UNIVERSITY OF WEST LONDON
The Career University

UWL REPOSITORY

repository.uwl.ac.uk

Person centered care: advanced philosophical perspectives

Loughlin, Michael ORCID logoORCID: https://orcid.org/0000-0002-2234-2146 (2020) Person centered care: advanced philosophical perspectives. European Journal for Person Centred Healthcare, 8 (1). pp. 20-33. ISSN 2052-5656

http://dx.doi.org/10.5750/ejpch.v8i1.1817

This is the Published Version of the final output.

UWL repository link: https://repository.uwl.ac.uk/id/eprint/7257/

Alternative formats: If you require this document in an alternative format, please contact: open.research@uwl.ac.uk

Copyright:

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy: If you believe that this document breaches copyright, please contact us at open.research@uwl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

Rights Retention Statement:

EDITORIAL INTRODUCTION

Person Centered Care: Advanced Philosophical Perspectives

Michael Loughlin PhD

Professor of Applied Philosophy & Co-Director, European Institute for Person Centred Health & Social Care, University of West London, London, UK

Keywords
Clinical reasoning, evidence-based medicine, health discourse, health policy, history of ideas, knowledge, person-centered care, philosophy, theory-practice gap

Correspondence address
Professor Michael Loughlin E-mail: michael_loughlin@ymail.com

Accepted for publication: 17 November 2019

Introduction

> "Clinical medicine involves interacting with and understanding persons, and thus addresses a problem that is fundamentally different from and conceptually more complex than the kind of reasoning involved in problems such as mathematical calculation or measuring the masses of chemical isotopes" [1].

What is person-centred care? Do we want health and social care to be more person-centred, and if so, how do we go about making it so?

With the exception of the final "how to" component of the previous sentence, these questions might seem too obvious to deserve a serious answer. Surely, it makes sense to put persons at the centre of care. As the authors of the second chapter in this new volume note [2], the claim that good treatment must be person-centred sounds close to tautological. However, as these authors, and indeed any readers familiar with the history of healthcare discourse and practice know, the devil really is in the detail.

The ideas and terminology of person-centred care (PCC) have been part of health discourse for a very long time. Arguments that in healthcare one treats the whole person, not her/his component parts, date back at least to antiquity [2-4] and the need to treat the patient as a person is articulated persuasively by clinical authors in the early twentieth century [5,6]. Yet it is only in recent years that we have seen a growing consensus in health policy and practice literature that PCC, and associated ideas including patient expertise, co-production and shared decision-making, are not simply "fine ideals" or "ethical add-ons" to sound scientific clinical practice, but rather they represent indispensable components of any genuinely integrated, realistic and conceptually sound account of healthcare practice [7,8]. Policy documents, training manuals and professional practice guidelines [9-15] recognise both that a "person-centred" approach to care is essential, if we are to respond adequately to the problems that confront us, and that it requires a "fundamental shift in how we work alongside patients and individuals" [9].

So what, precisely, is the nature of this "fundamental shift" and how is it to be achieved? The answers to these questions are by no means obvious [9,16]. Certainly, the rise of multi-morbidity and chronic, socially complex conditions has been identified as requiring a shift in focus to concerns about the complexity and uniqueness of health and social problems [9,16-18]. A growing awareness of the problems of epistemic injustice and the marginalisation of the perspectives of large groups of people, in processes that directly affect their wellbeing, is also a major motivation for change [19-22]. Typically, calls for PCC or "the personalisation of care" [9,16] appear alongside a host of apparently related terms, including "patient-centred care", "relationship-centred care", "patient empowerment", "patient engagement" and "self-management" - all terms used with apparently overlapping but also shifting meanings in the literature [7,23]. They are frequently associated with calls for a conceptual revision of our thinking about health and social care, redrawing the boundaries of these core concepts such that "health" cannot be understood in isolation from such ideas as social wellbeing and personal autonomy [24].

As the language of "person-centredness" increasingly permeates discussions of the future of health services, the need for its critical analysis becomes more urgent. There is an unfortunate history in heath policy and practice of transformative ideas being foisted upon organisations, practitioners and patients, without those charged with the task of implementing the transformation being given a clear account of what the ideas really amount to, let alone their implications for practice or the cultures they are explicitly designed to change [25]. It has been deemed appropriate for major "organisational change" projects to be "operationalised" before being "fully conceptualised" [26], in the apparent hope that a shared understanding and

beneficial implementation of the core ideas would "evolve". A predictable consequence is the privileging of rhetoric over substance in practical debate, sometimes undermining the critical and transformative ambitions that advocates of the approach began by articulating [25,27,28].

The underlying conviction of this volume - one belief that, despite their differences, unites all of its contributors - is that PCC should not become the latest "revolutionary" concept to be "operationalised" before being "conceptualised". It is imperative that we develop an open and inclusive dialogue about what we do and do not mean by "person-centred" to inform our attempts to implement PCC. This will of course require time and effort to take full effect, and it will involve numerous dangers: as several contributors to the volume note, PCC can be linked to a range of ideas and ideologies, not all of them contributory to progress in health and social care. But the history of ideas teaches us that practices do change, ideas that were once obscure or peripheral can become central to our thinking and practice - and indeed ideas that have fallen out of fashion can be recognised as essential to further progress [29].

The very beginning of this indispensable process is the act of investigating the underlying assumptions of PCC. Only by doing so can we hope to discover shared meanings - or, alternatively, to make transparent the nature of our differences, as the first stage to determining how to resolve them. This volume brings together leading authors in the field from a broad range of academic and practice backgrounds to provide a comprehensive review of current thinking about PCC and related concepts. Its contributors include major critics of PCC as well as its steadfast advocates. The sheer diversity of the contributions reflects the complexity of the issues and challenges we must confront if we are to advance our understanding of PCC and to realise its progressive potential. As the clinician who supplied the quotation featured at the start of this editorial observed, interacting with and understanding persons requires a firm grasp of scientific reasoning, but it also requires much more.

In their efforts to characterise what "more" is needed, authors challenge us to re-evaluate the nature of and relationships between knowledge, evidence, meaning, value, patient experience and the social context of care, as well as the social context of research and knowledge production. Chapters address the relation between scientific thinking and broader conceptions of human reasoning, practical wisdom and epistemic hierarchies, biomedical reductionism, the ontology of health and disease and the relationship between PCC and evidence-based healthcare (EBHC). Authors examine our understanding of causality as it informs both PCC and EBHC, the role of complexity and function in our broad understanding of health, the distinction between organisms and mechanisms, as well as the epistemic role of narrative, the nature of personhood and agency, epistemic injustice and shared decision-making. Several chapters focus on the specific problems of being person-centred in the context of mental healthcare, while others alert us to the political and ideological aspects of the debate, with reference to consumerism, neo-liberalism and the economic context of current health service delivery. While none of these contributions, individually or collectively, represents the "final word" on the philosophy of PCC, they do give us the basis for an intellectually serious assessment of the concept's scope, limitations, and potential to influence practice for the good. Perhaps most importantly, the reader's interaction with the arguments and counter-arguments presented will better equip her to assess and where necessary challenge claims about the extent to which her own practice or treatment can be meaningfully characterised as "person-centred".

Rhetoric, meaning and context: how to bridge the theory-practice gap?

The book is an extended exercise in critical thinking about the meaning and value of PCC. It is entirely appropriate, therefore, that Arnold *et* al, [2] offer an insightful critique of person-centred healthcare (PCH) and associated ideas, including patient empowerment. Noting the problems with contemporary attempts to implement PCC/PCH[1], Mark Arnold, Ian Kerridge and Wendy Lipworth are careful to distinguish numerous "rich and varied" philosophical constructions of PCH from PCH as "defined and implemented in clinical, institutional and public policy" [2]. The philosophical accounts "build from complex ideas about humanism and identity" and many have progressive aspirations, including "exposing the power inequalities in Society and in healthcare". These accounts, they stress, are not the target of their critique, and they even suggest that "the phrase 'person-centred' may be worth retaining". However, they note that the underlying commitments of such accounts to core philosophical ideas such as patient autonomy and the right to self-determination, when combined with "the lack of definitional clarity regarding its meaning or practical applications", can lead to the conflation of PCH with "consumer-driven healthcare". They proceed to offer an effective critique of consumerism in healthcare and challenge authors of the philosophical accounts "to consider how these accounts are being (mis)represented in practice and consider whether PCH in its hypothetical form can in fact be translated meaningfully into practice given the constraints of existing practices, structures and attitudes".

Their chapter reflects concerns mentioned above (articulated by advocates as well as critics of PCC) and spelled out in more detail elsewhere [25,30-32]. There is a sense in which academic movements can become 'victims of their own success': the terminology of a movement can become widely adopted by governments and policy organisations, but the price paid for this is the *de facto* dilution of its substantive meaning and associated loss of critical potential. The most striking precedent is that of

1 Some authors use the abbreviation PCC, preferring to talk about person-centred 'care', while others use PCH, preferring to talk about person-centred 'healthcare'.

"evidence-based". As numerous authors have noted, the language of "evidence-based", originating in a paper proposing "evidence-based medicine (EBM)" as initiating "revolutionary" changes to the teaching of clinical practice [33], has migrated from its initial context, to become embedded within professional and organisational discourse in a vast range of areas: "Most professional societies, the public, and funding agencies have accepted EBM with remarkable enthusiasm. The concept of evidence-based practice is now applied in management, education, criminology and social work" [34]. Some authors celebrate this migration, and the linguistic shift from EBM to broader notions of evidence-based healthcare and evidence-based practice, demonstrating that EBM has "evolved", "so much" and "so rapidly", "spreading like fire" to "guidelines, manuals, training days, seminars and workshops … across the globe" [35].

Others are less celebratory.[2] They note that the dissemination of the language of evidence-based practice has been accompanied by unacceptably wide variation in its implementation and "misappropriation" of the "evidence-based brand" by "vested interests" [27]. It has led to care that is "management driven rather than patient centred". Such consequences, the authors argue, were never intended by the founders of EBM [27]. They represent the spread of the rhetoric of "evidence-based" in the absence of a clear explanation of (or agreement on) its substantive import and implications for the real challenges and controversies facing health practice [25,28,36].

There have, of course, been numerous attempts to overcome the lack of clarity, bridging the theory-practice gap for EBM, and more recently giving an indication of how EBM can integrate a key concern driving the movement for PCC: the need to incorporate a serious consideration of the "values and preferences" of those receiving healthcare into any defensible account of clinical decision-making. As the authors of our third chapter, Mathew Mercuri and Amiram Gafni [37] note, the "Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) framework" is an attempt to produce evidence-based clinical recommendations that can not only guide practice but, *via* "the inclusion of values and preferences into the EBM framework", can make the practice of EBM "more person-centered".

Unfortunately, their detailed analysis reveals that the understanding of "values and preferences" within the GRADE framework is far from clear: "how one defines, measures, and uses information regarding values and preferences to determine the best treatment option for a patient, when practicing EBM" is effectively left to the user of the framework to determine [37]. The authors of GRADE offer no clear account of the notions of value and preference (or of the distinction, if any, between these key concepts) and the reliance on information about what the "typical" patient prefers suggests a mindset grounded in population-level studies, unlikely to take into account a core concern of defenders of PCC, that each individual's specific life context is relevant to determining the best course of action in any particular case.

Unsurprisingly, there is no substitute for conceptual clarification if theory hopes to provide a coherent and demonstrable basis for practice. If PCC is to avoid the "crisis" afflicting the EBM movement [27] then its defenders must rise to this challenge. While Bill Fulford does not dispute the need for conceptual clarification, his chapter resists the characterisation of the problem as a "lack of definitional clarity", arguing that the search for a definitive account of PCC is misguided [38]. A different kind of underlying "philosophical field work" is needed. Citing the methods of "ordinary language philosophy", Fulford argues that we understand the meanings of terms not by searching for definitions but by systematically examining their use in context, with a view to mapping a term's "logical geography". This method is particularly appropriate for what he calls "higher level" concepts, including "person" and "care".

Fulford illustrates his approach with reference to two influential articles on PCC. Construed as offering definitions of PCC (which is how the authors of each piece characterise their work) they are incompatible. However, analysed by the methods of ordinary language philosophy, these distinct approaches "become fully complementary", and the result is not "conceptual chaos", but rather "a more complete understanding of the meaning of person-centred care that in turn offers a more effective basis for implementation" [38].

While I agree with Fulford that distinct accounts can reveal what he calls different and compatible "aspects" of PCC, in the fifth chapter I argue that the goal of mapping the usage of the key terms is indeed necessary, but 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 [39]. I note that Fulford evidently agrees with Arnold *et al*. [2] that consumerist accounts of PCC are not legitimate - or to use his word, "genuine" - applications of the terminology of PCC. He argues that "genuine" PCC provides a proper balance between the "extremes" of paternalism and consumerism. This language is clearly normative, going beyond what Fulford characterises as the "empirical" exercise of mapping uses.

The language of PCC - like that of "evidence" and "ethics" - "is not simply diverse, it is *contested*" [39]. Fulford clearly would not support forms of PCC which involve transforming the "patient" into a "customer", thereby endorsing the sort of consumerism denounced by such authors as Yves Aquino [40]. The patient might indeed say she wants "big-eye surgery", for example, but it does not follow logically that we respect her personhood or give her proper, person-centred care by providing it. Real patient empowerment in this case might well require challenging the racist and misogynistic culture and campaigns advanced as driving this demand [40,41]. The exercise of "mapping logical geography" might help "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" [39].

2 Again, notably, they include some regarded as critics of EBM/EBHC and others identified as its staunch defenders.

In the sixth chapter, Nicola Blunden and Gideon Calder address some of these challenges [42], discussing the key political and ideological concerns raised by Arnold and colleagues, in particular their worries about social context and the extent to which PCC can "be translated meaningfully into practice given the constraints of existing practices, structures and attitudes" [2]. Focussing on the economic concept of co-production, they accept that in a political context that can be broadly characterised as "neo-liberal," both co-production and PCC "may be articulated or endorsed in ways which run either with the grain of neoliberalism, or against it" [42]. The original, core values of PCC are (as Arnold *et al*. [2] imply) compelling, but also often at odds with an instrumentalising, target-focused, commodified, transactional culture of care. While not "inherently immune to absorption into neoliberal institutional logic", both co-production and PCC can provide practically realisable ways of "subverting and circumventing" those aspects of neoliberal culture least hospitable to person-centredness in the institutional setting. This, they argue, requires "a retrieval of the explicitly political nature of both, in the sense that they depend on and contribute to the kinds of space for contestation and deliberation about the good - or 'substantive ethos' - which neoliberalism seeks to deny" [42].

Their important analysis is followed by a series of chapters that further expand the debate, arguing convincingly that PCC provides us with a great opportunity: to make explicit what are in fact much needed revisions to our conceptual framework, to our understanding of what the human organism is (ontology), the nature of knowledge (epistemology) and its relationship with ideas such as purpose and value. Authors focus on aspects of the 'modern' world view - in particular the "reductionism" assumed by much of biomedical science, once a cause of much progress but which is (so the authors argue) now standing in the way of further progress in terms of our treatment of real people in real contexts.

Conceptual foundations: rejecting false dichotomies

In a characteristically inspiring contribution, the late Stephen Tyreman distinguishes two ways of understanding PCC - asking whether it is "a humanitarian addition to good medical practice" or "a truly fundamental essential of good practice" requiring a fundamental shift in our understanding of the human creature [43]? If we take the former option, then PCC is simply a matter of considering a person's "needs and wishes" in the course of a project whose primary goal remains applying science (as currently understood) to the project of "mending the body". This understanding of PCC (reminiscent of GRADE's incorporation of "preferences and values" into EBM) gives us "merely desirable", but not "compelling", reasons to be person-centred.

In contrast to this more modest view, Tyreman's understanding of PCC is philosophically far more radical: "Human beings, like all living creatures, are organisms not mechanisms." The crucial differences between the two have been recognised for many centuries (and are explained in texts in ancient philosophy), but in the modern era "medicine has largely focused on body mechanisms for its theory and practice". He recognises that the modern era "has seen dramatic increases in knowledge and technological innovation" and a consequence of this has been a "further focus on the body as a machine and a failure to consider the implications of the organism for human health". Despite this historical association of mechanistic reasoning with progress, Tyreman argues that at this point in intellectual history we need to "put the organic horse back in front of the mechanical cart", to rediscover insights that have been sidelined (if not entirely forgotten) in modern times.

The chapter explains with great clarity the significance of this conceptual shift for our understanding and treatment of health problems. Organisms are "essentially whole at all stages of their development" (in contrast to machines that are not whole until assembled from component parts) and "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.

Tyreman's approach is complemented by Richard Hamilton's impressively detailed and theoretically rich analysis of a very broad range of biological and social scientific discourses and disciplines relevant to the "nature-culture dichotomy" [44]. Only by understanding the history of ideas that led to the development of this dichotomy can we "overcome" it, to develop an understanding of "the person as organism" capable of meeting what Hamilton (citing di Sarsina and Tassinari) sees as the key challenge confronting medicine in the current era: how to "broaden our concepts of science and medicine to investigate and heal the human being as a whole in a scientific way?"

For Hamilton, the "starting point" for this vital enterprise is the recognition that "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". Persons cannot be divided in this way because they are "not discrete objects." Just as Tyreman cited the process philosopher Whitehead, so Hamilton argues that we need a radical conceptual shift in our understanding of persons, seeing "personhood as itself one process among many" [44]. Once this shift is accomplished, "the existence of genuine agency becomes less of an anomaly than it is on most standard accounts" - the perceived need (demonstrated by Hamilton's detailed history of ideas) to "explain away" agency is based on an implicit picture that embodies "a false contrast between organisms as hapless objects acted on by forces beyond their control and a supernatural conception of human persons mysteriously transcending the natural world".

Our ninth chapter focuses not on the nature-culture dichotomy but on a related distinction, between the person and his or her disease. Like Tyreman, Alexandra Pârvan considers a common understanding of PCC as a

humanitarian addition to healthcare practice, requiring practitioners "to show concern, human kindness or personal involvement in a case" [3]. She contrasts this to her favoured conception of PCC as "a *method* of working," built upon a rejection of what has become an "instinctive" ontology for many practitioners and patients - the "split between disease/body and person". No matter how empathic and scientifically competent the professional may be, no matter how resolutely she refuses to "reduce" the person to a disease category, until this ontology is revised, she will fail to practise in an effectively person-centred way, directing treatment to a "bordered disease entity ... which is contained in the person." This implicit "substantialisation" of disease, treating it as a distinct entity "residing in" the person, inclines us to conceptualise the quest for health as the search for the most effective ways to "remove" or eliminate the disease entity, with the goal of restoring the patient to full health.

With reference both to real cases and an insightful analysis of the history of our thinking about the ontology of health and illness, Pârvan shows both the limitations of approaches based on the "instinctive" ontology and the potentials of a person-centred approach based on an alternative ontology. Only by rejecting the view of disease as a "natural kind" can we revise both research and practice to develop an approach that treats people as individuals, understanding their needs and health status within the context of their specific and unique lives. The chapter explains the crucial experience of "being healthy-with-disease" and its liberating potential for persons living with a wide range of diagnosed health conditions.

Harald Walach's chapter on "the materialist stance of biomedicine" [45] uses the term "materialist" in a way that is equivalent to how other contributors use the terms "reductionist" [46] or "physicalist" [43] to contrast a mechanistic understanding of health, illness and disease with a "fuller, humanistic account of life and disease, illness, suffering and healing" [45]. He uses the current popularity of complementary and alternative medicine (CAM) to argue that there is something missing in conventional healthcare that patients who turn to CAM are seeking. While there is a distinct difference in tone to the chapter by Hamilton (who associates CAM with an "obscurantist hostility to scientific medicine and an openness to untried and possibly dangerous alternatives" [44]) both would agree that its popularity requires explaining with reference to what conventional medicine is currently failing to provide, and there is in fact a remarkable similarity (despite their different starting points) in their analyses of the history of medical and broader scientific thinking that has brought us to our current position.

Walach characterises the dominant approach (as does Sturmberg, to follow) as a "paradigm", and the chapter includes a very helpful section on the use of this terminology in debates about medical epistemology. He identifies what Tyreman would characterise as the dawn of the "modern" era with the 17th Century philosophy articulated most powerfully by Rene Descartes, who postulated that all animals are, quite literally, machines [45]. As Hamilton observed, Descartes escaped denying the obvious fact of our own consciousness by regarding it as something which "transcends" the body[3] and, like both Tyreman and Hamilton, Walach recognises that this modern paradigm gave rise to extraordinary advances in mechanistic understanding. This is because a paradigm "steers the collective attention and effort of the scientific community", leading its members "to expect certain things rather than others, to focus on some aspects and to neglect others". As such it "directs attention, resources and effort" and "thus partitions the world into worthwhile and negligible aspects". This direction of our collective focus will of course have limitations as well as advantages, causing us to ignore or explain away phenomena that might otherwise simply be treated as obvious features of our world.

For Joachim Sturmberg, the key distinction between the current, dominant paradigm and the emerging, person-centred paradigm, is that the former treats health and disease primarily as "structural phenomena", while the latter regards them as "ecological phenomena", the result of "complex adaptive physiological dynamics within the person" [4]. In a chapter that integrates ideas endorsed by the authors of each of the previous four chapters, Sturmberg argues that the prevailing "structural mindset" is based on finding the "seat of disease" to deliver "cure-focused care". While this is undoubtedly appropriate in some cases, the current complexity of health problems requires a shift to a more "functional mindset," conceptualising health and disease with reference to "a dynamic response to constantly changing demands," understanding the "interdependencies between the particulars of this person's internal regulatory networks and his external environment". The subtle but vital shift from "looking at disease as a problem in the person" to seeing it as a "problem for the person to adapt to" can facilitate a "return" to our "healing roots", enabling a proactive approach to "achieving" and "maintaining" health across the life stages in contrast to the dominant "reactive" approach.

The chapter considers the implications of the paradigm shift for health policy, addressing issues discussed by authors in the previous section, regarding consumerism and prevailing neoliberal social and economic doctrine, and raising questions about value as conceived in market terms and with reference to the common good [4]. Sturmberg concludes that the new paradigm will render the question of whether medicine is "an art or a science" strictly meaningless, founded on a dualistic divide and reductionist focus that needs to be abandoned if progress is to be possible.

Our twelfth chapter includes a wonderful illustration of this broad approach to understanding and treating a particular case [46]. Eline Thornquist and Anna Luise Kirkengen urge their fellow clinicians and researchers to reframe their thinking, to "strive for a view that takes human conditions seriously and links subjectivity and sociality to the body." Such a reconceptualisation is "a fundamental premise for both superseding traditional dichotomies between matter/mind and nature/culture" and for "replacing the compartmentalization of the body" with a more integrated, genuinely holistic view of persons. The

3 Hence Ryle's phrase "the ghost in the machine" [47].

idea of a purely "biological body" is a construct that may have served the development of certain medical specialities, but only the concept of "the lived body" can enable us to recognise and respond adequately to the realities of health and illness.

The authors make astute use of the concept of "integrity", which since the work of Aristotle has been central to understanding the links between physical and personal aspects of our humanity, noting that "an ability to differentiate between self and endangering other is manifest on all existential levels, from the cellular to that of personhood". Social life is "an embodied affair," and they offer a vivid illustration of the significance of this claim with reference to the real case of a person presenting as "medically unexplained" but nonetheless with manifestly real and serious problems. The failure of traditional medical methods to understand this person's suffering brings out the fundamental importance of recognising that human beings "live in a world of meaning, and that this is not an additional matter - a 'human' appendage to the 'real' clinical practice and research work, but the very basis of both." The ontology they defend, which "recognizes and takes account of the body as being - simultaneously - a biological phenomenon and an experiencing and expressive socio-cultural being", requires us to re-evaluate other conceptual dichotomies, including the distinction between epistemology and ethics. The divide, which as they note is central to positivist approaches that have influenced thinking in medical epistemology, between "objective knowledge" and "subjective value", is unsustainable if we are to understand human beings, giving rise to the urgent need to develop "an ethically informed epistemology in medicine and the health care sector". These points will be taken up in detail by the chapters in our next section, on value.

Integrating knowledge and value

James Marcum's chapter provides a refreshingly radical challenge to the reductionist and scientistic frameworks criticised by our preceding authors. His "Axiological Analysis for the Role of Values in Person-Centered Healthcare" [48] incorporates a detailed exposition of the role of not only epistemic and ethical value, but also aesthetic value in an account of person-centred reasoning and decision-making in practice. Marcum grounds his analysis in a specific conception of personhood which identifies the human good with the "flourishing of each individual person within a community," incorporating the realisation of our definitively human potentials, including "self-transcendence", "truth-seeking", "interpersonal communion and love".

The concept of value is explained with reference to normative commitments, definitive of rational agency. For instance, the commitment to truth and understanding provides the foundation for logical and analytical reasoning, without which the human activity of science is impossible [48].[4] The activity of care requires a fundamental commitment to the value of human dignity, "the chief value that drives PCH". Marcum argues that in addition to these epistemic and ethical values, the aesthetic value of beauty is an essential component of our understanding of health and care. It is worth noting that he distinguishes this concept from the highly questionable considerations of "beauty" alluded to above (with reference to the demand for "big eye surgery"). For Marcum the quest for beauty is not about "cosmetic surgery", but rather it is a fundamental component of our understanding of order, meaning and wellbeing, the grounding of our ability to look at a human being as a "flourishing whole". Like other contributors to this volume (most notably Pârvan) he argues that our ability to practise well and to perceive the value in the lives of others involves the utilisation of our aesthetic or "artistic" capacities, which are inseparable from our ability to understand order and structure in the world.

The chapter co-authored by Jean-Philippe Pierron and Didier Vinot succinctly explains the need for a systematic account of the meaning of "value" in PCC, noting that "the world of care is a world structured by and saturated with values" [50]. While we can distinguish empirical from normative enquiries, we cannot have adequate knowledge of any complex area of human life without an integration of both, because human life is "a normative activity". The authors characterise health economics as "a normative scientific discipline", but echoing the concerns of other contributors, including Arnold *et al.* [2], Blunden and Calder [42] and Sturmberg [4], they note the temptation to effectively reduce all value to market value in health policy and management. The attractions of what they call "economism" in an organisational context are obvious, and have led to the development of such "scientific" methods for measuring the value of care as the "QALY" (Quality Adjusted Life Year). As they argue, such "economism" helps organisations to demonstrate "value for money" to funders, but in the process "problematically simplifies the world of care" and imposes its method of evaluation as "the" method [50]. Health economics fails to "measure correctly the value of person-centred care" because "the latter amounts to a rupture with the underlying anthropology of *homo economicus*, which presides over the omnipresence of analyses in terms of cost and benefits".

Far from this making PCC "unrealistic" in the context of current care systems, the authors suggest it is a needed response (or part of such a response) to an emerging "crisis" in Western social systems. The causes of the crisis are numerous and include "deficiencies" in systems of social protection, "the increase in the duration of human lives" and "the growth in the number of chronic illnesses" [50]. These elements "call for a reform of the system" and methods of evaluation that incorporate the plurality of the values of care. That said, the authors are clear that this process is extremely challenging, because the values to be

4 As others have noted [29,49], conceptions of "objective science" that reduce all value-commitments to subjective preferences undermine the rational basis of science itself.

incorporated are not only diverse but potentially contradictory - including agency and individual autonomy, community values and professional values, ranging from the values of truth and objectivity in biomedicine to conceptions of social justice and organisational efficiency. The training of carers requires "new skills" to help confront the ethical challenges and paradoxes inherent in contemporary practice.

The fifteenth chapter, co-authored by Jens Gaab, Marco Annoni, Charlotte Blease, Heike Gerger and Cosima Locher, builds on ideas evident in the work of Sturmberg and others, regarding homeostasis, the complexity of the organism and "its organization with and within fellow organisms" [51]. Their goal is to develop an analysis of what we mean by "treatment", with reference to what should be achieved by treatment and how it is achieved. They argue persuasively that a conceptually adequate account of "good treatment" must incorporate "biological, psychological and social treatment constituents in the context of ethical considerations", proposing a "biopsychosocioethical" model.

The authors stress that this model is not intended as a "definitive and distinct approach to clinical decision and management", but rather it proposes a fundamental "conceptual frame" for the discussion of particular cases. The complexity and diversity of real cases makes it difficult to define an "ultimate end" for treatment, but the model's account of the value of care makes it possible to distinguish "intrinsically person-centred" from more restricted, disease-centred approaches. They make important points about the role of deliberateness and trust in any sound account of good treatment, introducing arguments about the agency of patients, the virtues of practitioners and the concept of shared decision-making, that will be taken up in more detail in later chapters in this volume.

Clinical reasoning: cases, evidence and wisdom

As Mark Tonelli notes, while PCC requires recognition of the personhood of both practitioner and patient, the processes of diagnosis, prognosis and treatment require patients to become cases [52]. He acknowledges (citing Foucault) that there are risks associated with becoming "a case," but the main argument of his chapter is that, properly applied, a "renewed focus on case-based reasoning in clinical medicine" offers the best prospect of implementing a genuinely person-centred approach to clinical practice.

For Tonelli, the dominance of the EBM movement's approach to clinical reasoning since the early 1990s has made medical practice demonstrably less person-centred, emphasising a reliance on "deductive reasoning from general knowledge," in particular "randomized trials and meta-analyses". While there has been much discussion about how to "integrate" the context-specific features of particular cases into this model of clinical reasoning, it is a framework that effectively reduces such vital considerations to the status of "anecdote", by implication a "lower grade" of evidence than population-level studies. The reliance on randomised trials and probabilistic reasoning "suggests to clinicians that particulars of the case are unimportant, incidental features to be obscured by chance allocation" [52].

The chapter provides an admirably clear and accessible explanation of the casuistry associated with thinkers such as Toulmin, arguing that, properly understood, clinical decision-making "resembles a form of argumentation" rather than a deduction from general propositions to specific recommendations. He explains how analogical reasoning from exemplar cases "allows clinicians to focus again on the care of individuals, better able to incorporate the variability that distinguishes one from another". The history of case-based argumentation is "particularly rich in moral deliberation" and casuistry "relies upon acquiring and focusing on knowledge of particulars". Reading Tonelli's chapter in the light of the preceding contributions is fulfilling, in that it indicates a clear way in which the thinking of PCC can directly influence practice.

In the seventeenth chapter, Roger Kerry, Matthew Low and Peter O'Sullivan take as their starting point the discrepancy between traditional clinical reasoning models and conceptions of clinical practice developed in the light of "evidence-based medicine, now more commonly referred to as healthcare (EBHC)" [53]. Like Tonelli, they regard the latter as an inadequate basis for PCC. Despite recent attempts to revise or reform EBHC, its "essence" is still "in the prioritisation of particular scientific research methods which generate knowledge and information about healthcare". The chapter argues that it is the specific conception of scientific reasoning embodied by EBCH that places it in tension with the key insights of PCC: in particular, its notion of causal reasoning.

They note that: "the movement for PCC has developed at least in part as a recognition of the need for clinical reasoning to incorporate an understanding of the potential uniqueness of individual cases into its account of scientific reasoning." In contrast, the movement for EBHC was founded on a conception of causal reasoning grounded in the work of the philosopher David Hume [53]. Hume's conception of causality is inherently resistant to the idea of uniqueness - to explain an event causally is, by definition, to regard it as an instance of a general pattern: if the observation of X is repeatedly followed by the observation of Y, then we have grounds to posit a causal link between X and Y. Causal reasoning becomes a matter of finding statistical regularities, what Hume calls "constant conjunctions" between events of type X and type Y. Hence the centrality of "large-scale clinical trials" and probabilistic reasoning in EBHC and the de-emphasising of context-specific knowledge and clinical experience. They propose an alternative, dispositional analysis of causality, "based on a dispositional philosophy of science that takes causes not as discrete Humean statistical regularities, but rather as real features of the world that only ever tend towards an effect, and that are dependent on mutual manifestations with other causal partners." This "revised causal ontology" is the basis for clinical reasoning models "better able to explain and facilitate the integration of multiple sources of knowledge and information during

clinical decision-making processes in complex and context-sensitive instances."

Sarah Weiten's contribution takes on board the tension between EBM and PCC highlighted by authors such as Tonelli, Kerry and colleagues. Her chapter considers the possibility that "personalised medicine" - now more often, and more accurately, characterised as "precision medicine" - might provide the basis for a "more person-centred" approach to clinical practice, precisely because of the focus not on the sort of regularities that Kerry and colleagues note as the basis for reasoning in EBHC, but on features specific to an individual patient - his or her genetic make-up [54]. Wieten argues that, even if the predictions that "EBM will soon be replaced by genetics-based precision medicine" turn out to be correct, this does not imply that practice will become, in any meaningful sense, more person-centred. Despite its differences with EBM, precision-medicine generates related problems regarding the expertise of practitioners, the role of mechanisms in clinical reasoning and the role of patient values in any defensible conception of clinical decision-making.

Wieten's chapter is a very pertinent and helpful illustration of the points made by other contributors to this volume. (One is reminded particularly of Tyreman's concerns about the claim that genes provide the "blue-print" for the person [43] but, as already noted in this editorial introduction to the book, the broad concerns about reductionism or scientism are at work in many of the chapters). The problems which beset medical epistemology go far beyond the discourses of EBM/EBHC. These discourses have of course been affected by the underlying philosophical framework that mitigates against PCC, but the intellectual task facing proponents of PCC is to identify that framework and all of its manifestations, developing and defending their alternative approach. In this respect, her chapter resonates with the one to follow, where another feature of thinking in medical epistemology, sometimes identified as incompatible with PCC, is argued to have both valid and (philosophically) "corrupted" forms.

Chapter 19, co-authored by Peter Wyer and Loughlin, focusses on the role of epistemic hierarchies in accounts of clinical reasoning [55]. While we agree with the other authors in this section [52-54] and other critics of the uses of such hierarchies in debates about medical epistemology [56,57], we argue that defenders of EBM/EBCH are right on one crucial point, that "the notion of an epistemic hierarchy is indeed indispensable" [55]. The problem with the "hierarchies of evidence" that have dominated much of the debate about evidence-based practice for so long is that they devalue the human reasoning processes that are the basis for rational thought in research and practice. Based on flawed understandings of such core concepts as "objectivity" and "engagement", and the distorted dissection of the subject-object relationship exposed by authors in the preceding sections of this volume, they attempt to "depersonalise" practice in all the wrong ways. Science is a human practice, founded in a broader conception of human reasoning, ontologically dependent on human beings living and engaging with the world in social, emotional and ethical contexts. Too much of the debate about clinical reasoning fails to appreciate the significance of these points, leading authors to espouse an intellectually indefensible conception of science as the basis for models of clinical reasoning that devalue the personhood of practitioners.

After looking at different conceptions of epistemic hierarchies and their uses in the analysis and evaluation of reasoning in a range of practice contexts, we propose a "nested hierarchy" that effectively turns upside-down the flawed "evidence hierarchies" that have helped to depersonalise care. T.S. Eliot's "wisdom, knowledge, information" scheme (to which we add "data" below "information") provides a model for a "person-centred epistemic hierarchy" [55]. This crucial, "person-centred inversion" represents "levels of awareness that characterize more or less developed thinking and judgment on the part of the particular practitioner". In a section on "practical applications" we illustrate the utility and necessity of this construct.

Samantha Copeland's chapter opens with the important point that "person-centred" care is frequently conflated with "patient-centred" approaches, *via* the recognition that "the patient is a complex, situated individual with diverse interests" [58]. However, it is just as important for PCC to develop a conception of clinical decision-making that fully recognises the personhood of practitioners. Citing Montgomery, Copeland introduces the Aristotelian idea of "practical reasoning, or phronesis" as a way of integrating moral reasoning, context-specific knowledge and experience into "a framework for understanding the nature of clinical expertise".

Despite its attractions, Copeland notes that there are serious issues confronting the project of incorporating this notion of practical wisdom into a workable model of clinical practice. For Copeland "the reasoning process itself should take priority in our attempts to understand the nature of clinical expertise," rather than questions about "whether that process obtains any particular end" [58]. A theme clearly emerging from our diverse contributors (coming, as they do, from very different intellectual starting-points) is the need for genuinely "person-centred" approaches to care to focus on questions of process rather than outcomes - whether those outcomes are characterised with reference to clinical factors, the "values and preferences" of particular patients, or even the character-traits of professionals and the development of virtuous practice. We have seen that the health, wellbeing and autonomy of patients are better understood with reference to developmental and adaptive processes, relating to functioning within broader social and interpersonal contexts [4,42-46]. Copeland agrees, arguing against the equation of "success in healthcare" with "obtaining the state of being fully healthy". Similarly, the understanding of clinical expertise is best framed "in relational terms," within the context of an interactive process: "in the case of truly person-centered healthcare, there is more to be achieved through the mutual engagement of persons who practise healthcare and persons who seek their expertise than the return to a predetermined state of health" [58]. Her contribution is followed by chapters that specifically focus on this interaction, with reference to the processes of

shared decision-making, interactional expertise, epistemic injustice and the moral and epistemic role of narrative.

Patient expertise, authority, narrative and shared decision-making

As noted in the opening section of this *Editorial Introduction*, a major motivation for PCC has been a growing awareness of the problems of epistemic injustice and the marginalisation of the perspectives of particular patient groups. The chapter by Garrath Williams opens by noting that, minimally, a person-centred approach to healthcare requires that patients' accounts of their own illness and treatment, and their experience of healthcare professionals and systems, must be taken seriously [19]. Yet he also cites research revealing that medical professionals frequently fail to elicit patients' accounts of their condition, or may ignore, disbelieve or discredit some of what patients say about their symptoms, side-effects or treatment.

For Williams, the first stage in overcoming this "major obstacle to the development of person-centred healthcare" is developing an accurate account of its nature and causes. The very development of the term "epistemic injustice" represents an important advance. As Miranda Fricker, who coined the term, has pointed out, a common problem for sufferers of numerous social injustices is that they lack a language in terms of which to characterise their situation adequately [21].

Williams acknowledges the temptation of the "bad apples" theory, that attributes vices to individual professionals, but he comments astutely that "Justice may name a virtue, but it is primarily a feature of social structures" [19]. The chapter therefore focusses on structural and relational features of current healthcare encounters that create difficulties for professionals in hearing the "patient voice". Citing the work of such authors as Havi Carel and Ian Kidd, Williams discusses the nature of professional authority and institutional power, explaining the difficulties patients have in articulating their claims with reference to what he calls "tightrope walking" and "double binds": the "moral balancing acts" required of ill persons and the impossibility they may find in reconciling duties and demands. The chapter considers the options and pressures facing medical professionals, requiring them to seek out "paths of least resistance" and "the invisibility of power positions" to persons in authority. Williams argues that this characterisation represents a "diagnosis" and concludes by considering a number of "treatment options".

One such option, the recognition of patient expertise, is characterised and defended in extraordinary detail and clarity in Chapter 22 [59]. Mary-Clair Yelovich begins by observing that, while many practical problems in medicine are soluble "within a traditional, well-established epistemological framework", the ones that are not demonstrate problems with our underlying assumptions and limits for the framework itself. One such problem, she argues, is "patient non-adherence", and its solution "requires a revision of our assumptions about what we accept as valid knowledge or relevant expertise". With reference to literature on the relationship between scientific and other forms of expertise, she goes on to spell out precisely the nature of the revisions needed and how such revisions can be incorporated into standard practice, in a way that "dissolves" the problem of patient non-adherence by facilitating person-centred interaction as the basis of clinical decision-making.

Drawing on fascinating work on the resolution of scientific controversies and extensions of the concept of expertise, Yelovich sets out her "patient expertise framework," a new epistemological framework for clinical interaction, within which patient expertise becomes "centralized as a means of determining the nature of patient suffering". Yelovich is using the term "suffering" in a quite specific, technical sense. She explains "two aspects of the patient's tacit knowledge - the *body* aspect and the *meaning* aspect - both of which are context-dependent and directly accessible only to the patient." These aspects of knowledge must be recognized as essential to the success of the interaction. The physician's role "becomes that of both medical expert and possessor of *interactional expertise*, by which the physician recognizes and includes patient expertise in the treatment decision" [59]. A crucial feature of this expertise is the recognition and incorporation of the "negotiation of meanings" into the development of a treatment plan. The chapter thus presents what is at once a radical and eminently achievable proposal for the transformation of practice.

A similarly impressive proposal regarding the nature and role of narrative in clinical encounters, as a means of supporting person-centred practice, is provided by Mary Walker, Wendy Rogers and Vikki Entwistle [60]. The authors recognise that there are numerous interpretations of "narrative" in healthcare, some of which are "so broad" that they render claims about "attending to narratives" trivial, while other accounts in narrative theory are "too narrow a concept to encompass the illness experience of all patients". They also recognise that, frequently, the pressures facing medical professionals discussed by Williams, including time constraints and reasons to be cautious about taking patients' statements "at face value", can mitigate against the treatment of narrative as a significant source of knowledge in medical practice.

To address these concerns, they analyse different accounts of the knowledge that narrative can contribute to the clinical encounter, using "insights from this investigation to develop a pluralist account of the epistemic (and related ethical) value that narrative approaches can add in healthcare contexts" [60]. Attending to narratives can assist clinicians in developing therapeutic relationships "that support (or at least do not undermine) patients' abilities to participate actively in their healthcare". Narratives provide knowledge of different types of connections between events and insights into "the meaning-making interpretive activities of individuals". It is particularly instructive reading their chapter in conjunction with the preceding chapter by Yelovich, as the different types of knowledge which narratives convey clearly foster the interactional expertise Yelovich argues is an essential

skill of person-centred practice. There are also interesting overlaps with the chapter by Tonelli, in that the skills of argumentation, judgement and comparison he emphasises, are an essential component of the approach advocated by Walker *et al*. The authors stress that narrative, like any knowledge source, is not to be treated uncritically. Just as we recognise that randomised controlled trials "can have strong internal but weak external validity, and where we judge that this is so are cautious in applying their results to other populations", so we need to make judgements about the reliability of particular narratives. Cultivating this skill is a crucial reasoning ability for any practice that requires an understanding of the needs of real people.

In the chapter which follows, Marco Annoni and Charlotte Blease examine "shared decision-making (SDM)" and its relationship to person-centred care [61]. They note a diversity of models of SDM in the literature and, like Fulford [38], they do not see such diversity as necessarily problematic. They argue that "clinical practice is too variegated and complex to be reduced to a single overarching theoretical ideal" and that "depending on the circumstances, different decision-making models may be appropriate" [61]. They proceed to look at five models, labelled respectively the "instrumental", "paternalistic", "informative", "interpretative" and "persuasive" models. Analysing the underlying assumptions of each, and their applications in a range of contexts, the authors argue that, with the exception of the instrumental model, each model "may be appropriate depending on the circumstances".

The chapter discusses each model with reference to specific cases, arguing that decisions about the application of any given model to a specific case can only be made *via* an understanding of the patient, "highlighting the importance of structuring clinical care around actual persons - and their unique lives and philosophies". This entails "not only an understanding of the various issues of fact at stake – for example, the person's condition, her past clinical history, or the therapeutic regime in place - but also delving into her unique worldview regarding important issues of values and preferences." One pertinent consideration of this sort is "whether she prefers a more active or passive role with respect to clinical value-laden decisions". The authors argue that paternalism is not necessarily unethical and in some cases adopting a paternalistic model can be compatible with PCC, because some patients can autonomously prefer a more passive role in the making of complex clinical decisions. These claims, and the points the authors make about paternalism and patient competency (in particular, with reference to mental health), raise issues that concern authors in the final section of this volume.

Psychiatry, psychotherapy and personhood

In the twenty-fifth chapter, psychiatrist Juliette Brown observes that while her discipline aims to be person-centred, it "is often not experienced as such" [62]. Taking up the points raised by Williams about the pressures faced by practitioners, Brown characterises vividly the "brutal" context in which medical psychiatrists have to train and practise, and the associated "tendency of the professions, organisations and systems tasked with caring for the most vulnerable to retreat from the painful realities we face". The chapter brings out brilliantly the ways in which philosophically loaded conceptions of scientific rationality and objectivity can cause practitioners to repress or deny features of a broader, humanistic conception of reasoning, damaging themselves both as persons and practitioners, making it harder for them to engage with patients in the inclusive and beneficial ways that, as responsible practitioners, they aim to do.

Brown identifies other, associated obstacles to person-centred psychiatry, including a surprising exclusion of experiential expertise and failure to incorporate phenomenological work on mental distress in the knowledge base for the profession. The chapter includes important sections on "bearing witness to trauma" and the role of phenomenological accounts in informing person-centred psychiatric practice. It makes connections with the concerns of many of the preceding chapters in the volume, linking notions of embodiment and inter-subjectivity to questions about the role and limits of biomedical approaches and the broader, social and political questions that preoccupied authors in the opening section. In particular, Brown stresses the need to recognise openly that "there is no proper way to practise psychiatry other than by making value-laden moral judgements". While this does not render psychiatry inherently unscientific [29,63] or indeed oppressive (as those in the anti-psychiatry movement might claim [63-65]) it does give rise to the need for a "healthy scepticism about the functions and frameworks in which psychiatry is practised in order to test them against conceptions (subject to ongoing critique) of the human good". She notes the current "psychiatry training barely acknowledges the critical facility needed to engage with the moral judgements and the ethical and epistemic questions that rightly dominate our practise" [62]. Despite the obstacles, Brown sees change as achievable, stating that "we can view this moment as an opportunity, both ethical and scientific" to "scrutinise power inequities", "expand our field of knowledge" and "train confident clinicians" who are able to wield all the sources of knowledge and understanding relevant to person-centred practice.

Her chapter is followed by two other contributions that rather splendidly "join the dots" between preceding discussions, applying the crucial arguments about facts, values and the "modern world view" to areas and issues where they have had a particularly profound impact. While being rightly cautious about overly simplistic, "straw-man" accounts of "biomedical reductionism" found in some sociological critiques of biological approaches to psychiatry, Ketil Slagstad argues that "it still makes sense to trace the history of two main positions that are partly complementary, partly opposing" on the development of contemporary psychiatric epistemology, noting that by "looking at our past, we might better understand our present" [66]. After an extremely helpful exposition of the history of approaches to psychiatry based on genetic and

neurobiological findings, and of contrasting contextual, relational approaches, Slagstad explains the influence of "dualist views" of human suffering on the debate, reinforcing dichotomies such as "nature *versus* culture, brain *versus* mind, somatic *versus* mental".

While there have been attempts to integrate these different aspects of the modern world view into theory and practice, perhaps most notably the "biopsychosocial" model, Slagsted argues that such models risk "stabilising rather than deconstructing" the problematic dichotomies, and only a more fundamental revision of the framework can provide the basis for progress in future. The chapter outlines a new approach to psychiatric epistemology that aspires to be "truly transdisciplinary, borrowing tools from history, hermeneutics, anthropology, STS-studies, feminist theory and phenomenology." Only an approach such as this provides the possibility for an intellectually adequate characterisation of the relationship between "meaning" and "matter" that is the essential basis for a person-centred approach to understanding "why people get sick and what to do about it".

Focussing on psychotherapy, Henrik Berg examines the relationship between facts and values, and the impact of our assumptions about these concepts on both research and practice [67]. Berg begins by observing that the concept of the person is central to psychotherapy, but that there is little literature clarifying how precisely this concept is understood within the discipline. One of the reasons for this is that there is little agreement about the relationship between factual and evaluative understandings of personhood. This is particularly bizarre when one realises that "the typical aim of psychotherapy is to change how an individual patient thinks, acts and/or feels" so as to improve that patient's life. As Brown argued with regard to psychiatry, there is no "value-neutral" way to characterise and operationalise this goal. Thus, Berg states, "psychotherapy rests upon a presupposition that some ways of living are superior to others." Questions about the nature of value are therefore foundational to the discipline.

The chapter cites Snow's influential work on the traditional divide between the "two cultures" of "science" and "the humanities" in academia, supporting Snow's view that "this strict division of labour" represents "a major obstacle for solving many of the great challenges facing humanity" [67]. Berg applies Snow's analysis to the development of psychotherapy research and practice, arguing that, to overcome this obstacle, the discipline needs to develop a "non-modern framework ... better suited for capturing the kinds of values present in psychotherapy research and practice and to guide science and practice in a good manner." This "non-modern" framework reflects aspects of the thinking of philosophers from Plato through to Mill and Husserl. While fully recognising the importance of gaining an improved understanding of the mechanisms at work in psychotherapy, Berg argues that the framework he proposes will enable "the researchers providing the research and the practitioners using the research" to "understand the scientific findings properly", ensuring "genuine user-involvement". He concludes that "the problem of values in psychotherapy is a very complex one", but if we are to understand the persons whose lives we hope to improve, "there are no good alternatives to trying to develop models that encapsulate this dimension of psychotherapy" [67].

Chapter 28, our chapter, returns to debates about the nature of personhood and the application of the term "person-centred" in many healthcare contexts, including the context of mental healthcare. Bianca Andrade and Marco Azevedo focus in particular on persons with severe disorders of consciousness (SDC), but point out that many human beings - including young children and people with chronic or progressive conscious disorders - do not meet the criteria for personhood set out in many traditional philosophical accounts of the concept [68]. Such accounts frequently treat self-awareness, rationality and even a developed sense of moral agency as definitive of the concept of personhood and, as noted elsewhere [25], some philosophers classify people who "fall short" of this conception of persons as "marginal cases".

Since no credible contributor to this debate accepts what they call the "repugnant" conclusion, that such people should be relegated to the margins of medical concern, Andrade and Azevedo argue that the literature needs a more careful and detailed account of the meaning of "person-centred" than is evident thus far. In a chapter that is richly informed by debates in moral and legal philosophy, as well as arguments in the philosophy of mind, they set out a social conception of personhood with reference to community membership and the possession of a "personal unique biography". In a useful discussion of dementia and "multiple selves", they emphasise the need to assume a "second-personal stance", to explain what it means to "respect the personhood" of someone no longer capable of participating in rational, value-laden discussions about her own treatment.

Whether or not we agree with their specific account of personhood, the chapter is an important and powerful reminder of points made in the opening comments of this editorial introduction, regarding the need for continued critical reflection and clarification of the meaning of "person-centred". Their account of recognising personhood in practice resonates with other contributions to the volume - references to the need for a "biographical story" reinforcing Tyreman's points about meaning-giving narratives, and the arguments of Hamilton, Copeland, Sturmberg and others about the need to understand persons in the context of whole lives, as processes, not simply specific moments within those lives.

Conclusion

A recent editorial in the *Journal of Evaluation in Clinical Practice* concluded that:

> "The problems of complexity, the rise of chronic conditions, over-diagnosis, co- and multi-morbidity are serious and challenging, but we are rising to that challenge. Key conceptions regarding science, evidence, disease, clinical judgement, health and social care, are being revised and their relationships reconsidered: boundaries are indeed being redrawn; reasoning is being made 'fit for practice'. Ideas like 'person-centred care' are no longer phrases with potential to be helpful in some yet-to-be-clarified way: theorists and practitioners

> are working in collaboration to give them substantive import and application" [23].

The contributions to this volume are a fine illustration of this process. While the dialogue is by no means completed, and disagreements remain, these chapters provide us with a rich source of argument and analysis, both challenging our thinking and giving us the basis to form our own ideas about the future development of person-centred practice and its value for patients, practitioners and the broader community.

Conflicts of Interest

I declare no conflicts of interest.

References

[1] Henry, S. (2010). Polanyi's tacit knowing and the relevance of epistemology to clinical medicine. *Journal of Evaluation in Clinical Practice* 16 (2) 292-297.
[2] Arnold, M., Kerridge, I. & Lipworth, W. (2020). An ethical critique of person-centred healthcare. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 23-37. London: Aesculapius Medical Press.
[3] Pârvan, A. (2020). What is this thing called "health"? An ontology for person-centred care. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 121-142. London: Aesculapius Medical Press.
[4] Sturmberg, J. (2020). Person-centeredness - A Paradigm Shift for Health Care? In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 159-170. London: Aesculapius Medical Press.
[5] Tournier, P. (1940). Médicine de la personne. Neuchatel, Switzerland: Delachaux et Niestlé
[6] Peabody, F.W. (1928). The soul of the clinic. *Journal of the American Medical Association* 90, 1193-1197.
[7] Loughlin,M., Buetow, S., Cournoyea, M., Copeland, S., Chin-Yee, B. & Fulford, K.W.M. (2019). Interactions between persons - knowledge, decision-making and the coproduction of practice. *Journal of Evaluation in Clinical Practice* 25 (6) 911-920.
[8] Miles, A. & Asbridge, J.E. (2017). Person-Centered Healthcare - moving from rhetoric to methods, through implementation to outcomes. *European Journal for Person Centered Healthcare* 5 (1) 1-9.
[9] Department of Health. (2019). The NHS Long Term Plan. Available from: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf.
[10] Ham, C., Charles, A. & Wellings, D. (2018). Shared responsibility for health: the cultural change we need. The King's Fund. Available from: https://www.kingsfund.org.uk/publications/shared-responsibility-health.
[11] Person-Centred Training and Curriculum (PCTC) Scoping Group. (2018). Person-centred care: implications for training in psychiatry. College Report CR215. London: Royal College of Psychiatrists.
[12] Paparella, G. (2016). Person-centred care in Europe: a cross-country comparison of health system performance, strategies and structures. Picker institute report: https://www.picker.org/wp-content/uploads/2016/02/12-02-16-Policy-briefing-on-patient-centred-care-in-Europe.pdf.
[13] Health Foundation. (2016). Person-care made simple: what everyone should know about person-centred care. London: Health Foundation.
[14] Ekman, I., Hedman, H., Swedberg, K. & Wallengren, C. (2015). Commentary: Swedish initiative on person centred care. *British Medical Journal* 350: h160.
[15] Royal College of Physicians. (2014). Personalising Healthcare: The role of Shared Decision Making and Support for Self-Management. London: Royal College of Psychiatrists.
[16] Miles, A. & Asbridge, J.E. (2019). The NHS Long Term Plan (2019) - is it person-centered? *European Journal for Person Centered Healthcare* 7 (1) 1-11.
[17] Kirkengen, A.L. & Thornqvist, E. (2015). The quantified self - closing the gap between general knowledge and particular case? *Journal of Evaluation in Clinical Practice* 21 (3) 398-403.
[18] World Health Organisation. (2005). Preventing chronic diseases. Preparing a health care workforce. WHO, Geneva, Switzerland. Available at: http://www.who.int/chp/knowledge/publications/workforce_report.pdf.
[19] Williams, G. (2020). Explaining epistemic injustice in medicine: tightrope walking, double binds, paths of least resistance, and the invisibility of power positions to those who occupy them. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 303-319. London: Aesculapius Medical Press.
[20] Carel, H. & Györffy, G. (2014). Seen but not heard: children and epistemic injustice. *Lancet* 384 (9950) 1256-1257.
[21] Fricker, M. (2007). Epistemic Injustice: Power and the Ethics of Knowing. Oxford: Oxford University Press.
[22] Kidd, I. & Carel, H. (2017). Epistemic injustice and illness. *Journal of Applied Philosophy* 34 (2) 172-190.
[23] Loughlin, M., Mercuri, M., Pârvan, A., Copeland, S., Tonelli, M. & Buetow, S. (2018). Treating Real People: Science and humanity. *Journal of Evaluation in Clinical Practice* 24 (5) 919-929.
[24] Loughlin, M., Bluhm, R., Fuller, J., Buetow, S., Borgerson, K., Lewis, B.R. & Kious, B.M. (2015). Diseases, patients and the epistemology of practice: mapping the borders of health, medicine and care. *Journal of Evaluation in Clinical Practice* 21 (3) 357-364.
[25] Loughlin, M. (2014). What Person-Centred Medicine is and isn't: temptations for the 'soul' of PCM. *European Journal for Person Centred Healthcare* 2 (1) 16-21.
[26] Loughlin, M. (2002). Ethics, Management and Mythology. Oxford: Radcliffe Medical Press.

[27] Greenhalgh, T., Howick, J. & Maskrey, N. (2014). Evidence based medicine: a movement in crisis? *British Medical Journal* 348: g3725-g3725.
[28] Loughlin, M. (2010). Spin-doctors. *The Philosopher's Magazine* 51 (4) 68-73.
[29] Loughlin, M., Lewith, G. & Falkenberg, T. (2013). Science, practice and mythology: a definition and examination of the implications of scientism in medicine. *Health Care Analysis* 21 (2) 130-145.
[30] Loughlin, M., Bluhm, R. & Gupta, M. (2017). Research Problems and Methods in the Philosophy of Medicine. In: The Bloomsbury Companion to Contemporary Philosophy of Medicine. Marcum, J (Ed.). London: Bloomsbury Publishing.
[31] Upshur, R. (2014). Conventions or foundations? A response to Miles Little's ex nihilo nihil fit? Medicine rests on solid foundations. *Journal of Evaluation in Clinical Practice* 20 (6) 988-990.
[32] Upshur, R. (2014). A critique of modest foundationalism, chapter 17 (pp209-19) In: Debates in Values-Based Practice: Arguments For and Against. Loughlin, M (Ed.), pp. 209-219. Cambridge: Cambridge University Press.
[33] Evidence-Based Medicine Working Group. (1992). Evidence-based Medicine: a new approach to teaching the practice of medicine. *Journal of the American Medical Association* 268 (17) 2420-2425.
[34] Djulbegovic, B., Guyatt, G.H. & Ashcroft, R.E. (2009). Epistemologic inquiries in evidence-based medicine. *Cancer Control* 16 (2) 158-168.
[35] Dans, A., Dans, L. & Silverstre, M. (2008). Painless Evidence-based Medicine. Chichester: Wiley & Sons.
[36] Charlton, B.G. (1996). The limits of evidence-based medicine. *Hospital Update*. July, 268-269.
[37] Mercuri, M. & Gafni, A. (2020). Defining the meaning, role and measurement of "values and references" in the development of practice guidelines: The case of GRADE. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 39-56. London: Aesculapius Medical Press.
[38] Fulford, K.W.M. (2020). Groundwork for a Metaphysic of Person-centred Care: a Contribution from Ordinary Language Philosophy. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 57-72. London: Aesculapius Medical Press.
[39] 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.
[40] Aquino, Y.S.J. (2017). "Big eye" surgery: The ethics of medicalizing Asian features. *Theoretical Medicine and Bioethics* 38 (3) 213-225.
[41] Heyes, C. (2009). All cosmetic surgery is "ethnic": Asian eyelids, feminist indignation, and the politics of whiteness. In Cosmetic surgery: A feminist primer. Heyes, C. & Jones, M. (Eds.), pp. 191-205. Farnham Surrey: Ashgate Publishing Limited.
[42] Blunden, N. & Calder, G. (2020). Co-production and Person-Centred Care in neo-liberal conditions. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 79-92. London: Aesculapius Medical Press.
[43] Tyreman, S. (2020). Person-Centred Care: Putting the Organic Horse back in front of the Mechanical Cart. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 95-105. London: Aesculapius Medical Press.
[44] Hamilton, R. (2020). The Person Is The Organism: Overcoming the Nature-Culture Dichotomy in Person-Centred Healthcare. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 107-119. London: Aesculapius Medical Press.
[45] Walach, H. (2020). The Rise of Complementary Medicine and the Materialist Stance of Biomedicine. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 143-158. London: Aesculapius Medical Press.
[46] Thornquist, E. & Kirkengen, A.L. (2020). The lived body - a historical phenomenon. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 171-185. London: Aesculapius Medical Press.
[47] Ryle, G. (1983). The Concept of Mind. Aylesbury: Peregrine Books.
[48] Marcum, J.A. (2020). Axiological Analysis for the Role of Values in Person-Centered Healthcare. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 189-201. London: Aesculapius Medical Press.
[49] Popper, K. (1989). Objective Knowledge: An Evolutionary Approach. Oxford: Clarendon Press.
[50] Pierron, J.P. & Vinot, D. (2020). The Meaning of Value in "Person-centred" approaches to Healthcare. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 203-212. London: Aesculapius Medical Press.
[51] Gaab, J., Gerger, H., Blease, C. & Locher, C. (2020). The Good Treatment: a biopsychosocioethical proposition. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 213-220. London: Aesculapius Medical Press.
[52] Tonelli, M. (2020). Case based reasoning. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 223-234. London: Aesculapius Medical Press.
[53] Kerry, R., Low, M. & O'Sullivan, P. (2020). Person-Centred Clinical Reasoning and Evidence-Based Healthcare. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 235-251. London: Aesculapius Medical Press.
[54] Wieten, S. (2020). More Person-Centered?: the move from Evidence-Based Medicine to Precision Medicine. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 253-264. London: Aesculapius Medical Press.
[55] Wyer, P & Loughlin, M. (2020). Person Centred Healthcare and Clinical Research: the necessity of an evolutionary hierarchy of knowing and doing. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 265-287. London: Aesculapius Medical Press.

[56] Miles, A. (2012). Moving from a reductive anatomico-pathological medicine to an authentically anthropocentric model of healthcare: current transitions in epidemiology and epistemology and the ongoing development of person-centered clinical practice. *International Journal of Person Centered Medicine* 2 (4) 615-621.
[57] Upshur, R. (2002). If not evidence, then what? Or does medicine really need a base? *Journal of Evaluation in Clinical Practice* 8 (2) 113-119.
[58] Copeland, S. (2020). Moving past phronesis - Clinical Reasoning in Person-Centered Care. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 289-299. London: Aesculapius Medical Press.
[59] Yelovich, M-C. (2020). Acknowledging Patient Expertise and the Negotiation of Meanings in the Clinical Encounter. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 321-332. London: Aesculapius Medical Press.
[60] Walker, M., Rogers, W. & Entwistle, V. (2020). The ethical and epistemic roles of narrative in person-centred healthcare. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 333-346. London: Aesculapius Medical Press.
[61] Annoni, M & Blease, C. (2020). Persons over models: shared decision-making for person-centered medicine. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 347-358. London: Aesculapius Medical Press.
[62] Brown, J. (2020). Psychiatry, Power and the Person. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 361-378. London: Aesculapius Medical Press.
[63] Loughlin, M. & Miles, A. (2015). Psychiatry, Objectivity and Realism about Value. In: Alternative Perspectives on Psychiatric Validation. Zachar, P. & Stoyanov, D. (Eds.), pp. 146-163. Oxford: Oxford University Press.
[64] Szasz, T.S. (1960). The Myth of Mental Illness. *American Psychologist* 15 (2) 113-118.
[65] Cooper, D.G. (1967). Psychiatry and anti-psychiatry. London: Tavistock Publishing.
[66] Slagstad, K. (2020). Meaning and Matter in Psychiatry: A Historical View and New Approach. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 379-391. London: Aesculapius Medical Press.
[67] Berg, H. (2020). A non-modern vision: Facts and values in psychotherapy. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 393-400. London: Aesculapius Medical Press.
[68] Andrade, B. & Azevedo, M. (2020). Personhood and Disorders of Consciousness: Finding Room in Person-Centered Healthcare. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 401-420. London: Aesculapius Medical Press.