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Which is it, person-centred culture, practice or care? It matters

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Abstract

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DISCUSSION ARTICLE

Which is it, person-centred culture, practice or care? It matters

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Conclusion: Person-centred care is espoused within health policies, visions and mission statements. However, the focus should be on person-centred cultures and on how these can be developed and embedded. The Person-centred Practice Framework can aid understanding, implementation and evaluation of person-centred practice for all.
Implications for practice:
- A consensus on the meaning of 'person-centredness' in practice would be beneficial, as the lack of one impacts on who is accorded person-centredness, what it means and looks like in practice, and how to measure its impact
- The Person-centred Practice Framework provides clarity and guidance to health professionals, teams and organisations on how to operationalise and evaluate person-centredness for all
- It would be advantageous for policies, practices and care standards at a systems level to reflect the shift in thinking from person-centred care to enabling person-centred practices and cultures

Keywords: Personhood, person-centred care, person-centred practice, person-centredness, Person-centred Practice Framework, person-centred culture

Introduction
Globally, healthcare systems are continuously changing and being challenged, as has been starkly illustrated by the coronavirus pandemic. The difficulties have also been evidenced by the growing number of patients with chronic and complex conditions, rising costs and budget restrictions, increased workforce pressures and patient demand and the advent of new technologies (Francis, 2013; Roncarolo et al., 2017; National Academies of Sciences, Engineering, and Medicine, 2018; World Health Organisation, 2020). Against this backdrop, the need for responsive and responsible leadership and governance is pressing. The changes have seen different models of care being proposed as the paternalist biomedical model of healthcare that dominated the 20th century is no longer appropriate (Institute of Medicine, 2001). Early in the new millennium, the seminal paper Crossing the Quality Chasm (Institute of Medicine, 2001) noted that a lack of consistent high-quality evidence-based care was resulting in too many errors, and that a fundamental redesign was required to address health inequalities across the system. Six aims were developed, including a shift to a patient-centred care model. Patient-centred care was described the provision of 'care that is respectful of, and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions' (Institute of Medicine, 2001, p 6). However, patient-centred care can reduce the person to a patient, with concerns only for their healthcare needs (Dewing, 2008; Manley et al., 2011a; Scholl et al., 2014). Contemporary healthcare policy now instead endorses person-centred care, which focuses on the 'person the patient is', (McCormack, 2003). The World Health Organization states that person-centred care responds to a person's total needs, including preventive and curative needs, rather than simply disease categories (National Academies of Sciences, Engineering, and Medicine, 2018).

Despite the changes in directives, person-centred care is still not widespread practice (The Health Foundation, 2014a). However, its importance can be seen at strategic levels internationally (McCormack et al., 2015). With scholarly advancement to date we are now faced with myriad related terms such as personhood, person-centred care, person-centred practice, person-centred cultures and person-centred healthcare services. Confusion over the meaning and application of these concepts in healthcare has been identified as an issue, and such misunderstandings limit the potential for improvement in care practices (Clisset et al., 2013; Higgs and Gilleard, 2016; Dewing and McCormack, 2017). Given this uncertainty, placing these concepts at the centre of healthcare policies and practices, could risk further misunderstanding of what person-centred care means in practice (Clisset et al., 2013; Higgs and Gilleard, 2016).

Yet even with the global challenges, healthcare cannot afford to ignore the person-centred agenda. Indeed, healthcare complaints are rising and many relate to person-centred processes. These include a lack of respect for person, poor communication, a lack of empathy and the attitudes and manners of health professionals. More than a third of complaints are related to staff-patient relationships (Reader et al., 2014; Abdelrahman and Abdelmageed, 2017).

There is growing recognition that person-centredness should be extended beyond patients to include healthcare workers (McCormack and McCance, 2017). The move to a patient-centred model of care resulted in the welfare needs of patients coming first but patients and clinicians should be seen as equals, both having their personhoods respected, and both receiving mutual benefit from the relationship (Buetow et al., 2016). Person-centred cultures are required to ensure this happens (McCormack et al., 2018).

Aims
This discussion article aims to explore some of the historical and current perspectives on the interrelated concepts of personhood and person-centred care and to explain why multiple perspectives on these concepts are contributing to confusion, which has an impact on the understanding, implementation and evaluation of person-centred care. The article then aims to explain the reasons why person-centred cultures and practices need to be implemented, and to propose a way forward towards a person-centred agenda.

Methods
Using the terms personhood, person-centred care, person-centred practice and person-centred culture, a broad search of the following sources was undertaken, with the number of articles selected in brackets: grey literature (n=11); Medline and CINAHL (n=59); articles published in the *International Practice Development Journal* (n=12), and a selection of books (n=11). The selected articles were reviewed and grouped in order to gain a deeper understanding of the terms and the relationships between them, and to identify a potential way forward.

Discussion
Personhood
Personhood is defined as 'the state of being a person' (Dictionary.com, n.d.). This section will outline some perspectives on 'personhood', discuss the nature of being a person and consider how the different perspectives can apply to healthcare.

Some of the differing perspectives
The debate over who and what makes a person is centuries old. Kant (1724-1804), an 18th-century moral philosopher, proposed that each person who exists has equal worth and value, and deserves equal respect as a member of a moral community. The presence of 'self-governing reason' was his founding principle and he contended that we all have basic moral duties to ourselves and to others, based on the categorical imperative. This imperative is 'an objective, rationally necessary and unconditional principle' that we must follow with goodwill even if our desires say otherwise (cited in Johnson and Cureton, 2018, p 1). Kant stated that 'we should never act in such a way that we treat humanity, whether in ourselves or in others, as a means only but always as an end in itself' and this is essential to our humanity (cited in Williams and Bengtsson, 2018). Kant believed in 'duty' arguing that if duty is an element in our decision making then we have acted rightly, no matter the consequences (BBC, 2014).

A Christian perspective might be that all persons are afforded personhood no matter what, as 'a gift from God's grace and personhood is eternal, not something that is given and then taken away based on attributes' (Dameron, 2017, p 212). Martin Buber, a German-Jewish religious philosopher of the 19th century with an interest in the alienation of people, believed there were two distinct ways of engaging in the world, through experience or through encounter with others (Simon, 2018). Buber (1923) proposed an 'I-It' relationship based on things to be utilised or put to some purpose at a point in time, with little active engagement with the other, and an 'I-Thou' relationship based on encounters and relationships with the 'whole being' and not sums of their qualities. He stated: 'Thou has no thing for his object; thou has no bounds… but takes his stand in relation.' Recognising and responding to another as Thou, 'is the essence of making that person a person' (Higgs and Gilleard, 2016, p 774). Buber proposes that we can make choices to have encounters with others, but we usually take the road of I-It.

There is also a difference between Western and non-Western philosophical perspectives on personhood. In the latter, importance is placed on persons as social beings, living within social, political and cultural institutions and practices. Being a person may be transitional, such as in those cultures that have rites of passage (De Craemer, 1983). More emphasis is placed on the interdependency of persons with their social communities, rather than on self, and on their past and current connections, as these bring a sense of 'belonging' (De Craemer, 1983). According to non-Western cultures, persons cannot exist in isolation; this goes against terms Westerners' value such as autonomy, bringing different moral obligations such as family determination rather than self-determination.

The physicalist view might be that a person must have an intact set of cognitive or functional abilities (Post, 2013b). There have been extensive lists of physical criteria proposed to describe a person, but these have been generally reduced to two: 'autonomy' and 'rationality' (Kitwood, 1997, p 9).

Different perspectives and their application in healthcare
Burton and colleagues (2017, p 2) argue that treating someone as a person with long-term conditions includes recognising and responding to their individual characteristics and preferences. It also includes respecting them as a fellow human, 'recognition of their unique biography and identity and support their autonomy to shape and live their lives according to their values rather than those of others'. However, what happens when autonomy and recognition of the values of the person are diminished or have not been established? Legal debates on personhood occur and can be highly emotive and controversial, as they usually involve persons who can't legally defend themselves, such as those with severe disabilities or cognitive impairment. Ethical questions arise, such as when do we become a person? (Manninen, 2008), followed by questions such as when do we stop being a person? (Cudney, 2013), or is being human the same as being a person? (Cudney, 2013). Once these questions have been answered then what duties do we owe to a person as opposed to a non-person? (Dameron, 2017). These societal questions apply to healthcare, how care is resourced and how people are treated within the healthcare system.

Dementia care is used here as an example of how different perspectives on personhood can influence the care of the older person. The bioethicist Stephen Post (2013a, p 154) argues that the criteria for physicalism is set by those with 'hypercognitive values, providing the reasonable with too much power'. This gives the 'perfect justification for excluding people with serious disabilities from the personhood club' (Kitwood, 1997, p 9). A strong advocate for people with dementia, Kitwood, a psychogerontologist and former priest, rejected physicalism, aligning instead to a personalist view whereby all humans have intrinsic worth and are of equal value (Baldwin and Chapstick, 2007). The influence of Buber's use of 'thou' can be seen in the work of Kitwood, who defines personhood as '...a standing or status that is bestowed upon one human being by others, in the context of relationships and social being. It implies recognition, respect and trust' (Kitwood, 1997, p 8). The word bestow, however, has drawn criticism as it implies recognition by another and because not everyone can or will engage equally in a relationship (Anker-Hansen et al., 2019). The person with dementia should be seen as an embodied being, as they still experience feelings, perceptions and emotions, have the ability to form relationships, have aspects of self-identify that come to light occasionally, experience enjoyment and can still lead a satisfactory life (Dewing, 2008; Post, 2013b). Therefore, value should be placed on interactions, such as trust and love, which we feel in our 'totality as persons' (Sabat, 2010, p 172). Kitwood considers the effects that healthcare workers can have on those with dementia and their decline, stating 'both the according of personhood, and the failure to do so have consequences that are empirically testable', identifying what he called a 'malignant social psychology', a range of negative behaviours that have a negative effect on persons with dementia (Kitwood, 1997, p 8). These behaviours do not have intentionality, but form part of the deeper issues of how people with dementia are viewed and depersonalised in the world, through a lack of knowledge.

There are aspects of personhood that may be more important at different times in people's lives, such as the spiritual dimension for those nearing the end of life (Chochinov and Cann, 2005). There are also the cultural perspectives to personhood – some cultures take a spiritual viewpoint of dementia, simply seeing those who are forgetful as being on their spiritual journey, a path of detachment and enlightenment – perhaps they have 'already hopped on the last train for glory, but it just hasn't quite left the station yet' (Post, 2013b, p 367). From an utilitarian perspective, decisions may be made based on the quality of life over the sanctity of life, and some might argue that some lives are not worth living (Singer, 1993).

Summary
This section has highlighted several different perspectives and explores how philosophical, religious, cultural, spiritual, academic, legal and societal beliefs inform who is accorded personhood and how it is valued. It suggests that a failure to acknowledge personhood can have a negative impact.

Person-centred care

Person-centredness is seen as the 'operationalisation of personhood' (Anker-Hansen et al., 2019, p 130). When this is applied to patients, it can be considered 'person-centred care', and when it is applies to patients and others, person-centred practice is the term it should be known by (this will be discussed in the next section). Person-centred care is espoused within codes of ethics, standards of practice and organisational values. The way personhood is regarded and respected is critical to the provision of person-centred care (Dewing, 2008; Krishna and Kwek, 2015; Dameron, 2017). People's behaviour reflects the reality of what they believe, and it is that behaviour that demonstrates respect for person (Dameron, 2017). Entering and understanding the world of others and their personhood is where caring unfolds (Schoenhofer, 2002). Unfortunately, in healthcare, awareness of personhood occurs mainly where it has been lacking (Baumann, 2007), such as through care complaints reported to health service administrators or the media (Garling, 2008; Francis, 2013). Many complaints against healthcare staff relate to respect for persons and staff-patient relationships (Reader et al., 2014). This section will look at the historical and current perspectives on person-centred care and the impact these have on its delivery and evaluation.

The history

Early work in the area of person-centredness in healthcare appears to have focused on the patient and family and be related to person-centred care. Given this, the term person-centredness in this section relates to patients and families. Person-centredness as it applies to healthcare professionals will be discussed in section on the person-centred culture.

Person-centred care is not a new concept; it was originally discussed within the fields of psychology and older people's care. In the 1950s, the psychotherapist Carl Rogers developed a humanist theory of client-centred therapy in counselling – later renamed person-centred therapy – which is still popular in today's therapy practice (Joseph and Murphy, 2012). His work focused on relationships between the person receiving therapy and the therapist, where the therapist recognises the other's personhood and their internal qualities and resources. To achieve this the therapist embraces genuineness, transparency, warm acceptance, positive regard, empathetic listening and the ability to see the client's perspective. This can bring positive outcomes for the client by actualising their full potential (Rogers, 1967). This focus allows the therapist to see the client as a person and as someone 'becoming' rather than as a patient defined by their difficulties (Rogers, 1967). There was recognition that therapists needed to embed these same principles into their professional supervisory relationships – therapist to therapist (Tudor and Worrall, 2004).

In the 1990s and early 2000s there were competing agendas, the person-centred care agenda (Kitwood, 1997; McCance, 2003; McCormack, 2003) and the patient-centred care agenda (Institute of Medicine, 2001). Both focus on the patient. Patient-centred care is defined as 'care that is respectful of, and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions' (Institute of Medicine, 2001, p 6). Patient-centred care targets the patient and their family, and is an element of high-quality care with a focus on the patient's welfare. It focuses on the individual's healthcare expectations and wants, which can be discussed within an episode of care and centres on the management of disease (Starfield, 2011). Individual patient wants, needs and expectations of care may not be compatible with current public health resources (Buetow et al., 2016). Buetow and colleagues argue that a patient-centred care model fails to acknowledge the care required by the health professional and the carer, as they are seen as secondary and lesser than the patient. The popularity of patient-centred care over person-centred care at that time may have been multifactorial; it was a term used by medical staff and it applied to all patients, whereas person-centred care raised its profile significantly in the field of older persons' care, with significant contributions to the theory from nurses (McCormack, 2003; Brooker, 2003; Nolan et al., 2004) and psychotherapists (Rogers, 1967; Kitwood, 1997). In 2006, the Person-centred Nursing Framework was published and this was used to implement and measure person-centred nursing in a tertiary care setting (McCormack and McCance, 2006). Person-centred nursing care was permeating and broadening its scope across all patients. This framework will be discussed later in the article.

Contemporary healthcare policy has seen a shift from patient-centred healthcare models to a person-centred care model (National Academies of Sciences, Engineering, and Medicine, 2018). However, problems arise when person-centred care and patient-centred care are used interchangeably, as they are not synonymous (Junqiang et al., 2016; Buetow et al., 2016; McCormack et al., 2018).

The lack of consensus on a definition and the impact of this
To add to the confusion, there is no gold standard definition of person-centred care, or any agreement across disciplines (The Health Foundation, 2014b; Sharma et al., 2015). For example, The American Geriatric Society Panel on Person-Centred Care (2016, p 16) defines person-centred care by stating: 'Individuals' values and preferences are elicited and, once expressed, guide all aspects of their healthcare, supporting their realistic health and life goals. Person-centred care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision making to the extent that the individual desires.' The society developed its own definition in spite of finding many others. It is encouraging to see scholarly work being undertaken by different disciplines, and especially within medicine but this indicates a discipline-specific approach to person-centred theory development, rather than a person-centred approach. A discipline-specific approach to care and research may run contrary to a person-centred philosophy and is a possible barrier to progression (Dukhu et al., 2018). In a person-centred environment, all interdisciplinary members would work together to treat the whole person rather than the disease state of the person (Junqiang et al., 2016), so it could be argued that the theoretical work of person-centredness requires the same interdisciplinary respect. A move from a functional model of care to a more person-centred one implies interdisciplinary collaboration, effective communication and a team philosophy (Rose and Yates, 2013; The Health Foundation, 2014b; Walker and Deacon, 2016; McCormack and McCance, 2017).

Identifying the core elements of person-centred care is an important step forward (Dewing, 2008; Clisset et al., 2013; The American Geriatric Society Panel on Person-centred Care, 2016; Santana et al., 2018) and will support evaluation of person-centred outcomes (Waters and Buchanan, 2017; Dewing and McCormack, 2017). The Health Foundation offers a set of generic person-centred care principles available to all health professionals, no matter what the setting or what care or intervention the person being cared for requires. The principles include: 1) affording people dignity, compassion and respect; 2) offering coordinated care, support and treatment; 3) offering personalised care, support and treatment; and 4) supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life (The Health Foundation, 2014b). However, at the same time we are urged not to oversimplify the concept of person-centredness by relying on a set of attributes, such as compassion, as the ability to use these attributes is often affected by the culture and context in which care is provided (Dewing and McCormack, 2017).

A core element of person-centred care appears to be the development of relationships (Rogers, 1967; Kitwood, 1997; Nolan et al., 2004; Starfield, 2011; Buetow et al., 2016; Dameron, 2017; McCormack and McCance, 2017), or what the latter call 'being in relationship' (McCormack and McCance, 2017, p 17). These relationships in healthcare develop over time as knowledge about the person is accumulated alongside understanding of their healthcare needs in the context of their wider needs (Starfield, 2011). For example, interpersonal relationships are known to sustain personhood by supporting the psychological survival and human dignity of those with dementia (Kitwood, 1997). This in turn can slow the disease process and help prevent further loss of capacity even at moderate stages of the disease (Kitwood, 1997; Sabat, 2002; Baumann, 2007). However, it is important to recognise that relationships may not be equal, and they are broader than individuals as they can span organisations (Anker-Hansen et al., 2019). The Senses Framework was an addition to the person-centred care movement, being a model for caring relationships within residential care of older people that promotes security, belonging, continuity, purpose, achievement and significance between all stakeholders (Nolan et al., 2004).

These definitions focus on the care of patients, whereas Buetow and colleagues (2016, p 2) propose that 'person-centred care makes explicit the personhood of all participatory stakeholders whose

values and virtues dispose them to live the best life they can through interconnected life projects'. The clinician and the patient should be seen as moral equals. Those authors conclude that welfare is interdependent with flourishing for all rather than the health of the patient being the primary focus.

Dewing and McCormack (2017, p2150) draw our attention to the need for 'a conceptual definition to progress research and scholarship'. They argue that without this, person-centredness may be promoted as easier to implement than it actually is. A lack of consensus allows variability in person-centred interventions, study designs and methodologies. It could therefore be beneficial for future studies to be rigorous in their approaches, using clear and explicit language, and offering coherent explanations of context and the elements of person-centred care strategy. Standardised evaluation processes to assess the efficacy of interventions would also be advantageous (Brownie and Nancarrow, 2013; Olsson et al., 2013). Person-centred care implementation to date has however resulted in significant contributions to our understanding of the concept through theory development and implementation research, which has informed several concept analyses (Slater, 2006; Leplege et al., 2007) and conceptual frameworks (McCormack, 2003; McCormack and McCance, 2006, 2017; Santana et al., 2018).

The Health Foundation (2014a) acknowledges the difficulty of evaluation when there is no consensus on the meaning of person-centred care. As it stands, measurement of person-centred care is often undertaken as part of research projects rather than as part of routine evaluation (The Health Foundation, 2014a). The foundation encourages the use of a range of tools and methods as a more robust measure of person-centred care, including surveys, interviews or stories with people using health services, surveys of clinicians and observations of clinical practice. Ultimately, a positive evaluation is what matters most to the patient (The Health Foundation, 2014a) and to the stakeholders at different levels of an organisation (Wilson and McCance, 2015). These evaluations are important as they could help inform key stakeholders that person-centredness is happening and clarify which interventions are effective (Wilson and McCance, 2015). According to van der Cingel et al. (2016, p 10) the 'ultimate goal of good person-centred care is to cherish, preserve and protect someone's uniqueness as a person and their wellbeing'. The Person-centred Practice Framework (McCormack and McCance, 2017) has a suite of complimentary tools to support evaluation in this area . This will be discussed in the next section.

Summary
This section has discussed how different definitions of the term person-centred care can impact on its delivery and evaluation. Siloed approaches and a lack of consensus can also contribute to this effect.

Person-centred cultures and practices
Culture permeates all aspects of an organisation, determining how it operates, how it defines its goals and missions, and how it solves problems. Culture consists of 'an organisation's shared values, symbols, behaviours and assumptions' (Martin, 2006, p 1). Several high-profile health inquiries have found a direct relationship between suboptimal patient outcomes and poor organisational cultures in which efficiencies, finances, hierarchies and disease models were prominent (Garling, 2008; Francis, 2013). Organisational factors that impact on person-centred care can include work stress, time pressures, staff shortages, limited resources, interprofessional power issues, motivation and commitment, and too much change at the same time (McCance et al., 2013; Steenbergen, et al., 2013; Martin et al., 2014; van der Cingel et al., 2016; Walker and Deacon, 2016; Cardiff et al., 2018).

This section explores the concepts of person-centred cultures and person-centred practice, and their importance in progressing the person-centred agenda. A way forward is proposed, including the use of a person-centred practice framework.

Change must focus on developing person-centred cultures rather than care processes (McCormack et al., 2015) as it is the culture that sustains person-centred care (McCormack et al., 2018). Without a commitment to person-centred practices there will be tension between an organisation's policies and caregivers' ideals (Parley, 2001).

A way forward

Establishing a person-centred culture involves the adoption of person-centred practice that is inclusive of all stakeholders. Health professionals need to experience person-centredness (McCormack and McCance, 2017) and have their own personhood acknowledged as equals to that of patients. As Buetow and colleagues (2016, p 1) eloquently put it: 'Rather than take the spotlight off the patient, enlarge the light to include clinicians and others.' When all parties are acknowledged in this way, person-centred practice can get closer to meeting the definition of 'an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual rights to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development' (McCormack and McCance, 2017, p 60). Understood in this way, person-centred practice can be more encompassing and inclusive than person-centred care.

To mobilise change towards becoming a person-centred organisation, leaders could reassess the values and principles within their systems designs, especially the value of person-centredness (National Academies of Sciences, Engineering, and Medicine, 2018). Delivering person-centred practice at an organisation level may entail whole-system change rather than an organisational solution that is hierarchically designed or short-lived (The Health Foundation, 2014b; McCormack and McCance, 2017). Organisations may need to seek a balance between the ideal of delivering person-centred care at an individual patient level (Riste et al., 2018) and treating their staff in person-centred ways (McCormack et al., 2018) while still meeting the demands involved in delivering care to a large number of people (Riste et al., 2018). For this to occur, there is a need for person-centredness to be valued at all levels, including at the organisational level (Riste et al., 2018), at the clinical interface (Manley et al., 2011b) and at the individual level (Clisset et al., 2013). Organisations could facilitate this by defining their philosophical approach through their vision and mission, establishing their operational definition of person-centredness, and setting out how they will evaluate such processes (Santana et al., 2018).

Emancipatory practice development has shown promise as a way of transforming cultures to deliver person-centred care through engagement, skilled facilitation, learning from practice, collaboration between all staff levels and the sharing of person-centred values and inspiring of a shared vision (McCance et al., 2013; Martin et al., 2014; Akhtar et al., 2016; McCormack et al., 2018). When values are shared, they 'steer' behaviours and care practices (van der Cingel et al., 2016, p 12) while a vision provides a purpose for practice (Martin et al., 2014). Engagement includes the development of a shared purpose, responsibility and ownership in relation to person-centredness across an organisation (Manley et al., 2014).

The development of safe and effective cultures can be advanced by a community or collective of transformational leaders spanning the organisation, its systems and its clinical interface (Manley et al., 2011; Akhtar et al., 2016). At the same time, it is important that leadership development delivers measurable outcomes (McCormack et al., 2018). According to Cardiff and colleagues (2018), leadership in person-centredness is still in its 'infancy' (p 3057) and many leadership models applied within healthcare were developed in other settings. Person-centred leadership is a 'relational and contextualised practice' (p 3065), where the leader supports changes in workplace culture through the enabling of others to work towards a shared vision (Cardiff et al., 2018). Situational leadership theory, whereby leaders diagnose performance, competence and commitment of followers and determine the leadership style required, is another potentially beneficial strategy. Lynch et al. (2018, p 437) found that by using it to identify followers' effectiveness in delivering person-centred care in line with the prerequisites of the Person-centred Practice Framework, staff could be facilitated to move from 'doing' for residents to 'being totally present in the moment while doing the task'. The development of leaders to facilitate effective person-centred care led to the identification of seven core attributes of transformational leadership: relating to essence of being; harmonising actions with the vision;

balancing concern for compliance with concern for person-centredness; connecting with the other person in the instant; intentionally enthusing the other person to act; listening to the other person with the heart; and unifying though collaboration, appreciation and trust (Lynch et al., 2018).

Person-centred culture change cannot simply rely on teaching principles to meet the deficit in person-centred knowledge but requires an engagement with adult learning principles (McCormack and McCance, 2017), and the exploration of the work environment as a source of learning, development and improvement (Manley et al., 2011; Akhtar et al., 2016; McCormack et al., 2018). Developing reflective strategies is important for leaders and staff in order to raise awareness and acknowledge positive care practices, at the same time as challenging less effective embedded practices (Dewing, 2010; Post et al., 2014; Akhtar et al., 2016; Cardiff et al., 2018; Lynch et al., 2018; McCormack et al., 2018). These reflections can be undertaken before-action, in-action, on-action and beyond-action (Edwards, 2017). As well as group reflection, self-reflection appears to be a hallmark of person-centred practitioners (Akhtar et al., 2016; Middleton, 2017). Observations of practice can also be used as a point of discussion for clinical staff and leaders, where a mismatch may be found between the mission statements or ideal of person-centred care and the reality of what's happening in practice (Lynch et al., 2018). The social norms that influence behaviours require exploration (Manley et al., 2011). These critical discussions can lead to transformation when staff identify any mismatches for themselves, and are willing to make changes (Lynch et al., 2018). Clinical supervision is another strategy, with the provision of 'regular protected time for facilitated, in-depth reflection on complex issues influencing clinical practice' (Bond and Holland, 2010, p 10). This focuses on the clinical practice of individuals or a group and also has the potential to role model person-centred processes, such as the person-centred model of supervision based on the theoretical work of Rogers (Tudor and Worrall, 2004).

The philosophy of person-centredness needs to go beyond healthcare organisations. If person-centred practice is the way ahead, then the theory and practice start with students, the health professionals of the future. They can benefit from seeing and feeling person-centredness in practice, and this could be achieved through role modeling (Tuohy, 2003; Post et al., 2014; van der Cingel et al., 2016). A person-centred curriculum can support student nurses to understand person-centred concepts before they enter the clinical environment (Steenbergen et al., 2013), and when combined with reflective practice has the potential to help them deliver person-centred care (Tuohy, 2003; Landeen et al., 2016). Students' learning could be directed to focus on patients' knowledge, values and beliefs as legitimate sources of information as well as their signs and symptoms (van der Cingel et al., 2016). However, the engagement of students in person-centred practice is likely to remain difficult if learning is assessed on clinical tasks alone (DiLollo and Favreau, 2010).

Person-centredness is no longer the remit of nurses alone so rewards could be seen from investment in multidisciplinary person-centred work. Person-centredness has permeated other disciplines such as; dentistry (Lee et al., 2018), physiotherapy (Dukhu, et al., 2018), speech pathology (DiLollo and Favreau, 2010), social work (Janlov et al., 2015), medicine (The American Geriatrics Society, 2016) and teamwork (Ekman et al., 2012). Dentists, for example, are recognising the need to shift from a treatment approach, to one that is more inclusive of health promotion and improvement strategies, a need to take notice of patients' individual behaviours, context and lifestyles and integrate dental care with their overall health (Lee et al., 2018). Physiotherapists are recognising that person-centred care is desired by their patients and that they are required to take a more holistic view of the patient, rather than a biomedical approach (Dukhu et al., 2018). The Person-centred Practice Framework (McCormack and McCance, 2017) offers a multidisciplinary approach.

The Person-centred Practice Framework
The ongoing refinement of the Person-centred Practice Framework (McCormack and McCance, 2017) offers a significant contribution to the progress of the person-centred agenda. Described as a mid-range theory, it is 'more concrete and narrower than grand theories; made up of a limited number of concepts and propositions that are written at a relatively concrete and specific level' (Fawcett, 2005, p 34). This assists with reflection on, and operationalisation of person-centred practices across disciplines, with

different stakeholders and at different healthcare levels. It comprises five key interrelating elements: the macro context; prerequisites required by care providers; the care environment; and person-centred processes, all leading to person-centred outcomes, with the important element of strategic support (macro-context) being at the outer ring of the framework (see Figure 1). It provides a common language, a shared meaning and an understanding of the enablers and barriers to delivering a person-centred culture, unlike other models which consider only the relational elements. This framework recognises the importance of these relationships and provides clarity of how they can be operationalised through the person-centred processes, prerequisites and the environment in which care occurs. The influence of Rogers, Kitwood and Kant (discussed earlier) can be seen within the framework. The framework provides guidance on how to relate to and respect the personhood of staff, patients and self.

Figure 1: Person-centred Practice Framework (McCormack and McCance, 2017)
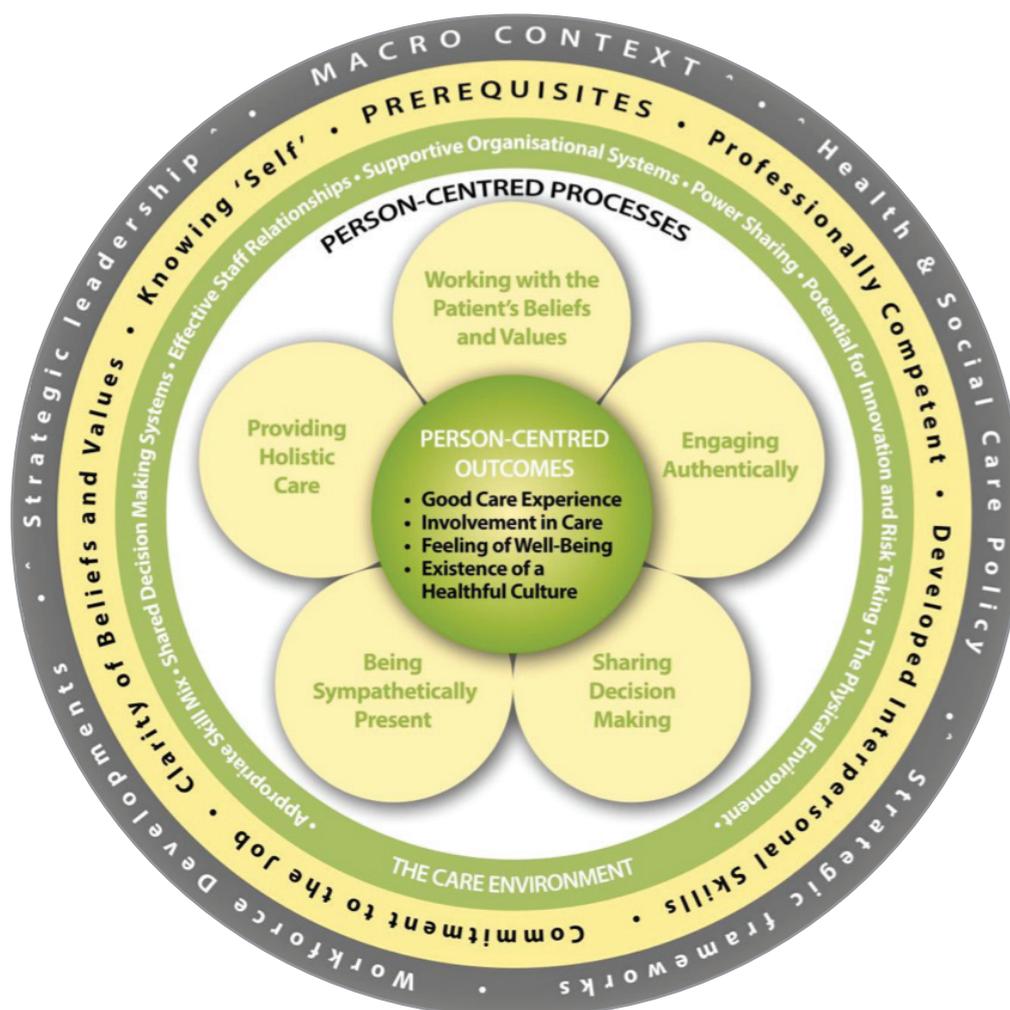
Reproduced with permission of the authors

Brendan McCormack and Tanya McCance have been responsive and receptive to advances in person-centred knowledge and research over a long period of time and the framework has been refined accordingly (2006-2019). It originated as a nursing framework – the Person-centred Nursing Framework (McCormack and McCance, 2006; 2010) – and has been used as the theoretical framework of many research projects (for example, Buckley et al., 2013; van der Cingel et al., 2016; Lannie and Peelo-Kilroe, 2017; Lynch et al., 2018; McCormack et al., 2018). This has provided greater depth and understanding as to how the theoretical framework can be applied to clinical practice. To date, research has focused on the earlier nursing framework, as the Person-centred Practice Framework was only introduced in

2017. An example is the mapping of empirical data from five person-centred research studies to the constructs of the nursing framework to find suitable illustrations of person-centredness and make it more tangible for nurses (van der Cingel et al., 2016). The researchers found the concepts within the nursing framework are manifested through nurses' behaviours and conversations within their daily practices, and by knowing the patient as a unique person and using this knowledge to adjust their care and relationship.

The Person-centred Nursing Framework began with the blending of two conceptual humanistic frameworks: Caring in Nursing Practice (McCance, 2003) and Person-centred Practice with Older People (McCormack, 2003). The former was developed by exploring 24 patients' experiences of caring, through narrative interpretation (McCance, 2003). The findings highlighted that outcome measures alone are not enough to measure and evaluate quality and that attention must also be paid to assessing the structures and processes. McCance used the Donabedian's Quality Care triad to explain caring within a quality context, highlighting the structures required for caring (nurse attributes, organisational issues and patient attributes) and the caring processes or interventions (activities of caring inclusive of caring for the patient's psychological and physical needs, being attentive, getting to know the patient, taking time, being firm, showing respect and the extra touch) and the outcomes of caring for patients (feeling of wellbeing, patient satisfaction and a positive effect on the environment). Caring is seen as both 'action and attitude' (McCance, 2003, p 114). One of the most significant findings was that providing for a patient's physical needs is not enough to constitute caring; interpersonal skills are also required. Through interpreting the patient's views of caring, McCance aligns the findings categorised under caring processes to several of Watson's (1985) curative factors. Watson, one of the early nursing theorists, believed in the profession having a caring-healing role (Watson, 1997). The attributes of the nurse within the structure element of Caring in Nursing Practice align to Roach's theory (1984) of professional caring, which includes compassion, competence, confidence, and commitment. According to McCance and colleagues (1999, p 1390), Roach's work describes caring as a 'human mode of being' and is 'unique in nursing'.

At the same time, McCormack published his conceptual framework Person-centred Practice with Older People (2003), which was developed from a larger study exploring the meaning of autonomy for the older person. The framework challenged the constraints imposed on older people that make them dependent on others. McCormack refers to the work of Kant (discussed earlier in the personhood section) and describes a number of imperfect duties, which are less enforceable than perfect duties. In his study, operationalisation of autonomy in the context of care includes the following imperfect duties: informed flexibility; mutuality; transparency; negotiation; and sympathetic presence. McCormack introduces the concept of 'authentic consciousness', which is facilitated by the nurse through levels of engagement and the establishment of a nurse-patient relationship (McCormack, 2003, p 203). Each person in the relationship has their own personal values, beliefs and life history, which influence their decisions in the context of their care and wellbeing. Older persons' decisions should be respected but may at times need to be negotiated in partnership with the nurse, who is encouraged to make their own values explicit, as this may help the decision-making process. The final elements of creating a person-centred environment is the context in which care occurs, and the organisation values, which may or may not be conducive to working in person-centred ways.

We can see the historical shift between the versions of the framework (McCormack and McCance, 2006, 2017). For example, in 2006 outcomes were patient focused, 'creating a therapeutic culture', while in the 2017 version intended outcomes are more inclusive of staff and the 'existence of healthful cultures', while the language has changed from working with patients' values to working with peoples values to be more inclusive of others (McCormack and McCance, 2006, 2019). In the 2017 version, a fifth layer was added to acknowledge the influence of the broader macro systems on person-centred cultures and practices. The name changed from a nursing framework to a practice framework to be more inclusive of other professions, although the Person-centred Nursing Framework is still available for nursing work.

Evaluation of person-centred practice is important as discussed earlier and the Person-centred Practice Framework explains clearly what outcomes are expected. The Person-centred Practice Inventory (Slater et al., 2017) is an instrument underpinned by the Person-centred Practice Framework, providing an advantage over many other person-centred tools as they do not map to a theoretical framework. The inventory measures how staff perceive person-centred practices and can be used to measure changes to person-centred practice over time. It was developed through a multiphase trial of development and testing of the tool, and resulted in a questionnaire with proven psychometric properties validated by an international expert panel. It provides a generic measure of person-centredness mapped to three of the five constructs of the Person-centred Practice Framework (prerequisites, care environment and care processes). A recent addition to the range of person-centred measurement tools is the revised Workplace Cultural Critical Analysis Tool (Wilson et al., 2020). This also maps to the 2017 framework.

Summary
The development of person-centred cultures can enhance person-centred practices, with strong leadership, reflection, role modeling and the value of person-centredness being lived in the workplace. The Person-centred Practice Framework, a well-tested midrange theory, brings together the concepts of personhood, person-centred care and person-centred practice and culture, and has a range of evaluation tools.

Conclusion
This article has discussed the concepts of personhood, person-centred care and person-centred practice and culture, using both historical and contemporary lenses. It highlights how multiple perspectives on these terms and concepts and subtle changes in wording can impact on how person-centredness is implemented and who it is accorded to. This article argues that, without a consensus on the terms, we lack understanding and the ability to properly evaluate impact. It proposes that person-centred cultures are needed to support person-centred practices, or healthcare will continue to strive to develop such practices, rather than embed person-centredness for all. The development of person-centred culture could be supported by implementing evidence-based strategies, including practice development, leadership and role-modeling, adult learning principles and the use of a guiding framework such as the Person-centred Practice Framework. The framework, a midrange theory, has evolved over time and provides a common language and guide for health professionals, teams and organisations to reflect and action plan. The setting of a vision and provision of resources at the organisational level will help to operationalise person-centredness for staff, patients and relevant others.

Implications for practice
- A consensus on the meaning of 'person-centredness' would be beneficial as a lack of agreement affects who person-centredness is accorded to, what it looks and feels like in practice and how it is impacting on care
- The Person-centred Practice Framework, a well researched and evolving theory, offers support with understanding and operationalising person-centredness in practice, by providing clarity and guidance to individual health professionals, teams and organisations
- Policies, practices and care standards should reflect the shift in thinking from person-centred care to enabling person-centred cultures and practices. This should be reflected in the organisation's definition of person-centredness, and in a clear vision of how person-centredness will be operationalised and evaluated

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