

A PHENOMENOLOGY OF ILLNESS: THE LIVED BODY, HEALTH, AND THE OTHER

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This paper explores the phenomenon of being ill (in cases of serious, chronic and terminal illnesses) both in its subjective and intersubjective dimensions. My main contention is that the philosophical tools of phenomenology uncover the framework for understanding the lived experience of the ill person as they privilege the first-person account of illness. It is through this that the essence of things and phenomena surrounding the body-in-illness are unveiled, as opposed to the medical world's perspective, a third-person account of diseases. A phenomenology of illness underscores that illness is a substantial parcel of human existence that alters the ill person's experience of the body, intersubjective relations with the other, and relation with the world entirely. This essay is constituted of four major sections dabbling with a phenomenological account of the experience of the lived body, the body-in-illness, the intersubjective dimension of the body-in-illness, and a note on health.

Keywords: body, health, illness, intersubjectivity, phenomenology

The future horrified me. When I was fifteen, my uncle Maurice died of cancer of the stomach. I was told that for days on end, he shrieked: "Finish me off. Give me my revolver. Have pity on me."

—*A Very Easy Death*, Simone de Beauvoir

INTRODUCTION

Humans as rational, as a thinking reed, had been popularly appropriated as the greatest proof that the human animal is beyond any other sentient life form. Some classical philosophical claims, such as that of Plato, suggest that the dominion of our non-bodily component represents the answer to the question, "Who am I?" Depending on the ruling characteristic of the soul, be it appetitive, sensitive, or rational, our faction and role in the state are identified with ease. Yet another great mind in the history of

philosophy, Aristotle, seems to be dissatisfied with such configuration as he is a believer in the so-called *embodied spirit*. The human animal is a whole of her body and spirit. At the dawn of the period of enlightenment, Rene Descartes postulates another solution via methodic doubt and reaches his earlier *Meditations* with an outline of how thinking, or simply being conscious, encapsulates the immediate proof of our existence in the world—“I think, therefore, I am.” The groundbreaking influence of the father of modern philosophy is beyond question, but from a phenomenological standpoint, it remains a question that if the two are entities divorced from each other, how do I make sense of the paradox that their relationship implies? What happens to this mind that is *me*, when troubled by the body which is also *me*?

For Jean-Paul Sartre (2018, 363), the body is revealed to us in our physical turmoil, such as certain illnesses or diseases, as these are suffered by consciousness. A health threat that directs our attention to our physicality transforms our perceptive understanding of the *lived body* and elucidates our apprehension of the world with others. In times of such bodily crises, we become more attuned to *having a body* (that suffers). With this, I explore the phenomenon of being ill (in cases of serious, chronic, terminal illnesses) both in its subjective, body-in-illness aspect and intersubjective, body-in-illness-for-the-other dimension. A body-in-illness pertains to the first-person understanding of the experience of the ill person’s body limited to chronic, terminal illnesses that are known to have no cure and are likely to lead to the patient’s death. This phenomenological account of the ill person’s experience of the body is extended to what I call the body-in-illness-for-the-other dimension that concerns the individual’s experience of being ill. The transformative world brought by the body-in-illness is usually agonizing not only to the ill person’s experience of the body but also to the concrete embodiment of others who are active participants in their shared world.

I argue that the philosophical tools of phenomenology frame a holistic approach to the subjective experience of the ill person’s body and relationship with the world as these highlight that illness is a substantial part of human existence. This challenges the medical world’s perspective, which is arguably a third-person account of diseases. I, therefore, use a phenomenological approach to illness and the body to propose a philosophy that is ultimately suited to analyzing and reflecting upon our *experience* of the lived body-in-illness. It privileges the first-person perspective for unveiling the essence of things and phenomena surrounding the experiences of the ill body, which include, most importantly, how their world is inevitably altered. This essay is then constituted by four major sections discussing a phenomenological account of the experience of the lived body, the body-in-illness, the intersubjective dimension of the body-in-illness, and health. It ends with a note on understanding illness as the night side of life—always there, but oftentimes overlooked.

THE LIVED BODY

It is a seemingly funny irony that one of the greatest minds of Western philosophy, Plato, illustrates the body in a mischievous fashion as it appears to be a mere entity in the realm of the world of objects (Kirsh 2016, 7-17).¹ In *Phaedo*, Plato (2002) writes that we must get rid of this physical substance that suppresses us to

remain in the shadows of the cave and henceforth contemplate through our soul alone, the non-bodily facet of us that we ought to trust. But Plato (1987), who was a professional wrestler in his prime years, also dedicated a few passages on the importance of (taking care of) the body to some considerable extent (Hayes 2012).

Have you noticed how a lifelong devotion to physical exercise, to the exclusion of anything else, produces a certain type of mind? Just as neglect of it produces another? Excessive emphasis on athletics produces an excessively uncivilized type, while purely literary training leaves men indecently soft (Plato 1987, 410c–412a).

These unpopular passages of Plato’s work welcome a more holistic outlook towards the body as it is hereby treated in equal respect with its non-bodily counterpart. However, denigrating the human body as a defective source of knowledge persisted in the golden age of Greek philosophy through the Middle Ages and eventually solidified by Cartesian philosophy. Descartes (2000) argues that our physical bodies (*res extensa*) are mere things that occupy space and are distinct from our immaterial minds (*res cogitans*). Descartes agrees with the English physician William Harvey, who assumes that the human heart is merely a machine, not a home for the soul, and its acts are ruled by mechanistic laws (Aho and Aho 2008, 16). Our organs are but “composites of (what today would be called molecular) particles” (Aho and Aho 2008, 16).

In hindsight, we know that we are not a mere conglomerate of particles of matter. A phenomenological reflection of the body would lead us to focus on and describe the body phenomena as they appear to our consciousness. As a distinctly philosophical practice, phenomenology uncovers the conditions of possibility for having a particular experience (Carel 2016, 21). A phenomenology of the body invites us to return to the proximity of our everyday life instead of dismissing our physicality as mere shadows in a cave (Aho and Aho 2008, 17). Turning our attention to our bodies which are the closest to us, we revive the Husserlian cry of going back “to the things themselves!”

The founder of phenomenology, Edmund Husserl, argues that phenomenology is a “presuppositionless science of consciousness” (Husserl 2002, 249-295; Carel 2016, 24). It is through phenomenological reduction (*epoche*) that the essence of a phenomenon is revealed in consciousness as consciousness is always intentional; consciousness is always directed towards something other than itself (Husserl 1970, xxxii). It is crucial to note here that the onset of Husserlian phenomenology was a reaction against the natural sciences that carry with them what Husserl (1990, 13-15) calls a “natural attitude” towards one’s conception of the world. Since Husserl construes phenomenology as a science of essences, its workings as a philosophical tool and method rest on the process of “bracketing” presuppositions brought by the natural attitude. While Husserl attempted to bracket the presuppositions of the natural sciences, this paper adopts such a philosophical attitude to specifically challenge the medical world’s perspective in construing the body and the body-in-illness.

Husserl’s departure from the natural sciences and the Cartesian treatment of the body is also evident when he puts emphasis on the distinction between the corporeal

body (Körper) and the lived body (Leib) (Al-Saji 2000, 52). The former suggests that the body is a mere physical entity among others that spatially participate in the world. Considering the body only as Körper is susceptible to having its physicality dissected by the scientific practice, or in the case of the ill body, the medical approach to the body. In bracketing the way of seeing ourselves in the natural standpoint of the sciences, as in the case of physics or biology, we discover our bodies as a “lived body”, or *Leib*, a term closely tied to *Leben*, meaning life (Aho and Aho 2008, 18). Understanding the body as *Leib* would then uncover the actuality of *my experience of my body* as opposed to experiencing *this* body as a mere physical substance or Körper. It is crucial to consider that we exist as we associate most of our experiences within the phenomenon of the body as alive, as *Leib*.

Phenomenology then prompts the disclosure that *my body* (as Leib) is revealed to me as a way of my being-in-the-world. For Martin Heidegger (1996), being-in-the-world is critical in understanding the existential structures of being. Being-in-the-world implies that I am *thrown* into the world, and it is a phenomenological fact that I am always in the world. His French counterpart, Sartre, is on board with the same idea. But for Sartre (2018), this thrownness is intertwined with an existential conception of human freedom. Since we are self-reflective beings (for-itself), it is from nothingness that the reality of our freedom emerges (Sartre 2018, 44-49). Unlike mere material entities (in-itself) like a mug, a guitar, or a mechanical keyboard, Sartre says that humans are both privileged and doomed to be free. This conception of freedom remains consistent with Sartre's (2018, 409-478) approach to the body—the body as subject, as object, and as intersubjective. With emphasis on the first two, the body as lived is first understood as it is experienced by the self-reflective being and secondly as a mere thing or object. The point being, none of this would occur had *I* not been a being-in-the-world as Heidegger puts it, whose existence in it is an offshoot of thrownness and condemnation to be free, as in Sartre.

By extension, I realize that my body appears before me as attached to the world. If this was not true, then it would be impossible to see and feel my body getting a tattoo, for example. I see and feel with my body in the immediacy of moments in time. Construing my body as Leib that is thrown into the world opens the possibility of recognizing *my body* as the center of my and other's perceptions and actions. Similarly, Aho and Aho (2008, 18) illustrate this through what they call “body-events” that our bodies carry with them—my sweaty hand crossed against the hand of someone I really like, a shameful first kiss, or that moment when I fell on my knees while walking inside the campus. I, therefore, am not a mere machine governed by mechanistic laws. My body is an all-encompassing reminder of my being-in-the-world.

More to the point, the body-events that recognize the body as lived make it also possible for me to exclaim that “my body is *mine*” (Aho and Aho 2008, 18-19; Calasanz 2001, 95-102). It is through this that my history, memory, and perception are shaped. However, this body is *not mine* in the same sense that my cat is mine, or this mechanical keyboard that I use in typing all these words is mine. Through a manner of seeing however, as Calasanz (2001) states, there is a considerable link between saying “I have my body” to “I have my cat.” They are both my possessions. On a more phenomenological note, Gabriel Marcel (1950, 103-104) says that this manner of ownership is to be construed in the way of understanding my relationship to the

possessed. I claim that my cat is mine because I take care of it, and it recognizes this relation to some extent when it comes to me for food or for petting. I also am the one who can decide whether I continue or stop taking care of my cat. Thus, I am accountable for what I possess; I have control and responsibility over them. It is in the same sense that “I have my body”—I am condemned to be free to govern and decide for my body. However, when I leave the house for work, my cat stays while I am in the workplace with my body, the very means through which the work is to be done. “Wherever I am, there also is my body, and wherever my body is, there I am too” (Calasanz 2001, 99). Unlike my relationship with my cat, my location and the history of my body are always together.

For Marcel (1950), our embodiment ought to be the point of departure for philosophical reflection. I ought to go beyond the level of primary reflection that presents my body as *a body* that is objectively conceptualized and analyzed as separate from me. Surely, this manner of thinking has been helpful to humankind as its method is what brought the biomedical sciences to discoveries crucial to the human body. But Marcel presumes that this does not constitute the whole truth about the body. We must enter the secondary reflection, Marcel (1950, 103-124) argues, and recognize that we are “thrown beneath” our bodies as we take part in reflecting on it subjectively as opposed to being “thrown in front” of our bodies as if it has nothing to do with us. Similarly, reflection is, in essence, the ground through which the Husserlian phenomenological method is made possible. Husserl thinks that the disclosure of the essence of things and experiences informs our knowledge and relation to the world. Comparatively, Marcel holds that arriving at the level of secondary reflection deepens *my* understanding of the lived body as *my body*.

Here comes the paradox. Realizing that “I have my body” or that “my body is mine,” opens the limits of this *having* to a possibility of *not having*—“my body is not mine.”

In other words, my body has a “life of its own,” so to say, a “heft” and a “heaviness” independent of the will, and against which *I* must sometimes exert myself (for example, to sit erect or to remain still). Vice versa, I can use my body as I would an instrument or tool to realize my goals. I can cut it, cover it, and color it to foster favorable impressions of me; and I can feel a steward’s sense of responsibility for its well-being. In short, then, my body is “‘mine’ most of all, yet [it is also] ‘other’ most of all”. It is an uncanny, paradoxical combination of opposites, at once alien and intimate (Aho and Aho 2008, 18-19).

The boundaries of the degree of awareness that I have with my body are evident when I simply know that my body performs multiple functions without me feeling every bit of these processes that I only knew through books. I am hungry, I fill my stomach with food through my mouth. However, I cannot recognize the intricacies of how my digestive system breaks down the meal. I can surely scathe my skin with a needle to draw a star-shaped scar, I have control over my body. But I cannot govern its mechanism of healing—how long would it take to heal or how much blood would

it shed—or whether a star-shaped scar would even be embedded. *My body has a life of its own* and in this sense, I am not my body.

While the paradox of being *my body* and *not being my body* implies ambiguity, this remains an essential component of our experience of our lived body. How “we are engaged participants in a shared world” is a necessary entailment of our embodiment (Aho and Aho 2008, 25). Approaching our bodies phenomenologically sets in motion a suspension of the Cartesian view that stresses the composite substances and dualisms that make us up. *I am not a mere ego cogito imprisoned in a material body, rather, I experience my body as me.*

BODY-IN-ILLNESS

A phenomenological attitude towards illness is viewed as an advantageous philosophical lens to amplify a subjective, first-person analysis of an individual's *experience* of illness (Carel 2016, 14-15). Havi Carel (2016), in *Phenomenology of Illness*, develops an approach that underscores the lived body's central role in the veracity of human life and experiences. For my purposes here, what is referred to as illnesses of the body-in-illness is limited to serious, terminal cases that are known to have no cure and are likely to lead to a patient's death. The most common examples of these are advanced cancer, dementia, neurological diseases, motor neuron disease (MND), and advanced heart diseases (Marie Curie: Care and Support through Terminal Illness, 2022). Echoing Carel's elucidation of the *phenomenological features of the body*, our journey with our bodies continues with emphasis on the discomforts that our embodiment entails. Carel (2016, 42) describes several phenomenological features of the body-in-illness in an attempt to ascertain the possible general and essential facets of an ill person's experience of various illnesses. We shall take a closer look at these features in this section.

Loss of wholeness. The experience of body-in-illness, that moment of shock when one becomes knowledgeable of a disease that ultimately threatens one's everyday life, inevitably leads to a loss of a sense of *bodily integrity* (Carel 2016, 42). The ill person becomes aware of the non-transparency of her body and that it can no longer be taken for granted. The body is now understood in parts. *I have an aggressive tumor in the lungs.* The body is no longer absent. *I have a weak heart.* This moment reveals that “illness disrupts the fundamental body-self unity, and the body is now experienced as other-than-me” (Carel 2016, 42). The body-in-illness is perceived as an impairment that threatens the self and the everydayness that it is most familiar with.

Loss of certainty. According to Carel (2016, 42), this second kind of loss follows from the loss of wholeness. It is at this moment that illness is experienced as “a capricious interruption.” Something unexpected has brutally disturbed the order of things that once surrounded a healthy person's routine. Illness slaps the patient with the heavy load of her vulnerability that impedes an otherwise charily crafted life. As a result, doses of anxiety and worry add salt to the wound.

Loss of control. Illness—especially in cases of serious, chronic, terminal illnesses—could be viewed as a menacing calamity that emerged out of the blue.

The illness in its seemingly random unfolding (*will the cancer cells respond to the chemotherapy? Why did I suffer the heart attack?*) is experienced more like a stroke of bad luck than freely chosen life circumstances (Carel 2016, 42; emphasis mine).

Without noticing it most of the time, we are usually in control of our bodies to complete our daily tasks. The simple act of eating means we have power over our body to grip the utensils and gobble up a meal to endure our daily feat. But this capacity is something that we eventually surrender in the volatile hands of fate when illness gets in the way. Talking about his tuberculosis, Franz Kafka once wrote to Max Brod in 1917 about his mind betraying his body, “My head and lungs have come to an agreement without my knowledge” (Sontag, 1991, 41). *My body has a life of its own*. And it can decide to totally dismiss our capability to rule over it as an effect of a known or unknown cause. Additionally, its extent could extend to our helplessness to make rational choices and judgments about whether a health professional claiming to cure can actually do so (Carel 2016, 42).

Loss of freedom to act. The fourth aching repercussion of the body-in-illness is the patient’s incapability to “freely choose which course of action (which medical treatment) to pursue” as she also becomes hindered by understanding what the best course of action may be for her condition (Carel, 2016, 43). The loss of control escalates to an infernal loss of freedom to act. *A nightmare*. The ill person’s body becomes objectified by subjects surrounding her—the medical professionals, nurses and family members—who, more often than not, become the most dependable in choosing the course of action for the patient.

Loss of everyday world. Everything collapses. It is in this instance that Carel (2016, 43) remarks, “The ill person can no longer continue with normal activities, or participate in the world of work and play as before.” A patient with a diabetic foot that needs to be amputated is already indicative of an altered everyday life with one’s lived body. The ill person’s world is transformed, and she can no longer live as she did previously. “The temporal dimension of one’s world is also shaken because future plans have to be adjusted in light of a medical prognosis and *the healthy past is broken off from the ill present*” (Carel 2016, 43; emphasis mine). The unsure future becomes horrifying altogether as the body-in-illness impedes the normalcy and familiarity that the subject associates with her everyday life. It is this loss that provokes the ill person to ask, “Why me?” when the prognosis discloses the wickedness that shatters not only the affected system of the body but also the hope of *Leben*.

Taken together, these five features of loss as a corollary to contracting a serious disease bring us back to the “I am my body”—“I am not my body” dialogue. In illness, this paradox remains cemented in *my* being-in-the-world as *I* am the one suffering from the repercussions of the disease and *I* am also the one clueless of the specifics of why and how this disease cripples my bodily functions. The body-in-illness becomes a reminder of the nuances of the existential structures of our everydayness. While Sartre assumes that we have a transcendent capacity entailed by human freedom, our *facticity* or our pre-given condition, *which includes the body and its limitations*, takes its place in the totality of our existence. The possibility of having and experiencing a body-in-illness is corollary to our pre-giveness, our facticity. I am a being-in-the-world whose

thrownness entails my facticity. In other words, I am thrown towards my pre-giveness. The body-in-illness witnesses the transformation of her world relative to the disease, and how the familiarity of her thrownness in this particular stage of life is no longer.

In the occurrence of any or all the aforementioned phenomenological features of the ill body, the body-in-illness will need immediate medical attention, support, and care from the people within her propinquity. This means that *my* altered world does not exempt those people around me; the ill person's shared world with *others* is also changing. I may also experience my body as it is reflected by the other. This is yet another realization that *my* thrownness in the world is not a facet of my existence that is unique to me. I exist in a world with concrete others. "We are engaged participants in a shared world" (Aho and Aho 2008, 25). This, then, opens our discussion of what I call the body-in-illness-for-the-other dimension—the intersubjectivity of the ill person's lived body.

THE INTERSUBJECTIVE EXPERIENCE OF THE BODY-IN-ILLNESS

Another substantial feature of the affliction that the body-in-illness undergoes is how her altered world is affecting and is affected by other people. Going back to Sartre's (1992) three orders of the body—body as subject, body as object, and body as intersubjective—the third order, *body as intersubjective* brings to light yet another tragic ambivalence in approaching the body-in-illness. Or in the words of Carel (2016, 52), "...My body as I experience it as reflected in the experience of it by others."

In view of Sartre's existential phenomenology, our self-reflective consciousness constitutes the meaning of our concrete relations with other people. As a self-reflective consciousness, *I* objectify the other in lieu of the freedom I have and reduce them to something or someone as I see fit (Sartre 1992, 252-302). Through our objectifying *look*, we see other people as beautiful, or ugly, or kind, or arrogant...and the list goes on. Since the other is also a free, self-reflecting being, her subjective culpability to objectify *me* is also enabled by our shared world. I am an I-subject to the objectified-other and vice versa. By the same token, I am also a body-subject and body-object in relation to other people. We shall go back to this later.

For Sartre, the idea of being free is something that we usually take in optimism as in the case of the particular prisoner in Plato's cave who has moved closer to the light and is finally *free*. On the other hand, a Sartrean take on freedom connotes responsibility as our actions are not based on mere reflex, but on our capability to choose the course of action, we wish to take. The free prisoner in Plato's cave then is someone who lives in good faith if he is self-reflective of the repercussions of leaving his comrades in the darkness in exchange for the light. *Anguish* then, is a necessary entailment of freedom. "It is in anguish," Sartre (1992, 65) writes, "that man gets consciousness of his freedom." Anguish is staring at our own freedom. And for that, we are condemned to be free.

Since we are not alone in our thrownness in the world, we realize that there are *others* who are equally conscious and free. The world where our lived body is made manifest is cramped with other bodies that relate to us in one way or another—we form

concrete relations with concrete others like those in the embodiment of whom we call friends or family. The lived body exists as a body known by an embodied other. As in the case of the body-in-illness, it is known by the physician that this person inhabits a body that is suffering from a certain disease. The diagnosis is made known to other people in the proximity of the patient's world—her friends and family. In a memoir for her mother, Simone de Beauvoir (1965, 58) recounts, "I asked myself how one manages to go on living when someone you love has called out to you 'Have pity on me' in vain." We sympathize with their anxiety and worry, to the extent that we partake in the ill person's world that begins to get out of hand.

In the process of the ill person's adjustment to her changing world, the same transformation inevitably happens to those who know her. *Her days are counted*. Through the inescapable objectifying look of the concrete others that surround us, the ill person is reduced to a diseased body. The medical world's perspective subjects her body to scrutiny and instrumental labels.

One is caught up in the wheels and dragged along, powerless in the face of specialists' diagnoses, their forecasts, and their decisions. The patient becomes their property: get them away from them if you can! (Beauvoir 1965, 57).

But this is the reality that comes with our existence. On some occasions, we become subjects to the work of physicians, physiologists, and other medical professionals. We are a mere body among a conglomerate of bodies. It also goes the other way around, as an ill person could perceive these professionals as the embodiment of those who may have the capacity to cure. The body-in-illness treats the medical professional, in this case, as a body-subject who has the capacity to address or alleviate the suffering of the body-in-illness. Consequently, the subjective perception of the ill person vilifies herself as a body-object subjected to the prescriptions of the medical professional. *I am a body-subject and body-object in relation to other people*. By the same token, the concrete others who surround and attend to the immediate needs of the ill patient may be perceived as body subjects who could aid in easing the weight of the altered world of the ill patient. Their everydayness is transformed altogether. The ill person's experience of losses—loss of wholeness, certainty, control, freedom to act, and everyday world—is enjoined by concrete participants in their shared world.

The intersubjective trades, although significantly altered, do not end in being ill. The fact remains that the complexities of our being-in-the-world with others is another essential component of our experience of our lived body. Thus, the intersubjectivity of the body-in-illness corresponds to an important facet to understanding the altered world of these individuals.

A NOTE ON HEALTH

The foundational thinker of modern nursing, Florence Nightingale, believes that *nursing care* ought to involve the use of the carer's brain, heart, and hands to create a

healing environment not only for patients' bodies but also for their minds and spirits (Kuhse and Singer 2009, 6). This connotes that a body-in-illness should be approached holistically in that it is treated with intimate respect as we are more than a chunk of flesh and skin. No wonder, the Hippocratic oath of the ancient times established that the medical profession must seek to benefit the patients and seek to prevent harm (Kuhse and Singer 2009, 5). Hence, the principle of beneficence and non-maleficence. To date, the inception of modern medicine prides itself on discoveries and new technologies that aided medical practitioners in scrutinizing our anatomical structure. The stethoscope, in Aho and Aho's (2008, 79) example, "enabled physicians to directly attend to ("auscultate") the poundings and rumblings of the heart and lungs." Other observational tools such as ophthalmoscope, for peering into the eye; the rhinoscope, for the nose; the otoscope, for the ear; the gastroscope, for the stomach, paved the way to objective metrics that rather moved the focus of medicine away from the lived experience and concerns of patients (Aho and Aho 2008, 79).

This has permitted modern medicine to render a *depersonalization* of the body-in-illness. The objective instrumentality of the tools used to examine the ill body silenced the patients at their first steps toward seeking the help that they needed. The depersonalizing trajectory of the medical profession has only contributed to the blurring meaning of health that ought to be a complete reflection of the so-called *healthcare*. The training in the medical school, corollary to this, is not an exception.

Students are awarded honors and prizes on the basis of exam scores, not for their interpersonal skills or practical life experiences, and certainly not for subjective considerations like bedside manner. And this does not end after graduation. The typical postgraduate resident undergoes an almost inhuman grind for two years, with work "days" sometimes lasting thirty-six hours. Although the ostensible goal of this procedure is to train young doctors to effectively manage time, the result is that *they often come to dread their patients, if not to despise them altogether* (Aho and Aho 2008, 78; emphasis mine).

A doctor's account even once revealed that he hoped that the middle-aged patient brought into the emergency room of his residency would die so that he could get back to sleep (Aho and Aho 2008, 78).² In relation to this, as an anecdote to similar encounters with specialists (and medical facilities) in the "developing" world, in the post-pandemic year of 2022, I had to have my father checked for recurring chest pain that he complained to be disrupting his sleep and usual routine for days. He must undergo the usual initial laboratory tests so that the physician can see through his flesh and draw an informed reasoning based on the laboratory report. It took at least three follow-up check-ups to hear the specialist insist that there was nothing wrong with my father's X-ray and laboratory examinations. We were sent home to believe that he was in fact *healthy* regardless of the consistency of the chest pain that has been troubling his nights for weeks.³ It seemed that painkillers and vitamins should ease the *illusory* disease disturbing the normalcy of the lived body of my father.

It is no secret that the Philippines has poor healthcare and medical facilities to accommodate the never decreasing population of patients needing medical attention day-by-day. In Ordinario's (2022) report, despite the implementation of the nation's Universal Health Care Law or Republic Act no. 11223 that mandates comprehensive healthcare for Filipinos that is expected to alleviate their financial strain, the out-of-pocket expenses for the healthcare needs of our fellowmen remained one of the biggest contributors of health spending in the country. When one is already crippled by the fact that one (or someone we know) is ill, the most apparent solution is to seek the healthcare provider's or professionals' help. But as the writer Oscar Lagman (2023) muses, universal healthcare in the country is still many years away. The rampant corruption in the Philippine government is also the enemy. Regardless of the suggestion of the World Health Organization (WHO) to our legislators to implement the universal healthcare fully in 2030, only when we are ready, they still pushed for enacting the law in a rush, in the interest of the 2019 national elections (Lagman, 2023). The proponents of the Universal Healthcare Law offered it as a "gift" to the Filipino people, and four of the authors running for re-election were successfully re-elected.⁴ As an archipelago with 7,641 islands, there are only 721 public hospitals in the Philippines and only 66 of which are managed by the Department of Health (DOH) (Ferrolino 2019; Lagman 2023). Ideally, the public hospitals should accommodate most of the locals who are in need. In its most ironic sense, what is hereby designated as "healthcare" lacks its most important part: *care*. The crooked system boldly emerges and patches the already altered world of the ill person and those around them. If the same system persists, the attention to the subjective experience of the body-in-illness will remain in the shadows. But unfortunately, and ironically, this too, stays as a part of the fullness of the experience of a body-in-illness in the world that surrounds them.

CONCLUSION: THE NIGHT-SIDE OF LIFE

Susan Sontag (1991) speaks of illness as a night-side of life in her now virtually forgotten work, *Illness as a Metaphor*. Illness as the night-side of life connotes that we hold a dual citizenship in *the kingdom of the well* and *the kingdom of the sick* from the moment we unknowingly acquired life on this planet (Sontag 1991, 3). Oftentimes, we are only consciously attentive to the former than the latter. While it is ideal to only use a good passport, the time comes when we have to identify ourselves as citizens of that other place. As it was already established, it is quite common that we are never aware of the mechanistic systems of our body that sustain our temporal life on earth until we are outraged by the dominance of pain that shakes our routine. We are only usually taken aback to pause and reflect on our *lived body* when a persistent experience of pain and bodily discomfort decides to squeeze itself into our otherwise healthily crafted life. In the words of Beauvoir (1965, 58), contracting a serious illness is "a race between death and torture." And in this race, we most earnestly hope that death would come first.

It was Heidegger (1996) who reminded us that our thrownness in the world does not exempt the certainty of our being-towards-death. And it is in moments of utter vagueness, such as suffering from a serious, chronic illness that this reality of our being-in-the-world becomes more apparent. As a matter of fact, we often characterize

illness—alongside and on top of old age—as that which constitutes what we call a natural death. For other existential-phenomenologists especially Sartre and Beauvoir, this is part of the existential dimension of our pre-givenness or facticity. While we are transcendent beings because we are free, self-reflective creatures, the undeniable boundaries can be found in our facticity, including the unpredictable possibilities resulting from our embodiment. For this reason, Beauvoir (1948) thinks that this tug of war between our facticity and transcendence constitutes the ambiguity of our existence. This account also applies to a phenomenological understanding of being-in-illness as a crucial dimension of our facticity that tries to pull us away from our vast capabilities to transcend via our freedom. *Anguish*. As Kafka observes, there are moments that will make us step back from the (unknown) mechanisms that occur in our bodily systems when we are ill—*my mind betrays my body*.

After losing our preconceived notion of wholeness, certainty, control, freedom to act, and the everyday world as we contract a serious, inescapable disease, the complexities and ambiguities that come with our thrownness in the world become evidently manifest. It transforms our notions of our lived body, health, and shared world with concrete others. *I am and I am not my body*. Nevertheless, recognizing illness as the night-side of life shall not stop us from finding novel ways to create meaning and craft a life that we can characterize as worth living, as meaningful *Leben*.

For my father.

NOTES

1. Ironic because the name that we remember him by, Plato, was his wrestling nickname meaning ‘broad’ (platon), which may either refer to his shoulders or his forehead. According to the Greek historian Diogenes Laertius, Plato’s birth name was “Aristocles”, taken after his grandfather. Plato clearly sheltered importance on his own body as his body shape tells us in preserved images and as evident in some passages he wrote in the *Republic*. As an athletic, he competed in the “Isthmian Games”, an athletic event comparable to the Greek Olympics (Kirsh 2016, 7-17).

2. The physician was David Schlim, a travel medicine physician in Wyoming, USA. (Doximity 2024; Aho and Aho 2008, 78).

3. Eventually, after seeking a different specialist who happens to have intuitively identified the possible cause of my father’s persistent chest pain, the diagnosis revealed that he already has a stage-4 lung cancer. Apparently, the chest pain was caused by a tumor in his lung—one that is not apparent in his earlier laboratory tests as reported by the first physician—that hit a nerve, causing the striking pain in the chest and, later, the back and arms. It was then characterized as a Pancoast tumor, a rare form of lung cancer. But finally, a diagnosis that is consistent with the ill person’s experience of his body was made.

4. Among those who were re-elected in the Senate are JV Ejercito, principal author, and Sonny Angara, Nancy Binay, and Cynthia Villar.

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