**Pathophobia, Vices, and Illness**

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**1. Introduction**

An abiding theme of Audre Lorde’s *Cancer Journals*, her reflections on her experiences as a woman of colour with breast cancer, is a ‘fury at the outside world’s viciousness, the stupid, brutal lack of consciousness or concern that passes for the way things are’. She castigates the ‘arrogant blindness’ of the healthy and privileged, the ‘hurt’ caused by the ‘cold and silent eyes’ of the women who shunned her, and other failures of empathy, understanding, and compassion (1997: 24, 25).

Lorde also explores the intersectional character of such ‘viciousness’ – the ways that gendered and racialized discrimination combined with novel forms of prejudice against her ill body. But while the concepts of sexism and racism were available for the former, no such term existed for morally objectionable attitudes and behaviour targeted at somatic illness. Even today, some thirty years later, there exist the concepts of sanism and ableism, which refer to forms of discrimination against persons with mental illnesses and disabilities. But no concept currently exists to name discrimination specifically against those with chronic somatic illnesses.

The aim of this paper is to provide a concept to fill that gap – ‘pathophobia’, which gathers together the variety of morally objectionable attitudes, norms, and behaviours to which somatically ill persons are typically subjected. I sketch the concept and then argue that we can use it to articulate the moral wrongs of pathophobia by connecting it to the framework of *vice ethics*. I will describe five clusters of pathophobic vices and failings, illustrated with examples from three influential narratives of the social experience of illness: Havi Carel’s *Illness*, which documents her diagnosis and early years with a life-limiting lung condition, and two breast cancer narratives, Kathlyn Conway’s *Ordinary Life* and Barbara Ehrenreich’s *Bright-Sided*, published in some countries as *Smile or Die*.

**2. The concept of pathophobia**

We need appropriately rich conceptual resources to identify, describe, and appraise forms of social oppression and to develop effective individual and collective ameliorative strategies. Pathophobia is intended to complement such existing concepts as racism, sexism, and homophobia. It tracks forms of socially scaffolded mistreatment which target those with somatic illnesses. (I therefore use the term differently from its current, idiomatic sense of ‘a morbid fear of illness or of becoming ill’, a fear that can of course motivate pathophobia in my technical sense).

A main source for detailed accounts of experiences of pathophobia are the testimonies and narratives offered by somatically ill persons and their carers, which are called ‘pathographies’, taking the form of autobiographies, diaries, letters, memoirs, and other forms of creative product. For most of the twentieth century, people’s writings about their illness tended to be didactic and paternalistic, offering advice and urging trust in doctors. But in the 1980s, a genre emerged that Anne Huntsaker Hawkins labels ‘angry pathographies’, documenting the callousness, coldness, and cruelty of doctors and healthcare systems. Into the 1990s, such critiques expanded to the wider social world and those instances of pathophobic ‘viciousness’ experienced across the many contexts of everyday life, with a main inspiration being Susan Sontag’s analysis, in her classic essay ‘Illness as Metaphor’, of the oppressive character of the culturally entrenched ‘mythology of cancer’ (1977:87).

Across these testimonies and narratives are detailed accounts and critically charged analyses of pathophobic phenomena, which are highly plural, shaped by three sets of factors. To start with, the forms taken by pathophobia will depend on the symptomology, effects and manifestations of an illness, and its cultural and symbolic associations. Sontag explores the moral, emotional, and symbolic meanings associated with different cancers: some appear ‘ill-omened, abominable, repugnant’, or as aesthetically ‘obscene’ or a moral ‘disgrace’ (1978: 9). Such associations and meanings are shaped by the typical effects of illnesses and their treatment modalities on a person’s abilities and appearance. An illness may cause disfigurement, slurred speech, sweating, bodily convulsions, memory loss, and other changes that affect the specific forms taken by pathophobia. Illnesses will also have different social and medical statuses – recognised or accepted, ‘contested’ or ‘stigmatised’ – all of which alter the specific sorts of pathophobic attitudes and behaviours to which one may be subjected.

A second set of factors contributing to the plurality of forms of pathophobia are agential. An ill person is never just an ill person, since that will be one of their many intersecting social identities, so their sick bodies will also be gendered and racialized, and thoroughly embedded in specific socio-economic structures. Such identities affect both susceptibility to pathophobic mistreatment and the resources available to ill persons when attempting to cope with it, such as credibility, empathy, and trust. Lorde located the ‘crisis’ occasioned by breast cancer within a ‘whole pattern’ of gendered and racialized injustice with resonated with pathophobic prejudices to generate a ramifying structure of ‘separation and powerlessness’ (1997: 11, 13). A contemporary example is *Sick*, Porochista Khakpour’s memoir of her experiences as a college-educated, Iranian immigrant, with a history of drug abuse, and Lyme disease, an illness whose status was openly contested by many of her doctors – all of which shaped the frequency, severity, and forms taken by the pathophobia she experienced (Khakpour 2018).

A final source of the plurality of pathophobia are features of wider cultural context. Ways of experiencing and responding to somatic illness are highly variable, depending on available and prevalent norms, ideals, practices, and stereotypes. Cultures supply scripts – some heroic and triumphalist, others accusative and shaming, often by invoking themes of personal failure and moral corruption (think of lung cancer and liver disease). Sontag said, ‘nothing is more punitive than to give a disease a meaning’, which is why certain cultural conceptions of illness – such as the ‘mythology of cancer’ – ought to be made ‘obsolete’ (1978:58, 88). Such cultural constructions of somatic illness will also affect the frequency and forms of pathophobia, especially when social norms and institutions tend to inscribe and enact morally objectionable attitudes towards and treatment of those with somatic illnesses.

There is a clear consensus within the pathographic literature on the morally awful character of pathophobia, across its many forms. Within the majority of the testimonial and narrative reports, there is an evaluatively charged rhetoric of anger, bitterness, and frustration, as in Lorde’s talk of the ‘fury’, ‘brutality’, and ‘stupidity’ of the pathophobia that, for an ill person, ‘passes for the way things are’. But knowing that pathophobia is wrong does not tell us the specific character of those wrongs, a problem complicated by the fact that pathographies employ a variety of moral languages – of injustice, violations of rights, and failures of autonomy, among others. Such pluralism generally suits the purposes of pathographers, whose main concerns are not in systematic moral theorising. Moral theory is not always useful, desirable, or necessary, and should therefore only be used carefully and sparingly. But developing a systematic framework, if done carefully and nondogmatically, can be useful – for instance, as a way of ensuring that certain deep, subtle features of pathophobia do not go unnoticed or misdescribed.

A respect for use of a plurality of moral vocabularies to describe pathophobia is consistent with the claim that certain of them can have distinctive advantages over others, relative to certain values or goals. In what follows, I propose that moral analysis of pathophobia is best served by a *vice-ethical* framework—a style of ethical theorising that focuses on appraisal of moral conduct in terms of sets of failings or defects of character and, crucially, the social conditions that sustain and amplify them.

**3. Pathophobia and vices**

Lorde’s description of the ‘viciousness’ that infuses the everyday treatment of ill persons exploits the technical sense of vice as negative character traits or ‘defects’, in the sense of ‘qualities that make us worse people’ (Battaly 2015:6). Some are broadly moral failings, such as cruelty or selfishness, while others are aesthetic, affective, or epistemic failings, such as snobbishness, coldness, or closed-mindedness, and there are many vices and many ways in which they can be grouped. Within recent Western character theory, the main focus has been on the virtues and such related positive notions as excellence, flourishing, and the good life. As a consequence, much less has been said about vices, failings, and corruption, and less work has been done applying those concepts to analyse specific social phenomena, such as pathophobia.

An exception is recent work by Heather Battaly (2015), who defends a pluralistic analysis of vice, according to which a trait can become vicious in two ways. An *effects-vice* is a trait that tends to create a preponderance of bad effects when exercised under typical or usual circumstances, where the bad effects can be defined in relation to any domain of value one likes. Cruelty, for instance, tends to create the bad moral effects of causing unnecessary and avoidable suffering to other people and creatures, such as physical harm or emotional distress – a clear example of a moral effects-vice. Dogmatism tends to obstruct one’s ability to critically revise one’s stock of beliefs in response to critical challenges or counter-evidence, making it an epistemic effects-vice. Such vices only need to *tend* to cause bad effects, since they might fail to do so in some circumstances and, relatedly, under conditions of oppression could sometimes create good effects – a possibility explored by feminist character theorists, such as Robin Dillon (2012) and Lisa Tessman (2005).

A second type way for a trait to become vicious is by expressing or manifesting bad values or motives, such as a desire to cause needless suffering to others, or an indifference to truth, which are morally and epistemically bad, respectively. Battaly calls these *motives-vices*, arguing that such traits reflect badly on one’s character, quite independently of any effects they might create. A cruel person might never act on their dispositions to cause suffering out of calculated self-interest, but are still vicious in the sense of their possessing a negative character trait. Moreover, attributing a vice to an agent need not entail *blaming* them for its possession, since agents can acquire vicious traits due to the suboptimalities of their socialisation or due to corrupting environments (Battaly 2016).

The viciousness of a trait can therefore be located in its typical effects, or the motives and values it incorporates, or both of these. Certain traits are objectionable by virtue of their effects and motives, making these what Battally calls *hybrid vices*. More can be said about the structure and the components of character vices, and their relation to the virtues, but this is enough for present purposes.

I want to propose that moral analyses of pathophobia ought to be framed in the terms of vice ethics for two reasons: *narrative fidelity* and *descriptive richness*. It’s vital that philosophical analyses of pathophobia are faithful to the lived experiences of those people who are subjected to it, for which the best source are pathographic testimonies and narratives (Kidd 2017a). Otherwise, the analysis is cut off from the concrete realities of pathophobia. When reading those pathographies, one consistently finds a vocabulary of vices, whether by way of explicit mention (‘cruelty’, ‘selfishness’) or through implicit descriptions (‘they didn’t care at all when I told them about my diagnosis’).

A second reason to use a vice-ethical framework it that it enables rich descriptions of pathophobic actions and behaviour, since vice-terms are so-called ‘thick’ moral concepts – they combine evaluative and non-evaluative description (‘cruel’, for instance, has a degree of behavioural particularity and cultural specificity lacking from such ‘thin’ concepts as BAD or WRONG). Our concepts of vice typically include specifications of various associated forms of bodily comportment – cruel sneers, haughty tones of voice, smug facial expressions, and so on, all of which is exploited by pathographers. Indeed, the pathophobic vices are mainly to be found in ordinary-everyday modes of behaviour and comportment, rather than being confined to occasional dramatic instances of egregious moral failure.

Before going onto the pathophobic vices, two more technical comments are needed on the nature of vices, each of which are relevant to the philosophical study of pathophobia. First, the bearers of vices will primarily be individual agents, to some specific person whose actions and speech are vicious, such as a cruel doctor, thoughtless colleague, or coldhearted stranger met on the street. But we also attribute vices to collective agents, such as dogmatic committees or unfriendly departments, and also to institutions, as when the United Nations Special Rapporteur on extreme poverty and human rights recently described the United Kingdom’s social welfare system as systemically ‘cruel’, owing to ‘the harsh and arbitrary nature of some of the sanctions, as well as the devastating effects that resulted from being completely shut out of the benefits system for weeks or months at a time’ (Alston 2018: 6). A system is viciously cruel when it imposes needlessly prolonged, complex obstacles that are making it difficult, if not impossible, for highly vulnerable, suffering people to access state support. Attributions of vices to institutions, policies, and systems should be taken seriously in studies of pathophobia, although my current focus is agential pathophobia.

The second comment is that my analysis of pathophobia does not rely on division of character traits into the categories of the ethical and the epistemic, as is customary within Western character theory since Aristotle. We do not find a division of this sort in ancient Indian and classical Chinese character ethics, and there are two sorts of exceptions within the Western tradition: the indissolubly ‘ethico-epistemic’ virtues, such as truthfulness, and the occasional appearance of such additional classes as the civic and the spiritual virtues and vices. I think that the ethical-epistemic distinction does not help us to appreciate and organise the specific forms and interrelationships of the pathophobic vices and failings. To see why, let’s look at them in detail.

**4. The clusters of pathophobic vices.**

I suggest that pathophobic attitudes, behaviour, and ways of thinking can be most usefully conceptualised, described, and analysed if we think about them in terms of *pathophobic vices*. Consultation of pathographic testimonies offers a huge range of candidates, of course, but also creates the problem of yielding a list that is too long and unwieldly to be useful for our practical and theoretical purposes. I keep a list of the vices mentioned in pathographies, which currently runs to about a hundred and twenty: the list is informative but unhelpful as a means of giving people easy, practical ways of thinking about pathophobia.

My strategy for cogently organising the variety of pathophobic vices into a workable system relies upon the neglected moral-theoretical practice of taxonomizing human failings into clusters organised around a generic type of salient feature. Earlier examples of this sort of exercise include the lists compiled by medieval Christian theologians of our sins and vices, or the Buddhist catalogues of our ‘taints’, ‘cankers’, and ‘defilements’. I propose to classify the variety of pathophobic vices into five main clusters, construed as pragmatic artefacts to guide our practices of evaluation rather than delineations of some objective ordering. I think that some vices could fit into, or can straddle, different clusters, due to the conceptual and psychological continuities between certain traits. Moreover, the five clusters are not taken to be exhaustive: others can be proposed, as long as they show fidelity to the content of the pathographic testimonies. I suspect, for instance, that there is a cluster of ‘vices of paternalism’, such as condescension, dismissiveness, and pathocentric testimonial injustice, which all tend to subvert the social and epistemic agency of somatically ill persons (see Kidd and Carel 2017).[[1]](#footnote-1)

My procedure for taxonomizing the pathophobic vices is to describe the general type of failing characteristic of the cluster and then to sketch some illustrative examples of those vice using examples from the pathographies by Carel, Conway, and Ehrenreich. My modest aim is to establish the practical and theoretical utility of the vice-ethical framing of analyses of pathophobia. If that is not granted, there would be no point moving on to more complex issues about collective vices, blame and responsibility, and amelioration which presuppose that framing.

1. *Aversion cluster*.

The vices in this cluster involve failures to engage interpersonally with somatically ill persons in appropriate ways. Aversiveness might include flat refusals or expressions of reluctance to interact with them, or, when that cannot be avoided, adoption of behavioural styles that tend to diminish the quality and frequency of those interactions – staring and glaring at the visible signs of illness, for instance, or peremptory tones of voice, or monosyllabic answers to questions. Typical aversive vices therefore include aloofness, coldness, evasiveness, and rudeness, each of which can create a variety of bad effects – causing upset and distress, for instance, or depriving the ill person of the social and epistemic goods often acquirable only through interpersonal communication. Aversive vices can also manifest bad motives, such as an indifference to the social isolation of other people, an unwillingness to do the moral and emotional work that is often required when dealing with vulnerable persons, or what Carel calls an implacable indifference to those ‘whose life trajectory is different’ (2007:48).

Pathographic testimonies frequently describe the embodied forms of the aversive vices and their objectionable effects and motives. Conway, for instance, describes the ‘grimaces’ of women who glare at her cancered body, which leaves her ‘feeling grotesque’, rather than ‘seen and accepted’ (2007: 136, 147). Carel describes the ‘stares on the street’ occasioned by her oxygen tank and nasal canula, and the blasts of ‘awkwardness’ that chill conversations with colleagues, alongside starker cases that teach her a grim lesson:

[It] is only a matter of time before another person – a drunk on the street or a rude teenager – will say something that will bring tears to my eyes, something that will make the true horror of my condition appear in broad daylight, my carefully constructed but fragile defences crumbling before it. (2007:48)

Such aversive pathophobia is complexly structured by roles and relationships and the social contexts pertinent to such experiences. Drunks and rude teenagers can be dismissed, given the marginal and incidental role they have in our life, but this is not true of those to whom one is more intimately related – friends and family, colleagues, healthcare practitioners, and others on whom one is more continuously and complexly dependent. Carel sadly describes the remorse and disappointment caused by ‘those [friends] who never get in touch, or promise to but never do, of those who call or visit but never talk about the illness’, offering that ‘what is tragic about being ill is this silence’ (2007: 54, 56).

These aversive traits assume the specific status of pathophobic vices because they tend to deprive chronically somatically ill persons of the practical, social, epistemic goods on which they are distinctively dependent. In life at large, even brief conversations can afford flickers of happiness, a sense of security, provide valuable information, and contribute to a sense of belonging in the world. Such small acts of recognition and affirmation as passing greetings can shape the character of one’s day, while subjection to stares and glares can lend to the social world an oppressive character. Taken together, the effects of subjection to aversive pathophobic behaviour can range from anger and frustration to social isolation, diminished mental health, and the entrenchment of painful sense of estrangement from the world.

An interesting feature of the aversive vices is that they can be fed by morally good motives even when they have bad effects. Aversive pathophobia can result from contempt, indifference, and other objectionable feelings and motives, in ways that are obviously bad. But three other sorts of motives are more complicated. To start with, a lot of aversiveness is caused by negative aesthetic responses to illness, such as automatic responses of disgust or revulsion at the appearances, sounds, and odour of diseased bodies. Ehrenreich describes herself as ‘transmogrified’ by her cancer into a ‘puking, trembling, swelling [thing], surrendering significant parts, and oozing’ (2009:68). Many people report genuine difficulties when trying to exercise virtues of care and friendliness with the hesitancy, reluctance, and evident disgust that are their involuntary responses to the bodies of their patients – responses that range from ‘squeamishness’ and ‘embarrassment’ to ‘panic and surprise’ through to ‘terror’ and ‘extreme discomfort’ (Carel 2007:57).

A second source of aversive pathophobia are the variations in people’s interactive preferences and styles depending on the situation, the social context, and the particularities of their relationships to the person with whom they are engaging. Some ill people are happy to talk about their illnesses, for instance, while others are to do so only at certain times or in certain contexts. Some chronically ill people may have a default willingness to converse, that is unfortunately contingent on their constantly changing bodily capacities. Carel notes that a person with a limited lung capacity cannot easily afford the oxygen budget needed for many conversations and much socialising: the oxygen might not be flowing at the same rate as the wine and conversation, which can necessitate either silence or retreat (2007: ch. 4).

A third source of aversive pathophobic behaviour is the interactive difficulties that are often intrinsic to experiences of chronic somatic illness, which often significantly affect one’s speech, memory, attention, stamina, energy, and mood. Conway recalls that during her cancer and its treatment, she had ‘no sense of humour; nothing rolls off my back; I am no fun to be with’ (2007:200). The problem was that she could no longer participate in the norms and practices of typical forms of social intercourse, most of which are premised upon certain levels of bodily and psychological capacity. Think of the typical speed of conversation – about 120 to 160wpm for native Anglophone speakers – or the cognitive complexity of the phenomenon of circumstantial speech, where conversations drift away from, then return to, the original topic.

I suspect that many people who act aversively may have genuine, morally admirable desires to treat ill persons in properly respectful, sensitive ways. But without appropriate social norms and practices to guide their interactions, people freeze in a state of interactive uncertainty and come across as ‘cold’. In these cases, aversive pathophobia would be a case of *backfiring virtue*, of having virtuous motives but vicious effects, owing to an absence of appropriate social guidance on the proper bodily performance of the virtues. The study of pathophobia can therefore reveal the existence of unusual forms of human vice.

2. *Banality cluster.*

The second cluster of pathophobic vices are interesting examples of traits that are usually minor moral failings that are elevated to major moral vices when exercised in the context of chronic illness. The vices of banality include glibness, superficiality, and triteness, which few of us would desire to possess even if equally few would regard them as substantive defects. I propose that what makes these traits into central pathophobic vices is that they all reflect failures to appreciate and honour the existential complexity of lived experiences of somatic illness. Condensed into those nine words is Carel’s characterisation of being ill as a ‘global disruption’ of our ‘habits, capacities, and actions’, the structures of our experience, and the wider integrity and rhythms of ‘the life-world’ (2007:8-9, 45). Such a fundamental alteration of our intermeshed orientation in the world which resonate a person’s experience, agency, and understanding of themselves and the world. It is the fact and effects of failure to grasp the extent and the depth of these alterations which sets up a distinct set of vices of banality.

Pathophobic banality mainly shows itself in ways of thinking and talking about illness and especially in conversational exchanges with somatically ill persons, who often comment on the clichés, bland assurances, and trite pieces of wisdom endemic to many contemporary discourses about illness. Conway recalls things said to her during her cancer and treatment:

Some people recount positive stories of survival. I hear about one woman who had breast cancer and cycles twenty miles a day throughout chemotherapy; another who looked gorgeous the entire time; a third who told no one of her diagnosis and acted as if her life were absolutely normal. Why are these stories not consoling me? (Conway 2009:58)

Banality, in these cases, involved a lack of connection to Conway’s own experiences. By failing to really connect with the particular course and structure of her needs, concerns, and preoccupations, remarks such as those cited as experienced as prosaic, predictable, and facile. Such lack of engagement is also a failure to evince any deep understanding of Conway’s experiences, so vices of banality will include glibness, superficiality, triteness.

Such traits become vicious, when exercised in the context of chronic illness, for two related reasons. First, pathophobic banality has bad effects upon the ill persons, ranging from anger and frustration to a reinforced sense of alienation from others, consistent with an acute sense, reported by Carel, of lived experiences of chronic illness as an ‘encounter between a body limited by illness and an environment oblivious to such bodies’ (2007: 52-53). Second, banality often reflects a fundamental epistemic defect of many persons, namely, a failure to acquire a deeper insight or understanding of the complexities of lived experiences of chronic illnesses. Sometimes, the failure might reflect what Carel calls the ‘obliviousness’ of healthy persons, their ‘inability … to conceive of the lives of others’ (2007:46). Granted, such understanding can be very difficult to acquire, so banality of that sort is not *necessarily* or *automatically* blameworthy. In other cases, banality is rooted in more morally objectionable motives, feelings, and desires, as when Conway reports her suspicion that many people ‘felt compelled to tell me these stories, I think, more for their benefit than mine – to quell the anxiety they felt’ (2007:3).

When appraising banality, one must remember that trite, superficial talk can serve to protect us from confronting the practical, emotional, and existential realities of chronic illness and can be useful for that reason, as many chronically ill persons and their carers well know. The viciousness arises when such banalities are not an occasional feature of discourse about illnesses – an act of pragmatic respite from the flow of overwhelming uncertainty, perhaps – but their continuous and defining feature. As a woman with a chronic illness put it to me:

Above all else, I hate that *fucking* slogan – ‘Whatever doesn’t kill you can only make you stronger.’ I see it *all the time* on T-shirts and on my Facebook feed and on those little planks of wood with inspirational messages that people hang in their kitchens. When people come out with that fucking slogan, they’re ignoring everything that is specific to you as a person. They utter it, then leave you alone (personal communication, original emphasis)

The sense of safety that comes with remaining at the surface level is understandable, when one really confronts the complexity that lies in the depths of experiences of chronic illness, construed as a life-transforming experience. Since the vices of banality confine us to the surface of those experiences, it becomes increasingly impossible for people to appreciate, explore, and describe the inner complexity of what it is like to be chronically somatically ill.

A desire for such existentially deep reportage and discussion of experiences of chronic somatic illness is often accompanied, however, by an ambivalence on the part of many ill persons. Carel says she often desires the sorts of sincere, sustained conversations of this deep sort, but finds that her capacity to participate in them often varies synchronically and diachronically. Moreover, much depends the particularities of her interlocutors and situation, all of which means, in practice, enormous uncertainty. One might prefer ritualised exchanges of banalities, or desire existentially deep exchanges, or, perhaps more likely, seek out some moderate position between those two poles:

If they ask questions, I feel uncomfortable, as if they are prying. If they say nothing, I think they are selfish, self-centred, oblivious to my plight. If it is difficult to talk about illness, it is especially hard for ill people. But what I learned from my illness is that in times of hardship, grief, and loss, there is no need for original, illuminating phrases. There is nothing to say other than the most banal stuff: “I am sorry for your loss”; “This is so sad.” (2007:57)

Setting aside the complex variety of agential and structural sources of pathophobic banality, what is crucial from a vice-theoretic perspective is the character of a person’s responses when realising the fact and extent of their banality. Understanding the phenomenological heterogeneity of experiences of chronic somatic illness across their situationally and culturally specific forms is hugely epistemically demanding (Carel 2016, Svenaeus 2000). But there are ways of trying to reduce the incidences and severity of pathophobic banality that do not require mandated crash courses in phenomenology of illness, such as closer engagement with narrative accounts of illness, sustained challenges to entrenched discourses of banality, and other practices that might help one to avoid inadvertent banality.

3. *Callousness cluster*.

In a striking shift, the ‘angry pathographies’ of the 1980s focused on the common callousness of doctors, nurses, and healthcare systems, while the contemporary narratives by healthcare practitioners – such as Robert Klitzman’s *When Doctors Become Patients* – report deep-seated worries that ‘the system and practice of medical education may facilitate or even exacerbate callousness’ (2007:112). Pathophobic callousness, however, is not confined to healthcare and its agents, but stretches out into every domain of the social world of the somatically ill.

I divide the vices in the callousness cluster into two sub-groups. The *vices of abuse* involve willingness or desire to exploit the vulnerabilities of ill persons, whether for pleasure or self-interest, and so include cruelty and unkindness. Second, the *vices of abandonment* involve failures to feel and enact care and concern for the vulnerable, such as negligence and selfishness, or what Lorde lamented as a ‘stupid, brutal lack of consciousness and concern.’

The vices of callousness are opposed to compassion, gentleness, kindness, sympathy, and the human quality Carel judges to be in ‘greatest shortage’, namely empathy, the virtue or disposition whose absence ‘hurts the most’ (2007:37). The systematic presence of patterns of abuse and abandonment, at the individual and collective levels, is a sad fact of human life, arising partly from our multiply and variably vulnerable bodies and identities, which build into our existence the permanent possibilities of ‘morally dysfunction or abusive interpersonal and social relationships and socio-political oppression or injustice’ (MacKenzie, Rogers, and Dodds 2014: 9). The abuses and abandonments constitutive of pathophobic callousness are specific to the morally dysfunctional experiences, relationships, and socio-political situations of the somatically ill. To borrow the useful terminology of Jackie Leach Scully, experiences of somatic illness always have certain ‘intrinsic vulnerabilities’—such as greater susceptibility to infection or fatigue—while subjection to pathophobia is a ‘contingent vulnerability’, the product of ‘historical and contemporary relationships’, which are shaped by ‘patterns of social, cultural, and political responses’ to oppressed groups (2014: 208, 209).

I want to focus on pathophobic callousness of healthcare practitioners and systems, rather than experiences in the wider social world, for two related reasons. First, shrugging off callousness is harder when it is perpetrated by people professionally charged with your health and treatment, whose conduct ought to evince what two virtue theorists call the ‘allocentric virtues’, traits aimed at ‘intelligent caring about people’, such as attentiveness and generosity (Guilliford and Roberts 2018). Such allocentric virtues are surely professional virtues for those engaged in healthcare practice, since their exercise is definitive of the morally and practically effective performance of their professional duties. Second, concern with callousness is central to narratives by doctors and by patients, to healthcare research and policy, and to wider sets of questions – ethical, legal, political, practical – about patient safety, medical training, and trust in healthcare systems.

Consider Conway’s descriptions of her experiences of hospital care, immediately after her mastectomy, in a chapter poignantly titled, ‘Loss’:

Not a single nurse ever attempts to talk to me. I feel tired, angry, almost frantic. It would be difficult to design a scenario more likely to make a vulnerable person feel out of control. I really need help and get no response. I am as much an object to the staff as is my pitcher of water or my adjustable bed; and even when they respond to my call, I am just another task, not a person in pain (2007:80)

The callousness, here, involves failures to perceive and respond appropriately to her physical and emotional vulnerabilities following three major experiences – her breast cancer, major surgery, and the loss of her breast, all creating entangled feelings of pain, ‘guilt’, and ‘shame’ (2007:93). The coldness, negligence, and indifference of the hospital staff continued until the day she was discharged:

I’m going home, and aside from my surgeons, not one of the hospital staff has spoken to me about the mastectomy, the postoperative adjustment, or what to expect with the healing. No one has even asked me how I am doing. How little it would take to make me feel better (2007:86)

The last remark underscores one of the most painful aspects of callous abandonment – the simplicity of small acts of attention and kindness contrast with their enormous moral effects, even if virtuously allopathic acts are often more demanding, practically and emotionally. Our admiration for those vocationally and professionally committed to caring for others reflects our sense of the demands and the importance of caring. The corollary is that we react more critically to acts of callousness by healthcare practitioners, who are professionally committed as well as morally obliged to exercise the allopathic virtues of intelligent caring.

Although narrative accounts of the callousness of healthcare practitioners sometimes aim to criticise the failings of specific individuals, many avoid attributions of blame and turn instead to the structural conditions – medical training, say, or workplace cultures – that may encourage or necessitate such failings. Confronted with pathophobic vices, one need neither default to blaming, nor remain focused on individual-level explanations, since our character and conduct is deeply shaped by the contingencies of our formation and the suboptimalities of our environments. Consider Carel’s account of an encounter with a sullen, emotionless nurse:

What sort of training has made her able to stand there, saying nothing, offering no word of comfort or distraction? Does she do this every day, to all her patients? Does she feel anything but annoyance towards me? Is this exchange sanctioned by the National Health Service? Does she think of me as a person?’ (2013:47)

Confronted with pathophobically callous acts by healthcare practitioners, one should attend to the social and material conditions of their working environments. Those allocentric virtues usually incur significant exercise costs which cannot always be met by overworked nurses or doctors trying to do work that is practically exhausting, cognitively complex, and emotionally exhausting within an underfunded healthcare system dominated by a target-based culture. Considered in this wider context, concrete individual failings must be understood relative to wider professional and institutional structures – a claim that is obviously compatible with the claim that some callousness people are fundamentally inattentive and negligent.

I have focused on the vices of abandonment, mainly for the reason that they are the most commonly reported kinds of pathophobic callousness reported in the pathographic narratives and testimonies. But what of the morally severer failures that I labelled the vices of abuse? For descriptions of these, one has to turn to a different literature, the medicolegal and policy documents that record acts of sustained cruelty, exploitation, and violence meted out to aged and chronically ill people usually homed in medical and social care institutions. In the United Kingdom over the last decade, a series of high-profile cases of severe breaches of duties of care within National Health Service Trusts led to a 2018 policy review into cases of gross negligence. Named for its chair, Sir Norman Williams, the report found investigation of cases of gross negligence was rare, while prosecution was even rarer (Department of Health and Social Care 2018). A report in the same year by University College London and the Camden and Islington NHS Foundation Trust found evidence of abuse of elderly persons in 99% of care homes (Cooper *et al* 2018). Here one sees patterns of abuse consistent with the worst forms of the vices of callousness that is being caused and exacerbated by structural changes to the UK healthcare system.

The study of the vices of callousness should therefore encompass the vices of abuse and of abandonment and take seriously both their individual and collective forms. I think this is true of all of the pathophobic vices, as explained in section two, but the existing empirical data indicates that agential callousness may be a secondary product of structural callousness – of a wider contingent structure of imperatives, constraints, and pressures that are tending to create healthcare systems that stifle the exercise of allopathic vices and instead establish conditions that increase the frequency of failures of empathy, compassion, and care.

4. *Insensitivity cluster.*

The pathophobic vices often reflect broadly epistemic failings, as when Carel remarks on how many healthy persons are ‘blissfully ignorant’ of the fragility of their health which feeds a sort of ‘obliviousness’ – an inability to ‘conceive of the lives of others’ (2007: 32, 46). It is this obliviousness that particularly underlies the fourth cluster, the vices of insensitivity, the set of failures of awareness and responsiveness to the personal, intimate, distressing nature of chronic somatic illness. Pathophobic insensitivity can manifest in all sorts of ways, from our speech to our facial expressions, attitudes, and actions (a neighbour of mine, shortly after being diagnosed with liver cancer, received a bottle of whisky as a birthday present bearing the message, ‘Now you *have* to share it!’)

Since vicious insensitivity takes many forms, I focus on insensitive forms of speech, specifically upon those that manifest the vices of *prurience* and *tactlessness*, which relate to our practices of questioning and the content and delivery of our speech, respectively. What characterises the pathophobically insensitive person is a tendency to talk in ways that cause anger, upset, and sadness (the effects-forms of the vice) and manifest failures of awareness of the sensitivities of ill persons or to attend properly to the content or timing of their words. The viciousness of insensitivity is clear in Conway’s encounter with a friend – a nurse – who opines that illness must be harder for the elderly because they ‘really know’ they are ‘going to die’:

Doesn’t she know that I also feel that I’m dying? And I have young children. She rambles on, and I sense my rage building. I try to explain the sense of mortality I live with, but she tells me that I sound like her depressed mother. I’m stunned by her insensitivity and cut the lunch short to go home. (2007:200)

Conway is ‘stunned’ due to her incredulity at what is being said, and an acute shock that it was being said by a friend – a trained nurse, no less – who, more than anyone else, ought to afford deep consideration and empathy.

Starting with the rather old-fashioned sounding vice of prurience, this used to refer to excessive curiosity about unwholesome topics, often of a sexual or erotic sort. I use the term more broadly to refer to a desire to acquire inappropriate sorts of epistemic goods, especially concerning the intimate or personal details of a person’s life, such as their bodily health. In its pathophobic forms, this vice includes what’s usually called ‘morbid curiosity’ about the effects of a person’s illness on their body – an epistemic appetite for the graphic and gory details, the grisly and gruesome information that properly belong only to the person and healthcare staff. Such curiosity about ill bodies can be virtuously motivated, of course, if it reflects fascination with the human body or a desire to better understand what a friend might be experiencing in their illness. Prurience, however, often has bad effects and reflects bad motives, which range from public embarrassment (when ‘everyone knows’) to angered indignity (at the violation of one’s privacy) to acute emotional and psychological distress, of the sort described by Carel in her story of a ‘Horrible Man’ she met at a dinner party:

“Oh wonderful!” says the man. “Are you going to have children?”

My heart sinks. The question drops straight into my core and sits there, heavy. My mind goes blank. “No,” I say, in a tone I hope sounds stern enough to ward off any further questions. But he presses on.

“Why not?” he asks. I am beginning to panic, but am not sure how rude I can really be to this man, a friend of our friends. I want to scream at him “because I am dying of lung cancer, you idiot.” I think how illegitimate this question has become for our generation, especially for couples in their mid-thirties, who are either having trouble conceiving or decided not to have children. I also think how personal, how damn personal, the question he is asking is.

I want to hit him. I want to vanish from the table. A storm rushes through my mind.

I say, “Because we can’t.” (2007:45-46)

Unfortunately, despite Carel’s manifest discomfort, the man ‘presses on’, ‘relentless’ in a way she describes as ‘somewhere between sadism and sociopathy’ (2007:46). The viciousness here arises from both the intrusiveness of the questions, the ‘relentless’ insistence, and the man’s insufficient attention to its effects. Indeed, later in the conversation, he comments explicitly on Carel’s dismay (2007:47).

A second vice of insensitivity is tactlessness, a failure to ensure the appropriateness of the timing, topic, and phrasing of one’s utterances, statements, remarks, and other forms of speech with and about illness or somatically ill persons. In pathophobic cases, the failure isn’t a lack of articulacy, relevancy, or other Gricean norms, although those may play a role. Instead the viciousness lies in the failure of attention and consideration about the effects of what one says and how and when one says it upon ill persons or those otherwise concerned deeply with illness (if, say, the audience includes the parents of a chronically ill child, for instance).

Carel offers a vivid instance of pathophobic tactlessness:

Several times when I told people about my illness they asked, “So how long have you got?” The question always left me gasping for air, as if I’ve been punched in the stomach. After overcoming my horror at the casualness with which the question was asked, I wondered why they wanted to know (2013: 144)

Treating chronic somatic illness ‘casually’ is a failure to appreciate or acknowledge its severity by using modes of speech that register the urgent seriousness of the information. Tactfulness often involves careful circumspection and thoughtful phrasing rather than reliance on loosely idiomatic language whose casualness fails to cohere with the seriousness of the situation.

Carel proposes that much insensitive speech arises from a general thoughtlessness on the part of ‘oblivious’ healthy persons, who fail to anticipate in advance the insensitive nature of what they speak until they hear themselves saying it:

I remember telling an old friend about my illness and how much I deteriorated in the past year […] When I told her I lost nearly 50 per cent of my lung capacity over a short period, she looked at me and said: “so if you lose about 50 per cent next year …” It took me a long time to regain my composure that day. I never discussed my illness with her again (2013: 67-68)

The vices of prurience and tactlessness are just two of those in the insensitivity cluster, which encompasses a range of intermingled affective, epistemic, and ethical failings – indiscretion, impassivity, and thoughtlessness, for instance. Such vices evince a failure to recognise or know the actual or probable sensitivities of the somatically ill and lack of sense enough to act toward them in appropriately responsive, sensitive ways.

5. *Untruthfulness cluster*.

Susan Sontag starts her essay ‘Illness as Metaphor’ by declaring her a desire to find a ‘truthful way of regarding illness’ (1978:3). Truthfulness devolves into a set of ‘virtues of truth’, defined by Bernard Williams as the ‘qualities of people that are displayed in wanting to know the truth, in finding it out, and in telling it to other people’ (2002:7). Williams offers two – accuracy and sincerity – which must be augmented by the virtues of truth described by Lorde, which enable us to ‘scrutinize not only the truth of what we speak, but the truth of that language by which we speak it’ (1997:31). Pathophobia can include failures to be truthful about the complexities and heterogeneity of experiences of somatic illness and, in particular, their various ‘dark sides’ – the anxieties, despair, frustration, loneliness, sadness, and the fact that these often yield no positive personal goods and find no satisfying resolution.

The pathophobic vices of untruthfulness range from failures to desire, discover, or tell the truth about own or others’ experiences of illness, or actively discouraging and interfering with such efforts on the part of others. I’m not suggesting ill persons must blurt out each and every detail of their experiences, nor that they are obliged to act as ‘witness [to] some of the realities of illness’, as Arthur Frank describes the aim of pathography (2002:5). Untruthfulness about illness arises when people do engage in pathography by providing their own testimonies or by engaging with those of others, whether through books, support groups, online fora, or during conversations. I therefore focus on vices of untruthfulness as they manifest in pathography, a striking case where pathophobic attitudes and behaviour are most visible among ill persons.

A powerful study of pathophobic untruthfulness is *Smile or Die*, a book by the medical writer and cultural critic, Barbara Ehrenreich, which explores the ‘ideology of positive thinking’ increasingly entrenched within American culture. Her central concept is that of ‘bright-siding’, a determined tendency either to deny or the ‘dark sides’ of aspects of human life – sickness and poverty, sat – or to insist that they are outweighed by the ‘bright-sides’, thereby glossing over their negative realities in conformity with a narrative of triumphal optimism that insists upon the ‘triumph of attitude over circumstance’ (2009:150). Ehrenreich was inspired to write the book partly as a result of her own experiences with breast cancer, whose discourses were suffused with a monotone optimism which she elected to test, one day, with a post on a forum entitled ‘Angry’. Her statements of angry at chemotherapy, insurance companies, and ‘sappy pink ribbon cultures’ were met with near-unanimous content and tone policing by the women on the forum:

“Suzy” wrote to tell me, “I really dislike saying you have a bad attitude towards all of this, but you do, and it’s not going to help you in the least.” “Mary” was a bit more tolerant, writing, “Barb, at this time in your life, it’s so important to put all your energies toward a peaceful, if not happy, existence. Cancer is a rotten thing to have happen and there are no answers for any of us as to why. But to live your life, whether you have one more year or 51, in anger and bitterness is such a waste […] I hope you can find some peace.”

This is the aggressive form of bright-siding that aims to confine and control illness discourses by active policing of their content and tone. Ehrenreich’s truthful reports of the ‘dark sides’ of her cancer were interdicted, since their did not conform to the norms of optimism and triumph governing that discourse. The operative vices here include myopia and dogmatism, the related failures to admit certain pertinent dimensions of experiences of illness and defensively resist efforts to change the scope of the discourse.

The heterogeneity of experiences of illness means untruthfulness can take many forms and many of these are usefully captured by the concept of ‘bright-siding’. Sometimes, there is a denial of the ‘dark sides’ of illness, a refusal to admit the bitterness, frustration, and sadness incurred by, for instance, the friends who never call back or the permanent loss of one’s hopes for a family or a career. Sometimes, the dark sides are acknowledged, but only if they can then be reclaimed within a narrative of triumphant reckoning with adversity. When the old friends stop calling, the initial sadness is soon replaced by the newer, better relationship one forms in the support group. After the diagnosis, one becomes resentful at the body that ‘betrayed’ – every tumour a ‘traitor’ – but then, after a while, one comes to feel more at home than ever within one’s skin. In such cases, one sees the logic of ‘bright-siding’ – of ‘battles’ that end in victory, never in defeat, of journeys that are completed but never abandoned, of suffering that always transforms one morally for the better (there is a genre of pathographies that use the metaphor of cancer as a gift, one that ‘gives’ more than it ‘takes’, to the point of being ‘the gift that keeps on giving’).

Such cultures of ‘bright-siding’ encourage the vices of untruthfulness because they are hostile to truthful reportage of the complexity of experiences of somatic illness, especially the negative aspects and ‘dark sides’. The content of pathographic testimonies is made to conform to the rigid dictates of optimism, heroism, and triumphalism, whether by omitting those dark sides or glossing over them, maybe by downplaying their awfulness and inflating or inventing their ‘bright-sides’. The consequences are systematic failures of truthfulness about the variety of experiences of chronic illness, since to tell the truth about what it is like to be ill often means attending to the dark and the bright sides. Some experiences of illness are positive and deeply edifying and acknowledging this is a truth about illness worth telling (Brady 2018, Kidd 2012). But most experiences of illness as complexly textured and resist accurate, sincere description within the artificial strictures of ‘bright-siding’. The vices of dogmatic optimism and myopia preclude the sorts of complexly discerning descriptions of most actual experiences of illness of the sort one needs for a properly truthful effort for what Sontag and Frank called a ‘more truthful’ attempt to ‘bear witness’ to living with illness.

A full analysis of the vices of untruthfulness is a complex task since they are motivated in so many ways and scaffolded by so many features of our societies. A natural fear of death, the difficulties of honesty, the understandable preference of publishers and readers for happy endings, the entrenchment of cultural and religious narratives that promise that suffering will be rewarded – to name just a few. It seems clear that truthfulness about illness requires us to acknowledge and confront the existentially disturbing realities of what it means to exist within forms of mortal existence whose fragility arises from our intrinsic embodied vulnerability and the contingent vulnerabilities arising from our dependence on a social world whose members and structures often respond to that fragile matrix of vulnerabilities with the variety of failings that constitute pathophobia. Truthfulness about our inherent embodied vulnerability and our awkward situation as perpetrators and subjects of pathophobia ought to be a main aim of any serious humanistic philosophical engagement with illness (see Ferry-Danini 2018, Kidd 2017b).

**Conclusions**

This paper introduces the concept of pathophobia to describe the range of objectionable sorts of treatment to which chronically somatically ill persons are typically subjected, whose wrongs can be analysed effectively using a vice-theoretical framework. I argued that we can usefully think in terms of five main clusters of pathophobic vices and failings, illustrating them with the testimonies offered by some influential illness narratives. Such vices can be objectionable due to their typical effects or their underlying motives and values, or they might be doubly vicious. It should be clear there is a lot of future work, too, which should include studies of structural pathophobia, investigation of specific vices and clusters, and the development of ameliorative strategies.

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1. I’m grateful to Rachel Handley for suggesting this cluster. [↑](#footnote-ref-1)