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Person-centered practice: from idiosyncrasy of care to health innovation

A prática centrada na pessoa: da idiossincrasia do cuidar à inovação em saúde

La práctica centrada en la persona: de la idiosincrasia del cuidado a la innovación en salud

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Abstract

Person-centered practice plays a significant role in the organization and management of health systems, as well as in the definition of health policies. This essay aimed to identify the ethical principles and theoretical structures of a person-centered practice, as well as the Portuguese and European national guidelines establish its regulation. A theoretical reflection was conducted based on the critical narrative review of the state of the art on person-centered practice, which aimed to answer the question: what are the structuring elements of the person-centered care practice that make it distinguished in obtaining health gains? Critical reflection contextualizes the paradigm shift to a person-centered practice and identifies the state-of-the-art domains associated with it: philosophical knowledge, theoretical frameworks for clinical practice, teaching and research, approaches to implementation, and regulation. These areas will necessarily have to be considered for a systematic and sustainable development and implementation with effective transformation into health gains.

Ethics; Patient-Centered Care; Persons; Integrated Delivery of Health Care

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Introduction

Sociodemographic and epidemiological changes challenge health systems regarding accessibility, integration, and cost-effectiveness [1]. Particularly, the increase in the average life expectancy of populations leads to more people experiencing chronic diseases or prolonged health/disease situations, which translates into an economic and human resource overload of health services [2].

These challenges require responses from health services, aiming at the integration of the user and the interaction between the several levels of care that simultaneously meet the uniqueness and specificity of the needs and resources of each user [2]. In this sense, health services have been transitioning from biomedical models of care delivery to a person-centered clinical practice, with evidence in health gains [3].

The importance of a person-centered practice is currently recognized by policy makers and managers of health organizations in the Western. The recognition made by the US Institute of Medicine (IOM) in 2001 of person-centered practice as an essential intervention in adapting health systems to the needs of current and future societies was the driver of the international movement towards a culture of person-centered care practices [4].

In 2015, the World Health Organization (WHO) reinforced the importance of changing the paradigm of care delivery to person-centered models that integrate the perspectives of individuals, families, and communities. These agents should be seen both as participants in the co-development of the services and as users, according to their expectations, preferences, and needs in a human and holistic way [2]. At the level of organizations, the working environment should allow the health care provider to achieve full functioning [5].

In Europe, the Scandinavian countries and the United Kingdom have contributed with sustainable approaches to the systematic and coherent development, implementation, and evaluation of person-centered practice. In this context, two pioneering research centers stand out in the development of benchmarks for the practice, research, and teaching of person-centered practice: (a) the University of Gothenburg Centre for Person-centred Care (GPCC, Gothenburg, Sweden); and (b) the Queen Margaret University Centre for Person-centred Practice Research (CPcPR, Edinburgh, Scotland).

In Portugal, the National Health Service (SNS) follows the European agenda in the shift to citizen-centered health care. The "SNS + Proximidade" is recognized as the basic effort to meet the needs and expectations of citizens, recognizing the central role of the person in the management of their health/disease processes and in the development of health services [6].

To contribute to the systematic and sustainable development of person-centered practice in the Portuguese context of care delivery in response to complex health transitions, this article aims to identify the ethical principles and theoretical structures of person-centered care, as well as the Portuguese and European national guidelines that establish its regulation. To this end, the article will seek to answer the following question: what are the structuring elements of person-centered care that make it a differentiating practice in achieving health gains?

Methodology

This critical reflection was anchored in a narrative review of the state of the art on person-centered practice. The narrative review was based on the scientific literature and regulatory documents, critically selected by research in databases, books, and events of dissemination of evidence related to person-centered practice. Complementary literature was identified by snowball process, starting from primary sources. Special focus was given to scientific publications from pioneering European research centers for the development and implementation of person-centered practice, i.e., GPCC and CPcPR. The identified literature was scrutinized by two Portuguese researchers who have been working closely with these centers over the past 10 years, and discussed in a larger expert group for critical analysis. The final literature that served as the foundation for critical reflection is included in the list of references of the article. The experts who assisted in the critical analysis are professors with extensive clinical and research experience, and with special interest in the fields of ethics, subjectivity of the person, and history of care delivery models.

Development

The identified literature was critically mapped into four domains that characterize the European discourse on person-centered practice: (1) philosophical knowledge; (2) references for clinical practice and research; (3) regulation; and (4) approaches to implementation.

From philosophical knowledge to an ethical obligation in care delivery

The paradigm shift to person-centered care has at its genesis a philosophical and ethical discussion of personality: what does it mean to be a person? Thus, the philosophical structure on which the ethics of health care is based revisits the principles of personalism.

The European currents of development and implementation of person-centered practice base their models on the central ideas of several philosophers, sociologists, or psychologists influential for their vision of the world and contributions to the conceptualization of centrality in the person [7]. This article presents a joint perspective of personalism to establish the philosophical basis of person-centered practice.

Particularly driven by Emmanuel Mounier in the European context, personalism represents the maximum respect for human rights and personality [8]. The perspective of the person as a being who cannot be reduced to their body (i.e., objectification) and the intersubjectivity of the person are two characteristic elements of personality common to various philosophers, and especially evident in the work of Merleau-Ponty [9].

Seeking to move away from the Cartesian ontological dichotomy of body and mind and regarding intersubjectivity, Merleau-Ponty [9] recognizes that, strictly speaking, there is consciousness and a single body, being a condition of openness to the surrounding world, its perception, and interaction with this same environment. The same perspective of social constructivism is reinforced by Paul Ricoeur [10], for whom a person cannot exist (i.e., to be, to transform oneself) without the other.

Ricoeur [10] thus reinforces the focus on reciprocity, recognizing that from authentic interaction between people emerges a symmetrical relationship that constructively benefits those involved. Through interaction, each person contributes so that the other also exists. In this line of thought, John Dewey [11] refers to the development of a space facilitating expression and interaction, a space in which, according to Charles Taylor [12], people interact with authenticity in a reflective way, based on their habits, expectations, perceptions, and prejudices.

Concerning authenticity, Taylor [12] recognizes the need for agents in this space of expression to be attentive to each other and willing to challenge the personal horizons of what is significant to them, in order to meet what is significant to the other.

In the context of objectification, Ricoeur adds to Merleau-Ponty the perspective that the person will inevitably be constituted as much by frailties and vulnerabilities as by capacities and resources (i.e., *Homo capax*) [13]. Ricoeur [10] also reflects on personal identity, on which he exposes autonomy as a characteristic of the personality of this capable being. Therefore, the ability to make decisions and be held accountable for their actions will always emerge in a context of interdependence and reciprocity with the other(s) and the environment that surrounds the person.

In line with the recognition of the person as an active and interventionist being, Dewey [11] problematizes in particular the character of a person's actions (i.e., routine action or reflective action). Dewey [11] recognizes that, on the one hand, there is an essence of the person that is in constant expression, while at the same time building and transforming itself. Ricoeur [10] also draws this parallel between something naturally present and relatively constant in the person, and something that is modifiable, transformable. In this context, centrality in the person can be seen as something that triggers an impulse and that puts us into action in order to make an impression on the other [11].

Finally, we highlight the perspective of the Austrian philosopher Martin Buber [14], who reflects on the objectification of the body in a relational perspective. Buber [14] adds to the element of intersubjectivity the need for openness, presence, authenticity, closeness, and awareness to achieve the good encounter. Such relationships are built from a genuine will to want to relate to the other on an equal basis.

References for clinical practice and research

The GPCC model for person-centered care [15] and the CPcPR approach to person-centered practice [16] are the European references with global expression in which the clinical practice, research, and teaching centered on the person are anchored in a consistent and systematic way. These theoretical frameworks share the philosophical principles of personalism, ethics about respect for the uniqueness of the person, importance of relationships, and responsibility for one's actions.

The GPCC model

The GPCC model is based on the premise of centrality of care in the person as the operationalization of an ethical duty of the health professional [15], fundamentally guided by the ethics of Paul Ricoeur [10] (p. 174) aimed at "*the pursuit of a good life, with and for others, in fair institutions*". For health services and person-centered care, such ethics can be translated into the objective of achieving health and well-being, with and for the person-user, family members, and health professionals in fair institutions [17].

Analyzing the first component of Paul Ricoeur's ethics (i.e., the pursuit of a good life), in the Aristotelian tradition, the "good life" means the essence that makes each person's life flourish. Transposing to person-centered care, in the ethical perspective of the GPCC model, it is important for the health professional, at each encounter, to question what a "good life" means for that person-user. The person-centered practice therefore requires both clinical knowledge about the disease and therapy, as well as about personality, preferences, beliefs, life habits, interests, and coping strategies of the person experiencing the disease. In the genesis for this understanding, the authors position the active listening of the narrative of the person [17].

The narrative is the way to access the attributes of the personality that will allow focusing care on the person and co-establishing a health plan that captures their perspective on the disease in their daily life context [15]. By complementing the anamnesis, the narrative brings the person's perspective on their needs, priorities, goals, and how they can/want to be helped to achieve them. In this narrative, it is expected that the user-person actively and freely tells their experience without necessarily receiving guiding questions. The health professional exercises a receptive and responsive listening, maintaining a phenomenological and interpretative attitude, with the objective of perceiving what the person-user wants to transmit [17].

The second component of the GPCC model for the person-centered care "with and for others" positions thinking about the person as a being in relation to others. Interpersonal relationships are the way of co-creating and assigning meaning to the social world that surrounds the person [13]. Giving the opportunity to the person-user to introduce themselves and describe themselves as a person in a narrative way of their experience about the disease is the starting point for building a collaborative partnership of mutual respect between two experts [18].

Within the scope of person-centered care, the partnership involves the meeting of at least two experts: the person-user, expert in their health/disease experience; and the person-health professional, expert in the clinical knowledge of treatment and care. The needs that the health professional identifies will thus have as much importance as those identified by the person and that threaten the meaning and coherence of their life project [15].

The partnership of experts implies the reciprocal sharing of knowledge between the two experts, as well as mutual dependence, which should not be seen under a negative perspective of loss of autonomy [17]. Dependence is the idiosyncratic characteristic of existing and being in relation to others, i.e., a relational phenomenon, and not of the individual isolated from the surrounding world [10]. The ability to be autonomous in action may be reduced by illness or malaise, but the autonomy for decision-making remains intact, and it is the responsibility of the professional to facilitate and support it [15].

The personal health plan within the scope of person-centered care allows the therapeutic partnership to be materialized. In it, the user is recognized as simultaneously active/participatory and fragile. The documentation of this health plan co-constructed between experts in the user's clinical process is the way to safeguard the care partnership [15,17].

The third component of the GPCC model concerns fair institutions. Since institutions are the extension of inter-human relations, this component leads to the organizational, social, and political

level as a requirement for person-centered care. The centrality of health care to the person requires an understanding of the socio-political context in which this care is co-defined and provided. The ethical principles of equal values, protection of human dignity, focus on the needs of the most fragile and vulnerable, and cost-effectiveness must guide health priorities.

Fair institutions recognize and ensure to people, i.e., employees and users, equal conditions, opportunities, and duties regardless of their social class, ethnicity, sexual orientation, and gender. Person-centered care is thus seen as a way to promote equity in health systems while protecting democratic principles of access and right to health services [17].

The CPcPR model

The CPcPR model supports the social perspective of health, in contrast to the biomedical perspective. It further reinforces that the genuine attachment to the principles emanating from personalism is the element that differentiates any strategy for improving the quality of health care (for example, promoting shared decision-making) from the continuous and systematic focus on the essence of the person's humanity.

In light of the CPcPR model, person-centered practice is an approach to the established practice by the development and promotion of healthy relationships between all care providers, health service users, and others who are significant to them. Such an approach is anchored in values of respect for the person, the individual right to self-determination, and mutual understanding. For the person-centered practice to occur, an institutional culture of empowerment is essential, which promotes continuous approaches to the development of the practice [19].

In the essence of person-centrality, McCormack [20] identifies four ways of being as people: being in relation, being in a social context, being in a place, and being with self. In this context, interpersonal relationships are valued as a process to be, grow, and transform; narratives as a holistic way of understanding the meaning that the person attributes to his world; the place as a generator of emotions and important for the experience; and the knowledge of the self as the recognition as a person by oneself and by others [20].

The conceptual model of the approach to person-centered practice (Person Centered Practice Framework – PCPF) was developed following participatory research-action processes in clinical contexts, to promote the centrality in the person of this same practice [21]. Although the development work originally took place in the nursing domain, the most recent evidence shows a cross-sectional usefulness and appropriateness to the professional category and the context of care (for example, primary and differentiated care) [16].

The PCPF consists of five key domains: the macro context, the prerequisites, the practice environment, the person-centered processes, and the end result. Thus, the PCPF circularly maps the complexity associated with the articulation of the various contextual, attitude, and moral constructs that characterize the human dimension of health care. Each of these, and their articulation at various levels, will be necessary to achieve the end result of person-centered practice, i.e., a healthy culture in health care. This healthy culture should be perceived by both users and employees and observed in shared decision-making processes, effective and collaborative professional relationships, and forms of leadership that support transformation and innovation [16].

Briefly, the macro context domain involves strategic leadership; workforce development; local, national, and international strategic approaches; and health and social care policies.

The domain of prerequisites identifies the attributes of health professionals that jointly reflect the person-centered professional, with the ability to adapt to the challenges of a changing context. These prerequisites encompass being professionally capable, with developed interpersonal skills, self-knowledge, clarity of beliefs and values, and commitment to work. Even if each health professional and the team as a whole expresses and exercises these attributes, the final result of the centrality of the practice will not be achieved if the practice environment is not conducive to it.

The domain of the PCPF practice environment is included in the context of health care and its complexity has received particular attention along with the development of the implementation science. Specifically within the scope of person-centered practice, seven elements promote centrality in the person: organizational support systems, potential for innovation and risk taking, physical envi-

ronment, power sharing, effective interprofessional relationships, shared decision-making systems, and diversity of skills.

Finally, person-centered processes constitute the operationalization of person-centered practice and include working with the person's beliefs and values, shared decision-making, authentic engagement, having an empathic presence, and working holistically. This domain focuses specifically on the relationship with the person-user in the context of providing care.

Centrality on person and regulation

Regulation and the existence of government policies are important drivers for changing current practices [5]. The European standard *SIST EN 17398:2020 – Patient Involvement in Healthcare – Minimum Requirements for Person-Centred Care* was developed by the technical committee CEN/TC 450 based on the person-centered care core dimensions of the GPCC model (i.e., narrative, partnership, documentation, and shared information) [22].

The standard is the first one to be published in the field of person-centered care and aims to facilitate the work of introduction, development, and research on person-centered care by different actors of health services, organizations representing users, researchers or companies. It can be useful to managers and administrators, as well as actors of the political system, to inform meta-programs with the necessary dimensions for person-centered practice. This standard may, therefore, be considered a tool to support both bottom-up and top-down activities.

In Portugal, the centrality of care in the person is one of the five dimensions of the quality of care considered by the National Health Assessment System (SINAS). This dimension, referred to as User Focus, is assessed by self-completion of a checklist by the care providers, which is then audited by sampling.

The checklist includes the categories of informed consent, second opinion, spiritual support, patient associations, training, communication with patients, documentation and support at hospital discharge, confidentiality, among others [23]. In addition to this dimension, SINAS also includes four other dimensions, i.e., clinical excellence, patient safety, adequacy and comfort of facilities, and user satisfaction.

The construction of this information collection model was based on a set of standards defined in the accreditation manual of the Joint Commission International, on the standards recommended by the Australian Commission on Safety and Quality in Health Care, and on the UK National Health Service.

As in any other field, legislation supplants the norm from the point of view of regulation. In Portugal, the *Order n. 9323-A/2018* [24] from the Office of the Department of State for Health, published October 3, 2018 in the *Republic Diary*, refers to the importance of improving the quality of health services by changes in the paradigm of care delivery, which must be reorganized around citizens, focusing on their needs and expectations.

Regarding this citizen-centered reorganization, one must also bear in mind the importance of promoting accessibility, speed, equity, proximity, and the humanization of services. The materialization of these strategies and priorities has led to the development of care models such as home hospitalization, which aim to approach citizens in the community in a holistic and salutogenic perspective [24].

From theoretical frameworks to implementation

Approaches to the implementation of person-centered care have received increasing attention in order to promote the implementation of theoretical models in clinical practice in a systematic, continuous, and rigorous manner. One of the reference sources of evidence in this field started from a narrative review of the evidence on person-centered practice to develop a conceptual framework for its implementation [25]. Anchored in the domains of structure, process, and outcomes of the Donabedian model for the improvement of health services [26], the literature was categorized and organized as a script for a practical approach to person-centered practice implementation.

In this approach, the structural domain is related to the health system or specific context of care provision, and it is considered the essential pillar to: (a) create a person-centered practice culture

cross-sectional to the care process; (b) co-design education programs, as well as health promotion and disease prevention ones, with health service users; (c) establish a support environment; (d) develop and integrate support structures to health information and communication technologies; and (e) evaluate and monitor the implementation of person-centered practice. In the procedural domain associated with the interaction between care providers and users, the Santana's et al. [25] script describes the importance of: (a) cultivating communication and health care processes with dignity and compassion; (b) involving users in the management of their health/disease processes; and (c) integrating care. As a result, access to health care and self-reported results by the user are identified as demonstrative elements of the gains from the implementation of person-centered practice resulting from the interaction between the health care system, care providers, and users [25].

In the European context, two interrelated projects have strongly encouraged the implementation of person-centered practice in response to financial constraints in health systems, without loss in the quality of care provided. WE-CARE was the first funded project where the script for the implementation of person-centered care was developed [1]. This script has been structuring the creation of several Exploratory Health Laboratories (LES) under the second funding received from the COST CARES Project [27]. The LES aim to produce scientific evidence on the transferability of person-centered practice and the efficiency of the WE-CARE script across care delivery contexts and in different European countries.

In a multinational joint effort informed by the evidence on person-centered practice and the GPCC model for person-centered care, the WE-CARE script has person-centered care and health promotion as essential drivers for the accessibility, quality, and sustainability of future health services. These drivers are interrelated with five critical enabler domains for their implementation: technology, quality strategies, infrastructure, incentive systems, and hiring strategies. An initial feasibility study on the implementation of person-centered care according to the WE-CARE script reveals that the GPCC model has the potential to be transferred between care delivery contexts with perceptions favorable to the implementation by health professionals as well as users and families [28]. This evidence is particularly promising in light of the impact shown in interventional studies where the GPCC model has been evaluated [3]. The ethics of person-centrality has shown gains for users in self-efficacy and cost reduction, associated with shorter hospital stay times [29].

Discussion

In the light of the philosophical and ethical knowledge identified, the impregnation of the person-centered practice references by the principles of personalism is the cornerstone of the shift in the care paradigm that can serve as an aid to the structuring of health services.

Person, individual, and patient

Focusing on language, it is important to adopt a discourse that reflects the centrality of health care in the person-subject and not in the object-disease, that is, that includes the narrative and the health plan in addition to the medical anamnesis, the experiences and preconceptions as well as the clinical background, the symptom and the way it is experienced beyond the sign. Although the terms patient and individual are used, they do not carry the same meaning and should not strictly be used lightly in the context in which it is intended to emphasize the centrality of the person beyond the disease (i.e., the patient) and in continuous relationship and interdependence with the environment (i.e., individual).

In the eyes of the health system and intersecting the concept of person and person-centrality, one must therefore aspire to see the user as the person with capacities and vulnerabilities, strengths and weaknesses that are naturally inherent and emerge to a greater or lesser extent over continuous well-being. To the weaknesses, which in essence will be the main motivation for the search for health services and the reason why the coherence of life has been disturbed, one can attribute the patient that is part of the person. Still, it will only be a component of the person as a whole, which therefore does not legitimize the objectification of the person that the term patient entails. Seeking distance from reductionism, the meeting and intersection of all parts of a person cannot equate to a medical diag-

nosis or disease. Despite the disease, the Homo capax retains their will and personal values, which are fed and nourished by the environmental and family context that surrounds them and in which they are inserted [13]. It is from the complexity of these various components per se and their interconnection that the subjectivity of the person emerges, which will therefore be far beyond the objectification that the disease brings.

From the relationship with others and with the environment that surrounds them also emerges reciprocity, an element of the persons that mirrors the process by which they build, define, and redefine themselves in continuous relationship with others. In the process of distancing from individualism, a person cannot be seen in isolation from the environment that embodies them, since their interdependence is also an element inherent in them as a whole [10].

Person-centered practice as a challenge to the clinical routine

In light of John Dewey's perspective on the act, the impulse, and the impression that these cause in the other without having a genesis in a habit, the person-centered practice can be seen as a challenge to traditional clinical practices [11]. This challenge is described as a "school of unlearning" [30], implying the unlearning of procedures, which by virtue of routine or cost-effectiveness pressure have been impregnated as daily modus operandi. The impulse that triggers such reflective activity on the practice may originate in peers, in users, in new knowledge about person-centered care, or in experiences of dissatisfaction.

The person-centered care has in its genesis what makes each person a unique being, therefore requiring openness to listen and learn from and about the other. In Ricoeur's perspective, it is through the narrative that we have access to the essence of who that person is [10]. In this context, it is important to note that the narrative identity has a temporary character: the person will tend to reformulate their life story in the light of new experiences [13]. It is therefore essential to continuously promote a space for expression that complements the objective and measurable data available by self-reported symptom assessment scales, auxiliary diagnostic tests, and new information and communication technologies, with the person's narrative. In this space, the impulse can be generated with the simple question of "how are you today?".

Martin Buber's perspective on the person and the relationship emphasizes the bilateral symmetry of the relationship in a therapeutic partnership centered on the person; when successful, reciprocity allows people to achieve a partnership in care in which the professional and the user are at the same level [14]. The recognition of symmetry and reciprocity in the encounter with the other will be essential to focus on the subject and ensure the involvement of the professional in the person's history.

In essence, each user-person has to be seen as an agent whose concerns and needs are qualitatively different. What constitutes the essence of the person and gives them meaning is not necessarily valid for another person with the same diagnosis and similar life situation. Even the same person will manifest different needs throughout their health/illness journey [31].

Person-centrality for the transformation of health services

Sporadic contact and more spaced in time is often identified as a challenge in accessing and co-developing the narrative, when contrasted with other therapeutic encounters that occur in a more prolonged way (e.g., in the context of hospital admission) [31]. Adopting the perspective of philosopher Dewey [11], in such circumstances, the maintenance of the space of expression that allows the sharing of the impulse by the person and the possibility of being impressed by the health professional, which goes beyond the physical and geographical limits allowing the connection between the context of care and the person's home, is of utmost importance.

This challenge was greatly evidenced by the COVID-19 pandemic, with the limitation of face-to-face contacts in favor of greater use of communication and information technologies to mediate health care at a distance. The mediation of person-centered care by technology is taking its first steps [32]. In this area, it is important to safeguard the requirements that such a space for expression at a distance bring to a technology-mediated care partnership. The difficulty in understanding the person

as a whole generates in the health professional uncertainties regarding clinical judgments, which can hinder the development of common values and shared decision-making [33].

In the Brazilian context, the objectification of care in the age of technology has also been pointed out as a concern [34]. The Person-Centered Clinical Method (PCCM) presents itself as a process of training health professionals to deal with the complexity of the person beyond the disease. Understanding this complexity makes each person unique and their experience of illness subjective [35].

The PCCM has been gaining particular visibility in the field of family and community medicine. It is aligned with the European references described in this article by the effort to aggregate traditional clinical medicine with existential medicine as an approach to health problems. In the light of the PCCM, it is essential to provide comprehensive care to the person, in which the health professional will pay attention to how the person experiences their illness and the impact it has on their life and well-being, culminating in joint health planning [35].

Knowing what a "good life" means for that person will be extremely challenging for the health professional if the encounter involves someone who is frail and very ill, unable to provide that perspective. In these situations, the joint planning and execution of a health plan may be difficult to achieve together [17]. The expertise brought by empirical knowledge may, in these circumstances, be the driver of the self-efficacy and confidence of the health professional and make the difference to identify elements of meaning for the person who cannot transmit them immediately. Can the person-centered practice be facilitated by level of experience? What, if anything, determines that level of experience? In these circumstances, the CPcPR theoretical model of person-centered practice, by offering a perspective of the various elements to be considered, and the ethics of the GPCC model of person-centered care, by valuing fair relationships in fair institutions, show the importance of perceiving the individual expertise of the various elements of the team in the light of the joint experience of the group, as well as the existence of shared values that allow effective relationships, by which the skills of the team complement each other.

Normative and regulatory documents are essential to identify the components of a good practice, to achieve its systematic implementation by all members of the multidisciplinary team, as well as to allow auditing processes towards continuous improvement of the quality of care. Portugal does not neglect the importance of the person-centered care for the quality of the health care provided. However, the current system of quality assessment is based mostly on parameters of self-completion by health professionals.

Similarly to other European countries, the inclusion of health service users in this evaluation would be an added value for the process of continuous improvement of the quality of care, for a triangulated analysis of the parameters from the perspective of several actors. The inventory for the person-centered practice [36] developed from the CPcPR theoretical model includes a version for health professionals and another for users of health services, with dimensions superimposable to those evaluated by SINAS. This self-reported measuring instrument can thus become a useful resource for the evaluation of health care provided from the perspective of those who receive it, in the sense of continuous improvement of the person-centered practice.

From the reviewed information in the field of knowledge related to the regulation of person-centered care, it is also important to highlight the absence of specific legislation in Portugal that, in a concrete and detailed way, clarifies the principles for the involvement of citizens in their care process. Person-centered practice legislation is one of the top-down approaches that has allowed people to structure initiatives promoting person-centered practice. In countries where user participation and person-centered practice are a constituent part of the legal system, research centers and implementation of good practices aimed at promoting the centrality of care in the person have been developed, as well as infrastructures and financing adequate for the work around this topic [3].

In the field of implementation, the sustainability of the SNS, like other European health systems, will have to include the knowledge that users have of themselves, their weaknesses and resources, and their health in the adjustment process in health/disease transitions, with a view to initiating and maintaining a continuous care partnership between the user and the health team. For this reason, person-centered practice cannot be an isolated act in time, characteristic of a health professional or a specific service. For innovation and effective change in the health system, it is imperative that person-centered practice is implemented and evaluated following a continuous, systematic, and rigorous approach [7].

This approach requires knowledge of the theoretical frameworks of person-centered care as an intervention, as well as implementation science methodologies as a process for the integration of person-centered practice in the context of care provision at the micro, meso, and macro levels. This is therefore a multidisciplinary work that requires wide and varied resources (e.g., human, economic, organizational, material). Given such complexity, the use of practical scripts to the implementation of person-centered care, such as Santana et al. [25] or WE-CARE, can be promising tools in identifying barriers and facilitators, as well as in planning implementation strategies appropriate to each context. Following such approaches, scientific evidence reveals gains in health for users, well-being for care providers, and cost efficiency [3].

Final considerations

This article contextualized the paradigm shift to a person-centered practice and identifies the state-of-the-art domains associated with it: philosophical knowledge, theoretical frameworks for clinical practice, teaching and research, approaches to implementation, and regulation. These areas will necessarily have to be considered for a systematic and sustainable development and implementation with effective transformation into health gains.

Based on the critical analysis of the state of the art, the importance of considering the transformation of health services to a person-centered practice as a long-term process is reinforced. The transformation will also involve the adoption of the discourse of person-centrality that develops to indicators of involvement of users and health professionals at a micro level, to various health services at a meso level, and to managers, administrators, and politicians at a macro level.

The involvement of citizens in their health care, by valuing the resources available and restoring the health/disease balance, is one of the precursors to a sustainable health system in the face of current societal challenges. It is important that this legislatively anchored involvement as a priority strategy for health is embodied in models of care delivery and modus operandi. In this context, the concept of person-centrality that characterizes the essence and ideal of care in health/disease transition processes should be translated into innovative person-centered practice models to achieve excellence in quality in the provision of care.

Contributors

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Additional informations

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Resumo

A prática centrada na pessoa assume um papel preponderante na organização e gestão de sistemas de saúde, bem como na definição de políticas de saúde. Este ensaio teve como objetivo identificar os princípios éticos e estruturas teóricas da prática centrada na pessoa, assim como as diretrizes portuguesas e europeias que sirvam a sua regulamentação. Foi conduzida uma reflexão teórica ancorada na revisão narrativa crítica do estado da arte sobre a prática centrada na pessoa, que visou responder à questão: quais os elementos estruturantes da prática de cuidados centrados na pessoa que a tornam diferenciadora na obtenção de ganhos em saúde? A reflexão crítica contextualiza a mudança de paradigma para a prática centrada na pessoa e identifica os domínios do estado da arte que lhe estão associados: conhecimento filosófico, referenciais teóricos para a prática clínica, ensino e investigação, abordagens para a implementação, e regulamentação. Esses domínios terão de ser necessariamente contemplados para um desenvolvimento e implementação sistemáticos e sustentáveis com efetiva tradução em ganhos em saúde.

Ética; Assistência Centrada no Paciente; Pessoas; Prestação Integrada de Cuidados de Saúde

Resumen

La práctica centrada en la persona tiene un papel preponderante en la organización y gestión de sistemas de salud, así como en la definición de políticas de salud. Este ensayo tuvo como objetivo identificar los principios éticos y las estructuras teóricas de la práctica centrada en la persona, así como las instrucciones nacionales portuguesas y europeas que están basadas en su regulación. Se realizó una reflexión teórica con base en una revisión narrativa crítica del estado del arte sobre la práctica centrada en la persona, que buscó responder a la pregunta: ¿Cuáles son los elementos estructurantes de la práctica de cuidados centrados en la persona que la hacen diferenciadora en la obtención de beneficios para la salud? La reflexión crítica contextualiza el cambio de paradigma para la práctica centrada en la persona e identifica los dominios del estado del arte asociados con ella: conocimiento filosófico, marcos teóricos a la práctica clínica, enseñanza e investigación, enfoques de implementación y reglamentación. Estos dominios necesariamente deberán ser contemplados para el desarrollo e implementación sistemático y sostenible que resulte en efectivos beneficios para la salud.

Ética; Atención Dirigida al Paciente; Personas; Prestación Integrada de Atención de Salud

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