JOHANNES TOBER

COLLAPSE OR REVOLUTION?

The future of our health.

We decide.



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The future of our health. We decide.

From the history of care to human-led medicine with AI

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Selected pages from the book

I write for people who seek help and feel unheard. I also write for doctors, physiotherapists, all other health professionals and people working in social care. Those who treat, care for or support others need time, support and healthy working conditions themselves.

This selection moves from the opening through personal stories in later chapters to a question from the epilogue and the listening journey. These excerpts do not form a continuous sequence of chapters. Omissions and transitions are identified. The conversations at the table are fictional; the companions' identities remain open. The German and English samples contain the same selection.

The selection includes the opening above Vienna, the leaf at the table and the beginnings of care, the path to the door, a summer person and a winter person, the first ally at lunch, help for those who help, both sides of a treatment day, parallel worlds and the free Thursday evening. It closes with a view of the complete book and an invitation to the listening journey.

Why I am asking this question

Music for this section: Vienna — Billy Joel
For the view across Vienna and the question of a life's pace.

I stop on my way home from a run.

Vienna glows in the distance. A sea of lights stretches out before me. Since the clocks changed, evening seems to arrive before the day is ready to end. A little earlier, I was running in the Lainzer Tiergarten, among trees whose leaves were changing colour. Fallen leaves rustled beneath my shoes. Now I feel the cold air with every breath.

A few weeks ago, I could hardly have imagined going for this run.

A herniated disc had suddenly reduced my days to a few questions. How can I lie down? How do I get up again? When will the pain ease? As a physiotherapist, I work with movement every day. In those hours, I was the person who needed help.

I received it: medical treatment, medicines and the expertise of people who cared for me. An AI-assisted prototype was also used in planning my treatment. My own experience cannot establish how much each intervention contributed to my recovery. Today, I can run again. Looking out over the city, I no longer take that for granted. [9]

I am grateful to live here.

Yet my work has shown me another side of care: people waiting for appointments and telling their story again and again. People moving between services without knowing who will help them next. For some, paying for another private appointment is a difficult financial decision.

How can these two experiences coexist? How can a society possess so much medical knowledge and still make it so difficult to obtain the right help in time?

My gaze travels across the lights. Behind all those windows, ordinary life is happening. Perhaps someone is sitting on a sofa in

pain, wondering who else to call. I do not know what is happening behind the windows. But I have come to know both sides: being the person who offers help and being the person who needs it.

That thought brings me back to a patient for whom even getting outside her own front door had become difficult.

It was only a kerb. A small step of the kind I took countless times without thinking. For the older woman beside me, it was an obstacle. She called her wheeled walking aid her “Ferrari”. Going outside with it meant accepting uncertainty and setting off anyway.

I supported her for three years. We practised walking and negotiating steps. We went outside, collected the newspaper and returned to familiar jokes. This memory brings together many visits; it does not reconstruct one complete day. [9]

She had been active, worked hard and travelled. Later, her world grew smaller. Getting up from a low sofa could be difficult. Shoes, a coat, keys and walking aids all needed organising. What other people did casually required effort from her and attention from me.

I sometimes felt tense too. I had to keep several things in mind while offering reassurance. A movement did not have to look perfect to matter. Reaching a door or getting outside again was what counted. We had to make room for uncertainty without ignoring her limits.

She sometimes felt she was getting worse. Yet I observed that she became more confident in practised activities or retained abilities over time. An additional walk might mean being able to collect her own newspaper. It was not a spectacular achievement. It could still make a considerable difference to her daily life.

As I recall, she paid most of the cost herself and received a smaller reimbursement. Not everyone would have had that option. Later, she did not want to continue the visits. I cannot conclusively explain her reasons or describe what happened afterwards. Her story cannot establish a single cause. It does, however, raise a question I cannot put aside: what happens when useful support is known, but money, distance, time or an absent contact prevents it from reaching someone?

My documented work with patients amounts to approximately 10,000 hours of care actually delivered. That experience shapes my questions; it does not replace systematic investigation. [9] I have worked as a self-employed physiotherapist since 2020, after earlier experience as an emergency medical technician. Responsibility for colleagues and the development of new approaches to care followed. I have met people who still lacked a clear understanding of their situation after several treatments. I have also seen how much medicine can make possible. My criticism begins where effective individual services fail to form an accessible route through care.

Under the name JT Health, I am developing ideas for better connected care from this practice. In this book, local health centres are real places for orientation, human encounters and qualified help. As hubs, they would connect a wider network. This international proposal describes a direction, not an already operating worldwide system.

Through travel and work in different countries, I have encountered different conditions of care. In 2024, I had an opportunity to see inside a clinic in Tanzania. It made me think about conditions that can become invisible at home: electricity, water, accessible roads and people able to maintain equipment. [9] A journey cannot explain an entire country. Waiting a long time in Vienna is not the same experience as missing treatment because infrastructure is unavailable. Yet both lead to a shared question: when does available knowledge actually reach the person who needs it?

This book follows that question from the history of care, through today's institutions, into possible futures. Austria is my starting point; the perspective extends beyond its borders. Artificial intelligence is one of the possibilities we need to examine. Which work can it make easier? Which mistakes can it introduce? And who benefits from the time it releases?

We cannot freely choose all the conditions of our lives. Illness, background and money limit our options. But we help shape those conditions within families, practices, businesses and communities.

We can influence how accessible help is and how much time people have for one another.

On the way home, the wind moves leaves across the ground. I think about what we could lose and what is already possible. Behind me, the city shines. The question I take home is larger than my own project:

If we could rebuild our healthcare system today, what would we do differently?

I hope we can renew it before we discover how much we depended on it.

I carry that question with me. The city bears the decisions of earlier generations: who should help, who pays, and whose suffering is taken seriously. My own answer begins in a practice. It cannot end there. To go further, I need questions I might not think to ask on my own. So I give those questions a place: a table, with companions who do not exist in this form. I can tell them about my work. Whether my answers stand up is something I will have to test against the world beyond our conversation.

From Part I How care became a shared responsibility

At the table · The leaf

On this imagined table lies a dry leaf, like one of those that skittered across the ground on my way home. Through the window, I can see lights. I have brought nothing that amounts to a finished answer. Only my experiences and the question of what might follow from them.

The older man opposite pushes it aside with one finger. The woman beside him has draped her coat over the back of her chair. A child stands at the window, tracing something on the glass.

“What do you want to change?” the woman asks.

‘For people to receive appropriate help in time,’ I answer. ‘And for those providing it to have enough time and energy.’

I tell them about my practice. About journeys between surgeries and people who have to begin their story again at every appointment. Then I return to the woman with the walking aid.

“She called it her Ferrari,” I say.

The child turns around. “Could she go faster with it?”

“She could go outside.”

“And without it?”

I think of the kerb. “That became difficult.”

The older man draws the leaf towards him again. He studies its fine lines while I explain how much we now know and what technology might make possible.

“Before we talk about that,” he says at last, “I would like to know who stayed with her.”

‘I was with her during my visits,’ I answer. ‘But that does not tell us who was available in between.’

I put my proposal aside. The older man’s question reaches beyond my work. It leads to people whose names appear in no medical record: relatives, neighbours and everyone who helps sustain a person’s daily life. To understand what a healthcare system takes on and what it leaves to them, I want to go further back. ‘I cannot read you a complete history,’ I say. ‘But I can show you the traces we have and what we may cautiously infer from them.’

1 How care becomes knowledge

To find the earliest traces, I have to go back long before hospitals and written medical records. There, the answers become less certain. A bone reveals a healed injury, but not a helper’s name. A skull may preserve an extraordinary story of survival without revealing the relationships that made that survival possible.

A skull discovered at Dmanisi in present-day Georgia, approximately 1.77 million years old, belonged to an early human who had lost almost all their teeth some time before death. The find raises questions. What food could this individual still eat? What abilities or social conditions might have helped? By itself it proves neither organised nursing nor any particular form of compassion. [20]

It is tempting to see the origin of our humanity in such a discovery. Yet the traces allow several explanations, care among them. The unanswered question tells us more than a certainty the evidence cannot support.

The question nevertheless takes us a long way. A vulnerable body sometimes needs something it cannot provide for itself. Food must be brought, a danger removed, support sustained until recovery becomes possible. Care makes it possible to live with dependence. It changes the limits of what one body could manage alone. This is initially a description of human possibilities, not a claim about how kind earlier societies were overall.

Today we often present independence as the opposite of dependence. A person seems independent when they manage without visible assistance. Yet even the most independent individual relies on knowledge, language, supplies and infrastructure provided by others. Illness simply makes these connections more noticeable. In that sense, a health system is a social response to a condition that never went away.

The first question about the future is therefore not which task a machine can take over. It is which dependencies we recognise as a shared responsibility. A dressing can help someone move. Someone must supply it, apply it properly and, when necessary, replace it. That small sequence already contains technology, knowledge, distribution and relationship.

It would be wrong to set a lost world of selfless care against a cold present. Contemporary institutions can do many things earlier communities could not. At the same time, we should not mistake their technical strength for the abolition of dependence. An intensive

care unit expands the possibilities of survival precisely by bringing many dependencies together reliably.

The past is not being declared a moral model here. It poses a question that will remain in 2050: who stays with a person whose present needs exceed their own capacity to act? Every subsequent organisational form gives an answer, even when it expresses that answer in a budget rather than in words.

I pause. The child looks at the leaf as though it, too, might hold something from a very early life.

‘So you don’t know who helped?’

‘No. The discovery tells us something about a body. It cannot tell us with certainty who was beside that person.’

‘Why tell us about it, then?’

‘Because we need to distinguish what we see from what we imagine. Especially when we like the story.’

I turn to the next page of my notes. Beside the question of who stays, there is another task: finding out what actually helps and passing that knowledge on so that others can build on it. That is where the history of writing things down begins.

From knowledge to reaching help

This new passage appears at the transition between the first and second parts of the book.

At the table · The path to the door

The child has stopped drawing on the window. Where a finger rested a moment ago, the glass is slowly clearing. The child looks outside, then at the books in front of me.

“If you have known for so long that people need help, why is it still so difficult?”

“Because knowledge alone does not provide care,” I answer. “Someone has to turn it into something people can rely on every

day. And we do not always agree about who is responsible, what it may cost or whose help comes first."

"But you agree that people should be helped?"

"Often. Until we start discussing what we ourselves would have to change."

The woman pulls my notes towards her. "You too?"

"Me too. It is easier to imagine better care than to arrange my own working day so that it has a place."

Outside, two lights pass the window. For a moment, our eyes follow them. Then the street is dark again.

I think of the journeys that often appear in my plans as no more than a connection between two places. Home and practice. Practice and hospital. A line I could draw on a map. For the woman with the Ferrari, that line consisted of many separate tasks. Getting up, putting shoes on, finding the key, reaching the door. And eventually there was the kerb I usually stepped over without noticing.

"I think I begin too often at the destination," I say. "With the treatment I want to offer. Yet for the person in front of me, something began long before they reached my practice."

"Then begin earlier," the woman says.

I take a blank sheet. At the top, I write the word appointment. Underneath, I leave space.

We can describe care from the perspective of its institutions: opening hours, responsibilities, available services and vacant places. These details are necessary. Each shows only part of the journey. An appointment can be free in the calendar and still be out of reach for a particular person. It may clash with a shift. There may be nobody to accompany them. The journey may cost too much, or the information may be so difficult to understand that booking itself becomes impossible. These examples do not explain every missed appointment. They show which questions we need to ask before turning a gap in a calendar into a judgment about a person.

This gives planning a practical task. We should follow the journey from the first need for help to support actually received. Who notices the problem? Who can be contacted? What must the person organise themselves? Where can they get an understandable response when something goes wrong? Only then can we see whether an additional service removes the decisive obstacle or waits behind another door that is hard to reach.

A digital solution could make that journey easier. It could make information clearer or help a question reach the right place. What matters is whether the person actually gets further. Sending a message successfully and receiving a reply are two different events. Even a reply may be unusable if it merely refers someone elsewhere. Anyone designing a system must keep asking until information becomes an opportunity a person can use.

For me, this also marks a limit of compassion alone. I can see a difficulty and be honestly moved by it. That has not yet built a ramp, staffed a shift or arranged cover. Being moved can begin a decision. Afterwards, people need to take responsibility and have the means to carry it out. Otherwise, attention remains with those whose stories happen to be told. Everyone else keeps waiting.

The child leans over my sheet.

“You haven’t written anything under appointment.”

“Because I am beginning to realise how much belongs there.”

“Then write door.”

I write the word.

The older man studies the two words. “And what would you like us to do now? Go for a walk?”

“Perhaps in our minds first. Imagine a route you know well. Then imagine needing help at a point you usually do not think about.”

“I can imagine that,” he says. “But afterwards, I still won’t know what someone else’s life is like.”

“No,” I answer. “I only hope we might ask more carefully.”

The woman slides the sheet into the middle. Now everyone can read the two words.

“Then we must be prepared for the answer too,” she says. “Something else may matter more than you expected.”

I nod. In my mind, the route to the practice had already been complete. On paper, it is only beginning.

From Chapter 8 A summer person and a winter person

The question of good care also leads to the people who shape it. One encounter reminded me that I cannot make my own way of life the standard for everyone.

At a summer gathering organised by Physio Austria, I met a colleague who was approaching retirement. She worked with pen and paper, was happy in her profession and was training a younger therapist. I arrived with my enthusiasm for new ideas. At first, we seemed very different, even in our preferred seasons: I seek warmth; she felt more comfortable in winter. [9]

We enjoyed each other's company and eventually travelled home together. What stayed with me was her advice to make room for a personal need within the means available: a journey somewhere warm if possible, a sauna, or simply a candle. I am recalling the idea rather than her exact words. What moved me was that neither of us had to persuade the other to like the same things. She did not have to become enthusiastic about technology to fit my vision of the future. I did not have to give up my curiosity to respect her satisfaction with her working life.

For me, that evening became a small test of a large idea: a good health system has to accommodate different ways of living. It should not assume that everyone wants the life preferred by the person designing it.

What felt natural that summer evening had not always felt natural to me. In my own life, I too had to learn to make room for different needs.

The first ally at lunch

'And if everyone around you wants something different?' the child asks.

'Even one person who stays curious can help,' I answer. 'That was my own experience.'

I tell them about a time when I felt I had to explain my choices before I was allowed to make them. If I brought food I had cooked, I expected comments. If I declined a drink, I did not want to spoil anyone's mood. So I fitted in. Resisting a small expectation could feel harder than acting against my own needs.

Later, individual people made a different experience possible. When we were alone, they would ask what I had brought with me or how I had cooked it. Explaining myself became a conversation. Someone tried a little of the food. We cooked together or shared a meal during a lunch break. I did not need everyone around me to approve at once. Sometimes one interested person was enough to make a new habit feel less unfamiliar.

This is not a heroic account of discipline. More time, greater freedom and financial security also made change easier for me. Someone finishing a long shift, caring for a relative or working with a very tight budget faces different conditions. The same advice can describe a small choice for one person and another burden for someone else.

Further discussion of habits and self-help is omitted here. The personal account continues with the question of how much flexibility a habit needs.

There also needs to be room for exceptions. Eating out with friends, or occasionally choosing fast food, does not erase every other decision. Frequency and context matter. If one spontaneous meal turns an entire effort into a supposed failure, the rule may have become harder to live with than the habit it was meant to support.

For a health platform, this experience raises a practical design question. Could it ask about a manageable next step instead of showing an ideal version of a person every day? It could simplify a shopping list, point to an affordable shared activity or help someone invite another person to cook. It would also need to accept that, today, rest might matter more than completing another task.

Personal responsibility would neither disappear nor become unlimited. My part would be to use an opportunity I actually have. Our shared task would be to make such opportunities available to others as well. The first ally might be a friend. It could also be

dependable childcare, an affordable canteen or an employer who makes a genuine break possible. A habit becomes easier to sustain when the world around it offers some support.

From Chapter 11 When the people who help need help

It is easy to say that people have different needs while we still have enough strength. It became harder when I needed help myself.

‘Did you need help yourself?’ the older man asks.

‘Yes. And I needed support to find it.’

When I write about strain in healthcare professions, I also think of 2025. I knew what it felt like to be burnt out and barely seen in my situation. My experience as a physiotherapist did not protect me from needing support myself. It leaves me with a question for every organisation: how easy is it to obtain help when you are usually responsible for others? [9]

My partner arranged the first appointment with a psychotherapist and came with me. I felt small and found it difficult to accept help. Before making the next call, I spent a long time looking at the number before dialling it myself. Looking back, both things belong to my story: someone accompanying me on the first part of the journey, and my being able to take a further step myself. My professional knowledge did not replace that support.

In my recollection, even close friends sometimes felt unsure what to do. I do not want to turn that into an accusation. Closeness alone does not answer the question of what support is needed at a particular moment. Responsible healthcare should therefore not leave people and those around them to recognise and solve everything themselves. For me, accessible professional support and people who remain connected in everyday life belong together.

During that time, I also noticed that the practice kept going. Team members took on tasks; people continued to come for therapy. I mattered, but I was not irreplaceable in every single action. There

was a relief in that which I had underestimated. A business that works only as long as its leader always works has tied its security to one person. My personal experience therefore also became a question about what I considered good organisation.

The complete chapter then considers psychological crises and access to support. This extract resumes with everyday working conditions.

Since then, I have asked different questions about a good working day. It is not enough for a practice to get through its appointments. The people in it must be able to get through their days as well.

Both sides of a treatment day

‘How do you find out what matters to the person sitting opposite?’ the child asks.

‘By asking, without deciding the answer beforehand,’ I say. ‘Even after years in the profession.’

People who come to my practice bring personal experiences, expectations and often worries. Their appointment does not begin at the time printed in the calendar. They may already have slept badly, exchanged a shift or arranged care for a relative. I see only part of that. They, in turn, see only part of my working day. The fact that other people need support before and after their appointment does not answer whether I am listening to them now. Both sides have a legitimate claim on the same limited time.

The working day also begins before the first conversation. Records need reading, the team needs to coordinate tasks and new findings need to be assessed. Afterwards come documentation, queries and preparing rooms. During hands-on treatment, I cannot write down every detail at the same time. If information is missing later, the same search may begin again. [9]

AI cannot perform all these tasks in the same way. Cleaning a room, examining a person and assessing contradictory findings require different capabilities. Repeating an examination may also be justified. What we should avoid is repeating a suitable, available investigation merely because services cannot exchange its findings

safely. Software needs shared definitions, appropriate access permissions and dependable handovers.

When discussing the future of care, I notice how quickly this becomes an accusation. Patients do not understand the pressure on clinicians. Clinicians do not understand how long patients have waited for help. This opposition does little for me. It describes people meeting at an unfavourable moment: one person needs something that another is expected to provide under difficult conditions. Improvement should address those conditions instead of demanding ever more understanding from both sides.

Documentation belongs to care. To establish later what was examined, what someone reported and what we decided together, I need a dependable record. So does the next professional. My objection concerns work with an unclear purpose and unnecessary repetition. Findings already recorded should not have to be copied by hand at every organisational boundary when they can be transferred safely and meaningfully.

My first priority for AI is therefore relief that makes a difference to the working day. An automatically prepared note would help if checking it took less work overall than producing the previous record. A draft that must be corrected in several windows and then typed again might simply move the burden. Assessing an application means following the whole process until the record can be used.

This is where a decision about work begins. If the number of appointments initially stays the same, assistance might allow longer explanations or a more punctual finish. If every minute released is immediately booked again, the practice's output might change while staff exhaustion remains. Calling both outcomes efficiency conceals the difference. I want to preserve the possibility of working more carefully with technology without continually taking on more cases.

Additional appointments are not inherently wrong. People waiting for care have a strong interest in available capacity. Decisions about time saved should therefore involve staff and reflect actual needs. Some of that time might improve access; some might reduce pressure. The allocation would be an organisational agreement that

needs review. A manufacturer's claim about minutes saved does not settle it.

What happens after a year, or several years, matters especially. Do people remain in their professions? Can they choose their hours instead of cutting them because they are exhausted? Changing employers is different from leaving a profession altogether. Reducing hours may itself be a good decision. A model that only counts the largest possible number of hours worked might classify a health-promoting change as failure.

My own experience of overload makes me attentive to these questions. It does not prove that a particular software application will solve them. Outside support helped me reconsider my responsibilities and expectations. For a practice, this suggests a practical step: introducing technology should include examining how work is organised. Otherwise, we may merely reproduce old pressures in a new form.

A healthier workplace would also make cover possible. A person should be allowed to become ill, need a break or care for a child without the service around them collapsing. Dependable handovers and understandable records could help. The aim would be a service where people support one another without permanently exceeding their limits. Technology would have a supporting, clearly bounded role.

Healthy enough to work and to live

One question interests me after the last appointment: can I go home and be present for the people with whom I share my life? That ability to switch off has become important to me. An organisation promising health should also ask what kind of life its way of working makes possible. [9]

This does not mean diagnosing people from individual habits. A cancelled meeting or an evening on the phone does not tell a person’s whole story. For an organisation, the question is more concrete: does an ordinary working day reliably leave room for

recovery and relationships? Any technical relief should be allowed to make itself felt there too.

‘How would you notice it in your own life?’ the woman asks.

‘I could go home and actually arrive there,’ I answer. ‘I would still have attention for family and friends. And during treatment, I could listen without mentally running through the documentation still waiting for me.’

The older man rests his hands on the table. ‘Then we would have to take seriously the time nobody bills as treatment.’

‘Yes. Care that only works while its staff keep enduring a little more is not my idea of a good future.’

At the table · Parallel worlds

While we are still talking about that working day, the woman checks her watch, then turns her wrist back.

“Now I have looked at the time myself,” she says. “While we are talking about not having enough of it.”

“Perhaps you are waiting for something,” I say. “Or someone is waiting for you.”

“And if I am simply impatient?”

“Then I would rather you told me than I made up a story about it.”

She smiles. The older man places his hands beside the sheet.

“How often do you do that? Make up a story?”

“Probably more often than I notice. I see a fragment and already think I understand what lies behind it.”

I think about my own illness. As a physiotherapist, I had known how important movement could be. Pain turned that knowledge into a different question: how do I get up from here now? The knowledge had not disappeared. But it had to reach a person who was suddenly me.

It is easier to tell a coherent story afterwards than to convey the uncertainty at the time. Today, I know I was able to run again. In the

difficult hours, I did not know what the next day would be like. When I tell my story from its ending, I must be careful not to erase the importance of that uncertainty.

“Was it harder because you help other people yourself?” the woman asks.

“Changing roles was difficult for me,” I answer. “I was used to having something to offer. Suddenly, I had to trust other people to help me. My profession had not fully prepared me for that.”

“Then you knew both sides,” the child says.

“I knew another side. My own illness still does not explain everyone else’s experience.”

This is precisely where I want to be careful. A personal crisis can change what we notice. It does not automatically give anyone better insight. Someone with a similar experience may feel understood more quickly; they may equally feel overlooked when the other person says too soon: I know exactly what that is like. Two people can name the same diagnosis and need very different support. Their work, relationships and financial resources may differ. Their wishes need not be the same either.

A word from a conversation about this manuscript has stayed with me: parallel worlds. To me, it describes entering the same room while being in very different situations. For the professional, it may be the last appointment of a demanding day. For the person opposite, it may be the first chance in weeks to voice a worry. Both experience the clock in the same room. Its minutes mean something different to each of them.

This excuses neither careless treatment nor an unfair demand. But it changes our opening question. Before judging the other person’s attitude, we can establish what is at stake. A professional may explain the limits of their time. A patient may say that their most important question remains unanswered. That must be able to lead to a concrete agreement: what will we address today, what needs another appointment, and whom can the person contact in between?

Simply asking everyone for more understanding would be inadequate. If each day is planned so tightly that an additional question threatens the schedule, the problem begins before the conversation. If support works only while one person sacrifices their break, it remains unreliable. Good collaboration requires conditions that make attention possible. Even a kind person has limited energy. A system should recognise that limit before exhaustion becomes the only acceptable reason to say no.

“Do we have to become ill to understand?” the child asks.

“No,” I say. “We can listen to people and let them correct us. Nobody should have to suffer before we take their experience seriously.”

The woman looks towards the window. Our faces are reflected in the glass, with the city behind them.

“And if someone has learnt nothing at all from being ill?”

“They do not have to justify that. Perhaps it has simply taken something away.”

We fall quiet. I do not want to cover that sentence immediately with a more hopeful one.

After a while, the older man slides the glass of water towards me.

“What would you ask differently tomorrow?”

“What matters most to you today? And once I had an answer, I would like to check whether I had understood it.”

“That sounds small.”

“It is a beginning. Whether it becomes help depends on what happens next.”

From Chapter 18 The free Thursday evening

Free time in a calendar is not the same as permission to leave it free. I learned that on an evening I initially found almost unbearable.

‘What would you do with the time if it really remained free?’ the older man asks.

‘At first, I hardly knew,’ I answer. ‘I had to learn not to fill it with plans immediately.’

On my first deliberately free evening, I lay on the sofa and wanted to get up. Unfinished tasks came to mind. It felt unproductive not to deal with them straight away. Yet the task from therapy was precisely to fulfil no further plan for once. I did not initially find that easy. Eventually, I did something, but it was something that occurred to me spontaneously. As I remember it, that was a first difference. [9]

Over the following months, I kept Thursday evenings free. Later, I told my therapist about encounters and new ideas. Looking back together, I realised how much had happened during that unclaimed time. This does not establish a universal method for creativity or health. In my life, it showed that valuable developments need not begin with a predetermined goal.

The discussion of research on attention and interruptions remains in the complete chapter. Here we return to the conversation at the table.

When stillness feels uncomfortable

“What was so difficult about that free evening?” the woman at the table asks. “Having nothing to do?”

‘Not only that,’ I answer. ‘It was also the feeling that I had no value unless I achieved something.’ I think of the sofa and the unfinished tasks. I had cleared time. I had not yet reached the point of feeling allowed to leave it free. Unease could not simply be deleted from my calendar along with an appointment. [9]

“Perhaps it was the question that remained,” I say. “What do I need when I have nothing to prove to anyone?”

The older man looks at the device in front of us. “And if you switch it on?”

“Then I immediately have something to respond to again.”

For a moment, we leave the screen dark. I could call this scene “Fear of reality”. But that would be too quick an explanation for other people’s lives. I can describe my own restlessness. It does not tell me whether someone opens a screen to avoid something, to rest or to reach a person who is available there. My view from outside is an interpretation too.

The question that concerns me is more personal: when does an activity help me through a difficult evening, and when does it keep postponing an important question? It might be another post online. For me, it might equally be a new task, a project or the next attempt to organise everything better. My calendar had been full even without an endless stream of messages.

“What would have to change if you answered yourself?” the woman asks.

‘I might have to ask for something or set a boundary,’ I answer. ‘And admit that my existing plan no longer fits my life.’

I do not want to turn this into a demand that everyone simply look closely enough or be brave enough. Some situations are already barely bearable. Some changes require possibilities a person does not currently have. Outside help was part of my story. The free evening did not prove that I could solve everything alone. Support had helped make it possible in the first place. [9]

That leaves an uncomfortable question for my work. If a patient disagrees with my assessment, may I conclude too quickly that they are avoiding reality? Perhaps I have overlooked something my assessment does not yet capture. A measurement can improve while concern about daily life remains. I therefore want to ask more precisely what has changed and what is still difficult. My clinical

knowledge should help sustain the conversation. It must not become a shortcut that allows me to stop listening.

I would ask the same of AI. I want assistance that helps me examine my perspective and makes clear what it cannot know. It should neither confirm every fear nor offer certainty for which it lacks a basis. Sometimes its most important question might be: what information is still missing before you decide?

The child turns the device over without switching it on. “Do we have to be quiet all the time now?”

“No,” I say. “We can talk to each other too.”

That brings me back to the place I want to create. No one should be pushed into self-examination there or left alone with uncertainty. People should be able to ask a question even before they can express it clearly, and reach someone who will help them work out what is needed next. Whether they own a smartphone must not determine whether that door is open to them.

A question from the epilogue

This short excerpt opens one of the questions raised at the end of the book. The conversation continues in the full manuscript.

We are still sitting at the table. The leaf has torn along one edge. The child tries to push its two sides together again.

“Would you want to live longer?” the woman asks.

“Yes,” I say. “If I could take part in that life. With support when I need it.”

“How much longer?”

I search for a number and find no reason to choose that particular one.

The older man waits. Then he asks, “And if the number were no longer the question?”

Where the book goes from here

I How care became a shared responsibility

How help becomes shared knowledge, and why progress needs people willing to question it.

II What makes a healthy life

What health makes possible, where self-optimisation reaches its limits, and why ways of living may differ.

III Institutions and the people within them

Who cares for those who care, how access could become fairer, and which interests shape healthcare.

IV The technological future and its limits

Which work AI might make easier, who remains responsible, and what must still work without technology.

V The future we choose

Possible worlds in 2050, first steps we can evaluate, and the question of who is included in we.

An invitation to the listening journey

With headphones, the story can accompany you to other places. Seven optional stops lead to the woods, a walk, an underground train, a station, a busy city, a Cry Room with optional music and back to the table. The sections differ in length; journeys and pauses are left open. Every stop also works at home. What follows is the drafted opening. It has not yet been recorded.

Perhaps you are listening at home. Perhaps you are already on your way.

Some sections invite you to change location. To the woods. To an underground train. To a place where many journeys meet. You will hear beforehand which place is meant and roughly how much time to allow. You can continue the recording there, return to it later or stay exactly where you are.

Choose a route that works for you. In traffic and at stations, your surroundings come first; pause the recording whenever they need your attention.

There are books and a dry leaf on our table. Outside are people whose stories we do not know. I want to think with you about what we can do for one another, without pretending that we can already understand everything from the outside.

Take the question with you. Let the place add something.

Your feedback matters

Thank you for taking the time to read. A few honest sentences help; a page number and the passage you mean are especially useful.

1. Which story moved you or made you curious?

2. Where do memories, table conversations and factual discussion work well together, and where do you lose the thread?

3. Is it clear what was experienced, what is fictional and what is presented as a research finding?

4. Do you feel addressed? Does the perspective of people working in health and social care come through?

5. Which claim feels too broad, too certain or promotional?

6. Would you keep reading, and which stop on the listening journey would you try?

Johannes

Sources and notes

Reference numbers follow the complete manuscript. Selection and omissions do not change their numbering.

[9] Johannes Tober. Personal recollections and original proposals. Recollections are not representative surveys; future concepts are the author’s proposals, not evidence of implementation already achieved. On 3 November 2026, the author confirmed that approximately 10,000 hours of patient care had actually been delivered and were documented. The underlying records were not independently audited for this editorial edition.

[20] Lordkipanidze et al. (2005). The earliest toothless hominin skull. Nature 434, 717–718. https://www.nature.com/articles/434717b

Generative AI supported research, structure and drafting. The personal passages draw on my accounts. A complete source check, independent specialist review and my final approval are planned before publication. The medical discussion does not replace individual care.

The listening journey is a concept. Music suggestions are optional associations; this sample contains no music recordings.


We decide.