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Cognition and the Crisis of Citizenship and Care

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Abstract: The American struggle over healthcare policy is emblematic of the larger crisis of citizenship and national identity. We have a crisis at the structural, policy level, but the problem also goes deep into our moral lives as individuals and commitments as a society. We struggle to come to a workable consensus about why and how we should provide healthcare, and for whom. Who belongs in our circle of care, and what are our commitments to one anothers' wellbeing? This identity crisis is spinning out into a breakdown of institutional structures and even loss of caring practices. As a Christian ethicist interested in how moral discourse works, my central concern is this: Why are so many American Christians speaking and legislating against health care programs – the Affordable Care Act, but even also Child Health Insurance Program, which covered children? They are using Bible verses to anchor and justify their policy stances. The American health care reform fight is a crisis of citizenship and national identity, but it is also a crisis of Christian mission and witness. A policy statement given by a conservative congressman is used as a test case with which to display how two experts on language could help us understand conservative Christian thinking on healthcare. Charles Taylor reflects as a philosopher on how "the politics of bringing about care" expresses our deepest commitments and our struggle with the impersonal forces of modernity. Charles Fillmore offers models for understanding how thought and language are linked and systematically structured, framed. There are alternatives to conservative ways of framing healthcare, ways that are arguably more coherent and more in keeping with biblical calls to love of neighbor and to building communities of the beloved.

Keywords: conceptual metaphor; conceptual blending; cognitive linguistics; conceptual frame; framing; moral discourse

Introduction

This essay explores how cognitive linguistic models can shed light on the ways American Christians live out ethics in the public sphere, especially in political discourse. I have used American healthcare policy as the focal issue to display the array of Christian viewpoints, commitments, and hopes expressed in differing views of civic participation and political opinions.

As I write, just before Christmas 2017, the United States government has just passed tax legislation designed in part to defund a significant portion of America's health programs. This flashpoint issue is emblematic of the larger crisis of citizenship and national identity in which Americans are immersed. There is strong disagreement about how the U.S. should provide healthcare. The problem goes deep into our moral lives as individuals and our commitments as a society. We struggle to come to a workable consensus about why and how we should provide healthcare, and for whom. Who belongs in our circle of care, and what are our commitments to the community's wellbeing? This identity crisis is spinning out into a breakdown of

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institutional structures and loss of caring practices. Many of us yearn to find more just and faithful ways to support our national wellbeing. Our current structures are flawed. How shall we discern and choose what is good for America's health?

I come to this discussion as an American Christian and social ethicist interested in how moral discourse unfolds – how we use language when we talk about good and evil, right and wrong, what is just and unjust. Here is my question: Why are so many American Christians speaking, writing, and legislating *against* healthcare programs, while other American Christians take the opposite stance? Some helped craft the Children's Health Insurance Program (CHIP), which provided low-cost health insurance for children whose parents earned too much to qualify for Medicaid but too little to afford insurance on the open market. People on both sides of this issue are using Bible verses to anchor and justify their policy stances on healthcare programs, including those for children. How does that make sense?

It will be obvious from the questions I'm raising and the way I've put them, that I have a perspective. I'm a progressive Christian, sincerely struggling to understand how my more conservative brothers and sisters are thinking. In addition to wanting to understand how they are thinking and arguing, I'd like to find ways to make more humane alternatives attractive. Because while the American healthcare reform fight is a crisis of citizenship and national identity, it is also a crisis of Christian identity, mission and witness. The American healthcare policy debate has become a focal point of practical and public theology and social ethics. And it is very much a work in progress. That is the motivating situation behind this essay.

I will begin by introducing several models that fit under the broad umbrella of cognitive linguistics and philosophy of language, with a focus on the work of Charles Fillmore and Charles Taylor. Both are experts on discourse and thought, and the social-cultural aspects thereof, careful observers of how language works in the modern era. Taylor reflects as a philosopher on how "the politics of bringing about care" reveals our deepest values and commitments while it displays our struggle with the impersonal forces of modernity. Fillmore offers models for understanding how thought and language are linked and systematically structured: how language reveals conceptual framing. Although they come from different disciplines and philosophical stances, there are important overlaps between their analyses. When Taylor points to the power of words and themes in public and philosophical discourse, he is noticing the kinds of structural patterns that Fillmore's semantic model can parse in detail.

I will use the work of both Fillmore and Taylor to help reveal the deeper conceptual patterns—the *framing*—of the discussion. Following this exploration, I will offer alternative conceptual framing for American healthcare policy drawn from two Christian theological ethical viewpoints: Stanley Hauerwas' model of communities of care and Paul Farmer's liberation theology-informed model of accompaniment.

In my arguments, the notion of semantic and conceptual *framing* will be key. Frames are not some kind of American artifact. Conceptual frames are inherent in all human thinking and speech. I hope to offer re-framing that will – if not "set us free" – at least provide more productive ways to speak about and reform American healthcare structures.

1 Problem and starting point

Scripture is being quoted in the American healthcare policy debate, and some conservative politicians explain their stances in moral terms. In the spring of 2017, a US congressman named Roger Marshall stated:

> Just like Jesus said, "The poor will always be with us." There is a group of people that just don't want health care and aren't going to take care of themselves. . . . Morally, spiritually, socially, some people just don't want health care.[1]

The congressman's statement makes perfect sense, and yet it makes no sense at all. A secondary but not trivial aim of this essay, then, is to explain that paradox, and why it matters.

1 Lowry, "Poor 'don't want healthcare,' Kansas Congressman says, and the backlash begins."

Here's a starting point before we turn to Fillmore and Taylor: If we want to understand an utterance, we should attend to the context in which it was said. George Lakoff and Mark Johnson, colleagues of Fillmore in cognitive linguistics and philosophy, offer this rule of thumb:

> The meaning is not right there in the sentence—it matters a lot who is saying or listening to the sentence and what his social and political attitudes are.[2]

To catch the congressman's meaning, then, we need to know that he is a physician and a first-term Republican from Kansas, who has joined a group of doctors in Congress determined to repeal the Affordable Care Act. Rep. Roger Marshall's comments were first reported in early March on STAT, a healthcare Website, in a discussion about Medicaid expansion and the effort to repeal the ACA.[3]

I would also emphasize that the readers of this paper, in order to understand their own interpretations, would do well to bring into consciousness their social and political attitudes. What presumptions do you bring to this discussion?

The congressman was broadly criticized for his blunt statement. When a reporter asked what he meant by "some people," he said, "Just, like, homeless people. . . ."[4] He later told the *Washington Post*: "When I said, 'the poor will always be with us,' it was actually in the context of supporting the obligation we have to always take care of people."[5] Marshall is, therefore, aware of the Scriptural call to care for others. Just as certainly, he knows Jesus was a poor man, sometimes a homeless man, whose healing touch was a hallmark of his mission and identity. How, then, does the congressman justify his determination to destroy structures American society has constructed to care for more "others," including many poor people? His stance seems incongruent with his stated values.

Here's how the *Kansas City Star* presented the rest of what Marshall said (quoting the congressman):

> The Medicaid population, which is (on) a free credit card, as a group, do probably the least preventive medicine and taking care of themselves and eating healthy and exercising.
> And I'm not judging, I'm just saying socially that's where they are. So there's a group of people that even with unlimited access to health care are only going to use the emergency room when their arm is chopped off or when their pneumonia is so bad they get brought (into) the ER.[6]

This extended quote provides a fuller picture. Marshall also said he thinks Medicaid has not really helped poor people, and is not good for them. He prefers a "free market" approach to healthcare provision, and is against anything that smacks of national healthcare because "we cannot completely craft a larger, affordable health-care policy around a comparatively small segment of the population who will get care no matter what."[7] Marshall is not alone. Many, many American Christians talk this way and seem to think this way.

But other American Christians' thinking is more in line with Pope Francis' teaching in his apostolic exhortation, *Evangelii gaudium* ("The Joy of the Gospel"). The Gospel does not distinguish between the "deserving" and "undeserving" poor, says Francis. "God's heart has a special place for the poor, so much so that he himself 'became poor.' . . . The entire history of our redemption is marked by the presence of the poor."[8] Pope Francis often speaks and writes in support of governmental policies and structures that address the needs of the poor, including their healthcare needs.[9] It is not just the Pope who takes this position. The Rev. William Barber, founder of Moral Mondays, has led demonstrations in the US capital to protest legislation that would take healthcare away from poor Americans. Explaining the thinking behind his actions, he said:

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2 Lakoff and Johnson, *Metaphors We Live By*, 12.
3 Facher, "Two months ago, this doctor was delivering babies," STAT Website.
4 Ibid.
5 Phillips, "The poor 'just don't want health care.'"
6 Lowry, "Poor 'don't want healthcare.'"
7 Ibid.
8 Francis. *Evangelii gaudium*, 2013. Vatican website.
9 Jenkins, "The strange origins of the GOP ideology that rejects caring for the poor."

> Some things . . . are not left versus right, but simply right versus wrong. It is wrong to take healthcare away from people, knowing that some of them will get sicker and die without it. We may not be able to stop this political violence, but we must raise a moral dissent. We who believe in justice must cry out to God against injustice.[10]

This progressive Christian pastor calls defunding healthcare programs unjust, "political violence." But Rep. Marshall is also crying out against injustice. This is no minor difference of opinion. We turn now to Charles Fillmore and Charles Taylor to illuminate what grounds these diverse stances morally, spiritually and socially, and what is at stake in this discussion.

2 Charles Fillmore's cognitive semantic frame model

Fillmore's first discipline was anthropology, and it was in the course of field study that his interest in language was sparked. Fillmore noticed that people seemed to use words in patterns, in what looked like thought clusters. They seemed to be drawing from a bank of categories connected to and represented by the words they used, and he wanted to understand how that worked. Fillmore developed some ways to explain a given word's or phrase's range of meaning by presenting and clarifying that clustering, the patterns in everyday utterances. Semantics, then, became his forte. He did not set out to found a field of study, but he was a pioneer in cognitive linguistics and semantics. Over time, he and his colleagues built a set of methods for studying language in use, to get underneath the kinds of "small meanings" rendered by word-by-word decoding attempts. Fillmore called his model "frame analysis" and said it is *U-semantics*. "U" stands for Understanding, and the aim is to study language as it is *used* in everyday communication in particular language communities.[11] So Fillmore was a phenomenologist, inviting us to notice some features in how human languages and texts function. Many biblical scholars and theologians find this model helpful, as John Sanders shows in his book, *Theology in the Flesh*. Perhaps some of us long ago crossed over into U-semantics; we realize that it is human-scale understanding that we are seeking.

From this perspective, words don't make meaning all by their lonesome little selves. Each word belongs to at least one *semantic frame*. Fillmore defines frames as:

> A system of categories structured in accordance with some motivating context.
> Any system of concepts related in such a way that to understand any one of them you have to understand the whole structure in which it fits.[12]

Words represent human categorizations of experience. Each expression has a "motivating situation occurring against a background of knowledge and experience."[13] Fillmore was interested in noticing that *motivating situation*. It's related to what Taylor called "the sense of things," but Fillmore is looking at specific contexts of particular utterances. The stronger claim is this: Fillmore argues that words only and always work via shared experience, "background" knowledge. Crucially, if we don't *get* the actual motivating situation behind Rep. Marshall's utterance, then we cannot understand what's being said, and will misinterpret. Frames are crucial to communication.

Before looking at the frames in the health care debate, it will help to explain a bit more about Fillmore's model. Using the example of the sport of American baseball, here are some utterances that only make sense in connection with the Baseball Frame:

-Strike three, you're out!
-Strike three called.
-O and two, the count.
-It's a high fly ball to right field.

10 Barber, "We Cannot Turn Back Now."
11 Fillmore, "Frames and the Semantics of Understanding," 223.
12 Fillmore, "Frame Semantics," 111.
13 Ibid., 112.

You can probably think of specialized vocabulary and expressions for other sports, too. There's a Tennis Frame, a Soccer Frame (and in most of the world, that's "football"), and so on. Each is a subframe of an over-arching Sports Frame. Each frame is made up of the particular objects, actors (roles) and other elements essential to a category of human experience. Frames often include rudimentary scripts – conventional scenes, scenarios – and coordinated metaphors. In fact, if you have (especially if you know from experience) the Baseball Frame, then each of the expressions above could trigger a scenario in your mind's eye.

All humans use conceptual frames every day. We rely on them in the academy, in theology, and in the churches. The Bible uses frames. And we use these same kinds of conventional scenarios to do ethical thinking and in moral discourse, as well.

An axiomatic aspect of Fillmore's frame model is that frames are gestalts. That is, introducing one item in a frame makes all of the other items and concepts in the frame conceptually available. These semantic and linguistic conventions and mechanisms are shortcuts in communication. They can work smoothly, beautifully, especially when we are talking to our own people, in our home languages and moral communities. But perhaps you can see already that there are traps and pitfalls, because we can mis-hear, mis-speak, misinterpret. We can make framing mistakes. The words "walk," "ball," "fly," and "strike," also belong to frames other than baseball.

2.1 Language communities, moral communities

Let us return to Rep. Marshall's statement now. Recall this part of what he said:

> Morally, spiritually, socially, some people just don't want health care . . .

Within his community – the literal one of his Kansas constituency and the larger one of conservative Republican American Christianity – Marshall's utterance likely made perfect sense. His constituency understood the American English sentence, and they understood its moral meanings, as well. They understood because they belong to the same moral community, and that works, says Fillmore, because they are sharing some frames (and subframes). It is not that everyone in Kansas would agree with Marshall's assessment but that they'd be apt to understand what he meant. He may have thought he was having a friendly conversation with like-minded folks, but his words hit a nerve. The national media picked up the story and spread it.

I'm guessing that most readers of this essay are not residents in Rep. Marshall's congressional district, so we are not members of that particular social, linguistic and moral community. Can we nevertheless understand what Marshall's message was? I propose that we do some Fillmore-style linguistic anthropology and try to name some frames that Dr. Marshall has drawn from, opened up, with his words. We are trying to understand what he is saying, and although we are not in Kansas or even in the US, as respectful observers we want to learn how he is framing the matter.

Notice first that Marshall opened up some abstract, over-arching frames when he used the words "morally, spiritually, socially." Those three significant domains of human experience are now part of the conversation, the discourse. In broad strokes, he's bringing up the topic of the moral, spiritual and social status of "some people," and connecting all of that with their relationship to healthcare. (Coincidentally, this framing, along with his citation of the Jesus saying about the poor, is why Marshall's utterance makes an apt exemplar for my study as a Christian social ethicist concerned with spiritual dimensions of healthcare and healthcare policy.)

We begin by examining the more specific frame he's evoked, Healthcare. A frame semantic chart can display the basic elements of the frame. A complete analysis would list the Lexical Units to indicate how the frame elements are expressed in a given utterance. Here is one way to display the Healthcare Frame.

Frame: Healthcare	
Frame Elements	Slot Fillers
Health practices & services	medicine, dentistry, psychology, etc.
Care sites	clinic, hospital, urgent care clinic, ER, etc.
Healthcare recipients	patients, clients
Health needs	medical, dental, etc. intervention and preventative care
Healthcare givers	medical practitioners and teams
Supplies	equipment, medicines

This is a basic, conventional (American) version of the frame. Most every American would find it uncontroversial and may very well share a lot of the same framing for healthcare. This is how I—as a person of very different political persuasion—can understand what he says, at least to some extent.

But what might Marshall's specific version of this frame look like? What would he add or alter? One place where he and I differ is in how we fill the "Healthcare recipients" slot. I find it puzzling that he thinks "some people" (homeless people, for example) do not fit in that slot or are what frame analysts might call "odd slot fillers." Marshall says these people "do not want" the services offered for "Health needs." The clue that he's using an additional, related frame is in a second clause: "There is a group of people that just don't want health care *and aren't going to take care of themselves*," he says. Marshall's utterance draws on a subframe in which not all recipients of healthcare are equal. There are Good Patients and Bad Patients. Good patients take care of themselves. They eat healthy foods and exercise. They follow their doctors' orders and heed their advice. Bad patients do not.

2.2 Accounting and moral accounting

Marshall is a medical doctor, an obstetrician. It sounds like he thinks of healthcare as a set of services he offers for patients to purchase, a business transaction in addition to a medical interaction. He wants to talk about how some patients pay for services, so we need to add another Frame Element to his version of the Healthcare Frame: Payment or Reimbursement Plan. That is an additional subframe structuring a conceptual metaphor Marshall's scenario relies on: Healthcare Is a Commodity or Healthcare Is a Business. [14] The Frame Elements listed in the chart above did not include anything having to do with finance. Goods and services are exchanged in the healthcare realm, and many Americans think of it as a commodity like any other. After all, people who provide services and care have to be paid, and that money has to come from somewhere. But how central a role should that frame element have? When we turn to Taylor, the Canadian, he advises us to pull healthcare out of that frame, to not let Market framing dominate. The US has not done that, and there is strong opposition to anything resembling "socialized medicine" here.[15] We need to understand where Marshall's evaluation of the unfairness of the present system comes from.

What sticks in the craw of many conservatives in the US is the very idea that some people seem to be getting healthcare services for nothing, or to not be paying their fair share. From the perspective grounded in the framing of Health As a Commodity or Business Transaction, the interaction ought to be straightforward: You get what you pay for.

To understand American conservatives' objections to government healthcare programs, we also need to talk about some metaphors for morality that rely on a number of Fillmorean semantic frames and blend them. Again, we are trying to see how – in a sample utterance – thought and language are connected. In particular, we are trying to understand how morality and framing is connected to social policy stances. One key from cognitive linguistic analysis is this: Semantic frames lend conceptual structure to metaphors, and these become metaphors we *live by*. Frames shape our various distributive justice models and policy stances.

14 Lakoff said it was a huge framing mistake to call it the "Affordable" Care Act because that frames healthcare as a commodity. Lakoff, *Don't Think of an Elephant*.

15 See T.R. Reid, *The Healing of America*, on the history behind the term "socialized medicine."

The congressman uses a novel metaphor when he calls government-subsidized health programs "a free credit card," and that metaphor's power is generated by the frames and related metaphors it is linked to. It's complicated, semantically, linguistically, and conceptually – and yet most Americans would understand it right away. One complex metaphor operating here is what cognitive linguists have called Moral Accounting. In fact, Fillmore's colleague George Lakoff finds linguistic evidence that this "meta-moral metaphor" is ubiquitous in moral discourse and a powerful shaper of American politics. Here's the basic idea: Americans have a habit of banking on our experiences and knowledge of *financial* transactions and using them when we talk about and think through *moral* interactions and consequences. Lakoff and Johnson have discussed this fully, and John Sanders explains it in *Theology in the Flesh*.[16]

For the present discussion, we need to note that the Moral Accounting schema relies on a more basic metaphor: Wellbeing Is Wealth. Other conventional metaphors are used to think about Wellbeing, too: Wellbeing Is Health or Uprightness or Strength. But when we're working on distributive justice – as in the health reform debate – we tend to rely on Financial Accounting framing. By the logic of that frame, anything that enhances our wellbeing is a "gain," and something that diminishes our wellbeing is a "loss," a "cost". A pleasing or satisfying experience is "rich" and "worthwhile" and the effort it took to get there is "worth it." That metaphorical way of thinking is often combined with language of "giving" and "taking," or transferring objects. So when someone does a good deed for us, we feel they "gave" us something and we "owe" them back: One good turn *deserves* another. The idea of keeping the moral books or accounts has a long history (it is even biblical). In fact, some people believe they are accruing moral credit in a divine ledger whenever they do something good, and incurring moral debits when they sin. The essence of the model is that we talk about moral interactions and consequences using financial language and concepts.

In the congressman's statement, he appears to be using a Moral Accounting scenario and a related informal model for distributive justice in which obeying and playing by the rules determines what you *deserve* to get, what is fair. Because of their irresponsible behavior, Rep. Marshall concludes, Medicaid patients do not *deserve* "free" healthcare. This makes perfect sense by the logic of the frames he uses. The American Work Ethic (a powerful frame) is also in play: It is *unfair* that the successful, hard-working majority is paying for the *idle* poor when the federal government gives them "a free credit card," Medicaid.

2.3 Families and the national family

Something else may be going on in the background experience motivating the congressman's statement. When Rep. Marshall says Medicaid patients "do not take care of themselves," he is talking about them as though they were rebellious teenagers or a weird uncle whose financial irresponsibility and bad personal habits embarrass the family. What might lie behind this statement? One interpretive key is this: Americans tend to talk about and think of our nation as a family. (In fact we are a family that is feuding over healthcare and money and personal habits.) Lakoff has discussed the American Nation As Family metaphor in detail.[17] In general, the conceptual frame for Family has two different instantiations: a family guided by Nurturant Parents, on the one hand, or a Strict Father alternative framing. In a Nurturant Parent family, the family as a whole will tend to help even adult children who've fallen on hard times – fallen ill, lost a job, or lost their homes to a fire or flood. The assumption is that as we help one another, we'll all be more likely to thrive. We're all in this together, as a family: "None of us is well until all of us are well," to paraphrase Emma Lazarus.[18]

The alternative framing for Family identified by Lakoff differs greatly. In the Strict Father Family framing, adults are expected to have developed healthy eating and hygiene habits and to be financially independent. That means grownups should pay for their own healthcare or for health insurance in a non-government-subsided market. Strict Father Family framing is often blended with Moral Accounting framing. Good

16 Lakoff and Johnson, *Philosophy in the Flesh*, 290-298; and see Lakoff, *Moral Politics*.

17 Lakoff, *Moral Politics*.

18 Lazarus said, "Until we are all free, we are none of us free." Emma Lazarus, *An Epistle to the Hebrews*, 1987 edition.

citizens are good (national) family members who obey the rules, live responsibly, and are independent. The government should act as a strict father displaying "tough love." By the logic of this informal (but tenaciously entrenched) moral scenario, it is not good for grown-up people to rely on the federal government to help them with healthcare. There are some notable exceptions: You *deserve* government-provided healthcare if you give military service or, as it turns out, you are a member of Congress.

Marshall might have different feelings about public assistance for victims of natural disasters than those he expresses about the idle poor with bad health habits. But his remarks about healthcare reflect classic Strict Father Family framing.

These clashing Nation As Family frames help explain why conservative and liberal or progressive Americans exhibit such different attitudes and policy proposals toward healthcare and social programs across the board. There's more than one way to frame poverty. In Rep. Marshall's statement, it appears that he holds the larger frame in which the plight of poor and homeless people is a direct result of their own bad decisions and life style choices. They have failed to take care of themselves. The gestalt quality of frames means that by the logic of Strict Father framing, it is obvious that homeless people "don't really want health care."

Americans who tend to use a Nurturant Parent version of the Nation As Family frame see poverty differently. The whole Family suffers when just one of them is struggling, and the family naturally wants to work together to alleviate that pain. Stronger family members help weaker ones. A nurturing family does what it can to prevent poverty, so parents attend to fostering children's coping skills, education, and health. In this model, poverty is understood to have complex root causes. Rather than reflexively blaming poverty on poor people's personal failures or bad character, it is understood that sometimes circumstances beyond an individual's control drive it. Natural disasters, systemic economic downturns, corporate "downsizing," or catastrophic illness – all these and more can be root causes of homelessness and poverty. Just as a nurturant parent would seek appropriate intervention for their teenage daughter if she had a drug problem, the Nurturant Parent version of the Nation As Family is willing to invest in drug and alcohol and recovery programs, for example. By the logic of this frame, such social programs are a legitimate function of government. Government is framed as the ways we organize our National Family to support everyone's wellbeing.

2.4 Stereotyping is thinking

There is powerful stereotyping in both of these approaches. Cognitive linguist George Lakoff defines "stereotype" thusly:

> A social stereotype is a model, widespread in a culture, for making snap judgments–judgments without reflective thought–about an entire category, by virtue of suggesting that the stereotype is the typical case.[19]

In other words, a social stereotype is itself a frame. Lakoff also speaks of pathological stereotypes, "the use of a pathological variant of a central model to serve as a stereotype for the whole category, and hence to suggest that the pathological variant is typical."[20]

Lakoff observes that *both* liberals and conservatives are apt to do this kind of stereotyping.

In the congressman's statement, all poor and homeless people are compressed into one category. They are caricatured as a group expecting a free ride in the ER when they mess up and get themselves injured. There's an attribution of group *moral essence* to the set of all poor, homeless and Medicaid patients.[21] I would argue that this is a pathological stereotype, and one that has become pervasive in conservative American discourse around healthcare policy, and social policy in general. For example, Senator Orrin Hatch of Utah recently declared, "I have a rough time wanting to spend billions and trillions of dollars to help *people*

19 Lakoff, *Moral Politics*, 311.
20 Ibid.
21 Lakoff and Johnson, *Philosophy in the Flesh*, 306.

who won't help themselves – won't lift a finger – and expect the federal government to do everything."[22] Hatch and Marshall are repeating a meme that's been part of American conservative framing of poverty and government since the Reagan era. Contemporary politicians have only to evoke one element of the frame to invoke the entire gestalt of this conceptual frame. This is the script: Poor, homeless Americans are lazy, don't take care of themselves, and want everything for free. This frame is powerful in the American healthcare policy debate, and many Christians use it reflexively.

Progressive Christians sometimes use the opposite stereotype: Poor, homeless people are victims of circumstances beyond their control. They are not responsible for their own plight, and should not be expected to work for their basic needs – food, clothing, shelter, and healthcare.

Open public debate about social policies is sabotaged when such pathological stereotyping is used. And yet how this all works, Fillmore would say, is via semantic framing. Frames hold powerful sway, then, in our moral and political discourse.

2.5 Frames, scenarios, and stories

Let us return to the core claim that Roger Marshall makes:

> Just like Jesus said, "The poor will always be with us." There is a group of people that just don't want health care and aren't going to take care of themselves. . . . Morally, spiritually, socially [some people, the homeless] just don't want health care.[23]

This is not a small statement, but a sweeping statement. Rep. Marshall is not parsing the Jesus saying about the poor in a "small meaning" way. He's drawing a big picture about the moral, spiritual, and social values underneath a group's behavior and attitudes around healthcare. These frames are combined, blended, to yield a short story, a scenario. It is a scenario that makes perfect sense to a lot of American Christians.

Progressives need to understand that conservative Americans like Marshall do have moral (and spiritual and theological) understandings framing their opposition to government assistance for the poor. From a Strict Father viewpoint, the moral thing to do, the most caring thing to do, is to allow people to be as fully responsible as possible for their own healthcare. That means not treating them in what amounts to a disrespectful manner, by giving them "free" or subsidized healthcare. Further, this framing coheres with economic policies that trust markets to work for the good in the long run. Interfering with those forces is wrong, by the logic of the frames Marshall uses.

We might ask, though, whose story Marshall is telling. Do any poor or homeless people's voices match or clash with this story? Could something have been lost in this particular framing? Congressman Marshall spoke about the poor and homeless, telling a story in which they do not want to take care of themselves and in fact do not want healthcare. Clearly, Marshall believes this is true. The frames and the background "sense of things" within which he lives shape his moral vision, and color his application of the Jesus saying he cites. He knows that Jesus said we should always be caring for others, but his experience tells him poor and homeless people in the US do not really want (or deserve) federal assistance in obtaining healthcare.[24]

In *Disrupting Homelessness,* Laura Stivers addresses the pitfalls of conservative framing that assumes individual culpability and blames victims. That framing fails to address the structural flaws in an economic system that pushes people into poverty and homelessness: unemployment or under-employment; low wages; high rents; inadequate public education, and high healthcare costs. Christians ought instead to aim to build more just social structures. The first step in doing that, she counsels, is to listen to homeless and other poor people so that their knowledge and experience shapes and drives whatever interventions and programs are devised.[25]

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22 Rubin, "After huge tax cuts for the rich, there's not enough for the sick and poor."

23 Lowry, "Poor 'don't want healthcare.'"

24 More thorough investigation of the motivating situation behind the Jesus saying Marshall cites could help New Testament readers and interpreters determine just how Jesus' accompaniment of the poor among whom he lived can be an exemplar for us.

25 Stivers, *Disrupting Homelessness.*

2.6 From descriptive to evaluative analysis

Here's an important point for those of us trying to anchor our social ethics in Scripture: We bring our favorite frames to our reading and interpretation of Scripture and to our understanding of what Jesus said and did. We cannot help bringing our conventional frames and "sense of things" to our readings. But we can become more aware of what we are doing, what frames and metaphors we tend to live by. I would argue that neither side has an entirely true story because they each erase too many people's voices. Neither presents a big enough story. Yet each makes some sense by the logic of the frames they use.

Raising questions that respectfully query the coherence of each side's framing and challenge its congruence with the Jesus story and biblical social ethical teachings is essential to this discussion. Learning to look for the framing *in* Scripture and in our reading communities, working together to discern how Scripture might read us, might push us to alter our frames.

We can describe viewpoints and their entailments using frame analysis. But can we evaluate stances and levels of coherence using this model? The answer to the evaluation question is "yes, but…" Yes, frame analysis offers ways to outline constraints and evaluate levels of coherence. Frames can augment and blend with one another; one frame can inherit logic from another. But frames often clash with each other and can include internal inconsistencies. Thorough frame analysis can highlight that incoherence and clash. However, a person (and a moral community) can hold multiple competing or incompatible framings.

In addition, frames carry both emotional and logical valence. In *Moral Politics,* George Lakoff uses frame analysis in conjunction with social scientific data to evaluate the cogency of Strict Father Family framing as opposed to Nurturant Parent Family framing and thought.[26] Lakoff points out that frames are not benign nor are they interchangeable. We can make choices about some of the frames we use; we can choose to re-frame our understanding of healthcare and social policies that support or undermine a nation's wellbeing.

2.7 Framing recap

Conceptual frames shape the American healthcare debate and anchor both conservative and progressive Christian stances in it. We've seen that Healthcare is a semantic frame in the Fillmorean sense, with subframes that tie into alternative Nation As Family frames. These in turn are linked to framings of Healthcare As a Commodity or Business Transaction, and then to Moral Accounting schemas in which some people are Good Patients who deserve healthcare, while others are not. These frames and the metaphors they ground structure our thinking and shape our understanding of the problems we face around healthcare in America. We argue and *live* by them. We read and interpret our Bibles and the Jesus stories with them.

All of this is important work, and yet even after having examined some of the frames at work in the healthcare debate, I sense that my understanding of Rep. Marshall's utterances and his stance is incomplete. Can we find further clarity? Let us turn to Charles Taylor for some wisdom.

3 What would Taylor say?

Over twenty years ago, the Canadian philosopher Charles Taylor offered some philosophical reflections on the American healthcare crisis. Taylor works at a deep register as he analyses philosophical and social-historical developments of thought. His analysis of root causes of the healthcare crisis fits his broader assessment of the challenges of living faithfully in this secularized age. Lately, he's been attending to the philosophy of language, and its import for current problems.[27]

26 Lakoff, Moral Politics, 335-388.

27 Taylor's latest work on the philosophy of language includes respectful coverage of cognitive perspectives, particularly in the chapter on figurative language. Charles Taylor, *The Language Animal*.

3.1 Framing and majorities matter

Taylor presents a multi-dimensional picture of the problems Americans face in this healthcare reform debate. He says Americans need to look at how democracies tend to organize their politics, including the politics of healthcare policy and systems. Market and economic forces must be considered, as well as distributive justice. We need to assess our general commitment to the community's wellbeing, and to listen when some people say that they are suffering, as well as to those who feel they are being asked to bear too much of the burden. I'd argue that the climate of opinion Taylor described in 1994 still fits the current dilemma in the US:

> There is an important general lesson for us in the politics of bringing about care, and that is a lesson in creating democratic majorities. When you have a system of impersonal mechanisms, like those of the market, that is producing some bad consequences for a small group of people, it is a mistake to focus on those consequences in such a way that the interests of a minority of people become pitted against the general welfare. The majority of people are going to think to themselves, 'Well, the market works pretty well for most of us. Why should we go out of our way to destroy this system in order to do our duty by this minority? They can ask something of us, but not too much.' That kind of framing of the issue will create a climate of opinion in which most people feel that unreasonable demands are being made on them.[28]

And so it is. A system of impersonal mechanisms and market forces creates a climate of opinion that powerfully shapes the debate. Taylor names this *framing*. Now, what Taylor means by "framing" is not identical to all that Fillmore is doing with semantic frame analysis. Taylor uses the boundary-defining aspect of frames to talk about how people use particular ideas or clusters of ideas to organize their thoughts – often to the exclusion of other ideas. He notices that our "sense of things" composes a worldview that provides coherence in an otherwise wildly divergent set of options. This too is an aspect of modern life, including socio-political life and discourse. Note Taylor's counsel: conservatives' "majority" sense of things is not unfounded. Market forces coupled with bureaucratic control and over-reach result in actual loss of autonomy. Yet there is still an over-riding expectation that each American should bear responsibility for his or her own wellbeing. All of these are motifs in what Taylor calls modernity's "melodies of malaise." But he insists that it is still possible to build democratic institutions and policies that reflect and sustain the "general welfare," the wellbeing of a nation.

Taylor prefers Canada's public healthcare system to the US's mélange of private insurances and government healthcare providers, and not merely for Canadian Health Care's logistical coherence and elegance. He wants Americans to understand that Canadian Health Care is a natural expression of the Canadian people's self-understanding, their national identity. The crucial factor that differentiates the American from Canadian healthcare systems is that Canadians see healthcare as something they *want* to do together for the *common* benefit of everyone. The driver is a commitment to the common good. This conviction and set of values frames healthcare in Canada's political discourse, policy formation and implementation.

3.2 Not charity but common benefit

Taylor's argument helps one understand Marshall's complaints and fears. There are resonances between what Taylor cautions against – structures that feel unfair to the majority – and what Rep. Marshall is decrying. Now, Marshall would surely not advocate adoption of a Canadian-style national health system. But Marshall might appreciate Taylor's observation that it is unworkable and unfair to expect the majority "haves" to underwrite healthcare for the "have-nots." Taylor can teach his southern neighbors that Canadian Health was never a case of ginning up guilt or empathy in the majority and persuading them to give over their treasure in service of the lowly. Taylor names the American "failure of charity," but finds it unexceptional, unsurprising. In fact he empathizes with Americans who are unwilling – as Rep. Marshall

28 Taylor, "Philosophical Reflections on Caring Practices," 179-180.

is – to underwrite healthcare for the poor and irresponsible. The philosopher tells us we should not be expecting that out of the goodness of their hearts or grim duty, the majority should feel obligated, let alone willing, to provide healthcare for the needy minority.

3.3 The general lesson: The politics of care

Taylor also has an insight about how anonymity affects our responses to need. Most humans can empathize with those who are close to them. We are capable of caring responses to family members, close friends, and our church family – all of those we belong with. Most of us can extend empathy to a few people beyond our family and close community when life events or emergencies bring others temporarily into our circle of concern. But Taylor says on the national scale, the majority cannot be expected to "transfer their goods" to "people they do not know." It is worth listening to how Taylor puts this:

> If we define it as simply in the interest of the least advantaged in the society for the society to care more, then we must call on the advantaged majority to care more and to care more in an impersonal way because they do not know those for whom they are called to care. We would tell the advantaged people to care more in this impersonal way, to pay out the money, raise the taxes, vote appropriately, and so on.[29]

Taylor is telling us that Canadians don't think of their public healthcare system as a charitable gesture or forced giving to strangers. Nor is it motivated by a simple duty ethic.[30] If it's not charity or stealing from the rich to give to the poor, what does ground and drive the Canadian system? How are they framing healthcare? Again, Canadians have a national identity such that health and wellness for everyone is something they want to support, so they've naturally decided to find a way to provide healthcare for everyone. The "sense of things" embedded in their national story and their psyches is that they hold a common interest in the health and wellbeing of the nation, a common good. That is a version of Nurturant Family framing. Canadians may be just as individualistic as US citizens; plenty of rugged individuals settled in the north country. Their story, like the American one, is about exploration and settlement of frontiers, of building a New World nation. But it seems that Canadians forged and retain a more robust commitment to the general interest of the country, to a common good.

A democratic politics of care centered on the common good requires, Taylor thinks, prying healthcare away from the financial market framing that has distorted, stifled and constrained it. Market forces alone cannot guard or maintain the common good because the market does not recognize the deep worthiness of each and all. It treats healthcare as a commodity sold to those who can pay. It frames worthiness, then, in terms of dollars and cents, secular capital.[31] But Taylor does not think socializing medicine works magic. Taking healthcare out of the market would fail, absent a prior consensus to embrace the worth and worthiness of all persons. The commitment to honor human dignity and worth drives a commitment to care. This, Taylor counsels, is the crucial shift needed if the US is to achieve meaningful and lasting healthcare reform.

In the US, such radical reform would entail enormously difficult cultural struggle that would need to be engaged across social structures, says Taylor. Schools, hospitals, and churches become crucial venues for the re-framing struggle because they are sites where we maintain and nurture caring practices.[32] These are places of belonging where we do our best at honoring every person, at believing in human dignity and worthiness, and putting that in action.

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29 Ibid., 180-181.

30 Ibid., 179, 180.

31 Taylor writes, "The institution of health care delivery needs to be taken out of the market and enframed so that it is seen as part of the general interest. Withdrawing it from the market alone is not sufficient; it is the enframing that will prevent the slow creep of the market back into health care." (Taylor, "Philosophical Reflections on Caring Practices," 180-181).

32 Taylor, "Philosophical Reflections," 181.

3.4 Drilling deeper: Words, complexities, and the sense of things

We're circling around some very basic concepts and questions. What kind of social ethic is Taylor offering, belonging to what sort of philosophical model? And what does it have to do with *language*? "Philosophy," says Taylor, "has to do with discovering empowering words and, in particular, with the dimension of articulating experience in narrative."[33] Our moral lives are too complex to be distilled to a single principle or a set of principles. Instead, moralities are developed in response to various influences, experiences and exemplars.

If I were to ask Taylor to apply his philosophy to the remarks of Congressman Marshall, I think that he would want us to remember that Marshall's position cannot be distilled to a single proposition, nor is the grounding for his stance on healthcare likely coming only from the one biblical text he cites or indeed any single frame he does or does not name. Other authorities are speaking. We'll become curious about the story (including the *motivating situation*, in Fillmore's terms) behind what Marshall is saying. We ought to pay attention to words and how human experience is being narrated. We ought to listen carefully and respectfully, not just for an ethical position or moral rule Marshall might be applying, but for the background "sense of things" underlying and providing the setting and tenor of his concerns.

Taylor notes, as well, a tendency in the modern era to over-simplify complex problems; he includes philosophers and social theorists in that assessment, and presumably, theologians too. Taylor notes that we have a habit of "understanding human life in terms of a single principle of explanation. Single principle explanations work against complex, multi-faceted understandings of human life."[34] In our zeal for clarity and simplicity, our love of elegant solutions, we sweep the details under the rug.

Here, then, is a congressman who is attempting to legislate in the secular political sphere of American society, to structure the social order, and to do so in conformity with the Gospel as he understands it. The better we understand the "sense of things," he's working with, the clearer picture we'll have of the congressman's commitments and thinking. A picture can "hold us captive," Taylor points out, quoting Wittgenstein. But we *all* are captives to some picture, some background "sense of things." Best become aware then, to the extent that is possible, of what that picture is.[35]

3.5 Malaise and melodies

As Taylor the philosophical historian looks at modern life, he finds it imbued with a general malaise. We have *all* lost what social historian Peter Berger termed "the sacred canopy." Belief in the transcendent remains possible, but it is no longer simply assumed. The "sense of things" shared in our disenchanted world has a pervasive harshness to it. People feel caught in a powerful vortex of impersonal forces, the mechanisms of the market economy and of governmental bureaucracy. Healthcare policy is mixed up with these forces. Market and nonmarket forces, bureaucracies, and unnamed fears permeate and constrain the healthcare debate. Those forces are combined with tremendous pressure on individuals to guard and forge their own authenticity, the meaningfulness of their lives, and their wellbeing. Modern Americans are achievement-oriented, zealous to tap into and wield our personal power; ironically, we also often feel politically powerless. The drive (and *call*, for Taylor) to achieve personal security and meaningfulness shapes and constrains any collective effort. This malaise renders a sad set of losses: a loss of security, loss of a feeling of belonging, and loss of community spirit.

In fact, this is how Taylor understands conservatives' reliance on and hopes in market forces and resistance to the impersonal mechanisms that power bureaucracies. He points to an ironic twist in the brand of individualism in this milieu. You would think modern citizens would feel empowered as autonomous agents, but there's actually a loss of autonomy: "Decisions are taken away from people, but

33 Ibid., 182.

34 Ibid., 177.

35 About Taylor's "sense of things," see *A Secular Age*, 550-551.

they are not given to other people. They are left to the play of impersonal forces. . . . The decisions repose in some impersonal institution."[36] Listening to Taylor, we can understand in a deeper way how even among Christians, a certain brand of individualism could drive opposition to healthcare systems that are wedded to impersonal, hegemonic bureaucracies. Taylor offers an implicit critique of the curious error in thinking when liberals believe that bureaucracies are the answer, or when progressives conveniently ignore what it is like for the people who have to deal with them.

Congressman Marshall's opposition to the ACA and Medicaid harmonizes with the melodies of malaise Taylor has outlined. The congressman's trust in "free market" forces to work for the good in the long run is also a song of individualism in the key of negative freedom: "freedom from." He embraces each individual's right to be left alone to pursue his or her own interests, own happiness and wellbeing. By this rubric, no one, especially not a government bureaucracy, should restrict individual liberty or require individuals to be responsible for the wellbeing of anyone else. Each individual bears primary responsibility for his own wellbeing, including his health. He or she has the right to bear that responsibility. So Taylor can help us interpret Marshall's picture of the flawed and misguided American health care system. It is painted in the colors of individual rights and responsibilities, coupled with deep fear of and resistance to bureaucratic usurpation of individual freedom of choice.

3.6 The pivotal question and commitment: Human dignity and worthiness

Taylor knows the history of moral philosophy and ethics, and he has a point of view. He's not satisfied with strict consequentialism or utilitarian models, nor does he think that duty ethics alone suffice to describe or ground the moral life. Taylor holds that the starting point for ethics is human dignity and worth. From that viewpoint, we can orient our actions towards mutual caring.[37]

But what if in the US there truly is a lack of consensus on that very point? What if the hierarchy of values and view of community and of the general good needs revision? Taylor says commitment to the concept of human worth and dignity arises from *experiencing others as worthy*. That experience can give rise to new convictions, motivate giving and caring. Can it motivate and shape the politics of healthcare, as well? Taylor thinks so:

> At the core of caring is a way of being among others in which you can care for others, can be sometimes moved by others . . . It is that being moved by the other person that cannot be programmed. It cannot happen all the time, but what would caring look like in a world where we were not moved by others?
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> . . .
>
> Care that is carried out without a sense of the real worth of the recipient is flawed in the most profound ways. . . . In the end, the stance of caring needs to be motivated . . . by the understanding of the other person as a lovable and worthy human being.[38]

But this is precisely where—for me—Rep. Marshall's stand against the ACA and Medicaid seems incongruent. Surely, he would say he believes in the dignity of each human being, including poor and homeless people. After all, he can quote Jesus' call to always care for others. But Marshall also seems to reason by the American conservative background story that says the behavior of the poor has rendered them unworthy of public health care. Marshall believes that poor people will never accept their personal responsibility and change their unhealthy habits if the government keeps giving them free care.

Taylor has shown how a position such as this makes a kind of sense. He's also shown exactly where the key moral problem in it lies. Now he has hinted at a way forward: it is about *experiencing* others as worthy and the *stories* that shape our moral lives.

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36 Taylor, "Philosophical Reflections," 175.
37 Ibid., 184.
38 Ibid., 182-183.

4 Blending Taylor and Fillmore: The morals of stories

This essay focused on a paradox: The congressman's statement that Jesus said we should always care for others, but "some people just don't want healthcare" both does and does not make sense. I have shown that it is understandable, given the logic of the frames Marshall is using. But because as a progressive Christian I work with other frames – such as the Nurturant Parent version of the Nation As Family – I think grounding healthcare policy in the common good makes better sense. I am trying to live by a different story.

Taylor argues that we ought to cultivate and turn towards richer, more nuanced narrative accounts of the moral life that open up a wide moral landscape. He encourages recalling, retrieving, and cultivating exemplars and *moral sources*. Admitting that this is hard to define, he offers a broad definition:

> A moral source is something that when turned toward and articulated can empower one to act in a way prescribed by the full moral view.[39]

What you read, the dramas or movies you see, the lives you have observed or biographies you have studied serve as your moral landscape and empower your creative action and responses. They open up the moral life beyond the narrow concerns of egocentric selves, moving us beyond self-interest as the sole motive and goal of action. Taylor's approach encourages us to expand the sphere of our concern and action beyond the needs and wellbeing of the self and immediate family, and even of our church family. Charles Taylor says he caught a new vision of caregiving when he saw a documentary about Mother Teresa that "made a difference in my capacity to care for others and see them as worthy."[40] This became for him a moral source to which he returns again and again.

My own understanding of the absolute worthiness of each human life was forged in my family's experience. My third brother had Down Syndrome, and was profoundly impaired. Walking one day with my dad, in my 40's, he asked me if I thought having Stephen in our family, having him as my brother, had affected my theology. Yes, certainly, I said. Stephen's value, the meaning of his life, does not depend on what he could or could not do, what he did or did not achieve. And truly, he was the one child my dad loved unconditionally. Just as truly, without the support of our church family and of the state-funded and operated programs that provided therapies and education and housing, my brother would not have had the long and fulfilling life he had.

Stories build up a world, and listening to people's stories can help us clarify our thoughts, our viewpoints and values, our deepest insights and hopes. Fillmore would say these are also frames that we can use to problem-solve, to interpret, and to communicate.

4.1 Switching healthcare frames

In the opening pages of *Suffering Presence*, the Christian ethicist Stanley Hauerwas says this about the heart of medical ethics:

> [F]undamental to understanding the moral art of medicine is the willingness of patient and physician alike to be present to one another in times of suffering. (By *physician* I mean all called to be with and aid the sick. I realize physician may be associated too strictly with doctors but it seems preferable to "health-care providers.") We assume that a physician should be available to the ill. After all, that is his or her job. But we forget the profound moral presupposition that underlies that "job description," namely that illness does not quarantine a person from the human community. On the contrary, the community should be present to the ill even as they suffer.[41]

39 Ibid., 184.
40 Ibid.
41 Hauerwas, *Suffering Presence*, 6.

Healthcare belongs to the domain of our shared desire to thrive, to be well, and not to suffer needless pain and debilitation. Every member of the human family has these needs, these hopes. What do families do when one of them gets hurt or sick? We don't shun or abandon the injured and ill, we come closer. We protect and hold them, we keep them warm, we give them food and medicine. We care for them. If the nation is a family, then our healthcare system is how the family cares for its own.

Notice that Hauerwas rejects Healthcare Is a Commodity framing when he rejects the language of "health-care providers". For Hauerwas, healthcare is not a mere commodity, nor is it essentially a contractual arrangement for providing services to paying clients. Instead, healthcare is a community effort in support of everyone's wellbeing. Hauerwas speaks of *willingness* to be *present*, of a *calling* to be with and to help sick people. Sometimes we do literally quarantine people for their protection and to prevent the spread of disease. But we do not abandon sick people, and in this vision, that includes poor sick people or disabled children. This is the profound moral presupposition in healthcare: we delegate some community members to be present on behalf of all of us. These are *physicians*, a subframe in which Hauerwas includes nurses and all the other practitioners and therapists. Hauerwas says further:

> Medicine involves the needs and interests that we all share. All of us wish to avoid untimely death. All wish to avoid unnecessary suffering. All wish to be cared for when we are hurt. . . . medicine provides a powerful reminder to Christians of our "nature" as bodily beings beset by illness and destined for death. Yet medicine also reminds us it is in our "nature" to be a community that refuses to let suffering alienate us from one another. The crucial question is what kind of community we should be to be capable of that task.[42]

Hauerwas's statement matches Taylor's insight. The question is, what kind of *community* should we be, so that we become capable of being present to *all* who suffer? At the outset I raised the question differently: Who belongs in our circle of care, and what are our commitments to the community's wellbeing? That is another way of putting the pivotal question.

4.2 Other stories that offer alternative frames

Documentaries and books about Dr. Paul Farmer's work as a physician and health policy expert have become moral sources that fill out my picture of medical care that honors the worthiness of every person. A co-founder of Partners in Health (PIH), Farmer is passionate about delivering quality healthcare to the poor. Here is a physician who does not turn away from patients who cannot pay in cash. Like Taylor, Farmer rejects a charity model. Instead, he's framed his work in patient care and building health systems as Accompaniment:

> To accompany someone is to go somewhere with him or her, to break bread together, to be present on a journey with a beginning and an end. . . . There's an element of mystery, of openness, in accompaniment: I'll go with you and support you on your journey wherever it leads. I'll keep you company and share your fate for a while. And by "a while," I don't mean a little while. Accompaniment is much more often about sticking with a task until it's deemed completed by the person or people being accompanied, rather than by the *accompagnateur*.[43]

Farmer applies this Accompaniment framing in all kinds of healthcare settings, from rural Haiti to urban Roxbury, Mass. In neither place does poverty or homelessness – or poor hygiene – disqualify a person from receiving healthcare. People who break bread together have opportunities to honor the worthiness of one another, and to be present to one another in the way Hauerwas envisioned. Farmer speaks of Healthcare As a Journey, too. He has in mind first of all the therapeutic relationship, and a mutuality in that dyad: patients also bear responsibility to do their part in the healing process. Farmer helps me understand Dr. Marshall's frustration with patients who do not do their part. But Farmer and his colleagues are determined not to give up on those patients who need help taking care of themselves. PIH creates "wrap-around services" that help patients become more active partners in their own healthcare.

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42 Ibid., 7.

43 Farmer, "Accompaniment as Policy."

That level of care-giving can't be sustained over the long haul absent two more pieces of the picture. Holistic healthcare depends on teams of practitioners willing to accompany one another. Armies of village and community health workers support medical caregiving teams. Then at the structural level, accompaniment relies on a larger social network procuring supplies and equipment, building clinics and hospitals and labs, and shaping health policy. Accompaniment frames healthcare policy that works for the common good, for community wellness and wellbeing. This model grew out of Farmer's experience as a lay Catholic practitioner. It is intentionally adapted from the Cuban American theologian Roberto Goizueta's theological ethic of accompaniment, and is in harmony with Gustavo Gutierrez's approaches to ministry in solidarity with the poor.[44]

Farmer is not naïve about healthcare economics and the funding problems and policy challenges we face. He has said that, while in his youth he was sometimes intimidated by medical economists who concluded it was impossible to deliver high-quality healthcare to poor people, he no longer listens to those voices. As a physician, his first commitment is to his patients, and their relative wealth or poverty does not change that commitment. The Partners in Health programs framed by Accompaniment are infused with extreme practicality that builds up and draws on peoples' skills and social networks in each locale.

5 Summing up

> Just like Jesus said, "The poor will always be with us." There is a group of people that just don't want health care and aren't going to take care of themselves. . . . Morally, spiritually, socially, some people just don't want health care.[45]

This statement expresses one kind of American Christian framing of the US healthcare policy crisis. Central to that crisis is a lack of consensus on some core commitments. Who belongs in our circle of care, and what are our commitments to the community's wellbeing?

Our answers to these questions are guided and constrained by the conceptual frames we inherit and use. I say "inherit" because perhaps the most powerful frames are those we use unconsciously.

This has been an exercise in attempting to bring a few powerful frames to consciousness so that we can consider how they shape our understanding. It has also been an exercise in beginning to ask why and how American Christians disagree so strongly with one another on healthcare policy issues. Many American Christians approach these issues primarily via a framing in which Healthcare Is a Commodity or Business Transaction, wedded to versions of the Nation As a Strict Father Family and Moral Accounting frames that render citizens without the ability to pay unworthy of receiving healthcare goods and services.

But these are not the only conceptual frames available. Once you understand the frames at work, then you can make some conscious choices, can choose to revise your own framing of health and caring. Charles Taylor advised Americans to drop the Market framing of healthcare over twenty years ago. When a nation becomes committed to the intrinsic value and worthiness of each and every citizen, then their healthcare system will be oriented by a sense of the common good and they'll embrace the goal of community wellbeing. Indeed, Stanley Hauerwas asserts that the central question of medical ethics is what kind of community we ought to be, in order to be capable of the task of caring for one another's health.

Many American Christians want to find more just and faithful ways to support our national wellbeing. Pictures painted in the monotone palette of individual rights and negative freedom cause civil society to break down. Democratic life requires more than individual rights and acceptance of personal responsibility for financial and bodily wellbeing. Democracy requires a *demos* and a *polis,* a community where each individual has a sense of belonging, solidarity with and commitment to others. Democracy requires a commitment to the greater good, and not just a dedication to one's own wellbeing and achievement. Americans who insist that people who cannot pay for healthcare do not deserve healthcare, that "you're on your own!" are missing an essential concept in the American project. We *are* our brothers' (and sisters')

44 Goizueta, *Caminemos con Jesús*; Farmer and Gutierrez, *In the Company of the Poor.*
45 Ibid.

keepers. That value, that commitment, is foundational to the American story and to our future wellbeing. Conceptual frames drive and shape the American healthcare debate, and re-framing might – if not "set us free" – at least give us more productive ways to reform American healthcare structures.

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