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Hospicing Modernity Systems Therapy (HMST): A Post-Postmodern Clinical Framework for Addiction and Metabolic Care

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Abstract
Contemporary clinical medicine treats addiction, and increasingly the cluster of cardiometabolic disorders, as deviations from a presumed-healthy baseline to which the patient is to be returned. This paper advances a position: that for a growing share of patients, the baseline itself – the conditions of ordinary late-modern life – is implicated in the pathology, such that a clinical paradigm organised around return-to-normal is structurally incomplete. We propose Hospicing Modernity Systems Therapy (HMST), a clinical framework that reads the addicted body as already engaged in a private, unaccompanied, and incompetent hospicing of a self that cannot inhabit late-modern conditions without anaesthesia. Drawing primarily on Vanessa Machado de Oliveira's hospicing modernity, and secondarily on Bayo Akómoláfé's post-activism and the multispecies ecological thought of Donna Haraway and Anna Tsing, we situate HMST as a post-postmodern reconstructive framework: one that accepts the critical exposure of modernity's harms yet declines both the modern impulse to rescue and the postmodern settlement of ironic paralysis. We outline HMST's clinical sequence – hospice, compost, recompose – and its grounding in a metabolic-ecological systems model. We illustrate the framework through addiction care, including its bearing on the emerging use of GLP-1 receptor agonists, and we name candidly the central methodological tension: how to operationalise a clinical register for ethics review and replication without manualising the framework into the very thing it refuses to be. This is a position and viewpoint paper; it proposes a framework and a research programme rather than reporting trial outcomes.

Keywords: hospicing modernity; addiction; post-postmodernism; metabolic health; clinical philosophy; planetary health; pharmakon; GLP-1 receptor agonists

1. Introduction: when normal life is the diagnosis

Modern clinical medicine is organised around a restorative grammar. Disease is a departure from function; treatment is the restoration of function; cure is the return of the patient to the life they led before. For most of medicine, most of the time, this grammar is sound and humane. This paper concerns the cases where it

is not – where the life the patient is to be returned to is itself a principal driver of the condition being treated.

Addiction is the clearest instance. A patient presents with a substance dependency; the substance is withdrawn under clinical supervision; the patient is stabilised and discharged back into the conditions of their life; and a substantial fraction return. Relapse rates across substance-use disorders remain stubbornly high despite decades of refinement in detoxification and pharmacotherapy; McLellan and colleagues established two decades ago that they are broadly comparable to the recurrence rates of type 2 diabetes, hypertension, and asthma when treatment adherence lapses (McLellan et al., 2000). The conventional reading attributes relapse to the chronicity of the disease, to incomplete treatment, or to insufficient aftercare. We propose a complementary reading that the restorative grammar cannot easily accommodate: that for many patients the substance was performing work – the anaesthetising of a self that experiences the ordinary conditions of late-modern life as, in some register, unliveable – and that to remove the substance and return the patient to those same conditions is to remove a coping architecture without addressing what it was coping with.

The same structure is becoming visible across the cardiometabolic disorders. Type 2 diabetes, obesity, metabolic-dysfunction-associated steatotic liver disease, and the broader cardiometabolic cluster are increasingly understood not as discrete organ failures but as the somatic sequelae of a way of living: ultra-processed diets, sedentariness, chronic stress, disrupted circadian and microbial ecologies, and the dissolution of the food, soil, and community relationships within which human metabolism evolved. The scale of this is not marginal, and it is not confined to high-income settings: the ICMR-INDIAB national cross-sectional study estimates 101 million adults living with diabetes and a further 136 million with prediabetes in India alone (Anjana et al., 2023). Here too the clinic treats the downstream organ and returns the patient upstream to the conditions that produced the disorder.

We do not propose abandoning restorative medicine. We propose that a second clinical register is required alongside it for this class of conditions – a register that does not lie to the patient about the world they are being returned to. The philosopher and educator Vanessa Machado de Oliveira has given the operative ethic for such a register its sharpest contemporary name: hospicing modernity. This paper takes that ethic into clinical-therapeutic form. We call the resulting framework Hospicing Modernity Systems Therapy (HMST).

Our central claims are three. First, that HMST belongs to a post-postmodern moment in clinical thought – a reconstructive turn that has passed through critique rather than around it. Second, that the addicted body should be read as a body already hospicing, incompetently and alone, and that the clinical task is the replacement of an incompetent private hospicing with a competent, accompanied one. Third, that this work proceeds as a sequence – hospice, compost, recompose – grounded in a metabolic-ecological systems model rather than in metaphor alone.

2. The theoretical architecture: a post-postmodern turn

To call a clinical framework post-postmodern is to make a claim about its relationship to critique, and the claim must be made carefully if it is to mean anything. We use the term in a specific, reconstructive sense, and we distinguish it from a naive return to modern certainty on the one hand and from a continuation of postmodern irony on the other.

2.1 After critique: the reconstructive move

The modern medical project inherits the Enlightenment confidence that human suffering yields, in principle, to the steady advance of knowledge and technique. The twentieth-century critical traditions – from the sociology of medicine through the anti-psychiatry movement to the postmodern critiques of biopower – exposed what that confidence obscured: the contingency of diagnostic categories, the entanglement of medicine with social control, the manufacture of normalcy, and the violences carried within the very language of cure. This critical work was, and remains, valid. But critique, pursued as an end, tends toward a characteristic exhaustion. Rita Felski has described the way the "hermeneutics of suspicion" can become a self-confirming and ultimately sterile posture; Eve Kosofsky Sedgwick distinguished the "paranoid" reading that anticipates harm and exposes it from the "reparative" reading that assembles resources for survival and repair. The reconstructive turn we name is the movement from the paranoid to the reparative – not a forgetting of what critique disclosed, but a refusal to be permanently immobilised by it.

Bruno Latour gave this movement a name in his "compositionist" manifesto: after the moderns, who believed in a ready-made nature waiting to be revealed, and after the critical postmoderns, who dissolved every such certainty into discourse, comes the labour of composition – the patient, never-finished assembly of common worlds from heterogeneous parts, without the guarantee that the assembly was always already there. The metamodern "structure of feeling" described by Vermeulen and van den Akker names the same oscillation in the register of culture: a movement that swings between modern sincerity and postmodern irony without resting finally in either. HMST is post-postmodern in precisely this reconstructive, compositionist sense. It does not return to the modern clinic's faith that the patient can simply be repaired and returned. It does not rest in the postmodern observation that "health" and "normalcy" are constructions. It takes the construction seriously as a thing that can nonetheless be lived or not lived, and it asks what competent care looks like once one has stopped pretending the world the patient is returned to is innocent.

2.2 Hospicing modernity (Machado de Oliveira)

The framework's primary debt is to Vanessa Machado de Oliveira's Hospicing Modernity (2021), and to the wider body of work she has developed, often under the name Vanessa Andreotti, with the Gesturing Towards Decolonial Futures collective. Machado de Oliveira's governing figure is double. Modernity – understood not as a historical period but as a way of being, knowing, and desiring, bound up with separability, extraction, and the single story of linear progress – is, on her account, a dying system. The work proper to a dying system is not its rescue but its hospicing: the provision of palliative accompaniment to what is ending, with enough honesty and care that its death does not become a trauma compulsively replayed on whatever comes next. Alongside the hospice she places a second figure, the midwife: the work of assisting the birth of something that cannot yet be named or seen, and that we are not in a position to design in advance.

Two features of her account are load-bearing for HMST. The first is her insistence that the work is not, in the first instance, about fixing the world "out there," but about the difficult interior labour of becoming the kind of being who could inhabit a different world – what she frames, in a register drawn from depth education and from her Indigenous interlocutors, as the composting of one's own inherited habits of being. The second is her diagnostic naming of the denials by which modernity sustains itself – the denial of the systemic violence on which modern comfort rests, the denial of ecological limits, the denial of entanglement (the fiction that we are separable from one another and from the living world), and the denial of the sheer magnitude of the predicament. We read these denials clinically. The patient who cannot inhabit

late-modern conditions without anaesthesia is frequently a patient in whom one or more of these denials has become unsustainable at the level of the body – a body that can no longer not know what the surrounding culture is organised to keep from knowing.

The clinical translation is direct. If modernity is a system whose competent hospicing is the work of the hour, then the addicted body is a body that has already begun that work – privately, without accompaniment, and with the wrong instrument. The substance is what Jacques Derrida, reading Plato, called the pharmakon: at once remedy and poison, the cure that is also the harm. The addicted person has reached, in the substance, for a genuine palliative – a way of making the unliveable temporarily liveable – and has found a failed pharmakon, one whose palliation exacts a mounting somatic and social cost. The clinical task, on this reading, is not to confiscate the failed pharmakon and call the patient cured. It is to replace an incompetent, solitary hospicing with a competent, accompanied one.

2.3 Post-activism (Akómoláfé)

If Machado de Oliveira supplies the framework's governing ethic, Bayo Akómoláfé supplies its tempo and its warning. Akómoláfé's post-activism – captured in his much-cited invitation that, the times being urgent, we should slow down – is not a counsel of passivity but a suspicion of the reflex to respond to a crisis with the same habits of urgency, mastery, and heroic intervention that helped produce it. He asks whether the way we typically respond to a crisis is itself part of the crisis. For a clinic, the warning is pointed. The instinct of modern medicine before a relapsing, deteriorating patient is to intensify: more intervention, tighter protocol, faster throughput. Akómoláfé's post-activism licenses a different clinical posture – the making of sanctuary, the deliberate slowing, the refusal to convert every encounter immediately into a managed outcome. It is also the register in which the clinician's own complicity becomes visible: the clinic is not outside the world that is making its patients ill. We note, without overstating it, that Akómoláfé writes from a Yoruba cosmological inheritance in which the trickster at the crossroads – Ẹ̀ṣù – is the figure of the threshold and the unexpected turn; the framework's attention to the clinical encounter as a crossroads rather than a conveyor draws on that sensibility.

2.4 Multispecies ecology and the compost (Haraway, Tsing)

The framework's third theoretical resource supplies the middle term of its clinical sequence and the justification for the word systems. Donna Haraway's Staying with the Trouble (2016) refuses both techno-optimist rescue and apocalyptic despair in favour of staying with the damaged present and making kin within it; her insistence that we are compost, not posthuman, names the process by which what has died is not discarded but metabolised into the conditions of new life. Anna Tsing's study of the matsutake mushroom, which fruits in forests ruined by human industry, develops a parallel insight: that life persists in capitalist ruins through collaborative survival and contaminated diversity, in assemblages that no one designed. Composting, in this lineage, is not a metaphor for decay but a precise name for a generative process – the transformation, by a living community of metabolisers, of dead matter into fertile ground.

This is why the framework is a systems therapy and not simply a therapeutic attitude. The body that is hospiced does not recompose out of nothing. It recomposes through the literal metabolic and ecological systems within which human health is constituted – the soil that grows the food, the food that feeds the gut, the gut and oral microbial communities that mediate metabolism and immunity, and the social and relational ecologies within which eating, resting, and recovering occur. The wider research programme within which HMST sits treats this soil–gut–oral continuum as a single clinical object. The composting middle term of HMST is where that systems model does its work: the hospiced self is metabolised, through restored ecological and relational systems, into the ground from which a recomposed self can grow.

3. From frame to clinic: the architecture of HMST

We can now state the framework directly. HMST is a clinical register, deployed alongside conventional restorative care, for conditions in which the patient's ordinary life is implicated in the pathology. It proceeds as a sequence of three movements, which are clinical processes rather than discrete treatment phases and which overlap in practice.

3.1 Hospice

The first movement is the competent, accompanied hospicing of the self that cannot inhabit present conditions without anaesthesia. Clinically, this means neither the simple confiscation of the failed pharmakon nor the promise of return to a prior normal, but the honest accompaniment of a grief: the recognition that something – a way of being in the world, a set of expectations, a self – is ending, and that its ending can be attended with dignity or denied. The clinician here works in a register closer to that of the palliative-care physician or the death doula than to that of the acute interventionist. The substance is withdrawn, but what is offered in its place is not exhortation to normalcy; it is accompaniment through the loss that the substance was anaesthetising.

3.2 Compost

The second movement is composting: the metabolisation of what has been hospiced into fertile ground rather than its denial or disposal. This is where the framework's systems grounding becomes operational. The patient's ruined metabolic and relational ecologies – dysregulated gut and oral microbial communities, disrupted circadian and nutritional patterns, severed food and community relationships – are the matter to be composted. Clinically, the compost movement comprises the concrete, systems-level rebuilding of these ecologies: microbial, nutritional, circadian, and relational restoration, undertaken not as lifestyle advice appended to the real treatment but as the substantive therapeutic work of the middle phase. The insight that organises this movement is that composting is what happens to the hospiced body: the death attended in the first movement becomes, in the second, the ground of the third.

3.3 Recompose

The third movement is recomposition: the slow growth, from composted ground, of a self able to inhabit a liveable life – not the prior normal restored, but a recomposed mode of living that does not require anaesthesia. This is deliberately the least manualised of the three movements, because its content cannot be specified in advance without reproducing the modern presumption that the clinician knows what a good life is and can prescribe it. The recompose movement is, in Machado de Oliveira's terms, the midwife's work: the assisting of a birth whose form is not yet known. The clinician's role is to hold the conditions within which recomposition can occur, and to resist the urge to specify its outcome.

3.4 Why "systems" – the metabolic-ecological grounding

It is worth stating plainly what distinguishes HMST from a purely philosophical or attitudinal reframing of addiction care, of which there are many. HMST is a systems therapy because its central therapeutic movement – composting – is enacted through measurable, modifiable biological and ecological systems, not through insight alone. The soil–gut–oral microbiome continuum, dietary and circadian restoration, and the rebuilding of food and community relationships are the concrete substrate of the compost movement. This grounds the framework's otherwise philosophical claims in a domain that is clinically actionable and empirically tractable, and it is what allows HMST to be studied rather than merely espoused.

4. Application: addiction care and the GLP-1 question

HMST is first being developed in addiction care, in a clinical collaboration in Gurugram, India, because addiction renders the framework's logic most legible: the failed pharmakon is explicit, the inadequacy of return-to-normal is measurable in relapse, and the grief that the substance anaesthetises is close to the surface. In this setting the three movements take concrete form. The hospice movement reframes medically supervised withdrawal as accompanied grieving rather than mere detoxification. The compost movement undertakes the systems-level rebuilding of the patient's metabolic and relational ecologies during and after stabilisation. The recompose movement holds open, without prescribing, the emergence of a liveable post-substance life.

The framework bears directly on one of the most significant recent developments in addiction medicine: the emerging and still-unsettled evidence that GLP-1 receptor agonists, developed for diabetes and obesity, may reduce craving and consumption in substance-use disorders. The evidence base warrants precision rather than enthusiasm. Individual randomised trials have reported significant reductions – semaglutide on drinking outcomes in alcohol use disorder (Hendershot et al., 2025), dulaglutide on alcohol consumption during smoking cessation – while pooled meta-analysis of the small existing trial set has not demonstrated a significant class-wide effect, even as large observational datasets suggest one (Sinha & Ghosal, 2025). The signal is real; its magnitude, mechanism, and durability are not yet established. An HMST reading situates this development with both interest and caution. The interest is obvious: a pharmacological agent that operates on the metabolic systems the framework already foregrounds, and that may reduce the somatic insistence of craving, is a potentially powerful adjunct to the compost movement. The caution is equally clear and follows directly from the framework's post-postmodern commitments: a GLP-1 agonist that merely substitutes a competent pharmacological anaesthesia for an incompetent one, while returning the patient to the same unliveable conditions, would be a more sophisticated failed pharmakon, not an exit from the structure. The framework's value here is precisely that it specifies the difference – between a pharmacological agent used within an accompanied hospicing and composting, and the same agent used as a more efficient return-to-normal. This is a researchable distinction, and we identify it as the single highest-value line of empirical enquiry the framework opens.

5. The central tension: operationalisation without betrayal

A framework that proposes to be studied and replicated must be specified; a framework whose third movement explicitly refuses to prescribe the good life resists specification. This is not an incidental difficulty but the framework's constitutive tension, and we state it candidly rather than conceal it. The risk is that, in the legitimate effort to render HMST suitable for ethics review, manualisation, and trial, the framework is reduced to a checklist of "hospicing" and "composting" interventions – at which point it becomes exactly the manualised, outcome-specifying, return-to-normal protocol it was formulated to displace.

We propose to hold this tension rather than resolve it, by specifying the framework asymmetrically. The hospice and compost movements admit of substantial operationalisation: accompanied withdrawal, grief-attentive clinical protocols, and the systems-level metabolic and relational interventions of the compost movement can be described, delivered consistently, and measured. The recompose movement is specified only negatively and procedurally – by what the clinician must refrain from doing (prescribing the outcome), by the conditions that must be held open, and by patient-defined rather than clinician-defined markers of a liveable life. Outcome measurement, correspondingly, must include patient-generated and

narrative measures alongside conventional clinical endpoints such as abstinence, retention, and metabolic markers, since a purely conventional endpoint set would silently re-impose the return-to-normal criterion the framework rejects. This is a demanding methodological posture, and we do not claim to have fully solved it; we claim that naming it honestly is a precondition of doing so.

6. Limitations, risks, and what HMST is not

Several clarifications guard the framework against predictable misreadings. HMST is not a replacement for evidence-based addiction or metabolic medicine; it is a clinical register proposed for use alongside it, and it presupposes rather than displaces competent pharmacological and medical management. It is not an argument that addiction is "really" a philosophical or civilisational condition rather than a medical one; it is an argument that, for a class of patients, the medical and the civilisational are not separable, and that pretending otherwise produces the revolving door the field already observes. It is not a romanticisation of suffering or a counsel of resignation; the hospice movement is a form of active, skilled care, not abandonment. It is not a covert evangelism for any particular vision of the good life; the negative specification of the recompose movement is the framework's structural guarantee against precisely that.

The framework's principal risks are three, and we name them. The first is dilution – the absorption of HMST's vocabulary into business-as-usual care without its substance, such that "hospicing" becomes a fashionable synonym for supportive counselling and nothing changes. The second is over-claim – the presentation of a framework, at the position-paper stage, as though it were an evidence base; we have tried throughout to mark the difference between what is argued and what is yet to be shown. The third is cultural mistranslation – the framework draws on Indigenous, decolonial, and non-Western cosmological sources, and its deployment in an Indian clinical setting carries both a genuine resonance with Indian philosophical traditions and a real risk of appropriative flattening; we regard the careful, located handling of these sources as an ethical requirement rather than an ornament. We also note the obvious limitation that this paper reports no outcome data; HMST is here a framework and a research programme, and its claims are to be tested, not assumed.

7. Conclusion

Medicine has always known how to attend to dying; it is one of its oldest competencies. What the conditions of late modernity ask of the clinic is the extension of that competency to a stranger object – not only the dying patient, but the dying world the patient is being treated to re-enter. Hospicing Modernity Systems Therapy proposes that, for the class of conditions in which ordinary life is implicated in the pathology, the clinic can do better than confiscate the patient's failed pharmakon and return them to the conditions that made it necessary. It can offer, instead, a competent and accompanied hospicing of the self that could not live as things are; it can compost what has died into fertile ground through the patient's restored metabolic and relational ecologies; and it can hold open, without prescribing, the recomposition of a liveable life. This is a post-postmodern clinical posture: it has passed through the critique of modern medicine and declined to be paralysed by it, and it returns to the bedside not with restored certainty but with a more honest and more patient form of care. We offer it as a framework to be tested, and we invite the clinical and research collaboration through which that testing can begin. A fuller theoretical exposition, together with the operationalisation architecture, measurement framework, and study protocol through which HMST is to be evaluated, is in preparation and will be reported separately.

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Ethics approval and consent: Not applicable. This is a conceptual position and viewpoint paper. It reports no human-subjects research, no patient data, and no clinical outcomes. Any empirical evaluation of the framework described here will be subject to prior institutional ethics review and approval.

Data availability: Not applicable. No datasets were generated or analysed for this paper.

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