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Abstract

Fulford's chapter discusses the conceptual challenges facing person-centred care (PCC) and the role of philosophy in addressing these challenges. He is right that this role - to investigate underlying meanings and reveal assumptions - need not and should not be restricted to the search for definitions of key terminology. The methods of "ordinary language philosophy" enable us to understand the meanings of terms by systematically examining their use in context, with a view to mapping a term's "logical geography". He makes effective use of this methodology to show that alternative accounts of what it means to be "person-centred" need not be contradictory and can indeed be fully complementary.

The approach of mapping the usage of the key terms is necessary if we are to understand the discourse, but it is by no means sufficient in gaining a coherent understanding of the meaning and value of PCC - let alone one that could provide the basis for its effective implementation. While it is true that distinct accounts can reveal different and compatible "aspects" of PCC, the language of PCC - like that of "evidence" and "ethics" - is not simply diverse, it is contested. Fulford argues that "genuine" PCC provides a proper balance between the "extremes" of paternalism and consumerism. This language is clearly normative, going beyond what he characterises as the "empirical" exercise of mapping usage. A broader inquiry, based on the distinction between philosophy as a body of theory and as dialogue, and incorporating a direct engagement with normative questions, is necessary if we are to address the challenges Fulford identifies.

The exercise of "mapping logical geography" reminds us that health discourse 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.

Keywords

Conceptual maps, dialogue, empirical, logical geography, normative, ordinary language, philosophical methodology

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Introduction

I once argued that the role of the philosopher in any debate of practical import is to ask the questions others would rather not ask, for fear of appearing naïve - indeed, whatever our training, we are all philosophers to the extent that we are prepared to raise such questions and to subject the answers we receive to careful scrutiny [1]. That annoying tendency to ask "What do you mean?" and "Why does that follow?" is as much needed in debates about contemporary health and social care as it was when Socrates probed his compatriots for explanations of their underlying assumptions (about justice, courage, happiness, love - all the things that mattered most in life) in the Athenian market place [2].

With regard to the debate about person-centred care (PCC) there is now a growing consensus that services need to be more "person-centred". While the language of "person-centredness" appears in policy documents (including, in the UK, the government's 'long term plan' for the NHS [3,4]) such uses are frequently characterised by a lack of precision [5] and in the supporting literature we are confronted with different, sometimes apparently incompatible accounts of what it means to be "person-centred". The relationship between PCC and associated ideas including "personalised care", "patient-centred care", "relationship-centred care", "shared decision-making", "self-management" and even "patient activation" is not always spelled out clearly and consistently to the working populations expected to implement the developing strategies. This is no doubt due in part to the fact that the associated conceptual framework is indeed in the the process of developing - though set against the historical background of debates about organisational quality and evidence-based practice [2,6,7], we may wonder how long it will take for shared understandings to develop and, in

any case, the speed of the development may well be a function of the willingness of policy makers to engage in critical dialogue with practitioners and patients.

The chapter contributed to the current volume by Bill Fulford [8] takes as its starting point the conceptual challenges facing PCC and the role of philosophy in addressing these challenges. He is right that this role - to investigate underlying meanings and reveal assumptions - need not and should not be restricted to the search for definitions of key terminology. Philosophers since Wittgenstein have been very much aware of the limitations to the search for a "definitive" account of a given term or set of terms and of the sheer impossibility of defining certain very common terms [9]. I think that most (or more likely, all) contributors to this volume would agree that its goal is not the discovery of a definitive account of PCC, which all rational parties will readily adopt, such that we can then move on neatly to the implementation phase of the person-centred project. Thinking is not something we should aim to get "over and done with" before commencing practice. In contrast to what I have elsewhere called "moderate anti-intellectualism" [10] or the "TV repair manual" approach to practical reasoning [11], the goal of any serious work in health philosophy is not to find a simple set of definitions and rules which one can "internalise" and then mechanistically apply across the (by implication) limited range of problem-types one expects to face in one's practice.

Rather, the types of problem human beings seeking health and social care present are diverse, potentially unlimited in nature. This insight could be characterised as one of the key features of any credible person-centred approach and, as Fulford notes, it acts in counter-balance to approaches to clinical decision-making that give "pride of place to the results of generalisable clinical trials" [8]. One engages with the philosophy of PCC to acquire certain habits of thought, reflective dispositions, ways of seeing the world and conceptualising problems that will equip us to think and react, creatively and sensitively, to the wide variety of problems and unique situations one may face in life. It is taken as read that the skills one acquires will include interpretation of what precisely it means to be "person-centred" in the situation at hand. What is more, this may not be so obvious that there is no scope for disagreement between reasonable people: the ability to consider alternative views to one's own on what PCC "really means" in the specific context one faces is likely to be an indispensable component of its effective implementation. In this chapter I address Fulford's reasoning, beginning with his approach using Ordinary Language Philosophy.

Defining person-centred care

Fulford contrasts understanding work in the philosophy of PCC as "attempts to *define* person-centred care" with "the novel methodological perspective" of Ordinary Language Philosophy [8]. Instead of searching for the correct definition of PCC, we should be examining the use of the terminology of "person-centred", mapping its "logical geography" in a range of social and discursive contexts. Looking at two influential papers on the philosophy of PCC, Fulford argues that, understood as attempts to define PCC, (which, as he notes, is how the authors in each case characterise their own projects) they come into conflict, while understood "as explorations of the *use* of the concept of person-centred care" their different findings "reflect different aspects of the meaning of person-centred care".

I am very sympathetic to this approach, having previously defended a view of philosophical methodology as concerned primarily with making explicit our typically implicit "conceptual maps", a task accomplished by examining the links we make between different situations, what we regard as *relevant* similarities and differences, the inferences we judge valid and the assertions we are prepared to make in particular contexts [11]. However, the point made above, about recognition of the diversity of human problems being "one of the key features of any credible person-centred approach", requires us to qualify the preceding comments regarding the search for a "definitive" account of PCC. Certain core ideas might turn out to be "definitive" in the sense that they are not just what Fulford calls "aspects" of PCC: they may be essential aspects, such that no approach to practice can credibly be called "person-centred" if it does not include them. This is a different use of "definitive" from the view that a particular account represents "the final word" on what the terms "really mean".

So the problem is with approaches to the philosophy of PCC that attempt to provide an account that is definitive in the sense of "exhaustive". It has seemed natural to many authors in the philosophy of medicine and healthcare - including contributors to the debates about evidence-based medicine and patient-centred medicine - to regard the ultimate goal of their activity as the production of a body of theory, a complete "philosophy of" the area, that explains its goals, methods and diverse practices with reference to a limited number of foundational, unifying concepts [12]. Based in part on (now largely abandoned) assumptions derived from debates in the philosophy of science [12] and a range of "temptations" facing contemporary academics wishing to provide demonstrable "outcomes" for their theories [13] authors have presented their respective approaches as "comprehensive clinical practice models or general theories of medicine" and definitive accounts of what "usual clinical practice" should be [12]. What, it might be asked, is the purpose of theorising, if not to produce a complete theory? And if one's theory is not complete then is it not still "work in progress"? So one's ultimate goal in theorising must, logically, be the development of a comprehensive body of theory that rules out all alternative approaches.

Such methodological assumptions undermine authors' subsequent claims that their distinct approaches are compatible: patient-centred medicine cannot act as a "balance" to evidence-based medicine if the two represent competing accounts of the goals and proper methods of clinical practice. If, however, we understand these terms as representing "distinct ways of conceptualising practice that bring to light otherwise neglected or de-emphasised

aspects" [12], then both can have a role in informing the practices of their readers in contexts where, in the judgement of the informed reader, they help her to make sense of the specific situation she is facing. This seems to be a far more realistic and useful goal than the attempt to provide a *definitive* theory of any given area of practice and, if it strikes some theorists as too modest, then this suggests they are in the grip of an account of the value of their own activity that needs revising.

Philosophy as 'body of theory' *vs.* 'an activity'

My preferred account of philosophical methodology rests on the distinction between regarding the subject as primarily "a body of theory" and regarding it as "an activity" [2,11]. Philosophy's value, and that of many other academic disciplines, particularly in the human sciences, lies primarily with its status as a particular kind of activity, the methods of thought and enquiry that activity promotes, the dispositions it engenders. All thinking requires us to conceptualise the data of experience in some way. Philosophical thinking enables us to focus on the ways we do this, "to bring our background assumptions into the foreground of thought, to understand how they help us frame our experience" [12]. Such intellectual exercise helps us not only to think critically about assumptions and to question the validity of our inferences, but also to defend them when they are subjected to invalid criticism, and so to arm ourselves against error, manipulation and fallacy. Philosophy in this sense can be equated with "training in intellectual and moral self defence", an approach that assists us both in developing our own distinctive positions on common controversies and in retaining our moral and intellectual integrity in the context of negotiating a complex and often confusing world [11].

Developing theories - pictures of the world and one's place within it - is of course a vital part of that activity, as is the willingness to revise them in the light of experience and criticism. But the move from valuing the *process* of theorising to regarding its value as primarily or entirely a function of its conclusions or "outputs" led to philosophy, typically concerned with what Fulford characterises as "higher level concepts" [8], being increasingly regarded as too "abstract" a discipline to have any practical implications or use [11].

The focus on developing a "body of theory" with substantive implications has also led to the growth of what Fulford has elsewhere characterised as "cut price" versions of applied philosophy [14], including attempts to extract moral principles from the underlying philosophical discourses that gave them meaning, present them as the "products" of philosophy and then "apply" them to providing definitive solutions to a series of "ethical dilemmas" [11,15-17].

As Toulmin argued [18], philosophy as initially understood did not need to develop a distinct, "applied" branch because it was always inherently concerned with the most pressing and engaging questions of "real life". His famous claim that medicine "saved the life" of ethics celebrated the fact that the subject had effectively returned to its roots, regaining a "seriousness and human relevance" by addressing "the Aristotelian problems of practical reasoning, which had been on the sidelines for too long" [18]. Philosophers achieved this by engaging in *dialogue* with practitioners about specific cases, learning from the experience and theoretical perspectives of their interlocutors and contributing to the resolution of practical problems by introducing their own characteristic style of thinking: asking naïve questions, making implicit assumptions explicit, searching for relevant similarities and differences, identifying the logical structure of arguments, clarifying debates by exposing ambiguities and errors of reasoning.

Teamwork and interdisciplinary collaboration *vs.* a 'sole trader' approach

Fulford's preference for "teamwork" and interdisciplinary collaboration over what he characterises (citing Austin) as a "sole trader" approach to philosophy resonates with this, and of course with the Socratic tradition of philosophy as dialogue. It is true that Socratic dialogue typically involved the questioning and seeking of definitions of key terms, but as many commentators have observed, the value of the exercise is not primarily in the specific conclusions reached but in the processes of reasoning demonstrated. Interlocutors struggle to characterise their own preconceptions more precisely than they have done before, consider their conclusions about specific cases in the light of these characterisations and in the process come to understand themselves and others better. This is why work that simply presents the definitions proposed as the "output" of the dialogue, imagining they are adding philosophy to their evidence-base or moral foundation for practice [19,20], have significantly missed the point. To abstract the conclusion from the processes of rational dialogue leading to it is rather like turning to the back of the maths book to find "the answers", avoiding "doing the working out" [11], or like getting a taxi to the finish line rather than going through the laborious process of actually running the marathon. Discovering the answer or outcome in this way does nothing to equip one to approach similar problems or tasks in the future, which was, in fact, the truly practical value of the whole exercise.

Fulford's concluding comments remind us that his goal is not to give us "the answers" to the challenges facing PCC, but to provide some conceptual tools that might help us in developing our own responses to those challenges. While the "philosophical fieldwork" necessary for ordinary language philosophy has "parallels with empirical research", he is aware that we need to do much more than map the uses of the language of "person-centred" if we are to meet those challenges and implement PCC effectively. Along with other commentators [5,21], I have noted elsewhere that forms of "patient-centred care" developed by some authors were consumerist in nature [13], conceptualising health professionals as "providers of

goods" and patients as their customers or clients. This conceptualisation has links to broader, ideological assumptions and projects [11]. Other contributors to this volume [22] make the important point that replacing "patient" with "person" (despite the crucial semantic difference between these terms) is not, in itself, sufficient to avoid the conflation of "person-centred" with "consumer-driven" healthcare [22] and on this point Fulford clearly agrees. He states that "genuinely person-centered care" avoids the "extremes" of paternalist and consumerist models of care.

The use of "genuinely" here is surely normative, implying that the consumerist model of PCC is not "genuine". The fact that some people use the term in this way does not make their usage genuine. The language of PCC - like that of "evidence" and "ethics" - is not simply diverse, it is *contested*. There are different interpretations and we do, indeed, need to decide for ourselves which is correct, sometimes when we know at least one of them must be wrong. Consumerist and communitarian conceptions of PCC are emerging and we are - each of us - going to have to decide where we stand when it comes to the differences between them. Mapping logical geography will not do this for us, but it might well help us to decide. It will certainly inform (or 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.

Conclusion

This is by no means a defect of Fulford's methodology: it reflects an inevitable feature of contemporary life. Problems seem complex because the world really is complex, and we can either pretend it is not, remaining in our particular theoretical and professional silos, or we can rise to the challenge our complex, inter-connected human world presents, developing methods of thinking and reacting that enable us to negotiate that complexity. The valuable contribution that the chapters in this volume make is that they show how many of us, from such diverse intellectual and professional backgrounds, are in fact rising to that challenge. Ideas such as "person-centred care" are no longer phrases with potential to be helpful in some yet-to-be-clarified way [23]. On the contrary, theorists and practitioners are working in collaboration to give them substantive import and application.

Acknowledgements and Conflicts of Interest

This paper reproduces Chapter 5 [a] of a forthcoming volume which is being serialised in the *Journal* in advance of the publication of the book itself in late 2020. For details see [b]. ([a] Loughlin, M. (2020). Mapping the territory of person-centred care: ordinary language and philosophical methodology. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 73-78. London: Aesculapius Medical Press. [b] Asbridge, J.E. (2020). Progress in the conceptual understanding of person-centered health and social care. "Person Centered Care: Advanced Philosophical Perspectives". Loughlin, M. & Miles, A. (Eds.). London. Aesculapius Medical Press. *European Journal for Person Centered Healthcare* 8 (1) 17-19. The author reports no conflicts of interest.

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