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Person-Centered Health Care: Capabilities and Identity

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Entwistle and Watt ([2013](#)) make an important contribution to the person-centered view of health care by reframing past thinking on the subject in terms of the capability approach. Past thinking about person-centered care, often rather characterized as patient-centered care (see their Table 1), employs a range of normative values that are arguably supportive of the concept of a person. But ironically these values are not clearly grounded in any account of what the person is. Thus, it is not clear what anchors these values and so how they are to be interpreted in concrete care settings. Suppose clinicians believe they respect the dignity of their patients. What should they look for to determine whether the way they deliver care actually does treat their patients as persons?

The capability approach employs a fairly specific conception of what persons are, namely, that they are *agents* of their own capability development (where capabilities are their opportunities to achieve different functionings to do and be what they value). This view of the person as an active being contrasts with the emphasis in many person-centered conceptions of care framed as *patient*-centered care. As the word itself indicates (derived from to wait, bear, or suffer), "patients" are recipients of care, therefore passively involved in their care, albeit seen in patient-centered accounts of care as deserving of respect and invested with dignity in that capacity. It is true that person-centered conceptions of care formulated as patient-centered often invoke

personal responsibility and self-determination. But absent a way of seeing people as agents who are actively involved in their own care, they often employ a narrow understanding of autonomy as noninterference. As Entwistle and Watt note, this can generate paradoxical views of clinician practice where those with expert knowledge are expected to defer care decisions to their patients in preference-sensitive circumstances to allow them to maintain their “independence.” Patient personal responsibility and self-determination have little meaning in this framework.

THE PERSON AND “PERSON-AL” CAPABILITIES

What Entwistle and Watt then offer is a way of understanding how people actively determine their health and care preferences in interaction with clinicians in terms of the idea of people developing their “person-al” capabilities. This gives one key part of how they ground the idea of a person as an agent, namely, their relational autonomy view of personal identity. In contrast to the noninterference view of autonomy, when people's identities are relational and derive from their interaction with others, that active interaction requires that others recognize them as agents. The person-centered value of respect that clinicians pursue is then tied to recognition of their patients as agents. Adam Smith ([1790](#) [1976]) long ago explained recognition using the impartial spectator idea, or here the idea that clinicians understand the point of view of their patients as their patients understand it. How they would actually do this goes to the second key part of how Entwistle and Watt explain “person-al” capabilities.

Consider what one might find when imagining oneself in someone else's place. As Entwistle and Watt explain, it is essentially the narratives people keep about themselves regarding why they are doing what they are doing, what their goals are, and what their views of their past are—all components of ongoing stories people maintain about how they see themselves as distinct persons, whether rightly or wrongly. Thus, when we respect people as relatively autonomous, their “person-al” capabilities are what might be called their personal identity capabilities (Davis [2011](#)), ones that they actively pursue to achieve who they each think they individually are, and around which they organize their broader capability development in terms of all the particular opportunities they pursue in life.

QALYS?

Many person-centered, or patient-centered, care accounts emphasize the need to respect patients' preferences, and represent these preferences using the QALY (quality-adjusted life year) measure. The QALY measure provides a single number evaluation of the value of health care outcomes derived from what people would prefer regarding the quantity and quality of life they could expect to live under those outcomes. Crucially, it assumes people's preferences are stable and given. But in the capabilities approach people's preferences are not hardwired and given but are instead the product of their continual efforts to develop who they think they are in terms of their “person-al” capabilities. The QALY measure thus has two weaknesses for a person-centered care account: It ignores the process by which preferences are constructed in the clinician–patient relationship, and it employs an inadequate proxy for what people fundamentally value, namely, their “person-al” capabilities.

The implication of this is that new “person-al” capabilities-based metrics need to be created in order to determine care priorities. Their emphasis would not be on standardized disease management protocols and assumed stable patient preferences but on people's shared participation in determining their health self-management needs. If the most important thing to people is their ability to function as persons—something that varies according to one's circumstances in life—then they should be able to register what this involves—indeed have responsibility to do so—in communication with clinicians, and with family members, in determining the care they receive. This means there is no “one-size-fits-all” solution to health care provision. A capabilities-based

metric is not a simple set of rules but rather guidelines for investigating and identifying people's values regarding their sense of themselves as persons.

THE CAPABILITY APPROACH

Finally, not to be overlooked is that Entwistle and Watt not only make a valuable contribution to person-centered care thinking, but also make an important contribution to the capability approach as well. One of the main disputes between proponents of the capability approach concerns whether there ought to be a basic list of universal capabilities as guidelines for human development (Nussbaum [2003](#)), or whether human capability development ought to be seen as a more pluralistic, open-ended process (Sen [2004](#)). In the health care context, the former view risks treating people as patients in the passive sense of the term because it sets out what capabilities people ought to pursue, while the latter gives emphasis to the idea that people are agents of their own capability development. Entwistle and Watt's emphasis on "person-al" capabilities provides a further way of understanding the latter position in tying the question of which capabilities people would seek to develop to their personal identity self-narratives. In this view, when we accord people dignity as distinct beings, we cannot say what they might believe would provide them their personal identities. Thus, it seems that people's capability development needs to be a relatively open-ended affair, including in the crucial domain of health care.

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