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Suffering, critical illness, and radical bodily doubt

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Suffering, critical illness, and radical bodily doubt

I. What restricts our understanding of suffering?

Suffering comes in many forms; when it is ours, it cannot be ignored. However, our poverty of expression, imagination and memory often restrict our understanding of the suffering of others. There are cultural restrictions on what we can say: many contemporary cultures espouse a bias towards 'bright-siding,' as Barabara Ehrenreich calls it in *Smile or Die*ⁱ. Another common barrier is the lack of words, concepts and interpretive resources for articulating suffering. Hence we often find ourselves in a double predicament: first we suffer, then our attempts to articulate this suffering are blocked by a culture suffused with 'positivity' and lacking in linguistic and interpretive resources. We often say we 'have no words' to describe our suffering or to acknowledge the suffering of others, such as in bereavement, and this is taken to be a culturally accepted way of expressing our linguistic trouble with suffering.

Second, our *imagination* - often fuelled by blissful ignorance of illness, bereavement, grief, mental illness and bodily suffering - is unable to fully furnish a picture of what such experiences are like. Attempts such as the ones seen in mainstream media often fall woefully short. And finally, memory is notoriously fickle. So, when we try to remember what it felt like for us, for example, when we were ill, we find that both the details and the quality of this suffering have escaped our minds. We therefore inhabit a social reality that is culturally and psychologically preloaded with talk of 'positive attitudes', 'resilience', and 'making the best of it' when we *want* to share opposite experiences of breakdown, mental chaos, and despair.

To be able to talk about suffering, articulate it, develop a shared account of it, and incorporate it into our lives, we need to overcome these obstacles. This set of problems - I call them 'effability problems' - applies to many, if not all, kinds of suffering. Here I focus on one type of suffering, illness, which I take to be a paradigmatic and hyper-intimate kind of suffering. It is infused within our bodies and sense of self, and is an experience that is both inescapable and universal.

The drive to overcome the cultural, interpersonal and psychological barriers for the expression of suffering motivates my approach to the study of illness, namely, the *phenomenology of illness*. This approach gives us tools with which to order and discern experiences that are of their nature chaotic and difficult to speak of, and provides a conceptual space within which such labour can be attempted. This enables us to

lessen the stronghold of ‘positive thinking’ and open expressive avenues for the articulation and sharing of suffering.

In this essay, I aim to do just that, building on previous work in *Illness* and in *Phenomenology of Illness*, in which I develop a framework for understanding illness experiences (see ‘further reading’ below). This framework relies on work by phenomenologists, mainly Martin Heidegger, Jean-Paul Sartre, and Merleau-Ponty. The foundational claim of my framework is that illness changes – often profoundly – not only the *type* of experiences we have but the *experiential framing* within which we have experiences altogether. For example, our sense of space and time fundamentally changes when we become incapacitated or disabled by illness, and when our life prospects and longevity diminish (for example, if we are given a poor prognosis).

Another profound change is of our attitudes and values. Perhaps what was once critical to one’s self-image (e.g. their good looks) becomes laughably insignificant. Perhaps things that seemed trivial in the past take on supreme importance. How one lives will differ – deeply, radically – in light of diminishing choices and resources, when one’s illness progresses. A complete revision of what one considers desirable, acceptable, liveable, takes place in tandem with disease progression. In other words, illness is also a *transformative experience*, because it changes the ill person both epistemically and personally.ⁱⁱ The question: what is a life worth living (for me)? is probed and reconfigured when what was only vaguely imagined, if at all, becomes the concrete and suffocating reality of illness.

Finally, illness changes – radically and inescapably – the ill person’s body, and hence their embodied self: perception, gestures, bodily habits, and modes of engagement with the world. That also includes what I call ‘the geography of illness’, in which spaces and places become hostile or difficult to reach and navigate, and ‘the social architecture of illness’, in which the ill person’s social world is buffeted and damaged by the squall of stigma and what Ian James Kidd calls *pathophobic attitudes* such as callousness, prurience, and insensitivity.ⁱⁱⁱ

II. Phenomenology of illness

These are some of the challenges a phenomenology of illness encounters when one aims to characterise what that experience is like. It has been likened to a series of losses (by Kay Toombs), a loss of transparency (famously by Jean-Paul Sartre), a feeling of homelessness (by Fredrik Svenaeus) and a dys-appearance (by Drew Leder). It is a profound disruption of one's experience in the ways noted above. The challenge, therefore, is: how can we conceive of these changes? How can we fulsomely grasp what the experience of illness might be like for a friend, family member, or a stranger?

One way to begin chipping away at the barriers to describing and communicating illness experiences, and more broadly suffering, is by developing fertile philosophical accounts, rich in detail and conceptually nuanced. One major way in which we can describe illness, is by latching on to the bodily and embodied transformation it brings about. This is the transition from bodily confidence to bodily doubt. I suggest that there is a particular kind of doubt, which I call *bodily doubt*, that characterises the transition from wellness to illness. After outlining bodily doubt, I'll focus on a specific type of such doubt, that is more extreme and hence rare, which I call *radical bodily doubt*.

III. Bodily doubt

In many somatic and mental disorders the sense of certainty and confidence we have in our own bodies is deeply disturbed. What was previously taken for granted— that my legs can carry me, that my brain will continue working as before, that my lungs can support my body's oxygen requirements — is suddenly and sometimes acutely thrown into question. Such cases of illness make apparent not only the bodily feeling of confidence, familiarity, and continuity that is disturbed, but also a host of assumptions that hang on it. For example, one's future plans depend on bodily capacities and thus are limited by ill health. One's temporal sense is radically changed by a poor prognosis. One's values and sense of what is important in life are frequently modified in light of illness; bodily limitations impact on one's existence generally.

Bodily doubt is not just a disruption of belief, but a disturbance on a bodily level. It is a disruption of one's most fundamental sense of being in the world. Bodily doubt gives rise to an experience of unreality, estrangement, and detachment. From a feeling of

comfortably inhabiting a world, the ill person is thrown into uncertainty and anxiety. Her attention is withdrawn from the world and focused on her body. She may feel acutely isolated from others, who maintain their connection to the world, and may become detached from both physical and social environments. The natural confidence in her bodily abilities is displaced by a feeling of helplessness, alarm, and distrust in her body.

Bodily doubt has distinctive features that make it philosophically revealing. First, the feeling can descend at any moment. Its precariousness and unpredictability make it more threatening and us less capable of incorporating it into our familiar world. Second, the feeling of bodily doubt invades the normal sense of things, the everyday. It results in feeling exposed, under threat. In this respect bodily doubt is different to normal kinds of bodily failure (slipping on the street or feeling too exhausted to go to a party) that may seem similar to bodily doubt. Bodily doubt throws one out of immersion and into suspension and the familiar world is replaced by an uncanny one.

Third, bodily doubt reveals the extent of our vulnerability. Once experienced, bodily doubt often leaves a permanent mark on the person experiencing it; it is the loss of a certainty that has hitherto never been disturbed. Moreover, the possibility of it being disturbed has not been countenanced. In this sense it is like other kinds of suffering (being the victim of violence, bereavement, being involved in an accident, and so on). Such suffering overthrows our most basic assumptions about the regularity, predictability, and benevolence of the world.

J.M. Bernstein describes such experiences as ‘revealing underlying and intractable dimensions of vulnerability, dependence, and potential helplessness that are normally hidden from consciousness.’^{iv} Bodily doubt reveals vulnerability of a specifically bodily kind. Once one’s basic orientation in the world has changed and the possibility of catastrophic bodily failure is now part of one’s horizons.

Fourth, bodily doubt makes the person experiencing it feel incapable. Confronting the loss of abilities and the frustration involved in ‘being unable’ (‘I cannot’) contrasts with the normal (healthy) feeling of competence and ability, even when this ability is punctuated by occasional failure. For example, if I decide to go for a walk I cannot walk indefinitely, but my bodily certainty is such that the project (going for a walk) dominates

the action. I walk until I am satisfied, so in effect I have walked without limit. In a state of bodily doubt I want to go for a walk, but I am restricted by my bodily limitation. I plan before I act (how far I can go; will it be too steep?) such that the action becomes entirely determined by my bodily limits. The limitless sense of myself, of my open horizons, as extending beyond myself and into the world collapses back onto my actual physical being. The experience of bodily doubt exposes the structure of how things normally are, and is hence philosophically revealing.

Bodily doubt not only changes the content of experience, it also pierces the normal sense of bodily control, continuity, and transparency in a way that reveals their contingency. Here are three such changes

1. **Loss of continuity:** human cognition and action are characterized by continuity of experience and purposeful action. In bodily doubt this continuity is lost and replaced by a suspension of normal action and a modified awareness of self and environment. In this suspension, experience is sliced by discontinuity. The characteristic smoothness of everyday routine is disrupted. Everyday habits become the object of explicit attention and conscious effort; the ongoing tacit sense of normalcy is lost. In this situation one is unable to pursue their goals; the normal flow of actions leading to the goals is disturbed. Minor tasks require planning and attention to detail, as well as contingency plans. The normal flow of everyday activities is halted by bodily uncertainty and when it is resumed it is altered by the experience of doubt. The doubt is a constant reminder of the contingency and fallibility of the original continuity.
2. **Loss of transparency:** the healthy body has been characterized as by Jean-Paul Sartre as transparent and as absent, by Drew Leder. Leder writes: 'while in one sense the body is the most abiding and inescapable presence in our lives, it is also essentially characterised by absence. That is, one's own body is rarely the thematic object of experience.'⁹ When the interaction between us and the world is smooth and regulated by well-developed behavioural repertoires, there is little need for conscious attention. But even in health the world may resist this smooth articulation and require conscious awareness. Perhaps the small knocks and resistances that befall us in minor accidents, bodily failures, bodily needs,

and the inability to easily learn new bodily skills disrupt this transparency in minor ways.

Illness, in contrast, creates areas of dramatic resistance in the exchange between body and environment, so is wholly different to these small knocks. As Merleau-Ponty says in *Phenomenology of perception*, we intend towards the world through our body, which is the medium through which we encounter the world, whilst the body itself remains in the background.

In cases of bodily doubt, the body's taken for granted capacities become explicit achievements. What was previously performed with little or no thought now requires conscious planning. For example, in the case of bodily doubt, shopping for groceries becomes a fullblown project, demanding planning, explicit attention to detail, and contingency plans. Moreover, the action is understood in terms of its limits which also leads to a loss of spontaneity and changes the meaning of routine tasks.

3. **Loss of faith in one's body:** the loss of faith pertains to the tacit set of beliefs we hold about our bodies. These beliefs support everyday actions as well as more specialized goals and projects. Whatever the action, it is hard to carry it out in the context of doubt. Not being sure one is able to achieve the simplest of tasks leaves one in turmoil and the implicit certainties underpinning the everyday damaged. The loss of faith is a way of experiencing one's body which replaces the previous certainty. This is an experience of vulnerability, hesitation, and doubt, experienced on a bodily level. It amounts to a disruption of one's sense of belonging to the world and the disappearance of the sense of ordinariness. The loss of faith in one's body reveals the contingency and fallibility of our normal trust in our bodies.

IV. Radical bodily doubt

Radical bodily doubt is conceptually and experientially more extreme. It is emblematic of liminal situations such as being in intensive care, or at the end of life (although there is a broad spectrum of experiences), in which bodily doubt hardens into the certainty of incapacitation. What we encounter is not

bodily doubt, but a certainty of bodily *collapse*: bodily abilities are altogether gone, not distrusted, as is the possibility of returning to the previous sense of bodily orientation, integration and intelligibility. In *radical* bodily doubt the person experiences a destruction – partial or complete – of their embodied agency. This attitude is no longer a doubt ('will I be able to do this?') but a *radical certainty*: ('I am completely broken and unable to do this.') What is experienced as fragile and precarious in bodily doubt is experienced as *lost* in radical bodily doubt.

So why is this still doubt at all? I use the term here to pick out a high-level *general* doubt rather than localised doubts about specific bodily abilities. What remains as a doubt, though, is the general orientation we have towards our bodies as intelligible and predictable. although bodily doubt becomes a form of bodily certainty (one loses something altogether rather than experiencing it as no longer dependable), this certainty also amounts to a non-localized form of doubt regarding everything else. A background sense of confidence or certainty that is usually integral to our relationship with the world as a whole is lost. And this sense of certainty is a prerequisite for taking anything to be the case in an unproblematic way.

This is not doubt in a conventional sense of the term. I distinguish doubt in a familiar sense from doubt as the complete or near-complete loss of the ability to take anything as certain, i.e. the capacity for a certain kind of conviction. We could compare this to Wittgenstein's distinction in *On Certainty* between mundane certainties (the things we don't question) and a more basic sense of certainty that sits at the basis of our ability to doubt or feel certainty at all.

I now return to the three features of bodily doubt, to examine how they are transformed when this bodily doubt becomes radical. The *loss of continuity* experienced in bodily doubt is now its *complete breakdown*; there is bodily chaos and the loss of the vantage point anchoring one in the world. The ill person is incapacitated, disoriented, in pain. As a result, one's bodily presentation collapses and what remains is not only a medicalised but a *scientised* body. As Dr Matthew Broome, reflecting on a period working on ITU

says, 'subjectivity and patients almost drop away [...] it is sort of applied physiology.'

The *loss of transparency* of bodily doubt becomes a *complete barrier* stopping all normal human exchange, a barrier with no corrective other than getting better. The body is now entirely opaque, because it has lost its transparency to the extent that it is longer possible for it to even momentarily recede into the background while we focus our attention on something else.

And finally, the *loss of faith in one's body* is replaced by a new certainty: the *certainty of negation*. The loss of faith does not result in doubt, but in the *negation of possibility*. This is the loss of all possibility to assert one's agency, wants or needs – which are (almost) entirely negated by the situation, because the radically ill person is entirely passive and reliant on others for all aspects of their existence.

This passivity is constituted by one's physical state: ill people in ITU can do almost nothing for themselves. Their ability to advocate for themselves is compromised, they often cannot speak or are unconscious. But it is also constituted interpersonally by those who look after the incapacitated person, not through malice or attempt to dominate but simply in virtue of the situation. This passivity is baked into the interpersonal dynamics: the patients are mostly unconscious, disoriented or unable to speak; there are real physical and communicative barriers. Other people enable or disable the ill person's most basic agency, e.g., bodily location. Bodily capacities are appropriated: patients in ITU are fed via a nasogastric tube; their vital functions are supported and regulated externally; they are ventilated. One risks being reduced to a passive, manipulable object before the clinical-other, not just for a moment but in an enduring way. Those who care for you play important roles in sustaining, restoring, or further eroding a sense of bodily subjectivity and agency. That, too, will need to be repaired, not just the critically ill body.

Where does this leave our understanding of critical illness and of suffering more generally? Here are three final thoughts I offer to conclude. First, one's

relationship to one's body is radically disrupted in illness in ways that are important to philosophically study (for example, using phenomenology). Second, understanding this disruption is crucial to our ability to understand and articulate illness experiences, both within and beyond healthcare contexts. Third, we ought to militate against a 'bright-siding' culture that shrinks the interpersonal spaces and communicative possibilities to speak of suffering, trauma, pain and illness. Both phenomenology as a method and the study of epistemic injustice in healthcare are significant ways of opening further spaces for such communicative efforts, that may jointly promote health justice, epistemic justice, and the ability to speak of what are currently largely unspeakable experiences.

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Further reading

Havi Carel, *Illness* (Routledge 2018).

Havi Carel, *Phenomenology of Illness* (OUP 2016).

ⁱ Barbara Ehrenreich (2010) *Smile Or Die: How Positive Thinking Fooled America and the World*. London: Granta Books.

ⁱⁱ Carel, Kidd and Pettigrew 2019. Illness as transformative experience, *The Lancet* Vol. 388, Issue 10050, 23 September 2016, pp. 1152–1153. DOI: [http://dx.doi.org/10.1016/S0140-6736\(16\)31606-3](http://dx.doi.org/10.1016/S0140-6736(16)31606-3).

ⁱⁱⁱ Kidd, Ian James (2019). Pathophobia, Illness, and Vices. *International Journal of Philosophical Studies* 27 (2):286-306.

^{iv} Bernstein, J. (2011) Trust: On the real but almost always unnoticed, ever-changing foundation of ethical life, *Metaphilosophy*, 42 (4), pp. 395–416.2011, p. 399.

^v Leder, D. (1990) *The Absent Body*, Chicago, IL: University of Chicago Press, p.1.