Entrevista / Interview

Illness and Experience: an interview with Havi Carel

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Interview with **Havi Carel**

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INTRODUCTION

Havi Carel is Professor of Philosophy at the University of Bristol. Her research focuses on phenomenology, philosophy of medicine, the experience of illness, and, more recently, epistemic injustice in healthcare. She also has a long-standing interest in death, in particular in the work of Heidegger and Freud, and more recently, on vulnerability and vulnerabilisation. In the field of phenomenology of illness, Havi Carel has made

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significant contributions, offering a rigorous philosophical account combined with rich first-person reflections on what it means to live with illness.

Carel's work draws mostly from her own experience of chronic illness, combined with a rigorous engagement with classical phenomenologists such as Husserl, Heidegger, Sartre and Merleau-Ponty. This combination has allowed her to illuminate how illness radically alters one's embodied relationship with the world, moving beyond traditional biomedical models in medicine and capturing the deeply personal and existential significance of illness.

Her most notable work to date is the 2016 monograph *Phenomenology of Illness*, which employs phenomenological methods to refocus the study of illness and medical treatment on the ill person's experience, with particular emphasis on embodied subjectivity, as thematized in the phenomenological tradition. In this work Carel develops a phenomenological framework for understanding illness not merely as a physical dysfunction but as a transformation of one's being-in-the-world. Through careful philosophical analysis, she explores how illness reshapes bodily experience, agency, temporality, social interactions, and so on, offering a sophisticated framework that resonates across diverse perspectives and proves valuable not only for philosophers but also for clinicians and patients.

In addition to her theoretical contributions, Carel's work has also been essential in advocating for the incorporation of patients' lived experiences into healthcare education and practice. Diagnosed in 2006 with lymphangioleiomyomatosis (LAM), a rare lung disease that leads to progressive respiratory failure, Carel has incorporated her own experience of breathlessness into her philosophical account of illness. More recently, after undergoing a double lung transplant, Carel also described how certain situations, such as those in the intensive care unit or at the end of life, may be experienced by the ill person.

We are very pleased to welcome Professor Havi Carel for this interview in the context of our special issue of *Ekstasis* on *Phenomenology of/and Illness.* We hope that, in the spirit of the phenomenological tradition, this interview may serve not only as an opportunity for philosophical reflection, but also for personal considerations on the meanings of health, illness, and, more broadly, of philosophy and life itself.

INTERVIEW

1. Professor Carel, thank you very much for taking the time to share a bit of your personal and academic journey with us. To get us started, could you tell us about how you first encountered philosophy? What initially drew your attention to the field, and when did you realize it was something you wanted to pursue as a career?

Havi Carel (HC): I didn't know much about philosophy prior to applying for my undergraduate degree. I (erroneously) thought I wanted to study politics but needed a second subject. My late father, Rafael Carel, who did a philosophy degree alongside his medical training, suggested that I put down philosophy as my second subject, because it will give me a 'good broad education.' I put it down on the application form without really knowing what 'it' was. Three months into my first term at university I switched to study philosophy as my sole subject. I experienced my first exposure to philosophy as a series of cognitive shocks. I didn't know it was possible to think so freely; it felt wild and exhilarating.

That enthusiasm was channeled into a more familiar pattern of studiousness; I sat in the front row, with coloured markers. My notes were – I discovered years later – sold by an entrepreneurial fellow student, who borrowed my notebooks and would lease them, in half hour slots, to be photocopied. My lecturers – this was the 1990s, when learning involved going to a library and digging through books – were gigantic edifices of knowledge that provided compact and instantaneous contact with ideas. So I would stay behind after lectures to ask and ask, ignoring their manifest desire for a coffee. I'm hugely grateful to those lecturers for my undergraduate education, which was superb.

During my MA I got very interested in psychoanalysis, feminist philosophy, and Heidegger. By the time I finished my MA in history and philosophy of science, I knew I wanted to do a PhD on the concept of death in Heidegger and Freud (which later became my first monograph). There was great interest in the connections between philosophy and psychoanalysis in the late 90s, for example, in the work of Sebastian Gardner, Jonathan Lear and Stanley Cavell. My PhD supervisor was Simon Critchley, and I learnt so much from him as well as others at Essex: Peter Dews, Beatrice Han-Pile and the late A. D. Smith.

By that point I knew I would want to apply for philosophy jobs, so I tried to prepare for that, in addition to the PhD research. I taught in different institutions, learned how to present, and most importantly for me, developed my English writing skills, because English was my second language. Those were hard years: I had very little money, a lot of badly paid hourly teaching, and was generally disadvantaged in the way that migrants often are. I tried to learn a culture, a world, not just that of philosophy but also of East London of the late 90s, with its squat parties, urban art, and bizarre cultural happenings. It was very intense – a vertiginous learning curve in which philosophy was one element, but within a bigger project: learning how to inhabit a new world.

2. Looking back at your student years, what was the academic environment like at the time? Did you have a "philosophical hero", someone whose work has particularly inspired you back then? And would you say you still have one today?

HC: At the time, academic philosophy was in the grip of the unhelpful distinction between 'analytic' and 'continental' philosophy, which I found useless and unnecessarily adversarial. The so-called divide meant that much time and energy were wasted on trying to justify particular modes of writing and engaging with figures who were continuously contested, like Heidegger, or French feminist philosophers like Irigaray. It created a siege mentality amongst PhD students working on 'continental' topics and figures, who in the UK were concentrated mostly at Essex, Warwick and Sussex universities. It was thanks to the open-mindedness of senior figures, such as Thomas Baldwin, Alan Montefiore and later Robert Stern and Stephen Mulhall, that the hostility towards continental philosophy subsided.

A great many philosophers influenced me; I only mention a few here. I always admired Maurice Merleau-Ponty's agility of thinking, the joy in his writing, and the persuasiveness of his ideas. Also ancient philosophers – for me, Plato, Aristotle, and Epicurus –with their concise precision, elegant argumentation, and immutable relevance.

I will mention three contemporary philosophers. Matthew Ratcliffe has given me much inspiration and confidence. He is a rare and deep thinker. Ian James Kidd, who I have written many papers with, dazzles with his deep analysis and knowledge. He is also a superb writer. Finally, Samir Okasha, from whom I learned to (aspire to) write with

clarity; he taught me what serious and thorough thinking are and how much work is needed to get it right.

3. Your work on the phenomenology of illness has been remarkably influential. Before we get into that more specifically, though, we'd like to ask: what first drew you to the phenomenological tradition itself? To put it differently, did your interest in phenomenology as a philosophical endeavor come first, or was it more the need to find a framework capable of describing certain aspects of illness experience that led you to it?

HC: My interest in phenomenology came through my engagement, in my MA and PhD, with Heidegger's concept of death. After becoming acquainted with Heidegger, I read 'backwards' (Husserl) and 'forwards' (Merleau-Ponty, Iris Marion Young). I was happily immersed in that when I was diagnosed, in 2006, with a rare progressive lung disease called lymphangioleiomyomatosis, or LAM for short. Once I got over the initial shock of the diagnosis, I sought guidance on how to live, and even live well, with illness. I turned to philosophy, thinking that it ought to offer that. So I started reading material that came under the category of 'philosophy of medicine.' But I realized that this was almost exclusively a sub-field of philosophy of science, which offered interesting and valuable ideas, but not the solace and meaning-making I was seeking. When I came across the work of S Kay Toombs, I knew this was an essential direction of travel. There was so little out there. I then encountered the work of Matthew Ratcliffe, Fredrik Svenaeus, Jenny Slatman, and others. But I also felt that a comprehensive phenomenological framework for understanding somatic illness is needed. So from 2006 onwards I engaged in that project. It was gratifying to see how valuable the phenomenological approach is to the study of illness. As a graduate student I was often challenged with the question: 'but what do you do with it?' Now I knew exactly what: it was the fundamental approach and set of concepts that allowed me to give shape and meaning to the inchoate panic and misery of diagnosis and the terrible physical deterioration that followed.

4. Now, turning more specifically to phenomenology and the experience of illness: phenomenology traditionally attributes significant methodological importance to the first-person perspective and to descriptions of the *what-it-is-like*

of experience. How do you see this methodological stance in relation to the philosophical study of illness? Do you think that some form of first-person experience of illness is strictly necessary to fully grasp what illness actually *is*?

HC: Yes, I do. The experience of illness, that is often treated as a special case within human life, is part of what Ian Kidd and I call 'the facts of life.' We all live, and we all die. And we almost always die from an illness. So illness is a much more significant phenomenon in everyone's life: as carer for someone ill, a witness of illness or as ill themeslves. This perspective reveals several important features of human life that I have focused on in the last few years. First, we are all mortal; this has important implications – spelled out by Heidegger who considered existence (being in the world) as being towards death. Second, we are vulnerable to illness, death, but also to the doings and failings of others; we depend on others' benevolence for our continued existence. Third, our projects rely on others to inform, enable or undermine them.

This has important implications for the experience of illness and of giving and receiving healthcare. This domain, often considered as a scientific endeavor, is in fact much more than that. It is the manifestation of a most basic human interaction: giving *care* to someone who needs it. How we do our caring derives from this basic orientation: seeing health care (which is broader than medicine) as primarily technological and pharmacological advancements whose goal is to reduce the impact of disease, or as primarily a holistic form of support aimed at alleviating the suffering of illness, which of course includes the above, but is much more than that.

To do the latter, we must attend to the experience of illness. We must understand what ails the person, what they want, need and value, and how best that can be provided. That can only be done if we listen to their accounts, not as anecdotes or emotive stories, but as offering unique kind of knowledge. We then need to use that knowledge to shape and design health care services.

This goes beyond generating illness narratives in the form of memoirs, literary accounts, patient stories or complaints. Such accounts must be philosophically analysed to distil their meanings and structures. And that is the role of phenomenology. These are not stories for the sake of 'sharing' alone, although that is important too. In my work I draw on varied resources, including first person accounts, public inquiries in cases of institutional failings, pathographies and memoirs, literary and cinematic depictions,

qualitative health research, archival historical material, reports by patient organisations, and more. There isn't one experience of illness, nor one source of accounts and testimonies. This richness of sources and experiences sits at the core of a phenomenological account aiming to capture the shared features of illness whilst retaining the connection to the personal and idiosyncratic.

The phenomenological study of illness does not focus on the physiological dysfunction that is the target of medical intervention, but on existential change. This is important because I see illness (and recovery) fundamentally as experiences that change the ill person as a whole. They change one's embodiment: what is and is not possible. And that embodiment, as Merleau-Ponty tells us, is our way of being in the world. Once embodiment changes, everything changes. The *disease* may be physiologically localized in one's kidneys or knee, but how we live this disease – what I call *illness* – globally affects us.

We can think of Husserl's 'I can,' which he takes to be our basic orientation to the world, as modified by illness to 'I cannot' or 'I once could but I'm no longer able.' This is not a simple binary – we need many interim or partial states to describe illness but also recovery, partial recovery, living with bodily limitations long-term and other health situations we find ourselves in. For example, recovering from a stroke, learning how to walk again as an adult, is profoundly different to learning that as a child. Recovering from drug addiction, or from a mental health crisis are also nonlinear and complex. All these need to be captured, studied, conveyed and then used for different purposes such as medical education and training and patient empowerment, and improving health services. I think about phenomenology of illness as an *emancipatory* and *ameliorative* project. It is a political stance militating for better and more compassionate healthcare and making the suffering illness causes a little less terrible, a little less lonely, and healthcare a lot more humane.

5. In addition to your academic engagement with illness-related issues, you're also known for your first-person experience of illness. Based on your personal experience, to what extent do you think language can capture and convey the full complexity of illness experience? For example, Virginia Woolf famously blamed what she called the "poverty" of language as an obstacle to describing illness in

literature. In your view, is there something about illness that necessarily remains beyond the reach of language? If so, what role do you see for patients, or so-called experts by experience, within clinical contexts in addressing this gap?

HC: This is a new topic I am working on now, that I outline in a new essay and a longer paper called 'Is illness ineffable?'. I don't think we can answer this question yet because the terms need to be more sharply defined. What does it mean to say that I can – or cannot – describe an experience? Is it a socio-linguistic question of vocabulary, interpretive frameworks, or opportunity for such sharing? Or is it a psychological sense of isolation and loneliness, feeling cut off from the world and others that gives rise to a feeling of ineffability of such experiences? Do we mean that such experiences cannot be described *tout court*, or that some aspects of them remain hidden? Or that their superficial aspects are shareable but their deep features are not? And what does sharing mean? Is it the safe receipt of an account by someone else? How do we ascertain the hearer's uptake?

It is not always possible for us to express, or even make sense of, our own illness. The experience can be too painful or chaotic to be effable. This is coupled with features of contemporary culture and human psychology that make it difficult to communicate suffering and hence understand the suffering of others. I call this the 'effability problem' and there are three reasons behind it.

First, there are cultural restrictions on what we can say: many contemporary cultures espouse a bias towards 'bright-siding', a positivity-infused attitude admonishing us to *Smile or Die* as Barbara Ehrenreich's book title suggests. There is also a lack or misapplication of words, concepts, and interpretive resources for articulating suffering. We often say 'we have no words' to describe our suffering or to acknowledge the suffering of others, such as bereavement, and this is a culturally accepted way of expressing our linguistic trouble with suffering. Those who are ill find themselves in a double predicament: attempts to articulate illness experiences are not only blocked by a culture suffused with 'positivity', but we also lack the relevant interpretive resources fit for the task.

Second, our imagination – often fuelled by a blissful ignorance of illness, bereavement, and grief – 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: they offer beatific portrayals of death as 'falling asleep', omit the harsh realities of bodily

dysfunction, and gloss over the hardships and trade-offs of almost any medical treatment. Finally, our memory is notoriously fickle. 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 actually want to share opposite experiences of breakdown, mental chaos, and despair. To be able to talk about illness, articulate it, and develop a shared account of it, we need to overcome these obstacles. This set of problems applies to many, if not all, kinds of suffering. But illness, I think, is a paradigmatic and hyper-intimate kind of suffering. It is infused within our bodies and sense of self and is both inescapable and universal.

Once we understand this context, we can turn to think about what ineffability means. The effability problem does not merely arise due to a lack of words or paucity of illness accounts, but due to the incompleteness of such accounts: what they leave unsaid as well as their lack of depth and authenticity. It may be that words are available but are dismissed in epistemically unjust ways. It may be that some aspects of an illness can be shared but others not, due to stigma, conversational and aesthetic norms, or shame. And it could be that some aspects of illness are sharable, while others must be experienced in order to fully understand them. In this sense, illness is a transformative experience as described by L. A. Paul: an experience you must undergo yourself to understand what it is like.

6. In an article published in The Independent back in March 2007, you were featured as a philosopher living under a "10-year death sentence". Fortunately, that prognosis did not hold, and you're still with us. In what ways has the experience of facing mortality so closely shaped your philosophical perspective on illness and life more broadly?

HC: I have now had the unique opportunity to first live as a healthy, able-bodied person, then become ill and live with a significant respiratory disease and disability for many years, and now, having received a double lung transplant 18 months ago, I have regained my mobility and my freedom (although the post-transplant care comes with its own complications). I am hugely grateful and indebted to my donor and their family, who

remain anonymous to me. Without their courage and generosity at a time of enormous distress, I may not have lived. After the transplant I was very ill for a long time. I came close to death several times, and health concerns that would usually cause great distress to others have become a routine part of my life. Things could go wrong at any minute, and life becomes a precious, compressed, string of moments, each to be savoured fully here and now, all hanging by a thread, because of the precarity of post-transplant life. Dealing with the twin risk of infection (due to being immunosuppressed, so my body doesn't reject the organs) and rejection (the body's immune system attacking the organs) means life is a delicate balance between the two, that could fail any moment. Jean-Luc Nancy expressed this so beautifully in his essay *The Intruder*. He says he was 'sewn open,' alluding to this dual risk and the fine line on which life can continue.

So facing mortality – in the practical and daily sense – is just a part of my life post-transplant. It is not just worry and careful monitoring, though. After my surgery I had to learn how to walk and exercise, how to trust my body again, and the process of recovery was slow and painful but also exhilarating. The first time I climbed a flight of stairs without oxygen, the first time I realised I could RUN, having boundless energy and a new body, in some sense, has been remarkable. It was an intense and abiding fantasy – to be free from breathlessness, to be able to move around unencumbered, to be able to jump, bend, laugh, dance – that was made possible.

So I am not frightened of death. I am frightened of once again losing this freedom. This would be intolerable to me. But right now I feel more alive than at any other time I can remember and I want to fully immerse myself in the joy of movement, freedom, and raucous aliveness. Death is there, for sure, a constant promise. But right now I'm letting Thanatos sit and wait.

7. One of your main contributions to the phenomenological understanding of illness is the concept of *bodily doubt*. In a paper from 2013, you propose bodily doubt as a core feature of illness that entails the disruption of the tacit certainty of the body's normal functioning when pathological processes emerge. A point suggested but not fully explored, however, concerns to what extent the concept of bodily doubt can be sufficiently generalized to all types of illnesses (somatic *and* mental, for example). When we consider the experience of psychiatric disorders, however, they

seem to introduce complexities that involve radical forms of instability and losses not entirely reducible to bodily phenomenology alone. For example, psychiatric disorders may also involve cognitive, affective, and behavioral disruptions (hallucinations, delusions, thought disorders), which, although bodily in their grounding, may give rise to doubts that exceed the *bodily* level. In light of this, how do you see the *scope* of the concept of bodily doubt? Do you think it applies equally to both somatic and psychiatric illnesses, for example? Or do you think certain forms of doubt (perhaps cognitive, affective, etc.), may also emerge in specific conditions, and therefore require distinct conceptual treatment?

HC: I think that in both 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 lungs can support my body's oxygen requirements, that my body is the seat of my agency and mastery – is acutely thrown into question. This applies in different ways to somatic and mental disorders, and to each disease and even symptom in variation. Such cases of illness disturb the bodily feeling of confidence, familiarity, and continuity, that is so crucial to our wellbeing and feeling anchored in the world.

Bodily doubt is not just a disruption of certain beliefs, but a disturbance at a bodily level. It is a disruption of one's fundamental sense of being in the world. Such doubt gives rise to an experience of unreality, estrangement, and detachment from oneself, which so intimately and overwhelmingly impact our mental health. The natural confidence in our bodily abilities, temporal continuity, and ability to carry out plans, is displaced by a feeling of helplessness, alarm, and distrust. From comfortably inhabiting a familiar world, the ill person is thrown into a world of uncertainty and anxiety. Her attention is withdrawn from the world and focused on her ill body, but also her unwell mind. She may feel acutely isolated from others and even become detached from her physical and social environments.

Bodily doubt is relevant to mental health and wellbeing in several ways. Its unpredictability makes it more threatening and us less capable of incorporating it into our familiar world. It invades our normal sense of things and accentuates the sense of ordinariness that normally goes unnoticed but is now lost. Bodily doubt throws one out

of immersion and into suspension, and the familiar world is replaced by an uncanny one. Thus it greatly colours the ill person's state of mind.

Bodily doubt also reveals the extent of our vulnerability. Once experienced, it leads to a loss of certainty that has hitherto never been disturbed. It overthrows our basic assumptions about the regularity, predictability, and benevolence of the world. Once experienced, the possibility of catastrophic bodily or mental crisis is always on one's horizon.

In a state of bodily doubt, I am immediately restricted by my bodily or mental limits. Thus, I must plan before I act (how far I can go? will it be too steep? what if I panic?) such that my bodily or mental limits (and not the project) determine the action. The sense of my open horizons, as extending beyond myself and into the world, collapses back onto my actual physical being. So I think bodily doubt can characterize mental disorders as well as somatic illness.

8. Recently, in a conference at Duquesne University, you put forward the concept of *radical bodily doubt*. Could you please explain to us what you had in mind when developing this concept? In particular, how do you see it relating to, or diverging from, the notion of *bodily doubt*?

HC: Radical bodily doubt is conceptually and experientially more extreme than bodily doubt, described in the previous answer. It is emblematic of liminal situations such as being in intensive care, or at the end of life, in which bodily doubt hardens into the certainty of incapacitation. What we encounter in *critical* illness is not bodily doubt, but a *certainty of bodily collapse*: bodily abilities are altogether gone. In radical bodily doubt, the ill 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').

Why still characterize this as 'doubt'? The term refers to a high-level, general doubt rather than localised doubts about specific bodily abilities. What is doubted 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-

localised form of doubt regarding everything else. A background sense of confidence or certainty that is integral to our relationship with the world is lost.

What happens when bodily doubt becomes radical? The loss of continuity is now its complete breakdown; there is bodily chaos and the loss of the vantage point that anchors one in the world. The ill person is incapacitated, disoriented, and in pain. As a result, one's bodily presentation collapses and what remains is not only a medicalised but a scientised body.

The loss of transparency becomes a complete barrier, ceasing all normal human exchange. The body is now entirely opaque because it has lost its transparency to the extent that it is no longer possible for it to even momentarily recede into the background while we focus our attention on something else. And 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, all of 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.

9. You have recently introduced the idea of pathology as a phenomenological tool where you propose, among other things, that illness can be developed into a phenomenological method in their own right. How do you see this proposal relating to other phenomenologically-inspired methods, such as micro-phenomenology, phenomenological interview among others? Do you see any potential empirical application of your so far rather theoretical approach within these contexts? If so, do you think any of these methods might be particularly suitable for such an application?

HC: I think there is huge potential for phenomenology to be applied in a range of ways, some of which have been pursued, some are being developed, and there are other avenues that will I hope be explored in the future. For example, there are already several qualitative research and interview methods, such as interpretive phenomenological analysis (IPA) and the second person method. More methods are being developed, for example in the work of Anthony Frenandez.

In terms of empirical application, all the above methods are empirically applied to interview people and better understand human experience in a variety of contexts, not just health. I developed a phenomenological toolkit which uses the concepts of bracketing, reduction, thematizing and being-in-the-world to elicit an authentic understanding of illness. Importantly, this is an understanding generated *by* the ill person and *for* themselves, so it overcomes the dual risk of being reduced to a biomedical account, or simplified to fit a stereotyped and general social script.

My proposal to view illness itself – and more broadly pathology – as a philosophical tool is not empirical, but programmatic. It suggests that illness, and pathology more generally, can be developed into a philosophical method in their own right. Studying cases of pathology, breakdown, and illness illuminate not only these experiences themselves, but also shed light on normal function and the tacit background that underpins it. They are hence of potential importance to areas such as philosophy of mind, philosophy of action, and perhaps political philosophy

I think there is an important reciprocity between philosophy and illness. Illness is not just a subject matter for philosophy of medicine or phenomenology. It is not only a life event that can be studied by philosophy, but also a *forceful invitation* to philosophise. So illness plays an active role as a motivation for, or entry gate into, philosophy. The role of illness is not limited to that of a passive object of phenomenological scrutiny. Rather, illness, and pathology more generally, can be developed into a phenomenological method in their own right.

The process a person undergoes when they fall ill is, in important respects, similar to Husserl's *epoché*, or bracketing of the natural attitude. The two share important features: They both distance a person from habitual ways of being; they both offer open, non-prescriptive ways of experiencing; and they both present an alternative to a set of metaphysical assumptions we tacitly make about the world. So studying cases of pathology, breakdown, and illness illuminates not only these pathological experiences, but the largely tacit way in which normal function operates.

The study of pathology, whether of body or of mind, can form the basis of a phenomenological method. First, illness is a "*limit case,*" helping to reveal the full spectrum of human experience, because it adds extreme or abnormal experiences to what we normally experience. Second, illness often gives rise to *reflection* on finitude, dis-

ability, suffering, injustice, and other existential themes. It tests conventional views, as well as norms and habits that have tacitly and pre-reflectively guided us. Third, illness *distances* the ill person from previous bodily and life habits and their accompanying tacit assumptions. This gives me reason to suggest that illness amounts to an entry gate into philosophical reflection and offers a phenomenological method in its own right.

There is a profound break between normal and pathological states, so that pathological states are not merely amplified or quantitatively more extreme versions of normal states, but of a different kind altogether and hence worthy of independent and thorough philosophical investigation.

10. What research projects are you currently working on? Is there anything new we should look forward to in terms of writing or publications?

HC: At the moment I am busy with my EPIC project, studying epistemic injustice in illness. My work now focuses on a few themes. I continue to study the predicaments of illness and how they relate to Ian Kidd's notion of pathophobia; I am developing a transplant phenomenology; and I'm also working on drivers of vulnerabilisation (for example, individual vices and institutional failings). Much of this is shared work with Ian Kidd, an outstanding philosopher and collaborator.

My ultimate longer term project is a new book that will link phenomenology of illness, epistemic injustice in healthcare, the ineffability of illness, vulnerability and vulnerabilisation, and mortality and ephemerality. This monograph will provide a humanizing account of illness, avoiding the Scylla of medicalized and reductive understandings of illness and the Charybdis of stereotypes, cliches and social scripts around illness. It will be a reclaiming of life as finite, as mortal and morbid, but also as enlivened and saturated with a sense of urgency.

11. Professor Carel, thank you very much for your time and for sharing your insights and experiences with us. Before we conclude, is there anything else you'd like to share with your Brazilian and Latin American readers? Do you have any advice for those interested in working at the intersection of phenomenology and illness?

HC: Thank you very much for inviting me to reflect on your interesting questions. In terms of advice for those working on phenomenology of illness, I think that a comparative project, looking at different phenomenologists and different sets of concepts (e.g. Husserl, Merleau-Ponty, Heidegger, etc.), and seeing what concepts are useful for which kinds of topics, would be helpful.

I also think that there has been a big emphasis on phenomenology of mental health, which produced excellent research. Somatic illness has been less explored and more can be said about different types of somatic illness, and different kinds of experiences (chronic vs acute, primary vs secondary care, care at home vs in hospital, etc.). It is a vast and growing field and I hope more researchers will choose to contribute to it.