The Arab Journal of Psychiatry (2021) Vol. 32 No.1 Page (43 -52) (*doi-10.12816/0058765)*

The British Experience of Person-Centered Medicine: from Conception to Innovations in Health Care and Psychiatric Education

Mohammed T Abou-Saleh

التجربة البريطانية في الطب المرتكز على الشخص: من المفهوم إلى الابتكارات في الرعاية الصحية والتعليم الطبي النفسي الاختصاصي

محمد طموح أبو صالح

Abstract

The National Health Service (NHS) was established in 1948 as a publicly funded healthcare system in the UK providing universal health coverage that is comprehensive, equitable and free at the point of delivery. The British experience of person-centered medicine (PCM) is enshrined in its constitution. Examples of PCM initiatives include the establishment of the National Institute for Health and Care Excellence (NICE); the introduction of values-based medical practice and innovations in person-centered coordinated care (P3C). There have been person-centered innovations in undergraduate and postgraduate medical education. The landmark development was the production by the Royal College of Psychiatrists in the UK of the first blueprint for a postgraduate psychiatric curriculum that is in tune with person-centered psychiatry. Whilst the British experience of PCM is in some respects unique, it could contribute to universal development of person-centered healthcare and health education.

Key words: British, medical education, medicine, NHS, person-centered, psychiatry

Declaration of interest: None

Introduction

Advances in medicine in the latter part of the 20th Century have been formidable and on par with advances in all sciences that have eclipsed advances in centuries of human endeavor: diagnosis of diseases have been well established, their etiology and pathogenesis elucidated, and pharmaceuticals have been introduced to treat these conditions.

Advances in medicine were made by converging on specific diseases and thus paving the way for the establishment of medical specialties that are focused on specific systems including psychiatric medicine. Inevitably this led to fragmentations of care for individual patients who may have more than one medical condition and importantly the whole person of the patient has been overlooked and almost became out of bounds. Individuals with a specific medical condition were reduced in common parlance to being labelled and defined by their disease: a patient may be labelled as asthmatic, diabetic, epileptic, schizophrenic or addict, labels that are reductionist and almost pejorative.

It is against this background and developments that person-centered medicine (PCM) was introduced: its aims are achieved by the promotion of medicine of the person (of the totality of the person's health, including their ill and positive aspects), for the person (assisting the fulfilment of each person's life project), by the person (with clinicians extending themselves as full human beings, scientifically grounded, and with high ethical standards), and with the person (in respectful, enabling and empowering partnership with the person presenting for care). The person is conceived of in a contextualized manner, in line with the words of Ortega y Gasset, "I am I and my circumstance and, if I do not save it, I do not save myself".[1]

Among the medical specialties, general practice by necessity has enacted what is conceived as whole person medicine laying the foundations for PCM. Importantly psychiatry led the way in adopting the biopsychosocial model for the comprehensive formulation of diagnosis and treatment of persons with psychiatric disorders and established the foundations of person-centered psychiatry. This notion was manifest in Carl Rogers' "client-centered psychotherapy". In the words of Carl Jung "Medicine has until recently gone on the supposition that illness should be treated and cured by itself; yet voices are now heard which declare this view to be wrong and demand the treatment of the sick person and not of the sickness. The

same demand is forced upon us in the treatment of psychic suffering."

The article provides an overview of the British experience and evolution of person-centered medicine (PCM) with focus on developments in person-centered care and innovations in undergraduate medical education and importantly the recent report from the Royal College of Psychiatrists in the UK on person-centered care and its implications for training in psychiatry.

The NHS Constitution

Person-centered healthcare is enshrined in the National Health Service (NHS) Constitution, uniting patients and staff in a shared vision, mission, and values of working together for patients; respect and dignity; commitment to quality of care; compassion; improving lives and everyone counts. The NHS over seven decades has faced many challenges and undergone much reorganization. However, it has maintained its person and people's centeredness. Moreover, the quality of care in all health and social care providers in England is assured by the Care Quality Commission for their safety, effectiveness, compassionate care, responsivity, and good leadership.

The NHS belongs to the people and it is there to improve their health and wellbeing, supporting people to keep mentally and physically well, to get better when they are ill and, when they cannot fully recover, to stay as well as they can to the end of their lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches peoples' lives at times of basic human need when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

Seven key principles guide the NHS in all it does. They are underpinned by core NHS values (Working together for patients, Respect and dignity, Commitment to quality of care, Compassion, Improving lives and Everyone counts) which have been derived from extensive discussions with staff, patients and the public: The NHS provides a comprehensive service, available to all and free at the point of delivery: access to NHS services is based on clinical need, not an individual's ability to pay; aspires to the highest standards of excellence and professionalism; the patient will be at the heart of everything the NHS does. The NHS works across organizational boundaries; is committed to providing best value for taxpayers' money and is accountable to the public, communities, and the patients that it serves.

In the words of Stephen Hawking "I have had a lot of experience of the NHS and the care I received has enabled me to live my life as I want and to contribute to major advances in our understanding of the universe, I would not be here today if it were not for the NHS".

Historical origin

The earliest reference to PCM in the British medical press was in 1974 by Tait on "person-centered perspectives in medicine", the title of the Gale Memorial Lecture in 1972.[2] The article was a visionary view on the paramount need to balance the predominance of the disease-centered knowledge base and practice of medicine by the perspective of PCM. On the imbalance in perspectives, Tait stated "the very success of scientific medicine is forcing doctors back into an area of work where the answers provided by the biological sciences are not by themselves enough. In that sense we are back where medicine found itself before the huge therapeutic triumphs of this century. Back to a position where we must attend much more specifically to the individuality of the ill person. This way of looking at medical care, by paying particular attention to the person in relation not only to his disease but also to his total environment can be called the person-centered view. It can be contrasted with the disease-centered view where the central concern is the disease process itself". Moreover, Tait highlighted the serious defect in medical education and the need to reform the training of doctors in person-centered aspects of medical care "in the words of the Royal Commission on Medical Education (1968) to produce doctors who are highly competent scientists, but who are not interested in or suited to handle the day-to-day needs of patients".

Tait provided insights and criticisms of the methods of medical training that disconnect basic sciences particularly behavioral sciences from the realities of medical practice. On what to teach in PCM, Tait stated "In simple language I think we could express it in terms of a progressive source of questions that the doctor has to ask and answer for himself. What kind of person (strengths and weaknesses)?, what kind of situation (supports and stresses)? making, what kind of adaptive responses (appropriate or inappropriate)? calling for What kind of help (from self or others)?".

The practical setting for teaching and learning PCM was general practice with "contributions from the behavioral sciences, which is appropriate in type and enough in

quantity. In considering what this contribution should be it is easier to think in terms of areas of concern rather than the contribution of separate disciplines".

NICE

The National Institute for Health and Care Excellence (NICE) is an executive public body of the Department of Health in England which publishes guidelines in four areas: the use of health technologies (new and existing medicines, treatments and procedures) within the NHS (England); clinical practice (guidance on the appropriate treatment and care of people with specific diseases and conditions); guidance for public sector workers on health promotion and ill-health avoidance and guidance for social care services and users.

These appraisals are based primarily on evidence-based evaluations of efficacy, safety, and cost-effectiveness in various circumstances.

The main principle for all guidance is person-centered care. For example, the guideline on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings[3] offers best practice advice on the assessment and management of people with psychosis and coexisting substance misuse.

Treatment and care should consider people's needs and preferences. People with psychosis and coexisting substance use should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If people do not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act.

Good communication between healthcare professionals and service users is essential. It should be supported by evidence-based written information tailored to the person's needs. Treatment and care, and the information people are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory, or learning disabilities, and to people who do not speak or read English.

If the person agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need.[4]

Values and ethics: perspectives on psychiatry for the person

Fulford et al. proposed that a key challenge for person-centered psychiatry is to combine the generalized findings of objectives to the diverse values of each individual patient.[5] They referred to the two main ethical resources for responding to this challenge, substantive/absolute and analytic/critical ethics.[6]

Analytic ethics is particularly relevant as "it is concerned with correct standards of reasoning as a basis for answering problems rather than with the answers to problems as such "This notion has ushered 'philosophical value theory' which is the basis for values-based practice: these issues facilitate the reconciliation of science (facts), evidence-based medicine with values that are unique to each individual."

Compulsory treatment in psychiatry offers a particular example of the ethical paradox that is resolved by substantive and analytic ethics: compelling patients to treatment contravenes a core ethical tenet of respecting autonomy and violates their human rights. In Britain, the Mental Health Act is complimented by the Code of Practice that provides guiding principles with training material that incorporate ethical moral reasoning. It is concluded that "the new philosophy of psychiatry as a whole represents a rich conceptual resource for a psychiatry that, is both firmly science-based but also genuinely person-centered".[7]

Fulford et al. outlined the UK experience of bringing together values-based and evidence-based medicine exemplified in initiatives in the 'personalization' of care.[8]

Values-based practice adds to the growing 'toolkit' for working with values, a new and primarily skills-based approach to balanced decision making where complex and conflicting values are involved.

Values-based practice has been adopted as integral to essential skills in mental health in the UK and in major policy initiatives besides the aforementioned one on the Mental Health Act Code of Practice. A second example of the policy applications of values-based practice has been assessment in mental health, as set out in a guidance document, called the '3 Keys to a Shared Approach in Mental Health Assessment':[9] The Department of Health of the UK government has included within a range of recent policy and service development initiatives under the broad banner of 'personalization', a program specifically concerned with diagnosis.

The 3 Keys are three aspects of assessment that a majority stakeholder in a wide-ranging consultation, including patients and carers as well as professionals, agreed are important: Key 1 is active participation of the service user concerned in a shared understanding with service providers and where appropriate with their carers; Key 2 is that there should be input from different provider

perspectives within a multidisciplinary approach, and Key 3 emphasizes the importance of building on the strengths, resiliencies and aspirations of the individual service user as well as identifying his or her needs and challenges.

Person-centered coordinated care (P3C)

Lloyds et al,[10] highlighted three potent and interacting problems that have contributed to the fragmentation of health and social care in the UK over the last 25 years: the first is increasing specialization of medicine and professional roles, the second is governments' initiation of repeated, rapid cycles of service reorganization, privatization and contracting and third concerns the nature of the available evidence and the accessibility of it to inform service delivery improvements.

These concerns led to the development of the innovative approach of person-centered coordinated care (P3C): an approach to support the development of a comprehensive system-wide solution to fragmented care.[10]

The P3C Group developed the Organizational Change Tool (P3C-OCT) to create and facilitate change for P3C based on its six core domains: (I) my goals, (ii) care planning, (iii) transitions, (iv) decision making (v), information and communication and (vi) organizational support activities.[11]

Further, they developed Patient-Reported Measures (PRM) providing a detailed compendium of P3C-PRMs using a pragmatic systematic approach supported by stakeholder engagement. The PRMs include all the known mental health patient reported measures. The user-friendly suite of tools is designed to act as a portal to the world of PRMs for P3C, and have utility for health care commissioners, managers, and researchers.[12]

The P3C Group then codesigned a measure of P3C to capture the experience of the patient and developed the P3CEQ, a brief, generic measure that covers core domains of P3C from the perspective of the patient. This measure is based on the Long-Term Condition-6 questionnaire including mental conditions, preferred for its brevity, utility, and tone.[13] The P3CEQ was validated and found to be a reliable measure of P3C: it is considered to have strong face, construct, and ecological validity, with demonstrable sensitivity to change in a primary healthcare intervention.[14]

Evaluation of P3C showed that medical practitioners use both Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) in various ways to improve different aspects of patient care. By sharing experiences, professionals can benefit from each other's learning and work together to extend the potential value that PRMs can offer to P3C delivery.[15]

Multimorbidity and 3D medicine

The concept of multimorbidity has attracted increasing interest in the past decade with the recognition of multiple burdens of disease and their escalating costs for the individual and the community. It is evident in clinical practice that multimorbidity has become the norm rather than the exception, occurring in an increasingly younger population particularly in areas of socioeconomic deprivation and in low-income countries.[16]

People with mental illness have a markedly reduced life expectancy due to NCDs predominantly cardiovascular and metabolic diseases. The combination of a chronic medical condition and a mental health problem presents specific complex challenges for the single disease model of care which continues to prevail as the current delivery system in which health care professionals are trained and operate.

The growing research and experience have indicated the need for adopting an integrated collaborative person-centered approach and models of care that are more individualized and focused on patient engagement to manage their multimorbidity and to enable them with preventative interventions including self-management.

Given the limited resources in current health care systems, this approach requires innovation and redesign of the system to provide comprehensive person-centered care encompassing early detection, coordinated multidisciplinary working across specialties as well as between primary and secondary care with easy access to basic healthy lifestyle care programs.[17]

Research in the UK has addressed the issue of multimorbidity and the challenge of developing patient-centered medical interventions. Salisbury et al.[18] in a landmark research project recognized that "Whilst there is international consensus that care for multimorbidity should be patient-centered, focus on quality of life, and promote self-management towards agreed goals, there is little evidence about the effectiveness of this approach". They conducted a systematic review that found few randomized trials of interventions, with many remaining uncertainties about their effect on a range of outcomes.[19] These findings prompted the introduction of a new patient-centered model of care that was investigated in a pragmatic cluster-randomized trial of the 3D approach

(based on Dimensions of health, Depression, and Drugs) for patients with multimorbidity aimed at improving their health-related quality of life.[18] The 3D intervention is based on a patient-centered care model and seeks to improve continuity, coordination, and efficiency of care by replacing disease-focused reviews of each health condition with one 6-monthly comprehensive multidisciplinary review. The results were disappointing: that although the intervention was effective at improving experience of patient-centered care, it was not associated with benefits in quality of life or the burden of illness or treatment. The authors concluded "It is possible that the 3D intervention improves patients' perceptions of the quality of their care but not the quality of their lives. Improving patient experience is one of the triples aims of health care, so providing care that is demonstrably more patient-centered is arguably sufficient justification for implementation in itself, especially since our evidence shows it is not associated with disadvantages in terms of disease management or hospital use".

Person-centered undergraduate medical education

The Medical Act 1858 established the General Council of Medical Education and Registration of the United Kingdom. The General Medical Council (GMC) is the public body that maintains the official register of medical practitioners in the UK. Its chief responsibility is to "protect, promote and maintain the health and safety of the public" and sets the standards for medical schools in the UK. It runs 'quality assurance' programs for UK medical schools and postgraduate deaneries to ensure that the necessary standards and outcomes are achieved.

In 2010, the GMC took responsibility for regulating and quality assurance of postgraduate medical education and training to oversee 'the continuum of medical education', from the moment someone chooses a career in medicine until the point that they retire.

The contribution of psychiatry to teaching undergraduate medicine in the UK has been studied since the 1960s.The first survey conducted by Carstairs et al.[20] showed great diversity in the amount, content, and methods of teaching psychiatry "no two schools are quite alike in the type of staff facilities, in the allocation of teaching time in the several years of the course, or in the persons available to act as teachers".

The second survey was conducted by the author on behalf of the Association of University Teachers of Psychiatry.[21] The survey involved 27 schools in the UK and Ireland. The findings showed variations in the number of teaching staff, the amount of clinical and non-clinical teaching of general psychiatry, and of sub-specialties and assessment procedures and regulations. All schools provided teaching of interview skills. Some schools provided teaching in community settings. Elective studies in psychiatry occurred in most schools. All schools had external examiners in psychiatry.

The teaching of interview skills and clinical communication was considered a core element and was championed by psychiatrists.[22]

In the late 1980s, the author in collaboration with teachers of general practice at the University of Liverpool introduced a core module on communication skills training early in the medical curriculum. The module was later introduced and evaluated at UAE University.[23] The aim of the study was to investigate the effectiveness of a five-day communication skills training course held during the second year of a six-year medical program. The results showed that the teaching was highly effective and the ability to establish rapport was the best predictor of skill in other components.

The author conducted two further studies on teaching psychiatric interview and therapeutic skills to medical students at the University of Liverpool. A teaching package of interview skills was introduced to large blocks of medical students whilst on their psychiatric attachment. The aims of this package were to reduce students' concerns about interviewing psychiatric patients, to reinforce students' knowledge of basic interviewing skills and to introduce students to the particular skills required in taking a psychiatric history and mental state examination. The package emphasizes the following teaching methods: 'hands-on' experience of interviewing a patient in front of small groups of peers; peer feedback using checklists which focus on three major aspects of interviewing; elicitation of facts, elicitation of feelings and control of the interview; facilitation of small group discussions in the presence of a senior psychiatrist. The active involvement of all students in interviewing psychiatric patients engages them in the learning process. Peer involvement increases motivation and was deemed by students as a supportive and constructive exercise. The presence of a senior psychiatrist ensured that discussion is focused on the process of interviewing rather than on patient pathology. Ideally this package would precede focused training throughout the subsequent psychiatric placement.[24]

We have developed a package for teaching psychotherapeutic skills for medical students at the University of Liverpool.[25] The aims of the package were to develop basic psychotherapeutic skills in the general student that would not only make the process of psychotherapy interesting and intelligible, but also sow

the seed that these skills, if generalized, could enhance all fields of medical practice. The skills would therefore be developed to be used in a continuum from the undergraduate to postgraduate trainee. Its methods were based on the Conversational Model of Psychotherapy[26] and the Grammar of Psychotherapy.[27]

A landmark development in UK undergraduate medical education has been the introduction of clinical communication as a core element of the undergraduate medical curriculum in the 1990s. In 2008, a consensus statement, reached by an iterative consultative process involving representation from all 33 UK medical schools, crystallized the core curriculum for clinical communication for undergraduate medical education.[28] A central component of this consensus statement is the communication curriculum wheel, a diagrammatic representation of the content of clinical communication curricula in undergraduate medical education. In this wheel, the key domains of clinical communication are shown as concentric rings, starting in the centre with 'respect for others' and moving outwards through the specific domains of communication learning which are set within a milieu of four over-riding principles which govern not only communication, but all areas of medicine.

In 2018, the consensus statement was updated, a revision that was driven by the relational, contextual, and technological changes which have affected clinical communication.[29]

The updated curriculum defines the underpinning values, core components and skills required within the context of contemporary medical care. It incorporates the evolving relational issues associated with the more prominent role of the patient in the consultation, reflected through legal precedent and changing societal expectations. The impact on clinical communication of the increased focus on patient safety, the professional duty of candour and digital medicine are discussed. The practice implications of the updated curriculum are that it provides a model of best practice to help medical schools develop their teaching and argue for resources. The authors concluded that "this is the consensus reached by UK medical schools about how to prepare our students to meet the demands of delivering effective, compassionate and contemporary patient-centered care". Further they aptly noted that "in the past ten years, there have been subtle but important changes in the use of language. Language plays a key role in the framing of the doctor-patient relationship and signaling to students that the patient is an equal partner and stakeholder in the consultation. Language of course continues to evolve; perhaps by the time the curriculum is updated again, 'patient' will be replaced by 'person'.

In a seminal publication titled "towards a person-centered medical education: challenges and imperatives", Miles et al. posited that whilst there have been unprecedented advances in medical sciences, that "modern medicine has entered into crisis - a crisis of knowledge (uncertainty over what counts as "evidence" for decision-making and what does not), of care (a deficit in sympathy, empathy, compassion, dignity, autonomy), of patient safety (neglect, iatrogenic injury, malpractice, excess deaths), of economic costs (which threaten to bankrupt health systems worldwide) and of clinical and institutional governance (a failure of basic and advanced management, inspirational and transformational leadership)". The authors advocated for the compelling need for the reform of medical educational programs towards person-centered approaches that will enable future health professionals to deliver person-centered care.[30]

A recent study of the inclusion of person-centered care (PCC) in medical and nursing undergraduate curricula in the UK, identified PCC components and themes in medical (GMC) and nursing (NMC) professional standards and university curricula.[31] The authors reported that "the GMC appears to promote a more paternalistic model of care with discrete PCC components in specific sections and the NMC a more collaborative model with PCC distributed throughout". Moreover, medical educators perceived greater barriers to inclusion of PCC than nursing educators including cultural and organizational attributes. There was a lack of clarity in PCC definition, how to teach/assess PCC, and competence expectations. The authors advocated the "development of a PCC skills competence framework would increase consistency and support teaching and assessment in undergraduate curricula. Further research to understand the perspectives of healthcare professionals involved in placements would help inform PCC teaching recommendations".

Person-centered care: implications for training in psychiatry

In a landmark development, the Royal College of Psychiatrists in the UK, produced a blueprint for a postgraduate psychiatric curriculum that is in tune with person-centered psychiatry.[32] The project was developed by the College's Person-Centered Training and Curriculum (PCTC) Scoping Group.[33]

The Report reviews 15 definitions and components of person-centered care including 12 definitions of patient-centered and three definitions of person-centered care. The three definitions of person-centered care were:

- Person centeredness has four main meanings: addressing the person's specific and holistic properties; addressing the person's difficulties in everyday life; regarding the person as an expert who should participate actively in their rehabilitation; respecting the person behind the impairment or disease.[34]
- Person-centered medicine is dedicated to the promotion of health as a state of physical, mental, sociocultural, and spiritual well-being, as well as to the reduction of disease, and founded on mutual respect for the dignity and responsibility of each individual person.[35]
- Person-centered care: (1) Affording people dignity compassion and respect; (2) Offering coordinated care, support, or treatment; (3) Offering personalized care, support or treatment; (4) Supporting people to recognize and develop their own strengths and abilities to enable them to live an independent and fulfilling life.[36]

The executive summary of the Report states the case of need for strengthening the focus on the person in clinical practice and giving person-centered approaches a central position in the practice and training of psychiatrists.

The aims of the project are to outline the rationale for embedding person-centered practice in postgraduate training and assessment and provide recommendations to enable the delivery of person-centered care through postgraduate psychiatric training and assessment.

In setting out a case for reinforcing and prioritizing person-centered care, the report offers guidance on bridging the gap between values and experience, principles and practice, and intention and achievement.

The PCTC Scoping Group reported their key findings: (1) There is an extensive literature that supports the benefits of person-centered approaches for clinicians, patients and service delivery; (2) The adoption of a person-centered approach is supported by other medical Royal Colleges and health professional bodies, UK government's health and social policies, and international bodies such as the World Health Organization and the World Psychiatric Association; (3) The core curriculum survey showed overall satisfaction with the curriculum but identified gaps in learning objectives related to therapeutic relationship building. A survey of MRCPsych courses showed patchy availability of person-centered training across the country, despite an overwhelming wish for its inclusion in psychiatric training on the part of both trainers and trainees and (4) The current RCPsych core curriculum signals the importance of respect towards people who use services but it makes no reference to 'co-production', 'values', 'personalization', 'personal budgets', 'ethics', 'human rights', the community context of people's lives, 'self-care' or 'self-directed care'.

The 17 Recommendations are extensive and comprehensive covering the prime areas of (1) Revising the curriculum; (2) Postgraduate psychiatric training; (3) Assessment of competencies related to person-centered care; (4) Quality assurance and (5) Values: reinforce the importance of the set of core values for psychiatrists.

The Report provides the first blueprint for a person-centered postgraduate curriculum for general professional training in psychiatry in the UK. Importantly it recognizes the paramount principle of 'personhood' and the overarching ethical core and values in medicine. It also recognizes the distinction of person-centered form patient-centered care: person-centered care goes beyond patient-centered care in placing the person with ill health rather that the patient - who is often labelled by their disease - at the center of a holistic, humane, compassionate, enabling them to utilize their strengths and personal resources, respecting their values and culture on the journey to recovery.

The PCTC Scoping Group recommended that training and the curriculum should be explicitly person-centered. Among its other recommendations was that skills relating to person-centered practice should be assessed, and the planning, development, and delivery of local MRCPsych courses should be coproduced alongside people with lived experience of mental health conditions.[33]

Further, this initiative has been matched by several positive initiatives aimed at supporting implementation.[33] There have been changes in regulation and medical law, reflecting GMC guidance. The UK Supreme Court's Montgomery ruling has made shared decision-making based on evidence and values the foundation of consent to treatment,[37] and NICE has set up a joint training program with the Academy of Medical Royal Colleges and the Collaborating Centre for Values-Based Practice in Oxford on values in shared decision-making[38] and the University of West London has established a new Master's program in Person-Centered Care under the joint leadership of Professors Andrew Miles and Michael Loughlin.[39]

It is timely for the College "to weave clear links between its person-centered values and the articulation of those values explicitly in the curriculum, their delivery in training through MRCPsych courses and, finally, their assessment through WPBAs and CASC".

Finally, the PCTC Scoping Group concluded that public demand, national policies, and legal and regulatory developments in areas such as shared decision-making are driving good medical practice towards more person-

centered practice. The challenges of the implementation of these recommendations can be addressed by a concerted effort from trainees, trainers, scheme organizers and indeed the patients and carers we work with: "Co-production in training can sow the seeds for collaboration and co-production in clinical practice, and we urge readers to acquaint themselves with the growing body of resources for co-production of training between clinicians and the people who use our services, as signposted in our report".[33]

The Report would have been enriched by accomplishments the global initiative of the International College of Person-centered Medicine ICPCM).

The ICPCM has introduced the major conceptual and operational advance of person-integrated diagnosis, published the international textbook on person-centered psychiatry and held its first international congress of the ICPM on the theme of Whole Person Health Education and Training.[40,41]

Conclusions

The British experience of person-centered medicine (PCM) has evolved perhaps deterministically over seven decades in the context of the establishment of the NHS and its universal health coverage that is free at the point of delivery. Person-centered healthcare is enshrined in its constitution, uniting patients and staff in a shared vision, mission and values of working together for patients; respect and dignity; commitment to quality of care; compassion; improving lives and everyone counts.

The British experience of PCM was first captured by Tait's Memorial Lecture in 1972 on "person-centered perspectives in medicine". The article was a visionary view on the paramount need to balance the predominance of the disease-centered knowledge base and practice of medicine by the perspective of PCM.

There emerged many initiatives on PCM in the establishment of the National Institute for Health and Care Excellence (NICE) as an executive public body of the Department of Health in England which publishes national guidelines on evidence-based medicine adopting the principles of PCM.

The British experience was enriched by the introduction of values-based medical practice.

There followed innovations in person-centered care: person-centered coordinated care (P3C) model of care and a new patient-centered model of care that was investigated in a pragmatic cluster-randomized trial of the 3D approach (based on Dimensions of health, Depression, and Drugs) for patients with multimorbidity aimed at improving their health-related quality of life.

There have been innovations in undergraduate and postgraduate medical education. The landmark development was the production by the Royal College of Psychiatrists in the UK of the first blueprint for a postgraduate psychiatric curriculum that is in tune with in person-centered psychiatry.

Whilst the British experience of PCM is in some respects unique, it could contribute to universal development of person-centered healthcare and health education.

References

1. Mezzich JE, Snaedal J, van Weel C, Botbol M, Salloum I. Introduction to person-centred medicine: from concepts to practice. J Eval Clin Pract. 2011;17(2):330-2.
2. Tait I. Person-centred perspectives in medicine.J R Coll Gen Pract., 1974;24(140):151-160.
3. Abou Saleh, M., Crome, I. National Institute for Health and Clinical Excellence (NICE) guideline: psychosis with coexisting substance misuse. Addiction. 2012;107(1):1-3.
4. National Institute for Health and Clinical Excellence (NICE) Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (CG120) .2011 https://www.nice.org.uk/guidance/cg120
5. Fulford KWM, Christodoulou GN, Stein DJ. Values and Ethics: Perspectives on Psychiatry for the Person. Int J Pers Cent Med. 2011;1(1):131-133.
6. Warnock GJ. Contemporary moral philosophy. London and Basingstoke. 1967 The Macmillan Press Ltd.
7. Stein DJ. Philosophy of Psychopharmacology: Smart Pills, Happy Pills, and Pep Pills. 2008; Cambridge: Cambridge University Press.
8. Fulford KW. Bringing together values-based and evidence-based medicine: UK Department of Health

Initiatives in the 'Personalization' of Care. J Eval Clin Pract. 2011;17(2):341-3.
9. Three Keys to a Shared Approach to Mental Health Assessment 2008 National Institute for Mental Health in England. https://www.adass.org.uk/adassmedia/stories/Mental_Health/Bull_Docs08/3keys.pdf
10. Lloyd HM, Pearson M, Sheaff R, Asthana S, Wheat H, Sugavanam D, Horrell J, Byng R. Collaborative action for person-centred coordinated care (P3C): an approach to support the development of a comprehensive system-wide solution to fragmented care. Health Res Policy Syst. 2017;22;15(1):98.
11. Horrell J, Lloyd H, Sugavanam T, Close J, Byng R. Creating and facilitating change for Person-Centred Coordinated Care (P3C): The development of the Organisational Change Tool (P3C-OCT). Health Expect. 2018;21(2):448-456.
12. Lloyd H, Wheat H, Horrell J, Sugavanam T, Fosh B, Close J. Patient-Reported Measures for Person-Centered Coordinated Care: A Comparative Domain Map and Web-Based Compendium for Supporting Policy Development and Implementation. J Med Internet Res. 2018;14;20(2): e54.
13. Sugavanam T, Fosh BJ, Byng R, Horrell J, Lloyd H. Codesigning a Measure of Person-Centred Coordinated Care to Capture the Experience of the Patient: The Development of the P3CEQ. J Patient Exp. 2018;5(3):201-11.
14. Lloyd H, Fosh B, Whalley B, Byng R, Close J. Validation of the person-centred coordinated care experience questionnaire (P3CEQ). Int J Qual Health Care. 2019;31(7):506-512.,
15. Wheat H, Horrell J, Valderas JM, Close J, Fosh B, Lloyd H. Can practitioners use patient reported measures to enhance person centred coordinated care in practice? A qualitative study. Health Qual Life Outcomes. 2018;4;16(1):223.
16. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet. 2012;380(9836):37-43.
17. Millar HL, Abou-Saleh MT. Multimorbidity in Mentally Ill People: The Need for a Person-centered Integrated Approach IJPCM. 2015;5(1):28-33.
18. Salisbury C, Man MS, Bower P, Guthrie B, Chaplin K, Gaunt DM, Brookes S, Fitzpatrick B, Gardner C, Hollinghurst S, Lee V, McLeod J, Mann C, Moffat KR, Mercer SW Management of multimorbidity using a patient-centred care model: a pragmatic cluster-randomized trial of the 3D approach. Lancet. 2018;392(10141):41-50.
19. Smith SM, Wallace E, O'Dowd T, Fortin M. Interventions for improving outcomes in patients with multimorbidity in primary care and community settings. Cochrane Database Syst Rev. 2016;3 CD006560.
20. Carstairs GM, Walton HJ, Smythies JR, Crisp AH .Psychiatric Education: Survey of Undergraduate Psychiatric Teaching in the United Kingdom (1966–1967) Br J Psychiatry. 1968;114(516):1411-6.
21. Abou-Saleh MT. Survey of undergraduate teaching of psychiatry in the UK and Ireland. Medical Teacher 1994;16;179-187.
22. Blackwell B, Goldberg DP. Psychiatric interviews in general practice. Br Med J. 1968;4(5623):99-101.
23. Harrison A, Glasgow N, Townsend T. Communication skills training early in the medical curriculum: The UAE experience, Medical Teacher, 1996;18:1,35-41.
24. Lovett LM, Cox A, Abou-Saleh MT. Teaching psychiatric interview skills to medical students. Med Educ. 1990;24(3):243-50.
25. Green B, Goepfert M, Abou-Saleh MT. Developing therapeutic interview skills in medical students. Psychiatric Bulletin.1991;15:157-158
26. Maguire GP, Goldberg DP, Hobson RF, Margison F, Moss S, O'Dowd T. Evaluating the teaching of a method of psychotherapy. Br J Psychiatry. 1984; 144:575-80.
27. Cobb JP, Lieberman S. The Grammar of Psychotherapy: A descriptive account. Br J Psychiatry. 1987;151:589–594.
28. von Fragstein M, Silverman J, Cushing A, Quilligan S, Salisbury H, Wiskin C. UK Council for Clinical Communication Skills Teaching in Undergraduate Medical Education. UK consensus statement on the content of communication curricula in undergraduate medical education. Med Educ. 2008;42(11):1100-7.
29. Noble LM, Scott-Smith W, O'Neill B, Salisbury H. UK Council of Clinical Communication in Undergraduate Medical Education. Consensus statement on an updated core communication curriculum for UK undergraduate medical education. Patient Educ Couns. 2018;101(9):1712-1719.
30. Miles A, Asbridgeb JE, Caballero F. Towards a person-centered medical education: challenges and imperatives. Education Medica. 2015;16(1):25-33.
31. Moore HL, Farnworth A, Watson R, Giles K, Tomson D, Thomson RG. Inclusion of person-centred care in medical and nursing undergraduate curricula in the UK: Interviews and documentary analysis. Patient Educ Couns. 2020; S0738-3991(20)30528-0.
32. Person-centred care: implications for training in psychiatry The Royal College of Psychiatrists. 2018. https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2018-college-reports/cr215
33. RCPsych Person-Centred Training and Curriculum Scoping Group Training in psychiatry: making person-centred care a reality. BJ Psych Bulletin 2019;43(3):136-140.
34. Leplege AF, Gzil M, Cammelli C, Lefeve B, Pachou VI. Person-centredness: Conceptual and historical perspectives. Disability and Rehabilitation. 2007;29: 1555-65.
35. Mezzich J. Snaedal J, van Weel C, Heath I. The international network for person–centered medicine: Background and first steps. World Med J. 2009;55: 104-107.

36. Health Foundation Person-Centred Care Made Simple – What Everyone Should Know about Person-Centred Care. 2014 Health Foundation.
37. Adshead G, Crepaz-Keay D, Deshpande M, Fulford KWMB, Richards V. Montgomery and shared decision making: implications for good psychiatric practice. Br J Psychiatry. 2018;213:630–32.
38. NICE. Shared Decision Making. NICE, 2018 (https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making).Google Scholar
39. University of West London. MSc Person-Centred Health and Social Care. 2019 (https://www.uwl.ac.uk/course/postgraduate/person-centred-health-and-social-care).
40. Salloum IM, Abou-Saleh MT, Krasnov V. (2012) Comorbidity, psychiatric diagnosis and the Person-centered Integrative Diagnostic Model. IJPCM. 2(2): 168-172.
41. Mezzich JE, Braš M, Dorđević V, Appleyard J. (2014) Professional health education and person-centered medicine. IJPCM. 4(1):1-5.

الملخّص

تأسست الخدمة الصحية الوطنية (NHS) في عام 1948 كنظام رعاية صحية ممول من القطاع العام في المملكة المتحدة يوفر تغطية صحية شاملة ومجانية ومتوفرة لجميع من يحتاجها. إن التجربة البريطانية في الطب المتمركز حول الشخص مكرسة في دستورها وتتضمن مبادرات إنشاء المعهد الوطني للتميز في الرعاية الصحية (NICE) الذي يهدف الى اعتماد الممارسات الطبية المستندة إلى القيم والابتكارات في الرعاية الشاملة والمتكاملة التي تركز على الشخص. كانت هناك ابتكارات تتمحور حول الشخص في التعليم الطبي الجامعي والدراسات العليا. ومن اهم التطورات استحداث الكلية الملكية للأطباء النفسيين في المملكة المتحدة لمنهاج التدريب الاختصاصي للطب النفسي الذي يتناسب مع الطب النفسي المرتكز على الشخص. في حين أن هذه التجربة البريطانية فريدة من بعض النواحي، إلا أنها يمكن أن تسهم في التنمية الشاملة للرعاية الصحية التي تركز على الشخص والتعليم الصحي في كافة مراحله ومن منظور عالمي.

Author

Professor Mohammed T Abou-Saleh, Professor of Psychiatry, St George's, University of London - UK

Email: mabousal@gmail.com