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REVIEW ARTICLE

Evolution, similarities and differences between patient-centered care and person-centered care

Evolución, semejanzas y diferencias entre la atención centrada en el paciente y la atención centrada en la persona

Evolução, semelhanças e diferenças entre o cuidado centrado no paciente e o cuidado centrado na pessoa

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ABSTRACT

Introduction: in recent years, given the avalanche of technology and specialization in the health sector, the concept of medicine centered on the patient and then on the person was introduced, which emphasizes the individual care of patients as subjects, with a holistic, general, non-fragmented approach that analyzes the human being in all its biopsychosocial dimensions. **Objective:** to describe the evolution, similarities and differences in patient- and person-centered care. **Development:** a review of the literature was carried out between 2021 and 2022. The milestones that have determined a change in current healthcare trends were specified. The contributions of research carried out and existing experiences in the implementation of patient- and person-centered care were considered. The information search was carried out in an advanced manner in databases such as SciELO, Science Direct, Redalyc, among others. Several articles were reviewed, in which the characteristics of both theories were addressed, as well as the state of the art in Latin America and Cuba. The need for a paradigm shift in attention to current theories was emphasized. **Final considerations:** the implementation of person-centered care would contribute to improving the quality of care taking into account the needs and preferences of people.

Keywords: patient-centered care; person-centered care; holistic health

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RESUMEN

Introducción: en los últimos años, ante la avalancha tecnológica y de especialización en el sector de la salud, se introdujo el concepto de medicina centrada en el paciente y luego a la persona, que enfatiza en la atención individual de los enfermos como sujetos, con un enfoque holístico, general, no fragmentado, que analiza al ser humano en todas sus dimensiones biopsicosociales. **Objetivo:** describir la evolución, semejanzas y diferencias en la atención centrada en el paciente y en la persona. **Desarrollo:** se realizó una revisión de la literatura entre 2021 y el 2022. Se precisaron los hitos que han determinado un cambio en las tendencias actuales de la atención sanitaria. Se consideraron los aportes de investigaciones realizadas y experiencias existentes en la implementación de la atención centrada en el paciente y en la persona. La búsqueda de información se realizó de manera avanzada en bases de datos como SciELO, Science Direct, Redalyc, entre otras. Fueron revisados varios artículos, en los que se abordaron las características de ambas teorías, así como el estado del arte en América Latina y en Cuba. Se enfatizó en la necesidad del cambio de paradigma en la atención hacia las teorías actuales. **Consideraciones finales:** la implementación de atención centrada en la persona contribuiría a la mejora de la calidad asistencial teniendo en cuenta las necesidades y preferencias de las personas.

Palabras clave: atención centrada en el paciente; atención centrada en la persona; salud holística

RESUMO

Introdução: nos últimos anos, dada a avalanche de tecnologia e especialização no setor saúde, foi introduzido o conceito de medicina centrada no paciente e depois na pessoa, que enfatiza o cuidado individual dos pacientes como sujeitos, com uma visão holística, geral, abordagem não fragmentada que analisa o ser humano em todas as suas dimensões biopsicossociais. **Objetivo:** descrever a evolução, semelhanças e diferenças no cuidado centrado no paciente e na pessoa. **Desenvolvimento:** foi realizada uma revisão da literatura entre 2021 e 2022. Foram especificados os marcos que determinaram uma mudança nas tendências atuais da saúde. Foram consideradas as contribuições das pesquisas realizadas e das experiências existentes na implementação do cuidado centrado no paciente e na pessoa. A busca de informações foi realizada de forma avançada em bases de dados como SciELO, Science Direct, Redalyc, entre outras. Foram revisados diversos artigos, nos quais foram abordadas as características de ambas as teorias, bem como o estado da arte na América Latina e em Cuba. A necessidade de uma mudança de paradigma na atenção às teorias atuais foi enfatizada. **Considerações finais:** a implementação do cuidado centrado na pessoa contribuiria para melhorar a qualidade do cuidado levando em consideração as necessidades e preferências das pessoas.

Palavras-chave: cuidado centrado no paciente; cuidado centrado na pessoa; saúde holística

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INTRODUCTION

The patient-physician relationship has undergone major changes over time. During the 1950s, the relationship between a patient seeking help and his doctor was characterized by the fact that decisions were made in silence by the patient. This interaction between doctor and patient, which was asymmetrical and unbalanced, has been questioned in the last 40 years in accordance with demands aimed at stimulating more active and autonomous participation by the patient, a reduction in the dominance of the doctor and better interaction between the two.[1,2]
In the same decade, the concept of patient-centred care (PCC) and later person-centred care (PeCC) emerged. The novelty of this initiative is that in the process of hospital management, care is organized around the health needs and expectations of the person rather than focusing on the disease.[3]

Since 2001, authors have increasingly used PeCC as a strategy for achieving and facilitating personalised, professionalized and responsive care for dependency needs.[3]

Despite the existence of various definitions of PeCC, all of them agree in one way or another on three fundamental aspects or pillars: maintaining a continuous respect for the person in terms of their values, always taking into account their preferences and acting on the basis of the needs expressed.

Authors such as Díaz-Álvarez,[4] Nápoles-Villa, et al,[5] Flores-Arévalo, et al.[6] approach hospital management from different angles, but none of them refer to the process of management centred on the patient and/or the person.

Different researchers also refer to PCC as a way of improving management processes in healthcare institutions, such as the study by Rodríguez, et al.[7]; however, other authors in their research focus on PeCC and particularize their studies on elderly people with chronic diseases.[8,9]

At the national level, there are studies on patient-centred care, such as the report by Bueno-Domínguez, et al.[9] who present interesting approaches; however, they do not refer to the application of this concept in a pediatric hospital environment in the country.

The change of orientation in health care facilities towards the interests of the people becomes a critical survival factor. The PeCC is seen not only as aiming at higher satisfaction but also at promoting sustainable hospitals for the future.[9]

For all of the above reasons, it was decided to conduct research with the aim of describing the evolution, similarities and differences between patient-centred care and person-centred care.

DEVELOPMENT

A literature search was conducted from October 2021 to February 2022 in databases such as SciELO, Science Direct, LILACS, Redalyc.

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Primary sources published in Cuba and other countries related to the topic of patient-centred and person-centred care were mainly used. These sources included scientific articles, theses and book chapters.

The most relevant contributions of studies that provided valuable elements for the theoretical systematization of the topic in question were taken into account.

Evolution of patient- and/or person-centred care

PCC emerged in the 1950s, when the psychologist Carl Rogers and the psychoanalyst Michael Balint spoke of "Client-Centred Therapy" and "Patient-Centred Medicine" respectively. What is new about these initiatives is that care is organised around the patient's health needs and expectations, rather than focusing on the disease.(10)

The term "patient-centred", coined by the English psychiatrist Enid Balint(11) in 1969, institutes the idea that "each patient must be understood as a unique being". In 1984, Lipkin, et al.(12) describe the doctor-patient interaction and define the patient as an unrepeatable being, with his or her own history, and the illness as part of his or her biopsychosocial dimension.

For their part, Levenstein, et al.(13) presented the patient-centred clinical method in 1986, with a focus on the person rather than the disease. This is an attempt to put it on a par with that of the doctor, who had historically governed the relationship. Recently, several authors have continued on the path of broadening the classical approach limited to the disease and transforming the doctor-patient relationship into a less asymmetrical and more empathetic interaction, with the intention of finding a more humanized role for the doctor.

Subsequently, Mead and Bower(14) tried to establish a preliminary conceptual framework, establishing five dimensions of PCC: the biopsychosocial perspective, the "patient-as-person", power and responsibility sharing, the therapeutic alliance and the "doctor-as-person".

However, it was McWhinney(15) who synthesized patient-centred care as one in which the physician must enter the patient's world to see the illness through the patient's eyes. It is this notion of "seeing the illness through the eyes" that makes it clear that in order to achieve "person-centred" care, it is not enough to improve the individual style of each doctor-patient relationship, but rather a radical change is needed in the health system in general and in institutions in particular.

In 1987, The Picker-Common wealth Program for Patient- Centered Care was born in the United States. The programme emphasizes considering the patient as the focus and object of an integrated form of health care delivery, superior to the initial "patient-centred care" movement, which begins as a rethinking of individual patient-physician interaction.(15)

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However, in 1997, Lambert points out that patient-centred care may not be enough and that a person-centred approach is needed. In recent years, the concept of person-centred care (PeCC) has been explained as a development of patient-centred care. The concept of person has its origins in philosophy and denotes what is most important in the human being that distinguishes him or her from everything else.[16]

Similarities and differences of patient- and/or person-centred care

According to the analysis in studies by Hakansson et al. PCC and PeCC involve empathy, respect, commitment, relationship, communication, shared decision-making, holistic approach, individualized approach and coordinated care. There are many similarities between the two concepts, but their goals differ in some ways.[17]

PCC was launched as an effort to recognise the individual in opposition to paternalistic biomedicine. It therefore seems logical that core concepts of patient-centred care such as empathy, communication and a holistic approach gain prominence. PeCC is a different concept and is developed to focus less on the role of the sick person and more on the unique individual with a disease or disability.[17]

These authors consider the concepts to be similar on a superficial level but different on a deeper level in light of their different objectives. Both PCC and PeCC are important alternatives that can and should coexist in clinical practice.[17]

Today there is a trend towards the use of PeCC rather than PCC to approach the patient as a person with needs and preferences beyond the medical perspective, so this author adopts this definition for her research.

In 2001, the US Institute of Medicine report "Crossing the Quality Chasm: A New Health System for the 21st Century"[16] proposed six goals: safety, effectiveness, efficiency, accessibility, person-centred care and timeliness. This consolidated the concept and made person-centred care one of the six main objectives of quality improvement.[18,19,20]

Three components are identified in the definition of PeCC: the uniqueness of users, the holistic approach that takes into account personal, social and environmental variables and the recognition of autonomy, i.e. respect for people and their capacity to decide.[18,21]

In short, PeCC is the model of care that considers two distinct dimensions, care for people and the positive environment. The concept of PeCC is complex and difficult to define; it is variously defined in the literature as "understanding the patient as a unique human being" or "entering the patient's world to see the illness through the patient's eyes".[18]

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PeCC is now seen as much more complex, with multiple components and dimensions. Stewart, et al.[19] identified six interconnected components:

a) The illness and the experience of illness.
b) The person as a whole.
c) Common management interests.
d) Prevention and health promotion.
e) Doctor-patient relationship.
f) Knowing personal limitations and resources.

In 2016, the WHO secretary in her report on the Framework for integrated, person-centred health services refers to person-centred care as "a way of understanding and practicing health care that consciously adopts the perspective of individuals, caregivers, families and communities as beneficiaries of health systems that inspire trust, are organised around the whole person's needs and respect preferences".[20]
Furthermore, he states that person-centred care also requires that people are given the information and support they need to make decisions and participate in their own care and that caregivers are able to perform at their best in a supportive working environment.[20]

According to Hakansson, et al. refer that the concept of person-centred care originates from care for the elderly and express that Kitwood develops the theory of person-centred care in the context of dementia care. Furthermore, Nolan points out that in elderly care settings the importance of feeling valued and acknowledged through satisfying relationships is used as a theoretical basis.[17]

Moreover, he notes that McCormack presents a concept of person-centred practice for the elderly, while Hakansson at the Centre for Person-Centred Care at the University of Gothenburg adopts an ethical perspective, stressing the need to know the person behind the disease.[17]

In short, a person-centred care approach puts them at the centre with their context, their history, their family and their individual strengths and weaknesses. It also means moving away from viewing the patient as a passive target of a health system to a model where the patient is an active part of their care and decision-making.

Hakansson, et al. refer to Edvardsson, Olsson, Hughes and others who in their studies justify the use of relationship, patient, person, client and family centred care. They found no thematic differences at the conceptual level between the different types of centred, but concluded that different types of centred were required in different contexts.[17]

However, it is important to note that the practice of person-centred care does not mean abandoning the goals of patient-centred care, as the former broadens and extends the perspective of the latter by considering the whole of the patient's life.[16]

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Person-centred care also requires that people receive the information and support they need to make decisions and, equally, to participate in their own care; it also recommends that caregivers are able to perform at their best in a supportive work environment.(18,19) This care is much more holistic than that proposed by Stewart, as the latter focuses on the disease.(19)

In summary, the WHO defines person-centred care as the axis around which the rest of the dimensions related to: evidence-based intervention, service organization, team, interdisciplinarity and environment revolve.(20,21)

Although the idea of putting the person at the centre, respecting their decisions, preferences and personal choices whenever possible, "adapting the centre to the people and not the people to the centre" are key elements, so is the search for a definition and a technical framework that will help the care model to improve based on organizational management.(21)

Faced with these changes in thinking about health care, it must focus on empowering the person and sharing power in the relationship, which means relinquishing control in the hands of professionals, i.e. they must perform the dual task of understanding them and understanding the illness.

The person becomes the central focus of care, with greater rights to demand certain standards of service quality, to have more information and to be included in decision-making about their health. This is why person-centred care programmes imply a complete transformation of the organizational culture; their success depends on the active involvement of each and every department (clinical and administrative) and person at all levels (from nurses, doctors, technicians, among others).

Person-centred care and the person-centred model of care are underpinned by 7 fundamental principles which are appropriate to this research:

- Principle of autonomy. This refers to the fundamental rights of people, with the right to make their own decisions and to control their lives.
- Principle of participation. This principle refers to the various situations of fragility or dependency that may be encountered and aims to establish the right to continued participation in daily life, to the enjoyment of social relations. Consequently, it is not only aimed at individuals, but also at their families or those close to them, who may also be present and participate in making decisions that affect the development of daily life.
- Principle of integrality. All human beings are multidimensional beings, so the care they receive must encompass biological, psychological and social aspects.
- Principle of individuality and privacy. Everyone is equal in terms of rights and duties, but each of us is different from the others in terms of needs and preferences. It is necessary that, despite not living at home, people in residential homes, supervised flats and hospitals, among others, enjoy adequate privacy and intimacy.
- Principle of social integration. Human beings are social beings by nature, which explains why, despite being incapacitated, fragile or in a situation of dependence, they must preserve social relations.

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- Principle of independence and well-being. All persons must have access to informative-training programmes aimed at preventing or worsening dependency, improving their well-being and promoting their autonomy.
- Principle of continuity of care. All persons who are in a centre due to a situation of fragility or dependency have the right to receive continuous and quality care, adapted to the circumstances and characteristics of each moment.

The achievement of integrated, people-centred health services will depend on what health systems deliver, including the availability, accessibility and quality of the health workforce and the services it provides. The draft global strategy on human resources for health identifies actions needed to ensure equitable access to a competent and motivated health workforce within a fully functioning health system.(21) In this regard, efforts have been made to ensure that the health workforce is available, accessible and of high quality.

In this regard, efforts have been made to establish clear linkages between the framework on integrated and people-centred health services and the global strategy, in particular by adapting national and global HRH investment frameworks to future health systems needs.(21)

FINAL CONSIDERATIONS

Hospitals must face a paradigm shift: placing the person's experience as an indispensable pillar when establishing the quality of clinical care together with the effectiveness of treatment, patient safety and the union of all the stakeholders of the organization to develop a culture of continuous improvement of the quality of care focused on the satisfaction of people and their families, hence the importance of its implementation.

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Authors' contribution:
Migdalia Fernández Villalón: conceptualisation, formal analysis, research, methodology, project management, original draft-writing, drafting-revising and editing.
Yanet del Carmen Pérez Ferreiro: formal analysis, research, methodology, project management, original draft, drafting and editing.
Emma Aurora Bastart Ortiz: conceptualisation, formal analysis, research, data curation, visualisation, original drafting, drafting-revising and editing.
Reinaldo Reyes Mediaceja: research, methodology, original draft-writing, drafting-revising and editing.
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