THEORISING PERSONHOOD: FOR BETTER OR FOR WORSE

Miles Little MD MS FRACS
Emeritus Professor, Centre for Values, Ethics and the Law in Medicine, Sydney School of Public Health, University of Sydney, Sydney, NSW, Australia

Abstract
Person-centered medicine is emerging as one of the most formidable critiques of evidence-based medicine. One of its claims to priority over patient-centered care, humane medicine, narrative-based medicine and values-based medicine is its attention to the philosophy of personhood. While it defines personhood in widely accepted terms, using adjectives employed by Cassell, such as 'embodied, purposeful, thinking, feeling, emotional, reflective, relational', it offers no examination of the numerous debates and disagreements about personhood. In particular, it has not so far explored the tension that exists between the neo-Lockean account of persistent psychological attributes, such as intention, cognition and rationality and the 'animalistic' account that ascribes personhood to human existence, to the human body and brain. Nor has it examined the significance of personhood as an emergent property of human beings imbedded in cultures and societies. Medical ontology is basically realist and its epistemology empiricist. Person-centered medicine faces the task of translating a contested, emergent concept into something realistic and empirically examinable, if it is to persist and have pedagogical purchase. Schectman's 'person-life view' may provide a starting point for conceptualisation and teaching and respect is a relationship that underpins an understanding of personhood, but other guidelines will be needed. Some relevant suggestions are made in this article.

Keywords
Discourse, evidence-based medicine, humanism, narrative-based medicine, patient-centered care, person-centered medicine, personhood, person-life view, respect, science, values-based medicine

Correspondence address
Emeritus Professor Miles Little, Centre for Values, Ethics and the Law in Medicine, Building K 25, Sydney Medical School, University of Sydney, Sydney, NSW 2006 Australia. Email: miles.little@sydney.edu.au

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Introduction
Person-centered medicine (PCM) has been launched with enthusiasm as an antidote to the threats of evidence-based medicine (EBM). If indeed EBM has diminished the personal and the humane in medical practice, PCM seeks to restore them. It defines itself as an amalgam of EBM and patient-centered care [1], capturing the undoubted good of both systems, but also bringing something new to medical education and practice — the concept of the person. But is PCM more than another portmanteau term — like EBM, patient-centered care (PCC), narrative-based medicine, values-based medicine (VBM) — that will attract enthusiasm for a time and then also lose its drawing power? The pioneers of PCM seem determined to make their vision work and work well because PCM is to have a sound theoretical and philosophical grounding. Miles and Mezzich, two of the most determined promoters of PCM, have written:

Here, we understand the personhood of the patient and of the clinician with Cassell, who defines a person as an 'embodied, purposeful, thinking, feeling, emotional, reflective, relational, human individual always in action, responsive to meaning and whose life in all spheres points both outward and inward', so that a person's behaviour, whether 'volitional, habitual, instinctual or automatic', has its genesis from and in meaning ... The concept of person within the context of the clinical encounter is, then, altogether more richly and vividly descriptive than that of patient and recognises that there are two individuals within the clinical encounter, the person of the patient and the person of the clinician. Often and desirably so, a clinical encounter also involves the persons in the patient's family [2].

PCM [can be described as] a medicine of the person (of the totality of the person's health, including its ill and positive aspects), for the person (promoting the fulfilment of the person's life project), by the person (with clinicians extending themselves as full human beings, well grounded in science and with high ethical
aspirations) and with the person (working respectfully in collaboration and in an empowering manner through a partnership of patient, family and clinicians) [2].

Our terminological use derives not from personal style or aesthetic preference, but rather from a philosophical understanding of personhood [2].

These clarifying statements appear in what seems to be an iconic document on person-centered medicine published in 2011 [2]. Miles and Mezzich are very clear that they seek to ground PCM in a philosophy of personhood (see third quote above) and they use Cassell’s widely inclusive definition for reasons that become clear in the second passage quoted above. But Cassell’s definition compresses a multitude of difficult issues that beset philosophers, psychologists, sociologists, anthropologists, legal theorists, ethicists and ordinary people relating to one another. What qualifies as a person? Are persons the same as human beings? Is a foetus a person? Is a severely demented individual still a person? Are some non-human animals to be regarded as persons? And what constitutes personal identity? Is personal identity numerically singular throughout a life-course or does change through time mean that one life may be led by different persons? If we are to accept continuity of the person throughout life, how is that continuity to be understood against the changes that affect the body and the mind in the course of a life? I will here describe the link between personhood and identity and review some of the debates about personhood that are of relevance to person-centered medicine

**Personhood and Identity**

Personhood and personal identity are closely linked and the nature of personal identity has been contested. The modern formulation of identity begins with Locke [3]:

> ...to find wherein personal identity consists, we must consider what person stands for; - which, I think, is a thinking intelligent being, that has reason and reflection and can consider itself as itself, the same thinking thing, in different times and places; which it does only by that consciousness which is inseparable from thinking and, as it seems to me, essential to it: it being impossible for anyone to perceive without perceiving that he does perceive....Consciousness makes personal identity.

The Lockean notion of personal identity as defined by continuity of consciousness and memory has been modified by his inheritors, the neo-Lockeans, to include a broader sense of psychological continuities. Contemporary debate stands explanation of personal identity in terms of this psychological continuity against persistence of embodiment [4-7]. There is also a debate concerning the relative importance of autonomous agency and social determinism in the development of personal identity [8,9].

The philosophical debate over the nature of personal identity has been summarised by Perry, and is clearly both heated and complex [10]. I do not review all of the arguments here, except to say that personal identity can be, in important ways, defined by embodiment, continuity and memory. There is an extensive literature in psychology dealing with personhood and its identity [5,7,11-24].

Each of us has a personal sense of identity that depends in some way on our own memories. We are also assigned personal identities by those who know us and we remember events that are part of our embodied lives and these assigned identities influence our internal sense of personal identity. The ‘reformed’ exterminator from a death camp may have the identity of a good citizen for those who have only known him since his rehabilitation, but he retains the identity of the murderer for those who saw him at work during the Holocaust [25].

Personhood, then, for our purposes, is the subjective and objective identity that places each of us uniquely in social context. Brisset and Edgley write:

> Almost all writers using the term imply that identity establishes what and where the person is in social terms. It is not a substitute word for “self.” Instead, when one has identity, he is situated — that is, cast in the shape of a social object by the acknowledgment of his participation or membership in social relations [26].

Personhood and personal identity have physical, cognitive, emotional and moral dimensions, just as Cassell and as Miles and Mezzich say. The sense of personhood is also a sense of both the performative and the moral, the agentic and the autonomous. Agency and autonomy are inextricably linked. The performative category is willed and experienced in terms of action and its relational consequences. The moral category has components that are relational, existential, experiential and ethical. Personhood is thus also the sense of agency, the sense of what it is to be this willing, choosing and acting entity, as experienced by the person and by the people with whom she interacts.

The breadth of personal identity is captured by Hermans and Kempen [15], largely following William James:

> The terms I and Me were discerned by James (1890) as the two main components of the self. The I is equal to the self-as-knower and continuously organizes and interprets experience in a purely subjective manner. Three features characterize the I: continuity, distinctness, and volition...[H]e identified the Me as the empirical self that in its broadest sense is described as all that a person can call his or her own, “not only his body and his psychic powers, but his clothes and his house, his wife and children, his ancestors and friends, his reputation and works, his lands and horses, and yacht and bank account”...

Its depth is characterised by Lockwood [27]:

> ...I would argue that there is, in any case, something wrong with the idea that personal identity can be taken simply to consist in such connections and continuities as are exhibited in consciousness and behaviour. Intuitively, one’s identity over time is, I would contend, conceived of as a deep fact: something we think of as lying behind these connections and continuities, something of which the latter are merely a manifestation... What is happening here, it seems to me,
is that personal identity is functioning as a natural kind concept.

Even this brief discussion indicates the complexity, depth and breadth of the concept of the person and his identity. Given that there are legal, moral, ontological, epistemological and psychological dimensions to the concept of persons, it seems best to select issues of relevance to person-centered medicine, rather than attempt to be inclusive. I will concentrate on a major difference that has developed between neo-Lockeans, who explain personal continuity by psychological connections between the remembered and experienced past, present and future and the 'animalists', who locate continuity in the human body and its brain. Let me from here on use the term 'person' to include 'personal identity', because it is the person who has status in law and moral reflection, who is granted dignity and respect in one way or another by civil rights and who is the moral agent and patient in his/her daily activities.

**Personhood and humanity**

For medicine generally, personhood is linked to being human. Neo-Lockeans use certain features of humans to define persons. These include cognition and rationality, self-awareness, intention and narrativity. They usually remain open to the possibility that non-human animals (such as dolphins) may be human according to these psychological criteria. More extreme 'animalists' assign personhood to the living human and his brain. While they recognise the complexities of brain function, including imagination and intention, they hold that the person can be reduced to the human body and its brain and that a person no longer exists when the brain ceases to exist.

There are variations on these themes. Kadlac, for example, seeks to 'humanise' personhood by arguing that moral status can be given only to humans who are moral agents and moral patients [28], where a moral patient is a person who is the object of moral judgement from moral criteria. Kadlac thus situates humanness in the moral context of interconnection with other members of the community. The individual person must be a moral agent, a moral patient, or both and this implies being imbedded in groups of other moral agents and moral patients. For Kadlac, being a member of the species *Homo sapiens* is the a priori condition of personhood. Moral agency and moral patienthood are the further defining conditions.

Schechtman [29] has taken this argument further in an endeavour to connect animalism and personalism in one concept. She argues that the practical agency of persons has been neglected:

> She points out that, intuitively, we view a severely demented human as a person 'spatiotemporally continuous with the person who was there before.' The human animal persists, but the Lockean person has gone. But does this mean that this being in the bed is still human or has he reverted to a purely animal state, to be considered as having a different moral status to a flourishing human person with all his faculties and capabilities still active? Emphasising the metaphysical, ontological problems inherent in dividing the psycho-social from the animal, Schechtman formulates a 'person-life view' that attempts to reconcile the person to the animal conceptually and ethically.

**The person-life view**

Schechtman's person-life view is culturally situated, like that of feminists who support the idea of relational autonomy [30,31]:

> '...a person-life is lived in a culture and in interaction with other persons...there is increasing evidence that the kinds of cognitive capacities that distinguish persons from other animals depend not just on the capabilities of individual human brains, but on the exposure of those brains to the appropriate cultural scaffolding.'

People occupy 'person-space' and they do so throughout the trajectory of their lives, a trajectory that includes both gain and loss. Most importantly, in Schechtman's view, 'there is only one thing throughout a human life — a human person — and so there is no difficulty in explaining the relation between the two entities' of person and human animal. There is also no difficulty in explaining the relationships between infant and child, child and adolescent, adolescent and adult, adult and old person, old person and person demented. All occupy the same 'person-space' and while a person's social status may change from being a dependent to being a resource and then back to another kind of dependence, there is no difficulty in considering our ethical acknowledgement of each stage of the person's life. Within this concept, we deal with one person imbedded within a culture. Each culture or subculture may have different ways of handling the evolution of a person-life, but each will have something to say about the significance of the stages, the relevant responsibilities of moral agents and the expectations of moral patients. The person-life does not evolve in isolation and evolves as much by loss as by gain. Entropy is an iron law for the many systems that constitute the person.

These arguments have direct relevance for person-centered medicine. Medicine deals specifically with human beings. Veterinary surgeons deal with other animals. Therefore, clinicians have already declared themselves as 'human animalists' from the start. Persons belong to the species *Homo sapiens* and arguments to the contrary generally fall outside medical discourse. Medicine deals with humankind in its full range from foetus to child to adolescent to adult and beyond to age with its concomitant declines. It accepts the truths of change, gain and loss and
knows the difference between the experience of loss and the loss of experience. Dilemmas arise when doctors-as-persons face intuitive uncertainty. What is the status of a foetus, of a man with Alzheimer's beyond communication, of a decerebrate boy after an accident? These have some unmistakably human form, but no semblance of Lockean personhood. Each occupies the space of a human being; each has a history or the vestige of a history; each can make us uncomfortable because their practical agency is absent. Yet they still remain moral patients, the objects of our moral concerns and commitments. And doctors are persons, moral agents and moral patients themselves, involved in interpersonal relationships. Schechtman's person-life view offers no ready solutions to such moral concerns, but contributes significantly to reflective equilibrium [32-34]. The concept of personhood may help us to place our patients, their families and ourselves within the cultural frameworks that formed us all, may help us to express respect for one another and to communicate well, but it still leaves a good deal of moral ground to ethicists.

Personhood as emergence

Personhood can be considered in other ways. Human beings are complex systems, each with a biology that is at once shared with others and unique to each individual. Each of us, doctor or patient, is imbedded in cultures and groups and subgroups and families and diverse friends and so on. These are systems too, with rules and relationships and complexities. Emergence is recognised in both philosophy and systems theory as the appearance of unanticipated and novel entities from complex systems [35-39]. Spencer-Smith [40] has examined the status of ontological and epistemic emergence and concluded that emergent novelty may seem to represent an irreducible mystery, but that — if we concede that emergence always takes place from a system — there has to be an explanation for what has emerged. We accept that water emerges from hydrogen and oxygen. At one time in history, water's emergence from the mixture was a mystery, only to be described, shown to have predictability and reversibility. Then it became explicable at the level of atomic and subatomic particles. The nature of water and the precise reasons why water emerges rather than some other substance may resist explanation for longer, but there is no reason to think that water itself should always remain an inexplicable mystery as levels of understanding reach deeper and deeper.

A similar argument applies to personhood, which emerges from the almost infinitely complex systems of human being and enculturation. Personhood can be seen as something supervenient on the phenomenon of human life and sociation. But supervenience always implies subvenience, something on which it rests. We may never completely explain personhood on a material basis, never reduce it to the raw functions of body and brain situated in sociation with other bodies and brains. Our understanding of personhood is almost certain to change as we continue to study it. Its relevance may decrease or increase. Reductionism is at best an aspiration in the face of such complexity and the intellectual position we are lead toward is close to that of non-reductive materialism [41,42]. The more we find out, the more we have to explain and the more theories we have to construct. The (qualified) free will that each of us possesses is under no threat from seeing personhood as emergent. The further genomics takes us toward the quantum level of understanding, the more we enter the realm of 'iron probability', the realm where probability dominates inquiry. If truth is warranted assertability, then our warrants and our assertions will go on changing for as long as we can think and refine our measurement techniques [43-46]. We may navigate toward physicalist explanations, but we cannot (yet?) reach adequate reductive explanations. The person and her agency will not reduce to a material base.

Once again, the emergent nature of personhood has implications for person-centered medicine. To say that personhood is 'emergent' does little to settle priority between being human and possessing Lockean characteristics of intention, reason and so on. Ultimately, personhood has to be construed as a substantive component of medical ontology and epistemology if it is to survive and flourish as a component of clinical theory and practice. Wulff and colleagues have characterised medicine's ontology as realist and its epistemology as empiricist [47]. Medicine is also materialist in its scientific orientation, while admitting the psyche into such domains as suffering, pain and the psycho-somatic. Person-centered medicine, if it is to succeed, would therefore need to convince medical students and practitioners that personhood is not simply an irreducible, emergent and insubstantial concept, but that it is real and that it has material consequences for the practice of medicine. And that will mean minimally that it can be shown to exist, can be discursively qualified, used in a therapeutic relationship and can be causally related in some way to illness and healing. It needs to be defined, given pedagogical and practical status and empirical support. Somehow, it has to be related to outcomes, to such things as safety, satisfaction and self-development, both for doctors and patients [48,49] and those outcomes will need to be demonstrable. Thomas's theorem [50] states that "If men define situations as real, they are real in their consequences". Making personhood a central part of the 'situation' of the clinical encounter is the formidable task that faces person-centered medicine. And when PCM promises to ground itself in the philosophy of personhood, it needs to be clear what that claim means and how something so complex and contested can be translated into medical reality.

Respect for persons

These reflections are important theoretically and help us to see that pinning down a theory of personhood, rather than a list of its attributes, may be difficult. Personhood is a construct with purchase in philosophy, politics, law, psychology, sociology, anthropology and common discourse. In each of those discursive domains, personhood
is assigned attributes that reify it. Yet our interest in personhood is in some ways an interest in something about humankind to which we assign value in an arbitrary way. If we insist that personhood for our purposes is adequately defined by the attributes that Cassell privileges in his definition, then we are simply declaring that these are the (currently) prized attributes of a ‘good’ and ‘flourishing’ human or at least of a human imbedded in a properly oriented culture or society. In the relatively recent past, personhood in one culture privileged immaculate Aryan ancestry, blue eyes, blond hair and cephalic measurements that fell within a certain range. Human beings falling outside certain desiderata were considered non-persons. Once again, Thomas’s theorem reminds us that defining situations as real makes them real in their consequences. The Nazi era testifies to the truth of the theorem. So we must enunciate our normative criteria for personhood with great care and still attend to deeper understandings of personhood that justify respect for the differences and preferences to which Fulford is so sensitive [51-53].

Respect is a word that travels as a fellow with personhood. Kant made respect for persons central to his deontological ethics [54] and that principle has remained central to debates about rights and human dignity ever since. But the argument is still unsettled whether we owe respect to all persons by virtue of their shared characteristics (the egalitarian or liberal view) or whether we owe it to persons as individuals by virtue of their cultural and individual differences (the ‘multicultural’ view [55]). Darwall [56] has introduced a further tension into the apparently simple notion of Kantian respect for persons, by distinguishing between two kinds of respect. Recognition respect is a disposition to give weight to some characteristic of the object of respect, simply because it is there and the disposition to give it weight has some value to the respecting person as a member of a group or culture. Respect for other humans qua humans is an example of recognition respect. Moral recognition respect is a particular version of recognition respect. It expresses the normative intuitions and explicit norms that govern the attitudes and behaviour of people toward one another in a particular culture. Appraisal respect is the attitude of hierarchical acknowledgement of the attributes of admirable people. Some people are appraised as better than others on implicit scales of attributes and achievements in such domains as morality, intelligence, physical strength and courage.

Doctors are taught that appraisal respect is both good and dangerous. It is good when directed toward mentors and role models, but dangerous when it comes to treating patients. Doctors should treat everyone equally, whether they are a prime minister or a homeless person. Recognition respect, particularly in its moral variant, is the kind that is relevant to the person in person-centered medicine. It is seen as a good in itself, as a Kantian imperative, but also as a consequential good because it is claimed to produce better care for patients and their families. It should therefore benefit everyone involved in the care of the ill, carers because they reap the moral benefits of respecting persons, patients and their families because they experience better relationships, communication and outcomes.

This Utopian structure is built on somewhat uncertain foundations. Bird [57] has pointed out — and this relates to the earlier point about the dangers of definition by normative attributes — that respect for persons is grounded far more in a hierarchical system than a purely egalitarian one. To respect people by appraisal is of course to acknowledge their greater excellence in some particular attributes and we do this all the time to our colleagues and to the powerful, wealthy, eminent, successful, famous and so on. But even to respect by recognition is to acknowledge the status of persons as in some way of special moral significance. To be accorded the status of an equal is a recognition of superiority over the non-human, the non-person. And herein lies a danger that brings us back to an earlier point about the fragility of personhood. All seems well when we can identify Cassell’s criteria: ‘embodied, purposeful, thinking, feeling, emotional, reflective, relational, human individual always in action, responsive to meaning and whose life in all spheres points both outward and inward’, so that a person’s behaviour, whether ‘volitional, habitual, instinctual or automatic’, has its genesis from and in meaning.’ Things are far more problematic when there is something that has a human form and the manifestations of life, but has either not yet developed these criteria or may be incapable of developing them, or has lost them to the entropic forces of time or trauma.

We seem, therefore, to be thrown back to something like Schechtman’s person-life view, discussed earlier, if we are to make full use of the person in person-centered medicine. Although the term ‘person-life view’ fails to capture the essence of Schechtman’s complex arguments, her kind of person-centered animalism seems to express something that is intuitively recognisable in the difficult clinical contexts where the patient is present, but the person is absent in some degree. Some examples will make that clear — the foetus and the new-born, the violent antisocial psychopath, the genocidal war criminal, the decerebrate teenager after a car accident, the young woman vegetative after a subarachnoid bleed, the severely demented man with Alzheimer’s. Can we really claim that we as clinicians allow equal moral status to each of these people or claim that we make the same therapeutic decisions under all conditions for each of them? They are clearly persons on the person-life view and deserving of moral regard. But as Warren [58] has pointed out, we live in a moral world where there is an implicit (and often explicit) hierarchy of moral status. We assign respect, whether we like it or not, by both recognition and appraisal. Doctors climb out of bed to save the lives of people they would appraise as being well down on the hierarchy of social contribution. They do so because they recognise their duty to whatever has human form, whatever may live a person-life. They may not approve the life trajectory, but humanness falls always within their remit because it is with humanness, intuitively recognised and acknowledged, that persons begin, develop their capabilities and end. And that generalisation applies to doctors as well as patients. Doctors are persons, embodied,
cognitive, emotional, burdened, tired, challenged morally throughout their careers and members of a number of societies with other persons. They, too, are moral patients and moral agents, just like their patients.

So what?

Person-centered medicine is a great name, but it does run the risk, as Miles and Mezzich [2] have acknowledged, of suffering the same fate as all the other portmanteau terms (EBM, VBM, PCC, humane medicine, narrative-based medicine) that have claimed reforming content for their portfolios. Miles and Mezzich have argued that person-centered medicine has particular strength because it appeals to the philosophy of personhood [2] and they cite Cassell's criteria as their reference point. But as I have pointed out, Cassell's criteria assume a theory of the person. They express, in other words, some underlying theory that justifies picking out these criteria. They look, as well, suspiciously like aspirations of Western liberalism: 'embodied, purposeful, thinking, feeling, emotional, reflective, relational, human individual always in action, responsive to meaning and whose life in all spheres points both outward and inward'. They are fine criteria within Western liberal culture; but do they capture the personhood of a Buddhist monk leading a contemplative life? Or the personhood of someone with Asperger's syndrome whose life may be productive and interesting, but unlikely to satisfy all of Cassell's criteria? And do they confirm or deny the personhood of a severely demented human being? They demand some inventiveness if they are to apply helpfully and meaningfully to personhood as a reason to practise medicine in a particular way.

Let me therefore suggest some guidelines for grounding person-centered medicine:

1. Medicine deals only with human beings. Non-human animals come under the care of other specialties.
2. Medicine's understanding of personhood covers both human animal existence and Lockeian cognitive, emotional and intentional criteria, such as those defined by Cassell.
3. Healthcare practitioners intuitively invest living human form with the capabilities of personhood, however, imperfectly those capabilities may be expressed. They are moral agents, in other words, when they relate to the moral patiethood of an anencephalic new-born or to a decerebrate stroke patient.
4. Personhood emerges from the complex systems that evolved into human life. It is situated in and powerfully shaped by culture and society.
5. Personhood is marked by both gain and loss throughout individual human existence.
6. The person-life view (Schechtman) respects the capabilities and the history of any human life form.
7. Respect is linked to personhood, as both recognition-respect and appraisal-respect.
8. Respecting personhood translates into actions that are beneficial to patients, families, communities and healthcare practitioners and is therefore morally desirable.
9. Personhood, thus articulated, describes intuitions and attitudes that are logical for healthcare. It does not provide answers to the ethical problems that come from those relationships. It may help reflection about ethical quandaries, but only as a component of reflective equilibrium [32-34].

Conclusion

Pioneers have kick-started person-centered medicine in a really impressive way, challenging established discourses such as EBM with energy and promise [1,2,59-63]. The promises have included a turn to 'the philosophical understanding of personhood' [2]. The energy comes from the clear and reasoned discourse that develops from a zeal to re-personalise medicine. Like all discourses, it will develop its way of talking, its situated meanings, its symbols of membership and exclusion, its iconic texts and so on [64-68]. In the same way, it will lead to critiques and counter discourses. Discourses suffer entropy and they need sustaining sources of energy.

Person-centered medicine seeks to do what others have sought before, to humanise and personalise the practice of medicine, while retaining its essential scientific component. The list of those who have had the same goal is formidable — Osler [69], Mechanic [70,71], Epstein [72], Charon [73,74], Brody [75-77], Frank [78], Montgomery [79], Hawkins [80,81], Skrabanek [82] — the list could go on and on. Yet it is evidence-based medicine that has colonised medical practice — witness the innumerable critiques it has spawned [60,83-88], let alone its huge literature of support [89-97] — and we have to ask why the relational and caring alternatives still struggle for purchase. A rich philosophical background to draw on might help person-centered medicine to survive and flourish, as it deserves. It needs to be something more than yet another complement to EBM.

Acknowledgements and Conflicts of Interest

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