

## GUEST EDITORIAL

# At the hustings: four quality indicators for a person-centered healthcare

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## Introduction

As headlined in the recommendations of the 2013 Public Inquiry into the Mid Staffordshire NHS Foundation Trust, chaired by Robert Francis QC, a total system failure had occurred within the organisation. The business management model for healthcare had floundered, the regulatory bodies were ineffective and person-centred approaches to healthcare had failed. A large number of recommendations, 290, were made to rectify a wide range of gross deficits which had resulted in over 1000 excess deaths during the period 2005-2008 [1]. Many patients had become dehumanised and a culture of care and compassionate empathy was lacking. Although scandals had occurred before the internal market was introduced into the NHS (England) (e.g., at Ely Hospital, South Ockenden, Napsbury and Normansfield), the findings of the Francis report were particularly shocking because of the depth of neglect and the number of deaths. The new system of healthcare funding with the purchaser-provider split was expected to empower the patient as ‘consumer’ and to motivate doctors and nurses to provide high quality care. Francis found, however, that these systems, when implemented in a top down manner and in a culture of secrecy and fear, were simply not conducive to providing good care for patients. In seeking to meet financial targets and seeking Foundation Trust status, the Trust Management had overlooked the need to ensure the quality of patient care and patients were not listened to, as we discuss in an additional article within the current issue [2].

Several responses to the Francis recommendations from the Royal Colleges, as well as from 21 health organisations in their joint election manifesto [3], did not directly consider the fitness for purpose of the competitive internal market. Nor did they discuss alternatives, such as a

‘Values-explicit and Systems-based’ approach [4]. With a UK general election imminent, politicians, NHS managers and clinical leads are now at the hustings, where the apparent dissonance between the values of person-centred healthcare and a perceived moral vacuum of the internal market is likely to be debated. This mismatch of values is eroding the morale and altruism of doctors and nurses and targets are leading to failure demand [5] and to an increased risk of burnout [6]. We perceived therefore a need to develop a number of quality indicators to help implement a person/people-centred health service that would value the patient and carer, as well as the staff member. Furthermore, we believe there is a need for greater conceptual clarity about the roots of compassion, the nature of personhood and the meaning of wellbeing.

Dr Kate Granger [7] has described her experience of being dehumanised when a patient and where the tendency for medical staff is to reduce patients to their biology and diagnosis. This reductionism, which is apparent in much current healthcare, is opposed by the philosopher and psychiatrist Werde van Staden [8], who has argued for a collective plurality (rather than a dualism or monism) which regards the person as primary and the biology, psychology and sociology as ‘extricates’, that is, as *derivatives* of a person. There are also religious insights which support this proposition, such as a belief that human beings are made in the image of a caring Deity and are therefore intrinsically of value and humanist beliefs based on secular kinship or neighbourliness [9]. Continental philosophers, such as Martin Buber, Karl Jaspers and Maurice Merleau-Ponty - as well as the writings of Paul Tournier [10] - are other sources to consider for the conceptual underpinning of the importance of the person of the patient and the person of the doctor - and the nature of their relationship. A *body - mind - spirit paradigm* may

provide a more inclusive framework for this approach to healthcare, as the biopsychosocial model can be dismissed as 'shallow eclecticism' [11]. The body, the mind and the spirit are construed in this paradigm as interlocked facets of the whole person and hence as 'extricates' of the person in the sense described by van Staden [8]. The spirit (meaning, purpose, intentionality and sense of the numinous) is a lived experience for many patients, carers and for many doctors throughout the world. The practice of whole person medicine can occur in any system of healthcare delivery and can be facilitated by local cultural norms. In Uganda, for example, where one of us worked in the 1970s, a successful partnership is presently established between an East London Hospital Trust and Butabika Hospital in Kampala. UK-based health personnel who worked in Uganda have commented on the values of the African psychiatric support workers, whose interpersonal caring skills for patients were truly inspirational [12].

## Four Quality Indicators (QIs)

It is within this context that we have suggested four generic quality indicators that might be considered as components of an enabling environment [13] and of the delivery of an integrative healthcare that puts patients and people first. These four humanistic indicators are derived in part from our clinical and research work, from familiarity with teaching a whole person healthcare module at diploma/masters level, from experience of person-centred counselling, from Balint groups and Schwartz rounds and from our training in group processes. Caring for the wellbeing of staff is a key component of being able to provide sustainable person-centred care in a competitive or collaborative health delivery system. Our proposed QIs are set out in Box 1.

Box 1 Four proposed quality indicators for the creation of an enabling environment

- (a) State how you will instruct, support and nurture all your staff to provide relationship-based person-centred medicine and person-centred healthcare.
- (b) Indicate how and when you will provide supervision from experienced mentors for all your staff.
- (c) Give details of the educational methods you will use to train all your staff in counselling and listening skills and compassionate empathy. Describe your strategy for Continuing Professional Development in person-centred care and state how and by whom this will be implemented.
- (d) Indicate how you will identify and support role models for the provision of person-centred healthcare and the implementation of a culture of intelligent kindness [9].

## Conclusion

The Francis report recommends that the needs and wants of the patient must be put first. We suggest that a collaborative rather than a competitive approach for healthcare delivery should be considered; where collaboration based on the primacy of the patient as person, the personhood of the professional and the healing potential of their relationship. This approach, focussed through the four quality indicators, could reduce burnout [6] and sickness absence. A collaborative network which shares these core values is also likely to prove cost effective. It would also effect cultural change, preventing another healthcare scandal such as Mid Staffordshire.

## Conflicts of Interest

The authors declare no conflicts of interest.

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