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Editorial: Tell me, how do you define person-centredness?

The International Community of Practice for Person-centred Practice (PCP-ICoP) coordinated from Queen Margaret University, Edinburgh, recently wrote about the current state of person-centredness across several countries in the world (McCormack *et al.* 2015). In that publication, we highlighted a number of concerns, the existence of which are working against the advancement of person-centredness as a coherent theoretically informed and practice-embedded framework for nursing. We believe that a focus on person-centredness provides an opportunity for nursing to rise above particular theoretical 'fan clubs' and work within a coherent set of principles that are multivariate, context nonspecific and trans-specialist.

To begin with, we, as a profession, should have major concerns connected with how person-centredness is defined across the nursing community and it is surprising to us that there is not more concern about this. We repeatedly observe across the arenas of research, education and policy that person-centredness is not defined or incompletely and poorly defined. There are two dominant features that troublingly, currently pervade descriptions of person-centredness. First, we repeatedly see person-centredness being introduced as hard to define. This has been the case since at least 2004 (Dewing 2004; McCormack 2004). Surely, we need to be moving on from this by now? There are now various definitions that can be used, although some caution is needed as not all of these are underpinned by research evidence or theory. Second, person-centredness seems to be more and more defined according to one or two of its more popular or appealing attributes. The favourites we observe recurring in the literature are that person-centredness is working with what matters to the patient; it is about acknowledging the values, choices and preferences of patients, and it is about a certain type of nurse–patient relationship – always a compassionate one! Indeed, person-centredness does include all of these attributes; however, this is not the totality of person-centredness and, to advocate it, promotes an unhelpful simplification of the concept. There is a paradox here, as the oversimplification also misses the point that, for example, facilitating choices and preferences or developing, maintaining and sustaining a compassionate relationship are probably *the* most challenging aspects of nursing in the complexity of practice contexts. It is easy to ask the question 'what matters to you' but it is quite another to meaningfully and authentically respond to another person's response. Further, should not we question the dominance of compassion as the 'only thing that matters in our relationships with persons? Is that what is always wanted? And what about my ability as a nurse to be compassionate even in practice settings that show little compassion to me as a nurse or as a person? These are not simple issues and are not ones that can be fixed with short cycles of change or practice artefacts (badges, symbols, aide-memoires).

A related concern is what almost amounts to squabbling between champions of different approaches to person-centredness and positioning these to achieve centre stage for their favoured definition. Definitions are being proposed that are not backed up by empirical research and are severely lacking on theoretical underpinnings. For example, we can perhaps see this in how Karl Rogers is repeatedly proposed as the founder of person-centredness when the etymology of the concept predates Rogers, or Tom Kitwood's definition of personhood unquestioningly accepted as the underpinning framework in research and development work, without considering the implications of using that definition out of context. Sitting on the periphery, we can see a theoretical knot about concepts related to person-centredness and whether or not they fit under the umbrella of person-centredness. Prominent here are the concepts of women-centred care, child-centred care and family-centred care.

The simplification of person-centredness for nursing practice in particular is in the longer term unhelpful for a number of reasons. It encourages a naïve understanding of person-centredness which immediately limits the potential to have the impact we know it can. Recent doctoral research (Wareing-Jones 2016) indicates that whilst practitioners have an outline appreciation of person-centredness, they tend not to draw on empirically developed theoretical models, have an incomplete personal understanding of what person-centredness is and generally experience working in contexts and cultures that are inherently unsupportive of person-centredness, meaning they cannot embody or practice in person-centred ways.

This leads us to raise the most pressing of concerns: that the majority of definitions of person-centredness completely miss that person-centredness is about a specific type of culture, that incorporates but does not isolate *care* and one that needs to apply to everyone in an organisation. It is not something that can be technically applied, and certainly, person-centredness cannot thrive

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or flourish in any type of workplace context and culture. It is here where the definitions being proposed in a number of influential policy documents are a particular cause for concern – they encourage many local policy-makers and healthcare managers to believe that person-centredness can be implemented and measured in a technical and concrete way and that the time needed to achieve and 'tick off' the introduction of person-centredness is much less than we know is really needed to achieve a transformed culture. Related to this is the language of 'measuring' person-centredness. Whilst it is a laudable and necessary aim to evaluate the development, implementation and sustaining of person-centredness, are we clear about what we are evaluating? A fundamental principle of any systematic evaluation is clarity of definition as without such clarity evaluation strategies can miss the target of the intended evaluation. Given that we observe few clear definitions in use, then how can organisations evaluate person-centredness? The Health Foundation (2014) highlighted this problem in their review of measurement tools for evaluating person-centredness when no tools included directly measured person-centredness and all of them were proxy measures.

The necessity of agreeing and drawing on clear conceptual definitions is a cornerstone of research and scholarship. Promoting and publishing incomplete and poorly considered definitions of person-centredness promotes the view that person-centredness is less complex than it is and that it is easier to implement than it is. This can lead to unnecessary burden or even guilt for many in our profession as to why we are not achieving it better than we do or even a collective false consciousness that we have already achieved it and should be moving on to the next fad or miracle improvement/innovation.

Person-centredness is still in its ascendency; therefore, we need to settle into exploring and expanding the concept with more rigour and drawing on relevant theories. The PCP-ICOP has been engaged in this work for a number of years, and so, finally, we offer for critique our current definition of person-centredness:

> Person-centredness is 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 (personhood), individual right to self determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development. (McCormack & McCance 2017:3)

We are not suggesting that this definition is fixed – and we are continuously dialoguing within our Community of Practice and with others to ensure we take a critical stance and refine it as our research findings and learning suggest/demonstrate. The challenge for all of us is to be clear about how we are defining our concepts, to show this clarity in our empirical research and to develop and test theory that can act as a robust framework for nursing irrespective of context, culture or practice specialty, because in the longer term, it really does matter. We will be judged on the quality of our scholarship by future generations.

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