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EDITORIAL INTRODUCTION

PROVIDING PERSON- AND PEOPLE-CENTERED CARE DURING THE COVID-19 PANDEMIC

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INTRODUCTION

Healthcare providers are formed to serve people and put people's needs at the center. They are expected to inform their patients as experts in health problems and health risk factors. During the clinical encounter they must integrate their knowledge with the unique characteristics, feelings, needs, and life circumstances of the person seeking their help. While this is the ideal scenario, the pandemic erased this script completely. Everything had to be learned by everyone without an expert guide. What are the risk factors, are mouth masks necessary, should we close schools, borders, or do we apply watchful waiting? How can we define cases, diagnose people, and treat them if they become ill? What do we do with other chronic diseases, health problems, or preventive services? Which resources do we need, including human resources (student trainees, retired healthcare workers, volunteers)? What was the view of healthcare providers on their duty to work during this health emergency? The latter question is answered by Muñoz et al in their paper in this issue of the *IJPCM* for nursing students in Chile and Spain [1].

The pandemic made healthcare providers aware that they were as human and vulnerable as the people they serve and that the duty to help with the "Primum

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non nocere" (first do not harm) became a real challenge. If we see a person with respiratory failure due to COVID-19 in a country where the hospitals are collapsed and no treatment protocols are yet available, do we give a treatment based on deduction from related pathophysiological mechanisms, do we just listen and provide support for the person in care without an intent to cure or do we walk away because of fear or impotence?

CREATING RESILIENCE IN ADVERSITY

Uncertainty, stigmatization, and potentially exposing their families to infection were prominent themes for healthcare providers [2]. At the start of the COVID pandemic in Bolivia some healthcare providers were denied access to their own apartment by their neighbors. Similar social stigmatization and discrimination took place in other parts of the world [3]. The emotional stress added up for many healthcare providers with a higher workload leading to reported anxiety or depression rates of up to 50% in 2020 [4, 5]. Coping behaviors, resilience, and social support were associated with a reduction in mental health problems [6] and an increase in patient safety. This latter topic is described in the paper by Meekes et al in this issue [7].

Communication with family, friends, and colleagues was for most healthcare providers their primary coping mechanisms, followed by religious coping mechanisms such as praying and distraction activities (such as engaging in sports, exercise, music, yoga or meditation). Effective leadership and organizational support through the implementation of a safe and resilient work environment, provision of complete and quality PPE and supplies to prevent infection, provision of updated and evidence-based guidelines for infection prevention, provision of accurate and timely information regarding the disease and implementation of trainings relevant to COVID-19 were seen as vital to promote resilience [8]. Other strategies like a Sustainable Work Force Model including remote working in disciplines like psychiatry can have a positive impact on COVID risk, life–work balance, and mental health as described by Millar in this issue [9].

PROMOTING SELF-CARE: EMPOWERING AND SUPPORTING

To achieve people-centered healthcare, people need to receive the education and support they need to make decisions and participate in their own care [10]. This is a shift from the paternalistic hospital and disease-centered care to collaborative care wherein people take back ownership of their health guided by a trusted healthcare provider. Although this seems a strategy that could reduce the workload during the pandemic by promoting self-care, there are various pitfalls. The

digital divide asks for a multilevel strategy that guarantees a thorough analysis of the community served. Which people have access to digital information, know how to use it and can identify its trustworthiness? Do healthcare providers have the capacity to adapt their information to the individual and cultural norms and understanding of their population? And are we not forgetting an important partner in promoting self-care? Developing community action and intersectoral strategies with a gender-based approach could help to reduce health inequalities and increase the success of people's adherence to health guidelines and self-care-promoting interventions [11].

Another pitfall is the attitude of healthcare providers towards self-care who often belief that their patients lack willingness and understanding to engage in self-care like described in the article by Smith in this issue [12]. Additionally, he describes how people identified self-care as being abandoned instead of empowered. Many questions remain unanswered related to self-care and remote care. Is person-centered care possible on the long term without in-person visits or is there a healing power in the physical presence of a trusted healthcare provider?

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