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Commentary

Person-centred Care in Rehabilitation: Shall we explore?

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The concept of person-centred care has developed over time due to significant changes in the interactions between patients and physicians in healthcare systems. Over the years, diverse healthcare professions involved in the care of patients have also evolved. It is useful to consider the changes which have occurred in patient care across time, keeping in mind the transition from patient-centred care to person-centred care in diverse social and cultural contexts.

Several conceptualisations have been discussed in healthcare literature regarding the development of interactions between patients and their physicians and other healthcare professionals through time. These interactions have developed greatly from Parson's theoretical analysis of the 'sick role' in 1951. During this period, healthcare was dispensed from the physician to patient according to the patient's medical or surgical needs (Parsons, 1951). The introduction of the biopsychosocial model by Engel in 1977 was the beginning of a revolutionary approach to healthcare, one which attempted to address social and cultural contexts. Later, the interpretative model suggested by Emmanuel in 1992 involved patients in decision-making within their care (Emmanuel et al., 1992), whilst also starting to include an appreciation of patient's values in the decisions made. The relationship between patient and the healthcare professionals involved in his care, including the physician, was transformed in later years, leading to the development of self-management programs, especially for people living with chronic disease. However, Tattersall (2002) highlighted the difficulties in this approach, especially in the evaluation of its efficacy. He noted that the ability for patients to manage and monitor their conditions safely depended on the confidence, skills and education required. Although this sounds perfectly true, Shaw and Baker (2004) challenged these notions, and helped to coin the term "expert patient". They highlighted that all patients are experts regarding their experience of living with their condition, regardless of their medical knowledge or level of education. They claimed that this understanding of the patient's life situation enhanced collaboration between patient and healthcare professional, promoted better adherence to treatment, and led to better outcomes and solutions.

This was easier said than done. Rogers (2009) argued that the effectiveness of the Expert Patient Program introduced in the UK in 2001 was limited. It was intended to enable patients with chronic conditions to work with healthcare providers in managing their conditions. She stated that since self-efficacy was mostly used as an outcome in the evaluation of self-management programs without considering other social needs, social inequalities were not being addressed. This led to poor comparisons in self-efficacy by patients with very little financial means and/or education. Moreover, this outcome of self-efficacy did not include the collective work done by caregivers, including family, friends, and societal networks.

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Since then, there has been a progression within healthcare systems moving from a disease-centred approach, to an illness-centred approach and now a patient-centred approach. This slow progression led to further investigations of the interactions and relationships between patients and the various healthcare professionals entrusted with their care. Research related to these relationships has included topics such as empowerment, autonomy, patient engagement (Jesus &Silva, 2016), patient-centred and person-centred care (Santana et al, 2017), and more recently, patient partnerships (Odero et al, 2020). A distinction between patient-centred care and person-centred care was made by both Ekman et al., (2011) and Starfield (2011). They differentiated between a focus on the patient's symptoms and disease, and a focus on the person's experience and perception of their illness. Although the evaluation of outcomes, impacts and sustainability of person-centred care have been difficult to establish (Santana et al., 2017), several important components have been considered within its conceptualisation. These include communication with patients, listening and sharing of information, discussing care plans and respectful and compassionate care of patients (Santana et al., 2017; Kitson et al., 2013). Arguably, these concepts might appear congruent with healthcare systems today. However, there seems to be a lack of universal agreement globally on how this is achieved at clinical level within diverse social and cultural contexts. The WHO, in its 2015 report 'Global Strategy on people-centred and Integrated Health Services' (WHO, 2015) placed an emphasis on the need for context-specific models of person-centred care. It states that each country needs to "develop its own strategy for integrated and people-centred health services", and that these "must respond to the local context, existing barriers and the values held by people within the state". Whilst emphasising on person-centred care, the WHO also stated that models of care should be specific to the local context, and include values which are important to people of specific states or countries. This must surely highlight the importance of generating data from individual patients within diverse societal and cultural contexts in order to be able to implement and evaluate person-centred care in clinical practice. This would identify specific perceptions and needs for individuals undergoing rehabilitation.

Social contexts and environments, together with levels of education, have been added to definitions of healthcare and rehabilitation for some time – the WHO added 'social well-being' to its definition of health in 1948 (WHO, 1948 cited in Misselbrook D, 2014). This primary idea was added conceptually to any individual's physical and mental health. Further elaborations also included the concepts of communication and negotiation within healthcare as important social determinants, one of which is health literacy (Donkin et al., 2017; Wong Chin et al., 2014). Health literacy involves the individual's capabilities of obtaining and understanding information together with negotiation processes within healthcare systems. The social and cultural aspects within patient-professional interactions, as a form of societal exchange, would therefore be important to identify and interpret (Cordina et al., 2018). One could consider healthcare systems as a social system with a specific purpose in mind – health, disease prevention and treatment, together with rehabilitation. The WHO instilled the importance of social and cultural contexts in its understanding of rehabilitation as the "set of interventions designed to reduce disability and optimising functioning in individuals with health conditions in interaction with their environment" (WHO, 2019). As the participation of patients in their healthcare management appears to be currently an important dimension in current healthcare strategies, (Ramdurai, 2020), exploration of diverse social and cultural contexts within interactions between health care professionals and patients might be important to consider to identify individual needs.

Culture has been described as a 'socially constructed and historically transmitted pattern of symbols, meaning, premises and rules' (Philipson, 1992). It has also been conceptualised as static or dynamic, which implies individual change over time, or predictable and generalisable from individual experiences (Al-Bannay, 2013). The patient participation required during rehabilitation practice suggests the exploration of the conceptualisations of societal and cultural understandings of patient experiences of illness and disability. The Mediterranean context invites this exploration due to the sociocultural nuances present within the Mediterranean Model. Changes in local traditional family structures and values (Abela, 2009) might also be influencing the experience of patients because of social capital and social cohesion offered by robust, or absent, familial, and societal networks.

Current healthcare needs and exigencies might therefore benefit from further exploration of the experiences of patients within rehabilitation in the Maltese context. It has been shown locally that the social determinants of health and well-being appear to be influenced by social dynamics, including roles of extended family, traditional attitudes towards the institution of marriage, gender roles and religious beliefs (Satariano & Curtis, 2018). This influence of social norms and practices on patient experience could also be addressed. Further exploration of patient experience might shed light on how interactions between patients and healthcare professionals, together with contextual familial and societal networks, influence the process of rehabilitation. Current Maltese healthcare strategies have, in fact, highlighted the importance of person-centred care (National Health Systems Strategy for Malta 2014-2020). Chapter 7 in this report indicates objectives within local health strategies which include the implementation of "the right care at the right place and at the right time" and the inclusion of different aspects of services within this, such as both hospital and community services, with individualised attention where necessary. Research is essential to identify where these objectives need to be implemented in order to achieve person-centred care.

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