Person Centered Care 2025 – it's high time that we nudge the rhetoric into reality.

By **Professor Andrew Miles** and **Professor Sir Jonathan Elliott Asbridge**

Introduction

The European Society for Person Centered Healthcare (ESPCH) last contributed to the *Winter Newsletter* in 2023, and we are grateful for the opportunity to do so now again in the present issue. A good place to start, we thought, would be to ask ourselves the question: 'What *major* progress has been made in person-centered care (PCC) over these last two years?' Sadly, we have to answer: 'Broadly speaking, worldwide, very little'. So we ask, then, a second question: 'Why is this the case?' In the current piece we aim to provide a corresponding answer, before proceeding to suggest some solutions which, if successfully adopted, may come to mean that by the time we contribute to this newsletter again, we will have more positive conclusions to report.

PCC is integral to clinical practice, and the lack of it, in full or in part, shortchanges the patient/client, and denudes medicine and healthcare of their historic imperatives to care, comfort and console (think *humanity*), as well as to ameliorate, attenuate and cure (think *technoscience*). PCC, by its very nature, is uniquely able to hold these indispensable components of care in tight association, thereby precluding a real risk of their decoupling into perceived polar opposites and selectable options. We recognise that achieving PCC in 'hands on' operational practice is a complex endeavour with a wide range of obstacles militating against it. How, then, to proceed?

To overcome the many barriers to achieving PCC in real time, we need first to address the core issue that tops the list – a confusion as to what care should 'look like' within increasingly complex, resource-constrained, contemporary health and social care systems. We have become content, lazy even, with maintaining the 'default option' of a legally acceptable, regulator-satisfying basic competence. Much less attention, however, has been given to the need to strive way above that necessary imperative, in the active pursuit of the high excellence that is PCC.

We consider below how such disruptive thinking can, and must, lead to a much overdue transformation of clinical and care services. We detail our observations, and suggest ways forward, in a spirit of collegial dialogue, and although we have found it necessary to offer some limited critique, we do so within a framework of constructive advice and essential optimism.

Talking PCC, *vs.* doing PCC

It remains very easy to 'talk PCC', rather than to 'do PCC' - and indeed to continue the talking, rather than embarking on the doing. There are many reasons why this is the case. In our view, the principal factor underpinning this observation is a continuing and widespread confusion as to what exactly PCC is, and what it isn't. We find this hardly surprising, given the hundreds of definitions of PCC that exist within the general literature, formulated as they have been over many decades by a multiplicity of academic institutions and care organisations worldwide.

The varying definitions thus derive from differing geographic, demographic, cultural, and economic care contexts. Given this degree of substantial heterogeneity, to produce a universally agreed definition of PCC, in explication of what PCC is and what it is not, would therefore need to accommodate a very wide variety of different beliefs and worldviews, and would need to recognise and incorporate a common set of human and societal values.

It needs hardly to be said that such an exercise would be an enormously complex undertaking as a function of the sheer range of differences that would immediately be encountered. Of course, the lack of such a universally accepted definition of PCC creates a methodological conundrum. If we cannot agree on what we mean by PCC, then on what basis do we design and construct a model for its implementation and use, and how can we recognise that we have achieved PCC if or when we do?

The answer is that, until we reach a definitional consensus, which is in reality many years away, we have little option but to be content with a 'many models PCC, based on a many concepts PCC'. This allows us, at least, the freedom to explore the commonalities of, as well as the differences between, the most prominent and recommended of the many definitions – always with operationalisation at the forefront of our collective minds.

While on first consideration this might appear a 'messy' way to move forward, we argue that it is an entirely rational and pragmatic thing to do. After all, the alternative is *stasis*, with no progress of any sort being made - and that, surely, is unacceptable. But this does not prevent some colleagues from asserting that we must wait for detailed answers to every question relating to PCC before attempting to operationalise it. For our part, we have always resisted the indulgence of engaging in the luxury of endless philosophical ruminations, in favour of clinical expediency. In short, we respond to objections to our suggested approach in the words of one notable paediatric cardiologist who, when confronted by such arguments for delay, responded: "You just have to get on with it".

PCC will be realised in practice via evolution, not revolution

We maintain that progress in PCC will continue to occur through evolution rather than revolution. And there is no shame, as it were, if institutions, when evaluating their services and finding key definitional components of PCC to be lacking, then seek to introduce these incrementally. Such an approach stands a far greater chance of success than an overly complex one loaded up-front in a 'big bang' approach, not least because of the education and training of staff that will be necessary, and the resource limitations which are ever-present.

As part of any methodological approach based on a wisely selected definition of PCC, and the development of an agreed model for implementation and use based on it, continuous feedback from patients/clients, from families and friends, and from care staff, is vital to collect, listen to, and to be assimilated into practice through audit and related such processes.

This is what characterises a reflective, responsive, and learning organisation - institutional characteristics which indicate a high order of understanding and ambition. Here, typical outcome measures are likely to be patient/client and family satisfaction with care processes and outcomes, staff satisfaction, as well as a resulting national, regional, and international recognition of achievement and excellence.

"Education! Education! Education!"

If this is a familiar and constantly recurring political slogan, then it is certainly a mantra that we must adopt for PCC, because without it PCC is certain never to become an operational reality.

We need education and training to enable an understanding of the patient/client as a unique individual with unique individual needs - and not a subject, object or complex biological machine - because this is the only route to providing compassionate and empathetic care. We need education and training in how to to draw on the plethora of available definitions of PCC, in order to design and develop context-specific care models of PCC that are appropriate for the given care institutional environment and its patient/client populations. And we need education and training in how to implement such a model in operational practice, maintain it in place, and actively develop it over time.

But who provides the education and training? It is frustrating that formal educational programmes, such as Master's degrees or professional doctorates in PCC, are available in very, very few countries. Rare, too, are well designed and properly structured certificate and diploma courses, short courses, residential weekends, and summer schools. Until we greatly expand formal education and training in PCC, we will sorely lack the transformational and servant leaders and mentors that are crucial to progress in the field.

The need to identify and disseminate example of 'best practice' in PCC

In the current absence of the major leaders and mentors we describe, systematic progress is difficult, but moving the field forward in their temporary absence is far from impossible. We are aware that many readers may view our suggestions set out above as a 'big ask' and a 'big task', yet it is this general approach that MOSAIC Home Care Services, for example, has taken in its own pioneering approaches to person-centered care. That organisation, drawing on a definitional understanding of PCC with high context specificity for homecare, has designed and validated important models of PCC for implementation, operation, and continuous assessment and development, that have proved highly successful and indeed award-winning.

For sure, we need many more such examples of best practice in PCC for dissemination across all sectors of health and social care as a whole, and the ESPCH is currently engaged in the identification and cataloguing of these in preparation for our forthcoming Seventh Annual Conference and Awards Ceremony (ESPCH7) in London UK. We are grateful to MOSAIC for accepting our invitation to chair and present at that event, for which further details will be made available shortly.

Conclusion

If we are to raise the standards of care from the lower denominator of basic competency to the higher numerator of care excellence that is PCC, then pragmatic approaches to the development of clinical care services of the nature we describe in this article will in our view be required. The ultimate aim is to inculcate PCC, through undergraduate curricula, postgraduate training,

and continuous professional development (CPD), as an entirely natural way of 'thinking and doing' in clinical care. For too long, PCC has been viewed as a 'nice to have', rather than a 'must have', as an optional 'add on', and not an integral component of care. This mentality does not act in the higher interests of patient care, and neither does it advance notions of excellence in clinical professionalism. Is it all achievable? Yes, most certainly. Indeed, 'together we can do it, but it needs us all'.

Biographies

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Recommended Reading

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MOSAIC (2024) Person-Centered Care – 1.
https://www.youtube.com/watch?v=kiV8VyFovY4&t=31s&ab_channel=MosaicHomeCareServices%26CommunityResourceCentre

MOSAIC (2024). Person-Centered Care – 2.
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