

How to Care with Words: Perspectives from Clinical Philosophy and Philosophical Dialogue

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***Abstract:** Clinical philosophy began by self-consciously acknowledging that at its core lies nothing other than the philosophy of care. While clinical philosophy incorporates a huge diversity of approaches to care, a diversity that cannot be fully treated here, allow me to offer a brief introduction to the ideas of clinical philosophy, as multifaceted and ever in the making as it still is.*

1. Harmful care?: Initial questions for clinical philosophy

In 1998, we chose the title “Clinical philosophy” for the modified Chair of Ethics in the Graduate School of Letters at Osaka University. Over time and for various reasons, we had come to focus on medical care and education as our field study. From there, we began introducing to nursing researchers, healthcare workers, and care workers modes of philosophical dialogue from Europe—specifically, philosophical cafés and Socratic Dialogue—in order to investigate issues pertaining to care generally and medical care specifically. Below, I want to introduce some episodes from the more than 20 years that has passed since the inception of clinical philosophy. This essay is very much embedded in what I have learned from these experiences. From a methodological viewpoint, it should be added, I am myself involved in the clinical philosophical movement. By attempting to clarify its position in the world today, I practice a style of clinical philosophy that contrasts with what Shimizu Tetsuro once described as the role of philosophers vis-à-vis healthcare workers in healthcare settings: a mere “describer”.¹

In my view, clinical philosophy cannot be discussed without dealing with its “history”, without a process of “recollection” that leads us back to its founding. Yet, to call this *my* “narrative” would mean to let go, all too easily, of clinical philosophy’s

¹ See the pioneer work, Shimizu Tetsuro, 清水哲郎『医療現場に臨む哲学』[*Iryo Genba ni Nozomu Tetsugaku. Philosophia Medicinae*] (Tokyo: Keiso Shobo. 1997). Our lively discussions with Shimizu were significantly encouraged by the contributions of Mr. Nishikawa, himself *both* a philosopher and a nurse.

claim to universality. Instead, “recollection” must involve the Hegelian meaning of *Erinnerung*: the internalization of what has happened that reconstructs “memory” in its own specific way.²

“What is the essence of care?” was one of the main questions in the initial discussions among the members of clinical philosophy. Nursing researchers tended to mention the significance of empathy, not only for nursing practice, but also for human care in general. One day, however, Mr. Nishikawa, a male nurse with many years of clinical experience in psychiatry and dialysis as well as working in a nursing home, challenged them saying, “Empathy? A beautiful word! But sometimes care can’t avoid harming the concerned. Does it make sense to talk about ‘harmful care’?” While Mr. Nishikawa himself did not make this connection, he could have pointed out that the term “care” can imply something cunning or even dangerous; we can say, for instance, “The detective took care of the spy”, meaning that the spy was killed or incapacitated. “Care”, therefore, does not always mean caring or benign acts. On this point, it is worth referencing Heidegger’s concept of *Sorge*, which he associates, though does not identify, with the Latin word *cura* or “care”. Heidegger’s *Being and Time*, a groundbreaking work published in 1927, has been considered by many to offer to healthcare workers a wealth of philosophically suggestive ideas. Giving due attention to Heidegger’s ontological-existential claims, one is sure to find modes of thinking highly attractive to application in the healthcare setting. For one thing, his concept of *Sorge*, or care, is as philosophically broad-minded as it is practically insightful. We human beings, as Being-in-the-world, always care about both the things and people around us. Heidegger distinguishes “care about things” (*Besorgen*) from “care about humans” (*Fürsorge*), or “(concernful) solicitude”.³ Such care about other human beings, in turn, has two possibilities: *einspringen*, or “leaping in”, and *vorausspringen*, or “leaping ahead”.⁴ This distinction is of great interest to those who aim to be of true assistance to others. While “leaping in” can make the recipient of care *dependent* on

² See my contributions to: Homma Naoki/ Nakaoka Narifumi (ed.), 本間直樹/中岡成文編 『ドキュメント 臨床哲学』 [*Document Rinsho Tetsugaku*](Osaka Daigaku Shuppankai, 2010), especially p.3. I agree with my co-editor Homma when he says: ‘The “document” style, or the method of imitating it, does not mean fact-finding or nostalgic gestures. It is a fictional and reflective practice that demands an attitude of telling everything to the future, even though it is present’. (p. xv.)

³ Martin Heidegger, *Sein und Zeit*, 9. Auflage, Tübingen, 1967, 121.

⁴ Martin Heidegger, *Sein und Zeit*, 122. It reminds me an anecdote I heard many years ago: A rehab staff member was taught by a peer supporter for ALS patients that providing something convenient to a patient was only for the convenience of the medical staff and actually undermined the patient’s potential. How shocking the realization was!

assistance, “leaping ahead” can *give care back* to the recipient instead of taking it from him or her. To mention another fruitful suggestion, Heidegger points out the significance of the dead to family members and friends, using the German dual concept of the dead: *der Gestorbene* and *der Verstorbene*. The former signifies only the dead person, while the latter is the object of human love and respect. In no way, however, was his task in *Being and Time* to characterize the peculiarity of “death” as the “griefwork” of the bereaved family, nor was his interest directed to exploring a better possibility of care for the surviving family. While I acknowledge the philosophical validity of the ontological difference and the priority of the ontological to the ontic in this work, as a clinical philosopher, I would have liked to see an alternative approach to the average way of dying and death, one alternative to the transcending—and rather heroic—concept of *Sein zum Tode*.

As evincing a new wave of philosophy, clinical philosophers have, through their interaction with people of various fields, brought into question the authority of the philosophical tradition as well as the expertise of philosophers. Washida Kiyokazu, my colleague and the founder of clinical philosophy, was eager in those days to philosophically explore the essence of care, but would reflect on a graduate student who, attending a meeting of nurses, was asked sternly, “What kind of expert are you? What kind of professional are you here?” To this, the student was at a loss for words. Then, the students seemed to gradually overcome the confusion and started to move on to independently, without pretense of any expertise.⁵

Along with this criticism of expertise, there was a criticism of the political naiveté of clinical philosophy. For example, the act of questioning the “essence” of care among care workers veils a politics that covers over the poor working environment in the field of healthcare.⁶ Looking back from my present point of view, we should have countered by pointing out that power in the field of care is more complex than a “poor working environment”. Indeed, lurking behind the question, “What kind of expert are you?” lies the pride of the nurses, confident that, “We are, of course, nursing professionals”. Whether such pride could be felicitous with the attitude of clarifying and tackling the power structures within the healthcare field is yet to be seen.

2. Is a robot capable of care?

⁵ *Document Rinsho Tetsugaku*, vii. ix.

⁶ *Document Rinsho Tetsugaku*, vii.

Since the inauguration of clinical philosophy in 1998, there has been a Friday-evening seminar open to citizens (including healthcare professionals) interested in clinical philosophy. At the first seminar, Mr. Washida talked about the “phenomenology of illness” and requested that nursing-related participants give presentations on their direct experience about illness. In response, Ms. Takeda made a presentation entitled “What is a holistic view of patients?” in the second session, and Ms. Nihei gave a presentation entitled “My thoughts on alcoholism and the lives of patients” in the third.

The Friday-evening seminar in 1998 was, in this way, almost totally focused on “care”. The seminar stimulated heated, and sometimes awkward, discussions between philosophy researchers and nurses. The philosophy researchers present were there not only to learn from those with experience in nursing, but to contribute to the discussions. For instance, there was the suggestion that the essence of care might include a relationship of “co-presence”, that is, a relationship wherein, for example, a novice nurse takes “care” of a psychotic patient simply by sitting at his or her side. Or there was the suggestion that “care too is a desire”, a suggestion that focused on the aspirational motivations and dynamics of caring agents, which, while certainly altruistic, are not without the demands of self-actualization and the unique pitfalls implicated therein.

The search for how philosophy and nursing should come together, learn from one another, and thereby jointly shape “clinical philosophy” caused some frustration and conflict. A symbol of such frustration and conflict appears in the case of the “robot remark”, which transpired in the second year of clinical philosophy.⁷ Nursing researcher Nishimura Yumi was invited one evening to give a presentation at the Friday seminar and reported on her interview with a certain “Nurse A”, who was responsible for patients in persistent vegetative states. Nurse A believed that, despite many physicians’ skepticism, her line of sight could once in a while become “entangled” with that of the patients, which would imply that communication with someone in a “vegetative” state was somehow possible. This interview was the highlight of Nishimura’s phenomenological study, *Speaking Body*, which was published soon afterwards⁸ and became a bridge between nursing and philosophy.

The Q&A session after the presentation gradually heated up. Graduate student Horie Tsuyoshi asked the nurses, “What if the patient lying over there on the bed, the

⁷ *Document Rinsho Tetsugaku*, 12.

⁸ Nishimura Yumi, 西村ユミ 『語りかける身体——看護ケアの現象学』 [*Katarikakeru Shintai. Kangokea no Genshogaku*] (Yumiru Shuppan. 2001).

patient you are nursing, were in fact a robot? Would that make a difference for nursing?” I remember him saying something about the “self-motion of care” or the “hypothesis that we may be caring for a precision machine”, all the while believing that this machine is a human. Horie was, in fact, so impressed by Nishimura’s presentation that he believed, based on his knowledge of systems theory, to have discovered something of great theoretical potential in primary nursing. Yet, his seemingly inhumane assumption—one probably inspired by the well-known skepticism of Descartes’s second meditation about the apparently human figures beyond his window—caused annoyed reaction from both philosophy students and, more vehemently, the nurses present.

Horie later explained the intention of his “robot comment” as follows. On that evening, he heard Ms. Nihei say, “As I see the behavior of the person in front of me, I can construct care on the spot, I can nurse in my mind”, and thought, “This is autopoiesis in nursing! From the perspective of self-actuated nursing, nurses act as if the unconscious patient is communicating with them. That is exactly what communication is”.⁹

It remains an open question whether his vision of autopoietic nursing care as “operational closure”¹⁰ is persuasive and promising or not grounded in nursing practice. Yet what’s clear is that those who gathered for the seminar on clinical philosophy, whether their backgrounds were in philosophy or in nursing, did not divide into camps, but rather reflected on their respective discipline and, over the course of the encounter, contemplated the theoretical potential of the other side. This opened up, or at least suggested, a theoretical and practical soil for care common to both sides. Mr. Nishikawa, who, having studied philosophy with Washida prior to becoming a nurse, embodied a fusion of both sides. Moved by Nurse A’s appeal in Nishimura’s presentation, he commented that the premise itself—that nurses care for those who have the ability to understand—should be reconsidered. He then added a rather challenging comment: while it is good to respect the patient’s self-determination, it is problematic to rely too heavily on what the patient has expressed. When a patient asks to be allowed to die or to stop dialysis, for example, ordinary nursing can only respond with empathy or love. Here, Nishikawa wishes to introduce “thinking”, which he calls the “philosophical turn of clinical nursing” that corresponds to the “clinical turn of philosophy” on philosophers’ side.¹¹

⁹ *Document Rinsho Tetsugaku*, 25.

¹⁰ *Document Rinsho Tetsugaku*, 25.

¹¹ *Document Rinsho Tetsugaku*, 19.

In this way, both Horie and Nishikawa revealed somewhat unusual aspects of the way nursing care should communicate with patients. Although their questions were about whether nursing settings could include possible cases of taking care of robots, it led to the question of whether robots could take care of human patients. It offered, in other words, a new perspective on the current trend of introducing AI into medicine.

3. Letting yourself be pulled in—A middle voice approach in caring fields

Clinical philosophical activities include implementing or participating in dialogues in an indirect encounter with the problems occurring in the various fields. In this way, we come to touch the site indirectly. Some graduate students seemed to interpret the practice of the philosophical dialogue as clinical philosophy per se.¹²

When we meet various people in dialogue, listen to the worries that people are having in the field, think about these problems together, and try to find words for them, manners of expressing these issues, both familiar and surprising, appear to simply crop up. I have witnessed this for myself and not once. One could say that it is precisely in these moments of dialogue that clinical philosophy takes place. We are, in such moments, occupying *ourselves*, engaging *ourselves* in the field.

Usually, such participation or engagement is considered to be “active”. The decision to participate was my own and, in that sense, I was not passive. I do not, however, intentionally cause the results that occur there. Rather, I listen to other people’s words, get involved, and pull myself in a direction that I did not necessarily intend or anticipate. I have thus been stimulated and have my thoughts pulled in that direction. That phenomenon lies somewhere between activity and passivity.

Or again: While listening to the words of the people in the field, I am stimulated and find myself listening to my own words as they appear. And then come your next words, spinning out. In consideration of what is happening in such a chain of events as a whole, we would like to conjure up the, originally grammatical, term *middle voice*, an inflected form of verbs unique to some ancient languages such as ancient Greek, where the subject of the verb cannot be categorized as either agent or patient. Modern languages such as English or French have no middle voice, but rely

¹² Nakaoka Narifumi, 中岡成文「臨床哲学の〈引き込まれ〉——自己変容論として」[Rinsho Tetsugaku no <Hikikomare>. Jikohenyo Ron toshite] in *Shinran Kyogaku*, vol. 104 (March 2015, 79–102).

instead on *reflexive verbs*, like “occupy oneself”. It is interesting to note—and I believe it is of no little significance for philosophical inquiry—that some human activities and phenomena can most appropriately be described or explained with reference to the middle voice.¹³

Let me give yet another example from clinical philosophy. Washida’s *The Power of Listening*¹⁴ is a veritable manifesto of clinical philosophy and since its publication in 1999, the attitude of listening—sheer listening—has been very important to clinical philosophy, even regarded as *the* basis of clinical philosophy itself. Is it really possible, however, to *just* listen, simply and earnestly? Say I silently sit in a waiting posture. It is not very likely that this will make it any easier for my interlocutor to open themselves up to me. Suffice it to say, in order to be in a position to really listen to the other, various conditions must first be fulfilled. Therefore, listening is neither merely active nor merely passive, but can only be implemented in a middle voice approach. A similar situation of “getting involved” in order to “draw out” occurs in educational settings. When and how does a child’s spontaneity arise? Spontaneity does not follow from our telling them to be free and to grow. On the one hand, direct help and support may well encourage the child to grow; but, on the other, the helper may often need to persuade him- or herself to *wait* for the child’s change in direction (surely enduring a period of some anxiety).¹⁵ When we say education and nurturing, it feels like other people, such as parents and teachers, are active, and not the child. But isn’t it possible to think, rather, that the surroundings help the child “grow up” (intransitive)? In a similar way, perhaps, the medical community also values the self-care of the parties concerned in the middle voice image of “health”: for the traditional idea of healthcare (*yojo* 養生), which we will deal with below, is also considered to belong to the middle voice approach.

¹³ See my discussion about “The subject which transforms in the process—Thinking beyond passive and active” in: Nakaoka Narifumi, *Klinische Philosophie als Erfahrungskritik*, in: Hans Peter Liederbach (Hrsg.), *Philosophie im gegenwärtigen Japan*, IUDICIUM Verlag, 2017, 94–123, specifically 114–123.

¹⁴ Washida Kiyokazu, 鷺田清一『聴くことの手—臨床哲学試論』 [*Kikukoto no Chikara. Rinsho Tetsugaku Shiron*] (Hankyu Communications, 1999).

¹⁵ Creating a Buddha statue from natural stones or tiny pieces of wood from the field is perhaps a middle voice invitation, beckoning the imagination of the sculptor, rather than a result of his active intention; with the Buddha statue being created and the sculptor himself transforming, religiousness is formed as a result. See Nakaoka Narifumi, 中岡成文『試練と成熟—自己変容の哲学』 [*Shiren to Seijuku. Jikohenyo no Tetsugaku*] (Osaka Daigaku Shuppankai, 2012), 53–54.

To expand on the above question of listening, we can ask ourselves the further question, who is it you are listening to? Certainly, I'm listening to that person out there; I want to hear that person's words. But *who* is that person? He or she is in front of you, but whose word is it that comes out? Is it really that person's words? Or, possibly, was it forced out due to some sort of role expectation? In any case, the entity that is formed there can be considered as a big self (a big subject that is separated from the individual); or rather, the place of the relationship itself can be called one Self.

4. Individuals and Relations—Interactive Entity

Since 2016, I have been regularly hosting *philosophical dialogues* for the patients and families dealing with cancer or intractable diseases, as well as for medical professionals. These dialogues are based on the principles of clinical philosophy and are conducted in cooperation and consultation with many physicians and nurses. The following comments focus on the perspective of *end-of-life care*, which will become important in organizing and facilitating the dialogues, especially with *advance care planning* (ACP) in mind.

Especially when considering the reality, dynamism, and effectiveness of care or interpersonal assistance, it seems insufficient to consider individual actions in isolation, that is, only in terms of individual involvement (activity). We could say this is the limit of the individualistic view. It is, instead, concepts of *shared decision making* (SDM) or *relational autonomy* that are now being proposed in medical and other settings.

SDM is a type of patient-participatory medicine that involves more specific focus on the role of the patient in the patient-physician relationship. In informed choice, patients are expected to make informed decisions, but in SDM patients make such decisions based on their own preferences (values and beliefs). From a slightly different perspective, we could think of SDM as “a model of shared decision making where both patient and provider contribute to the decision” in contrast to “a patient delegating a decision to the health care provider”. In any case, the patient is considered *responsible* to take part in the decision, although “patients who have just received a serious diagnosis and feel vulnerable may not want the responsibility of being involved in decision making”.¹⁶ In my view, this is especially the case with many

¹⁶ Betty Chewing et al., “Patient preferences for shared decisions: A systematic review”, *Patient Educ Couns.* (2012 Jan, 86 (1), 9–18).

Japanese who are really in need of medical or nursing care but cannot narrow down their preferences, who actually don't know what they want. Such people are likely to get empowered from a decision coaching that develops patients' skills.¹⁷

SDM is considered by some to include an *interprofessional shared decision making model* (IP-SDM) “designed by an interprofessional team to broaden the perspective of shared decision making beyond the patient-practitioner dyad”. This model “is based on a detailed theory analysis of SDM models, key IP concepts from a systematic review, and a stepwise consensus-building exercise”.¹⁸ While it is important from the patient perspective, at the *micro* or individual level, to “take the necessary time to work through a structured process to make an informed, preference-sensitive decision while interacting with one or more health care professionals and family members”, the deliberation among those involved is to be complemented by the *macro* level perspective of broader healthcare policies and social contexts.

Whereas SDM tries to maintain and promote the worth and dignity of the individual patient in his or her situatedness—that is, in his or her concrete relationships with loved ones or healthcare workers—some theorists observe a kind of separateness here, and so propose a new model of the caring relationship based on the *relational self*.¹⁹ In order for human beings to think and make judgments about things and situations related to themselves, the existence of others is indispensable. Others are necessary even for clarifying or making decisions about one's own self-identity. Autonomy is cultivated through constructive relationships. The concept of relational autonomy may be understood and welcomed most by a Japanese physician or nurse working with patients in the final stage of life, because, despite the obvious need of such patients for help in the decision-making process, healthcare professionals hesitate to intervene for fear of “violating” the patient's right to self-determination. This is a natural consideration in Japan, where individuals are not always free to state their preferences, *caring* rather about the intentions and conveniences of their family and the medical staff, where prognosis is not always announced to a 19-year-old cancer patient due to the parents' opposition.²⁰ The whole triad of patient, family and healthcare provider could benefit from a workable—not only theoretically convenient—concept of relational autonomy. Or perhaps, we should move on—as

¹⁷ See, for instance: <https://decisionaid.ohri.ca/coaching.html>.

¹⁸ See: <https://decisionaid.ohri.ca/ip-sdm.html>.

¹⁹ See among others: Jennifer Nedelsky, *Law's Relations: A Relational Theory of Self, Autonomy, and Law* (Oxford University Press, 2013).

²⁰ This was a case presented at a meeting of clinical ethics that I attended.

does Nedelsky²¹—to talk about the structuring or *restructuring of the relations*, since “relationships are not necessarily benign”.²² Instead of sticking to the assumptive boundaries of self, we could deal with them flexibly to creatively jump into interaction with others. This fits well, if I may add, with the concept of clinical philosophy.

In cases of advanced dementia, it is even more urgent to work out a relational autonomy model among the concerned person himself or herself, the family members, and healthcare providers or care workers who take care of the person. Such a model would be important not only for medical institutions, but also for nursing homes and other welfare facilities.—Supporting a patient’s fragile sense of self and autonomy demands that close dialogue, consultation, and feedback take place among those who are close to and who care about the patient; it demands, in other words, the kinds of communicative interaction and reflection that have proven more challenging in the pandemic situation.²³ While trying to keep the ego’s boundaries is a problem, it is certainly difficult to talk to people with advanced dementia who do not have the socially expected sense of self-identity, or who are not consistent in memory or in their claims or demands; it is even more difficult to care for them. One does not know exactly to “whom” one is speaking or for “whom” one is caring. When you become old and “senile”, your rights are not diminished and you are still considered an autonomous person, but the substance of autonomy moves significantly in the temporal process, with physical and mental weakness. Those who are aware that they are actually living that weakness will say—even to people who are already feeling a decline—“Young people wouldn’t understand”, half giving up and half blaming. Sure, it’s not easy for the younger generation to understand physical weakness and the associated phenomena of one’s mind and energy, but if you’re willing to take care, you’ll want to try to understand. The self-assertion of those who feel themselves weak can be an expression or part of autonomy, no matter how much it may seem to the carers to be biased and at odds with reality. Many—young—academic oriented philosophers might think, “Well, that’s none of our business!” But I would consider that the empowerment—as precisely the business of clinical philosophers.

5. Self Care in the Coming Age—Why and How

²¹ Nedelsky, *ibid.*, particularly chap. 8.

²² So is titled a section in Nedelsky’s book.

²³ It should be noted that my discussions about health care in this essay often apply to care in the welfare area as well.

As I became ever more aware of my own aging, the traditional idea of healthcare (*yojo* 養生) came to be an important theme for me as a clinical philosopher living in an East Asian culture. My research on this theme culminated in a book for the general public.²⁴ The historical character and potential of *yojo* thought can be divided into the following four aspects.²⁵

First is its aspect of cultural communication. *Yojo* thought in the Edo period can be defined as “the product of health-themed cultural communication between the creator and the recipient of culture in an ethnic group”.²⁶ There was “compatibility” between the ruling class, such as aristocrats and rulers, and the common class, as to whether they are the creators or recipients of culture. This might provide an interesting point of contact to some healthcare proposals of today, which I will introduce later. Anyway, let’s keep in mind that, in contrast to our modern healthcare tools, the only tools at the disposal of Kaibara Ekiken’s (貝原益軒) time were personal attention and traditional medicine.

Second is its aspect of social adaptation. It is not surprising that the ideology of *yojo*, like other beliefs and values, was defined or influenced by social, political and economic factors. Ekiken’s ideas of “enduring” (忍ぶ), “abstaining” (慎む), and “satisfying with a small amount” (少で満足する) were suitable for the low-growth and regulatory era of the early Edo period. He forbids frequent bathing for the economic reason that the skin becomes open, causing one to lose precious “*ki*” (気) with sweat.

Third is its aspect of behavior adjustment or self-construction. Approaching the issue from a slightly different angle than social adaptation, one could cite Foucault’s discussion of “the care for self” (*le souci de soi*)²⁷ in ancient Greece and Rome, where he conceives of the practice of regimen or healthcare as a policy that constitutes oneself as a subject who gives proper consideration to one’s body. In both China and Japan, the mind is the master of the body. Ekiken gives voice to this point, saying that, since the mind is the lord of the world, it should be kept quiet and peaceful. This offers us some suggestions for how we should control ourselves in our modern,

²⁴ Nakaoka Narifumi, 中岡成文『養生訓問答－ほんとうの「すこやかさ」とは』 [*Yojo-kun Mondo. Honto no Sukoyakasa towa*] (Puneuma Sha, 2015).

²⁵ The four aspects are organized by adding the perspective of Schipperges (footnote 29) to the discussion in Takizawa Toshiyuki 瀧澤利行『養生論の思想』 [*Yojo-ron no Shiso*] (Seiri Shobo 2003).

²⁶ Takizawa Toshiyuki, *Yojo-ron no Shiso*, 4–5.

²⁷ Michel Foucault, *Histoire de la sexualité 3: Le souci de soi*, Édition Gallimard, 1984.

medicalized society. Self-control today faces the difficult task of processing a very large amount of information about one's health (for example, genetic information). In the days of Ekiken, the body was, so to speak, a black box. Today, a person with, say, a late-onset genetic disease has a difficult life plan because the time to "know" about the disease and the time to "get sick" are different. It is also possible to demand "the right not to know" and so control yourself by intentionally blocking out information. Genetic information and genetic networks go beyond the boundaries of individuals. Considering this, Ekiken's view of the body may offer something suggestive.—According to him, "the human body is based on the parents, and starts from heaven and earth. My body is not my property because it was born and nurtured by the grace of heaven and earth as well as of parents".²⁸ This idea may go beyond Ekiken's ancient Confucian ideology and lead to a new view of physical and mental health based on the human network that runs through the cosmos and microcosm.

Fourth, then, is the aspect of cosmic order or *salus communis*. From this aspect we might be able to re-evaluate the view of the ancients who thought of the cosmos and *oikonomia* as where humans can live and overlook. Isn't it just as necessary for us to comport ourselves according to a good life order through a certain "style"? Health promotion in daily life is linked to the structure of a given society, to the leading values of given cultural and social classes. On the other hand, health and illness are most certainly "basic experiences" belonging to each individual: for it is a fact that we will each have no choice but to deal with these personally and at any time. In medieval Europe, one was expected to live with three perspectives: (1) personal well-being or *salus privata*, (2) public well-being or *salus publica*, and (3) joint well-being or *salus communis*, which mediates (1) and (2).²⁹

If we turn our eyes to modern Japan, one of the leading R&D healthcare projects today, "Suggestions from healthcare on the ever-changing self through introspection and dialogue" (「内省と対話によって変容し続ける自己」に関するヘルスケアからの提案),³⁰ suggests a value shift from the now standard model of problem-solving care, which is based on a causal relationship model with control and governance to "make-ends-meet" style and "moderate" care based on relationship change. As the project asks how stakeholders receive and organize information in today's or near-future healthcare societies and how they interact with others, they are

²⁸ The opening sentences of Ekiken's long selling health book 『養生訓』 [*Yojo-kun*], originally published in 1712.

²⁹ H.Schipperges, *Gesundheit und Gesellschaft. Ein historisch-kritisches Panorama*, Springer-Verlag Berlin Heidelberg, 2003, S. 27.

³⁰ <https://www.jst.go.jp/ristex/hite/community/project000080.html>

considered to have the conflictive sides of vulnerabilities and growth potential. A new expert model is foreseen to arise following the introduction of medical AI. Medical experts will find themselves in the role of receiving the emotions of their clients, emotions that spring up in response to information technology; they will become interpreters of medical information or perhaps something like an “emotion terminal” that could *generate meaning* in those emotions. Intriguing! We are, however, yet to see whether our modern society is really mature enough to follow this self-care centered model of self-transformation that is mediated by “introspection and dialogue”, and whether we could possibly recruit AI robots as our colleagues in this process.

6. How to Empower Transformation: In and Out

It is not only the client or care receiver who needs to be cared for. The caregiver, being a weak, sensitive, and perplexed creature himself or herself, also needs to receive care. If their pride allows them, sometimes healthcare providers or care workers consider counseling; if not, they may turn toward self-care or to their friends for dialogue. This is why clinical philosophy has, from the beginning, focused on the goal of “caring for the caregiver”. All human beings are dependent on others to take care of themselves while they live. It will be of benefit to the caregiver, in caring for others, to sometimes reflect on his or her own way of life or to participate in philosophical dialogues.

Self-communication is another theme that continues to be a focus of my interest. Communication is usually thought of as the act of my “self” having contact with other people. This is certainly true. But since the self is such a complicated thing, I would be bound for trouble if I were to neglect organizing my inner life before or during “communication” with others. With so many parts of ourselves that remain opaque, we often, or even usually, misunderstand ourselves. We may work too hard when we should stop. As a result, we get sick. For this reason, I would like to stress the significance of self-communication, especially that through various wisdoms of life, such as improving the “ventilation” within myself. Such “ventilation” does not entail making transparent everything opaque within me. Such a task is by no means even possible. But it’s okay for there to be various parts of yourself that remain, unexpectedly, hidden. Successful self-communication cannot attempt to cast light on everything, but remains content with achieving a kind of balance between what is opened up and what remains closed—with, in other words, good ventilation.

Of course, self-communication does not oppose interpersonal communication or philosophical dialogue. To the contrary, an intensive and fruitful dialogue usually presupposes that each participant engages in careful introspection and self-communication inside and outside of the dialogue. Philosophical dialogue with patients with cancer and other intractable diseases, in which I have been involved mainly in Osaka and Tokyo,³¹ helps them to sort out their experiences and reconstruct their lives. The help or care offered here is not, to put it in Heideggerian terms, directed at taking over or removing the person's *Sorge* (concern), but giving it back to the person as something to be truly cared for.³² This type of help or care can be compared with the "leaping ahead" in one's existential possibility, as described by Heidegger;³³ yet, during the philosophical dialogue it occurs in a less existentialist way. The good outcomes that we somewhat expect yet cannot control arise from mutual trust among participants; they occur more fluidly and contingently in the process of dialogue, less in the decidedness of each participant or the leadership of the facilitator.

I would like to conclude this article with the story of an engineer, Mr. Hisazumi, who became a patient of the intractable disease ALS. For people living with advanced ALS, means of communication become increasingly limited. As they lose the ability to speak, they communicate through a transparent dial, if their interlocutor is within sight, or through IT devices, if their interlocutor is at a distance. For the dial to appropriately facilitate communication, they must, first, select a model that suits them, and, second, have an aid (a family member or helper), that can correctly read the letters that their eyes are directed to, an aid who can construct the intended message and finally transmit the message to the audience. Anyone who has witnessed this procedure will find it to be very demanding.

Now, while healthy people use their hands to operate IT equipment, especially for communication, advanced ALS patients resort to the parts of body still capable of movement. It could be a toe or even a cheek muscle. Mr. Hisazumi continues to devise and manufacture special "switches" for his clients to operate IT equipment and other devices, despite his own increasing physical difficulty due to ALS. He is a peer supporter who helps other ALS patients to improve their communication environment. His engineering spirit knows neither bound nor compromise. He talks to students who volunteer to make devices for patients and the disabled. If he sees that they are only

³¹ We call it "oncolo café", *oncolo* suggesting oncology. See our website: <https://oncolocafe.com/en/>

³² In this respect, the oncolo café sessions can be described as both group care and self-care.

³³ Martin Heidegger, *Sein und Zeit*, 122.

focused on keeping up with the schedule, if the students lack the motivation to fix flaws in the product, to improve its usability, and to make the users as satisfied as possible, he scolds them: “Have you no greed (*yoku* 欲)?” The lesson is a hard one, but the students learn little by little, sometimes on the verge of tears, sometimes on the brink of anger.

An educator’s gentleness is not necessarily an attitude of care. It can also be caring, even more caring, to scold a student, drawing out his or her “greed”. This attitude toward educating dovetails with Mr. Hisazumi’s own attitude toward life. He says wryly, “Only greed leads to hope”.

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