EDITORIAL

Progress in the conceptual understanding of person-centered health and social care. 'Person Centered Care: Advanced Philosophical Perspectives'. Loughlin, M., & Miles, A. (Eds.). 2020. London: Aesculapius Medical Press

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Introduction

In this issue of the *Journal*, we begin the serialisation of a seminal new text which has significantly advanced current understandings of the conceptual basis of person-centered care (PCC) [1]. The volume, edited by Michael Loughlin and Andrew Miles, brings together 42 distinguished scholars, writing over the course of 28 chapters, divided into 6 definitive sections, spanning some 420 pages of text. Each of the chapters has distinct merit and, when studied collectively, the scale of their contribution to current thinking in the field becomes quickly apparent. The volume is scheduled for production towards the end of the current year and will be published by Aesculapius Medical Press (AMP), the publishing Imprint of the European Society for Person Centered Healthcare (ESPCH). A detailed overview of the volume has been provided by Loughlin, the lead co-editor of the book [2].

Loughlin's paper [2] is a model of clarity, providing admirable insight into the content of the individual chapters, placing each of them within the context of the ongoing debate. As Loughlin [2] rightly notes, "the ideas and terminology of person-centred care … have been part of health discourse for a very long time … (and) … arguments that in healthcare one treats the *whole person*, not her/his component parts, date back at least to antiquity" (italicisation mine). He emphasises that "… 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*" (italicisations mine). These observations, indeed truisms, explain the rationale which underpinned the creation of the European Society for Person Centered Healthcare, and which continue to direct its mission.

Theory and practice, practice and theory

Loughlin [2] insists that because "…the language of "person-centredness" increasingly permeates discussions of the future of health services … the need for its critical analysis becomes more urgent". This clear necessity led to the commissioning of the current philosophy volume, with such a core premise being embraced by each of the chapter authors, as is evident throughout the text. However, when Loughlin continues by asserting that " … there is an unfortunate history in health 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", then I find myself minded to articulate in counterpoint what might be termed a 'real world, operational perspective'. Here, I make clear my

own view that just as theory informs practice, so can practice inform theory.[1]

The claim, advanced by some, that 'without theory, practice is impossible', is not in my own view axiomatic [cf. 3-9]. Indeed, to anyone who asserts that we must wait for complete philosophical resolutions on every question pertaining to PCC before attempting to operationalise it, I would pose this question: "When and where did you acquire this taste for luxury?" Patients, and those who love and care for them, cannot afford to wait for such academic 'niceties'. For sure, it is perfectly possible to proceed to the development of models of person-centred care that are based on provisional understandings of what PCC is and what it is not, with such provisional models naturally subject to given degrees of change if/when further theoretical insights become subsequently documented. It is, then, entirely legitimate to operationalise a model of care on this basis and carefully to observe its effects and impact in practice. To do otherwise is to risk a *stasis* in the field that is unacceptable to patients and their families, unacceptable to policymakers and politicians, unacceptable to methodologists, and indeed unacceptable to practising clinicians themselves, who, when confronted by arguments for delay, not untypically assert: "You just have to get on with it".[2]

Ongoing reservations of philosophers of medicine and healthcare

It remains true (as indeed was and is the case for EBM), that the prefix 'person-centered' possesses a degree of rhetorical force, having an emotive component as well as a descriptive one [10]. In consequence, philosophers of medicine and healthcare are understandably reluctant to engage in its uncritical use [11, cf.12]. However, for those of us who are uniquely privileged to act as leaders of the PCC movement, our continued employment of the prefix 'person-centered' remains necessary not for reasons of hubris or sensationalism in an uncritical deployment of terms (which I contend, with others, characterized the dramatic inception and relentless promotion of EBM [13,14]), but is, rather, simply a means to remind medicine and healthcare of an unalterable and indispensable focus - the person, who, having become ill, presents to clinicians asking us for help [15-17].

Miles and Loughlin [10] posit that when the arguments are won for a medicine informed by the E of EBM and not one based on it, and where the person of the patient returns to the very centre of the clinical encounter, the detachment from medicine and healthcare of prefixes such as 'evidence-based' or 'person-centered' will become possible, their usefulness and necessity by that point having become "mercifully defunct" [10]. That time has not yet arrived and is, in fact, nowhere in sight. But what appears certain is that, over the course of the current decade, PCC will inevitably permeate further into the collective clinical consciousness and become of ever increasing interest to policymakers and the commissioners of health services, not least on account of the ability of this model to contain or lower costs while increasing service quality and patient satisfaction [18-20]. Philosophers of medicine and healthcare should acknowledge the same and play their part in bringing about such important outcomes.

Conclusion

The operational implementation of PCC requires a multi-stakeholder approach. It necessarily draws from the healthcare ecosystem upskilled clinicians of all types, policymakers and politicians, professional and also family carers, social care professionals, expert patients, patient advocacy organisations, chaplains, health economists, health and social care managers, and members of the pharmaceutical and healthcare technology industries [18-20]. Without question or controversy, philosophers of medicine and healthcare must sit firmly alongside all such colleagues, actively collaborating with them in striving to make PCC an operational reality. On reading the current volume it is clear that the text compiled by Loughlin and Miles [1] directly enables, and in no way precludes, such an approach to progress in the field. In consequence, it represents a valuable resource for education and training, helping clinicians and others to grow, ontologically, into fully person-centered professionals and to work with and mentor others to do the same. In this way, the standards of care can be raised from an all too frequently encountered legally acceptable, basic technical competence (which satisfies only Regulators or 'second raters'), to a rarer excellence in the care of the sick and suffering, the pursuit of which surely remains the hallmark of an authentic professionalism.

The philosophy volume, while of considerable importance to the history and philosophy of medicine and healthcare, is not intended as a text exclusively for the use of scholars in these particular disciplines alone. On the contrary, it is expressly aimed at practising clinicians and carers within health and social care systems, to enable these colleagues to gain a richer and deeper understanding of the principles of person-centered care, and how the core tenets of the new imperative which is PCC can inform a more person-centered practice.

In studying the text, the reader would do well to remember that ethical experimentation and visionary innovations within the realm of 'hands on' clinical practice

[1]Having had the privilege of holding a wide range of UK Secretary of State for Health appointments, and also teaching hospital board level positions charged with policy implementation, executive governance and transformational / servant leadership in the UK NHS over some 35 years, I draw here on the resulting experience.

[2] In writing, I recall the reaction of a consultant paediatric cardiac surgeon in Bulgaria who, when asked how extant conceptual deficits in the person-centered thesis affected her approaches to the care of seriously ill neonates and their parents, responded *verbatim* in precisely this way. This response is not singular, and I have been party to many such reactions from service clinicians over the last decade or so as interest in PCC has risen exponentially.

can themselves act to stimulate revisions and development in the underpinning theoretical base.

Note to readers

Readers who would like to gain full access to any one or more of the philosophy papers currently being serialised in the *Journal* in advance of the projected publication date of the book (November 2020) are invited to write to Mr. Andrew Williamson, Senior Production Editor of the EJPCH at: andrew.williamsonprofunit@gmail.com. Pre-orders for the textbook itself may also be placed *via* the same contact details.

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