The Philosophy of Person-Centred Healthcare

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This book is dedicated to Professor Stephen Tyreman (1952 – 2018), a friend and colleague, whose important work on the philosophy of person-centred care was a major influence on the ideas in this book.

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CHAPTER ONE

INTRODUCTION

> You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved, and their needs are recognised, assessed, and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.[1]

> You must be polite and considerate.
> You must treat patients as individuals and respect their dignity and privacy.
> You must treat patients fairly and with respect whatever their life choices and beliefs.
> You must work in partnership with patients, sharing with them the information they will need to make decisions about their care.
> You must support patients in caring for themselves to empower them to improve and maintain their health.[2]

These are fine intentions from two highly respected professional bodies, the United Kingdom Nursing and Midwifery Council and the General Medical Council, from which, those of us living in the UK draw most of the people who look after us when we are unwell. It is interesting to reflect, even at this early stage of the discussion that, in the two codes of good practice, we seem to have what appears to be already a person, or at least patient, centred approach. We might in the circumstances be tempted to ask them to just "get on with it". [3] However in neither of these admirable expressions of intent do we see any philosophical ground for the approach they recommend, and without this we cannot be sure that the aims they intend will be delivered. [4] It is also interesting to see that the code of good practice for nurses talks about "people" while the equivalent code for doctors refers to "patients". This difference is repeated throughout the full text of these codes of practice and may well reflect underlying philosophical differences. These philosophical differences may begin to tell us, as we proceed with the argument, something about what it is to be a patient and

what it is to be a person, and why this might be important when we consider how we are treated.[5]

While the meaning in the codes of practice at first appears clear it becomes problematic the moment we begin to try to define. It feels as if we all think we know what we mean when it comes to person centred healthcare, but as soon as we discuss the subject our differences become more apparent than the commonality that we thought we all shared. Few, if anyone, would disagree with these fine intentions, but the question as to what they really mean remains at best contentious and at worst unclear. We do not really understand what success looks like in respect of these intentions or how to devise systems which will guarantee their delivery in practice. This is a problem; and in order for these intentions to be put into widespread everyday practice we need to gain a deeper understanding of their intellectual origins and thereby to understand what we really mean. [6]

Philosophy is the instrument through which we understand why systems work because philosophy is argumentative, the more argumentative the better,

> It proceeds by way of arguments, and the arguments are argued over. Everything is aired in the bracing dialectic wind stirred by many clashing viewpoints. Only in this way can intuitions that have their source in societal or personal idiosyncrasies be exposed and questioned.[7]

The purpose of philosophy is to unsettle us and to make us question ourselves, to make us unsure about what we think and do, and to constantly challenge ourselves in order to be the best we can. Neither can the power of philosophy be denied as Gadamer points out,

> for philosophy … I take care to tell my students: you must sharpen your ear, you must realize that when you take a word in your mouth, you have not taken up some arbitrary tool which can be thrown in a corner if it doesn't do the job, but you are committed to a line of thought that comes from afar and reaches on beyond you.[8]

As the powerful process which concerns itself with looking into the presuppositions of arguments, and in creating consistent foundations for new positions and arguments, philosophy becomes the key to unlock the potential of person centred healthcare. This book will begin to uncover the philosophical basis of person centred care by a process of presenting and critically evaluating arguments which support a person centred approach to healthcare. This will then show both how practice can be improved and how examples of good practice in this area can be transferred between the

individuals and institutions involved in the commissioning and provision of healthcare. By establishing a robust philosophical basis for a person centred approach to healthcare those involved in the provision and commissioning of care will be provided with an intellectually consistent method with which they can achieve their aim of giving help to those who need it, and in the ways that they would like to have it given.

Why person centred healthcare?

The promotion of a person centred approach to the commissioning and provision of healthcare is stimulated from two quite different directions. The first is a deep rooted feeling that it is inappropriate to treat humans like ourselves as anything other than just that (whatever "that" might be), but this is not enough and the problem with Health Service and Government initiatives to promote person or patient centred healthcare is that they are usually based on a popular presumption that person/patient centred care is a "good" thing. This is all very well and makes these initiatives easy to swallow. However, the presumption underlying these laudable initiatives is rarely, if ever, examined. This means that when it comes to the implementation of person centred care initiatives in difficult times, and with competing priorities and vested interests which may clash with a person centred approach, these initiatives are insufficiently intellectually and philosophically robust and are easily swept away.[9]

The second approach is more simply practical as a response to the increasing numbers of people in Western societies who are living with long lasting chronic illnesses, and who require care (sometimes only a little care, sometimes a lot) to live their lives. This creates a problem in that large numbers of people now require often expensive care to be provided by services, which in their turn consume more and more of the wealth of these societies. The question as to how these services are to be paid for becomes increasingly pressing. In a way this is a problem that is of our own creation. Not so long ago many of the conditions with which people now live well would have killed them quite quickly, diabetes and left side ventricular failure to name but two. Advances in medical technology have resulted in many of us living longer lives but without the benefit of perfect health (whatever that might be) and the question as to how to provide us with the care we need in the most cost efficient way becomes paramount and, so the argument goes, drives us in a person centred direction.[10,11] Supporters of a person centred approach to the commissioning and provision of this kind of care suggest that this approach offers a way of coping with large numbers of people who need care. By treating people as individuals and by tailoring

the care they get to their individual needs they are helped to become more self-reliant and therefore less dependent on health and social care services. The shorthand for this case is "making patients into persons", or to put it another way to avoid making persons into patients. Increased resilience and increased self-management by independent people who are living with illness reduces the pressure on health and social care services and makes these systems tenable. This second approach makes an appeal to the presumption that people who receive person centred care are made more confident, more resilient, more independent, and therefore less dependent on services. The theory that some kind of "health activation" produces long term benefits has begun to show that, by engaging with the everyday lives of people who are unwell, systems and practitioners can improve outcomes and perhaps reduce costs.[12,13,14] While this work makes a practical case for a person centred approach to healthcare it still rests on an unexamined presupposition about what constitutes person centred healthcare in the sense of an underlying relationship between those who provide care and those who receive it. We will look at this again in more detail in a discussion of Salutogenesis.

The thing that both of these approaches have in common is that neither rests on any clarity of meaning as to what we understand as person centred care. A third approach – one we propose to develop in this work – is founded on a philosophical understanding of the nature of personhood and the sense in which this idea is *relational*: persons are not atomistic egos living in separate worlds. Their reality lies in their activity, in their journey through the physical and social world, their interaction with *others*.[15] One way of expressing this point, associated with the work of the philosopher Martin Heidegger, is that Being-with-Others[16] is *constitutive* of the Being of each and every one of us. Not only do we live in a world with Others like ourselves, but the being of these Others is so closely tied up with our own being that the relationship is mutually constitutive. To overlook this is not to overlook some 'abstract' philosophical point. Failure to be clear on this has led to interpretations of 'person centred care' that have legitimately been criticised for being 'preference driven', 'individualist' and 'consumerist'; the failure to examine the philosophical underpinnings of person centred care leading to applications that completely undermine the progressive aspirations of its advocates.[17,18]

In terms of healthcare, the understanding of Being defended in this work will lead us to the notion of authentic solicitude as the ground for the provision of care to Others when they are unwell. This approach, by showing the nature of the relationship of our own being to the being of Others, provides us with a strong reason why we might behave in the

explicitly other regarding way that is manifested in person centred healthcare. It is the task of philosophy not to direct the decisions we make about the creation of values (to tell us what we ought to do) but to inform the choices we make. It is true that, even with this knowledge, we may choose to act in such ways that will jeopardise the necessary structures of our own Being, but it makes such choices less appealing and therefore less likely, and in this way provides a more robust ground on which the advocates of person centred healthcare can make their arguments.

Phenomenology

A key philosophical method that we will employ will be phenomenology, and specifically the existential ontological phenomenology of Martin Heidegger. Phenomenology offers a rich and subtle way of thinking about how we know what we know, and this applies to our knowledge and understanding of how healthcare works just as much as it does to all other kinds of knowledge. Phenomenology, with its emphasis on the first person lived experience of people who are ill and receiving care provides a method of discussing, understanding, and grounding person centred healthcare which is philosophically robust, and which offers policy makers and those commissioning and providing healthcare clear guidance about how to make their practice, and their services, person centred. In effect phenomenology will give us an epistemology and an ontology of person centred healthcare, grounding our account of person centred care in an understanding of being. However it is in the nature of phenomenology (and particularly the phenomenology of Heidegger) that it provides us with demonstrations rather than the kind of proofs that we might conventionally look for. The emphasis which this method places on first hand lived experience and the first-hand accounts of individuals means that to understand what is being said we need somehow to experience these demonstrations ourselves. In Heideggerian fashion the truth is to be revealed or unhidden[19] and it will be directly related to the context we find ourselves in.

When it comes to phenomenology we either “get it” or we don’t, and the strength of the case can only be judged according to how successful it has been in helping us to “get it”. In view of this, in some of its aspects, this work will not only use the insights of phenomenology but it will be phenomenological itself. To achieve this we will use examples of real life experience of healthcare to illuminate the philosophical architecture. By using anecdotes and personal examples we will show how phenomenology can illuminate our thinking about healthcare, all the way from the level of

an encounter between an individual patient and a clinician to the level of healthcare commissioning and large scale provision. This means that this part of our work will be a combination of philosophical argument, first hand personal reflection (our own), and second hand personal reflection (the published reflections of others who have written about their own illness and the illness of others). We begin and end with our experience of care; this will result in an approach which recognises clear roles for everyone involved, including those who receive care, and puts their experience at the heart of everything we do. We will set out how people who are ill, individual practitioners, commissioners, and institutional providers can use a phenomenological approach to improve services, charting a route from philosophical theory into healthcare practice.

Above all we believe that any piece of philosophy which does not set out to have an effect on the way that we behave is of very limited worth, and philosophy in the area of healthcare which makes no attempt to improve the experience of healthcare seems to us to be a pointless exercise.

Summary

The work will proceed as follows. In Chapter Two, called *Philosophy, engagement and what it means to be a person*, we will establish the field of person centred care, bringing out the links between different philosophical approaches and the value of philosophy as dialogue.

In Chapter Three, *Characterizing person centred care: alternative conceptions* we will discuss two specific and different approaches apparent in the literature on 'person centredness' and related issues. The first treats person centredness as an "ethical add-on" to good biomedical practice while the alternative regards it as a fundamental conceptual shift in our thinking about health and care.

These two chapters will provide the overall context of the debate about person centred care in which the following chapters are situated, and which put the case for the conceptual shift in our thinking about person centred care.

In Chapter Four we will aim to begin to provide a sound philosophical basis for the argument which will include a setting out of the nature of our relationship with those we call Others. For this we will need an outline of Heidegger's phenomenological ontology and to show how he arrives at the equation;

phenomenology = hermeneutics = ontology

This equation will provide the philosophical basis for the entire argument and will be combined with the hermeneutics of Hans-Georg Gadamer[20] to develop what we will call a hermeneutic of healthcare, in which the healthcare system will be understood as the sum of all of the encounters between those who seek help with their health problems and those who offer this help. This means that the healthcare system has no fixed identity and is constantly in flux and changing. It also means that it is not describable by any conventional means. If we accept this understanding then we take a hermeneutic approach to our study of the philosophy of healthcare. Under this approach the details of the system (individual encounters) can only be understood in the context of the whole system, and conversely the whole system can only be understood in relation to the details (individual encounters). We are therefore returned constantly to the individual encounter. In this chapter, by clarifying what we mean by the healthcare system and by gaining an understanding of what it is to be in a world with Others, we will prepare the ground on which a person centred approach to healthcare can be built in a way which is consistent with our fundamental ways of existing in the world.

A clear understanding of the nature of illness and particularly the experience of illness in the individual is necessary if we are to pursue phenomenological insights. In Chapter Five we will consider, from a number of philosophical and real-life perspectives, what happens to us when we fall ill, and what the experience of falling ill tells us about the nature of our being. We will take up the oft used Myth of the Cave from Plato's *Republic* and use this as a means to interpret the experience of falling ill. We will also refer to the work of Havi Carel on illness and mortality, the conception of illness as leading to a feeling of not-being-at-home with our bodies (unheimlich) discussed by Frederick Svenaeus, and Gadamer's notion of illness as a loss of equilibrium. Underpinning the argument throughout will be Heidegger's existential analysis of dying in which he discusses the experience of anxiety and the way that separates us from the world of involvements.

In Chapter Six we will argue that autonomy is the end of healthcare. Illness is experienced as the inability to do things that we have been used to doing; a gap opens up between our willed existence and our biological existence. We can no longer do the things that we want to do. In illness this is experienced as a sudden or relatively sudden loss of ability to act as we will, while in ageing the loss is more gradual and therefore less noticeable. In both cases the loss is, at bottom, a loss of personal autonomy. In the case of illness, when this loss becomes more than we can manage, we consult someone with expertise in healthcare as a means of seeking the assistance

we need to restore our previously experienced autonomy. Of course the notion of autonomy is not always simple, and we will discuss some of these complexities in this chapter with brief reference to the core philosophical texts of Mill and Kant. Overall we will argue that it remains clear that, while there are many varied and complex scenarios that occur every day in every healthcare system, all of them, however complex and varied, conform in essence to this basic analysis of loss and attempted restoration of autonomy.

In Chapter Seven we will consider in some detail the relationship between what it is to be a patient and what it is to be a person and why this matters. We will do this using a discussion of Heidegger's notion of solicitude as our way of Being-with-Others. This will also include a consideration of the dialectical relationship between clinicians and their patients and the idea of mutually informed consent. This in turn will lead to the setting out of the barriers to person centred healthcare and some of the ways that these may be overcome through the process of reforming the idea of consent, as part of the underlying process of restoring and maximising autonomy.

Having identified the encounter between individuals seeking care and those providing care as central to our argument, Chapter Eight will be a detailed philosophical deconstruction of the healthcare consultation itself. This will have specific current relevance following the dramatic increase in the proportion of consultations which now take place remotely both as a result of restrictions put in place to limit the spread of Covid-19 and the long term shortage of medical and other healthcare practitioners. Hermeneutics tells us that a change in the mode of consultation, as the central element of the detail of healthcare, must also change the nature of the whole system and we need to understand the impact of this change as it affects a drive towards more person centred healthcare. We will pursue a phenomenological investigation beginning with an investigation into the phenomenon of the consultation and progressing thus to an understanding. The questions will be: What makes the consultation possible? What kinds of beings are required for the consultation to take place in the first place?

This will mean that any lessons we may learn can then be transferred back into the practice of consultation in our attempt to make the whole system more person centred. Our aim in this chapter is to provoke thinking about the nature of the consultation in healthcare and its place in the system in order to better understand the effect of changes in the way that consultations are conducted on the system as a whole.

In Chapter Nine we will use the very personal reflections of Havi Carel[21,22] and Atul Gawande[23] in a discussion of living well with illness and of dying well, and the ways that person centred care can make this easier.

In addition we will show how the ontology which we believe underpins person centred healthcare is revealed in the practice of end of life or palliative care.[24] This will, not surprisingly, turn out to be a species of what is now termed holistic care, an expression more commonly heard in nursing circles than in those inhabited by doctors, but which has really been around for much longer than the terms we now use to give an account of this kind of care. It includes consideration and sympathy for others, respect for individuality, attending to the psychological and "spiritual" needs of patients, and simply caring. Philosophically understood, these ways of caring, represent authentic being in the practice of healthcare. While this way of caring is perhaps most prominent in palliative care, we hope to show that it can be central to person centred care in the delivery of healthcare in all sectors.

In Chapter Ten under the heading *Humanizing Healthcare* we will look at three examples which we think exemplify the kind of person centred care that is implied by the theory that we have set out and which also reveal the underlying philosophical structures through the important features that they have in common. In short this chapter will show the philosophy of person centred care that we have set out realized in current healthcare practice.

Chapter Eleven will conclude the work and show in summary why a person centred approach to the commissioning and provision of healthcare works, not only for those of us who need care but for those who organize and pay for it. The central importance of personal autonomy and self-management will now be apparent as the most significant features of any system of person centred healthcare. We will refer briefly to an example from one of our own experiences of implementing a large clinical effectiveness programme in United Kingdom General Practice.[25] Our endeavour in this chapter will be show how the philosophical structures which we have shown to underlie person centred healthcare can be effective in the practice of commissioning and providing healthcare, and furthermore, how the lessons that we can learn from these examples, and from the philosophical approaches that we have been using, can be applied in many other areas of healthcare.

Notes

[1] United Kingdom Nursing and Midwifery Council Code of Practice. http://www.nmc.org.uk/standards/code/

[2] United Kingdom General Medical Council Good Practice Guidance. www.gmc-uk.org/guidance/good_medical_practice.asp.

[3] Asbridge, J.E. 2020. Progress in the conceptual understanding of person-centered health and social care. *European Journal for Person Centered Healthcare* 8 (1) 17-19
[4] Loughlin, M. 2021. Forty-seven years later: Further Studies in Disappointment? *Bioethical Inquiry* 19(1) https://doi.org/10.1007/s11673-021-10144-w
[5] Walach, H and Loughlin, M. 2018. Patients and agents – or why we need a different narrative: a philosophical analysis. *Philosophy, Ethics, and Humanities in Medicine* 13(13) https://doi.org/10.1186/s13010-018-0068-x
[6] Loughlin, M. 2020. Person Centred Care: Advanced Philosophical Perspectives. *European Journal for Person-Centered Health Care* 8 (1) 20-33, ISSN 2052-5656
[7] Newberger Goldstein, R. 2014. p.39.
[8] Gadamer, 1975, 2006. pp.551-552.
[9] Loughlin, M. 2014. What Person-Centred Medicine is and isn't: temptations for the 'soul' of PCM. *European Journal for Person-Centered Health Care* 2 (1) 16-21, ISSN 2052-5656 https://doi.org/10.5750/ejpch.v2i1.689
[10] Taylor, Angelina. 2015.
[11] Coalition for Collaborative Care. 2015. *Action for long term conditions - Our Vision for the Future*. www.coalitionforcollaborativecare.org.uk
[12] Royal College of General Practitioners. 2014.
[13] Hibbard, J.H. and Mahoney, E. 2010. pp.377–381.
[14] Hibbard, J.H. and Greene, J. 2013. 207-214.
[15] Tyreman, S. 2020. Person-Centred Care: Putting the Organic Horse back in front of the Mechanical Cart. *European Journal for Person Centered Healthcare* 8 (1) 86-93
[16] The capitalization of these terms is in line with Heidegger's use of them – they have a specific meaning within the context of his philosophy, distinguished from their usage by other philosophers to whom he was responding, most notably Descartes. The capitalized 'Others' refers to beings whose existence is both distinct from and intimately linked to our own.
[17] Arnold, M., Kerridge, I. & Lipworth, W. 2020. An ethical critique of person-centred healthcare. *European Journal for Person Centered Healthcare* 8 (1) 34-44
[18] Blunden, N. & Calder, G. 2020. Co-production and Person-Centred Care in neo-liberal conditions. *European Journal for Person Centered Healthcare* 8 (1) 75-85
[19] Heidegger, M. 2002.
[20] Gadamer, H-G. 1975, 2006.
[21] Carel, H. 2008.
[22] Carel, H. 2106.
[23] Gawande, A. 2015.
[24] As exemplified in, *Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020.* National Palliative and End of Life Care Partnership. www.endoflifecareambitions.org.uk.
[25] Spooner, A., Chapple, A., Roland, M. 2000.

CHAPTER TWO

PHILOSOPHY, ENGAGEMENT AND WHAT IT MEANS TO BE A PERSON

Person centred care is, of course, by no means a new idea. The view that good healthcare practice involves treating the whole person, and that the person is more than the collection of their component parts, dates back to the ancients.[1] The need to understand humans as biological, psychological and social beings is neatly captured in Aristotle's famous phrase: "man is a social animal".[2] Understanding the nature and well-being of the human individual with reference to that person's life in the broader community, Aristotle also understood the function of a body part with reference to its role in facilitating the flourishing of the whole organism.[3]

While never entirely forgotten or abandoned in responsible health practice, the imperative to focus on the person has been somewhat sidelined in the modern era, leading to numerous calls over several decades to revive 'personalised' or 'whole person' approaches. These calls have been presented as an urgently needed remedy for a clinical practice culture variously described as "scientistic", "reductionist", "de-personalised", "disease-focused" and "mechanistic".[4,5,6,7,8] Authors argue that the patient, construed primarily not as a person but as a case requiring a solution in the form of a cure, tends to be conceptualized as a biomechanism that needs fixing, threatening a "collapse of humanistic values in the principles and practice of medicine" and an associated "crisis" of compassion and care.[9] The effect is to reduce clinical reasoning to a form of technocratic 'know how', undermining the clinician's ability to understand and interact with real people, in all of their diversity and complexity.[10]

To evaluate such claims, and to address the serious concerns about modern health practices these authors are raising, we need a full account of the nature of the problem identified and an explanation of its causes. Though it may seem counter-intuitive to some readers, this very practical problem needs analysis with reference to the disciplines of philosophy and the history of ideas. In so far as biomedically led healthcare practice does have a tendency to become 'de-humanised', this is not the fault of medical

science or practitioners *per se*, but rather it is a product of broader cultural assumptions that helped to frame our thinking about the nature of science and the relationship between science and practice, in healthcare and elsewhere. We need to utilize our shared human capacity for critical reflection, to bring our background assumptions into the foreground and subject them to analysis, before we can decide what, if anything, we can change to develop an outlook more compatible with creating the sort of health service that most of us say we want. We need also to understand our place in intellectual history, why certain ways of thinking about the world and our place within it became dominant at certain points in time. Even assumptions that facilitated significant progress at an earlier stage in history may now need revising, if we are to build on the advantages we inherit and to make further progress in future.

Philosophy as practice: critical reflection and dialogue

One very common conception of philosophy, based on the Platonic dialogues, is the search for definitions. In a typical dialogue, Socrates will encounter someone making claims about the nature of knowledge, justice, virtue or some other often used but rarely defined concept. He will promptly request a definition of the term, invariably finding that his interlocuters are as unclear about its meaning as he is. A series of definitions may be proposed and subjected to scrutiny, only to be rejected on the basis of counter-instances (examples of things or actions conforming to the definition that do not seem genuine cases of the term being defined, or instances of genuine cases that do not seem covered by the definition) or because they are circular, such as Euthyphro's much-discussed definition of piety or holiness as "that which is loved by the gods."[11] This definition naturally invites the question as to whether something is holy *because* the gods love it, or whether the gods love a thing *because* it is holy; the first option being problematic for a number of reasons, the second being blatantly circular.

The attempt to define one's key terms as far as possible is undoubtedly an important aspect of philosophical discourse, and debates about how to define such terms as 'health', 'disease' and 'person' have produced extremely useful exchanges in the philosophy of healthcare. It would, however, be a mistake to think of philosophy as an activity whose whole – or 'ultimate' – purpose was to produce definitions. Even if this view of philosophy is the impression some modern readers get from Plato's dialogues, it is surely not what he intended. It seems highly unlikely that Plato would be happy to see the value of his various works reduced to a

series of 'learning outcomes' in the form of definitions for us to memorise, such that the bulk of the dialogue could be by-passed as we skip to the 'results' on the final page.

There are works of "applied philosophy" which attempt to do just that, offering "guidance" to physicians concerning "the applications of philosophy, logic and critical thinking" to medicine by helpfully summarizing the "outputs" of philosophical dialogue, in the form of definitions of contested terms such as "knowledge" and "evidence".[12] Unfortunately, abstracting the conclusion or "end-product" from the processes of rational dialogue that produced it is about as helpful in facilitating "critical thinking" as advising the reader of a maths text simply to 'turn to the back of the book', where all the answers to the problems in the text are listed, or offering to drive the marathon runner to the finish line to save her the time she would otherwise have to waste in doing all that running.[13]

In each case the exercise, intellectual or physical, is the source of the value, which is why Plato's 'inconclusive' dialogues (the ones in which no agreement on a definition of a key term emerges) are not thereby failed enterprises. The activity of proposing, interpreting and criticizing definitions, only to find that none of the accounts considered stands up to scrutiny, can advance our thinking and teach us a lot. At the very least, the exercise may challenge us, awakening us from our "dogmatic slumbers" regarding shared understandings of the meanings of terms we use in our practices, in much the same way that Kant credits Hume's sceptical arguments with forcing him to rethink his own assumptions regarding the basis of human knowledge.[14]

It might also alert us to problems in the whole process of attempting to define certain terms, raising fundamental questions about meaning. As Wittgenstein notes[15], many terms cannot be defined. For concepts such as 'time', and perhaps also 'person' and 'health', it seems possible that no definition is ever going to capture all (and only) the legitimate uses of these terms in the very diverse range of contexts in which they operate. Instead, we may need to treat them as "family resemblance" terms, such that their meaning is a matter of their overlapping usage across the contexts in which they are employed, and their contribution to the "forms of life" this employment facilitates.

In the case of person centred care, this point has led some authors to advocate abandoning the search for a definitive account of what it means for care to be 'person centred', adopting instead the approach to understanding meaning explained in JL Austin's work on "ordinary language philosophy".[16,17] Bill Fulford argues that the "philosophical fieldwork" needed to understand the meaning of person centred care

involves mapping the "logical geography" of the term (and related language, including "values-based practice" and "shared decision-making") as it is used in practice. He notes that this approach enables us to meet the "challenge of pluralism", in that different, and mutually incompatible definitions of person centred practice may well be used coherently in different contexts.

As with the approach to philosophy based on defining one's terms, the mapping of "logical geography" seems to be an important component of the philosophical project. We must understand different uses of the key terminology in different contexts if we are to address the on-going debate about the implementation of person centred care and the other concepts Fulford identifies. He is also right to stress the need for "pluralism", in that we may well find there are different conceptions of person centredness that make perfect sense, have rational justification and the potential for meaningful and productive implementation. Certainly, it should not be the role of theorists (of any particular disciplinary background) to pronounce finally and definitively on the nature of person centred care, instructing practitioners to "just get on with" implementing this definitive account in the manner we criticized in Chapter One.

However, there are also limitations to the "mapping" approach. Understanding how a term is in fact used in a particular context is an essential starting point for engaging in debate about its proper use, but if we want to be part of that debate then we need to do much more than simply describe different positions within it. And we do need to have a full, on-going debate about how to use the language of person centred care *properly*, because that language "is not simply diverse, it is *contested*."[18]

In our opening chapter we mentioned notions of 'patient' and 'person' centred care based on individualist conceptions of what it means to be a person, which give rise to approaches to healthcare that critics have astutely identified as "consumerist" in nature.[19] The example of "big-eye surgery" provides one of many powerful illustrations of the extent of consumerism in global healthcare. If an Asian woman wishes to undergo surgery to make her face resemble more closely that of a Caucasian woman, it is at least not obvious that the "person centred" response is to "supply" what this "consumer of healthcare" is "demanding". It may well be that some will use the language of person centred care in this way, arguing that it would be "paternalistic" to refuse her request. However, in addition to noting that this is how the terminology is in fact used in certain contexts, as responsible beings we are also confronted with the question: but is this usage legitimate?

As Yves Aquino argues, a more appropriate way to respect this person, and the community of which she is a part, might be to challenge the racist

and misogynistic culture and campaigns driving this demand.[20] Do we really "respect the autonomy" of this woman by characterizing her as a "consumer"? Or should we instead regard her as a victim of economic arrangements and social stereotypes that lead her to think she would be more employable, more attractive and generally a more credible human being if she could just look more like the European woman who got the job she had applied for last month? The point is, there is a normative debate here, and one of a potentially complex nature, raising underlying questions about how to conceptualise the proposed intervention and the broader context that frames the beliefs and decisions of those involved. Efforts to map logical geography should remind us that "a map of the territory of healthcare has no clear borders, such that, by following its links to their logical limits, we will find ourselves inevitably in the midst of broader dialogues about the social nature of persons, the nature of value, agency and the basis for our obligations to one another."[21]

The map, as it were, is not complete, and an important role for philosophy is in enabling us to find ways not only to understand, but to reflect upon and, where appropriate, criticize dominant uses of terminology. This means identifying and being prepared to challenge and to revise the conceptual map giving rise to those uses. In philosophy, as in life more generally, what matters is the journey.[22] We need to understand how we got to where we are now, hence the indispensable role of the history of ideas in enabling us to recognise what we have inherited from our ancestors – the advantages as well as the problems they have bequeathed. But we also need to go forward. In what follows, we will identify features of the world picture that we, as citizens of the modern era, have inherited, as a necessary pre-requisite to developing proposals for a more meaningfully person centred approach to delivering healthcare. These proposals consist in alternative ways of understanding ourselves, as people and as communities, of understanding the nature of healthcare systems, the nature of illness and the value of health.

Our proposals are not meant as the definitive solution or final word on the problems we discuss, but a contribution to the on-going dialogue. Whether she agrees with our conclusions or not, the true source of value in the book will be the reader's engagement with it. Philosophy is an activity, an interaction. The version of 'applied philosophy' described above, which attempted to abstract the conclusions of philosophical texts from the processes of dialogue that generated them, reflects the authors' failure to examine critically a key feature of the modern conceptual framework.

As we will explain in more detail in the next section and in chapter 3, this framework is structured around a number of strict dichotomies

including 'subject-object', 'mind-body' and 'theory-practice'. Focusing for now on the third of these, the idea that there is a sharp divide between theory and practice has led to the picture of 'applied philosophy' as bringing some completed thing, a "body of theory", to bear upon something called "practice" whose nature can, it seems, for the most part, be understood without appeal to any theoretical framework.[23] Philosophy, on this account, is either the preserve of a small group of theorists or an inner, reflective process one gets over and done with before returning to the business of "real life". It is not the business of, nor of much interest to, "busy professionals", who only need the "points of substance" to take away; meaning the conclusions (ideally including clear statements of practice goals) along with any handy "how-to" instructions regarding the theory's implementation.[24] We have elsewhere described this as the "repair manual" approach to applied philosophy,[25] because on this view "practical" people – be they service-users or health professionals – have as little interest in the underlying nature and purpose of care as a typical viewer of *Real Housewives of Beverley Hills* has in the inner workings of her television set.

Our own approach is predicated on the rejection of this simple theory-practice divide. Thinking, theorizing, understanding the world – these are not names for some 'inner event,' something that just happens 'inside our heads,' as distinct from the 'outer' world of reality and practice. This whole inner-outer split is at the core of our contemporary problems in numerous areas, including health and social care. Rather, theorizing is an activity, something we *do* – an aspect of the whole person. What is more, it is a social activity. We are able to engage in it because we are social animals, ones who can ask each other questions, respond to queries and objections, raise and debate possibilities. It is an essential aspect of our interaction with each other and the world, characterized and expressed by dialogue.

To be "practical" is not to be thoughtless: the model of practice as mechanically following simplistic guidelines is clearly a recipe for bad practice. If practitioners are indeed too busy to reflect upon the nature and value of their work then this is something theorists should identify as a serious problem – not as a feature of the "current reality" to which they should cater, adapting their own methodology to sustain, rather than challenge, that current reality. Philosophy is not something only certain theorists do: we all do philosophy, when we think critically about our own underlying assumptions, or attempt to challenge the assumptions of others. It is everybody's "business". All practice takes its place in a context of intellectual and social history, and whether we are professionals, service users or simply citizens who care about the future of our society, we need to be aware of our underlying assumptions and to be open, in principle, to

revising them. To fail to do so is not to act in a 'theory free' way – it is rather to bring unexamined and unchallenged assumptions to life and practice, to allow your behaviour in matters of importance to be determined by theories you can't explain, let alone justify.

What we need, then, in health care, social care and every area of civilized society, is inclusive, on-going dialogue. Activity does not have to "wait" until theorizing is "complete". Good theorizing is of course influenced by practice in that it is part of an on-going interaction with the world. We think in a context, and the nature of that context both shapes and is shaped by our thinking. Both are evolving. The question of which provides the 'foundation' embodies errors analogous to famous musings regarding the chicken-egg relationship. We can and should modify our theories with respect to a dialogue which includes contributions from practitioners, patients and the broader community.

This is the approach to philosophy Stephen Toulmin championed, in his much quoted (and often misquoted[26]) account of how medicine "saved the life" of ethics.[27] He explains that philosophy as initially practiced did not need to develop an "applied" branch, because its concerns were to address whatever were considered the most pressing questions of "real life". However, modern philosophy (particularly in the 'analytic' school) had become almost willfully detached from such concerns, with authors apparently celebrating the irrelevance of their work to any issues of practical import.

It was the need for philosophers to engage in genuinely practical and interdisciplinary debate – with groups including lawyers and clinicians – that led to a revival of the subject's historical methods. By engaging in dialogue regarding "the vexed topics raised by particular cases", philosophers were required "to address once again the Aristotelian problems of practical reasoning, which had been on the sidelines for too long."[28] Toulmin's examples show how the participants in these dialogues learned from each other, with each party bringing their particular experience and theoretical perspectives to the discussion of the cases. In this context, the philosophers were required to use their own skills (asking naïve questions about meaning, consistency and underlying assumptions, exposing ambiguities and errors of reasoning) to advance the debate. This process enabled participants to achieve a level of consensus that would surprise those (in academia and elsewhere) who take it as read that all ethical questions are purely "subjective," in a sense that means they resist any rational solution.

Toulmin notes that via this engagement, philosophers had found their subject "coming alive again", and we suspect he would agree that the revival

of "ethics" he describes could not be achieved in artificial separation from other aspects of philosophical thinking. Ethical questions concern what we should do in a given situation, and as such are embedded within our whole understanding of the situation. This concerns our beliefs about what is the case (ontology), what we feel we can claim to know (epistemology), our broader beliefs about reasoning (logic) as well as the meaning we ascribe to different aspects of the situation or to our perception of it (hermeneutics and phenomenology).[29] All of these aspects of philosophical thinking are relevant to our understanding of what person centred care means, and the more fundamental question of what it means to be a person.

Being a person

As any attentive undergraduate philosophy student can tell you, Rene Descartes is "the father of modern philosophy".[30] It would of course be bizarre to treat him as the inventor of the modern era, as though he just sat at his desk one day, wrote down some ideas, and the whole way of thinking that characterizes modernity followed as a consequence. Rather, his work represents an extremely astute interpretation and articulation of ideas and distinctions that were emerging at the time. Using concepts and methods implicit in the developing scientific culture of his age, he eloquently captured a new world picture, giving clarity and credibility to ways of understanding the world and our place within it that differed radically from those dominant in antiquity and the ancient world.

He is known as a metaphysical dualist because his philosophy divides the world into two distinct ontological realms, the mental and the physical.[31] The physical world consists of material objects that are subject to mechanistic, causal laws. For Descartes, the terms "matter" and "body" are interchangeable and defined as that which has "extension": to be a material object is to fill up space. Thus, the objective world contains only things and properties that are measurable or 'quantifiable'. It is the job of science to discover the laws which govern the behaviour of these "essentially extended things".

All the features of our everyday, lived experience that cannot be understood in this way are part of the subjective or mental realm. In contrast to matter, the mind has no extension – it does not have a place in the physical world because it is an "essentially thinking thing". Values, purposes, desires and emotions, pleasures and pains, along with all of our qualitative perceptions of the world around us, exist in this world of thought. Even the phenomenal colours which form part of people's everyday visual experience cannot be part of "objective reality". Rather, we need to distinguish between

the inner perception of colour and the features of the external world that cause this experience. Hence, we understand the frequency at which the surface of an object refracts light as being what it "really is" for an object to have a certain colour. This is the case for our every perceptual experience: we are aware directly not of physical objects and their properties, but of the inner, subjective experiences that we take to be the causal effects of those external properties. We know this world of inner experiences immediately and with certainty, via the faculty of "introspection".

The Cartesian world view had profound effects on the development of numerous academic disciplines, including medicine and psychology. His conception of science is reductionist in a fairly straightforward sense, in that it narrows (or his defenders might prefer, sharpens) the focus of scientific investigation, encouraging emphasis on the quantification of observable features of the physical world. The Cartesian concept of the "man machine" influenced the nature of medical research, and has undoubtedly led to extraordinary progress in certain areas.[32] It is also worth noting that certain ideas that are key to work in person centred care, such as "patient expertise", find vindication in Cartesian thinking regarding the special epistemic authority of a subject with respect to her own experience.

That said, the Cartesian legacy has included extremely serious problems that have been the cause of perplexing academic debate throughout the modern era. His own work in the *Meditations*[33] brings out eloquently and succinctly the fact that his strict subject-object divide, with the insistence that each human subject is only directly aware of her own, immediate experiences, gives rise to a radical scepticism that undermines the epistemic basis for the claims we make, not only in science but in everyday life. The hypothesis that all of life might be a dream, explored in so many popular films in the modern era, has no coherent refutation given the assumption of an unbridgeable ontological divide between experience and reality. Similarly, once you insist that the human mind is metaphysically distinct from the physical body, and that in the "objective world" there are only physical bodies, "the problem of other minds" arises – and once it has been allowed to arise, it becomes insoluble.

More broadly, the radical separation of "mind" and "body" dissects the human person, making human life and its defining features, including awareness, engagement and agency, inherently problematic ideas.[34] The notions of "inner" and "real" at work in Cartesian theory bear little resemblance to the ones we use in ordinary life. Even the organs of my body are, on Descartes' picture, part of the "external world". If cause-and-effect concern the relationship between physical objects, and human choices and experiences are not physical things, then it is just not clear what it means to

posit a causal relation between these two metaphysically distinct realms. Thus the 'mind–body problem' and the 'problem of free will' became major preoccupations of modern philosophy, with science positioned not as an ally to advancing human autonomy, responsibility and control but as a fundamental threat to these very ideas.

Our natural awareness of our own activities is holistic. We experience ourselves as embodied beings, complete organisms, directly perceiving physical objects, making choices, engaging in conversation with other people. The attempt to split the human being into a combination of immaterial self and physical body makes a coherent account of these processes impossible. As Heidegger says, "The 'scandal of philosophy' is not that this proof has yet to be given, but that *such proofs are expected and attempted again and again*."[35] Given the Cartesian conception of the "real world", organisms are "really" mechanisms, while "choices" and "actions" have no place in a world where there are only events, subject to the laws of mechanistic cause and effect. The whole person becomes a metaphysical oddity, straddling two incompatible metaphysical realms.

A theoretical framework that renders the previously straightforward inherently problematic is by no means an unequivocal advance. Materialist authors have attempted to "solve" this problem by denying the reality of the subjective side of the Cartesian picture, replacing his dualism with radical metaphysical reductionism.[36] Such authors insist that the "objective" world (still understood as something devoid of phenomenal properties, containing only causes and effects as understood in reductionist science) is all there really is. On this view, we do not have to bridge the gap generated by Descartes, between the subjective and the objective features of human life, because the objective features are the only ones that exist.

These authors will sometimes go to great lengths to explain why they are not (appearances to the contrary) quite literally denying the obvious, such as the experiences we have when we open our eyes, or indeed think or feel anything at all. The distinguished philosopher UT Place famously argued that phenomenal properties are "mythological", that a green after-image "has no place in the world of physics" and the world of physics is, quite simply, the only world there is. You know what an experience of greenness "really is" not by experiencing it, but rather by learning about neurology, because it really is a brain process, and nothing more, just as a cloud really is "a mass of tiny particles in suspension" and nothing more. So, Joni Mitchell really doesn't know clouds at all,[37] while the scientist knows literally all there is to know about them. It is very hard to see how one solves the problem of having fractured our lived reality by depositing