Treating the whole person: Philosophical health

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COMMENTARY

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Editorial for the 2023 philosophy thematic edition: Treating the whole person: Philosophical health

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1 | TREATING THE WHOLE PERSON: PHILOSOPHICAL HEALTH

As recent special editions of this journal make very clear, the idea that we need to focus on the 'whole person', if we are to understand and better promote human health, has very much regained currency in contemporary healthcare debates.[1–8] This 'whole-person' approach, dating back to the ancients,[9] requires not only understanding a person's biology, but also seeing that person as a social being whose needs, well-being and flourishing are essentially relational in nature. To live a human life is to be engaged with one's 'environment' in the broadest sense of this term, concerning one's interactions with other people, animals, the natural objects and the human constructions that constitute one's world.[10,11] For a long time now, ideas about bio-psycho-social aspects to health have been a fundamental component of health education for all serious practitioners.[12] The need to consider the relationships between emotional health, personal autonomy and the social context of a given person's life have been recognised explicitly in foundational documents produced by health organisations and policy makers across the globe,[13–19] giving rise to the important and on-going debate about how to make 'person-centred care' both meaningful and a reality for healthcare users.

In this edition, we will consider arguments that attempt to derive a significant logical conclusion from these developments. If, in healthcare, we are seriously attempting to consider the whole person, then we need to add a key conceptual perspective to our understanding of health. In addition to the fundamental component of biological functioning associated with our idea of physical health, and our understanding of psychological health as central to the person's well-being, we need to think about the person's values, beliefs, attitudes, purpose and outlook on life: how that person understands the world and her place within it, what she sees as a meaningful and valuable life. In other words, we need to consider her *philosophical health*.[20,21] Only by doing so, contributors argue, will we be able to assist a broad range of patients in *making sense* of their lives and conditions.

By incorporating philosophical counselling into our lexicon of healthcare activities, we can explicitly address some of the issues confronting person-centred practice, providing methods to clarify and operationalise our understanding of such crucial ideas as patient-professional understanding, patient expertise, lived experience and shared decision-making.[21,22] This process involves engaging with patients in understanding their experiences, the meaning they attach to those experiences, their sense of self, of purpose, their broader values and crucially their sense of what is possible given their situation.[21] It is a process with the potential to give substantive meaning to the idea of patient empowerment, providing the autonomy that is a core goal not only of person-centred care but also, arguably, of any defensible conception of healthcare.[11]

The edition opens with a selection of papers that address and develop the crucial arguments that have been the subject of analysis and debate in previous health philosophy editions of the journal. The first of these is an important contribution from David Chambers[23] to the on-going debate about shared decision-making.[3,4] Based on a thorough conceptual analysis of what we mean by 'sharing' and

'a decision', Chambers develops an operational definition of shared decision-making for use in a wide range of healthcare contexts.

This is followed by discussions of situations in which clinical and patient perspectives conflict. Gianluca Montanari Vergallo and colleagues focus on the problems created for shared decision-making when patients request Caesarean delivery without clinical indications.[24] Ernest Volinn considers the influence of cultural factors in situations where patients' assessments of treatment for subjective symptoms are at odds with authoritative assessments in biomedical literature.[25] Joelle Robertson-Preidler and Holland Kaplan note that clinicians and families often disagree on goals of care for incapacitated, minimally interactive patients near the end of life.[26] They advocate the application of the concept of 'social death' to help clinicians avoid bias and improve goals-of-care discussions at the end of life, explaining and defending a person-centred approach including values elucidation and philosophical counselling, to help families think through what their loved one finds important and meaningful.

Richard Armitage examines the differences between socially and individually optimal dosing strategies under conditions of vaccine scarcity, with reference to the principlism framework.[27] This framework is critically evaluated in the paper by Doug Hardman and Phil Hutchinson, who offer an alternative account of the relationship between principles and practice.[28] Shlomit Zuckerman and colleagues also criticise the principlist framework, recommending an alternative Virtue Ethics framework as the best approach to overcoming the gaps between the different spheres of doctors and patients.[29] The authors make a convincing case for training medical students and residents in virtue ethics, as an effective way to enable future practitioners to balance the demands of clinical practice and emotional responsiveness in their professional lives. Ognjen Arandjelovic addresses the 'ethical quagmire' of the Persistent Vegetative State, laying out a sentientist approach to addressing the concerns raised by the interests of patients, their relatives and healthcare staff confronted with painful decisions regarding the patient's care.[30]

Helpful methods for addressing the interwoven epistemic and ethical concerns in these discussions are available in the insightful contributions to this edition from Roy Dings and Caitríona Cox. Dings uses a philosophical approach to clarify experiential knowledge, throwing light on the concepts of lived experience and experience-based expertise that have become central to the literature on person-centred care.[31] Cox's systematic analysis of patient understanding in medical decision-making provides criteria to help practitioners in both assessing and assisting a patient's capacity to make autonomous decisions regarding their care.[32] Her article is followed by three articles that address the concerns raised in the previous health philosophy thematic edition of this journal.[1]

In a discussion of the relationship between emotion, ethics and epistemology, Penelope Lusk's work illustrates how shaming practices in medical education can propagate epistemic injustice.[33] Maryam Golafshani develops critical phenomenologies of shame and empathy, applying them to an analysis of practitioner and patient behaviour in the context of Covid-19 vaccinations.[34] Jerome Kroll and Abdulahi A. Mohamed present a pressing discussion of shame and other moral emotions (including guilt, regret and remorse) in cross-cultural practice, with reference to the experiences of refugees and the methodological problems confronting evidence-based and narrative psychiatry in addressing the needs of these patients.[35]

The section concludes with Luis de Miranda's book review[36] of *The Philosophy of Person-Centred Healthcare*, by Derek Mitchell and Michael Loughlin.[11] de Miranda argues that the emerging philosophical health movement provides a means for practically implementing the philosophy of person-centred care the authors defend.

2 | FROM HEALTH PHILOSOPHY TO PHILOSOPHICAL HEALTH

Examining our practices of care and institutional healing from a philosophical perspective is essential, but a more radical move is to consider health as a philosophical dimension, not only *in abstracto* but also in our everyday lives and embodiments. This is what the authors in the 'philosophical health' section of this issue are doing, from different perspectives, in the continuation of the seminal anthology produced by Luis de Miranda and colleagues from the Philosophical Health International network.[21]

This section opens with de Miranda's and Loughlin's proposal for a person-centred method of dialogue allowing us to unveil or codefine the patient's personal philosophy by using de Miranda's SMILE_PH method (Sense-Making Interviews Looking at Elements of Philosophical Health).[37] The implementation of such a method would allow us to make better decisions, based on factors different from mere technocratic efficiency, for example, the patient's sense of purpose. Matt Sharpe and Rob Nolan remind us that, in the ancient world, philosophy was not pursued as a merely abstract, cognitive endeavour, aiming at esoteric theory-construction, but rather the disciplines of philosophy and medicine intersected.[38] They suggest that resources from philosophy as a way of life (PWL), in particular the prescription of targeted 'spiritual exercises' (a term taken from the work of Pierre Hadot), can be used in palliative counselling. Their innovative paper applies PWL work on the ancient philosophical spiritual exercises to contemporary clinical settings, arguing this approach is consistent with current efforts to reestablish an effective dialogue between the science and philosophy of well-being.

The question of how to meaningfully cope with chronic illnesses, aging and other sources of bodily impairment, is crucial for patients and clinicians alike. Cowritten by a philosopher (Drew Leder) and cardiologist (Mitchell W. Krucoff), the next paper of the 'philosophical health' section uses a clinical case scenario to outline the 'chessboard of healing', including 20 different self-reflexive strategies patients and practitioners may employ in the face of bodily breakdown.[39]

Sylvia Martin argues that cognitive therapies should learn from philosophy, reminding us that in doing so, therapists are recognising and learning from the intellectual heritage of their own practices.[40] Martin notes that Stoicism has informed cognitive behavioural therapy (CBT), notably its emphasis on establishing psychological distance from emotions, but that more recently, CBT has renewed its relationship with philosophy via the use of values, dialectics and the development of self-questioning practices reminiscent of classical Socratic principles. CBT, acceptance and commitment therapy and radically open dialectical behavioural therapy rely heavily on the use of values, which is a philosophical strategy that should be less understated in future discussions of practice.

One could argue, however, that there is an aspect of the illness experience that is so basic and biological that a philosophical health approach, with its focus on meaning and reflection, would be incapable of alleviating it, and that is pain. Yet, Charles Djordjevic makes a convincing case to the effect that meaning and pain are not necessarily antithetic.[41] His paper argues that starting to address this requires viewing pain-assessment as a form of sense-making that occurs between patients and providers. Indeed, extreme cases in chronic pain and trauma are not devoid of self-innovative strategies appealing to a philosophical sense of life and a sense of purpose. de Miranda and colleagues investigated the personal philosophies of eight patients affected by spinal cord injury (SCI).[42] The purpose of their study was to discover if there is a philosophical mindset that may play a role in living a good life with a traumatic SCI. The interviewees reported having gone through a reinvention of themselves which implied questioning the meaning and purpose of their life in particular, and indeed of life in general.

Pain is also a preoccupation of the paper by Roberta Lanfredini and Letizia Cipriani.[43] The authors employ a phenomenological analysis of the experience of pain and the ways in which this experience is expressed in natural language, to develop an ontological modelling of the language of pain. They use this analysis to propose a revision of the traditional MPQ questionnaire for assessing and measuring pain.

The two last articles of this section turn their attention to oriental philosophical health approaches. Lehel Balogh, one of the authors of the Philosophical Health anthology,[21] describes the Japanese Morita therapy,[44] a special mode of conceiving mental illness akin to the techniques of meaning-centred therapies. Veronica Bâtcă & Andrei Simionescu-Panait examine de Miranda's SMILE method for philosophical health with the lens of Chinese wuxing ontology, an ancient healthcare tradition that actively relies on philosophy.[45]

Philosophical sense-making and the corpus of philosophy are now increasingly used in practical contexts. These approaches are characterised by the belief that there can be a symbiosis between a healthy mind, a healthy embodiment and healthy environments. It is hard to dispute the claim that there is an important link between the health of individuals and the social as well as the physical environment in which they live their lives. The methods proposed by the philosophical health movement represent a way to build a deeper understanding of this relationship, via dialogue between patients and practitioners. This is sometimes characterised as a deep-listening care for others and a more general care for the earth, these two aspects being intertwined and intercreative. This special issue is an important contribution to the emergent conversation about the necessity, in our disparate practices, of not just physical health or psychological health, but also philosophical healing.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

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