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Dancing in the Street: Convivial Medicine at the End of Normal

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> *One of the really hard issues, and it is a cultural issue, we don't need to think of everything as pure material politics, but can the kind of changes we're talking about feel to people not like austerity but as some kind of moral crusade, can they feel somehow nourishing instead of depriv[ing]?"*[1] *–Ezra Klein*

Ivan Illich, the prominent 20th century Jewish-born Catholic priest, insightfully submitted modern Western medicine to deep critique based on its own stated goals and values. A polyglot European educator, writer, and cultural critic, his growing dissatisfaction with the trajectory of institutional and cultural life coalesced in the 1970's around the concept of *nemesis*. As in its eponymous Greek myth, the phenomenon of nemesis refers to the human tendency to overshoot and pay a price. Illich argued that, after finding incomplete success in an endeavor (e.g. improving health), we do not reconsider or refine our method but blindly intensify the efforts by which we first attempted the task, thereby endangering the very good we attempted to augment. Illich perceives "this self-reinforcing loop of negative institutional feedback"[2] in multiple fields: 'education' threatens genuine learning, 'transportation' threatens autonomous movement, and industrial medicine threatens health.[3] Indeed, the contemporary interlocking crises of, inter alia, the COVID-19 pandemic, looming climate collapse, neoliberal social atomization, and rising

[1] Wendy Brown and Noah Smith, interview with Ezra Klein, "Neoliberalism and its discontents," *The Ezra Klein Show* (Vox), podcast audio, October 24, 2019, https://www.stitcher.com/podcast/vox/the-ezra-klein-show/e/64811077.
[2] Ivan Illich, *Medical Nemesis*, (New York: Pantheon Books, 1976), 34.
[3] Ivan Illich, *Tools for Conviviality* (New York: Harper & Row, 1973), 7-8.

authoritarianism all share a common nemesis character; any movement beyond the deadly 'normal' which led to the present moment must both analyze its roots and offer convivial alternatives. In this paper, I argue that Illich's thought offers a cogent analytic lens for contemporary social challenges and that his concept of conviviality helps us to reimagine medicine for passage through the current confluence of crises, offering a new imagination for how medicine may participate in a hoped-for world of flourishing.

Illich's critique is elucidated and contextualized by Gerald McKenny's historical framing of modern medicine. McKenny describes how the modern thought, especially in the work of Rene Descartes and Francis Bacon, shifted medicine's thought structures and values. No longer was medicine the pursuit of health contextualized within a larger pursuit of a good life, itself possible only within limits set by fate and finitude; medicine instead becomes the imperative to "eliminate suffering and to expand the realm of human choice – in short, to relieve the human condition of subjection to the whims of fortune or the bonds of natural necessity."[4] At first glance these goals do not seem objectionable, yet this philosophical conception of medicine has unintended negative consequences. McKenny claims contemporary philosophical bioethics is uncritically engaged in this 'Baconian project' and thus unable to provide perspectival distance. McKenny's hesitancy in using the professionalized and mainstream language of the field is helpful as we consider reading McKenny's helpful description alongside Illich's critique. McKenny's account offers a complementary account of an Illichian philosophical threshold contemporary medicine has overstepped. Most importantly, bringing these two critiques of modern medicine into conversation will let us begin to construct a vision of 'convivial'

[4] Gerald McKenny, "Bioethics, the Body, and the Legacy of Bacon," in *On Moral Medicine: Theological Perspectives in Medical* Ethics, ed. M. Therese Lysaught and Joseph Kotva (Grand Rapids, MI: William B. Eerdmans, 2012), 398.

medicine, which uses the best of modern medicine while submitting it to higher values that transcend it and are buried within its long tradition. Illich aids us in retraining our vision of medicine. The future of medicine must be neither a return to the past, nor an intensification of the processes of the present.

In part I, we will consider issues facing modern medicine and their interlocking social problems, consider the importance of limits in Illich and McKenny, and draw out Illich's critique of tools and tool culture. Pivoting, part II explores Illich's concept of conviviality and its centrality in facing any one of the major social challenges he considers. Finally, part III considers what a convivial medicine would entail: its ability to meet the challenges of (medical) nemesis, its requirements for change in our institutional, social, and professional conceptualizations, and its call to finally be true to medicine's role of healing and not harming.

I. Limits and Tools

American medicine is experiencing the erosion of gains in vital statistics, increasing costs, a small political discursive field for changes, and a restrictive philosophical imagination. The average life expectancy at birth in the United States has decreased since 2016 and is primarily driven down by overdoses, liver disease, and suicide, the so-called "deaths of despair."[5] American healthcare spending has reached approximately 18% of GNP,[6] nearly double that of its rich industrial peers. While the United States spends significantly more for a variety of unique historical, commercial, and political reasons, its rate of annual increase is

[5] Saiidi Uptin, "US Life Expectancy Has Been Declining. Here's Why," *CNBC*, July 9, 2019. https://www.cnbc.com/2019/07/09/us-life-expectancy-has-been-declining-heres-why.html.
[6] "National Health Expenditures Data (Historical)," Centers for Medicare & Medicaid Services, December 11, 2018, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

comparable to peers and is driven by such universals as increasingly expensive medical technologies.[7]

In American political discussion, 'health' is reduced to 'healthcare', and 'healthcare' reduced to 'healthcare access' (or insurance coverage). Mainstream political opinion is primarily concerned about inclusion and access. Medicare for All, a popular progressive political position, and the Affordable Care Act both aim to increase healthcare coverage. Conservative opponents to these positions would prefer to decrease the costs associated with medical care or insurance, thereby hoping to increase its availability. Both imaginations are constrained by the focus on access. Yet this approach does not align with empirical data. The contribution of restricted health care to premature death and unwanted health outcomes is only roughly 10%, and is greatly outweighed by behavioral and structural influences.[8] For the obvious importance of healthcare in the lives of individuals, our conceptions what leads to health must be much broader.

Medical advances are often assumed to have caused our general increase in life expectancy and decrease in mortality. Yet, Illich informs us that it was as late as the 1910's that a generic patient (with a medically recognized disease) would be more likely than not to receive a specifically effective treatment from a physician.[9] Thomas McKeown's careful historical study of recent centuries has determined that the influence of medical intervention on disease process was not the driver of the population-level improvements: "The improvement of health during the past three centuries was due essentially to provision of food, protection from hazards, and limitation of numbers."[10] With the additional factor of lifestyle in developed countries, these four

[7] Daniel Callahan, *Taming the Beloved Beast: How Medical Technology Costs Are Destroying Our Health Care System* (Princeton, NJ: Princeton University Press, 2017).
[8] Robert M. Kaplan and Arnold Milstein, "Contributions of Health Care to Longevity: A Review of 4 Estimation Methods," *The Annals of Family Medicine* 17, no. 3 (2019): 267–72, https://doi.org/10.1370/afm.2362.
[9] Illich, *Tools for Conviviality*, 1.
[10] Thomas McKeown, *The Role of Medicine: Dream, Mirage, or Nemesis?* (Princeton, NJ: Princeton University Press, 1979).

together will continue to be the primary drivers of health and disease in the future. The progress in increased life expectancy and decreased mortality had largely preceded the advent of the powers of modern medicine. While even in an ideal environmental and behavioral milieu medicine has a beneficial role, the fact remains that historically, medicine cannot be cast as the health's only, or even the most powerful, beneficent force. The larger dynamics and crises which threaten individual and community health must be included into medicine's analytic and therapeutic framework if it is to do justice to its pursuit of health and flourishing.

Medicine's current self-conception, however, is not limited to merely being providers of health, even in a limited way. Since Rene Descartes and Francis Bacon, medicine has taken on the tasks of furnishing choice and relieving suffering as its primary objective. [11] Contemporary medicine does have an expanded imagination as to its role, but it is, at present, focused on the wrong moral pursuit. As McKenny, following Charles Taylor, recounts, European Protestantism began to see ordinary life as theologically as valuable a vocation as previously had been restricted to priestly or monastic vocations in Catholicism; this is reflected in the wide contemporary use of the word 'vocation'. The work of ordinary life is that which meets the needs of one's neighbors, and if one desires to be disciplined and effective in one's work, what is ultimately required is an instrumental approach to nature to fulfill this new moral project. It was for this reason Bacon praised the mechanical arts over the speculative. The medieval conception of teleologically-ordered nature shifted to a Protestant vision of creation as a law-governed mechanism susceptible to human control and neutral regarding ends. The Baconian project is then the fulfilment of Protestant moral and religious aspiration, even as other secular Enlightenment figures like Jeremy Bentham and Thomas Newton stripped the theological

[11] While this section largely follows McKenny's critique, Illich also highlights Francis Bacon as a pivotal figure. Cf. Illich, *Tools for Conviviality*, 30.

justification and radicalized Protestant instrumentalism. Good and evil become simply equated to pleasure and pain, and thus the relief of suffering becomes a moral obligation. The new mechanical and value-neutral worldview both requires the elimination of suffering and makes it possible. Three major changes emerge: first, the body becomes not a source for the practice of wisdom but rather technical control; second, health becomes an end in itself (along with the elimination of suffering) rather than a constitutive part of a virtuous, good, and integrated life; and finally, rules or prohibition over what is to be done with the body are considered (cruelly) insensitive or arbitrary in the face of a potentially curable disease.[12]

Without restraint on the unleashed powers of medicine, the human person becomes an object of technique and control. Further, the imperative to relieve suffering combined with a Romantic notion of the unique creativity of the individual means medicine should "eliminate whatever anyone might consider to be a burden of finitude or provide whatever anyone might require for one's natural fulfillment."[13] A grand project to relieve unnecessary pain has turned into justification for an extension of medicine's authority into new areas of life. This view of human life, while purportedly neutral, carries significant philosophical content. Ethically and empirically, medicine's project and self-conception are not as simple, beneficent, and neutral as they may appear.

McKenny's intuition of the role of limits is more clearly seen through the conceptual framework Illich developed. For Illich, a trajectory of development is charted in relation to two historical watersheds. After the first,

> new knowledge is applied to the solution of a clearly stated problem and scientific measuring sticks are applied to account for the new efficiency. But at a second point, the progress demonstrated in a previous achievement is used as a rational for the exploitation

[12] McKenny, "Bioethics, the Body, and the Legacy of Bacon," 400.
[13] McKenny, "Bioethics, the Body, and the Legacy of Bacon," 401.

> of society as a whole in the service of a value which is determined and constantly revised by an element of society, by one of its self-certifying professional elites.[14]

In medicine, Illich frames these as roughly 1913 and 1955: in the beginning, water was purified; aspirin, quinine, and sterile surgeries controlled disease; and fresh air, exercise, a balanced diet, and hygiene were popularly linked to health. Yet since roughly the middle of the century, while there have been true breakthroughs for many diseases and conditions, the medical establishment's success was now measured by its own hand (increased discoveries, and increased costs), and the social costs of medicine's monopoly rose:

> The second watershed was superseded when the marginal *dis*utility increased as further monopoly by the medical establishment became an indicator of more suffering for larger numbers of people … Society can have no quantitative standards by which to add up the negative value of illusion, social control, prolonged suffering, loneliness, genetic deterioration, and frustration produced by medical treatment.[14]

Resonating with McKenny's concerns of medical materialism overrunning traditional limits, Illich's *Medical Nemesis* describes medicine as past the second threshold injuring health in three specific arenas: clinical iatrogenesis, social iatrogenesis, and cultural iatrogenesis.

Most immediately, clinical nemesis describes the increasing number of side effects and direct or indirect physician-caused suffering. This is concomitant with the increasing power of biomedical intervention. Beyond the side effects of desired treatment or the varieties of malpractice, clinical iatrogenesis also includes the unnecessary care given to avoid litigation.[15] Medicine also shapes society socially: some who now survive can only live in institutions, while others with medically-endorsed symptoms are exempted from work and from a political struggle to reshape the conditions which made them ill. Finally, the most subtle effects are found in the broad cultural sphere. As industrial medical language and technique becomes our exclusive

[14] Illich, *Tools for Conviviality*, 7.
[15] Illich, *Medical Nemesis*, 32-3.

language and means of relating to its subject, individuals are unable confront their human weakness, vulnerability, and uniqueness in a personal and autonomous way. This paralyzes healthy responses to suffering, impairment, and death. 'Better health' is not an engineered product.

Illich is clearly interested in matching our proper human finitude and autonomy to the systems and tools we create, and for all his critical language he is not completely skeptical about technology. His dating the moment of the second watershed to 1955 is likely too early and too precise. Nevertheless, he identifies the second half of the 20th century as the moment when many fields crossed the second threshold and beginning to threaten six areas: the ecological environment on which we depend, the right to convivial work, human creativity (through required overprogramming for an artificial environment), the right to participatory politics, and the right to tradition through enforced obsolescence, and genuine equanimity (through pervasive frustration from engineered satisfaction).[16] Thus, his analysis of medicine is inseparable with analogous phenomena in other realms which have converged in the interlocking present crises. Philosophically modern modes of thought, in some sense inaugurated by Baconian and Cartesian thinking, placed too much emphasis on the linear regimes of progress, ceaseless growth, and control. These trajectories allowed for the overstepping of the crucial limits which delimit the possibilities for human and non-human flourishing.

Moreover, one of the distinctive features of Illich's convivial thought is his critique of the tool. By comparison, McKenny describes our tool use as secondary to our philosophy, for "modern technology does not render traditional moralities obsolete … so much as it expresses and carries out an existing (modern) morality."[17] Illich would reverse the priority, for his

[16] Illich, *Tools for Conviviality*, 47-8.
[17] McKenny, "Bioethics, the Body, and the Legacy of Bacon," 402.

"subject is tools and not intentions" and would focus "on the structure of tools, not on the character structure of their users."[18] Tools are not neutral; they have distinct input systems and output systems, and are built to be operated in specific ways. Tools have an intrinsically social, and therefore ethical, character:

> To the degree that he masters his tools, he can invest the world with his meaning; to the degree that he is mastered by his tools, the shape of the tool determines his own self image. Convivial tools are those which give each person who uses them the greatest opportunity to enrich the environment with the fruits of his or her vision. Industrial tools deny this possibility to those who use them and they allow their designers to determine the meaning and expectation of others.[19]

Tools, defined broadly enough to include screwdriver, factory, or social institution, should be designed to allow its members autonomous action by means of tools least controlled by others. The modern dream of machines as mechanical slaves to replace human labor was more literal than metaphorical; humans are not meant to be slaveholders, and justice is not an equal distribution of slaves.[20] Ideally, humanity would work *with* its tools instead of tools working *for* their owners.[21]

Non-convivial industrial production, favoring centralization of control, generally requires a small number of credentialed professionals with the liberty of its use; contra Marx, the issue is primarily not the ownership of said tools.[22] The threat is that their inputs and outputs come in such large quanta that, for Illich, they threaten healthy human society. Only inhumanly large, technical, and standardized organizations are able to arrange the inputs and handle the outputs. A simple example would be the way that large-scale and destructive monoculture farming facilitates and requires such large plots of land, abundant fluxes of fossil fuels, and complex

[18] Illich, *Tools for Conviviality*, 14-5.
[19] Illich, *Tools for Conviviality*, 21.
[20] Illich, *Tools for Conviviality*, 20.
[21] Illich, *Tools for Conviviality*, 10.
[22] Illich, *Tools for Conviviality*, 26, 42.

agricultural equipment such that human-scale farming – much more in touch with the possibilities and limits of land and community – is effectively prohibited. Another example is the way in which industrial production modernizes poverty. Illich recounts how a Mexican campesino could *house* himself well enough, but is too poor to purchase standardized *housing*; thus, housing becomes not an endogenous activity but an identifiable 'problem' for managerial control.[23] He is thus furnished housing (or not) by government social programs and, if so, must receive social work visits to learn to appropriately live in public housing. This dependency becomes hereditary as his children lose the skills to house oneself.

Industrially created needs and products (e.g. education, transportation, housing) are too expensive for all but the rich, and yet they threaten everyone's ability to learn, move, and house oneself, and threaten the six previously mentioned arenas (resilient ecology, convivial work, human creativity, participatory politics, tradition, and equanimity). Moreover, industrialized products are homogenized; roads, hospitals, classrooms, apartments, and stores across the world look the same.[24] Their homogenization of personality and relationships flatten the resplendent diversity of culture. Non-convivial tools, finally, can exert a 'radical monopoly': any specific automotive company may not have a monopoly, but the car-road system itself does. Fast cars eventually require freeways which cut off other forms of traffic. Thus, industrialized *transportation* prohibits a farmer's natural *movement* to his field, or a student's movement to class, by bike or by foot. Although admitting the necessity and desirability of certain industrially produced goods (if their social cost is not too high), Illich nevertheless proposes we pursue a balance tipped towards primarily non-exclusionary, democratic tools for human flourishing. Convivial tools generally multiply human force, are broadly accessible, and do not destroy

[23] Illich, *Tools for Conviviality*, 39.
[24] Illich, *Tools for Conviviality*, 15.

human sociality. While he explicitly offers a method to analyze tools instead of an itemized list, tools such as (powered or unpowered) bicycles, public transportation, telephones, sailing ships, the mail system, libraries, and open-source laboratories would be considered convivial. The creation of the internet was influenced by Illich's writings. At the speed of a bicycle or sailing ship (Illich's proposed maximum speed), one can still travel around the world in forty days.[25] Compulsory standardized education, nuclear reactors, strip mines, and multilane highways are not convivial, for they hinder social interaction and stifle autonomous capability.

II. Conviviality

Yet, who has forty days to travel around the world? While Illich denies being utopian, as we have seen he offers 'conviviality' as a desirable trait in tools. It is also the criteria for larger social flourishing. Conviviality is not only possible and desirable, it is necessary for the survival of our culture:[26] "A convivial society is one in which people *eat*, people die when they are *fed*," [27] which is to say when they are made dependent on inhumane systems which flatten the world and are unresponsive to the dynamics of genuine life. At present, our world is "divided into those who do not have enough and those who have more than enough, those who are pushed off the road by cars and those who drive them."[28] As he presciently foresaw, this takes special meaning when rich minorities (of people and countries) cause most ecological damage, yet the poor majorities are those who will most suffer. As it stands, our world will not survive if the poor become rich, a reality which negates the dreams of mainstream economics, the basis of which is

[25] Illich, *Tools for Conviviality*, 82.
[26] Illich, *Tools for Conviviality*, 44.
[27] Illich, *Tools for Conviviality*, 44.
[28] Illich, *Tools for Conviviality*, 15.

the logic of indefinite exponential growth on a finite host – the same logic shared by cancer. The hope for rich and poor alike is conviviality.

A convivial society's members "know what is enough [and] might be poor, but … equally free," able to enjoy the "sober joy of life in this voluntary though relative poverty."[24] Warped industrial minds may have a hard time imagining this world of "rich texture of personal accomplishments, within the range of modern though limited tools … a society in which members are free from most of the multiple restrains of schedules and therapies now imposed for the sake of growing tools."[24] Yet just as premodern Thai rice farmers seasonally rested during the dry season, a convivial society "that can afford long holidays and fill them with activities is certainly not poor" in what matters most.[29] As Illich foresaw, a world of justice, discovery, community, and beauty is pursuable. It is one of creative exchange among persons with each other and environment, instead of the conditioned responses made upon one by others in a man-made environment eventually ending in the "amorphousness and meaninglessness that plague contemporary society."[30]

It should be clarified, however, that while this is a departure from economic dreams of unlimited wealth, it is certainly not what we know as 'austerity,' the enforced social reality of neoliberalism. Yet, a decreasing GNP and 'degrowth economy', which climate scientists say is necessary to avoid ecological catastrophe, accompanies this shift from exchange-value to use-value.[31] Planning for such a future is not the domain of a professional elite but must reflect democratic political control over tools and institutions.[32] Societies, just like tools, are to be

[29] Illich, *Tools for Conviviality*, 38.
[30] Illich, *Tools for Conviviality*, 11.
[31] Jason Hickel and Giorgos Kallis, "Is Green Growth Possible?" *New Political Economy*, 2019, 1–18, https://doi.org/10.1080/13563467.2019.1598964.
[32] Illich, *Tools for Conviviality*, 12.

judged by survival, justice, and self-defined work leading to participatory and distributive justice.[33] Human self-image and imagination must be liberated from the present structure. To merely intensify current efforts is the deep logic of contemporary 'normalcy,' a deadly logic.

III. Convivial Medicine

Can medicine have a convivial future at the "end of the world"? Answering this requires the admission that the end of the world seems to be already here. This paradoxical situation, as Timothy Morton has described, requires an ethical

> strategy […] to awaken us from the dream that the world is about to end, because action on Earth (the real Earth) depends on it. The end of the world has already occurred.[34]

As our multiple crises have shown, we are not approaching the cliff (most worryingly, of climate collapse) so much as already falling; we must awaken to that reality and act ethically in light of it. An ethical approach cannot act with the optimism of preventing the end of the world, nor the pessimism our situation suggests. Rather, it walks in hope by resisting systems of death and finding a way through them in community, minimizing further damage, gingerly stepping through the wreckage, and dancing a vision of flourishing and beautiful interrelation into being. For Illich, three obstacles stand in the way of ethical and convivial progress: the idolatry of science, the corruption of ordinary language, and the loss of respect for the process by which social decisions are best made.[35] Even in light of its many benefits, it is clear that widespread, intensive, expensive biomedicine will not guarantee health; the hospital is not a factory of good health. As has been implied, ordinary language, not technical jargon, must be the lingua franca of

[33] Illich, *Tools for Conviviality*, 13.
[34] Timothy Morton, *Hyperobjects: Philosophy and Ecology after the End of the World*, (Minneapolis: University of Minnesota, 2013), 7.
[35] Illich, *Tools for Conviviality*, 85.

public discourse on medicine. Finally, a truly democratic process must determine medicine's course and role; professions (to be clear, not professionals) have often been more invested in cementing their continued legitimacy when it conflicts with their public mandate. Community members and community health workers should sit on the boards of healthcare institutions like medical school and hospitals, and outnumber their physician peers. Human rights, interrelated flourishing, solidarity, justice, and dignity must serve as the deep values instead of profit and prestige. Dignified medical care should be considered a human right and provided as such, with this right vociferously protected by healthcare professionals. If private medical systems continue to exist, they should be owned primarily by the healthcare workers themselves, cooperatives, or communities themselves instead of finance capitalism.[36] Yet the institutions of medicine are not the only culprit, for patients must also change their expectations of healthcare.

In Illich's *Medical Nemesis*, human societies must grapple not only with neighbor and nature in its search for flourishing and health, but also with the myths through which they understand the world.[37] McKenny focuses on the creation of a community to recognize the limits of medicine and weaves sacred narratives of the good life enabling a loving community and resisting popular norms.[38] However, Illich believes we are past mythic justification (religious or ecological) and must rationally realize we would be "happier if [we] could *work* together and *care* for each other."[39] Illich's suspicion about the general utility of exclusivist narratives in a moment of crisis is appropriate. To take merely the example of religion, it is impossible to expect religious individuals and communities to become secular, or vice versa. Nevertheless, modernity

[36] Contemporary examples of such inspirational institutional models include the Basque Mondragón model, the Italian co-operative movement in northern Italy and Emilia-Romagna, the integrated and publicly-funded Harris Health System, Cooperation Jackson in the state of Mississippi, and in Latin America, Cecosesola.
[37] Illich, *Medical Nemesis*, 261.
[38] McKenny, "Bioethics, the Body, and the Legacy of Bacon," 407-8.
[39] Illich, *Tools for Conviviality*, 50.

has not flattened and secularized societies as it globalized them, as the once-popular secularization thesis suggested. Meaning-making traditions will continue to stimulate activity and create traditioned, coherent, moral communities. Thus, convivial alternatives require rooted, yet open, sacred narratives. I suggest Nicolas Wolterstorff's description of *shalom* as a thoughtful orienting concept for animating and directing social change, action, and research:

> The goal of human existence is that man should dwell at peace in all his relationships: with God, with himself, with his fellows, with nature, a peace which is not merely the absence of hostility, though certainly it is that, but a peace which is at its highest is *enjoyment*. … A condition of shalom is justice, and a component in justice is liberation from oppression. Never can there be shalom without justice. Yet shalom is more than justice. Justice can be grim. In shalom there is delight.[40]

Though it emerges from Jewish and Christian theological tradition, *shalom* is comprehensible and accessible to all and serves convivial imaginations by critiquing present failures in light of a rich and nuanced vision of flourishing.

Medical research may begin to change by taking up what Illich's terms 'counterfoil analysis,' which weighs increasing marginal disutility against growth, and discovers general institutional approaches to optimize convivial production. Counterfoil analysis relates society and its tools and holds the consequences of their use before the public eye.[41] In a convivial medicine, there would still be room for bioscientific non-convivial research, yet its goals must be pursued by community-led and shalom-oriented processes. The most prominent and supported area of research is one that is a nonpriority in contemporary research: 'appropriate' or 'intermediate technologies' as described by E.F. Schumacher in *Small is Beautiful*.[42] Being people-centered, such technology is decentralized, environmentally benign, inexpensive,

[40] Nicholas Wolterstorff, *Reason within the Bounds of Religion* (Grand Rapids, MI: Eerdmans, 2009), 114.
[41] Illich, *Tools for Conviviality*, 82-3.
[42] E.F. Schumacher, *Small is Beautiful: Economics as if People Mattered* (New York: Harper Collins, 1974).

autonomously built and operated, open source, and small-scale. As an example, Practical Action is a non-profit which designs intermediate technology and does quality engineering for conviviality instead of high-dollar high-tech industrialism. Analogously, appropriate medical research would focus on areas such as nutrition and agriculture, appropriately scaled medical technology, active transportation, community building, built and natural environments, and behavioral change. This would be much better suited to the true determinants of human well-being.

The structures of medicine and role of a physician would also be recognizable but altered. The Kerala model of healthcare, with its focus on education, primary health care, nutrition support for infants and new mothers, and universal health care financing bucks international trends: its population is that of California, its annual per capita income is roughly $300, its size is that of Switzerland, yet its nearly universally literate population lives almost as long as anywhere in the Global North.[43] Similarly, Costa Rica has community-based teams of public health workers, nurses, and physicians who are geographically assigned and cover the whole population. The Cuban healthcare system assigns primary physicians to a distinct neighborhood with a small medical office to serve its residents.[44] We do need secondary and tertiary care hospitals and the specialists and surgeons to staff them, but this must be demoted to a minor (yet legitimate) form of medicine. The paradigmatic physician must be communally embedded: conversing, diagnosing, and treating, rather than a subspecialist institutionally holed away with the newest technology. Her vocation includes empowering the community to take care of its own in a real sense, and thus to spend a significant amount of time educating, collaborating, and

[43] Bill McKibben, *Hope, Human and Wild: True Stories of Living Lightly on the Earth* (Minneapolis, MN: Milkweed Editions, 2007).
[44] A common theme between these examples is their attempt to practically enact the human right to health.

capacity-building – this is medicine as an enabling profession. The ratio of primary care to specialists would dramatically shift as would their pay, but this is only a minimal beginning. Illich goes so far as to endorse the "progressive expansion of lay therapy and the parallel progressive reduction of professional medicine."[45] One may apprentice modern "barefoot doctors" as lay extenders,[46] increase the number of Community Health Workers via New Deal/Works Progress Administration-like programs, and build on the "Friendship Bench" model of easily-accessible mental health interventions. Bonds across various divides would be built for mutual education, financial support, and service to one another.

For Illich, the practice of basic medicine may not be limited to the credentialed employees of corporation or state – for medicine is not to be the final arbiter of health. As a physician-in-training, this lack of credentialing worries me (there are many abuses that can be prevented by professional self-policing) but his challenge still stands: there must be a vision of the healing profession(s) beyond self-interested monopolistic exclusion by a professional group. Amongst the non-medical laity, communities must again learn the art of the *ars moriendi* and the practice of dying well as a human and cultural skill, with medical comfort through that terminal process as necessary. Even if all of this were to be accomplished, a necessary level of advanced professionalized medical care and industrial pharmaceutical production would still be required. Medicine will be decidedly less 'glossy' in its convivial future but will be truer to itself and more honest in its charge. These healers will work

> In a society in which people can once again be born in their homes and die in their homes and in which there is a place for cripples and idiots in the street, and where a distinction is made between plumbing and healing, [and] quite a few people would grow up capable of assisting others to heal, to suffer, or to die.[47]

[45] Illich, *Tools for Conviviality*, 35.
[46] Illich, *Tools for Conviviality*, 34.
[47] Illich, *Tools for Conviviality*, 35.

This social change will be necessarily accompanied by a change in consciousness: we must desire health in the confines of a good life in the confines of a good society in the confines of a good environment. This is the challenge McKenny's account raises as well, for in raising the ramifications of a medical culture outside of a robust conception of 'a good life,' he thereby draws our attention back to the place of medicine and healing in a larger system of meaning and flourishing. Society must learn to love, care for, and engage the "cripples and idiots" in the street (dancing and playing, not without shelter), and develop the habits of heart, mind, community, and purse to joyfully welcome, rather than terminate or cloister, those who visibly remind us of our own frailty. This, along with communal practical responses to suffering, are broad tasks that can especially be undertaken by religious communities, as Stanley Hauerwas and John Swinton have detailed.[48,49] Our way of social life must change, for conviviality among fields is linked: "Professional goal-setting produces goods for an environment produced by other professions. Life that depends on high speed and apartment houses make hospitals inevitable."[50] Ever increasing speed, intensity, and efficiency will not magically and technologically unlock a key to utopia; conviviality is not achieved simply through the logic of *more*. The emerging concept of *buen vivir* – the indigenous concept which offers a socioeconomic alternative to traditional Western economic development approaches[51] – is a conceptual parallel to conviviality which could also encapsulate medicine's ideal focus on both the mere fact of life and a qualitative sense of integral value.

[48] Stanley Hauerwas, *God, Medicine, and Suffering* (Grand Rapids, MI: Eerdmans, 1994).
[49] John Swinton, *Raging with Compassion: Pastoral Responses to the Problem of Evil* (Grand Rapids, MI: Eerdmans, 2007).
[50] Illich, *Tools for Conviviality*, 41.
[51] Eduardo Gudynas, "Buen Vivir: Today's Tomorrow," *Development* 54, no. 4 (2011): 441-447. doi:10.1057/dev.2011.86.

The formation of those training in healthcare is locus for change. Not only must the curricula change (education, tools, and assessment), the culture of medicine must stop glorifying prestige or income as a marker of success in the field; this is the task of mentors and leaders. Enlightenment idol like unceasing progress and limitless control must relinquish their hold on medicine's imagination, which must turn instead to "accompaniment" of the sick and poor as the fundamental moral thrust of medicine.[52] Care and cure – currently professional goals which have been split along gendered lines into medicine and nursing – must come together once again, as their common etymological Latin root *cura* suggests. Medicine must not be seen as an insular and value-neutral set of skills, but rather as a unique yet humble piece of an intimately interrelated yet kaleidoscopic social pursuit of *shalom*, the flourishing of human and non-human individuals and communities. In a moment of multiple-collapse, *shalom* and conviviality are both means and ends, they allow both surviving and thriving. Medicine's moral task, then, includes addressing questions of justice, racism, environmental destruction, economic exploitation and inequality, anti-democracy, militarism, and so on, for these – like suffering and death – threaten flourishing life. Training to be a healer should imply a deeply philosophical and humanistic understanding of our work, as Galen endorsed.[53] One possibility is to more explicitly affirm a human rights framework – which integrates the right to health with other fundamental civic, human, social, and economic rights – as Paul Farmer has encouraged[54] and as the 1978 WHO

[52] Paul Farmer and Gustavo Gutiérrez, *In the Company of the Poor: Conversations with Dr. Paul Farmer and Fr. Gustavo Gutierrez*, ed. Michael Griffin and Jennie Weiss Block (Maryknoll, NY: Orbis Books, 2013).
[53] Galen, *Selected Works*, trans. P.N. Singer (New York: Oxford University Press, 1997), 60.
[54] Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley: University of California Press, 2005), xxiv, 18.

Alma Ata Declaration affirmed. Financing must be such that it does not bankrupt our patients[55] nor chain trainees to the pursuit of high-paying careers via educational debt.

Finally, medicine must grapple with its fundamentally political character. Politics means engagement in the life of the *polis* and life of the people, and this does not simply mean partisan politics. This is one of the most insightful critiques Illich makes, for political life refers to a vision of how we as living creatures should live together. He speaks of the subjugating effects of "professional imperialism" over forms of knowledge and legitimating discourse,[56] a reality explaining the sociocultural forms of iatrogenesis, even as it conceptually generalizes the dynamic beyond medicine. Physicians qua professionals are not only individuals trying to do good but exist as members of a social class with certain responsibilities to the rest of society. Illich would have medicine deprofessionalize to avoid a culture of authority and exclusion, yet while his critique of professional authoritarianism stands, the American response to the COVID-19 pandemic and its interlocking crises expose the mirror danger of the distrust of expertise and wisdom. Thus, as a tentative start, physicians could start by using their present authority to become explicitly involved with political life on behalf of, and in coordination with, our patients.

Illich's eventual goal is the conscientization of society regarding health. Living lives of communion in our patients' communities – living where they live, eating together, and facing challenges together – actualizes the ideals of accompaniment and avoids professional mystique. Indeed, political engagement by healthcare workers – active life in the *polis* – is not a foreign imposition of outside considerations into the pure and objective field of medicine, but rather an extension and outworking of medicine's basic commitment to life and flourishing. Physicians

[55] Gilligan, Adrienne M., David S. Alberts, Denise J. Roe, and Grant H. Skrepnek, "Death or Debt? National Estimates of Financial Toxicity in Persons with Newly-Diagnosed Cancer," *The American Journal of Medicine* 131, no. 10 (2018). https://doi.org/10.1016/j.amjmed.2018.05.020.
[56] Illich, *Tools for Conviviality*, 43.

observe from the front lines how social problems manifest in clinics, hospitals, and emergency rooms. This fundamental posture of 'witnessing' brings with it a responsibility to speak out for our patients' health and against our own attempted professional monopoly on the means and ends of health. Physicians have responsibilities as individuals to use their voices, lives, and authority to critique the social injustice easily seen in medicine, and especially when injustice is caused or exacerbated by medicine itself.

Rudolf Virchow presciently remarked in 1849 that "if medicine is really to accomplish its great task, it must intervene in political and social life. It must point out the hindrances that impede the normal social functioning of vital processes, and effect their removal."[57] We must have imagination enough for creative intervention on the entire biopsychosocial spectrum, for, after all, insufficient healthcare is only roughly 10% of premature death and undesired outcomes. The necessary changes in medicine will require new conceptualizations and constellations of formation, research, tool use, the role of medicine, our institutional structures, and our broad sociopolitical frameworks. This paper has laid out ways in which conviviality and medicine intersect, even as it takes occasional leave from Illich's analysis. A move towards convivial medicine will require meditation on our deepest dreams for society and our hopes for *shalom*, and the realization of the interlocking nature of both threats to, and the possibility of, thriving life. Even in the face of present crises, as we look through Illich's eyes a possibility of conviviality beckons.

[57] Quoted in Paul Farmer, *Pathologies of Power*, 323.

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