Person Centred Care in Primary Practice

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Abstract

Ensuring the delivery of good quality health services at the primary care level is important if we wish to improve the overall health of the community. One of the pillars of quality assessment is person centred care. Person centred care is that which respects responds to, and resonates with, the necessities and needs of the individual seeking health care. In this review, we describe the various definitions of person centred care, and explore its scope and spectrum, as related to primary care. We suggest ways of incorporating person centricity, and thus improving satisfaction with healthcare services in South Asia.

Keywords: *Chronic disease, patient centred care, person centred care, primary care.*

DEFINITION

Person centred care is an essential part of quality health care. The World Health Organization (WHO) Western Pacific Region defines people-centred health care as "a balanced consideration of the values, needs, expectations, preferences, capacities, and health and well-being of all the constituents and stakeholders of the health care system". It has identified four domains; individuals, families and communities, health practitioners, health care organizations, and health systems for policy action [1].

The Institute of Medicine, USA, identifies person centred care, or patient care, as one of the six aspects of quality of health care. It describes the concept as providing care that is respectful of, and responsive to, the preferences, needs, and values of patients [2]. These definitions facilitate the creation of a healthcare ecosystem that promotes person centricity. In simple words, the provision of person centered care means ensuring that the person seeking care feels a welcome guest in the health care ecosystem. While the final biomedical target of ideal health, e,g. control of diabetes without drugs, or 6/6 vision without spectacles, may not always be achieved, but the person should feel that maximum efforts have been put in by the healthcare team to optimize outcomes. Person centered care also means that psychological and social components of health are given equal importance as compared to biological health.

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DESCRIPTION

Various organizations have published documents that assist planners in understanding what must be done to achieve Person centred practices. The National Institute of Clinical Excellence (NICE), United Kingdom (UK), offers guidance in five domains of person centred care. These are knowing the patient as an individual, offering essential requirements of care, tailoring or individualizing care as per needs ensuring continuity of care and relationships, and enabling active participation in their care [3]. The Picker Institute has listed eight domains of patient-centred healthcare. These include fast access, effective treatment, patient involvement, information and respect, attention to physical and environmental needs, emotional care, involvement of family and caregivers, and continuity of care/smooth transition [4]. Person centered care pervades the structure, process, and outcomes of health care, as is noted from its domains, listed in Table **1** and Fig. **(1)**.

Table 1: Domains of primary centred care (PCC).

STRUCTURAL DOMAINS
• Creating a PCC culture
• Co-designing health education programs with patients/caregivers
• Providing a supportive and accommodative environment, both for staff and patient/caregivers
• Utilizing information technology
• Creating structures for measurement and monitoring of PCC
PROCESS DOMAINS
• Cultivating communication skills
• Respectful and compassionate care
• Engaging patients in managing their care
• Integration of care
OUTCOME DOMAINS
• Access to care
• Patient Reported outcomes

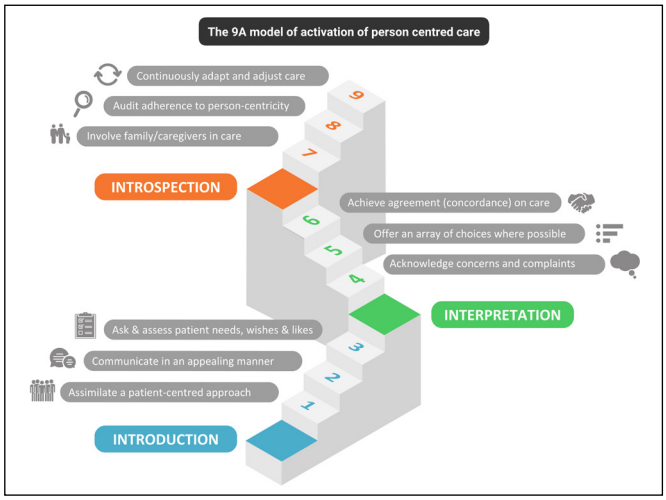

Fig. (1): The 9A model of activation of person centred care.

The International Association of Patient Organizations (IAPO) Declaration on Patient-Centred Health care (PCH) lists five principles upon which healthcare must be based. These are respect, choice, empowerment, patient involvement in health policy, access, and support, as well as information [5]. It must be noted that while person centered care is a technique to achieve good health, it is also a target in itself [6]. Person centricity serves as a tool for the evaluation of healthcare services and can be used to benchmark quality [7].

MEASUREMENT

Santana *et al.* (2018) list the various components of person centred care in three domains: structural, process, and outcome domains [6]. Table **1** helps simplify the concept for healthcare professionals and planners alike.

The International College for Person centred Medicine has developed a Person Centred Index (PCI) which serves as a checklist for improving one's quality of care. Structured in eight sections, the index lists 33 qualities of person centred care [7].

The indicators are classified as ethical commitment (6 indicators), cultural sensitivity (4), holistic scope (2), relational focus (3), individualized care (3), common ground for diagnosis and care (3), people-centred systems of care (9), and Person centred education and research (3). These allow one to measure the person-centredness of a health care system, a health care professional, or a health care interaction. Each of these indicators is scored on a 4-point Likert scale (1= never, 2= occasionally, 3= frequently, 4= always). The total score is read as a global average score and can be compared across practices, as well as across time. In a study conducted in Lucknow, India, inter-rater reliability indices were found to range from 0.86 to 0.99. A similar study, done in California, USA reported an inter-rater reliability of 0.89. This varied, however, from 0.06 for people-centred systems of care to 0.80 for both ethical commitment and cultural sensitivity. Users in London, UK, reported high suitability and usefulness of the PCI [7].

THE GLOBAL SOUTH CONTEXT

This is especially important in the context of the global South, where the sociocultural ethos requires, requests, responds to and reciprocates person-centricity in care. The importance of spiritual support in Person centred care has been described from a Biblical, Vedic as well as Islamic perspective [8-10]. The OCI includes mention of the patient's spiritual needs [7]. It lists the biopsychosocial model of health and adds cultural and spiritual domains to it as well.

While "personal values, choices, and needs are understood and respected", and individuality/personal growth and development promoted, inter-personal trust, empathy, and partnership are also encouraged. The focus on community participation reflects the global South ethos, too. South Asian and Middle Eastern families are amongst the most resilient in fighting diabetes. Data from the Diabetes Attitudes, Wishes, and Needs 2 (DAWN 2) study shows a high level of psycho-social support from family members of persons living with diabetes in Algeria, China, India, Mexico, and Turkey [11].

Person centred care is required at all levels of health care, and in all specialties. The concept of dialysis distress highlights how personalized counseling is needed in chronic kidney disease [12]. Similar insights have been published for virtually all spheres of medicine and nursing [13]. Person centred care, therefore, is a concept that must be integrated into our health care systems. This has been discussed at length by experts from Africa, Mexico as well as South Asia [14-16].

INTEGRATION IN EXISTING CARE

While Person centred care should come naturally to all persons, some health care professionals find it challenging to incorporate this into their routine praxis. One reason for this may be the lack of a Person centred ethos in modern medical curricula [6]. Assistance is available from leading professional organizations to help in this regard. The Institute for Patient-and Family-Centred Care (IPFCC) offers education and assistance in advancing PCC [17]. It helps foster an organizational culture and philosophy of PCC in various healthcare systems and centres.

THE 9A MODEL

We propose a simple 9A model, designed to assist in the activation of Person centred care (**Table 2, Fig**. **2**). This model has been created during informal discussions amongst endocrinologists from various continents – South America, Africa, and Asia. Initially, the aim was to create an educational aid to assist in integrating diabetes therapy into existing primary care systems. However, we feel that this framework is relevant to all

Table 2: The 9A model of activation of person centred care.

Hierarchy	Step	Domains for improvement
Introduction	• Assimilate a person centred attitude and approach • Appealing behavior and conversation • Ask and assess needs, wishes, likes	Self-realization and development Conversational skills History taking
Interpretation	• Acknowledge and address concerns, complaints, challenges • Appraise and offer array of choices, wherever possible • Achieve concordance and arrive at agreement	Medication counseling Motivational therapeutics Coping skills training Team skills
Introspection	• Allow and advocate participation of family members/caregivers • Audit, adherence to person-centricity • Adapt and adjust continually	Inclusivity Community orientation Self-audit Team skills

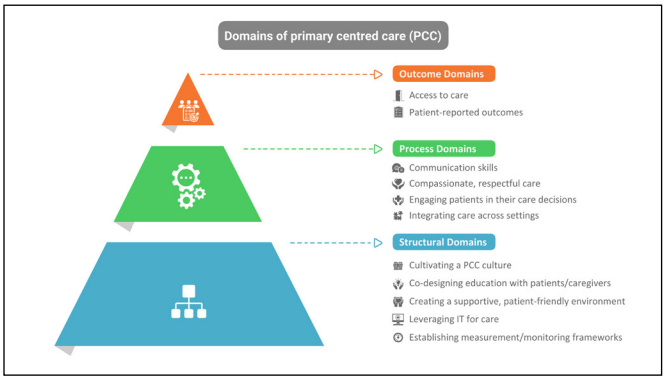

Fig. (2): Domains of primary Centred care.

fields of medicine, including maternal and child health, geriatric health, mental health, and other aspects of primary health care.

The nine steps are structured in three hierarchical parts. The first part focuses on the healthcare professional's mindset and history-taking skills and encourages them to incorporate person-friendly behavior in their thoughts and speech. The second layer reminds professionals about the need to interpret their patients' needs and preferences through a meaningful dialogue. It highlights the need for interpretation of the person's words, and nonverbal cues, in an individualized and empathetic manner. The third layer, which we term introspection, promotes continuous self-audit, and improvement in one's person-centric skills. It also calls for enhanced awareness of Person centred medicine at a community level.

This 9A model should prove helpful for all healthcare professionals, as they activate and assimilate person-centricity in their professional work. Person centred care has been shown to improve not only patient satisfaction but biological outcomes as well [18, 19]. We hope that the use of the 9A model will improve not only patient satisfaction but self-satisfaction as well. The use of this model will help improve adherence to therapy, and create a long-lasting relationship between the physician and family [20].

CONCLUSION

This movement should begin at all levels of medical care, ranging from primary to tertiary. It is at the primary level, however, that the vast majority of people seek health care. It is at this level, therefore, that the maximum benefit of Person centred care will be achieved. Medical students, at undergraduate and postgraduate levels, should be taught the importance of person centred care. The departments of preventive and social medicine, or community and family medicine, should take the lead in sensitizing all medical and health professionals about this.

Commitment, communication, and concerted action are required to do so. This is what we try to accomplish through this paper. Sensitizing ourselves to the importance of a Person centred conversation with critical analysis of information, supported by continued checks and controls, is the first step.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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AUTHORS' CONTRIBUTION

SK and NK conceptualized the framework of the manuscript. SK wrote the first draft, which was corrected by RM and AS, and then reviewed by IB and JA.

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