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Person-centred care and psychiatry: some key perspectives

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This paper outlines the importance of person-centred approaches to the practice of contemporary medicine and psychiatry. In considering the many aspects of person-centred approaches it outlines some key perspectives, including freedom and human rights; improving individual practice and the quality of services; increasing clinicians' work satisfaction; combining value-based and evidence-based practice; and the training of future generations of psychiatrists.

Person-centred approaches have deep roots in medical practice and historically have been a part of both Eastern and Western approaches to medicine.¹ They have been given a greater profile in the past 70 years and assume particular importance now with the move towards personalised medicine. Person-centred approaches are supported internationally by the World Health Organization, World Psychiatric Association and other professional and patient bodies.^{1,2}

This paper, discussing the importance of person-centred approaches and highlighting some implications for psychiatric practice, is based on a recent report from the Royal College of Psychiatrists' Person-Centred Training and Curriculum Scoping Group,

which we led. The recommendations of the report were focused on the training and work of core trainee psychiatrists in the UK. Although these recommendations may not be internationally applicable, we hope that a person-centred approach to practice will be.

Why person-centred care?

In many countries in the second half of the 20th century we saw a shift in the practice of medicine, not only in the technical delivery of care and treatment but also in the voice of the patient, moving from a predominantly acquiescent subject to a participatory agent. This has been accompanied by broader concerns that routine healthcare has become commodified and impersonal, with a focus on profits. Medical advances towards a more targeted 'precision-medicine' approach can only happen with a more personalised (and human) approach to care.

Internationally, these scientific advances and improvements in quality are inequitably distributed. The provision of healthcare varies dramatically, with over one billion people remaining without any access to healthcare. The rise in the prevalence of long-term and mental health conditions, accompanied by a significant strain on human and financial resources, has highlighted the need for integrated people-centred health services.³

So, why is this important for psychiatry?

After all, psychiatry adopts a biopsychosocial approach and is inherently person centred. Despite this, the history of psychiatric practice has varied between the humane and the oppressive. Psychiatry has a long history of being criticised for its focus on categories and classes of disorder that are seen as dehumanising people and labelling them as deviant while ignoring key aspects of subjective experiences of culture, ethnicity, political oppression and trauma. And even today, in many parts of the world (including many higher-income countries) people with mental health conditions are marginalised and mental health services are poorly resourced compared with physical health services.

Independent care quality reports in the UK highlight the power differential that continues to exist between professionals and patients, with only 60% of patients reporting definitely being involved in decisions pertaining to their own care.⁴ In psychiatry, with a significant number of patients detained against their will, issues such as personal capacity and the conflicts between personal and public good pose additional challenges in implementing person-centred care. However, clinicians' attitudes seem to be the key barrier to a successful implementation of person-centred care in routine psychiatric practice. Psychiatrists tend to overestimate their person-centredness.⁵ Observational studies of psychiatrists' interview style show that psychiatrists vary significantly in their ability to work collaboratively with patients,⁶ raising questions about standardisation of training and professional practice. Clinicians may falsely believe that person-centred care is more time-consuming and costly. Moreover, they are often ignorant of human rights legislation and other primary legislation that underpins person-centred practice.⁷ Learning outcomes that might help embed person-centred care are often not stated explicitly in training curricula,⁸ posing yet another challenge to implementation.

From patient- to person-centred care

A further obstacle to widespread implementation has been the gamut of definitions and the shift from patient-centred to person-centred care. But what runs through the various definitions are several constant themes: the provision of holistic, biopsychosocial or integrative care that is responsive to people's needs and values, that treats people with dignity, respect and compassion, and that empowers them and offers choice, involvement and a partnership approach. The single overarching theme that links these definitions is ethical: the idea that patients should be 'treated as persons'.⁹

This move of focus from patient to person is important as it embraces the central principle of 'personhood' – put simply, that 'people with severe mental illness are people'.¹⁰ This

description then applies to all people, of all ages, with mental health conditions and with intellectual disabilities. By embracing this principle, personhood then becomes the superordinate principle from which other principles arise and offers the lens through which the individual's experience of illness and its challenges are viewed. In a subtle but significant shift, person-centred care focuses on the patient's history, strengths, values, beliefs, etc. not merely to inform decisions about diagnosis and treatment but to help them live the life they wish to lead.

Given the central importance of personal identity, a person-centred approach requires consideration of the person's social and community connections and of the cultural milieu that helps define their identity. This focus on the sociocultural dimension is important not only to understand the individual in their social and cultural context, but to appreciate how these reflect on care interventions and the choice of clinical interventions. This achieves particular relevance in today's globalised and diverse world, where migration is commonplace and adds another layer of complexity to personal identity.¹¹ Digitalisation has led to more and more people having a social media presence, which also has an impact on personal identity and, by extension, on person-centred care.¹² Equally important is the spiritual dimension, which, although commonly associated with particular religious traditions, is applicable to many faiths and cultures.¹³

Embracing a person-centred approach in medicine can have a powerful effect, bringing together not only medical professionals but other clinical and non-clinical groups working in health and social care. The focus on the person points to a change in the way the therapeutic alliance is viewed, with co-production becoming a central tenet of clinician–patient collaboration. This focus on justice and fairness is not only relevant clinically but also has wider policy implications, given the current context of global health inequality.

Key facets of person-centred approaches

There are many aspects to person-centred approaches, but five important global considerations are: rights; relationship to practice and service organisation; importance for clinicians; values and evidence; and training.

Rights

Psychiatric practice occasionally involves restricting individual freedom, an act that can become a clinical decision to deliver the best outcome for patients. But treating patients as people and citizens points us immediately to a consideration of freedom and human rights. Clinicians are then tasked with balancing the right of a person with mental illness to lead a life they value and choose with the need to provide resolution for the acute presentation. Thus, mental health services and other social and economic

arrangements can be evaluated and judged from this perspective. From a training and practice perspective, knowledge of human rights and other relevant legislation, the ability to consider proportionality in applying such legislation that restricts individual freedom, along with an attitude that demonstrates respect for a person's wishes and human rights, become critical.¹⁴

Relationship to practice and service organisation

The principles and values that underpin a person-centred approach and the implications for practice and services have considerable overlap with those of personal recovery.¹ Enhancing the person-centredness of mental health practice and services strengthens a recovery orientation and facilitates personal recovery outcomes.

At present, a patient's history, strengths, goals, social circumstances, activities, values, beliefs, etc. are regarded as informing decisions about diagnosis, treatment and support. But placing an emphasis on the person leads to a shift in focus to consider diagnosis, treatment and support in terms of the extent to which they help the person to do the things they want to do and live the life of their own choosing. This has the significant implication that, in co-designing the treatment plan for patients, psychiatrists may be required to collaboratively agree with treatments that current evidence would rate suboptimal.

Importance for clinicians

Adopting a person-centred approach can improve the experience and outcomes of people who use healthcare services,¹⁵ but can also result in greater work satisfaction and reduced stress for professionals delivering healthcare.¹⁶ Professionals want to treat people with dignity, compassion and respect; they want to consider wider emotional, social and practical needs; to help people develop their own strengths and abilities and live an independent and fulfilling life; they do not want to work in poorly coordinated services. A person-centred approach recognises that clinicians are people too, and we know that the well-being of practitioners is a key determinant of the quality of care. Burnt-out and depersonalised practitioners cannot offer person-centred care. This aspect is particularly relevant at a time when psychiatry is facing a recruitment crisis.

Values and evidence

The practically universal adoption of clinical guidelines and protocols demonstrates the institutionalisation of evidence-based medicine. However, clinical decision-making does not involve a blind application of guidance. Instead, it involves the collaborative resolution of conflicts between the values of various stakeholders (patient/carer/doctor/organisation) in ensuring that the guidance is tailored to the individual's particular situation. This framework that views evidence-based practice and values-based practice as mutually

complementary is a critical tool in delivering person-centred clinical decision-making.¹⁷ Evidence-based medicine is then firmly balanced with the values that support clinical practice. The Royal College of Psychiatrists (RCPsych) outlines eight core values: communication, dignity, empathy, fairness, honesty, humility, respect and trust.¹⁸

Training

Although the facets of person-centred care outlined above may seem obvious, a recent report from the RCPsych on training for core trainees highlighted that current curricula failed to explicitly outline capabilities/competencies related to person-centred care.¹⁹ Embedding person-centred care approaches in clinical practice would necessitate embedding such approaches in the training and assessment of future generations of psychiatrists. The RCPsych report made 17 recommendations, and its key points were that in a revised curriculum the language of the curriculum should reflect its 'person-centred' nature as outlined above; that relational competencies related to person-centred care (e.g. shared decision-making, self-directed support, co-production, collaborative care, support-planning) should be included in the curriculum; and that competencies related to broader aspects of person-centred care (e.g. ethics, community engagement, social inclusion, human rights and other relevant legislation) should be included in the curriculum. The report advocated a central role for the inclusion of patients and carers in planning and delivering postgraduate psychiatric training, including for MRCPsych courses and supplementary skills training. Finally, the report emphasised that assessment drives learning; thus, person-centred competencies should be assessed in both summative (MRCPsych papers and Clinical Assessment of Skills and Competencies (CASC) examination) and formative assessments (e.g. workplace-based assessments).

Conclusions

As the practice of medicine (and psychiatry) becomes more complex, both technically and systemically, the need to anchor it in the relationship and connectedness between people becomes all the more critical. A central aspect of retaining this core feature of clinical practice is to cultivate the right values and attitudes in clinicians, which, while seemingly obvious, is not always present. Although psychiatric practice and training may vary globally, person-centredness of the care we offer is a universal feature that needs reflection in local curricula and practice guidelines.

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Author contributions

J.B. wrote the first draft of this paper and S.D. edited it and added sections. S.D. did the revisions to the paper and J.B. did the final corrections and edits.

Declaration of interest

J.B. and S.D. were co-chairs of the Royal College of Psychiatrists' Person-Centred Training and Curriculum Scoping Group. ICMJE forms are in the supplementary material, available online at <https://doi.org/10.1192/bji.2020.21>.

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