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Mechanisms, organisms and persons

Philosophical health and person-centred care

Michael Loughlin

In his initial call for contributions to this volume and in the opening paragraph of the *Philosophical Health International (PHI)* website, the volume's editor, Luis de Miranda, characterized 'philosophical health' as 'an emerging concept' (<https://philosophical.health/>). While he offers his own account of its meaning (to be considered in what follows), he stresses that the concept is 'open' and that the whole purpose of the new PHI movement is to explore 'its full and multifarious potential'. Elsewhere, de Miranda states that, in contrast to 'physical health' and 'psychological health', 'the idea of 'philosophical health' may still appear to be a curiosity' (de Miranda, 2021). However, he also points out that, far from being entirely new inventions, the notions of philosophical care and counselling represent a partial revival of ancient Greek ideas regarding 'the holistic good of humans' (de Miranda, 2022: 1).

Ten years earlier, in one of the first editions of *The International Journal of Person Centered Medicine*, its editors characterized person-centred medicine in similar terms. Describing it as 'an emergent model of modern clinical practice' with the potential to revive the ancient conception of medicine as care for 'the whole person', they note its transformative potential and regard it as an attempt to restore 'the soul of the clinic' (Miles and Mezzich, 2011: 207). However, they also note the serious concern that 'the nomenclature of "person-centred medicine" risks the accusation that such a term represents a further rhetorical addition to the already rhetorically overburdened nature of health services' (Miles and Mezzich, 2011: 216).

In this chapter, I will argue that the movements for philosophical health and person-centred medicine (or as it is now more typically, and in my view far more appropriately called, person-centred care) are indeed related. It is fair to say that, at the moment, both concepts are 'up for grabs' (Loughlin, 2014: 20) in that there is no agreement on a standard definition to cover all legitimate uses of the terms. Since I made this comment regarding person-centred care in 2014, the debate in that area has moved on considerably, with different views emerging regarding what is needed for care to be 'genuinely' person-centred (Fulford, 2020: 66, Loughlin, 2020: 22). It is perhaps no longer appropriate to characterize the language of 'person-centredness' and 'personalized care' as 'emerging',

given its incorporation into numerous widely read, influential policy documents, including the 2019 NHS long-term plan (Department of Health, 2019; PCTC Scoping Group, 2018; Health Foundation, 2016). Over a relatively short period, this language has shifted from being marginal in health discourse to being a core component of debates about the future of health service provision and practice (Loughlin et al., 2019). However, the significant differences regarding its proper interpretation and implementation are by no means resolved, with astute critics noting a radical disconnect between understandings of this terminology in the context of policy discourse and the progressive philosophical aspirations of many authors in the field (Arnold, Kerridge and Lipworth, 2020).

My argument here is that the emerging debate about philosophical health (exemplified by the arguments in the chapters of this volume) has an important contribution to make to the development of this ongoing dialogue. On the one hand, the most plausible forms of person-centred care need to incorporate, explicitly, the idea of philosophical health. While this idea can be argued to be implicit in the work of numerous authors in the field, it is typically not spelled out, even when the contributors have an impressive background in the discipline of philosophy and its application to debates about healthcare. On the other hand, philosophical health can best be understood as a logical development of the core insights of the movement for person-centred care (PCC).

I appreciate that exponents of PCC will initially have legitimate questions about the introduction of this latest ‘rhetorical addition’ to the discourse, just as health workers have raised legitimate concerns about the language of person-centredness in clinical contexts. We have seen that, by addressing such valid questions, we can generate fruitful exchange on underlying issues about the nature of health, science and value, as well as the relationship between health and our understanding of physical, psychological and social well-being (Loughlin et al., 2019). The conceptual borders between health and social care have effectively been challenged, with substantive implications for health education, policy and practice (Loughlin et al., 2015). The discussion of philosophical health represents a further opportunity to expand our understanding of what it means to treat patients ‘as persons’, as well as clarify and vindicate the significance of key components of the PCC lexicon, including ‘patient expertise’, ‘patient empowerment’, ‘shared decision-making’ and ‘values-based practice’.

To make the case for these claims, I will begin by identifying a common starting point for PCC and the PHI movement considering, in the first instance, what it is that they both reject. I will then use de Miranda’s statements on ‘philosophical health’ as indicative of the positive conception of health each view embodies. This sets the scene for a contrast between what I see as the two key alternative positions regarding the nature of person-centred care. Thus, when I set out my reading of de Miranda, I will do so with the specific goal of using it to inform the debate about PCC – ideally promoting further dialogue between participants in each debate.

Philosophical health and PCC: ‘Pragmatically attuned’ ideas

What, then, is de Miranda’s conception of philosophical health, and why do I regard it as a logical extension of the arguments for person-centred care? The emergence of these

academic movements represents a progressive development in our ongoing thinking about health and care: what they reflect is an important re-focussing on ideas that have never been entirely abandoned or forgotten in healthcare thinking and practice, but that have been somewhat sidelined in the modern era (Tyreman, 2020; Loughlin, 2020). Both movements can partially be defined with reference to what they reject. They represent a reaction against the dominance of ‘reductionist accounts of the person and the sort of narrow scientism that threatens to reduce both professional judgement and patient care to forms of technocratic “know-how”’ (Loughlin, 2014: 18). Scientism in medicine privileges causal, biomedical accounts of disease over accounts of health and illness based on human experience, regarding the latter as the phenomenal data to be fully and reductively explained with reference to the former. At the right point in history, this privileging represented real progress, as reductionist science delivered extraordinary advances in our understanding of bodily mechanisms. However, there are inherent dangers as methodological reductionism (entirely legitimate in certain areas of science) slips into philosophical reductionism – when focusing on the workings of ‘the parts’ leads one to believe that the whole does not exist, that the parts are all there ‘really is’. As will be explained in more detail, in biological science this frequently involves a shift from understanding the mechanisms at work within an organism to treating the organism itself as a mechanism (Tyreman, 2020).

This is a philosophical position that often does not identify itself as such, because its most strident exponents regard philosophy as a discipline irrelevant to all truly pragmatic discourse, enabling them to systematically equate the questioning of scientism with an attack on science (Colquhoun, 2011). Despite their unwillingness to subject their own underpinning assumptions to scrutiny, or to recognize them as philosophical in nature, the world view they presuppose can be articulated and subjected to appropriate intellectual interrogation (Loughlin, Bluhm and Gupta, 2017). As a consequence of doing so, defenders of PCC have argued convincingly that we have reached a point in intellectual history when we need to reintroduce more holistic understandings of organisms, persons and communities (Thornquist and Kirkengen, 2020; Parvan, 2020; Tyreman, 2020). Scientism now stands in the way of further progress. Indeed, prominent thinkers have argued that scientism’s insistence on a reductionist account of thinking and value renders it ultimately incapable of explaining the nature of scientific reasoning and the value of science itself (Popper, 1989).

What is the type of understanding that has been ignored or sidelined in the modern era but which now needs to be re-established as a central focus in healthcare? De Miranda (2022: 1) characterizes philosophical health as ‘a state of fruitful coherence between a person’s ways of thinking and speaking and their ways of acting, such that the possibilities for a sublime life are increased and the needs for self- and intersubjective flourishing satisfied’.

While there is plenty to unpack in this quotation, it is worth noting its significance in the context of the debate about person-centred care. The notion of ‘fruitful coherence’ is an interesting one, suggesting a focus on the need for integration between the different aspects of our humanity, if we are to realize our full potential. The employment of the Aristotelian notion of ‘flourishing’, linked subsequently to the importance of a ‘balance’ between our physical, psychological and social aspects (de Miranda, 2021: 4), suggests

that the realization of this human potential is being equated with living a healthy life. In the context of the debate about the nature of health, this is very much a 'positive' and holistic definition, a long way away from the traditional, negative biomedical definition of health as 'the absence of disease or infirmity' (Boorse, 1975: 60). The definition put forward by de Miranda takes the rejection of this approach as its starting point, building on the decades of debate that led to the development of person-centred approaches to health.

The emphasis on 'intersubjective flourishing' is also significant and reflects extensive arguments regarding relational and contextual accounts of personhood and their implications for the traditional distinctions between health and social care (Slagstad, 2020; Loughlin et al., 2015). De Miranda stresses that this notion of 'health' can be ascribed to a group as well as an individual, and in each case, it ensures that 'the goals and purposes of the whole are pragmatically attuned with its highest ideals while respecting the regenerative, plural, and possibilizing future of multiple forms of life' (de Miranda, 2022: 1).

As we will see, the most plausible accounts of a 'person-centred' approach to health and care stress the need for an explicit focus on the concept of flourishing and the corresponding need to construe human beings as subjects of a whole life, embodied agents negotiating their physical and social environments, attempting to preserve their identity and coherence in the context of an ever-changing world (Tyreman, 2020; Hamilton, 2020; Thornquist and Kirkengen, 2020). The methodology of breaking a subject down into its component parts fails when we are thinking about how to improve human health, as does the attempt to insist on any strict, ontological dichotomy between the social and the biological. As Richard Hamilton (2020: 101) notes, 'the whole human being is not a composite made up of biological and cultural bits' because 'culture goes all the way down, while biology goes all the way up'.

What is needed instead is what Ketil Slagstad (2020: 383) characterizes as 'a truly integrative approach where the social is biological and the biological social'. Slagstad's concern is that even the biopsychosocial model – designed initially to challenge the reductionist tendency in medicine – can function in health discourse to reinforce the conceptual dichotomies of the scientific system, such as 'nature versus culture, brain versus mind, somatic versus mental or hard facts versus soft sciences' (Slagstad, 2020: 376). There is always the temptation (in the context of our modern intellectual heritage, shaped by often unexamined scientific assumptions) to try to 'piece together' these components of our modern, fractured reality. Something more fundamental is required if progress is to be possible at this point in our intellectual history: the replacement of the dominant world view with a conceptual framework that does not fracture our shared, lived reality in the first place.

When we consider the 'science plus' account of PCC in the next section, it will be clear that it, too, is an attempt to 'piece together' the 'objective' and 'subjective' sides of the scientific world, rather than challenging its underlying dichotomies. The need to avoid the fragmentation of our lived reality, if we are to develop a proper understanding of health, is a key theme to be found in the contributions to the current volume by authors focusing on the debate about philosophical health. See, in particular, de Miranda's Chapter 17 in this volume discussing the need to get beyond

the ‘mind-earth divide,’ but also Laura McMahon’s discussion of embodiment and engagement (Chapter 6). Her argument that ‘our very identities are from the beginning and irrevocably intertwined with and shaped by others’ in a world where ‘things and others call out for our engagement’ strikingly evokes the arguments of authors such as Thornquist and Kirkengen (2020), for the relational conception of personhood central to the more philosophically radical approach to PCC discussed in the ensuing section of this chapter.

Thus, de Miranda’s holism, his emphasis on inter-subjectivity and the realization of diverse potentials are features of his account that resonate with the work of such thinkers as Tyreman, Hamilton and Slagstad. To any student of the philosophy of health over the last few decades, the most obvious point of comparison between de Miranda’s definition and the work of these theorists is its unequivocally value-laden nature. The oft-quoted negative definition of health as ‘the absence of disease or infirmity’ is invariably accompanied in biomedical reductionist literature by an account of ‘disease’ as a value-neutral term. It is the assumption of such influential biomedical theorists as Christopher Boorse that, however we (patients, practitioners and members of the public) use the term in the course of our ordinary lives, endeavours and practices, any adequate theoretical account of ‘health’ must explain what it ‘really is’ without reference to such ‘subjective’ ideas as ‘value’. Such work takes as its starting point a strict theory-practice divide, distinguishing carefully between the language of health and illness as used in the context of our subjective, human projects and a true, objective theoretical account of health and disease provided by science. For Boorse, it is the confusion between ‘the theoretical and the practical senses of “health”’ (Boorse, 1975: 49) that generates the conviction that health is a value-laden concept.

On his view, ‘illness’ is a value-laden term because it expresses the human experience of ‘disease and dysfunction’, objective processes whose true description is to be found in the ‘theoretical corpus’ of medicine: ‘a body of doctrine that describes the functioning of a healthy body’ and ‘classifies various deviations from such functioning’, identifying the causes of such deviations with reference to known forms of ‘disease’ (Boorse, 1975: 55–6). The underlying logic of this position treats ‘objectivity’ and ‘engagement’ as diametrically opposed, a stipulation that not only renders our understanding of other persons strictly impossible but which also ignores the fact that science is itself a practice, and that knowing, investigating and theorizing are definitively human (and social) activities (Loughlin, 2020: 27). As noted earlier, Karl Popper demonstrated that a framework based on such strict dichotomies cannot accommodate such things as ‘theoretical systems’, ‘problems and problem situations’ and ‘critical arguments’. As such, it cannot accommodate the normative structures that make scientific thinking possible (Popper, 1989).

With specific reference to ‘disease’, Alexandra Pârvan (2020: 104) argues that the ‘split between disease/body and person’ is so enshrined in modern biomedical thinking that it has become an ‘instinctive ontology’, not only for biomedical theorists but also for practitioners and patients. The achievement of health is equated with the identification and removal of a separate entity, the disease, that is treated as the cause of dysfunction. However, this instinctive ontology must be replaced if we are to meet the challenges facing contemporary health services, including the rise of chronic

conditions, co- and multi-morbidity and the pressing need to facilitate ‘health-within-illness’ – and ‘being healthy-with-disease’ – for persons living with a wide range of diagnosed medical conditions (Pârvan, 2020: 109). The alternative, person-centred ontology involves the revival of an idea dating back to antiquity, which can be found in the theological work of such thinkers as Augustine.

For Augustine, the term ‘evil’ does not refer to a real property of the world, a substance or entity existing in opposition to ‘good’. Rather, evil is a privation – the diminishment of that which is real, a failure to exist to the full (Menn, 2002). Similarly, Pârvan notes that something is identified as a disease because it is harmful to the whole being, to a particular person or community. This irreducibly evaluative concept of harm is essential to our understanding of the broad range of diseases identified in clinical practice. Disease is not an independent being, substance or ‘natural kind’ but a diminishment of the person. To understand what it ‘really is’, we need to understand the person, her full potential and what it means to live well within the context of that specific and unique life. When treating real people, we have to abandon the idea that there is an ideal state of ‘normal health’ to which they need to return, focusing instead on enabling them to realize their possibilities given their actual capacities and situation. This requires attending to their ideas and goals, their understanding of themselves and the relationship between their ideals, lives and habits.

In other words, what Pârvan (2020: 103) characterizes as the person-centred ‘method of working’ seems to incorporate what de Miranda would characterize as ‘philosophical counselling’: understanding the relationship between their ways of thinking and acting, with not simply the goal of ensuring consistency but with the aim of enabling them to realize their potential and to flourish. The concept of philosophical health is both compatible with and a natural development of the best work in PCC. Arguably, its explicit articulation could help to move the debate about PCC forward, by facilitating a clearer expression of the distinction between two dominant accounts of PCC, explaining why one of these accounts must be fully embraced and defended if the full, transformative potential of PCC is to be realized.

Two concepts of PCC

While the work of the thinkers cited earlier represents what I consider to be the most convincing and valuable expressions of PCC, as indicated in my opening comments, not all uses of the terminology reflect those I have been emphasizing in the preceding section. In this section, I will identify two ways of understanding the meaning and practical significance of a ‘person-centred’ approach to medicine and healthcare. I will expand on the account of the important work of Stephen Tyreman, building on his exposition of two alternative conceptions of person-centred practice and bringing out the relevance of the concept of philosophical health to the debate – in particular, seeing the introduction of this concept as a logical implication of Tyreman’s analysis.

On the one hand, PCC can be understood as ‘a humanitarian addition to good medical practice – considering the person’s personal needs and wishes on top of mending the body’ (Tyreman, 2020: 86). In contrast to Pârvan’s ‘method of working’,

this view treats PCC as ‘normal science plus’ the consideration of additional human, social and context-specific factors. Influential policy guidelines such as the ‘Grades of Recommendation, Assessment, Development and Evaluation (GRADE)’ framework (Mercuri and Gafni, 2020) address the need to ‘integrate’ such ‘subjective’ factors as the personal ‘values and preferences’ of recipients of healthcare into a biomedical account of clinical reasoning. As Tyreman (2020: 87) notes, this approach presents person-centredness as a ‘positive psychological adjunct’ to sound scientific practice, making the experience of health services more ‘bearable’ and potentially improving clinical outcomes. It poses no challenge to the dominant conceptions of science or the ‘instinctive ontology’ Parvan identifies. As such, it renders PCC a ‘merely desirable’ feature of clinical practice, providing no ‘theoretically compelling reasons’ to make ‘the person’ central to healthcare decisions when ‘the medical focus is primarily on the workings of the body’ (Tyreman, 2020: 87).

On the other hand, Tyreman’s preferred approach treats PCC as a ‘fundamental essential of good practice’, thus providing us with the ‘theoretically compelling’ reason to be person-centred that is missing from the ‘science plus’ account. This conception of PCC represents a call for a revision of the modern conceptual framework, including a philosophical reframing of the medical enterprise, raising underlying questions about nature, purpose, science and its relationship with value. As such, it represents an unapologetically philosophical account of PCC, grounded on the premise that ‘the holistic person is primal to understanding human health and healthcare’ (Tyreman, 2020: 86).

The attractions of the ‘science plus’ approach can perhaps best be explained by consideration of recent influential work on the topic of ‘values-based practice’, in particular the ‘two feet principle’ developed by authors such as Bill Fulford (2014) and Ed Peile (2014). I need to be careful in spelling out this point, though, so as not to mislead the reader unfamiliar with the work of Fulford and Peile. It is not my claim that they would endorse the ‘science plus’ position as characterized here. Given that its implications are strictly incompatible with their own account of shared decision-making, I’m actually certain that they would not. Rather, my discussion here serves as an illustration of a problem mentioned in the opening section of this chapter. Critics of PCC have focused on its interpretation and implementation in policy contexts, noting that the application of the terminology can be at odds with the progressive aspirations of its philosophical defenders – in particular lending support to consumerist arrangements and an ideology of ‘preference-driven healthcare’ (Arnold, Kerridge and Lipworth, 2020: 34).

As I have noted in response to such critics (Loughlin, 2020), this makes it imperative that we maintain a culture of inclusive critical reflection and dialogue, involving patients, practitioners and the broader public – with concerns about interpretation and application forming an important part of the ongoing dialogue. The understanding of ‘philosophy’ as something one does prior to practice, getting the theory accepted by policy makers and then instructing practitioners to ‘get on with’ its implementation represents a misconception of the theory-practice relationship (Loughlin, 2021). Thinking is not something we need to get ‘over and done with’ before launching into the ‘real world’ of practice; thinking (including philosophizing) is a practice. As de

Miranda (2022: 1) notes, philosophy – the reflection on our fundamental assumptions and conceptions that frame our every thought and action – is not something engaged in only by a small group of academics: ‘any human being possesses philosophical beliefs, intellectual allegiances, and conceptual concerns, even if not yet fully explicit or compossible’, and the role of philosophical dialogue is to render those underlying allegiances explicit. Failing to engage in this sort of critical reflection is to ‘allow one’s ideas and attitudes, and ultimately one’s behaviour, to be shaped by forces which one fails even to perceive, let alone control’ (Loughlin, 2002: 16).

Returning, then, to the influential ‘two-feet’ principle, while its defenders do not wish to challenge the traditional, Humean philosophical distinction between ‘facts’ and ‘values’, they are keen to stress that clinical decision-making stands on the ‘two feet’ of ‘facts *and* values’ (Fulford, 2014: 11). Fulford argues that the movements for evidence-based medicine and values-based practice are not ‘in opposition’ but rather they are ‘partners’. Citing the work of one of the founders of the evidence-based medicine movement, David Sackett, he asserts ‘the need for a “two feet” “evidence *plus* values” approach to health care decision making’. Peile (2014: 20) puts the point as follows: ‘Whereas, arguably, any decision involves some, usually inexplicit, consideration of evidence and values, it is the professional obligation to explicitly consider both the relevant scientific evidence and the values of the individual patient that distinguishes clinical reasoning.’

The work by Sackett and colleagues that both authors cite characterizes ‘patient values’ as ‘the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient’ (Sackett, Straus and Richardson, 2000). One natural reading of this principle, then, suggests that what the clinician supplies to the decision-making process is the ‘objective’ side of the equation – knowledge of ‘the research evidence’ plus ‘clinical expertise’ – while what the patient supplies is the ‘subjective’ side: the ‘values’ that Sackett equates with ‘preferences’.

It is easy to see how this account of PCC or, as Fulford (2014: 8) prefers, ‘person-values-centred-care’ could be interpreted as providing the basis for a consumerist, ‘preference-driven’ approach to healthcare (Arnold, Kerridge and Lipworth, 2020). As Yves Aquino (2017) observes, in numerous countries, increasing numbers of Asian women have been requesting ‘big-eye surgery’ – surgical intervention to make the shape of the woman’s face resemble more closely that of Caucasian women. If this is the individual’s expressed preference, does it follow logically that the clinician is respecting her personhood and giving her proper, person-centred care by meeting this demand? If the clinician’s role is simply to supply clinical knowledge and expertise, and it is the patient’s role to supply ‘the values’, then the answer would appear to be a straightforward yes. In that case, what we have is a version of PCC that replaces a crude form of medical paternalism (where the clinician determines what is best and the patient complies) with a form of consumerism that reduces the clinician to the provider of the medical goods and services that the patient ‘demands’.

This model is associated with simplistic readings of ‘patient expertise’ and ‘patient empowerment’: the evidence for what is best for the patient is whatever she says she wants, and the way to empower her is to provide what she requests. Yet cases such as

this bring out the difficulty in drawing credible boundaries between psychological and social issues, between ethical and broader political concerns and between the health and well-being of individuals and groups. As Aquino argues, aesthetic judgements can reflect ingrained stereotypes reflecting prejudiced and oppressive attitudes. Real patient empowerment in this case might well require challenging the racist and misogynistic culture and campaigns driving the demand for this sort of intervention – the entrenched attitudes and social arrangements that make large numbers of women feel they are inherently inferior because they do not conform to a stereotype of the ‘ideal’ female appearance. In such a context, to agree to meet the demand is to risk further entrenching the aesthetic prejudices that damage the health of entire groups of people.

Does this mean we have to abandon the goal of empowering individuals, or indeed the very idea of patient expertise? Not at all. You do not respect or empower someone simply by asking them what they want and making a record of their answer. You treat them as an equal by *engaging* with them. This means entering into a dialogue: discovering their ideas and values, attempting to understand what matters to them, being prepared to question and challenge the claims they make. Mary-Clair Yelovich (2020) provides an impressively clear and detailed account of what this involves in the clinical context, and the sort of ‘interactional expertise’ the genuinely person-centred practitioner needs to develop. Understanding the broader context of the patient’s life involves much more than simply inviting her to select between available interventions – a simplistic approach that of course reflects a consumerist framework. It requires a full, human conversation, learning from her expressions of her own needs and suffering and the meaning she ascribes to her experiences (Yelovich, 2020: 336). The recognition of her expertise requires the realization that, in addition to the clinical evidence available, this personal interaction with the patient is an indispensable source of evidence in the development of a treatment plan. The goal is to arrive at a shared decision that respects the personhood of both parties.

Yelovich’s account of interactional expertise clearly resonates with de Miranda’s explanation of the nature and goal of philosophical counselling. As noted earlier, the goal of ‘fruitful coherence’ is explained within the context of meeting the person’s needs for ‘self- and intersubjective flourishing’, not simply as the quest to establish a consistency between their ways of speaking, thinking and acting. Suppose the person seeking ‘big-eye surgery’ explained that she really had internalized the philosophy that members of her racial group were inherently inferior, and this is why she is taking action to change her appearance, so that it can at least approximate more closely to that of the superior race. It is certainly my hope that the philosophical counsellor would consider that an important stage in the quest to identify the problem, not a satisfactory ‘solution’ and the conclusion of the dialogue (‘Consistency achieved – next patient!’). Value neutrality is not an option for anyone seriously working to improve human health, any more than we can avoid having any particular underlying commitments regarding ontology and epistemology. The best we can do is to be as clear as possible about the values and underlying assumptions that inform our own practice (Loughlin, 2002; Loughlin and Miles, 2015). This is why some authors are advocating a training in philosophy as a crucial part of the education of health professionals (Milgrom, 2021).

What we need, then, is the more radical, philosophical reframing that Tyreman associates with the second, ‘theoretically compelling’ basis for PCC. He puts the point in a characteristically engaging way, arguing that the time has come for us to ‘put the organic horse back in front of the mechanical cart’. The tendency to reduce the world to its ‘building blocks’ (Tyreman, 2020: 87) has indeed facilitated progress in our understanding of bodily mechanisms, but the machine metaphor has to be recognized as just that: a metaphor, not a philosophically sound reductive account of human nature. Organisms are essentially whole at all stages of their development. Machines, in contrast, are not whole until assembled from component parts. Referencing process philosophy (an influence also cited in de Miranda, 2022: 4), Tyreman notes that organisms are ‘always in transition in response to the ever-changing environment’. Framing our understanding of humans in this way gives us the basis for an understanding of biological processes with reference to the broader ideas of purpose, meaning and narrative that define our personhood. Ultimately, our understanding of the role of the mechanism is dependent on an underlying understanding of its role in this whole process.

Persons are constituted by ‘their unique set of experiences together with a narrative that interprets and gives meaning to them’ (Tyreman, 2020: 86). Far from being a curious ‘add-on’ to our concepts of physical and psychological health, it would seem, then, that the idea of philosophical health is the logical implication of the only credible account of person-centred care. The work on ‘engagement’ and ‘meaning-making’ published in this volume can be understood as an important development of this ongoing project. It is only by understanding the nature and meaning of a specific person’s unique narrative that we can assist them in realizing their human potentials, within the context of the complex and distinctive problems encountered on the specific journey that is that individual’s life.

What is more, the focus on the individual’s life does not require a form of ‘individualism’ associated with consumerism. Our concept of the person is relational. The dichotomy between understanding each person as unique and seeing each person as a member of a community (indeed, with an identity defined by her/his/their environment) is another conceptual divide that a philosophically informed conception of PCC should challenge. Just as we do not need to reject science to reject scientism, we do not need to abandon respect and concern for the individual to reject individualism. Indeed, a proper account of the good of the individual requires understanding her/his personhood as an ongoing interaction with the world, including communities, humans, non-humans and the natural environment. For the flourishing human being, to be is to be engaged.

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