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**SPECIAL ISSUE ARTICLE**

# Developing philosophical and pedagogical principles for a pan-European person-centred curriculum framework

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**Abstract**

*Background:* In the associated article in this special issue of the *International Practice Development Journal*, Phelan et al. (2020) offer an analysis of the global positioning of person-centredness from a strategic policy perspective. This second article, an international person-centred education curriculum development initiative, builds on that foundational work. It outlines the systematic, rigorous processes adopted by academics from five European countries to analyse stakeholder data, theoretically frame the data, and thereby identify philosophical and pedagogical principles to inform the development of person-centred curriculum frameworks.

*Aim*: To identify key principles that have the potential to create an international curriculum framework for the education of person-centred healthcare practitioners.

*Methods*: A hermeneutic praxis methodological approach was used, where multiple rounds of data analyses were conducted. These were initially undertaken in each country, then collaboratively with partners, while engaging with other forms of evidence.

*Findings*: The project group generated a set of principles embedded in four philosophical dimensions: (i) transformative; (ii) co-constructed; (iii) relational; and (iv) pragmatic. The purpose of the curriculum was identified as being transformative, facilitating journeying through knowing, doing, being and becoming a competent and committed person-centred practitioner. A person-centred curriculum is built on a philosophy of pragmatism, adopts a co-constructionist approach to curriculum design and implementation, and encourages connectivity with self, other persons and contexts. Pedagogical principles, aligned to the four philosophical dimensions, identified the required learning environment, and the learning, teaching and assessment approaches required to educate person-centred healthcare practitioners.

*Conclusion*: This article represents steps to foster a more focused and engaging way of implicitly and explicitly embedding person-centred care in curricula. Our theoretical framework has enabled us to consider the different layers of practice while staying true to the purpose of curriculum design. The presentation of the framework in this article makes it available for wider critique to those with an interest in this area of study.

*Implications for practice*:
- The draft framework provides an opportunity for curriculum teams to critically reflect on and have dialogue around current curricula
- Person-centred curricula have the potential to improve service-user experiences of care
- Prepared person-centred practitioners will contribute to person-centred cultures
- Students and practitioners will experience person-centredness
- Practitioners will be bold and innovative

**Introduction**

This article builds on the previous article in this special issue, which examines current global developments in person-centred healthcare (Phelan et al., 2020) and focuses on the first stage of the Erasmus+ project outlined in McCormack et al. (2020). This pan-European Person-centred Healthcare Curriculum Framework project builds on a well-established and strong global partnership that exists to advance person-centred healthcare. We suggest that despite policy and practice being underpinned by person-centredness, both philosophically and theoretically, education and research have some way to go to embrace such principles fully. To our knowledge, and as highlighted by O'Donnell et al. (2017) and Royal College of Psychiatrists (2018), few educational curricula exist that are truly person-centred or that focus on educating person-centred healthcare practitioners for the future. Although these curricula advocate person-centredness as a concept central to curricula, they are less committed to embodying a theoretical understanding of the concept or exploring the philosophical base. Rather they retain a medical, or traditional, perspective that may include some components of person-centredness but not all of them. We will, therefore, outline the process we have adopted of identifying principles that we believe have the potential to create an international curriculum framework for the education of person-centred healthcare practitioners.

**Background**

Person-centred principles and concepts that underpin contemporary healthcare policy, strategy and practice are commonplace, as is person-centred language. Global healthcare policy positions such as that of the World Health Organization (2015) have 'persons' and people-centredness at the core of their strategic position statements. Significant funding is being invested in developing systems, processes and practices that are aimed at innovative approaches to person-centredness and ensuring healthcare systems are responsive to the needs of persons first (McCormack et al., 2015). In practice, however, evidence from service-user feedback, patient-experience surveys and patient/family outcome data continues to suggest varying degrees of dissatisfaction with care experiences, although there are some pockets of satisfaction (Raleigh et al., 2015).

Humanising healthcare has therefore come into focus and efforts are being made to develop systems, processes and practices that prioritise 'human factors' (Gurses et al., 2010; Broom, 2020) or persons (McCormack and McCance, 2010; 2017). Despite these efforts, most person-centred developments focus on the artefacts of practice (McCance et al., 2011) rather than the core values that drive health and social care delivery. In such a global context, there is obvious need for healthcare education programmes to plan strategically for a workforce that is ready to respond appropriately.

Education curricula must therefore be innovative, not only in preparing practitioners but also by proactively developing healthcare practice environments and cultures supportive of person-centred practices. In a narrative review of the evidence underpinning person-centredness in the curriculum, O'Donnell et al. (2017) highlighted the lack of a consistent focus on person-centred principles in curricula purporting to have person-centredness as their underpinning framework. At best, person-centredness appears to be used as a heuristic for containing a diverse range of principles, processes and practices in teaching and learning, rather than as an explicit conceptual or theoretical framework informing all stages and contexts of educational delivery. We found few examples of professional

education curricula that adequately prepare healthcare practitioners to work in person-centred ways. These same practitioners are expected to graduate from their respective professional programmes with the qualities and attributes of person-centred practice. Our belief that principles underpinning person-centred healthcare practice are universal, albeit context-dependent, has guided us towards a transnational approach to developing principles to inform curriculum design. We believe principles derived from stakeholders across different countries will promote acceptability and utility. To realise this vision, teams from the UK, the Republic of Ireland, the Netherlands, Norway and Slovenia formed an Erasmus+ project group, Person-centredness in Healthcare Curricula. Each partner is involved in delivering person-centred educational programmes at undergraduate, postgraduate and/or doctoral levels, with some having successfully delivered person-centred curricula.

**Methodological approach**
The Person-centred Practice Framework developed by McCormack and McCance (2017) was used as the theoretical framework guiding the approach to our project and its design. A participative hermeneutic praxis methodological approach was created to systematically guide the co-creation of principles to provide a framework for pan-European person-centred curricula.

Methodological guidance was sought from the philosophical tradition of hermeneutics. Employing the perspectives of Gadamer and Dutt (1993), we aimed to develop an understanding of the focus of our study using the subjective interpretations of individuals, as well as the collective consciousness of the group. Understanding thus arises from repetitive reading of the various datasets and being open to the concepts sought, as well as being aware of our prejudices and critiquing/allowing them to be critiqued in light of newly formulated meanings (Boomer, 2010). Two processes key to understanding the data were the hermeneutic circle (Heidegger, 1967), and the fusion of horizons (Gadamer and Dutt, 1993). The hermeneutic circle holds the idea that understanding of the data as a whole is established by reference to the individual parts, and understanding the parts is possible by reference to the whole. Neither the whole dataset nor the parts can be understood without reference to the other, so a circle of continuous movement between the parts and the whole is established. Interpretation is never free of presupposition: what we know cognitively, precognitively, and feel (pre-understanding) is the frame of reference (Gadamer refers to these as 'horizon') from which a person starts. During dialogue with others while analysing the datasets, each individual started within their own horizon, and through listening, questioning and theorising, these personal or cultural horizons were challenged, became broader and fused with others', resulting in a new, broader understanding of what is needed to prepare practitioners for person-centred practice.

This process, consistent with person-centredness, was grounded in respect for personhood and mutuality. Phases and steps in the process were realised progressively, guided by a form of practical reasoning and moral intent. Each partner participated actively, and the process was characterised by critical and creative dialogues. Understanding and respect for each cultural background and the different languages used by participants were key to the process, as were mutual acceptance and growth for individuals and the team. Through communal processes of enquiry into what was significant in the context of the initiative and how to apply it in a situation, a co-constructed praxis design was generated.

**Project design**
The overall process consisted of three co-designed phases that demonstrated movement between the parts and the whole, intersecting on several occasions of critical dialogue. Critical conversations, with the aim of collaboratively reflecting on and working with the data and creating the opportunity to fuse horizons, were key elements.

*Phase 1*
*Moving from the whole...* The project group co-constructed questions to engage with stakeholders in the UK, the Netherlands, Norway and Slovenia to collect perspectives on what is needed to make

person-centred practice a reality. Each project partner used different methods to engage with stakeholders to capture their views.
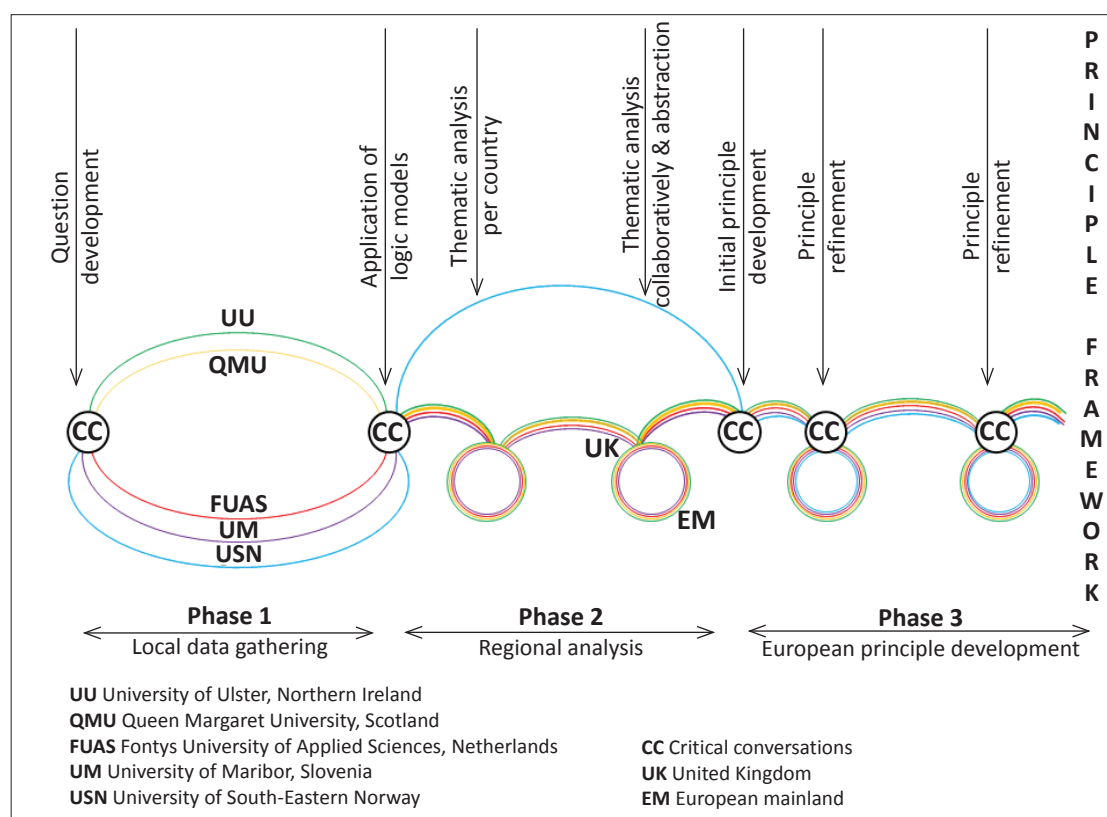
### Phase 2

***...to the parts...*** Moving through the hermeneutic circle, the intention of the second phase was to understand and create new meaning, through a fusion of horizons. Multiple rounds of data analysis were conducted. A first step was a thematic analysis in each country, then a collective analysis of the whole dataset with partners. The third step was an abstract level of data analysis, in which the partners engaged in theorising, using the Person-centred Practice Framework and Wouter Hart's purpose, life, and system world model (2019). Creative workshops with all five partners were used, working in subgroups to synthesise data, thus identifying and mapping themes within the datasets by movement up and down through different levels of abstraction.

### Phase 3

***...back to the whole*** During this phase, the analysed datasets were used for the development of the principles that will inform the development of a person-centred curriculum framework in the next phase of our Erasmus+ project. The hermeneutic process continued with multiple rounds of identification and refinement of principles. A small workgroup with representatives from the partner countries led this process. Multiple draft versions of the principles were shared with partners for critique. As part of this process, the principles were checked with original stakeholder data to ensure consistency.

An overview of the process undertaken is shown in Figure 1 (the Republic of Ireland participated from the second part of phase 2).

**Figure 1: Overview: participative hermeneutic praxis methodology**



UU University of Ulster, Northern Ireland
QMU Queen Margaret University, Scotland
FUAS Fontys University of Applied Sciences, Netherlands
UM University of Maribor, Slovenia
USN University of South-Eastern Norway

CC Critical conversations
UK United Kingdom
EM European mainland

**Rigour**

The project design includes several measures to ensure appropriate project governance: project partner expertise, associate partners, creation of an advisory board and stakeholder groups, and application of a logic model. Within their work, the five project partners are currently advancing knowledge about person-centredness, developing concepts and theories of person-centredness and person-centred practices, as well as designing participatory, inclusive and collaborative approaches to implementing these in a variety of healthcare and educational settings. The range of expertise ensures credibility (Guba and Lincoln, 1989). Each is engaged in activities that will contribute to the work of the project, such as existing person-centred curriculum developments, international staff mobility and exchange. Similarly, there are several associate partners involved in the project, who are all members of the International Community of Practice for Person-centred Practice (PcP-ICoP).

PcP-ICoP is 'an international community of collaborating organisations committed to improving the understanding of person-centredness and its advancement in clinical practice, research, education/learning, facilitation, management, policy and strategy' (McCormack and Dewing, 2019, p1). The members are from Northern Ireland, the Netherlands, Norway, Australia, Austria, Republic of Ireland, Switzerland, and Scotland. They will contribute to specific tasks in the project, including the stakeholder engagement reported on in this article. Between Phases 1 and 2 (see Figure 1, above), the logic model of McCawley (2001) was introduced and applied to ensure quality and progress against the overall programme objectives. This model is being used consistently during each phase of the overarching project. Other methods to ensure rigour are outlined throughout this article.

**Ethical considerations**

Formal ethical approval was not required for this project. Erasmus+ projects are not funded as research projects per se, and activities engaged in under the auspices of the programme are meant to be consistent with routine work in which the education or development partners are engaged in day-to-day practice. As such, each partner uses stakeholder engagement as a routine practice for curriculum development. In some participating countries, stakeholder engagement is required by regulatory bodies (such as the Nursing and Midwifery Council in the UK). Therefore, while the data reported in this article for this particular project are described as a separate dataset, the data were in fact collected as an integral part of curriculum development and extracted for analysis specifically for this project.

The partner countries collected data according to their national guidelines for educational development projects. For all, the guiding ethical principle of person-centredness meant all stakeholders were informed of the reason for invitation, data gathering and data use. Each stakeholder had the opportunity to withdraw from participation before or during data gathering, and any details leading to personal identification were removed before the data entered the analysis process. Consequently, the dataset used to construct the framework of the principles was founded on informed written or verbal consent. All permissions collected in the study, audio recordings of interviews and transcribed material have been saved, with access restricted to project partners.

In the next section, each of the phases will be explained, and then illustrated with fragments of the different steps in the process in the following section.

**Findings**

***Phase 1: Data collection 'moving from the whole...'***

*Step 1: Co-creation of questions*

At our first face-to-face meeting at the beginning of the project, partners brainstormed who key stakeholders would be and the questions we wanted to ask them, based on our knowledge of person-centredness and its application in practice. Co-created questions were then refined and checked against the Erasmus+ project aim and intended outcomes. Using the questions as a guide (Box 1), data were collected by each partner in January and February 2020, using methods appropriate to their national and cultural context.

**Box 1: Co-created questions to guide data collection**

1. What do you need to enable service users and staff to understand what person-centred healthcare is?

2. What would help you to have the courage to speak up about care/experience?

3. What are the current barriers that need to be addressed to improve person-centred healthcare?

4. What do you believe are the core knowledge and skills needed to provide person-centred healthcare?

5. What would enable you to provide person-centred healthcare?

6. How does a person-centred healthcare practitioner behave?

7. How would you describe person-centredness?

8. What are the biggest policy and strategic barriers to, and enablers of, person-centred healthcare?

9. How could politicians help?

10. What do you need from us that would help?

*Step 2: Data collection in each country*
Data collection methods included focus groups, workshops, and questionnaires with service users, undergraduate and postgraduate students, mentors, educationalists, service managers, professionals and leaders (n = 391). Qualitative methods were selected because they:
- Are oriented to the groups of stakeholders
- Enable the exchange of experiences and perspectives during group interaction, providing an in-depth view of the topic of inquiry (Krueger and Casey, 2009; Doody et al., 2013)
- Ease the exploration of complex and unexplored areas (Boger et al., 2015), such as the provision of person-centred healthcare
- Can create a safe environment, which potentially facilitates critical dialogue/discussion (Boger et al., 2015) in the group

Questionnaires were used for pragmatic reasons, including to access the views of large cohorts of diverse students. Project partners (SK and ML), at the University of Maribor's faculty of health sciences in Slovenia's north-eastern region, facilitated three focus groups. Participants (n = 15) included students, educationalists, practitioners, education commissioners and providers, colleagues from third-sector organisations, and regulatory bodies. The focus groups lasted between 40 and 70 minutes and were audio recorded and transcribed verbatim. A focus group of similar duration was also conducted at the department of nursing at the University of South-Eastern Norway. Participants were researchers' colleagues (n = 7) in leadership positions. The focus group was conducted in Norwegian and translated into English by KS. A 40-minute creative focus group at Ulster University was used to engage UK and international postgraduate students (n = 23) undertaking a person-centred practice module on the post-registration MSc programme. Students from a variety of clinical settings worked in subgroups to consider responses to each question, mapped their discussions and fed back to the larger group. Agreed themes were recorded on a flipchart by the facilitators (DB, NC and TM). Questionnaires were sent to engage undergraduate students across all three years of a preregistration nursing programme.

The questionnaire, using Qualtrics® (qualtrics.com), was structured with open text design. A total of 112 responses was received. A similar method was used at the knowledge centre at Fontys University of Applied Sciences as part of its programme review process. Invitations were sent to approximately 100 stakeholders external to the school, and a general invitation was posted on the internal newsletter. Stakeholders (n = 30) were informed about the Erasmus+ overall project goals. Participants were first asked to individually think about the questions, and then discuss them in small groups of two

to four people. Individual and collective answers were noted on the supplied sticky notes and put on two wall posters – one depicting the professional, and the other depicting the micro-/meso-/macro-level environment. Following contributions to the posters, participants shared the patterns they saw emerging. Consensus was sought by endorsement, challenge, or additions to identified patterns and the discussion was audio recorded. At Queen Margaret University Edinburgh, the undergraduate and postgraduate teams across nursing, occupational therapy and arts therapies used the questions as part of their programme reviews. Stakeholders, service users, undergraduate and postgraduate students, practitioners, managers, practice educators and third-sector colleagues were invited through formal and informal networks via email (n = 232). Programme leaders used focus groups, workshops or personal communications as they felt appropriate, including the stakeholder questions in their data collection.

### Phase 2: Data analysis '...to the parts...'
#### Step 1: Thematic analysis undertaken in each country
Once the data had been gathered in each country, each partner thematically analysed the multiple sources of data they had collected, which resulted in different thematic frameworks around the question: what is needed for person-centred practice? To ensure rigour, we all followed four principles (Guba and Lincoln, 1989):
1. Credibility was ensured because the same project partner conducted the interviews and transcribed the recordings and posters, with the involvement of all project partners. The thematic analysis process was performed independently by at least two project partners, and any disagreements between them were discussed
2. Transferability was ensured through participants' quotations supporting the themes, which enabled partners to judge applicability of these themes to their own contexts as the meanings of the quotations were traceable
3. Dependability was ensured through the accurate description of the processes used for the analytical process
4. Confirmability was ensured through the hermeneutic praxis methodology adopted

As methodological principles are intended to guide processes but not to fix them, thematic analysis differed in each country. Tentative themes and subthemes emerged and were captured by project partners in draft thematic frameworks.

#### Step 2: Collective analysis of the whole dataset
This first round of data analysis was presented and reflected on, in a facilitated critical conversation with all partners during our second face-to-face project meeting. This allowed patterns and divergences to arise in different analyses. This is in line with Heidegger's notion of interpretation being a circular process, pre-understandings of understanding being made explicit, to form a whole. According to Mackey (2005), reconsidering the findings in new ways allows new understandings to emerge from a complex dialectic between the knower and known. Each partner engaged in active listening and questioning, as we tried to understand each 'horizon' or perspective. Through critical discussion, we asked these questions: what and how do we want our students to be, and what would a supportive environment look like? (Table 1).

| Table 1: Collective analysis of the whole dataset |
| --- |
| Through the discussion we identified that prerequisites for person-centred practice require us to attract students who: |
| <ul><li>Are brave, able to ask questions and engage in conversations</li><li>Use their values to have courageous conversations</li><li>Are advocates for themselves and others</li><li>Can harness their own autonomy</li><li>Listen to what matters to others (service users and colleagues)</li><li>Are clear about boundaries</li><li>Can grapple with ethical issues</li><li>Understand the multiple meanings of health</li><li>Can promote health and wellbeing</li><li>Have a can-do attitude</li><li>Can think creatively and outside the box</li><li>Can work within a team</li></ul> |
| They need to operate in a context where: |
| <ul><li>Everyone works together and is supportive – reciprocity is key</li><li>All parts are interconnected and barriers are broken down</li><li>Person-centredness is the norm, not something to aspire to, and where care is organised around the person, rather than the condition or the organisation</li><li>Multiple perspectives are explored and considered</li><li>There is a shared vision</li><li>All people feel empowered, facilitation is the norm and there is a learning environment</li></ul> |

During the discussion, we remained true to the Person-centred Practice Framework (McCormack and McCance, 2017) but introduced Hart's model (2019) to help us reconsider the purpose of a person-centred curriculum and the conditions needed to fulfil that purpose. Hart states that, contrary to the realities of practice, the direction of thinking and dialogue throughout organisational development and transformation should consider 'purpose' (why we are here), the 'lifeworld' (the being here), and then the 'system world' (rules, regulations and structures influencing the lifeworld, and inevitably the achievement of purpose). In doing so, creations, adaptations and transformations in the system world will guide engagement in the lifeworld and are aimed at supporting the realisation of purpose. This model is consistent with our theoretical framework, as it draws on the critical social science philosophy of the Frankfurt school (Tarr and Landmann, 2011; Corradetti, 2013; Freire, 2018), in which there is an assumption that critical dialogue among stakeholders is essential for the co-creation of a social world where there is equity, and which strives for the common good. We believe, such an approach could make a significant contribution to another issue currently receiving attention, that of decolonising the curriculum. By drawing on an intersectional pedagogy perspective, as intersectional theories are brought into pedagogical practices social justice can be brought into a learning environment. This approach promotes complex critical dialogues about multiple socially constructed identities and social locations (or systems of privilege and oppression) and what they bring to the learning journey (Case, 2017).

A model began to emerge as we considered the purpose of a person-centred curriculum (person-centred, competent, and committed healthcare professionals), lifeworld (supportive local environment) and systems world (supportive meso/macro context). As the critical discussion flowed, we described a dynamic process that we represented in a spiral around the purpose arrow of person-centred practice (Figure 2). We considered learners as students, teachers and others involved in curriculum delivery. We described a living curriculum, where the requirements of person-centred practice, the conditions and processes necessary for learning are engaged in an interplay around the purpose. This is represented in the triple-coloured spirals, where learners connect and move through the three layers of prerequisites, context and outcomes, in order to become person-centred within their area of practice. This process continues throughout the learning journey.

**Figure 2: Purpose arrow of person-centred practice**
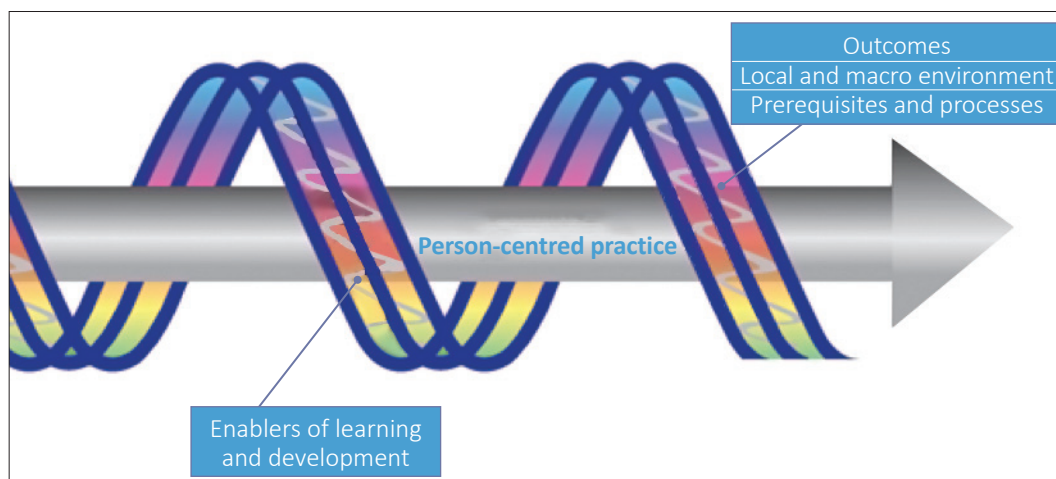


*Application of the logic model*

As part of the hermeneutic process, and to ensure rigour, we questioned our collective data analysis and interpretation against the overall project aims and intended outcomes, using the logic model proposed by McCawley (2001). We applied the model by asking ourselves a series of questions (Table 2). This enabled us to confirm emerging themes and ensure we were staying true to the stakeholder data.

| Table 2: Data mapped against logic model (McCawley, 2001) to ensure rigour |
|---|
| **1. What is the current situation?** |
| • Questions over existing healthcare curricula, and the extent to which they enable the development of person-centred healthcare practitioners<br>• Variability<br>• Lack of shared understanding, knowledge, and language<br>• Need for person-centredness to be explicit in curricula<br>• 'Curricular suitcase'<br>• Theory/practice gap<br>• Issues with the learning environment<br>• Context dominated by a task-driven and medical focus |
| **2. How do we know when we achieve the outcome?** |
| • A living person-centred curriculum<br>• The outcome of a person-centred curricular framework will be real<br>• Gold standard in person-centred curriculum design that can be applied in a variety of models and contexts<br>• Flexible<br>• Stakeholder ownership: they can translate it (the curriculum) into practice |
| **3. What behaviours need to change to achieve the outcome?** |
| • Insufficient reflection on misunderstandings and preconceptions about person-centredness<br>• Disempowering behaviours<br>• Didactic teaching and learning strategies that do not facilitate engagement and understanding<br>• Lack of acceptance of deficits in knowledge and skills, and willingness to engage in lifelong learning<br>• Demands that the new framework should conform with existing curricula |
| **4. Knowledge and skills** |
| • Understanding of person-centredness<br>• Understanding of person-centred framework<br>• Theoretical foundations<br>• Underpinning evidence<br>• Function of a curriculum framework<br>• Understanding the need to change<br>• Understanding the existing reality |
| **5. Activities** |
| • Co-creation with stakeholders<br>• CPD<br>• Public review and critique of data/dissemination<br>• Examination of own experience<br>• Use of vignettes/films<br>• Use of multiple materials to stimulate thinking |
| **6. Resources** |
| • Protected space<br>• Expert facilitators<br>• IT platform and expertise<br>• Administration<br>• Twitter<br>• Graphic design support – digital story<br>• Infographics<br>• Curriculum committees |

*Step 3: Abstraction level of data analysis*
At the level of abstraction, we decided to create two subgroups from four country partners, to explicitly theorise using the Person-centred Practice Framework (McCormack and McCance, 2017) and Hart's model (2019). The subgroups worked together based on similarities and differences in the thematic frameworks: Maribor and Fontys universities used Hart's model (2019); Ulster and Queen Margaret universities used the Person-centred Practice Framework. Each country partner separately re-analysed, or went back to the first round of data analyses, and combined them using one of the two models. While re-analysing the collective data, abstract level themes were teased out. The abstract themes from the two subgroups are presented in Table 3.

| Table 3: Abstract themes from project partners' subgroups | |
|---|---|
| **Maribor/Fontys using Hart (2019)** | **QMU/Ulster using McCormack and McCance (2017)** |
| Theme 1 | |
| Healthcare practitioners need to be educated to become competent and committed person-centred practitioners who: | |
| • Accept and respect a person as a unique individual<br>• Are holistic<br>• Lead (others in) healthcare<br>• Are emotionally intelligent<br>• Are critically reflective and reflexive<br>• Build caring relationships<br>• Are entrepreneurial | • Role modeling person-centredness (prerequisites)<br>• Practising person-centred care (processes)<br>• Becoming an authentic communicator (prerequisites)<br>• Developing the skills to challenge practice (prerequisites) |
| Theme 2 | |
| There needs to be a local person-centred healthcare environment/culture where: | |
| • All involved are supported and given a voice<br>• Person-centred healthcare is the norm<br>• Person-centred healthcare team relationships are the norm<br>• Person-centred healthcare relationships are the norm<br>• Person-centred healthcare leadership relationships are the norm | • Understanding student needs (practice environment)<br>• Being sensitive to student wellbeing (practice environment)<br>• Learning from people's experience of care (prerequisites)<br>• Using best evidence (processes)<br>• Developing positive relationships (practice environment) |
| Theme 3 | |
| There needs to be a whole-system understanding of person-centred healthcare with: | |
| • Whole-system thinking<br>• Creation of communicative/learning spaces<br>• Provision of transparent (resource and material) frameworks<br>• Person-centred healthcare set in alignment with other/similar perspectives<br>• Boundaries removed<br>• Frontline staff and service-user experiences used as major evaluation criteria of whole-system quality | • Managing resources (practice environment)<br>• Understanding the challenges in practice (practice environment)<br>• Staff knowledge and skills, including academic and clinical (prerequisites) |
| Theme 4 | |
| There needs to be a supportive meso-/macro-context with: | |
| 1. Service-design thinking<br>2. Guidelines or criteria for the implementation of person-centred healthcare<br>3. Organisations open to suggestions and critique<br>4. Organisations (and staff at all levels) who explain, illustrate, and live person-centred healthcare as a core value<br>5. Attention to recruitment and retention | |

Maribor and Fontys identified four secondary level subthemes that connect to the main themes:
- Healthcare practitioners' competence and commitment to person-centred practice
- Local person-centred healthcare environment/culture
- Whole-system understanding of person-centred healthcare
- Supportive meso/macro context

Ulster and QMU mapped the secondary data analysis to the constructs of the Person-centred Practice Framework (McCormack and McCance, 2017): person-centred processes and prerequisites, the practice environment and the macro context. These mapped to the four themes. The following short narrative, illustrated with themes identified from each level of data analysis by each country and as a collaborative analysis, highlights the essence of stakeholders' perspectives from five countries on what is needed for person-centred practice in healthcare.

To be person-centred in healthcare, attention must be paid to a triadic relationship between the practitioner's competencies and commitment, together with the local environment. There also needs to be a whole-system understanding of, and support for, person-centredness. Stakeholders felt there is a need for practitioners who 'care with' others, rather than just 'care for' or 'about' others (*Theme 1*). Therefore, they need to acknowledge and work with the whole person, be reflective and be a good communicator. In order to explicate and illustrate person-centredness, there needs to be a shared understanding and the ability to reveal discrepancies between actual and espoused practices. Stakeholders also expressed the need for practitioners to feel a responsibility to be competent and courageous in challenging and changing their practice, thus championing person-centred practice. There should also be a commitment to living person-centredness and to connect with (those upholding) related perspectives. This requires academic and healthcare staff to model person-centred ways of being, and to live out person-centred ideals in their interactions with students (and practitioners) and in navigating conflicting values, structures and policies. Stakeholders indicated they have a desire and a requirement to explore both theory and practice if they are to become proficient person-centred practitioners.

There is a requirement for a local person-centred environment and a culture valuing staff diversity and expertise, sensitive to and understanding of the experiences, feelings and needs of all stakeholders (*Theme 2*). All stakeholders need to adopt a collaborative, inclusive and participative approach to the development of any relationship, and to the student-teacher nexus. However, issues of culture, context and people's behaviours, across healthcare and university settings, are often perceived to act as barriers to an individual student's (and a practitioner's) learning. Generally, a whole-system approach is needed in organisational thinking and design (*Theme 3*), requiring minimal bureaucracy and with structures and processes to serve the lifeworld and relationships of people, not the other way round as is currently more common. Stakeholders value a supportive meso/macro context that guides practice development (*Theme 4*).

Additionally, it is essential to provide guidance so that opportunities are created in learning environments, for example, critical conversations with organisational leaders and managers, and with experienced clinical and academic staff, where boundaries are removed. In this context, the focus could be on coping with challenges to person-centred practice, as well as reflecting on the intended outcomes of related innovations. Ultimately, this will enhance the opportunities for students and practitioners to learn and practice in more person-centred ways in a safe environment (*Theme 1*). The data revealed that learning can only occur in an environment where the evidence and knowledge of clinical and academic staff are up to date (*Theme 2*). Meso/macro contexts should consistently attend to retaining sufficient staff to prevent a shrinking workforce (*Theme 4*).

### *Phase 3: Development of Principles '...back to the whole.'*
*Step 1: Identifying emergent principles*
Drawing on the stakeholder data, the project group adopted five steps for principle development. The group met online (due to COVID-19 public health restrictions), and shared the data abstraction. Members then divided into three groups with representatives from each country. Each group worked with data themes to identify emergent principles. These were then shared with the larger group, followed by further refinement in the three smaller groups.

*Step 2 Emergent philosophical dimensions and refinement of principles*
During Step 2, a small working group with representation from each group (and country) collated and integrated the draft principles from each of the groups. Draft philosophical dimensions and methodological principles were identified as we considered the approach to curriculum design that emerged from the stakeholder data.

*Step 3 Theoretical framing principles*
In Step 3, draft principles were reviewed by the whole project group and theoretically framed, using our theoretical framework models (McCormack and McCance, 2017; Hart 2019). We reached a consensus that:

> *'A curriculum is person-centred if it is transformative (purpose), grounded in a philosophy of pragmatism (systems world) and enables all learners to co-construct (lifeworld) and experience connectivity with oneself, other persons and contexts (lifeworld) throughout their personal learning journey.'*

*Step 4: Mapping principles back to stakeholder data*
To ensure rigour, the small working group further refined the principles and mapped them to the stakeholder data, checking that we remained true to the dataset. A summary of philosophical dimensions, and methodological and pedagogical principles for person-centred curriculum design was then confirmed by the whole group. This is set out in Table 4.

| Framework<br>Purpose, lifeworld, systems world | Methodological principles<br>The philosophical approach to curriculum design | Pedagogical principles<br>Teaching, learning and assessment (TLA) and the content of learning |
|---|---|---|
| Purpose<br>(person-centred outcomes) | Philosophical dimension:<br>Transformative<br><br>Methodological principle: curriculum is transformative and enables journeying through knowing, doing, being and becoming a competent and committed person-centred practitioner | **A person-centred approach to teaching, learning and assessment**<br>TLA strategies<br>1. Learning is holistic, focusing on multiple ways of knowing the whole person<br>2. Teaching, learning and assessment approaches guide learners' journey through knowing, doing, being and becoming a person-centred practitioner<br>3. Learning is progressive, progressing to the point where person-centredness is embodied as a learner, practitioner and leader of person-centred practice<br>4. Reflexivity is integral to active learning approaches, enabling movement from preconsciousness and consciousness to critical consciousness, thus creating perspective transformation as a person-centred practitioner<br>5. Active learning enables new insights to become translated into actions to be tested and evaluated in practice<br>6. Eclectic teaching, learning and assessment strategies draw on critical creativity, as well as technical-rational approaches, to enable learning to be systematic and incremental with deliberate intent<br>7. Learners and facilitators learn together, with and from each other, shaping new knowledge<br><br>Learning environment<br>Person-centredness is embodied by all involved in and supportive of the curriculum<br>Learners experience and practice person-centredness<br>Learners are helped to become brave in expressing their voice to challenge practice |
| Lifeworld<br>(healthcare relationships) | Philosophical dimension:<br>Co-constructed<br><br>Methodological principle: a co-constructionist approach to curriculum design and implementation where the curriculum is flexible and adaptive to the learner | TLA strategies<br>1. Learning is participative, inclusive and collaborative in all learning relationships<br>2. There are opportunities for creating shared social responsibility in co-creation of curricula, based on moral intent<br>3. TLA are sensitive and responsive to these mutual learning needs, which are open to negotiation<br>4. Learners determine their own learning pathway<br>5. Learners at different stages of the learning journey are encouraged to learn together<br>6. Learners and teaching staff should actively engage in mutual learning<br><br>Learning environment<br>1. A culture of safety, relationships and learning is co-created<br>2. Safe learning environments are created for exploration, shared understanding, decision making and action<br>3. Preconditions are created by those with a stake in the curriculum to co-create the processes necessary for curriculum design<br>4. Educators show courage, humility and vulnerability in the facilitation of learning<br>5. Practice-based mentors are engaged as part of the programme team<br>6. Freedom of individual expression is encouraged<br>7. Taking risks and (calculated or intentional/moral) experimentation are encouraged, supported and subject to wider critique through reflective processes<br>8. Practitioner and service-user experiences are evaluation criteria used to critique and promote knowing, doing, being and becoming a person-centred practitioner<br>9. Safe spaces evolve into brave spaces, in which everyone feels comfortable with diversity and experiences respect, inclusion and emotional support |

**Table 4: Draft principles for person-centred curriculum design**

| Table 4: Draft principles for person-centred curriculum design (*continued*) | | |
|---|---|---|
| **Framework**<br>Purpose, lifeworld, systems world | **Methodological principles**<br>The philosophical approach to curriculum design | **Pedagogical principles**<br>Teaching, learning and assessment (TLA) and the content of learning |
| Lifeworld | Philosophical dimension: Relational<br><br>Methodological principle: curriculum encourages connectivity with self, other persons, and contexts | TLA strategies<br>1. Fundamentals of person-centredness are continually revisited<br>2. Learning involves maximising generation and transmission of multiple sources of evidence to support knowledge of person-centred practice<br>3. Person-centred facilitation is embedded in teaching, learning and assessment approaches<br>4. Social learning and meaning making are encouraged through safe communicative spaces<br>5. Opportunities are given to reflect on relationships with others and with materials and space<br><br>Learning environment<br>1. Person-centredness is embodied by everyone engaging and communicating authentically<br>2. Critical questioning is embedded in learning processes<br>3. Caring relationships that foster mutuality are created<br>4. Diversity is welcomed and respected<br>5. All involved in the curriculum accept moral responsibility for others |
| Systems world (environmental/ organisational structures, processes and administration, which create a systems world that supports the lifeworld in realising purpose) | Philosophical dimension: Pragmatic<br><br>Methodological principle: curriculum is built on a philosophy of pragmatism | TLA strategies<br>1. Theory and practice are intertwined<br>2. Debate and discussion create opportunities to deconstruct idealism versus realism<br>3. Engaging in enquiry-based learning to become facilitators within whole and multilayered contexts<br>4. Learning is embedded in movement between local, national and global contexts<br>5. Generation and sharing of multiple sources of evidence will support the development of competence (knowledge, skills, and attitudes) in an inclusive way<br>6. Learners consider themselves to be agents of social change<br>7. Embracing, working with and being comfortable with complexity through enquiry-based learning<br>8. Ongoing evaluation of learning in relation to ever-changing practice milieux<br><br>Learning environment<br>1. Communicative spaces create opportunities for social learning and meaning making<br>2. Safe spaces evolve into brave spaces<br>3. Learners understand the relevance of person-centred practice through contextualised learning within real-life experiences |

**Discussion**

The Erasmus+ project has given a group of international partners the opportunity to contribute to the burgeoning body of work around person-centredness and education development. The expectation that practitioners can be person-centred, or organisations can create conditions to support person-centredness, without experiencing preparation helps explain why there is evidence of continued dominance of the medical model, and few practice innovations that keep people at the centre of their care (Phelan et al., 2020). According to Freire, (1996, 2018) education has the potential to transform an individual's world, opening up possibilities of a fuller and richer life. However, he also contends that context has the means to keep people 'submerged' (p 90). Gibbs (2017) aligns himself with this perspective arguing that if compassion is central to curricula, learners will be encouraged to have a voice, and there could be far-reaching consequences for society. He goes further to challenge neoliberal higher education institutes to weave compassion through the ethos of organisations but warns against its becoming commoditised. In the course of the work undertaken in this part of our Erasmus+ project, our data also highlight the importance of the context within which we educate future healthcare practitioners. It is clear from our data that education programmes cannot change contexts that 'submerge' without considering the context of teaching and learning itself, as highlighted by the connections shown between lifeworld and system world. It is through the system world that our shared and common purpose – person-centred healthcare – is realised. Thus, the embedding of person-centred methodologies and strategies in the ways we engage with future healthcare practitioners is paramount. A curriculum that helps learners to recognise the taken-for-granted, to be brave and to question, and equips them to grasp opportunities for change is aligned to our philosophical position and is reflected in the pedagogical principles. The purpose of the proposed curriculum, therefore, is to be transformative and enable journeying through knowing, doing, being and becoming a competent and committed person-centred practitioner.

Of course, this focus on the relationship between lifeworld, system world and the adopted pedagogical principles is central to the advancement of humanistic learning theories that have a focus on self-understanding, self-development and self-transformation (for example, Freire, 1996; Illeris 2014); the curriculum principles outlined here are consistent with this worldview. Humanistic principles are embedded in transformative learning that focus on helping all persons to release themselves from systems that oppress and become liberated towards acting. Emancipatory and transformational practice development methodologies (Manley et al., 2013) have embraced these humanistic and critical processes, and their implementation has enabled practitioners and leaders to 'change the conversation' about practice and how it is developed, especially at micro and meso organisational levels (McCormack et al., 2013). However, the lack of person-centred curricula that are transformative and enable all persons to engage in these conversations in systematic and rigorous ways has been problematic and, it could be argued, has limited the impact of practice development as methodology. Thus developing principles to underpin such person-centred curricula – humanistic in intent, connecting the lifeworld and system world, and transformative – has the potential to create a sustained impact in practice.

Illeris (2014), suggested that for learning to be transformative, curricula must address the cognitive and the emotional as well as the social dimensions of mental capacity and learning. This is reflected in the holistic nature of our pedagogical principles. Additionally, we believe learning must be progressive and reflexive, within an environment where learners and facilitators of learning grow and learn together. Aligned to Gibbs' (2017) pedagogy of compassion, we propose the perspective of relationality will establish caring environments where there is respect for diversity, mutuality and moral responsibility for others. Being relational reflects the need to understand what being person-centred means and therefore the theory and philosophy would be continually revisited. Social and active learning methodologies will encourage learners and facilitators of learning to be open to becoming person-centred. The philosophical dimension of pragmatism, meanwhile, acknowledges the need for competence development and learning to be grounded in the realities of practice. Learning should

be embedded in practice, valued by stakeholders, with their contributions as active members of the education team. This facilitates seamless integration of theory and practice. Learners will be able to use multiple sources of evidence to make sense of complexity and harness social change. Lastly, we propose that co-constructing the curriculum will enable flexibility, as advocated by Gibbs (2017). This flexibility means a curriculum without boundary that supports learners in understanding their own learning needs in relation to person-centred practices and offering them choice in how to meet them. However, (Freire, 2018) suggests this is only possible in environments where exploration and dialogue are encouraged. Aligned to critical theory, within such environments learners are encouraged to take risks (Tarr and Landmann, 2011; Corradetti, 2013; Freire, 2018). Scharmer (2018), in his Theory U, suggests transformation happens when we go through a process of knowing, being and becoming a new future and this is fundamental to our approach. Key to this process is 'presencing', where we create conditions to 'let [a new future] come' (p 161). Presencing encourages stillness and a time for sense making. The learning environments reflected in our pedagogical principles, therefore, emphasise spaces for learners to be brave enough to be open and to question. A key contributory factor in creating these conditions within person-centred curricula is the need for educators to view themselves as members of the learning community, and to show humility.

The strength of this study is its diverse stakeholders across five European countries. The sample was heterogeneous in relation to gender, age, profession and educational programmes, increasing the transferability of findings. The different means of data collection and analysis are viewed as a strength of this work, offering flexibility rather than being entrenched in boundaries by traditions. To minimise the impact of subjectivity in the analytical process, all the project partners participated to strengthen interpretation and to ensure credibility. The hermeneutic methodological process ensured a systematic approach, moving initially between individual country data and the whole dataset, and then between work undertaken by smaller groups in principle development, checked against, accepting contributions from, and seeking agreement with, the whole project team.

**Conclusion**

At the outset of this article, we recognised the gap between policy and the authentic practice and experience of person-centredness. This article represents steps to foster a more focused and engaging way of implicitly and explicitly embedding person-centredness in curricula. The aim of developing a set of principles that reflect the 'voices' of service users and other stakeholders, and have been generated through a systematic, transparent process, has been met. By adopting the lens of person-centredness, together with the purpose-lifeworld-system world model (Hart, 2019), the findings demonstrate dependability and transferability (Guba and Lincoln, 1989). Our theoretical framework has enabled us to consider the different layers of practice while staying true to the purpose of curriculum design. By presenting our framework in this article, we are opening it up to critique from those interested in this area of study and beyond. In the next stage of our project, stakeholders will be asked for their feedback, and to reflect on whether their original data has been adequately processed, and the confirmed principles will be used to develop the curriculum framework. Consistent with our approach and with our philosophy, this too will be collaborative, involving stakeholders from the five European countries and employing methods that encourage participation. Questions, offered from one of the reviewers of this article and which may guide this stage of the project are:

- To what extent does neoliberal higher education policy challenge the development of person-centred curricula?
- To what extent are the risks of 'person-centredness' becoming commodified?
- How can educators in fields beyond healthcare, such as social sciences, adopt the principles of a person-centred curriculum to ensure future generations of policymakers and practitioners from these disciplinary backgrounds have experienced person-centred higher education?

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