, and your colleagues, wherever you are and no matter the time. 'Connected', however, is a funny word to use when one considers carefully such digital tools and the current of dataflows they reinforce. It's humorous since the middle English means to be united, *physically*; and the Latin *connectere* is a conjunction of 'together' or 'to gather' and 'bind'.[25] The use of such physical phrases in our digital age disguises the excarnated realities we're trying to reveal.

But *connection* is not the only promise made by our digital tools and techniques. By turning your attention and creative energy to such digital tools, you might also be(come) a leading *innovator* in medicine, as the AMP also indicates.[26] And it is not that difficult to take on the role of the innovator. As the report indicated, you need only to accept and implement these technologies as they are introduced to and intended for medicine by those trained outside of medicine. It seems that being an innovator in medicine, in large part, is reducible to being an early adopter and regular user of machine learning algorithms. You need only to do one thing: face the responsibility to routinize your habits around them.

Don't think about it. Simply face the inevitability of our digital present and imminent future and simply adopt and use such tools. For if you do think about it, perhaps as Berardi has done, you might worry that such innovation is leading us towards a kind of chaos where 'the flows [of information] are too intense for our capacity' to understand and to converse with the data meaningfully.[27] Where one is unable to understand or engage meaningfully with the dataflows, the actuality of biological limitations reveals the limits of humanism, justifying further the excarnation, even *extinction*, of human material in favor of immaterial data, as anthropologist Abou Farman might contend.[28] Of course, the idea of extinction might be more hyperbolic than it is realistic. Yet while thinking about the ubiquity and onward advances of technology in your clinical practice, you might come to share this realistic feeling with Atul Gawande instead:

[24]Bill Gates and Collins Hemmingway, *Business @ the Speed of Thought: Using a Digital Nervous System* (New York: Viking, 1999).

[25]Oxford English Dictionary, oed.com.

[26]Tweedie, Hordern, and Dacre, p. 93.

[27]Berardi, p. 125.

[28]Abou Farman, 'Informatic Cosmologies and the Anxieties of Immanence', *The Immanent Frame*, 2017 <https://tif.ssrc.org/2017/10/25/informatic-cosmologies-and-the-anxieties-of-immanence/> [accessed 24 June 2024].

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'a system that promised to increase my mastery over my work has, instead, increased my work's mastery over me'[29] – if not mastery over the worker, at the very least we are at risk of being constrained by the determinations of such tools that reinforce their continual usage and our instrumental reasoning about the problems we confront in our technological age.[30]

Of course, don't let our suspicions distract from those questions, which we're supposed to be asking and answering. However, we understand the answering of those questions will need to wait until you consume and produce information further through the kinds of ergonomic habits we all seem to be performing 'in front of a screen' and that make, 'from a physical standpoint', all of our work the same.[31] Whether you work as a physician or as a philosopher, an administrator or an architect, and the list of jobs could go on, many of us are postured for much of our days in the same way, in front of a screen, because of the demands placed upon us by a revolution whereby information has become everything since everything is thought, fundamentally by some, to be information. Accordingly, the production and consumption of immaterial data increasingly order our affections and labors.

Surely, we imagine, one might protest while suggesting that we can get a standing desk, or rearrange the location of screens, or take advantage of large-language models and generative artificial intelligence to facilitate better practices. Others, of course, might argue, whether one sits or stands, medicine will win if it gets the data procurement and management right. At least, that is what the book, *Business @ The Speed of Thought* promised twenty-five years ago, while Bill Gates evangelized his 'simple but strong belief … *how you gather, manage, and use information will decide whether you win or lose*'.[32] Even healthcare can win too, Gates argues, if it only creates and manages systems 'built from digital parts' that organize and coordinate 'information flow'.[33] The challenge for medicine, however, like that of any other business (and the healthcare industry in America where we now reside is certainly and profitably that), is not a software or hardware issue. Computer information and communication systems have been competent for decades now. The 'coefficient of elasticity', or limitation that slows the

[29]Gawande, A. Why doctors hate their computers', *The New Yorker*, 5 November 2018, <https://www.newyorker.com/magazine/2018/11/12/why-doctors-hate-their-computers>, para. 7.; Some, such as Dietrich Bonhoeffer argue, while responding to concern of technological principalities, that 'Technology has become an end unto itself. It has its own soul; its symbol is the machine, the embodiment of violation and exploitation of nature' (Dietrich Bonhoeffer, *Ethics,* ed. by Wayne Whitson Floyd Jr., trans. by Reinhard Krauss, Charles C. West, and Douglas W. Stott, Dietrich Bonhoeffer Works, vol. 6 (Minneapolis: Fortress, 2005), 116). Its symbol now remains a machine, but no longer industrial. Instead, digital machines seduce adoption and use for the production and consumption of information, while humanity becomes determined by the progress, rather exploitation, such technology demands: 'Technology is the power with which the earth seizes hold of humankind and masters it' (Ibid., 16). Accordingly, the warning that concerns Gawande above is a repetition of Bonhoeffer's earlier concerns: 'We think we are the one making the move, whereas instead we are being moved. We do not rule; instead, we are ruled. The thing, the world, rules humankind; humankind is a prisoner, a slave, or the world, and its dominion is an illusion. Dietrich Bonhoeffer, *Creation and Fall: A Theological Exposition of Genesis 1-3,* ed. by Wayne Whitson Floyd, trans. by Douglas Stephen Bax, Dietrich Bonhoeffer Works, vol. 3 (Minneapolis: Fortress, 1997), pp. 66–67.

[30]Gabriel Marcel, *Man Against Mass Society,* trans. by G. S. Fraser (South Bend: St. Augustine Press, 2008); Moyse, *The Art of Living in a Technological Age*.

[31]Berardi, p. 76.

[32]Gates and Hemmingway, p. 1. Emphasis in original.

[33]Gates and Hemmingway, p. 82.

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production and consumption of information, are the workers themselves – the human component to such systems.[34] It is vital, then, for such a belief to take effect in others, including, for example, the workers within a business who must come to desire the mobilization of information (digital capital) too. So desiring, they might also become unbothered by the eventual extinction of human inefficiencies and might learn to see such extinction as both necessary and good for the *telos* (understood as the aim or goal) of business as usual. For example, doctors have to get excited about the promise of wearables and the promises of diagnostic competencies that machine learning and artificial intelligence will proffer. One's affections and attentiveness then must become converted to such belief. That is to say, physicians, for example, must become catechized into a kind of liturgy where the consumption and production of information are thought natural to the work – even when such 'nature' extinguishes the material and social practices inherent to medicine (hazarding to constrain medicine differently, and away from its touching purposes).

So, what is the winning ideal? A doctor doesn't need to see you unless she has to. She only needs to monitor the incoming data. And everyone who needs to see the information can and will see it wherever and whenever they are. It is not the *physical* standpoint, therefore, that matters at all. Only the soul matters, as Berardi argues.[35]

Perhaps more needs to be said here. Yet even without a comprehensive argument, it might be that the perspective offered above discloses the need for medical workers and administrators to ask some essential questions: Have we left behind the body for senseless purposes? Does medicine succumb to such senseless purposes when its traditional practices are ordered differently, constrained by habits of information production and consumption?

If medicine is so succumbing, it truly is not proving itself to be soulless. Rather, it is becoming the any-occupation of excarnated souls. Yet, students of theology will recognize the cognitive dissonance of such a phrase, 'excarnated souls'. The soul, at least in the Christian tradition, is the form of the body; incarnation is the very nature of every soul. Some students of philosophy, too: Aristotle, after he shed the dualism of Plato, thought likewise, for example.[36] We should ask, then: when our bodies no longer matter in the postindustrial medical milieu, can our souls matter either? Maybe Kleinman's soullessness is not so far off, albeit unable to reveal the problem in its fullness, being beholden still to body-soul dualism. Soullessness *and* bodylessness, a total loss of self, may be closer to the truth.

In fact, there are clues within Kleinman's essay that reveal the unity of body and soul in defiance of his dualistic argument. For instance, he recalls a conversation with a medical student who, upon being asked by a dying patient where her soul would go

[34]Jacques Ellul, *The Technological Society*, trans. by John Wilkinson (New York: Vintage, 1964), p. 136.

[35]Berardi.

[36]Aristotle discusses the syntheton (the composite) in relation to body and soul in *De Anima (On the Soul)*, Book II.1, 412a–413a. Here, he explores the relationship between the body and the soul as a unified composite entity, where the soul is the 'form' or actuality of a natural body that has life potential. In 412a19–22, Aristotle describes the soul as the 'first actuality of a natural body which has life potentially'. He emphasizes that body and soul are not separate substances; rather, they form a composite unity, with the soul giving life to the body, similar to how form and matter are united to constitute a complete substance. This is fundamental to his hylomorphic (matter-form) theory, where body and soul together create a single, unified being.

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when she died, refrained from answering on the question's own theological terms.[37] Instead, the student turned the question back on the patient, inquiring about her beliefs so that her end-of-life care might be better prescribed and managed. 'As a clinician', writes Kleinman, 'I recognized his [the student's] engagement with the patient was exemplary … [because it was] medically useful'.[38] Of course, to enter into theological and doctrinal conversations on their own terms would not be medically useful, since it would not contribute to the flow of information needed to categorize and control and manage medical needs. As such, theological questions having to do with the soul are neither valued nor attended to; rather, they are turned into information-generating opportunities. In one sense, Kleinman is fully contributing to the soullessness of medicine he aims to critique when he teaches his students to value only medically useful conversations with patients. In another sense, he is revealing the actual coherence of soul and body, always and everywhere, by admitting that even the soul, like the body, is beholden to the ascendancy of medical knowledge for the control and management of soul-bodies, even in their dying.

We, therefore, worry that physicians, and other medical workers, might discover themselves to be(coming) producers and consumers of information without touching purpose – corrupted by the distracting radiance of a computer screen and the flow of information that both pass the time of our increasingly tactless inattention. Thus, the dissension of excarnation and the recovery of touching purpose seem to us to be an apparent need within the contemporary and increasingly digitally managed and informationally ordered medical milieu.

A vision of medicine as deeply incarnational calls for a practice that honors the ensouled body and embodied soul, recognizing the human person as an inseparable unity essential to the healing process and the practice of medicine itself. Yet, perhaps more than unity of two opposites, one might consider the soul and body as one *thing*, doing away with the kind of dualisms that persist and leave both thinking and practice vulnerable to the exploitation of one or the other – which is, in reality, an exploitation of the whole person. Such thinking is not heterodox. Dietrich Bonhoeffer's reflections in *Creation and Fall*, for example, echo this holistic perspective: 'a human being is a human body … a human being "is" body and soul. The human being…is one'.[39] Such sentiment, of course, follows a tradition of thought traced, at least, to Irenaeus, who writes that the human being 'consists in the commingling and union of the soul receiving the Spirit of the Father, and the admixture of that fleshly nature which was moulded after the image of God'.[40] Moreover, the body, by way of such thinking, enlivens or reveals the person in the unity of their being, which anchors and orients not only understanding but also the solidarity shared with other body-persons. The human person, in acting, encounters another not just as an individual but as an embodied being, which situates them within a communal world. The unity of body and

[37]Kleinman, p. 631.
[38]Ibid.
[39]Dietrich Bonhoeffer, *Creation and Fall*, pp. 76–77.
[40]Irenaeus of Lyons, 'Against Heresies', Book 5.6.1, in A. Roberts, J. Donaldson, and A. C. Coxe, eds., *Ante-Nicene Fathers: Vol 1*, (Buffalo, 1885) [online facsimile], <http://www.newadvent.org/fathers/0103506.htm> [accessed 18 July 2021].

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soul in each person enables a real connection, making it possible to acknowledge and affirm the other's personhood, establishing the basis for community.[41]

Such anthropology, as endorsed by Bonhoeffer, Irenaeus, and Wojtyla, among other theologians and philosophers,[42] challenges us to see medicine as a practice that attends to and honors this 'one' – the person not merely as a body to be fixed but as a unified being, who is like me and, like me, is undergoing transformation.

Unfortunately, Kleinman's suggestion to reintroduce the 'soul' into healthcare does not do enough to reinforce this unity: 'we need soul to specify the human quality at the heart of care in order to animate the souls of patients, family members, and clinicians'.[43] Rather, his notion of 'soul' risks abstraction if divorced from bodily reality. Accordingly, the vision of medicine as deeply incarnational must be ordered through a synesthetic encounter with the reality of bodies, which we not only see but sense in every respect. The honorable recognition of an incarnational medicine, therefore, would be an ontological recognition that the ensouled body *is* the embodied soul *and vice versa* – and simplified talk about bodies or flesh is to speak with such syncytial, or holistic, understanding. Of course, knowledge of such ontological unity is not gained by abstraction or the parsing of speculative argument. Rather, for an incarnational medicine that honors such an ontological actuality (and strives both out of and after its veracity), knowledge is simply recognized as coming from understanding (sensing and perceiving and interpreting) bodily experience – habituating incarnational understanding foundational to compassionate care. Such understanding of incarnational medicine (re)orients the flesh, of both patient and physician, introducing it as the primary site of meaning and immanent revelation and responsibility. But, let us reiterate, flesh, here, is not merely physical but a medium of sensing disclosure, which underscores how attending to bodies in medicine becomes an encounter with the unity of life (and the indissoluble correlation of inter-corporeality[44]) itself.

Charles Péguy articulates this vision by describing how 'God has hitched the body to the soul … neither of the two, neither the [soul] nor the [body], will be saved without the other'.[45] Rooted in the incarnational reality of Christ, Péguy's view offers a theological foundation for medicine that honors the unity of body and soul, and the 'in-carnal-ation' of the moral life, resisting reductionist approaches. A consequent phenomenological consideration might deepen this point: we propose that incarnation is a lived reality wherein the flesh reveals the healthy-and-sick life of our

[41]See Karol Wojtyla, *The Acting Person*, trans. by Andrzej Potocki (Dordrecht: D. Reidel, 1979), pp. 275–80.

[42]Consider, for example, Aristotle, Athanasius, Aquinas, Hildegard of Bingen, and Karl Barth, or see the following: *Religion and the Body*, ed. by Sarah Coakley (Cambridge: Cambridge University Press, 1997); Jeffrey P. Bishop, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame: Notre Dame University Press, 2011); Ola Sigurdson, *Heavenly Bodies: Incarnation, the Gaze, and Embodiment in Christian Theology,* trans. by Carl Olsen (Eerdmans, 2016); Emmanuel Falque, *The Wedding Feast of the Lamb: Eros, the Body, and the Eucharist* (New York: Fordham University Press, 2016); Deborah Beth Creamer, *Disability and Christian Theology: Embodied Limits and Constructive Possibilities* (Oxford: Oxford University Press, 2009).

[43]Kleinman, p. 631.

[44]Wendell Berry, 'Health is Membership', Speech given at conference 'Spirituality and Healing' (Louisville, KY: 17 October 1994).

[45]Charles Péguy, *The Portal of the Mystery of Hope*, trans. by David Louis Schindler, Jr (Grand Rapids, MI: Eerdmans, 1996), pp. 51–2.

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body-and-soul, itself. In caring for the sick, medicine thus becomes a form of communion, where suffering meets the presence of another, an encounter at the heart of medicine's craft. By such communion through craft, physicians might discover and rediscover its sensing purpose again and again through practices oriented toward and tending to each body caringly (as Christ's mother tended to his so that he might tend to ours by inviting us back to the experiences of senses – inviting us to look upon and to touch his wounds and to feed his hunger [Luke 24:41] and to touch and feed again when we look upon His face in the face of others [Matthew 35]).

With such communion ordering one's habits, the craft of an incarnational physicianship is illumined further by Aristotle's virtue of *techne*, which he divides into three levels of mastery: the artisan, the experienced craftsperson, and the master craftsperson.[46] The artisan is skilled in procedural tasks and mechanical execution, bound to technique but lacking an understanding of the underlying principles. The experienced craftsperson, by contrast, gains insight through repeated practice, improving in judgment but without fully grasping the *logos*, or ultimate purpose, of the craft. Only the master craftsperson operates with a profound knowledge of the *logos* – the essential meaning or reason that unifies practice and theory into a coherent whole. The master embodies a wisdom that sees beyond the immediate task to understand the purpose of the work, an integration of skill and insight to be oriented toward true human flourishing.

Those who pay close attention to the lived experience of clinical encounters point toward an understanding of *logos* that refuses detached, excarnate logic and accepts wisdom emerging as life itself made present in flesh. For phenomenologists and hermeneuticians – in the lineage of Martin Heidegger, Maurice Merleau-Ponty, Hans-Georg Gadamer, Paul Ricoeur – this *logos* reveals itself in bodily encounters, where the human person becomes known not through abstraction but through lived reality, in moments where life (including both health and sickness) discloses its essence.[47] The master craftsperson in medicine, then, embodies the *logos* of care, attending to the patient's suffering with both skill and insight, anchored in and always maturing through the understanding of the human condition and the *telos* of medicine itself.[48]

However, without this incarnational depth, medicine risks remaining excarnate, depriving practitioners of the formative experiences necessary to cultivate this highest level of mastery. In such a context, physicians might find themselves restricted to the roles of either artisan or experienced craftsperson – competent in procedure and

[46]Aristotle, Metaphysics 1.1, c.f., David Charles, 'Wittgenstein's builders and Aristotle's craftsmen', in *Wittgensteinian Themes: Essays in Honour of David Pears*, ed. by Charles and Child (Oxford: Clarendon, 2001), pp. 49–79, p. 60.

[47]Fredrik Svenaeus exemplifies these insights in his book *The Hermeneutics of Medicine and the Phenomenology of Health: Steps Towards a Philosophy of Medical Practice* (Boston: Kluwer Academic Publishers, 2001). Separately, Jeffrey P. Bishop describes the necessity of getting beyond abstractions and toward the essence of being itself (which is an affiliative encounter) in his essay 'On the Liturgical Consummation of Any Future Enhancement', *Christian Bioethics*, forthcoming. See especially the sections 'On the Limitations of Analysis' and 'Structure and Dynamics'.

[48]See Farr Curlin and Christopher Tollefsen, *The Way of Medicine: Ethics and the Healing Profession* (Notre Dame: University of Notre Dame Press, 2021).

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experience, yet unable to reach the maturity of understanding the fundamental meaning of their craft as one aimed at the restoration of health (even health within illness[49]) for those who are sickly and infirm. Without engaging the *logos* of medicine, they are bound to methods without insight, practice without wisdom.

Aristotle's model underscores that the highest form of medical knowledge is not merely technical skill but the application of a number of moral and intellectual virtues that emerge from disciplined, habitual bodily engagement. The cultivation of virtues is essential to developing *phronesis*, or practical wisdom – discernment honed through embodied encounters that respect the particularities of each patient and the actualities of human being (including the reality of human dying). The master craftsperson in medicine, therefore, must be capable of perceiving and responding not only to symptoms but to the full, unified reality of the patient, which includes both physical and nonphysical dimensions.

This deeply embedded approach to *techne* fosters a profound sense of purpose, suggesting that the master physician knows and acts in a way that integrates skill with the wisdom of *logos*. Bodily encounter is essential. Medicine becomes reasonable, or *logos*-oriented, through this ethical, incarnational act of care, revealing that maturation toward mastery of the craft is only cultured when the physician's touch is both skilled and understanding – an encounter that discloses life in its fullness.

Péguy's theological anthropology further underlines this incarnational approach. Medicine, we might learn from him, must be(come) and remain a practice moving 'toward the world and not … away from it'.[50] Péguy's poetry, therefore, warns against abstracted approaches that remove practitioners, and people in general, from embodied, lived experience. Such detachment deprives medicine of its intellectual and moral core, leading to a profession emptied of its humanity and estranged from its purpose. Yet, if medicine embraces its carnal, incarnational purpose, it will remain (or become again) a vocation of encounter, a practice in which physicianship is both intellectual and moral craft. Each sensory interaction, each touch and gaze, cultivating a *phronetic* capacity for perceiving the patient's full humanity – and for understanding the arc of human living, inclusive of dying. Through touch, sight, and sound, physicians do not simply work upon bodies (like an industrial endeavor) or trade in the production and consumption of information (as digital endeavors tend) but engage with embodied persons, bearing witness to their suffering and contributing to their healing.

Our incarnational view of medicine as a reasonable, embodied practice reclaims it from excarnate tendencies that reduce it to mere functionality. When physicianship aligns with the *logos*, each encounter becomes a moment of healing that reveals the human person's dignity and depth. A phenomenological hermeneutic of flesh supports this, positing that such carnal encounters are reasonable precisely because they are grounded in bodily reality – a shared engagement with life's fragility and facticity that allows for genuine understanding, caregiving, and healing. The physician, like the master craftsperson, serves not just as a technician but as a custodian of the

[49]Which is, of course, an underexplored and underarticulated end of chronic illness management. See Havi Carel, 'Can I be Ill and Happy?' *Philosophia*, 35 (2007), 95–110; *Phenomenology of Illness* (Oxford: Oxford University Press, 2016).

[50]Charles Péguy, *Temporal and Eternal,* trans. by Alexader Dru (Indianapolis: Liberty Fund, 2001) p. 93.

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*logos*, attending to the mystery of life made visible in flesh. Through this incarnational, embodied practice, medicine fulfills its ethical purpose, drawing physician and patient alike into a profound encounter with life's inherent worth, one act of healing at a time.

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