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Six differences between Person-centred Medicine and Patient-centred Medicine

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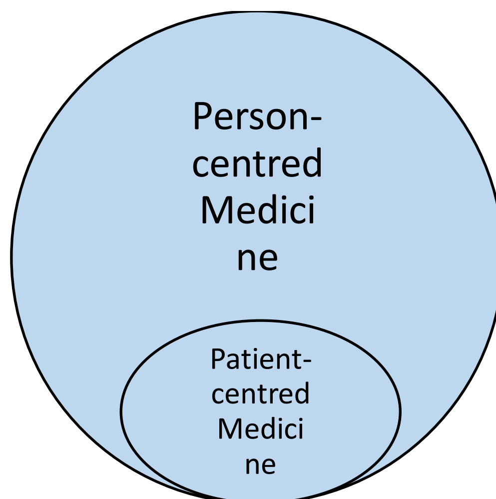
In this Newsletter, I summarise six differences in conceptual scope between Person-centred Medicine and Patient-centred Medicine. There are of course similarities between these approaches too. Notably, both advocate a deliberate shift from too narrow a focus on merely a disease, symptoms and signs, a bodily organ, a physiological system such as the cardiovascular system, the body, or the mind (as for psychiatric disorders). Patient-centred Medicine advocates a shift from these clinical foci to putting the patient central to clinical practice, attending to what the patient wants and (as it features most commonly in the literature) his or her satisfaction with clinical services. Person-centred Medicine extends further, notwithstanding the overlap. I represent this in the Venn-diagram as follows:



Person-centred Medicine extends further than Patient-centred Medicine in no less than the following six ways:

1) *The person is more than a mere patient*

   Person-centred Medicine puts the person before his or her role as a patient. This difference is important in that it recognises a) the various roles of the person including his or her roles of patient, parent, citizen, student, etc.; b) that a specific person is not the same as the next person (as if just another patient for example); and c) each person is constituted in part by his or her particular circumstances, expressed by the philosopher Ortega as “I am I and my circumstance”.

2) *The practitioner is also a person with various roles*
Person-centred Medicine puts central not only one person in his or her patient role, but recognises that the practitioner is also a person with various roles. These roles are both professional and personal. Professional roles include being a service provider, a representative of his or her profession, an agent of his or her institution or employer, a researcher, or a clinical pedagogue. Personal roles include being a potential patient, a parent, a family member, an employer, an employee, a community member, a citizen, etc.

3) *Other persons are crucial too, also when neither a patient nor practitioner*
Person-centred Medicine recognises persons other than the patient or the practitioner as being crucial in healthcare. These include family members, employers, institutional managers, policy makers, etc.

4) *Interpersonal relationships are crucial*
Person-centred Medicine situates a person not only in his or her roles and circumstances (see above), but also within relationships with other people. As part of healthcare, these relationships should be nurtured. They are furthermore constitutive of Person-centred processes. For example, within these interpersonal processes shared understanding is pursued, treatment plans are conjointly created, shared decisions are made, and informed consent is sought and given (or declined).

5) *Experiences of persons are crucial*
Experiences of persons are crucial. They are not just about satisfaction, but what it is (like) “for me”, what matters to “me” in “my” specific circumstance. Taking the first person experience of a specific person as crucial means his or her values, interests and preferences are given a central place in healthcare, not merely as an add-on but at the core of healthcare and shared decision making.

6) *Both positive and negative health should be attended*
Person-centred Medicine attends to negative health - that is, for example, when someone is diseased. Person-centeredness requires more than this, though. It requires attention to positive health as well. This includes the person’s well-being, strengths and resilience. Congruent with the WHO’s definition of health, this means health promotion extends beyond the prevention and treatment of disease. Furthermore, attending to both positive and negative health should extend to the experiences of persons (see point 5 above). This means the person’s experiences of not only negative health but also his or her well-being feature in a person-centred approach.

The above differences are about the conceptual scope of Person-centred Medicine. Its scope should be distinguished from the means and principles by which its scope is addressed. There are of course many means by which to pursue the full scope of Person-centred Medicine. These include for example communication, interpersonal interaction and engagement, and accounting for values and experiences of all the people involved. Principles by which to pursue Person-centred Medicine include for example honouring the dignity, autonomy and rights of the person(s), beneficence, non-maleficence, distributive justice, duty to care, respect for differences and diversity, social and communal responsibility, etc. Means and principles of Person-centred Medicine are also captured in the Person-centred Care Index.

I trust this summary would be helpful to colleagues for shaping their practice to become more and more person-centred. It may also help to situate within the description above the rich and varied publications on Person-centred Medicine in for example the *International Journal of Person-centred Medicine* (http://www.ijpcm.org/).