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## Chapter Nine

### THE PHILOSOPHICAL ROLE OF ILLNESS

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“For what is it to be ill? Is it that you are near the severance of the soul and the body?”

(Epictetus, *Discourses*)

#### Introduction

This paper examines the philosophical role of serious, chronic, or life-threatening illness.<sup>i</sup> Illness has been a theme in the history of philosophy, in particular in relation to its moral, existential, and spiritual value. For example, Epictetus (2004), Seneca (2004), Marcus Aurelius (1995), Boethius, and Descartes (1988) write about illness and its contribution to the modes and themes of philosophising, as well as the relationship between health and virtue, and health’s contribution to the good life (e.g. Boethius’ *Consolation of Philosophy*, Book IV, Seneca’s *On the Shortness of Life*, Epictetus’ *Discourses* and Marcus Aurelius’ *Meditations*). We find Descartes commenting in his *Discourse on Method*: “For even the mind depends so much on the temperament and disposition of the bodily organs that if it is possible to find some means of making men in general wiser and more skilful than they have been up till now, I believe we must look for it in medicine” (1988, 47). He sees health as “the chief good and the foundation of all other goods in this life” (ibid.). Perhaps most famously, Montaigne, following Socrates, claims that the whole point of philosophy is to prepare us for illness and ultimately death.

Philosophical reflection on illness in the Western tradition has tended to be shaped by Stoic, Epicurean, and, later, Christian philosophies, each of which emphasise the importance of achieving a reflective coping with illness, seen as an essential feature of the world. Why this reflective attitude to illness is essential differs, though, by tradition. The Stoics seem to argue that everything that exists, including ostensibly bad things like illness, are all essential components of the rational order

of the cosmos, so the properly philosophical response is to recognise this and reflectively accept illness. We find Epictetus saying : “A man who has a fever may say: If I philosophize any longer, may I be hanged: wherever I go, I must take care of the poor body, that a fever may not come. But what is philosophizing? Is it not a preparation against events which may happen?” (*Discourses*, “In what manner we ought to bear sickness”).

But for later Christian thinkers, such as Boethius, illness is a mark of our corrupt, imperfect state, and hence not an original feature of God's design. Boethius characterises wickedness of the soul as akin to bodily sickness; while the former deserve hatred, the latter should be treated with pity (*Consolation of Philosophy*, Book IV). So the properly philosophical response is to use illness in a doubly edifying way: first, as a reminder of the frailty and corruption of our mortal status and, second, as a source of moral and spiritual improvement (Kidd 2012).

This is now largely a lost theme in philosophy because of the gradual erosion of philosophy's phronetic role (although see Nussbaum 1994 ).<sup>ii</sup> I propose that this theme should be reawakened and that more work needs to be done to examine and describe the philosophical role of illness. This paper outlines some of the ways in which illness is philosophically relevant, as part of the attempt to ignite this reawakening (see also Kidd 2012).

I suggest that illness is relevant to philosophy because it uncovers aspects of embodied existence and experience in ways that reveal additional dimensions of human life. It does this by broadening the spectrum of embodied experience into the pathological domain, and in the process shedding light on normal experience, revealing its ordinary and therefore overlooked structure. Illness broadens the range of bodily as well as mental experience (e.g. delusions, dementia). Moreover, illness is (at present) an integral part of biological life and thus must be taken into account when considering human life as a whole. Discussions of the good life, human relationships and ethics would be incomplete if they did not take into account the full spectrum of human life and experience, spanning sickness and health, childhood, adulthood, and old age. In addition, illness is an opportunity for reflection, because of its distancing effect, which illuminates taken for granted

values and expectations by destroying the assumptions that underpin them (e.g. assumptions about longevity, capability and autonomy). I suggest that these characteristics warrant illness a philosophical role.

However, illness is a unique form of philosophizing. While the execution of most philosophical procedures, such as casting doubt or questioning, is volitional and theoretical, illness is uninvited and threatening. Illness throws the ill person into a state of anxiety and uncertainty. As such it can be viewed as a radical, violent philosophical motivation that can profoundly alter our outlook. I argue that the radical nature of illness should be utilised to sharpen and expand philosophical discussion.

I conclude by examining the ways in which illness may impact upon the practice of philosophy. I argue that illness can be integral to philosophical method in a number of ways: in shaping and influencing philosophical methods and concerns, modifying one's sense of philosophical salience and conception of philosophy, and increasing the urgency and appeal of particular philosophical topics.

The structure of the paper is as follows. Section one outlines the centrality of the body for human experience and discusses how illness changes embodiment, meaning and being in the world. Section two discusses illness as a form of *epoché* performed through objectification and uncanniness. Section three discusses illness as a motivation to philosophise and outlines how illness may change our modes and styles of philosophising.

### **1. Illness modifies embodiment, meaning and being in the world**

Three aspects of existence are significantly modified by illness: embodiment, meaning, and being in the world. Embodiment is the fundamental characteristic of human existence (Merleau-Ponty 1962; Clark 1997, 2008; Wheeler 2005). Cognition and behaviour cannot be accounted for without considering the perceptual and motor apparatus that facilitates our dealing with the world (Calvo & Gomila 2008, 7). The body is the condition of possibility for perception and interaction with

spatial objects and our means for having a world. As Gallagher and Zahavi write “the body is considered a constitutive or transcendental principle, precisely because it is involved in the very possibility of experience” (2008, 135). Every worldly experience is mediated and made possible by embodiment (Zahavi 2003, 99). Or as Merleau-Ponty put it, the body is “that which causes [things] to begin to exist as things under our hands and eyes” (1962, 146).

Counter to a purely naturalistic understanding, the body is not merely a thing among things. Embodiment determines spatial relations and temporal experiences, whilst also participating in these relations as a secondary form. The body is “the centre around which and in relation to which space unfolds itself” (Zahavi 2003, 99). According to Husserl, motility and tactile experience are fundamental not just for perception but for any organised subjective experience (Husserl 1997). In this sense the body is the foundation of human experience. As Taylor Carman writes, the body “plays a constitutive role in experience precisely by grounding, making possible, and yet remaining peripheral in the horizons of our conceptual awareness” (1999, 208). Or to use Merleau-Ponty’s famous formulation, the body is “our general medium for having a world” (1962, 146).

The form of my embodiment serves as part of the background of my experience (Smith 2007, 223). This structure defines, for example, the coordinate system of my visual field and my proprioception. Different sensory fields are bound together to create a unified stream of meaningful experiences, united by a body with an established repertoire of habits, activities, and style (on style see Meacham 2013). In Husserl’s terms, the constitution of my body is essential to the constitution of objects appearing to me and indeed to the constitution of space and time (Husserl 1997, §73).

Given how central the body is, a change to a bodily function entails a change to one’s way of being in the world. Such a change will also affect the meaning of experience. For example, the experience of dancing will be radically altered by respiratory disease, both on the level of bodily feeling, which turns from a pleasurable experience to one of exertion, and on the level of meaning, when it changes from an experience of ‘I can’ to an ‘I cannot’ (cf. Carel 2012). The types of changes affected by illness may range enormously, from changes to sensory experience, meaning, and to

cognitive and emotional experience. If we think about symptoms as disparate as loss of mobility, loss of memory and incontinence, we can see that such changes are radical and remove the ill person from the realm of familiar, predictable and well understood experience. This displacement from the familiar destabilises the structure of experience and reveals new aspects of our being, such as our ability to adapt, mourning and dependency. The bodily foundations of autonomous adulthood are often removed, revealing the tentative and temporary nature of these foundations. Illness can disclose finitude, dis-ability, and alienation from one's body as extreme modes of being.

The philosophical illumination offered by the study of illness has been recently explored by Matthew Ratcliffe, who studied the experience of time in depression (2012b). Ratcliffe argues that there is strong evidence that the experience of time is affected in a number of ways in depression. He offers a phenomenological analysis of this experience, using Thomas Fuchs' application of Husserl's notion of retention and protention to the experience of time in depression. On this account time both slows down and accelerates in depression. This alteration to the normal experience of time can be explained by the effects of depression. On Ratcliffe's account, depression removes meaning, obliterates the desire to carry out projects, and stops the attribution of value to different projects in the depressed person's world (ibid.). Ratcliffe claims that the breakdown in such cases is not merely in the *contents* of experience but in the *structure* of experience itself.

Because illness can affect many body parts and functions, it can delineate different aspects of embodiment by serving as a limit case (Carel 2013).<sup>iii</sup> The loss in illness may be of overall functionality, but also of flexibility and variability. With a narrowed spectrum of activity, one's motility, assessment of duration, and notions such as 'difficult' and 'far', are modified. The restriction is not only a conscious understanding but underlies the kind of action one's body spontaneously performs. Here is a description of such pre-reflective modification:

Every time I tried – and failed – to do something that was too strenuous my body stoically registered the failure and thereafter avoided that action. The change was subtle, because this happened by

stealth [...] I stopped feeling all the things I could not do. They were quietly removed from my bodily repertoire in a way so subtle I hardly noticed it (Carel 2008, 34).

Illness may lead to a collapse of meaning, or what Heidegger calls anxiety (1962). In anxiety one's overall sense of purposeful activity is lost, leaving the person experiencing anxiety unable to act. Action is grounded in meaning: I pull a shirt over my head in order to get dressed. I get dressed in order to go to work. I go to work in order to earn a living, and so on. Ultimately, this nested set of goal-directed activities comes to an end and human existence is ungrounded. A realisation of the groundlessness of human existence leads to what Heidegger calls anxiety (*Angst*). In anxiety purposefulness disappears and the meaning of entities is lost. They turn from being ready-to-hand (*Zuhanden*) entities we use (t-shirt, shoes, reading lamp) to being present-at-hand (*Vorhanden*) entities which confront us with their lack of usefulness, and hence their lack of meaning. In anxiety intelligibility is lost because the practical coherence of entities has been lost with the sense of purposefulness.

Loss of meaning is often reported in cases of mental illness. Matthew Ratcliffe cites a schizophrenic patient who says:

When, for example, I looked at a chair or a jug, I thought not of their use or function – a jug not as something to hold water and milk, a chair not as something to sit in – but as having lost their names, their functions and meanings (2013).

Illness can also give rise to another kind of loss of meaning, related to the loss of the ability to perceive things as useful tools, and experiencing the contingency and irretrievability of meaning. In somatic illness a ready-to-hand entity like a staircase can turn from being a practical tool to being a present-at-hand entity, or even a conspicuous obstacle. S.K. Toombs, a philosopher suffering from Multiple Sclerosis, writes: “the bookcase outside my bedroom was once intended by my body as a ‘repository for books’; then as ‘that which is to be grasped for support on the way to the bathroom’, and is now intended as ‘an obstacle to get around with my wheelchair’” (1995, 16). Somatic illness may cause a sudden and often disturbing sense of the contingency of the meanings and uses we

assign to things: “The bookcase holds books. Of course it does! What else might it do? It might obstruct, impede, sadly remind ...”. There is also a sense of the irretrievability of certain meanings: “the bookcase will always be an obstacle and will only cease to be so once I cease to be so”. The sense of inhabiting a space of possibilities can be replaced by a sense of this space becoming delimited and static.

The changes brought about by illness are not localised to a specific object, but modify one’s entire interaction with objects and the environment, i.e., their being in the world. For a wheelchair user it is not just this shop or that doorway that are inaccessible, but the environment as a whole becomes less inviting or even hostile. Illness can expose not only the limits of human existence but also the biases of an environment.<sup>iv</sup>

Illness may be philosophically salient in one of two ways. It is, in some cases, a severe and sudden disruption of our life. In this situation the illness is something foreign, threatening, and disruptive which we seek to get rid of. A bout of ‘flu or gastric infection are examples of this type of illness. This type of illness is philosophically useful because of its acute disruption of the everyday; it makes visible the taken for granted manner in which we structure our routine life. We take for granted that we can plan our day, perform a variety of activities and get from one place to another. These tacit assumptions are placed in abeyance in the case of a sudden illness. Feelings of missing out, being useless, and feeling unwell expose the underlying sense of participation, purposefulness, and potency that has been disturbed.<sup>v</sup>

But illness may also appear more subtly and tacitly. The symptoms may be minor and not quite noticeable until they reach a certain threshold, or until they are picked up in routine screening. In this case the illness is not an acute disruption of the everyday, but still alters the everyday capacities of the ill person, and thus may also give rise to philosophical reflection, albeit of a different sort. Shaun Gallagher describes this kind of illness as one that “either sneaks up on us, or that we become so habituated to (perhaps because it won’t go away) that it defines our form of life – it becomes us, or we become it” (unpublished presentation). Whereas in acute illness the



expectation that the illness will 'go away' is very much part of the experience of illness, this expectation disappears in chronic illness. Arthur Frank contrasts his heart attack, which he interpreted as 'an incident', with his cancer:

After an incident like my heart attack I was able to bounce back [...] That's accurate because in most cases we do not sink into an experience, we only hit the surface. I may have bounced back from a heart attack, but with cancer I was going to have to sink all the way through and discover a life on the other side (1991, 28).

The second type of illness is not a disruption, but a "complete form of existence", as Gallagher writes, following Merleau-Ponty (Gallagher, *ibid.*; Cf. Merleau-Ponty 1962). In this case, the disturbance runs deeper and longer, and thus must be dealt with in a different way than a passing illness such as food poisoning. When illness becomes a complete form of life, concepts (such as 'worthwhile' or 'difficult') are modified, the expectations the ill person has of her life change, and her understanding of time and value needs to be readjusted. Chronic or progressive illness is a comprehensive realignment of meaning, values, and ways of being that culminates in illness becoming one's complete form of existence. This process is a kind of distancing from one's previous form of existence, and as such it throws it open to philosophical examination.

## **2. Illness as *epoché*: objectification and uncanniness**

Because illness removes the taken for granted nature of motility and bodily capability, it makes what is normally natural and unreflective become artificial and conscious (Gallagher 2005). In this section I explain how this process gives rise to philosophical reflection. It is characterised by *objectification* and *uncanniness* which I use in this section to demonstrate the role of illness as a mode of philosophising.

Illness can be seen as a crisis of meaning in one's life. This crisis arises from a collapse of the ill person's life narrative (Williams 2003) but also a disruption of routines, habits, expectations and

abilities. This disruption shakes one's everyday life, and provides a distance from it. This distance has been described by Arthur Frank as a 'dangerous opportunity':

Critical illness offers the experience of being taken to the threshold of life, from which you can see where your life could end. From that vantage point you are both forced and allowed to think in new ways about the value of your life. Alive, but detached from everyday living, you can finally stop to consider why you live as you have ... (1991, 1).

This brings to mind the ancient Greek conception of philosophy—introduced by Socrates and embraced by the Stoics, and later valorised by Montaigne—that to philosophise is to learn how to die (Montaigne 1993). Learning how to die in this context may mean more than accepting one's mortality. It furnishes this highly abstract demand with concrete content. Learning how to die means learning to be ill, confronting pain and disability, accepting diminishing abilities and dealing with mourning, envy and sadness. In the words of Epictetus: "What is it to bear a fever well? Not to blame God or man; not to be afflicted at that which happens, to expect death well and nobly, to do what must be done" (*Discourses*, "In what manner we ought to bear sickness").

Illness calls upon the ill person to explore her life, its meaning, priorities, and values; this personal quest is well documented in sociology of medicine, medical anthropology, qualitative healthcare research, and cancer psychology (Brennan 2001; Thorne & Paterson 1998; Thorne et al 2002). But illness can also be used as a distinctively *philosophical* tool to move beyond the idiosyncratic and personal to more general and abstract exploration of embodiment as a source of meaning and the condition of possibility for the self. In particular, the anxiety, loss of meaning and de-familiarisation described in the previous section give rise to a peculiar form of what Husserl termed the *epoché*, the bracketing of the natural attitude. The *epoché* asks us to dislodge ourselves from everyday habits and routines in order to reflect on them; this, I suggest, is what happens in illness, albeit in a raw and unformulated manner.<sup>vi</sup> Illness is a particular form of *philosophical motivation*, characterised by violence, negativity and being forced upon the ill person. The *epoché* asks us to shift our focus from objects to acts of perception, but does not involve ceasing to

perceive; it is not a sceptical procedure. It is not a removal from the world but a shift in a way of being in the world that enables philosophical reflection, without ceasing to take part in the world. Exercising the *epoché* involves stripping away of shared meaning, known uses and familiar connections between person and object. The object then becomes estranged and appears in novel ways. Thus the experience of illness, or anxiety, as a particular type of *epoché* can shed new light on taken-for-granted aspects of the world.

Illness suspends the natural attitude - the taken-for-granted, meaning-laden and metaphysically determined way of experiencing the world. Such suspension does not mean doing away with the natural attitude, as that is impossible, but maintaining the attitude whilst suspending the underlying metaphysical beliefs underpinning it. This is the neutralization of one's belief in the existence of the world or of an object, which Husserl called the *epoché*. This neutralisation is employed in the shift from the natural to the critical attitude (Drummond 2007, 67-68).

We do not affect the *epoché* in order to “deny, doubt, neglect, abandon, or exclude reality from our research, but simply to suspend or neutralise a certain dogmatic attitude toward reality [...]” (Zahavi 2003, 45). Bracketing the natural attitude is a withdrawal from the ordinarily implicit commitment to the reality of the world (Ratcliffe 2008, 4). Bracketing turns the world into a phenomenon of being, instead of something that is. As Husserl makes clear, this is not a sceptical or idealist position. Rather, this ‘inhibiting’ or ‘putting out of play’ of the natural attitude exposes “my pure living [...] the universe of phenomena in the phenomenological sense” (Husserl 1999, 20). This suspension neither questions nor negates reality; rather, it allows under-theorised aspects of experience to become an object of enquiry, because it enables us to shift attention from the given object to the way in which it is given and its modes of appearance. As Husserl writes in *Ideas I*, “the whole pre-discovered world posited in the natural attitude [...] is now without validity for us; without being tested and without being contested, it shall be parenthesised” (1982, §32, 62). But importantly, the *epoché* “leaves everything exactly as it is” (Smith 2003, 23).

Zahavi characterises the *epoché* as a philosophical entry gate (2003, 46). I suggest that because of its de-familiarising effect illness is such an entry gate into philosophy. It is an invitation to investigate subjectivity under the conditions of illness, and thus to expand the conditions under which subjectivity is studied. As such it can reveal novel facets of subjectivity that otherwise remain unnoticed. For example, Merleau-Ponty gives a philosophical analysis of the case of Schneider, a World War I soldier with brain injuries, studied by neurologists Adhemar Gelb and Kurt Goldstein in 1918 (Merleau-Ponty 1962, 103ff.). Merleau-Ponty interprets Schneider's inability to perform abstract movements, initiate sexual relations, or stray from a daily routine as the breakdown of his intentional arc:

[...] the life of consciousness – cognitive life, the life of desire or perceptual life – is subtended by an 'intentional arc' which projects round about us our past, our future, our human setting, our physical, ideological and moral situation [...] It is this intentional arc which brings about the unity of the senses, of intelligence, of sensibility and motility. *And it is this which 'goes limp' in illness*" (1962, 136, my emphasis).

This breakdown of normal human existence provides a unique opportunity to uncover facets of normal existence that are not visible under normal conditions. Similarly, Shaun Gallagher (2005) discusses the case of Ian Waterman, who suffered from de-efferentation from the neck down. Waterman was forced to use vision to locate his limbs and identify his posture. Gallagher uses this case to provide an in-depth account of normal proprioception.

In illness, the *epoché* is *forced upon* the ill person, because of the modification to and limitation on her body imposed by illness. The ill person may have no interest in philosophy and no desire to undergo existential change. However, illness – an uninvited guest – forces itself upon the ill person, and compels her to modify and thus re-examine her bodily habits, existential expectations, experience of body, space and time, and way of being in the world (Carel 2012). Illness is a form of violent removal of the natural attitude, which enacts a philosophical procedure in a way that is far more brutal than usual philosophical reflection. Illness motivates ill people, and often those around

them, to confront practical concerns, and this, in turn, gives rise to theoretical reflection on one's embodied situation. It is an uninvited type of reflection, but such coping with practical concerns reveals the normal conditions under which one previously operated in health. It replaces health, which is "life lived in the silence of the organs", as the French surgeon Leriche wrote (cited in Canguilhem 1991, 91). This allows these conditions to be explored, as their silent function is lost and they become the object of explicit attention. The natural attitude is not immune to theorising or meta-reflection, under circumstances which disrupt it. Illness is one such circumstance.

Merleau-Ponty characterises the *epoché* as an experience of "wonder in the face of the world" (1962, xiii). This sense of wonder, interrogation, puzzlement, characterises some experiences of illness. For examples, it drove Randy Pausch to write *The Last Lecture*, a series of talks about life and death, after being diagnosed with pancreatic cancer. "Many people might expect the talk to be about dying. But it had to be about *living*", he writes (2008, 9). Because of changes to the somatic or mental architecture of one's body (or mind), one's contact with, and experience of, the world can be radically modified in illness. One's sense of comfort and familiarity may be displaced by alienation and a sense of 'not being at home' (Svenaeus 2000). Merleau-Ponty writes: "[Reflection] slackens the intentional threads which attach us to the world and thus brings them to our notice; it alone is consciousness of the world because it reveals that world as strange and paradoxical" (ibid.). I suggest that illness is such a slackening of the intentional threads which reveals the world and embodiment as uncanny. In other words, illness problematises the relationship to one's world, or one's being in the world, thus lending itself to, or even forcing, philosophical reflection.

The *epoché* also arises from the rift between the biological and lived body, which becomes observable in certain cases of illness. In health the two aspects of the body usually cohere, or respond in harmony to a normal range of experiences (but see Carel 2014). In illness the biological body comes to the fore, as it ceases to cooperate with the ill person's desires. For example, a diabetic's biological body will be unable to cope with a chocolate mousse, despite her lived body's craving for it. In addition to the rift, the biological body also becomes the source of pain, disability

and failure. In this respect it becomes the source of negative experiences and the focus of medical attention, which often further distance us from it (Carel 2008).

Lawrence Hass views illness as conflict between the biological body and life projects. Whilst the individual person's 'personal life' is engaged in a project the biological body obstructs it. For example, one's personal aim may be to become a parent. However, if the biological body is infertile, the result is a clash between the desire to have a child and the biological barrier. The impersonal operations of the biological body, over which we have little or no control, interfere with the intentional arc of the person, the meaningful connection between person and world which is aimed at a particular goal (Hass 2008, 87). This sense, that one's body is an obstacle, a problem, something that is no longer well-understood, may initiate a kind of *epoché*. The metaphysical status of the body is thrown into question, because it is no longer familiar and predictable. In other words, the body is subject to a process of objectification in illness, as well as becoming uncanny – two processes to which we now turn.<sup>vii</sup>

**Objectification** – the natural process secondary to experiencing the lived body is experiencing the body as an object amongst objects. In illness this process takes on a new dimension, as so much of modern medicine and the sciences underlying it rely on viewing the body as a physical object.<sup>viii</sup> This objectification takes place under the dual experience we have of our bodies. The body is experienced as both a lived, pre-reflective body (my first-person experience of and through it) and as an objectified, observed, spatial object (the third-person experience of it) (Merleau-Ponty 1962; Sartre 2003). It is both a physical object, made of matter, *and* the seat of consciousness.

The exploration of objects implies a simultaneous self-exploration and self-constitution; there is a reciprocal co-dependency between the processes. "The world is given to us as bodily investigated, and the body is revealed to us in this exploration of the world" (Zahavi, 2003, 105). We are aware of perceptual objects because we are aware of our bodies and how the two interact. When we investigate objects, this is always accompanied by some kind of bodily self-awareness. In

illness objectification gives rise to a distance between oneself and one's body, which is now reified into an object of medical inquiry and treatment. Objectification breaks down the natural taken-for-granted attitude towards the body, the seamless unity between the body as object and the body as subject.

Merleau-Ponty claims that the body is the first object we perceive *as* an object, thematising and learning to interpret and judge it according to cultural standards (Merleau-Ponty 1962). Prior to that event, I do not experience my body; rather, I experience *through* my body. As Zahavi writes, "Originally my body is experienced as a unified field of activity and affectivity, as a volitional structure, a potentiality of mobility, as an 'I do' and 'I can'" (2003, 101). Illness impedes the natural sense of ability and activity, and enables us to explore the volitional structures of embodiment. Our natural orientation is one in which the body serves as the perceptual centre of our experience, with our attention directed away from it, rather than to it. The negative, unwanted focus on the body in illness reorients our attention back towards the body, but this time viewed as an object. Many of us have had the experience of seeing an x-ray of scan of our bodies and having to relate our subjective feeling of our body to this objectifying image.

The duality of the body plays a complex role in healthcare provision. The health professional experiences the patient's body as an object, but is also aware of its subjectivity (so will apologise for having cold hands when touching a patient). The patient may feel objectified by the physician's gaze, but this objectification is only possible because she is first a subject (Carel & Macnaughton 2012). The physician perceives an appearance of an experienced object: a swollen arm. The patient perceives a localised sensing: the sore arm. She may also be shown an x-ray of her arm, and will thus oscillate between the two experiences – the immediate pain localised in the arm, and the arm as an object that is gazed at and imaged. She can focus on the sensing (observing the swollen arm) or the sensed (the arm itself), and each will yield a differently thematised experience.<sup>ix</sup> Health professionals often view the body as thematised and objectified, focusing on a particular organ or function in

order to understand it as a medical object. But for the patient, the awareness of her body as an object is secondary to her subjective experience of receiving healthcare.

As Fredrik Svenaeus claims, modern medicine expands the objecthood of the body through imaging and conceptualisation of organs, functions, and molecular processes (2012). The medical emphasis on the objecthood of the body contributes to the rift between the body as lived and the biological body. This intense experience of the objecthood of the body in illness alienates the patient from her body. Jean-Dominique Bauby, who suffered a stroke that resulted in locked-in syndrome writes:

Reflected in the glass I saw the head of a man who seemed to have emerged from a vat of formaldehyde. His mouth was twisted, his nose damaged, his hair tousled, his gaze full of fear. One eye was sewn shut, the other goggled like that doomed eye of Cain. For a moment I stared at that dilated pupil before I realised it was only mine (2007, 32-3).

As this passage shows, illness may force us to adopt a reifying and abstract view of our own body – this is often the shift that is required from patients when discussing their disease with health professionals. However, although most of us can adopt an abstract view of our body, we are not able to sustain it; that is existentially unbearable. We cannot actually view ourselves *objectively* in any sustained sense, and it is unrealistic to expect that of others. Health professionals need to be aware of this because of medicine’s way of privileging third-person perspectives. Objectivity is seen as an ideal by many health professionals, but when subjected to philosophical analysis, it can be seen that merely relying on an objective stance is a naïve and non-practicable ideal that ought to be replaced with a more nuanced understanding of intersubjectivity.

A further objectification takes place in the clinic. When a patient awaits her blood test results, she is as ignorant about her cholesterol levels, for example, as an objective observer. When she asks the physician ‘how bad is it?’ that is because she is genuinely unable to access this information by examining her bodily sensations. In that sense the patient’s body is an object not only to the physician but also to the patient herself. Other experiences of objectification can be seen in



the encounter with medical technology. Seeing one's tumour as a set of CT images, or aligning your limbs for a bone density scan, can make the objecthood of the body prominent in one's experience. These objectifying experiences may lead to a sense of alienation from one's body, and to treating that body as an aberrant object over which one has little control. The ill body becomes despised, feared, and alien.

However, this objectification is not complete. There is an oscillation between treating one's own body as an object of medicine and the subjective experience of apprehension, feeling cold, or flinching from the physician's touch. Husserl's example of two hands touching each other makes this duality salient (Husserl 1999). When the right hand is the active, touching one, it is at the same time being touched by the left hand. If we consciously decide to reverse the roles and concentrate on the left hand as touching, we still oscillate between both dimensions, the active touching one and the passive dimension of being touched. According to Husserl, this duality of experience is a unique feature of human existence. In order to touch, one has to be a thing among things, a physical object. As such an object, one has to be open to the possibility that one can be touched. However, in illness the natural movement between the two dimensions is disrupted because the passive dimension becomes prominent. For example, internal examination gives rise to an experience of being touched from within (e.g. one's cervix or intestines), expanding the domain of passivity. The body as object takes precedence in the clinical context, and its foreignness is accentuated by the inaccessibility of some medical facts to the patient other than via a third person report. In illness one's body becomes an object in ways it would not otherwise have.

**Uncanniness** – In illness the body becomes an obstacle and a threat, instead of my home, a familiar place I inhabit. A change to one's body is a change to one's sense of being at home in the world. The body ceases to be the 'null centre' of my orientation towards the world (Smith 2003, 221) and instead becomes the source of negative experiences. The primitive sense of 'I can' becomes replaced by a conscious, artificial, mediated sense of 'I cannot', or 'I once was able to but am no

longer' (Kesserling 1990). The perspicuous nature of bodily orientation as being the foundation of all experience becomes occluded with attention.

Illness can suspend the familiar setting and feelings that underpin normal everyday actions, giving rise instead to an experience of 'being not at home' (Svenaesus 2000, 9; 2012). Uncanniness arises most forcefully from the disruption of this background, which happens as a result of changed embodiment. Our concepts, habits, routines, expectations, and norms may be disrupted, or even destroyed by illness. Uncanniness arises from a new, negative focus on one's body, a sense of this body becoming an alien destructive force, or even the threat of annihilation that become salient in serious illness. This changes the ill person's relationship to her environment, as well as her concepts. Illness causes disruption of the lived body, which interrupts the relationship between one's body and the environment. Concepts like 'far', 'difficult', and 'heavy' change their meaning for the individual, who may experience a further sense of alienation because her new use of concepts moves away from the norm. In addition, such concepts acquire new *objects*, e.g. routine activities such as carrying a laptop bag, or nipping upstairs to pick up one's wallet, become marked as *difficult* in illness. Many concepts change their meaning, as well as attaching to new objects, and so expanding in scope. The change is not merely linguistic; the ill person actually *experiences* the physical world as less welcoming, full of obstacles, difficult. Distances increase, everyday routines take up more time, activities have to be forsaken or redesigned, and so on. Toombs describes loss of mobility as "anchoring one in the Here, engendering a heightened sense of distance between oneself and surrounding things" (1990, 11). Illness modifies not only one's body, but one's sense of space.

Not only the experience of space and the use of concepts change in illness, but also the experience of time may change and contribute to the sense of alienation and uncanniness brought about by bodily changes, fear, pain, and limitation. Sustained pain or a poor prognosis may completely transform one's experience of time (Toombs 1990). Activities may take more time, and thus expand, or may become impossible, which may cause the ill person to experience herself as 'useless' or as more disabled than she is (Toombs 1988). Insecurity and anxiety about future health

and ability may make one focus on the present (Carel 2008, Chapter 5). And memories of a healthy past become objects of regret, yearning, or a sense of discontinuity (Bury 1982). The experience of time may also change in response to an uncertain prognosis. Priorities might change and it is an opportunity to question how one has lived and how one would like to live (Lindsey 1996; Lindqvist et al 2006). These changes are fundamental and may lead to seismic shifts in identity and selfhood (Williams 2003) as well as triggering philosophical questions. How plastic is the experience of space and time? What determines 'normal' experience? Can there be continuity in identity and personhood given the radical change in one's experiences of these fundamental categories? The way in which such questions can arise by bodily modification in illness demonstrates that illness can trigger philosophical activity. We now turn to examine in what ways this triggering is philosophically salient.

### **3. Illness as invitation to philosophise**

So far I have explained how illness can be philosophically illuminating, by disrupting everyday taken-for-granted assumptions about embodied existence, and thus performing a kind of *epoché*.<sup>x</sup> In this section I look more closely at this process, and suggest that illness is a peculiar kind of motivation to philosophise.

Illness is unwanted; it is almost never welcome or easily accepted into one's life. It is also a radical event: it gives rise to a rethinking of values and meaning, given the changed life conditions. Illness changes our relationship to our bodies, our environment, our plans, and judgment. In short, serious illness is a dramatic life event that affects all aspects of life. Because of these features illness can *motivate* philosophical reflection. However, the claim I wish to make is not simply that illness motivates the person who falls ill to become more reflective, although this is certainly true, but rather that the features that motivate reflection in individuals who become ill make illness salient to the practice of philosophy.

Illness certainly invites or inspires reflection of a philosophical sort. But it can also brutally force this reflection on ill people – for example, the way a poor prognosis may force the ill person to consider death. It also forces the ill person to consider such issues not in the abstract – a luxury of the healthy and young – but in their most intrusive application to one’s own life. Illness does not permit inauthentic reflection on death, for example, as an abstract, far away event that may befall one at some point in the future. Illness forces the ill person to face her own death in the most concrete possible way. From practical arrangements to choosing one’s funeral song, writing a will or saying what is pressing, illness is a strict philosophical instructor forcing the ill person to confront death in its most concrete and immediate. This can be seen as a fuller, more existentially salient form of philosophising. Indeed, for Heidegger, authentically facing death demands precisely this kind of first-person engagement with death.

Illness is also different to other motivations to philosophise. Whereas normally one chooses to perform a philosophical procedure, of say, questioning or criticising an argument, illness motivates in a non-volitional manner. It is violent, unwanted, destructive and uncontrolled. In this sense illness forces the ill person to reconsider their situation. We normally take the practice of philosophy to be a matter of choice, whereas illness is almost never something we *choose* to happen to us. We think of reflection as a pleasant experience of intellectual challenge; but the reflection prompted by illness is all-consuming, extreme and terrifying.

Nietzsche argued that physical illness affords insights into the body, life, and indeed reality. He saw illness as instructive as well as edifying, claiming that careful philosophical attentiveness to experiences of illness is an important feature of an examined life. Nietzsche describes how his illness sharpened his perceptions and inspired his philosophical view:

It was as if I discovered life anew, myself included; I tasted all the good things, even the small ones, as no other could easily taste them – I turned my will to health, to *life*, into my philosophy [...] the years when my vitality was at its lowest were when I *stopped* being a pessimist (2004, 8).

Illness affects different aspects of philosophical reflection: it can call for more radical and personal methods, such as existentialism or nihilism. It affects the philosophical concerns of the ill person – issues such as death, the good life, the injustice of the natural lottery, and time can be central and pressing for ill people in a way they would not be otherwise. Because it forces the ill person to engage with their physical or mental decline and death, it triggers reflection on finitude, dis-ability, suffering, injustice, and so on. Similarly, the urgency and salience of particular philosophical topics may change in light of illness (e.g. Seneca’s *On the Shortness of Life* (2004)). The very activity of philosophising may change and become more urgent and personal. Illness may also change the ill person’s conception of philosophy (if she has one) as a vital practice aimed at a good life, rather than an abstract theoretical enquiry seeking truths, for example, as can be seen in ancient philosophical schools such as the Epicureans and the Stoics. Illness may also bring about the sense that philosophical enquiry ought to be integrated into, and so intrinsic to, one’s life as a whole. A case in point is Alasdair MacIntyre (1999), who stresses the fact of our vulnerable, dependent, afflicted state as a precondition for a style of moral philosophising attentive to the human condition.

An important caveat is that illness does not always or necessarily fulfil its role as inviting to philosophise. It is disorientating and overwhelming, and can – like other extreme hardships – destroy reflection instead of bringing it about. Illness is not philosophical reflection in itself, but can be – and often is – a *way into* reflection. Illness is a compulsive invitation to philosophise:

The experience of illness and its sweeping effect on every aspect of life shocked me into thinking about these issues. I found that I had to reinvent my life... I learned to rethink my aspirations and plans. I relinquished the sense of control I previously had... My experiences pushed me to reflect on health and illness (Carel 2008, 7).

“True philosophy”, Merleau-Ponty wrote, “consists in relearning to look at the world” (1962, xx). Illness forces us to relearn not just to look at the world, but also to cope with it, to negotiate new limitations and to continue to live to the best of our ability within new constraints brought about by illness. The consequences of such coping with practical limitations can be existential and

philosophical illumination. Perhaps illness is a kind of philosophical *method*, which illuminates normalcy through its pathological counterpart. However, Merleau-Ponty calls on us to make this claim carefully:

It is impossible to deduce the normal from the pathological, deficiencies from the substitute functions, by a mere change of the sign. We must take substitutions as substitutions, as allusions to some fundamental function that they are striving to make good, and the direct image of which they fail to furnish (ibid., 107-8).

Merleau-Ponty is acutely aware in this passage that the pathological is not merely 'a change of the sign'. Rather, pathological cases allude to some function they are 'striving to make good' and in this striving end up creating a complete form of life. It is this completeness that requires further philosophical investigation, to unravel how what may seem pathological and deficient may give rise to phenomena such as adaptability (Carel 2007) and edification (Kidd 2012). Canguilhem defined disease as "a new way of life for the organism", the creation of new norms that govern the relationship of the diseased organism to its environment (1993, 84). The richness of the experience of illness and the understanding of health and illness as distinctly *normative* activity attest to the fact that illness both requires and merits further philosophical exploration.

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In the remainder of the paper I will use the term 'illness' to denote serious, chronic or life-threatening illness, rather than common and transient illnesses, such as 'flu. However, less serious

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conditions can also be philosophically important, as they disclose more minor interruptions to the flow of experience. Sartre (2003) gives the example of a headache as disrupting reading.

<sup>ii</sup> There is much discussion in the philosophy of medicine about the concept of illness (and disease), and its relationship with the concept of health. But this conceptual analysis does not touch on the existential or philosophical role illness may have. For a notable exception see S.K. Toombs, *The Meaning of Illness*.

<sup>iii</sup> Death would not be the ultimate limit case but crossing the limit.

<sup>iv</sup> This bias underlies academic research in fields such as disability studies, gender studies, queer studies, black studies, Deaf studies, and so on. Academic inquiry in these fields is, in part, motivated by identifying biases and discrimination.

<sup>v</sup> The experience of ageing may also give rise to these sensations, but more gradually than sudden illness.

<sup>vi</sup> Distancing can also arise as a result of other life events, for example bereavement, divorce, and trauma.

<sup>vii</sup> Young, healthy embodiment is typically oblivious to the possibility that the body might be experienced in this way. The confidence in one's physical and cognitive capacities can occlude a sense that these capacities might change (even with natural ageing) and that this change will increasingly come to radically impact one's identity. This can be seen as a failure of moral imagination, compassion, humility, or even a misunderstanding or denial of the biological expiration that delimits human life.

<sup>viii</sup> This is a good thing. Modern medicine has made huge progress because of this objective view of the body.

<sup>ix</sup> The health professional may also alternate between the sensing (her experience of gazing at the x-ray or examining the arm) and the sensed (the arm or the x-ray), but this oscillation does not involve self-objectification.

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× This process may affect family members or carers who become distanced from shared practices and understandings by the limitations of illness.