



<http://www.diva-portal.org>

This is the published version of a paper published in *Journal of Medicine and Philosophy*.

Citation for the original published paper (version of record):

Svenaesus, F. (2019)

A Defense of the Phenomenological Account of Health and Illness

Journal of Medicine and Philosophy, 44(4): 459-478

<https://doi.org/10.1093/jmp/jhz013>

Access to the published version may require subscription.

N.B. When citing this work, cite the original published paper.

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited.

Permanent link to this version:

<http://urn.kb.se/resolve?urn=urn:nbn:se:sh:diva-38683>

A Defense of the Phenomenological Account of Health and Illness

FREDRIK SVENAEUS*

Södertörn University, Stockholm, Sweden

*Address correspondence to: Fredrik Svenaeus, PhD, Centre for Studies in Practical Knowledge, Södertörn University, Stockholm, Sweden. E-mail: fredrik.svenaeus@sh.se

A large slice of contemporary phenomenology of medicine has been devoted to developing an account of health and illness that proceeds from the first-person perspective when attempting to understand the ill person in contrast and connection to the third-person perspective on his/her diseased body. A proof that this phenomenological account of health and illness, represented by philosophers, such as Drew Leder, Kay Toombs, Havi Carel, Hans-Georg Gadamer, Kevin Aho, and Fredrik Svenaeus, is becoming increasingly influential in philosophy of medicine and medical ethics is the criticism of it that has been voiced in some recent studies. In this article, two such critical contributions, proceeding from radically different premises and backgrounds, are discussed: Jonathan Sholl's naturalistic critique and Talia Welsh's Nietzschean critique. The aim is to defend the phenomenological account and clear up misunderstandings about what it amounts to and what we should be able to expect from it.

Keywords: *health, illness, naturalism, Nietzsche, phenomenology*

I. INTRODUCTION

In the 1980s, a subfield of philosophy of medicine emerged that has since become increasingly influential: the *phenomenology* of medicine. Within this field, philosophers and representatives of various health care and other professions have developed concepts and carried out empirical studies from what is usually referred to as the first-person perspective. The objects of these studies have mainly been experiences of living with illness, encountering health care and being diagnosed with a disease, mental disorder, or disability,

and life with such maladies. Phenomenology of medicine has been applied also to other experiences taking place within the framework of contemporary health care, such as giving birth or dying (for surveys of the field, see Meacham, 2015; Zeiler and Folkmarson Käll, 2014).

The recent phenomenological theories and studies of medicine are all inspired by what we may call “classic phenomenology”: philosophical accounts developed between 1913 and 1945 by well-known philosophers such as Edmund Husserl (2012 [1913]), Martin Heidegger (1996 [1927]), Jean-Paul Sartre (1956 [1943]), and Maurice Merleau-Ponty (2012 [1945]) (on the phenomenological tradition, see Moran, 2000). The theories and studies of contemporary phenomenologists of medicine are also predated by the works of some less well-known figures in the tradition of phenomenology, such as F. J. J. Buytendijk, Hans Jonas, Herbert Plügge, Erwin Straus, and Jan Hendrik van den Berg, who in contrast to the aforementioned classics addressed *medical* issues from a phenomenological vantage point back in the 1950s, 1960s, and 1970s (Spiegelberg, 1972). Also, even before that, phenomenology exerted a certain influence in psychiatry, with scholars such as Karl Jaspers (Stanghellini and Fuchs, 2013). Jaspers in his *General Psychopathology*, published in 1913 (the same year as Husserl’s *Ideas*), famously separated two different angles and frameworks that the psychiatrist needs to explore and combine in his practice: understanding and explanation (Jaspers, 1997). This way of describing medical practice is very much similar to the contemporary focus of medical phenomenologists upon the *lived experience* of the patient in health care (the first-person perspective) to complement the causal explanations provided by the doctor in investigating the body as a diseased organism (the third-person perspective).

The trigger point for phenomenologists of medicine has been the observation and judgement that contemporary medicine is too dominated by the explanative, third-person perspective of science, and that it, therefore, needs to be augmented by a systematic study of the first-person perspective of the patient. Human bodies become diseased (or afflicted by other maladies such as injuries or congenital defects), but only persons are ill in the sense of experiencing dis-ease (illness). This wordplay carries etymological significance: *diseases* are studied and treated by doctors to eradicate or mitigate the *dis-eases* experienced by ill persons. That diseases make us suffer is exactly the reason why we want to find out more about them—in order to be able to stop or alter processes going on in ill persons’ bodies. Medical practice begins with the suffering person because this suffering is what the doctors want to treat and, therefore, always need to return to. But not only that, medical knowledge is broader than biochemistry and physiology as it includes psychological, social, cultural, and existential perspectives, which need to be taught in medical education and learned by way of clinical experience if doctors, nurses, and other health care professionals are to become *good* at what they do. The meaning of “good” here reflects not only

clinical excellence, but also moral knowledge attempting to respect and help persons in difficult circumstances involving hard decisions about what to do (or not to do). Medical practice in this sense is a hermeneutical endeavor proceeding from an understanding of the experiences of the individual patient and enveloping medical explanations by way of disease findings when this is possible and adequate (Svenaesus, 2000, 2017).

A large slice of contemporary phenomenology of medicine has been devoted to developing an account of health and illness that proceeds from the first-person perspective (including what we may call the second-person perspective—i.e., the perspective of the health care practitioner meeting patients) when attempting to understand the ill person in contrast and connection to the third-person perspective on diseases. A proof of the increasing influence of this phenomenological account of health and illness (hereafter PHI) in philosophy of medicine and medical ethics is the criticism of it that has been voiced in some recent studies. In this article, I want to discuss two such critical contributions proceeding from radically different premises and contexts: Jonathan Sholl's "Putting Phenomenology in its Place: Some Limits of a Phenomenology of Medicine" (2015) and Talia Welsh's "Many Healths: Nietzsche and Phenomenologies of Illness" (2016). My aim is to clear up misunderstandings about what PHI amounts to and what we should be able to expect from it. Needless to say, in my defense of PHI I will also have some critical things to say about the arguments being made in the two articles. The ultimate aim, however, is not only to defend PHI but also to show how the critiques found in the articles in some cases expose weak spots of the phenomenological approach that need to be dealt with in future studies.

II. THE PHENOMENOLOGICAL ACCOUNT OF HEALTH AND ILLNESS (PHI)

Before providing a rebuttal of the critiques of PHI, we need to be more precise about which theory of health we are defending. Roughly, it is possible to discern two contemporary proposals for how to conceptualize health and illness: the one proceeding mainly from the philosophy of Merleau-Ponty with Drew Leder (1990, 2016), Kay Toombs (1992), and Havi Carel (2008, 2016) as main proponents, and the one proceeding from Heidegger with Hans-Georg Gadamer (1996), Kevin Aho (Aho and Aho, 2008), and Fredrik Svenaesus (2000, 2013) as main advocates.

The essential idea of the first proposal is that illness consists in an appearance of the own body as conspicuous, obtrusive, or obstinate in the activities of the afflicted person. This is not a question regarding maladies present in the *living body* of the person—the body as it appears from the third-person perspective of medical science. Every human experience is embodied (we are beasts rather than angels), and from the phenomenological perspective

this means that the body is a person's point of view and way of experiencing and understanding every part and thing of the world (Merleau-Ponty, 2012). Not only can I experience my own body as an object of my experience—when I feel it or touch it or look at it in the mirror—but the body is also that which makes a person's experiences possible in the first place. The *lived body* (in contrast to the living body) is an intentional arc—a body schema—that makes it possible for me to exist in space and time and experience a world shared with others (Gallagher, 2005; Slatman, 2014).

The second approach acknowledges this pivotal role of the lived body in falling ill, but emphasizes that illness amounts to finding oneself in an alienating mood that involves the whole *world* of the suffering person (Heidegger, 1996; Ratcliffe, 2008). The difference between the two approaches is mainly one of emphasis and terminology, since the version found in Leder, Toombs, and Carel certainly also involves the life-world matters and existential themes present in Gadamer, Aho, and Svenaeus. In addition to this, one should mention the influence of Sartre's philosophy on PHI visible in the theories of Carel (2016, ch. 2) and Svenaeus (2009). In his main work, *Being and Nothingness*, Sartre made some interesting observations about being ill versus being diagnosed with a disease and the ways these experiences are linked to different ways of being embodied (1956, 401ff.). Gadamer's musings on health and illness are a bit of a special case since he belongs to the group of classics mentioned earlier rather than to the contemporary field of phenomenology of medicine. The reason for including him among the contemporaries is that the collection of papers published in 1996 (German original in 1994) with the title *The Enigma of Health* has attracted quite a few readers in philosophy of medicine and medical ethics and has been important for Aho and Svenaeus in developing more substantial health theories on Heideggerian ground. The important articles of this volume were originally published or presented as talks in the 1980s, so in this regard Gadamer's thoughts on health belong to the contemporary group of phenomenological studies.

For reasons of clarity and precision, in this article I proceed primarily from the phenomenology of health and illness found in Svenaeus's—my own—works when defending PHI. The main reason for this is that this particular attempt at a theory of health and illness includes *defining*—that is, providing a concept of—health, in addition to *describing* illness matters. In this sense, my account is possibly more demanding than the other ones referred to earlier and, therefore, more vulnerable to the criticism voiced in Sholl (2015) and Welsh (2016). I will proceed from the phenomenological account of health offered in *The Hermeneutics of Medicine and the Phenomenology of Health: Steps Towards a Philosophy of Medical Practice* (Svenaeus, 2000), and from the more recent synopsis given in “Naturalistic and phenomenological theories of health: Distinctions and connections” (Svenaeus, 2013; but see also Svenaeus, 2009, 2011). The latter work is particularly fitting in this

context, as it explicitly compares my phenomenological account of health to the account offered by naturalists (the alternative supported by Sholl) and to Nietzsche's philosophy of health (the alternative supported by Welsh). The following states the rudiments of the theory:

To sum up the foundations of my phenomenological theory of health: illness is an unhomelike being-in-the-world in which the embodied ways of being-in of the person have been thwarted. In illness the body shows up as an alien being (being me, yet not me) and this obstruction attunes the entire being-in-the-world of the ill person in an unhomelike way. Health, in contrast to this, consists in a homelike being-in-the-world. Homelikeness is supposed to catch the character of the normal, unapparent transparency of everyday activities, *not* of feeling happy. (Svenaesus, 2013, 233–4; italics in original)

Proceeding from this quote (and from my discussion earlier of the works by Leder, Toombs, Carel, Aho, and Gadamer), it becomes obvious why I have chosen in this article to talk from the start about the phenomenological account of health *and* illness and not simply about the phenomenological account/theory/concept/definition of health. PHI addresses health mainly indirectly via an analysis of illness. Illness is easier to get hold of from the phenomenological vantage point—the first-person perspective—since not being at home with one's body and world calls for attention in a painful way. The homelikeness of health is more of a preconscious phenomenon, a supportive background feeling that makes it possible for a person to direct attention to the things with which (s)he is busy in the world. Health and illness are *attuned* manners of *being-in-the-world*:

Homelikeness and unhomelikeness in my phenomenological analysis, inspired by, but not identical to, Heidegger's, refer to two opposed *dimensions* of the attuned being-in-the-world of human beings. To be ill means to be not at home in one's being-in-the-world, to find oneself in a pattern of disorientation, resistance, helplessness, and perhaps even despair, instead of in the homelike transparency of healthy life. (Svenaesus 2013, 232; italics in original)

It is possible to direct one's attention to this homelike way of existing as a lived body transcending to a meaningful world—what the phenomenologists refer to as the life world—but this demands a reflective stance, and what appears will not be as easy to describe as the often striking and painful moods of illness. Gadamer puts it well:

So what genuine possibilities stand before us when we are considering the question of health? Without doubt it is part of our nature as living beings that our conscious self-awareness remains largely in the background so that our enjoyment of good health is constantly concealed from us. Yet despite its hidden character health none the less manifests itself in a general feeling of well-being. It shows itself above all where such a feeling of well-being means we are open to new things, ready to embark on new enterprises and, forgetful of ourselves, scarcely notice the demands and strains which are put on us . . . Health is not a condition that one introspectively

feels in oneself. Rather, it is a condition of being involved, of being-in-the-world, of being together with one's fellow human beings, of active and rewarding engagement in one's everyday tasks. (1996, 112–3)

We will return to how to distinguish health from happiness or well-being (the German phrase Gadamer is using in the quote is “sich wohl fühlen”, which does not translate as feeling happy), but we also need to note from the start how illness is different from being *unhappy* in the phenomenological view:

What I would like to stress here is that the unhomelike being-in-the-world of illness, in contrast to other forms of unhomelike being-in-the-world, is characterized by a fatal change in the meaning structures, not only of the world, but of the *self* (that is, the person). This unhomelike-making change in the openness of the self to the world is furthermore, in the case of illness, at least typically, a change in embodiment. The lived body forms the core of the self, and the “body-tools” are most fundamental for our being-in. (Svenaeus, 2013, 233; italics in original)

One more thing needs to be mentioned before turning to the criticisms of PHI found in Sholl (2015) and Welsh (2016). The most obvious critique a naturalist or a Nietzschean can level at PHI is that this way of exploring and defining illness and health is *normative* in a fatal manner. That is, the phenomenological theory rests on contingent *evaluations* regarding the goodness or badness of human experiences and ways of living, and this makes the theory corrupt, as it is not objective enough (the naturalist critique) or radical enough (the Nietzschean critique) as regards the concepts in question. The naturalist takes health to be the absence of dysfunctional states of the body that can be detected by medical science on a value-neutral ground (Boorse, 1997). Illness, for the naturalist, reflects the subjective experiences of a person, but the judgement of healthy or non-healthy is always determined by the doctor in checking that person's body for diseases. The phenomenologist would agree that illness most often occurs when the body is diseased, but would allow for the possibility of illness without disease, as everyday experience and not medical science has the final word in defining health or illness.

The Nietzschean takes health to be an authentic form of life, which may involve and even demand illness as an intense and rewarding experience that faces the truths of human existence. There are many ways of being healthy and health is not the opposite, but rather an affirmative overcoming, of painful, bodily experiences brought on us by life (Nietzsche, 1974, 177). For the Nietzschean, the phenomenological account of health is not normative *enough* as it underestimates the human ability to be healthy in many individual ways, even involving illness, and certainly disease.

I will return to the naturalist as well as the Nietzschean critique of the way the phenomenological account is normative; however, as will become clear in what follows, I take the phenomenological way of addressing

and involving human values to be a strength rather than a weakness of PHI. Normativity cannot be escaped in exploring and defining health, and the way naturalists attempt to cover this up is just as faulty as the way Nietzscheans mix up the norms that determine health with those that determine personal identity and the good life. The goodness and badness of health and illness need to be phenomenologically explored and contrasted to other human norms that have more to do with culture than with nature.

III. SHOLL'S NATURALISTIC CRITIQUE OF PHI

The first major critical point Sholl makes about PHI is that it underestimates the possibilities of the third-person scientific perspective and, therefore, tends to make naturalism—its major enemy—into a straw man (Sholl, 2015, 395–400). In stressing the need for a first-person perspective in contemporary health care, phenomenologists assume the medical model to be a mechanical and reductionist way of viewing persons as merely biochemical machines. Naturalism is much more multifaceted and dynamical than that, allowing for studies made on ill persons on many different levels: biochemistry, physiology, psychology, sociology, and even addressing cultural questions (Sholl, 2015, 398–9).

It may be true that some phenomenologists offer rather simpleminded and stereotypical pictures of modern “techno-scientific” medicine; nevertheless, I think the basic critique and starting point of the phenomenologist will hold: modern medicine has underestimated the importance of a systematic study of the first-person perspective, and it is precisely this that phenomenology can provide. All third-person-perspective ways of studying human experience—in this case, illness—miss the essential point: it is the *subjective* first-person perspective on illness, involving the person’s feelings, everyday life, and life story, that needs to be taken into account in its own right. If Sholl wants to argue that these experiences can be studied from the naturalist platform just as well, then I am puzzled about what he puts into the word naturalism. What matters is how the issues of health are studied and defined—from the third-person (naturalism) or from the first-person perspective (phenomenology). Sholl mentions that naturalists can very well make use of psychological descriptions of illness (2015, 399), and that more dynamic versions of naturalism, like network theory proceeding from systematic grouping of reported symptoms, can be used to make naturalist models more nuanced (2015, 398). However, in all of these cases the first-person reports are used either merely as clues to get at the real thing (the state of the living body) or as a form of statistics relying on isolating and objectifying symptoms in a way that makes it possible to count and group them (for instance, in psychiatric

diagnostic manuals). They are not used to develop a theory about the suffering person's being-in-the-world.

Questions like "Do you feel pain?," "Are you stressed out?," and "Do you experience panic attacks?" do not automatically make the investigator into a phenomenologist. The questions that need to come as follow-ups are ones like "How does the pain affect your everyday life?," "What are you stressed about?," and "Can you tell me about the situations that make you anxious?" The problem for the naturalist is that the follow-up questions will introduce meaning issues that cannot be accommodated in the scientific theory. As a matter of fact, the attempt to avoid the individually experienced meaningfulness of symptoms is exactly the *aim* of the naturalist, as such issues will make it impossible to study human experiences in the way one studies objects in the scientific world (causal laws or statistical generalizations). There is nothing wrong with empirical psychology, but it will not automatically make naturalism less reductionist and mechanical if it does not adopt the first-person stance as the place to reside in when carrying out the analysis. The reductionism for which the phenomenologist blames medical science is not mainly about reducing all science to biochemistry or even physics; it is about reducing the first-person perspective (including the second-person perspective, see earlier) in medicine to the third-person perspective, and this blame the naturalist will clearly have to accept and take to heart, as this is exactly what his/her whole project is about. No science by way of empirical experiments or statistical modeling can be made from the first-person perspective—that is precisely what is unscientific about it, according to the naturalist. Phenomenologists deal with meaning structures and introduce terms like "lived experience," "lived body," "life world," and "being-in-the-world" to better *understand* human experiences; they do not aim at causal or statistical explanations like the naturalists. Phenomenology and its close relative hermeneutics are *human* sciences, and this means that they make use of methodologies different from the experimental and quantifying methods applicable in the natural and, to some extent, behavioral and social sciences (Gadamer, 1994).

Sholl thinks the difference between ontological and methodological naturalism is a major issue that the phenomenologists neglect, but I think the most obvious way of understanding the phenomenological critique is that the naturalists unjustly prioritize the epistemic perspective of natural, behavioral, or social science in all types of situations in health care. The criticism is not that medical science should never have priority in health care; this would be an absurd view. The criticism is that the third-person perspective is overused and that in many situations it would have to be *complemented* and, in some situations, also *overtrumped* by the phenomenological perspective.

The second major critique of Sholl's is that the phenomenologist needs to fall back on a statistical model of normality in order to start talking about health and illness in the first place (Sholl, 2015, 400–3). This seems to reflect

a misunderstanding of what phenomenology is and how it goes about doing philosophical analysis. The claims found in my own words, cited by Sholl in a rather truncated form, about the “homelikeness of health” as “supposed to capture the character of the normal, unapparent, transparency of everyday activities,” something experienced and had “all the time” by persons (except when ill, of course), are obviously not meant as inductive generalizations. The method used by the phenomenologist consists in performing a “reduction,” meaning to abstain from scientific pre-understandings of the phenomena investigated and carry out an imaginative variation of how the phenomenon in question could be changed but still remain of the same kind (Svenaesus, 2000, 77–78, 106–7). This is a form of *conceptual* analysis, which relies on previous experiences had by the phenomenologist him/herself and on the experiences that (s)he has accessed through talking to others and reading about experiences of this type in books, articles, blogs, etc. That health is a homelike being-in-the-world in opposition to the unhomelikeness of illness does not reflect a statistical concept of normality; it is a result reached through examining the way human experiences characteristically differ in situations of health and illness.

Perhaps Sholl would reply that some kind of third-person-perspective *identification* of the experiences and situations in question as healthy or ill would still have to be carried out *before* performing the phenomenological reduction (adopting the first-person stance to study meanings and concepts), but here I think he would be wrong. Such an assumption only mirrors the naturalist prejudice that the only way to classify things is from the third-person perspective (this is the same prejudice that makes illness necessarily dependent on the identification of a disease for the naturalist). The phenomenologist could start with strikingly clear examples of being ill, such as the experiences of suffering an intense headache or chest pain, becoming nauseous and vomiting, breaking one’s leg, or being deeply depressed and suicidal. (S)he could then continue the analysis by expanding the variety of illness situations in exploring the borderlines to health situations by identifying meaning structures (like bodily alienation and unhomelike being-in-the-world) characteristic for illness. This analysis does not presuppose any disease investigations or statistics made from psychological observations, although it may be inspired by such studies in the process of the phenomenological investigation (Zahavi, 2013).

Sholl’s assuming that a phenomenological account that strives to give a definition of health—in contrast to only offering descriptions of what it feels like to be healthy versus ill—needs to aim for explanations of why people fall ill versus stay healthy is yet another presumption made from the naturalist position and standpoint (Sholl, 2015, 402–3). As referred to earlier, Jaspers long ago distinguished a phenomenological *understanding* of the experiences and situation of the ill person from *explanations* of why the person has become ill (diseased). Phenomenology does not aim for scientific explanations; instead,

it fleshes out a conceptual structure found inherent in the world-embedded experiences of persons. To lay bare these meaning structures will facilitate our understanding of health and illness in the individual cases, as it provides a foundational pattern in which to make sense of them. I do not experience my body and my life situation in an unhomelike manner *because* I am ill. Causal claims belong to the scientific world of diseases, which forms a necessary complement to the illness-understanding analysis in medical practice (Svenaeus, 2000, part 3). Bodily alienated, unhomelike being-in-the-world is *constitutive* of illness; this conceptual structure and definition show us of what illness (and health indirectly) *consists*. As such a constitutive analysis, it can help us to better understand and possibly, by way of this knowledge, change the experiences and worlds of ill people for the better (notwithstanding that the detecting and curing of diseases can be equally or more important in many situations). The most salient examples of when phenomenology could be of such help and use in medicine are cases of illness without detected disease, chronic illness, and terminal illness, but almost every patient case contains matters that need to be dealt with on the illness-lived-body level rather than on the disease-living-body level.

In addition to the two major critiques discussed earlier, Sholl identifies five more weak spots of PHI. Two of these overlap with the points made by Welsh, and I will, therefore, discuss them in the next section on Nietzschean critique (the question of the relationship between health and the good life and the medicalization charge). The remaining three weak spots to be dealt with are the following.

First, Sholl claims that phenomenology, by making the first-person perspective pivotal in health analysis, unduly ties the status of being ill to the *identity* of the person. There is something to this criticism; to adopt a third-person perspective on the health problem one is experiencing can be liberating: the disease is not a part of me, it is rather something preventing me from realizing my true potential. Yet, this counter-strategy to illness-identity also has its risks and problems. When a person diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) in this spirit claims: "I am not ill, but my brain is," this is surely a paradoxical statement, considering the standard terminology of illness versus disease applied earlier. The proper way of expressing the naturalist claim would be: "I am ill because my brain is diseased" (whether the latter is really the case is another matter), and this way of moving the core problem from the realm of persons to the realm of brains is arguably not the ultimate solution in all, or even the majority, of the presently diagnosed cases of ADHD and other rapidly expanding medical diagnoses. The strategy of moving the responsibility for problems in life from the realm of personality to medical science can be just as problematic as moving them in the opposite direction, and it has a name: *medicalization* (Conrad, 2007). Accordingly, I think the naturalists rather than the phenomenologists, as Sholl claims, are responsible for the potential contemporary

abuse of medical diagnoses, but I will return to the issue of phenomenology and medicalization later.

There are also other cases in which the illness-identity claim is not as farfetched. Consider the field of disability studies and the political movement with which it has teamed up. Disability activists often claim that disability is not a health problem, but rather a matter of political repression: the people in charge in our society have chosen to design the everyday environment in ways that make it hard or impossible for people who cannot walk, hear, or see to live a good-enough life (prejudices regarding disabled people do a similar repressive job). That disability is not a health problem is a claim that does not sit well with the naturalist health theory. This might not be a problem for the naturalist if the claim is false—if the disabled actually *are* unhealthy as a result of maladies (injuries, congenital effects, etc.) that are constitutive of bodily dysfunction in the same way as diseases are—but what about the claim that disabilities are also part of the afflicted persons' identities (not all people affected with disabilities would make this claim, but many do)? Is this a claim that all disabled people should be talked out of, just as they should be persuaded that they are actually unhealthy and not (or, at least, not only) politically repressed?

A general critique of naturalistic theories of health, ever since Boorse stated his biostatistical definition in the 1970s, has been that the naturalist has problems in accommodating the fact that we are all constantly having minor diseases (like caries) that neither make us feel ill nor believe that we are unhealthy. As my goal in this article was not to criticize the naturalistic account of health but to defend the phenomenological account, I will not pursue this line further, but see Lennart Nordenfelt's (1995) *On the Nature of Health: An Action-Theoretical Approach* for a substantial attack on the naturalist attempts to define health.

The second weak spot of PHI, according to Sholl, is that a comprehensive study of illness cases does not support the view that illness is always a case of bodily alienation. The argument he gives for this is actually a rather weak and questionable one: he claims that historical accounts prove bodily alienation experiences to be a contemporary phenomenon only. Considering the way severe illness is and has been experienced in all human cultures—also, according to historical sources, in those that no longer exist—these experiences appear to (have) always include(d) the body as a conspicuous, obtrusive, and obstinate element in the ill person's life. This is not only a matter of medical objectification of the body by way of modern technology and science, but a lived, bodily characteristic of illness itself (Leder, 1990; Slatman, 2014). A stronger case could be made for mild illness as not involving bodily alienation and unhomelike being-in-the-world. Is having a cold really a matter of being alienated? Perhaps not if we consider the identity-changing connotations of the word, but is there nevertheless not a case to be made for the sore throat, fever, dizziness, and muscle aches making the embodiment

and world experience of the person in question unhomelike, if only for a couple of days or so (Svenaeus, 2000, 80–81)?

Yet another criticism that could be voiced regarding the claim that illness is always unhomelike in character is the case of chronic illness or disability in which the afflicted person appears to have adjusted to the disease or other bodily defect (s)he is having in a way that makes her/his being-in-the-world homelike. This, however, is a difficulty for the naturalist rather than for the phenomenologist, as the latter could readily encompass the possibility of being healthy despite having bodily dysfunctions. As a matter of fact, “suffer” is a misnomer here, as only a person can suffer in the true sense of the word (having experiences); the living body is merely in a *state* that is either dysfunctional or not. Thus, from the phenomenological point of view, a person could be healthy (enjoying a homelike being-in-the-world) despite being diseased or disabled (and the fact that we name some such persons “chronically ill” is a mix-up of concepts if what we really mean is “chronically diseased”) (Svenaeus, 2000, 112–3).

Finally, the third weak spot, according to Sholl, is that PHI can deal neither with the cases of animals that lack self-understanding and language, nor with the cases of human beings that are not self-conscious—fetuses or comatose individuals. This is undoubtedly true, and it is one of the important reasons for voicing phenomenology as a *complement* to rather than a replacement for medical science in health theory and health care. Only persons can be healthy or ill from the phenomenological point of view, and a first-person perspective must be present in order for the analysis to apply. However, this does not look like a main problem for the phenomenologist of health; it is rather a potential problem for the phenomenologist in bioethics taking a stand on how we should look on and deal with individuals who are in the process of becoming persons, or who are no longer persons, or who may be persons despite not having human DNA—nonhuman animals, smart computers, and post-humans (Svenaeus, 2017).

IV. WELSH'S NIETZSCHEAN CRITIQUE OF PHI

The questions about the animal and the post-human lead us almost inevitably to the philosophy of Nietzsche, infamous for statements about “the blond beast” (1969a) and “the overman” (1976). There appear to be many different philosophies or even philosophers present in Nietzsche’s enormously innovative and influential oeuvre, and Welsh does her best to distil a comprehensive health theory from some of the arguments found in his works (Welsh, 2016).

Welsh starts by giving a good overview of the phenomenological accounts of health and illness found in Merleau-Ponty, Toombs, Carel, Heidegger, Gadamer, and my own works. Health is a form of homelike, silent harmony

that recedes to the background of a person's being-in-the-world, whereas illness involves painful and obtrusive moods demanding attention and making it hard or impossible for the afflicted person to carry out everyday actions and projects. Her focus is on Heidegger's philosophy of *das Unheimliche* and the way it has inspired the present author's claim that illness is an unhomelike being-in-the-world (Svenaesus, 2000, 93). The German concept has a double meaning, which is essential to Heidegger: not only unhomelike but also *uncanny*. The type of alienation occurring in illness when one's body and world show up in unhomelike ways can be truly uncanny. However, the experience and situation from which Heidegger is proceeding when introducing the concept of *das Unheimliche* is not illness but existential anxiety (1996, 184ff.).¹ This mood, according to Heidegger, reveals to us that the everyday things we are standardly busy with in the world together with other persons do not really matter. They are only ways of covering up the inescapable truth that we are all going to die alone and must carry responsibility for our choices (it is easy to see how Kierkegaard influenced Heidegger on this point as he in turn influenced Sartre's existentialist ethics). Existential anxiety pulls us back from the business of everyday life and reveals the fragile and finite nature of human existence as a being-toward-death (Heidegger, 1996, 260ff.). This is not only a painful experience but also the possibility of a more authentic way to exist in which we do not shy away from death but choose who we want to be and what we want to accomplish precisely in light of the finite and vulnerable nature of every human life project.

Welsh notes that there appear to be similarities between the moods of illness (with which Heidegger did not preoccupy himself to any large extent, but see Heidegger, 2001) and existential anxiety. Severe illness reveals our vulnerable nature and our having-to-die, and it makes it hard to take part in everyday activities together with others (what Heidegger rather derogatorily refers to as the life of "the they" (1996, 167ff.)). This may spur philosophical reflection and lead to a more authentic life in the sense that a person reflects on what it means to exist and what really matters to him/her in the end (Carel, 2016, ch. 9). However, there are also differences, and I have explored these in *The Hermeneutics of Medicine and the Phenomenology of Health* (2000, 90–92). The moods of illness often make the afflicted person *more* preoccupied with carrying out everyday life matters, simply because these matters become hard and painful to accomplish. However, as Welsh notes, other illness experiences are more similar to, or overlapping with, existential anxiety, particularly those that reveal to the sufferer that his/her life conditions have radically changed and/or that his/her life is soon to end (such an experience may also be spurred by the severe illness or death of a loved one). A considerable difference between all phenomenological proposals for illness and Heidegger's characterization of existential anxiety is that Heidegger denies the lived body any significant role (Aho, 2010). However, this might mainly reflect Heidegger's fear that his philosophy

would be interpreted as a philosophical anthropology rather than the “fundamental ontology” it aspires to be (Heidegger, 1996, 45ff.). On closer phenomenological inspection, anxiety in all intense forms proves to involve a rather conspicuous form of embodied experience that does not preclude the mood from carrying existential significance (Ratcliffe, 2008).

Whereas I have been eager to stress the differences between the counterparts of authenticity and inauthenticity, on the one hand, and health and illness, on the other, Welsh’s message is that the philosophy of Nietzsche in a reading inspired by the phenomenologists can make us see how health is a form of authentic life in which illness plays a decisive role. Consequently, she thinks, one should not, in the manner of Svenaeus, exclude illness from health, but rather interpret illness as a challenge and possibility for a fuller, more authentic life.

For a typically healthy person, conversely, being sick can even become an energetic *stimulus* for life, for living *more*. This, in fact, is how that long period of sickness appears to me *now*: as it were, I discovered things anew, including myself; I tasted all good and even little things, as others cannot easily taste them—I turned my will to health, to life, into a philosophy. (Nietzsche, 1969b, 680; italics in original)

Welsh goes on to claim that Nietzsche’s philosophy can show us how to include a greater variety of life experiences and possibilities within the domain of the healthy life and accordingly counteract the contemporary drift toward medicalization (2016, 350, 356). Health, according to Welsh, is not a silent background phenomenon; it is an *intense* experience in which we feel alive and vibrantly present (2016, 350–1). She also claims that illness reveals the *transient* nature of personal identity; we change as persons in going through illness, just as we can find our true identity in an individually accomplished health that overcomes pains and sufferings (2016, 352–3).

Is it true that PHI underestimates the creative and transformative powers of illness and that health in the true sense of the word is not the absence of, but, instead, the ability to endure and overcome illness? I think not. There is nothing in the phenomenological theory that denies that illness could have a revelatory and life-changing effect in *some situations*—say, for instance, becoming aware of the things in life one has taken for granted after undergoing a heart attack and accordingly changing life priorities when recovering. Terminal illness is an obvious example of a similar possibility; although there is no recovery, it may very well involve a gradual becoming more authentic in one’s “being-towards-death” (Aho, 2016). But does illness always, or even in most cases, have such a revelatory and life-changing effect? Hardly, and it is even more difficult to defend the idea that illness would in itself be *more* healthy than the homelike being-in-the-world that the phenomenologist understands as health. Perhaps the idea is rather that health evolves *out of* illness, that we need first to become ill—perhaps over and over again—in order to become *truly* healthy. This sounds a bit

like the way our immune system works: we need the spurs of minor infections to keep the system alert for future dangers (on medical metaphors in Nietzsche, see [Krell, 1996](#)). Sadly, however, illness does not always have this effect. We often become weaker as the result of illness instead of the other way around.

To my mind, it appears that Welsh is mixing up being healthy with other and different things, such as moral superiority or happiness (the question if Nietzsche himself is guilty of such confusions needs to be addressed separately). This is not by accident, of course, but is the healthy life—if we proceed from the way we ordinarily use this concept—always better than the unhealthy life in any of these two senses? It appears possible to be in good health despite being a morally suspect and miserable person. It also appears perfectly possible to be a morally excellent and content person despite being seriously ill. If we limit the comparison to authenticity and health (assuming authenticity to include moral as well as good-life aspects) we will notice the same discrepancy: the authentic life is often unhomelike and the inauthentic life is often homelike in character.

Welsh thinks that the silent-in-the-background-receding theory of health invites a reductive view of illness as mere functional failures of the body ([2016](#), 354), but I see no reason why this should necessarily be so. PHI reveals the body rather as lived and meaningful than as a machinery of biological functions, *particularly* when the body displays an alien nature. Also, as we have seen earlier, Svenaeus's theory allows for many ways to be healthy *despite* having functional failure (chronically diseased but yet homelike), so there is no need to introduce a healthy effect of being ill in order to avoid a naturalistic view on health. What should rather be pointed at is the way a healthy individual is able to overcome *threats* to health by adapting to new environmental stressors ([Canguilhem, 1991](#), 196–201; [Svenaeus, 2013](#)).

Let us finally return to the issues of personal identity and medicalization. Do being ill and becoming healthy change one's personality in the way Welsh outlines? Or, rather, is Sholl correct in keeping health issues outside the realm of personality change? The truth is probably somewhere in between these extreme views, and this, I think, speaks for PHI. Severe illness *could* have personality-changing effects; this I do not think even Sholl would like to deny—think of the illness-authentic-experience examples just discussed. But, these events very seldom make us into completely *new* persons the way Welsh seems to imply ([2016](#), 352–3). This only happens in very extreme cases—amnesia, psychotic disorders, Alzheimer's disease—and even then, the claim that a new person has replaced an old one is problematic ([DeGrazia, 2005](#)). Actually, it all depends on what we mean by personality-versus identity-change in these cases.

Drastic and, above all, permanent changes in a person's life condition will often have an effect on his/her personality traits. Think of falling ill with renal failure demanding a radically changed lifestyle with hemodialysis,

for instance (Gunnarson, 2016). The unhomelike, bodily being-in-the-world of the sufferer will make him/her not a new, but likely (at least slightly) a person different from what (s)he was before the onset of the disease. These cases are rather unproblematic because the personality change is a consequence of the way a disease (or another significant life event) *forces* a new form of being-in-the-world on the person. Since a person exists as a being-in-the-world according to PHI, the novel, unhomelike character of living with renal failure will likely affect personality traits, at least in the long run.

A different situation arises in cases in which the self-understanding of a person is affected simply by way of being *diagnosed* with a disease, disorder, or other type of medical condition. To get back to the ADHD example discussed earlier, the experience of being diagnosed with a mental disorder in many cases rather leads to identification with the diagnosis (I am an ADHD-person) than to a rejection of any form of identification á la Sholl (I am a person with a diseased brain, but this does not affect my identity as a person). In such cases, it is not a novel bodily process but a novel *interpretation* that is responsible for the change in identity. Such changes of personal identity are neither transformations that bring forth brand-new persons nor transformations brought about by disease processes. They are changes that *consist* in a novel self-interpretation made by the person as the result of being diagnosed.

Sholl thinks we should be skeptical about such interpretations, as they can lead persons to blame themselves for the way they feel and behave (2015, 404). He sees naturalistic disease explanations as opportunities for persons to look on their bodies rather than their personalities as defective. This is exactly the process that Welsh fears, as it may lead to a never-ending medicalization when people blame bodily dysfunctions for their miseries instead of facing the personal pains and shortcomings they need to go through in order to develop and flourish (2016, 356).

In my view, naturalist assumptions about dysfunctions that are claimed to be responsible for human suffering by medical researchers and pharmaceutical companies are to be viewed with skepticism when no robust findings can be presented. We need to uphold the distinction between unhappiness and illness, and the phenomenological key is to look for *bodily* alienation along with other unhomelike characteristics in a person's life when suspecting a health problem. If a bodily dysfunction is found to be present, this should be taken into account as a *clue* in the phenomenological analysis, although not as providing the last word in identifying a health rather than a life problem. The lesson to be learnt from Nietzsche would be a different but equally important one: to explore by way of phenomenology how the being-in-the-world of a person could possibly attain a more homelike character *despite* the presence of bodily dysfunctions and suffering. Life can be changed for the better in so many other

ways than by medical therapies, sometimes by the power of sheer will or acceptance:

Even the determination of what is healthy for your body depends on your goal, your horizon, your energies, your impulses, your errors, and above all on the ideals and phantasms of your soul. There are innumerable healths of the body, . . . In one person, of course, this health could look like its opposite in another person. (Nietzsche, 1974, 177)

V. CONCLUSION

In this article I have defended a phenomenological account of health and illness against the criticism leveled by naturalists and Nietzscheans represented by Jonathan Sholl (2015) and Talia Welsh (2016). In discussing and rebutting the critical points found in these two articles, I hope to have shown that PHI is not only appealing and coherent but also badly needed in contemporary society and health care. PHI is an important complement to naturalist as well as Nietzschean theories because it shows how health and illness are normative in nature but yet different from the norms constituting the contents of an authentic and flourishing versus an inauthentic and unhappy human life. Medical practice begins with the suffering person because this suffering is what the physician wants to treat and therefore always needs to return to. This also makes obvious that medical knowledge is broader than biochemistry and physiology as it includes psychological, social, cultural, and existential perspectives addressed by PHI. However, in taking the cultural and existential aspects of health and illness into account, one should take care not to confuse health with authenticity or illness with unhappiness.

Naturalist ways of defining and articulating health indirectly by way of detected or assumed bodily dysfunctions lack a systematic access to the first-person perspective from which the tendency to medicalize human suffering must be countered. Such a phenomenological approach to human suffering should take care to neither conflate illness with unhappiness nor with the opportunity to become healthier in some authentic sense. Falling ill may change a person's identity by way of bodily and existential alienation or by way of identification with a diagnosis, but it is very rarely a personality-changing process in the strong sense of becoming another person altogether. PHI can account for identity changes without falling into the traps of either excluding the issue of personality change from the account of health and illness altogether (naturalism) or absorbing the idea of personality change in making it the key part of the theory as such (the Nietzschean account).

No doubt, some weak spots of PHI addressed by Sholl and Welsh have not been totally covered in this article, and I have underlined that PHI in some situations needs support by theories that emphasize disease, on the one hand, and aspects of the good life that exceed health issues, on the other. Being the object of critical scrutiny in the academic community is a sign of respect; in this case, the criticism shows that phenomenology of medicine is increasingly recognized as an important field that needs to be taken seriously in philosophy as well as in health care. Important work in exploring a greater variety of health care issues from the phenomenological perspective and in fine-tuning PHI is still ahead.

NOTES

1. Page references for [Heidegger \(1996\)](#) are to the German original found in the margins of the English translation.

ACKNOWLEDGMENTS

I would like to thank two anonymous reviewers for very helpful comments that have assisted me in better presenting the key points of the article.

REFERENCES

- Aho, K. 2010. *Heidegger's Neglect of the Body*. New York: SUNY Press.
- . 2016. Heidegger, ontological death and the healing professions. *Medicine, Health Care and Philosophy* 19(1):55–63.
- Aho, J. and Aho, K. 2008. *Body Matters: A Phenomenology of Sickness, Disease, and Illness*. Lanham, MD: Lexington Books.
- Boorse, C. 1997. A rebuttal on health. In *What is Disease?*, eds. J. Humber and R. Almeder, 1–134. Totowa, NJ: Humana Press.
- Canguilhem, G. 1991. *The Normal and the Pathological*. Trans. C. R. Fawcett and R. S. Cohen. New York: Zone Books.
- Carel, H. 2008. *Illness: The Cry of the Flesh*. Stocksfield, United Kingdom: Acumen Publishing.
- . 2016. *Phenomenology of Illness*. Oxford, United Kingdom: Oxford University Press.
- Conrad, P. 2007. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore, MD: Johns Hopkins University Press.
- DeGrazia, D. 2005. *Human Identity and Bioethics*. Cambridge, United Kingdom: Cambridge University Press.
- Gadamer, H.-G. 1994. *Truth and Method* Trans. J. Weinsheimer and D. G. Marshall. New York: Continuum Publishing.
- . 1996. *The Enigma of Health: The Art of Healing in a Scientific Age*. Trans. J. Gaiger and N. Walker. Stanford, CA: Stanford University Press.
- Gallagher, S. 2005. *How the Body Shapes the Mind*. Oxford, United Kingdom: Oxford University Press.

- Gunnarson, M. 2016. *Please Be Patient: A Cultural Phenomenological Study of Haemodialysis and Kidney Transplantation Care*. Lund, Sweden: Lund Studies in Arts and Cultural Science.
- Heidegger, M. 1996. *Being and Time*. Trans. J. Stambaugh. Albany, NY: SUNY Press.
- . 2001. *Zollikon Seminars: Protocols—Conversations—Letters*. Trans. F. Mayr and R. Askazy. Evanston, IL: Northwestern University Press.
- Husserl, E. 2012. *Ideas: General Introduction to Pure Phenomenology*. Trans. B. Gibson. London, United Kingdom: Routledge.
- Jaspers, K. 1997. *General Psychopathology. Two Volumes*. Trans. J. Hoenig and M. W. Hamilton. Baltimore: Johns Hopkins University Press.
- Krell, D. F. 1996. *Infectious Nietzsche*. Bloomington, IN: Indiana University Press.
- Leder, D. 1990. *The Absent Body*. Chicago: University of Chicago Press.
- . 2016. *The Distressed Body: Rethinking Illness, Imprisonment and Healing*. Chicago: University of Chicago Press.
- Meacham, D., eds. 2015. *Medicine and Society, New Perspectives in Continental Philosophy*. Dordrecht, The Netherlands: Springer.
- Merleau-Ponty, M. 2012. *Phenomenology of Perception*. Trans. D. A. Landes. London, United Kingdom: Routledge.
- Moran, D. 2000. *Introduction to Phenomenology*. London, United Kingdom: Routledge.
- Nietzsche, F. 1969a. Beyond good and evil. In *Basic Writings of Nietzsche*, trans. W. Kaufmann, 320-600. New York: Modern Library.
- . 1969b. On the genealogy of morals. In *Basic Writings of Nietzsche*, trans. W. Kaufmann, 601-780. New York: Modern Library.
- . 1974. *The Gay Science*. Trans. W. Kaufmann. New York: Vintage Books.
- . 1976. *Thus Spoke Zarathustra*. Translated by W. Kaufmann. Harmondsworth, United Kingdom: Penguin Books.
- Nordenfelt, L. 1995. *On the Nature of Health: An Action-Theoretic Approach*. 2nd ed. Dordrecht, The Netherlands: Kluwer.
- Ratcliffe, M. 2008. *Feelings of Being: Phenomenology, Psychiatry and the Sense of Reality*. Oxford, United Kingdom: Oxford University Press.
- Sartre, J.-P. 1956. *Being and Nothingness: An Essay on Phenomenological Ontology*. Trans. H. Barnes. New York: Philosophical Library.
- Sholl, J. 2015. Putting phenomenology in its place: Some limits of a phenomenology of medicine. *Theoretical Medicine and Bioethics* 36(6):391–410.
- Slatman, J. 2014. *Our Strange Body: Philosophical Reflections on Identity and Medical Interventions*. Amsterdam, The Netherlands: Amsterdam University Press.
- Spiegelberg, H. 1972. *Phenomenology in Psychology and Psychiatry: A Historical Introduction*. Evanston, IL: Northwestern University Press.
- Stanghellini, G. and Fuchs, T., eds. 2013. *One Century of Karl Jaspers' General Psychopathology*. Oxford, United Kingdom: Oxford University Press.
- Svenaesus, F. 2000. *The Hermeneutics of Medicine and the Phenomenology of Health: Steps Towards a Philosophy of Medical Practice*. Dordrecht, The Netherlands: Kluwer.
- . 2009. The phenomenology of falling ill: An explication, critique and improvement of Sartre's theory of embodiment and alienation. *Human Studies* 32(1):53–66.
- . 2011. Illness as unhomelike being-in-the-world: Heidegger and the phenomenology of medicine. *Medicine, Health Care and Philosophy* 14(3):333–43.

- . 2013. Naturalistic and phenomenological theories of health: Distinctions and connections. In *Phenomenology and Naturalism: Exploring the Relationship Between Human Experience and Nature*, eds. H. Carel and D. Meacham, 221–38. Cambridge, United Kingdom: Cambridge University Press.
- . 2017. *Phenomenological Bioethics: Medical Technologies, Human Suffering, and the Meaning of Being Alive*. London, United Kingdom: Routledge.
- Toombs, S. K. 1992. *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient*. Dordrecht, The Netherlands: Kluwer.
- Welsh, T. 2016. Many healths: Nietzsche and phenomenologies of illness. *Frontiers of Philosophy in China* 11(3):338–57.
- Zahavi, D. 2013. Naturalized phenomenology: A desideratum or a category mistake? In *Phenomenology and Naturalism: Exploring the Relationship Between Human Experience and Nature*, eds. H. Carel and D. Meacham, 23–42. Cambridge, United Kingdom: Cambridge University Press.
- Zeiler, K. and Folkmarson Käll, L., eds. 2014. *Feminist Phenomenology and Medicine*. Albany: State University of New York Press.