2 *Person-centredness: exploring its evolution and meaning in the health system context*

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Introduction

> *The right of citizens and patients to participate in the decision-making process affecting health care, if they wish to do so, must be viewed as a fundamental and integral part of any democratic society.*
>
> Council of Europe, 2000

As we have seen in the introduction to this book, there remains a lack of consensus about the actual meaning of patient or person 'centredness' in the context of health systems. There is considerable overlap with concepts such as 'empowerment' and 'participation'. Some view empowerment as a core principle or dimension of patient-centred care (Docteur & Coulter, 2012; International Alliance for Patients' Organizations, 2006), while others define centredness as a foundation or prerequisite for achieving empowerment (Castro et al., 2016; Lhussier et al., 2015).

A wide range of reviews have been carried out over the past two decades to better understand patient- and person-centred care and related concepts. Yet uncertainty remains, mainly because reviews tend to differ on a number of characteristics, such as:

- *the methodological approach*: including scoping review (Constand et al., 2014), systematic review (Kogan,Wilber & Mosqueda, 2016), meta-narrative review (Kitson et al., 2013), and integrative review (Sidani & Fox, 2014), as well as dimensional (Hobbs, 2009) or concept analysis (Castro et al., 2016; Lusk & Fater, 2013; Morgan & Yoder, 2012; Holmstrom & Roing, 2010), discourse analysis (Pluut, 2016), or a combination of these (Hughes, Bamford & May, 2008; Mead & Bower, 2000; McCormack & McCance, 2006; Scholl et al., 2014);
- *the disciplinary perspective*: mainly medicine (Lhussier et al., 2015; Mead & Bower, 2000; Scholl et al., 2014) and nursing (McCormack & McCance, 2006), although several studies looked across disciplines

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(Castro et al., 2016; Constand et al., 2014; Hughes, Bamford & May, 2008; Kitson et al., 2013; Morgan & Yoder, 2012; Sidani & Fox, 2014);

- *the setting*: considering for example general practice or family medicine (Hudon et al., 2012; Mead & Bower, 2000), acute or post-acute inpatient care (Castro et al., 2016; Morgan & Yoder, 2012; McCormack & McCance, 2006; Hobbs, 2009), rehabilitation (Leplege et al., 2007), dentistry (Mills et al., 2014), or across settings (Constand et al., 2014; Hughes, Bamford & May, 2008; Scholl et al., 2014; Sidani & Fox, 2014); or
- *the patient population or service area*: such as chronic care (Hudon et al., 2012), older people (Kogan, Wilber & Mosqueda, 2016) or maternity services (de Labrusse et al., 2016).

As a consequence, it remains challenging to arrive at an overarching common conceptual framework relevant to policy-making. At the same time, seminal work in the field has informed key policy documents at national and international levels, embracing the notion of patient- or person-centredness as fundamental to the delivery of health care that is accessible, effective and of high quality (Australian Commission on Safety and Quality in Health Care, 2011; Department of Health, 2010; Institute of Medicine, 2001; International Alliance for Patients' Organizations, 2006; International College of Person-centered Medicine, 2011).

In this chapter, we explore the evolution of patient- or person-centredness and seek to synthesize the insights emerging from existing reviews in the academic literature and policy documents. We begin by briefly tracing the emergence of the different notions and their objectives in the health and care sectors. We then critically examine the range of definitions and conceptualizations and consider the role of the perspective of different stakeholders and disciplines in shaping the understanding of these concepts. We close this chapter with some overarching observations and conclusions.

Informed by the review of the different concepts in this chapter, we use the term 'person-centred' throughout the entire volume. This decision was driven, mainly, by a recognition that the term 'patient-centred' may too narrowly focus on the patient–provider interaction within the individual (clinical) consultation and insufficiently take account of the social context within which people live and that influences disease trajectories and care choices (Hobbs, 2009; Starfield, 2011). More importantly perhaps, the notion of 'patient' may unduly reduce

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the individual to one affected by a given health problem (or disability) within the medical care system while within the context of this book we consider the broader context of health systems with the individual person at the centre in terms of exercising voice and choice and actively involved in shaping health services at the different tiers in the system (*see* Chapter 1). However, when reviewing the academic literature and policy documents we have considered both patient- and person-centredness because of their frequent and, at times, interchangeable use in the health care context.

Tracing the evolution of patient- and person-centredness as a concept in the health care context

The roots of some of the core principles underlying the idea of patient- and person-centredness date back to ancient civilizations that conceptualized health holistically and viewed respect for individuals as a key value (Mezzich et al., 2009). It is only more recently that either notion has emerged as a distinct term, although descriptions and interpretations of the evolution of these concepts vary among authors. This largely reflects the underlying differences in disciplines and perspectives (Hobbs, 2009; Kitson et al., 2013; Leplege et al., 2007; Mead & Bower, 2000; Laine & Davidoff, 1996; Stewart et al., 2003). For example, in the UK and Canada the terms patient-centredness and patient-centred medicine have been most closely linked to family medicine and general practice (Levenstein et al., 1986; Mead & Bower, 2000). Here, the concept can be traced to the writings of Balint in the 1960s, who described patient-centredness in medicine in the context of the physician–patient encounter, arguing for the physician to understand the patient as a whole person and "unique human-being" (Balint, 1969, p. 269). Similar developments have occurred elsewhere in Europe from around the mid-20th century, including in France, Switzerland and Sweden. Here, the approach to the medical encounter that emphasizes the whole person has been more commonly referred to as person-centred medicine (Leplege et al., 2007; Pfeifer, 2010; Mezzich et al., 2009).

In the USA the emergence of patient-centredness in medicine can be traced to the patient rights movement since the 1960s, and the concept is seen to have evolved at different paces in different aspects of medical care, from the process of patient care, to medical law, medical education and quality assurance (Laine & Davidoff, 1996). Some of the most

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influential work in the field that eventually led to the establishment of the Picker Institute and the formulation of the Picker principles of patient-centred care (*see* below) originated from empirical research undertaken in the hospital setting in the USA during the 1980s (Gerteis et al., 1993; Picker Institute, 2013). That work also informed the formulation of patient-centred care as one of the core components of high quality care as advanced by the US Institute of Medicine's influential 2001 report, 'Crossing the Quality Chasm' (Institute of Medicine, 2001).

The nursing literature has linked the idea of 'centredness' more closely to the notion of caring, tracing its origins to Florence Nightingale and the emergence of modern nursing, with its focus on the patient, in contrast to medicine with its focus on the disease (Morgan & Yoder, 2012). This understanding is most often, although not always, expressed through the use of the term person-centred care (McCormack, 2003; McCormack & McCance, 2006; Morgan & Yoder, 2012). In this context, a number of scholars both in the medical and the nursing literature have referred to the writings of Carl Rogers in the 1940s on client-centred psychotherapy, which are seen to have influenced the understanding of the relationship between the professional (doctor, nurse, therapist) and the patient in building a therapeutic alliance as a key component of person-centred care (Hughes, Bamford & May, 2008; Morgan & Yoder, 2012; Leplege et al., 2007; Mead & Bower, 2000).

The concept has evolved and expanded over time, with a broad range of terminologies, definitions and multiple dimensions discussed in the literature. Thus, Scholl et al. (2014) identified, in a systematic review of patient-centredness in health care, 417 articles that contained a definition of the concept. Their review also noted that over 80% of reviewed papers had been published after 1999, pointing to the exponential increase in recognition of the notion of this and associated concepts in both research and the policy context. Box 2.1 presents a selection of definitions of patient- and person-centred care that have been proposed since the late 1960s.

The range of definitions presented in Box 2.1 is not meant to be exhaustive but rather serves to illustrate the variety of understandings of the concept and the different emphasis placed on particular aspects. However, notwithstanding the differences between definitions and characterizations, a number of common themes can be identified. These relate to the fundamental ethical premise that patients should be treated as persons, with respect and dignity, and that care should take

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Box 2.1 Selected definitions of patient- and person-centred care

Balint (1969)	Patient-centred medicine understands the patient "as a unique human-being" (p. 269)
Gerteis et al. (1993)	Patient-centred care is "an approach that consciously adopts the patient's perspective" (p. 5)
Laine & Davidoff (1996)	"Patient-centered care is health care that is closely congruent with and responsive to patients' wants, needs and preferences" (p. 152)
Institute of Medicine (2001)	"Patient-centered – providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (p. 6)
International Alliance for Patients' Organizations (2006)	"[T]he essence of patient-centred healthcare is that the healthcare system is designed and delivered to address the healthcare needs and preferences of patients so that healthcare is appropriate and cost-effective." (p. 1)
Berwick (2009)	Patient-centred care is "the experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care." (p. w560)
Canadian Medical Association (2010)	"The essential principle is that health care services are provided in a manner that works best for patients. Health care providers partner with patients and their families to identify and satisfy the range of needs and preferences. Health providers, governments and patients each have their own specific roles in creating and moving toward a patient-centred system" (p. 8)
International College of Person-Centered Medicine (2011)	"Person-centered medicine is dedicated to the promotion of health as a state of physical, mental, social and spiritual wellbeing as well as to the reduction of disease, and founded on mutual respect for the dignity and responsibility of each individual person" (p. 1)

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Box 2.1 (cont.)

The Health Foundation (2014)	"Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care. It is coordinated and tailored to the needs of the individual. And, crucially, it ensures that people are always treated with dignity, compassion and respect" (p. 3)
Haut Autorité de Santé (2015)	"The patient-centred approach is based on a partnership of the patient, their relatives and the health care professional or a multi-professional team to achieve the development of a care plan, the monitoring of its implementation and its adjustment over time" (p. 1)

into account their needs, wants and preferences (Duggan et al., 2006; Entwistle & Watt, 2013), which reflect the key concerns that the idea of patient- or person-centredness is expected to address.

Indeed, the emergence of patient-centredness in medicine has been linked to the perceived shortcomings of the conventional way of providing medical care, in particular the physician–patient interaction (Duggan et al., 2006; Laine & Davidoff, 1996; Mead & Bower, 2000). This interaction was seen to be too disease- or illness-oriented, where the patient is "reduced to a set of signs and symptoms" (Mead & Bower, 2000, p. 1008) and the health care professional to a technician who delivers a given intervention and performs procedures (Duggan et al., 2006). The traditional model was also viewed as too paternalistic and system- or staff-centred, that is, inappropriately focused on the needs and interests of those providing the services, thus giving insufficient attention to the needs, preferences and values, and autonomy of the individual patient (Entwistle & Watt, 2013). A patient- or person-centred approach, then, is seen to provide a strategy to overcome or correct for these limitations as reflected in the range of characterizations shown in Box 2.1.

It is against this background that different authors have proposed conceptualizations of patient-centred care that distinguish a set of dimensions or domains from specific perspectives and Table 2.1 presents a selection of influential frameworks. The most commonly known is

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Table 2.1 *Dimensions of patient-centred care as identified by selected seminal frameworks*

Gerteis et al. (1993)	**Stewart et al. (1995)**	**Mead & Bower (2000)**
Conceptual framework that explicitly adopts the patient's perspective; developed from empirical research with recently discharged patients, their families and hospital staff	Model of the patient-centred clinical method, building on both theoretical and empirical research	Conceptual framework focused on the physician–patient relationship, based on a review of the published literature
• *Respect for patients' values, preferences and expressed needs*: paying attention to patient's quality of life, dignity, needs and autonomy; involvement in decision-making • *Coordination and integration of care*: clinical care, ancillary and support services, front-line patient care • *Information, communication and education*: on clinical status, progress and prognosis; on processes of care; information and education to facilitate autonomy, self-care and health promotion	• *Exploring both the disease and the illness experience* (history, physical, lab; dimensions of illness [feelings, ideas, effects on function and expectations]) • *Understanding the whole person*: the person, the proximal (e.g. family, employment, social support) and the distal context (e.g. culture, community, ecosystem) • *Finding common ground*: problems and priorities; goals of treatment and/or management; roles of patient and doctor	• *Bio-psychosocial perspective:* perspective on illness that includes consideration of social and psychological (as well as biomedical) factors • *Patient-as-person*: an understanding of the personal experience of the illness for each individual patient within their unique context • *Sharing power and responsibility*: recognition of patients' needs and preferences and respect for patient autonomy, encouraging active patient involvement

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Table 2.1 *(cont.)*

Gerteis et al. (1993)	Stewart et al. (1995)	Mead & Bower (2000)
• *Physical comfort*: pain management; help with activities of daily living; surroundings and hospital environment • *Emotional support and alleviation of fear and anxiety* • *Involvement of friends and family*: accommodation; involvement in decision-making; involvement as caregivers; recognizing needs of the family • *Transition and continuity*: provision of information; coordination and planning of ongoing treatment and services; ongoing support	• *Incorporating prevention and health promotion* • *Enhancing the patient–doctor relationship*: compassion, power, healing; self-awareness; transference and counter-transference • *Being realistic*: time and timing; teambuilding and teamwork; wise stewardship of resources	• *Therapeutic alliance*: developing common therapeutic goals and enhancing the personal bond between the doctor and the patient • *Doctor-as-person*: awareness of the influence of the personal qualities and subjectivity of the doctor on the practice of medicine

perhaps the conceptualization which was developed within the Picker-Commonwealth Program for Patient-Centered Care. This programme began in the 1980s in the USA to promote the movement of patient-centredness into a comprehensive health care system as a way to deliver better health care services (Gerteis et al., 1993). Adopting an explicit patient perspective, the framework put forward by Gerteis et al. (1993) identified seven dimensions of patient-centred care (Table 2.1). As noted earlier, these dimensions became the Picker principles of patient-centred care, with an eighth dimension (access to care) added subsequently to emphasize the need for care to be available and accessible in a timely manner (Picker Institute, 2013). This programme was the first to identify that patient-centred care should not only occur at the interpersonal level, between care provider and patient, but also at the organizational level (Kitson et al., 2013). As noted earlier, it informed the US Institute of Medicine's programme on health care quality, as well as health policy internationally.

In Canada, at around the same time, Stewart et al. (1995) developed a model of the patient-centred clinical method in the context of primary care, building on both theoretical and empirical research. This work identified six dimensions of the patient-centred process and it has been seen to be influential in stimulating patient-centred research in primary care, in particular around effective doctor–patient communication (Kitson et al., 2013). The model developed by Stewart et al. (1995) also informed work by Mead & Bower (2000), who proposed a conceptualization of patient-centred medicine that focused on the physician–patient relationship. This framework identified five key dimensions with each representing a particular aspect of the physician–patient relationship (Table 2.1).

The nursing literature has evolved in parallel but is less frequently referred to in the writings about patient-centred care. Indeed, the nursing perspective has tended to use the term 'person-centred' rather than patient-centred care, reflecting its focus on caring rather than diagnosis and treatment options, as highlighted above. Work by McCormack and colleagues (McCormack, 2003; McCormack & McCance, 2006) is seen to have been particularly influential in informing the development of person-centred nursing (Kitson et al., 2013). Arguing from the perspective of nursing theory and influenced by Donabedian's work on quality of care, McCormack & McCance (2006) proposed a person-centred nursing framework that comprises these constructs:

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the characteristics and attributes of the nurse; the context in which care is delivered; person-centred process: how care is delivered; and expected outcomes.

Similar to the aforementioned work of the Picker-Commonwealth Program for Patient-Centered Care, McCormack & McCance (2006) highlighted the importance of the care environment in enabling the delivery of person-centred care. Indeed, the care environment is seen to have a "major impact on the operationalization of person-centred nursing, and has the greatest potential to limit or enhance the facilitation of person-centred processes" (p. 476). We will return to this issue below.

Patient-centredness and person-centredness: the same but different?

So far, we have considered the terms patient-centredness and person-centredness in parallel, as if they were interchangeable. However, as indicated above, this is not necessarily the case and here we explore the similarities and differences between these two notions in order to encourage a more nuanced debate of their actual meaning.

As noted earlier, based on our assessment of the available literature, we have observed that differences in the usage of these terms appear to reflect, to a great extent, different disciplinary traditions, perspectives and settings. For example, considering the perspective of the medical encounter, we have seen that the Anglo-American literature has, at least traditionally, tended to emphasize the notion of patient-centredness and patient-centred medicine (and more recently, patient-centred care) (Australian Commission on Safety and Quality in Health Care, 2011; Berwick, 2009; Gerteis et al., 1993; Laine & Davidoff, 1996; Mead & Bower, 2000; Picker Institute, 2013), whereas some of the continental European literature has tended to use the notion of person-centred medicine (Leplege et al., 2007; Mezzich et al., 2009; Pfeifer, 2010) and person-centred care (Ekman et al., 2011).

This is, in part, reflected by the frequency with which either term is used in the predominantly medical literature as compiled in PubMed, the archive of biomedical and life sciences journal literature at the US National Institutes of Health's National Library of Medicine, and illustrated further in Figure 2.1.

Clearly, the number of mentions of a particular term in the biomedical and life sciences literature can only be seen as an approximation of

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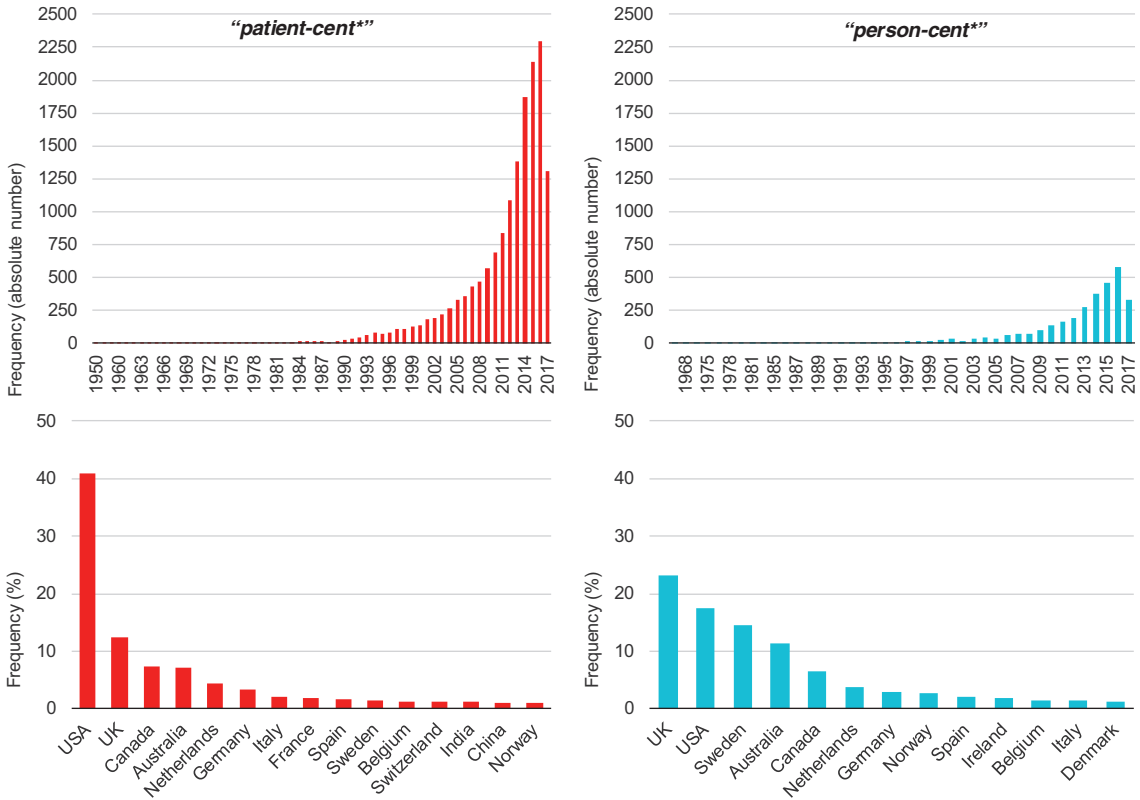


Figure 2.1 Frequency of articles mentioning versions of 'patient-centred' or 'person-centred' in the biomedical and life science database PubMed by July 2017

Source: authors' compilation based on PubReMiner, 2017

the use of a given term in practice; however, Figure 2.1 indicates that 'patient-centred' is by far the most commonly used term in the literature overall, and in particular in studies originating from the USA, reflecting, at least in part, the predominance of US-based papers in PubMed (Xu, Boggio & Ballabeni, 2014).

The nursing literature has tended to more explicitly use the term person-centred care (Kitson et al., 2013). This view is confirmed by, for example, the Royal College of Nursing in the UK, which uses the notion of 'person-centredness' deliberately to bring the different roles of service users (as patients in health care; clients in mental health care; residents in residential care homes) together using one term (Royal College of Nursing, 2015). Yet this is not consistent, with some nursing work also using 'patient-centred' care, although that work tends to focus on the acute, inpatient setting (Hobbs, 2009; Lusk & Fater, 2013).

It may be worth noting in this context that the Royal College of General Practitioners, also in the UK, highlighted in a 2014 report the importance of using the term patient-centred (Royal College of General Practitioners, 2014). It argued that the term patient was easily understood by professionals and the public and, notably, it would "challenge any negative associations that the word patient may suggest in today's NHS" (p. 10). However, at the same time the report emphasized the desirability of using 'person-centred' to describe the vision of an individualized, whole person approach to care.

The Health Foundation, an independent charity based in the UK, promoted a widely cited conceptualization that explicitly promotes the use of the term person-centred care as an approach that takes into account the whole person and "their preferences, wellbeing and wider social and cultural background" (Health Foundation, 2014, p. 9) – the very same characteristics that were identified to be among the core dimensions of patient-centredness as proposed in the seminal work by Mead & Bower (2000) (*see* below).

Are patient- and person-centredness the same, then? Hughes, Bamford & May (2008) carried out a review of the term 'centredness' across health care more broadly, to help clarify the use of the different concepts that have been emerging over recent decades, including client-, family-, patient-, person- and relationship-centred care (Table 2.2).

They found that the different types of 'centredness' contained, at a conceptual level, similar themes, and these, they argued, "could be used to characterize any particular type of centredness in health and

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Table 2.2 *Types of 'centredness' identified by Hughes, Bamford & May (2008)*

Type of centredness	Description
Client-centredness	Initially focus on empathic understanding, unconditional positive regard and therapeutic genuineness as (necessary and sufficient) conditions for therapeutic relationships; subsequently broadened to also include wider aspects of communication, in particular the provision of information to help inform decisions
Family-centredness	Emphasizes partnerships among providers, patients and families that are mutually beneficial; primarily used within paediatrics although considered to be applicable to all patient groups; linked to the practice of family therapy
Patient-centredness	Originated in large part from general practice with a focus on fostering joint understanding of illness and its management
Person-centredness	Originated in client-centred psychotherapy and subsequently adopted in other fields, such as dementia care, emphasizing communication and the relationship
Relationship-centredness	Intended to support the central role of relationships in modern health care; suggestion that the patient-centred model may not be sufficiently inclusive

Source: adapted from Hughes, Bamford & May, 2008

social care settings" (p. 461). This view might indicate the need to further specify the definition of the different concepts, a call that has been made by a number of authors in order to enable operationalization and measurement of patient-centredness in particular (Kogan, Wilber & Mosqueda, 2016; Mead & Bower, 2000; Scholl et al., 2014). However, given the multidimensionality of each of the concepts, Hughes, Bamford & May (2008) argued that it may not be possible to identify one single aspect that defines, say, patient-centredness as a whole. Also, existing measurement tools of, for example, patient-centredness address only some of the dimensions that are seen to be relevant to this concept, such as patient trust and satisfaction. As a consequence, most empirical

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studies of impacts of patient-centredness have only been able to identify evidence for some aspects of patient-centredness (McMillan et al., 2013; Rathert, Wyrwich & Boren, 2013; de Silva, 2014). Indeed, as argued by Hughes, Bamford & May (2008), given the complexity of the concept it may be unrealistic to measure it in its entirety within a single study.

Similarly, Sidani & Fox (2014) considered a wide range of disciplines and settings in their review of patient-centred care. They noted that while there were slight variations in, for example, the terminology used, they found more similarities than differences with regard to the components distinctive of patient-centred care. Hobbs (2009), in her review of patient-centred care, also noted that the (nursing) literature did not appear to fundamentally differ in terms of defining underlying constructs. At the same time, she asserted that the term person-centred care may more adequately reflect the shift of focus away from illness and disease towards the person experiencing illness. Hobbs further suggested that the core element of recognizing the patient as a person with the ability to make autonomous decisions was common to literature that used either term but that this element was more developed in the literature using the label 'person'. Based on this observation, she proposed that moving away from the use of 'patient' to that of 'person' "may enable broader conceptualizations of the individual experiencing illness" (Hobbs, 2009, p. 58). This latter view was reinforced in a commentary by Lines, Lepore & Wiener (2015), who highlighted the importance of terminology in recognizing that the social context within which people live can affect disease trajectories and care choices and ought to be taken account of in order to improve outcomes.

A similar view was offered by Starfield (2011), who, based on a review of the evidence, noted that definitions of patient-centred care tended to be organized around patient–provider interactions within individual consultations, which may be episode-oriented. Conversely, conceptualizations of care focused on the person would typically stress the longitudinal nature of the patient–provider relationship, which would see diseases and body systems as "interrelated phenomena" (p. 63) and which would be concerned with understanding people's experienced problems. This was seen to be of particular relevance in the context of chronic and multiple care needs, which also highlights the role of collaboration and coordination as a key feature of person-focused care.

Finally, the late 1990s also saw the emergence of a new concept of 'people-centredness'. This was first discussed in the context of health

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reforms in the UK at that time, which envisaged enhancing efficiency and maximizing health gain, alongside offering patients greater choice and calls for local communities to be more engaged in setting health care priorities (Williams & Grant, 1998). The notion of people-centred health systems was subsequently taken up by the World Health Organization in the context of efforts to address the continued pressures facing health systems, in particular equitable access to care that is both of high quality and responsive to the needs of people (World Health Organization, 2016; World Health Organization Regional Office for Europe, 2012; World Health Organization Western Pacific Region, 2007). These documents explicitly identify patient-centred care as focusing on the individual seeking care, while people-centred care would also consider the health of people in their communities and their crucial role in helping to shape health policy and services (World Health Organization Regional Office for Europe, 2012). More specifically, people-centred care is interpreted as an approach to care that "consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences" (World Health Organization, 2016, p. 2). This approach would require that people have the education and support to enable them to make decisions and participate in their own health and care, while also supporting carers.

Implications and conclusions

This chapter set out to synthesize some of the key insights emerging from the evidence around the concepts of patient- and person-centredness in the health care context. In line with other authors, we have shown that there remains considerable debate about the specific meanings of the different concepts, reflecting the different professional disciplines, perspectives and clinical settings, as well as different regional and country contexts, within which either notion has been approached and discussed. However, we have also seen that despite variations in terminology, when considering seminal texts from different disciplinary backgrounds (e.g. health policy, medicine and nursing), these tend to be fairly consistent regarding broad themes (Hughes, Bamford & May, 2008; Kitson et al., 2013; Sidani & Fox, 2014). These themes relate to the fundamental ethical premise that patients and service users should be treated as persons, with respect and dignity, and that care should

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take into account their needs, wants and preferences (Duggan et al., 2006; Entwistle & Watt, 2013).

Much of the literature on patient- and person-centredness has tended to focus on the interpersonal level between the care provider and the individual patient. Indeed, according to Kitson et al. (2013), it is only the health policy and nursing literature that has tended to focus explicitly on wider system and contextual issues, whereas the medical discourse tended to be "constructed around a very clearly delineated relationship between the individual medical professional and the patient" (p. 12). Hobbs (2009) highlighted the importance of the organizational and institutional context for providing person-centred care, with the distribution of authority and interaction of systems found to be of particular relevance. For example, organizations that relied primarily on a command-and-control style of leadership were less likely to provide person-centred care compared to those with shared governance. Few analyses and conceptualizations go beyond this meso-level awareness, however, with a subsequent systematic review noting that of the various dimensions characterizing patient-centred care, none addressed the macro-level of health systems (Scholl et al., 2014).

In this context, it is notable that there is considerable variation across the reviews and documents considered in this chapter as to whether patient- or person-centredness is to be seen as a concept or a framework that helps inform the delivery of care (e.g. McCormack & McCance, 2006; Mead & Bower, 2000; Stewart et al., 2003), a complex intervention (Sidani & Fox, 2014), a means to enhance the quality of care more broadly (e.g. Institute of Medicine, 2001) or an end, that is, a principle guiding the design of health systems more widely (e.g. World Health Organization, 2016; World Health Organization Regional Office for Europe, 2012; World Health Organization Western Pacific Region, 2007). Each of these perspectives, also linked to the philosophical and performance-based arguments as discussed previously (*see* Chapter 1), is of course legitimate but they will have different implications for the further development of health services and systems.

Finally, although work reviewed in this chapter has covered different disciplines, perspectives and settings in interpreting the conceptual foundations of patient- and person-centredness, few studies have explicitly considered the views of different stakeholders (Kitson et al., 2013). For example, Gillespie, Florin & Gillam (2004) found, in an interview study of clinical, managerial and lay stakeholders in the

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UK, that each group tended to place different emphasis on different aspects of patient-centred care. Notably, health professionals were more likely to interpret this notion as communication skills in terms of explaining and eliciting information (but not necessarily in terms of shared decision-making) within the individual consultation, while managerial stakeholders tended to view patient-centred care to be grounded in quality assurance measures. Conversely, lay groups viewed patient-centredness in the context of a social or whole person model of health, and this was frequently expressed to occur at the level of patient involvement in planning and delivery of services rather than within the individual clinical encounter. This reflects only one study in a specific health system context but similar findings have been reported in a study set in Switzerland (Gachoud et al., 2012).

These observations illustrate that while different stakeholders all agree that patient- or person-centredness is important, the concept very much remains subject to debate, with different perspectives attaching different meanings and with different implications. To help inform policy development it will be important to better understand this diversity of interpretations of centredness at the different tiers within the health system and backgrounds in order to achieve the goal for health systems to take a more person-focused approach.

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