Articles

Effaced Enigmata

When Ethics Precedes Neuroscience

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Abstract: Severe head injury or brain injury presents clinical neuroscientists with a unique challenge. Based on an objective assessment of cognitive and neurological function, it is sometimes hard to recognize our patients as members of our moral community (actually or potentially) but we treat them as if that were is the case, and, therefore, as if they need rescuing. Thus their existences as enigmata—beings who may or may not reveal themselves to us through social and personal function realized in conversations and relationships—are in doubt. However, the objective mode of assessing individuals and their mental functions needs to be bracketed here, as we reconnect with them and offer them our help in the restorative journey that they need to take. The journey has many tortuous paths comprising it, not the least of which is the existential question of whether the damaged human being with whom we are engaged actually can be restored to a meaningful life. A negative answer to that question can bring the whole process to an abrupt end. Neuroscience cannot answer some of these questions, as they are ethical. Is this a life worth living and are our commitments going to go the distance that must be traversed here. Therefore, this is an area where ethics take priority over neuroscience, and it is on our ethical response that everything else hinges. Understanding the light this throws on the nature of a human being takes us to the heart of the value of every human being and the nexus of mutuality that is the moral community.

Keywords: neuroscience; ethics; moral community; head injury; brain injury; cognitive function; neurological function

Patients with severe head injuries are a very challenging group of people for clinical neuroscience in a number of ways. They are challenging to our neurodiagnostics, a problem in which clinical assessment is increasingly being supplemented by dynamic and functional imaging,[1] but also, and equally importantly, they demand moral sensibility of us, and ask that we reach across a divide of incomprehensibility and disconnection so that our clinical skills of discernment and neurorehabilitation can recognize what is required of us and others who are concerned with them. A severely brain damaged patient implicitly demands to be recognized before we can even begin to act ethically toward that person. Chief among the needs for ethical action is to be reconnected with the world, to be included in the kingdom of ends as the persons they were before the injury effaced their ability to self-present as real human beings living among us as part of our moral community. Recognizing that they need someone to be the other who connects with them in a human relationship is the beginning of a long journey of our potentially becoming reacquainted with an enigma who has been effaced by a cruel injury that has unravelled the neural structures serving consciousness and personality.[2] Emmanuel Levinas argues that any human being is an enigma—a mystery whose character is not independent of the way we act toward him or her—and whose nature unfolds through relatedness.[3] This makes vivid and urgent "ethics as first philosophy" whereby the metaphysics of identity and subjectivity emerges as not merely something to be discovered, but secondarily from a primary ongoing ethical encounter

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in a way that is shaped by the quality and commitment of that encounter. In the clinical neuroscience setting, only with the emergence of a person from such a restorative encounter can the issues associated with supported autonomy and the unequal partnership that allows negotiation of a treatment course and its limits be meaningfully addressed.

Two Stances Toward a Patient

A neurologist approaching a brain inured patient has an attitude requiring him or her as a clinician to assess the patient in relation to a detailed clinical map of deficits and syndromes. The patient's integrated performance expressing his or her personal being must, during that assessment, be rendered into isolable functions such as speech comprehension, voluntary control of movement, and visual acuity, and these must be used to generate a set of neurological signs and symptoms that allow the clinical neuroscience team to make a diagnosis: for example, sudden loss of voluntary control of the right face and impairment of movement in the right hand along with expressive aphasia in a 61-year-old man with type 2 diabetes might indicate a small left middle cerebral artery infarct. The implicit objective stance enacted here is basic to clinical life, and the assessment and treatment of patients whereas the more reactive elements of clinical relationships[4] (toward the person as a person with a moral and narrative personality) are secondary to that stance. The objectivity striven for requires a neurologist or neurosurgeon, as assessor, to counter some of the devices used by patients who, if brain damage is not too severe for them to cooperate with a neurological examination, try to function as integrated persons with will, cognitive flexibility, a repertoire of personal skills and tricks, and a desire to do their best for the clinician. Therefore, for example, when a neurologist testing verbal comprehension asks the patient to take an apple from the bedside fruit bowl, the clinician is careful not to do the natural thing, which would be to look toward the apple or give any paraverbal cues as to what response is required, that artificility attempts to isolate the exact functions being assessed so as to arrive at a clear idea of the patient's deficit. This departs markedly from the full-on communicative and facilitating efforts normally involved in clinical communication with patients struggling with their illness.

The style of the neurological examination and the picture of neural function being employed is a "bottom up" (or reductive) model whereby the full performance comprises a combination of more simple skills integrated together and, as a clinician, one is interested in assessing the local deficits that indicate where the lesion is in the brain. In normal life, a person uses much redundancy and coordination of different functional capacities to achieve the seamless performance that is everyday sensorimotor and cognitive activity adapting us to a domain of dynamic human interaction. Human adaptation, as John Hughlings-Jackson noted, is a matter of doing this work of integration and self-formation as a highly evolved creature so that one presents oneself as a skilled subjective participant in the human world.[5]

The artificial dissection of normal human self-presentation required by objective clinical assessment is a deliberate exercise that reveals the basic sensorimotor functions normally coordinated or combined in a multifaceted interaction to establish a skilled mode of relating to others in a given environment. That type of

function is so organized that the integrative or meaningful whole emerges flexibly and dynamically from a variably deployed palette of neurological and cognitive skills that is reorganizing itself continually on the basis of experience. Therefore, for example, a hearing-impaired adult may give a slightly delayed response to a remark in conversation because that person's cognitive "meaning extraction" system, with a slight latency as compared with sensory-perceptual pickup, compensates for the indistinctly heard acoustic signal that is the message they receive. We do this kind of "filling in" and ampliative work all the time because we are attuned to whole situations and their demands, rather than to a mere composite (constructed from the bottom up) of the sensory inputs that we receive.

That is why objective assessment, as we normally practice it in the clinic, delivers a "double whammy" to a patient struggling to establish the dynamic rapport that moderates and facilitates normal human adaptation, including the complex interpersonal activity that connects us with others, and through them a world that bears the mark of the human or cultural and is no longer simply natural. The brain-damaged patient loses out on the ready rapport and rhythm of relationship building that draws on diverse bodily and cognitive elements to make human identity a kind of performance and exchange within a context that is subtle and structured in complex ways that can cause a breakdown in one's connecting with the other and making something of what passes between us: per Butler, "my own perspective is not reducible to the perspective of the Other, since the perspective is also what governs the possibility of my recognizing the Other, and the Other recognizing me. We are not mere dyads on our own, since our exchange is mediated by language, by conventions, by a sedimentation of norms that are social in character."[6]

Ideally, an interpersonal context includes two people in a charitable and mutually supportive engagement so that the fledgling attempts at re-establishing interactive abilities receive "help coming from the other direction" (scaffolding). The context itself therefore creates a moral burden—the requirement to adopt a primarily ethical stance of intersubjectivity—in dealing with severely brain-damaged human beings and those of us who have been made alien by some fracture of our relationality. That stance underpins our ability to understand who someone is and what that person is capable of, because there has to be a reaching across the often unbridgeable gap between a damaged human being (particularly if the damage is extensive and de-humanizing) and those who happen to come in contact with that human being.

The bridge of intersubjectivity within which one can be nurtured as an "I" - who is built from the "you" that others connect with - cannot even begin to be built unless, through the distortions such as spasticity, incoordination, paralysis, and dysarthria or dysphasia those that happen by or become companions on the illness journey can recognize the whole through its fragmentation, because that whole is the basis on which an integrated human being as a whole organism "is adjusted to an environment."[7] On that holistic basis, we respond to a fellow human being and work toward including that person back into our networks of support, acceptance, and personal growth. That task is much more accessible to someone who is already connected to the patient and who, therefore, already holds him or her[8] as a whole being with an identity and personality in his or her own psyche than it is to a stranger who has to perform an initial feat of imaginative reconstruction of a whole person who has sometimes been so degraded as to seem

inaccessible or irretrievably lost to us. "Holding in being," in the way indicated, is a service we do for those we love in many settings, and is one of the most powerful ways that we demonstrate the underlying spirit of humanity as in Ubuntu: "I am because you are because we are in this together."[9]

That intersubjective orientation is particularly important because for human beings, top-down or autopoietic self-formation to fit themselves for a discursive and interpersonal ethology is the key to their adaptation as beings-in-the-world-with-others (Martin Heidegger's characterization of the essential feature of a human being).[10] The process of self-formation with others, as is shown particularly in psychiatry, is inescapably ethical,[11] so that human dysfunction cannot be understood purely descriptively as reflected in the ongoing debate about the nature of psychiatry and whether it fits a biomedical disease model.[12] If we regard ourselves as, *ab initio*, ethical beings, then the implication for rehabilitation from a devastating brain injury parallels the implications of our inherent relatedness for psychological development—that there is more than biology needing to be minded even though, in metaphysical terms, the human soul can be thought of as a mode of biological function suited to a special ecological niche—one of reason and moral community.[13]

Adapting to the community of reason and interpersonal encounter engenders certain forms of psychological development, the culmination of which could be thought of as becoming finely aware and richly responsible among others so that we are people upon whom, at our best, nothing is lost.[14] That is a high calling but, as observed by Michael Tomasello, it follows from an acknowledgment that our nuanced self-making fits us to occupy a sustainable personal niche in an objective–reflective–normative domain.[15] That concept combines the idea that there is a common domain to which we adapt in a cooperative and mutually informative way, and that our functioning in that mode demands that we intelligently improve our cognitive abilities so that they track what is actually there for us to exploit, that we can give an account of how we are thinking, and that it meets certain norms that we promulgate as creatures who participate in a discourse in which we legitimately expect things of each other. A closer exploration and analysis because of its holistic implications for cognition and emotion would be out of place here, but the hill that has to be climbed by a patient who is cognitively impaired and wants to regain that community becomes immediately obvious.

A sense of life is the emotional/perceptual concomitant of functioning well as part of the human life world, and it has implications for our relationships to those who suffer and are damaged, and particularly to those who are confronting their own mortality (whether they know it or not).[16]

When human beings present to us with a broken story because they have strayed from the life that they envisaged into the world of the sick,[17] then they need to find a reception for the metaphors they are forced to draw on to convey the meaning of the illness that has beset them. When cancer patients talk eloquently of being able to feel the cancer growing inside them and eating away at their lives they are going beyond what they register with their nerve endings and conveying what they sense, but many of the messages that come from that place where none of us want to go, although we inhabit it already in our dual citizenship, are less articulate and more of an inchoate plea for someone to venture across the border prepared for an open-ended journey with the suffering person back to the land of the well, of friendships, family, and community. And that preparedness reminds us of the need for an ethics (as Levinas would have it)[18] as first philosophy.

Ethics as First Philosophy

Regarding ethics as first philosophy reverses the oft-accepted order of philosophical thought whereby conceptual clarification precedes metaphysical description (about how we ought to think of or define this or that phenomenon, informed variably by current science) and then leads to practical or applied conclusions, which rationally follow from that preliminary philosophical work (this is a reversal in the twentieth century of the priority adopted by Baruch Spinoza whereby how we should live is the first, and to some extent most important, question a philosopher should ask). When patients sustain brain damage, we make concessions to them acknowledging their sequestration into a different space where corrective interventions must be calibrated and delivered to match the deficit that has arisen, and that conceptualization precedes our understanding the full force of the challenge that presents itself to us. The alternative to an objective and distanced perspective is laid before us by Levinas: "a radical attention given to the urgent preoccupations of the moment" in which "the abstract question of the meaning of being qua being and the question of the present hour spontaneously reunite."[19] The thought derives from a theoretical acceptance of the discursive, argumentative nature of philosophy whereby human beings draw on their skills of discourse and conversation to attend to one another, discern each other's trains of thought, and enter into a process of engagement and response, listening to voices, and resonating with what others and their faces are telling us. However, in the illness context, the urgency is greater because the threat of marginalization is immanent "Don't be offended, it's the brain injury talking." But the patient may interject, "It bloody well is not, I am myself, listen to me, this is awful and I will not be sidelined I want to be in the midst of things where I am used to being and, even if it's a bit messy, we can learn how to clean up later rather than deferring life until my illness can be overlooked."

It is as life's urgencies prompt a response that must be heard and not discounted that we enter the cut and thrust of thinking in the face of the risks and satisfactions of being-in-the-world, and are released from the enforced passivity of spectators whom life passes by. Those relegated to the land of the sick are not pale and pathetic shadows of human beings who cannot be brought into the hurly-burly of life and relationships, they are in it and must relearn the skills of existing, standing forth as the people they are who make a difference to what is happening. Therefore, we can, if we develop and hone the skills that enable the afflicted to be, to the extent they can, people who matter to us and are real, become the witnesses to illness journeys on whom nothing is wasted in the midst of clumsy efforts to be recognized and included so that we are all (to a greater or lesser extent) well-formed for - thinking, a discursive activity in which we dispute through word and deed the evaluations applied to us as ends in ourselves.[20]

That process does not so much provide definitive answers to our questions as bring to bear on them the multiperspectivality of the objective–reflective–normative domain that is, in its inclusive entirety, a nuanced creative milieu disclosing the lives of others as enigmata. This is the world from which the severely head injured have fallen and to which they need, as far as possible, to be restored. It is a world from which many marginalized human beings, including those with less radical neurological and psychiatric disorders, can find themselves excluded in many ways. Inclusion and exclusion in the human world are elusive discursive movements

encompassing our embodiment as much as our intellectual attributes, as is hinted at by Maurice Merleau-Ponty when he says of a woman that she is "a certain manner of being flesh which is given entirely in her walk or even in the simple click of her heel on the ground."[21] His observation can be broadened to include the various bodily accompaniments or disruptions of our human modes of being-in-the-world-with-others that tend to alienate from the rest of us those whose brains have been subject to commotion from any of the many causes operating in the biopsychosocial engenderment of human states of unwellness, among which violent head injury is one of the most extreme.

Michel Foucault refers to a human being as a volume in perpetual disintegration;[22] however, in the light of autopoiesis and self-formation under the adaptive shaping of the discursive level of human engagement, we could add to disintegration the possibility of evolution or reintegration, to emphasize the dynamic process of being human which engenders new connections as it destabilizes established ones. Given the body as a subjective locus where that ongoing subjective dynamic is being played out (and in part performed) under diverse influences, there is an underlying continuity to the narrative constituted doubly by a grammatical demand that each of us occupy a discursive place among others and give an account of ourselves, and that we take ownership of a set of (intentional) bodily doings that affect others and are only properly explicable within a situated human life.

Head injury and brain events preceding and causing such conditions as minimally conscious states[23] seriously disrupt this normal quasi-stable and dynamic form of human engagement to the point where we question our moral and medical commitments to the human beings concerned, and concepts such as futility come into play. This then is the predicament that calls for the requirement for a primary abandonment of objectivity in favor of ethical engagement to try to restore the means of self-formation which, for any of us, is a process of responsivity to others who reach out to us and make a place of hospitality, attachment and interaction for us in the human community.

Jean-Paul Sartre talks of psychiatric and neurological conditions implicitly being understood as a disintegrated transformation of a whole: the person as a totality who is a "you" before he or she is an "I."[24] To that perspective, we can add the observation that our brain circuits are designed to hook into our lived world, completing within ourselves arcs on intentionality that are built through life and enable us to act in the present so that every experience is an amalgam of protention—looking to do something intentional—and retention—drawing on what we have done in the past, as Edmund Husserl states.[25] His analysis focuses on the moment of mental life in which we enact a human way of being, through our sensorimotor connections and the projects that subsume our active behavior, under "one intelligible core, bringing to light through them an identifiable unity."[26] The dynamic integrated subjective now that is an ongoing lived experience for any human being is, according to Merleau-Ponty, more basic that the moments of sensation and movement treated as basic in empiricist and physicalist analyses of perception, thought, and action, and it derives from the human being in context each of whose acts is a seamless fusion of soul and body: "the sublimation of biological into personal existence."[27] That wholeness makes the person - to whom we reach across the gap created by brain damage - a prior reality needing to be recognised through whom alone the process of restoration can take place.

Recovery As a Project of Self-Remaking or Autopoietic co-Production

The conceptually prior integrity of the person as a being-in-the-world-with-others highlights the fact that cognitive and relational recovery involves an extended process of top-down configuration as a project constructed from the integration of intentional arcs: intelligent ways of being and relating to the world.[28]

These are not outputs somehow provoked by inputs, as might be built from a causal analysis of neurological function, but bringings-forth of objects and modes of being in relation to them so that, as suggested by Anthony Chemero, the entities of my world are real insofar as they are foci for embodied cognitive adaptation on the basis of which I inhabit a world in which things can be done and thinking can occur.[29] Melding Merleau-Ponty's insights with those of embodied cognition theory allows us to see consciousness itself as a meaning-giving mode of action whereby human beings inhabit the world[30] and find both their intelligence and their motivation to deal with what has emerged, a process that makes vivid the dangers of reduction of the biological to the purely physical or physiological.

The line of thought here has a link back to the work of Immanuel Kant, in which he notices that making sense of what organisms do in terms of their natural purposes (teleology) is indispensable for biology even though it does not immediately meet the desiderata for knowledge according to mechanistic science and our tried and true causal thinking.[31] That line of thought, once again, re-centers our gaze on the one who needs to be restored to us rather than the fragmented repertoire of neurological abilities that have retained a vestige of function after a devastating brain disruption.

The Dangers of Reductionism

Stanislas Dehaene[32] has analyzed the global neurocognitive workspace and shown how many of its intriguing features thrown into relief by the natural experiments of stroke and brain injury allow a useful reduction of consciousness—our meaningful mode not only of intellectual and sensorimotor integration but also of interpersonality—that is subserved by multiple interwoven brain processes.

> If you had any lingering doubts that your mental life arises entirely from the activity of the brain, these examples should lift them.[33]
>
> Consciousness lives in the loops: reverberating neuronal activity, circulating in the web of our cortical connections, causes our conscious experiences.[34]
>
> The evidence inescapably leads to a reductionist conclusion. All our conscious experiences, result from …the activity of massive cerebral circuits that have reproducible neuronal signatures.[35]

His summary conclusion embodies the reductive conclusion compatible with a shift toward the bottom-up view found in empiricist philosophy and psychology and rejected in phenomenology. "Consciousness reduces to what the workspace does: it makes relevant information globally accessible and flexibly broadcasts to a variety of brain systems…This global availability is precisely what we subjectively experience as a conscious state."[36]

A phenomenologically inspired neurophilosopher or philosopher of psychology might insist on a slightly different formulation consistent with the current account: *Consciousness is the subjective state of being-in-the-world-with-others neurally realised by the global workspace* as it "makes relevant information globally accessible and flexibly broadcasts to a variety of brain systems," (my reformulation of Dehaene's characterization.)

The phenomenological orientation puts the subject—potentially a member of our kingdom of ends or moral community—an enigma upon whose self-realization and self-revelation we depend so that a truly human entity can emerge or be brought forth. There are ways of understanding this in broadly framed contemporary natural science, but they depart from the analysis of the identifiable and self-contained entity of which the inner workings and constitution comprise a purely physiological essence able to be theorized according to reductive natural science.[37]

Systems Theory?

George Engel aimed at a new inclusive theory to deal with the complex embeddedness of human organisms in their adaptive, ethological milieu: that of interpersonal life with its rhythms and codependencies (Kant speaks of entities whose "parts … so combine in the unity of a whole so that they are reciprocally cause and effect of each other's form")[38]

Engel shifts the focus of attention to the multiple forms of knowledge relevant to a clinical situation: "Focussing on what the physician does in contradistinction to what the bench scientist does highlights the appropriateness, indeed the necessity, of a systems approach, as exemplified in the proposed biopsychosocial model. While the bench scientist can with relative impunity single out and isolate for sequential study components of an organized whole, the physician does so at the risk of neglect of, if not injury to, the object of study, the patient."[39]

The patient participates and has been formed in multiple mutually embedded contexts: the context of society-nation embeds that of culture-subculture, which in turn embeds community, family, and others, until we reach the level that is so defining for each of us, that of intersubjectivity and the microsociological or psychological level that shapes individual psychological identity and characteristics. Analysis of a clinical situation must be performed with an eye attuned to each of these levels, otherwise the patient as a whole tends to slip out of the picture. Nevertheless, it is the person who, in an important way, stands at a significant junction as we bring together the different types of inquiry, and whom neuroethics has to encompass.

Assisting a Person in the Work of Autopoiesis

The neural correlates of the form of responsivity that we call human consciousness are helpfully described by Dehaene and others and include thalamocortical circuits of recruitment with sensorimotor and emotive-conative links. These underpin iterative and re-entrant cycles of sensorimotor coupling, affective relevance, and symbolic resonance implicating multiple cognitive maps serving as the basis for representation, re-representation and re-re-representation (to use John Hughlings Jackson's terminology) and the result is what we can call "triply responsive, integrated, neurocognitive assemblies" (TRINcAs), which attune us to a world of

doings and sayings where we experience hospitality and being connected to others. Fragmented instances of these assemblies can pick up on fragments of conversation, but often with little communicative effect, as is eloquently described by Joseph Fins in his narrative study of cases of severe brain damage that may evoke fragmentary responses; however, most of us are deprived of the contextualizing knowledge of the person as a relational being who is inhabiting the margins of our community as a spastic, inarticulate, variable, and intermittent presence.[40] Recognizing the type of being we are dealing with demands not only the more holistic reaching, as described by Fins, but also a focused and educated clinical acumen that takes close account of the brain injury and its likely effects.[41]

The Philosophy of Antireductive Intersubjectivity

Neurophilosophy, with its derivative relationship to empiricism and reductionism, has often overlooked important strands of philosophical thinking needed by neuroethics in this area of intense ethical challenge. The central importance of integration in human cognition and our ascending adaptation to a discursive mode of being means that "light dawns gradually over the whole"[42] as the human mind equips itself for the knowledge we so freely and charitably share through our semantic intentions as communicating embodied beings. We have to take up an antireductive stance to appreciate human beings as the creatures they are rather than confusing them with the causal parodies of themselves from which their essential lived meaningful relations have been subtracted.[43] When we pursue our analysis of lived human being "to the things themselves" or "what I live through"[44] we make a number of observations often bypassed in neurophilosophy and the philosophy of psychology:

> Consciousness is as clear in his face and behaviour as in myself.[45]
>
> But can't I imagine that the people around me are automata. Lack consciousness, even though they behave in the same way as usual?…just try and keep hold of this idea…in the street…you will produce in yourself some kind of uncanny feeling.[46]
>
> Being seen by the other" is the *truth* of "seeing the other…the other is on principle the one who looks at me.[47]
>
> The look which the eyes manifest…is a pure reference to myself.[48]

These thoughts lay before us the enormity of the task that is recovery from brain injury, not the reassembly of a new whole from individual neural circuits that must be put together again, but an aided reconstruction of oneself and one's circuits of responsivity to the *umwelt* when the *imwelt* is effaced and massively disrupted. This, as already noted, is work one cannot do by oneself; cycles of responsivity require respondents just as our infants require those who will scaffold their early strivings toward engaging with the world so that their efforts do not fall flat and come to nothing and so that they will never become someone without a grip on our shared world.

First Philosophy: Resonances and Clinical Applications

When we begin to look at the enigmata we meet in the emergency room not as specimens of this or that neurological category to be assessed and characterized,

and to have their clinical profiles described, we encounter the most indispensible structures of understanding: structures of an interpersonal encounter that may or may not sustain an intellectual discourse, but that is fundamentally a moral demand for our concern and care. Here, the selective resemblance and non-resemblance within a use practice or context in which we are enabled to do certain things takes second place,[49] because what is about to happen in the clinical setting must be built on a commitment to intersubjectivity from which all else will follow.

The sharp and focused thinking of an objective or maximally intersubjective world is indispensable as part of the process, because that gives us access to cognitive maps where our if–then or "let's try this" mode of problem solving takes hold. Without that thinking, our inventive, exploratory, flexible, and imaginative techniques of interpersonal connection cannot begin to unfold and articulate the relationship to which we are called. The invariants of being-in-the-world-with-others are, however, less distancing and objectivizing in their totality than the partial foci and directed methods of description and intervention that we have increasingly at our disposal. An intuitive values-based mode of praxis that retains a focus on people and relationships must be deployed to allow ongoing recognition and holding in being through intersubjectivity, because it is being recognized and received back among us, which is the aim not just of restoration but also of functional competencies. The latter will almost take care of themselves, as long as the pull is there to reconnect and participate with us in the co-construction of bringings-forth that makes our shared human life-world.

We could describe this (in terms pioneered by Merleau-Ponty)[50] as the union of soul and body in the multiplicity of intentional arcs that give a human being a grip on the world; a unity of function that is arguably just as important in the subtle dysfunction of being in the world that we call "mood disorder" as it is in head injury.

The emergence of evidence of the enduring person being present to us from a volume in sustained and protracted re-integration is what we see as the process extends itself throughout the damaged soul, and it effectively re-inscribes the body as Tangata/Ubuntu— people whose being is inextricably tied to the being of others—such that nothing is lost at a level where solicitude becomes a web of support for each of us, whose fragile competence can be shattered by so many touches of the real.

The antireductive clinical encounter is old fashioned and, as Fins notes, often out of touch with effective, directed, evidence-based care as it reforms our health services worldwide. We cannot abandon the call for evidence of efficacy and effectiveness or turn back the clock, but it is not the clinical gaze, or the symptom and sign as indicator of taxonomic positioning, or any other category, that obscures the person that those of us who suffer are looking for. They do not want only to be seen as assemblages of functions susceptible to well-delivered interventions, but rather, we reach out to be engaged with through a health system that puts value on hospitality and solicitude, and that responds to variably silent moral demands by those of us who have lost their way or had it snatched from their vision and their grasp. Their need is to be cared for and brought back among us.

Our moral connection with effaced enigmata—people whom we can fail to recognize as having a sense of their own life that they will only reveal to us as they connect with us and trust us to the point of being themselves in our presence—is based on the unconditional commitment of rescue that prevails in our clinics and

emergency rooms. That, then, must be framed and reframed on an ongoing and changing basis by a nuanced commitment to care so that we are able to commit ourselves, where possible, to an antireductive restoration of subjectivity. Sometimes our subjective connection will show that what we are asking of a person and ourselves is a bridge too far, and that we must defer to mortality - the full stop that each of us will meet, sometimes unexpectedly, in the violence of head injury, and sometimes in a much more protracted way. If our first philosophical orientation is not ethical, then we will miss the mark tragically once the rescue imperative has faded and something has to take its place. Here, we and our patients can lose out badly if objective appraisal functionally overrides our connectedness to the one we may be losing; however, if we do look consistently for those who have been separated from our shared world by tragic events and if we remain sensitive to whether they can be retrieved in a meaningful way, that is not a generic mistake to which we will be prone.

A brain-injured person glimpses from afar and strives in a limited way toward being-in-the-world-with-others. Only if someone else reaches out to that person is it "doable" to reassemble the nonlinear dynamic connections required to be a person adapted to being-with-others; however, in some cases, it can be too hard and, for the shattered subject the long sleep beckons irresistibly.

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