

# BMJ Open Who is at the centre of what? A scoping review of the conceptualisation of 'centredness' in healthcare

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## ABSTRACT

**Objectives** We aimed to identify the core elements of centredness in healthcare literature. Our overall research question is: How has centredness been represented within the health literature published between 1990 and 2019?

**Methods** A scoping review across five databases (Medline (Ovid), PsycINFO, CINAHL, Embase (Ovid) and Scopus; August 2019) to identify all peer-reviewed literature published since 1990 that focused on the concept of centredness in any healthcare discipline or setting. Screening occurred in duplicate by a multidisciplinary, multinational team. The team met regularly to iteratively develop and refine a coding template that was used in analysis and discuss the interpretations of centredness reported in the literature.

**Results** A total of 23 006 title and abstracts, and 499 full-text articles were screened. A total of 159 articles were included in the review. Most articles were from the USA, and nursing was the disciplinary perspective most represented. We identified nine elements of centredness: Sharing power; Sharing responsibility; Therapeutic relationship/bond/alliance; Patient as a person; Biopsychosocial; Provider as a person; Co-ordinated care; Access; Continuity of care. There was little variation in the concept of centredness no matter the preceding word (eg, patient-/person-/client-), healthcare setting or disciplinary lens. Improving health outcomes was the most common justification for pursuing centredness as a concept, and respect was the predominant driving value of the research efforts. The patient perspective was rarely included in the papers (15% of papers).

**Conclusions** Centredness is consistently conceptualised, regardless of the preceding word, disciplinary lens or nation of origin. Further research should focus on centring the patient perspective and prioritise research that considers more diverse cultural perspectives.

## INTRODUCTION

High-quality, effective, evidence-based healthcare places the recipient at the centre of care.<sup>1</sup> The concept of patient-centred or person-centred or client-centred care has been explored by researchers across several countries, and has resulted in numerous models that have attempted to explain the concept.<sup>2–5</sup> Most of this literature begins by

## Strengths and limitations of this study

- We included all healthcare disciplines, settings and qualifier terms for centredness.
- We are a multidisciplinary team from five healthcare disciplines, from four countries.
- Consumer involvement has been included from the start of the project through to coauthorship.
- We were unable to include papers in languages other than English.

lamenting the lack of a universal definition for centredness, and it is commonly proposed that the application and implementation of patient/person/client centredness is hampered by this uncertainty.<sup>5 6</sup>

This lack of consensus regarding a definition is, we suggest, a result of a similar lack of consensus about the constructs underlying the concept of centredness. The fuzziness of the concept makes teaching and research more difficult and could well contribute to some of the variability observed in interventions based on centredness.<sup>7</sup> A common understanding of the constructs of centredness would help clarify the definition, and better focus clinical teaching, professional development and evaluation approaches. It may even offer a road away from the endless esoteric debates that have occupied the literature for decades.

There is a large body of literature devoted to differences between patient centredness, person centredness, or client centredness in healthcare. Many authors have spent time and energy defining the different types of centredness, patient/person/client etc, under the assumption that they are differing concepts. However, among these different qualifier terms for centredness that are often used in different healthcare settings, it remains unclear how and to what extent centredness is conceptualised in the literature, and who

is the focus of centredness. This scoping review aims to explore the conceptualisation of centredness in the healthcare literature with a view to identify core elements, approaches to the study of centredness, and key contextual factors in the conceptualisation of centred care.

Centredness is a multidimensional concept, that can operate at different levels of healthcare (eg, health system, organisation, provider/individual level), and the concept has evolved in time across diverse disciplines and contexts. Centredness is not a linear, static, and simple concept. In this review, we adopt a view of centredness as a complex system.<sup>8</sup> This particular lens broadens the focus of our review from not only the what and why of centredness, but also the how. Using this lens of a complex system, we bring our attention to the constitutive components (or dimensions) of centredness (the what) alongside the intentions (or justifications) and values that underpin the concept as described in the literature (the why). It also brings the focus of our search onto how centredness comes to unfold in different contexts, with specific consideration given to its processes and relationships (how it works, with whom).

Based on this, our specific questions are:

How has centredness been described within the peer-reviewed health literature published between 1990 and 2019?

- ▶ In these descriptions, what is reported in terms of:
  - Elements of centredness.
  - Underpinning values.
  - Level of analysis (for a situated view of centredness across contexts).
  - Justification for the concept as a component of healthcare delivery.
- ▶ What approaches (study types) have been used to generate these descriptions of centredness?
- ▶ What key contextual factors are associated with these descriptions, including disciplinary approach, country and year of publication, and included perspectives?

## METHODS

We conducted a scoping review using a prospective protocol available online at the Open Science Framework (<https://osf.io/v9hdx/>). Our aim was best served by the scoping review method as we mapped the literature base across a broad range of disciplines to explore the concept of centredness. Our protocol was based on methodological guidance from the Joanna Briggs Institute.<sup>9</sup> The Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for scoping reviews has guided the reporting of this review.<sup>10</sup>

We included peer-reviewed publications reporting on the concept of 'centredness' within any healthcare setting. No restriction was made on the setting or discipline, but we limited papers to those published since 1990, given the early definitions of patient centred care arose in the mid to late 1980s. No restriction was made on the setting or discipline, but we limited papers to those published since 1990, given the early definitions of

### Box 1 Complete search string for Medline

centredness OR centeredness OR "centred care" OR "centered care" OR "Patient-centered care" [MeSH] AND (concept OR concept formation OR phenomena OR framework OR model OR theory OR pathway OR mechanism OR review OR context)

patient centred care arose in the mid to late 1980s. We only included publications in English due to our language ability, and excluded papers solely about implementation of centredness-based programmes or interventions. We did not include grey literature as our research question is focused on how centredness is conceptualised within peer-reviewed literature.

Our search strategy targeted all terms that could be used to refer to 'centredness', including patient, person, user, client, relationship, woman, family; there was no limitation on the word placed prior to 'centredness' in the title or abstract.

In August 2019, we searched Medline (Ovid), PsycINFO, CINAHL, Embase (Ovid) and Scopus using the terms centredness, centeredness, 'centered-care', 'centred-care', the MeSH term 'patient-centred care', concept, concept formation, phenomena, framework, model, theory, pathway, mechanism, review and context (box 1). The search strategy was reviewed by an academic librarian at the Royal Australian College of General Practitioners.

We used Covidence to facilitate independent, duplicate screening for title and abstracts (EAS, TLC, SL, AP, LH, LR, LB and GR); and again for full text articles (AP, EAS, TLC, SL, LH, GR and LB).<sup>11</sup> We initially screened 20 manuscripts and then met to refine the criteria and ensure our screening practices were aligned. Any conflicts were resolved by a third author (GR and MS).

We extracted the following data: country of authorship, year, healthcare discipline and study type. We also extracted whether the original authors reported centredness at the level of the provider, multidisciplinary team, discipline or organisation. We extracted the elements or dimensions of centredness described in the paper, the justification for reporting on centredness, and any underlying values. We were also interested in who's perspective was represented in the paper: academic or researcher, patient, policy-maker or healthcare providers.

When considering the dimensions of centredness, we used the Mead and Bower framework of patient centredness and the categories from the Langberg review,<sup>2 5</sup> to contextualise our work and develop initial codes by taking the categories already identified in these papers to begin the coding tree. We chose to split 'Sharing power and responsibility' that typically are presented together as we were interested in mapping power sharing in its own right.

We developed a detailed code book to guide the extraction process that we added to as new elements arose, iteratively during discussions in team meetings. Elements were added to the coding tree as they arose in

each paper, similar to a coding process used commonly in qualitative research. We mapped all items that were raised in the papers and did not attempt to attach more or less importance to each element.

Approximately half of the papers were extracted by two independent authors (AP, EAS, LB, LH, LR and TLC), with a third author determining consensus on the extraction (SL). The team met regularly throughout the project, increasing in frequency for key milestones and discussion of new concepts and observations. A formal assessment of methodological quality was not part of this scoping review.

We used excel to visually display our data extraction with colour coding to highlight the features of each article and discussed the descriptive findings with the authorship team.

To enhance the rigour of our approach, we are a multidisciplinary team covering five healthcare disciplines, from four countries. We value the contribution of our consumer representative (DV). Our team has

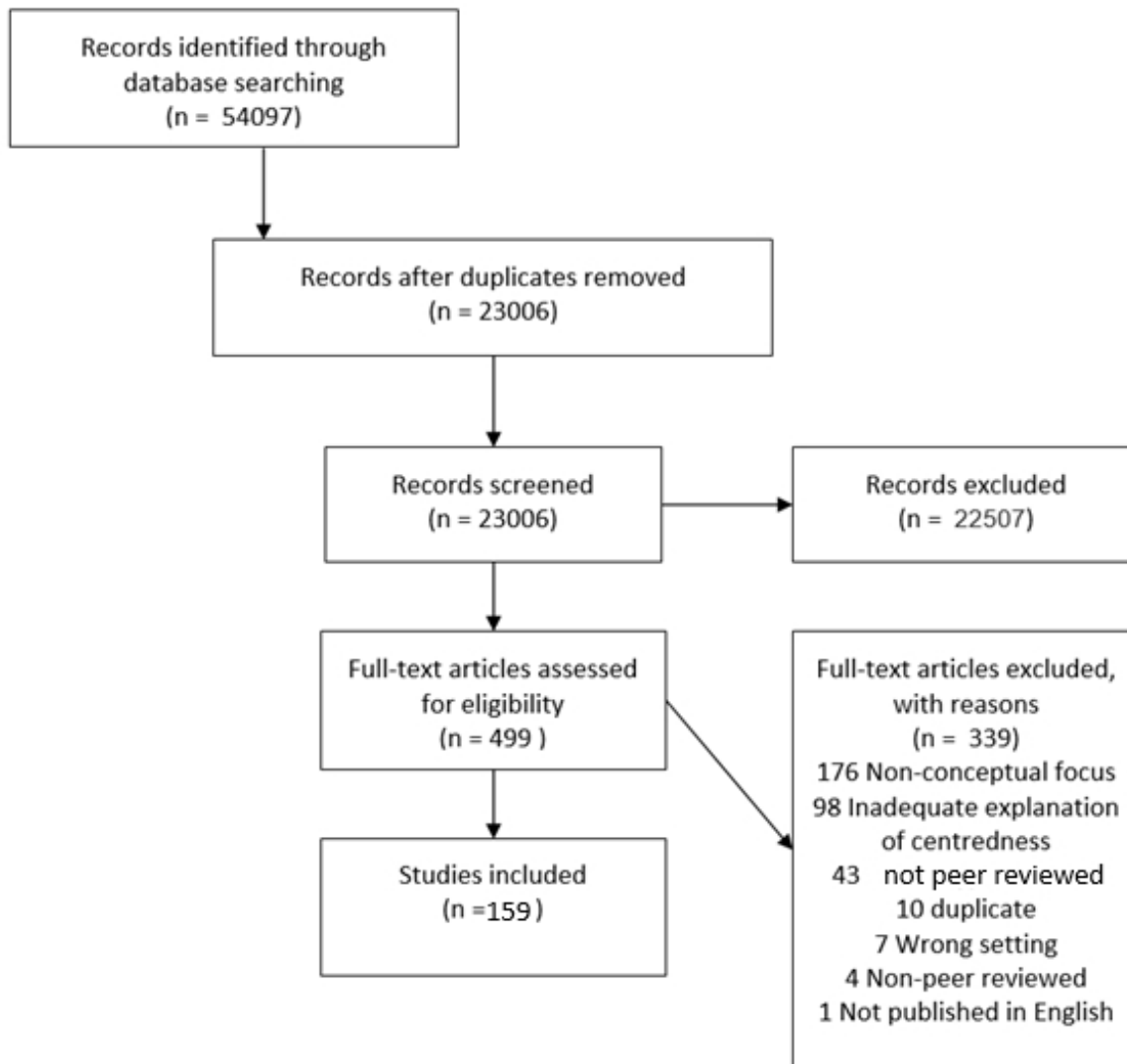
varied disciplinary knowledge, personal, and professional experiences which allows us to have a broad view of the concept and characterisation of centredness. We brought our distinctive approaches to centredness to this project with a view to answering the research questions. Our regular meetings included reflexive elements to consider how we were to analyse the data and where data best fit within each of our conceptualisations of centredness.

**Patient and public involvement**

Author, DV, was involved in the study from the start of the study and had input into the methods. DV was involved in the final analysis and interpreting the findings.

**RESULTS**

A total of 23 006 title and abstracts were screened, and 499 full text articles. 159 articles were included in the extraction (83 papers extracted by two authors) (figure 1).<sup>2 4 5 12-167</sup>



**Figure 1** PRISMA flow chart with reasons for exclusions in a scoping review of the concept of centredness in healthcare. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

**Table 1** Country of authors, year of publication, discipline and study type; total papers n=159

	n (%)
Country	
USA	53 (33.3)
UK	27 (17.0)
Canada	20 (12.6)
Australia	15 (9.4)
Netherlands	6 (3.8)
NZ	3 (1.9)
Multiple countries	6 (3.8)
Other	29 (18.2)
Year of publication	
1990–2000	14 (8.8)
2001–2010	40 (25.2)
2011–2019	105 (66.0)
Discipline	
Nursing	52 (32.7)
Medicine	22 (13.8)
Paediatrics	13 (8.2)
Occupational therapy	6 (3.8)
Physiotherapy	4 (2.5)
Primary care	3 (1.9)
Neonatal	2 (1.3)
Other	58 (36.5)
Study type	
Empirical—qualitative	22 (13.8)
Empirical—quantitative	3 (1.9)
Literature review	46 (28.9)
Opinion	28 (17.6)
Systematic review	13 (8.2)
Other	47 (29.6)

Fifty-three papers were from the USA, and the most common disciplinary perspective was nursing (52 papers) (table 1). There were few papers explicitly originating from primary care (three papers),<sup>4 101 105</sup> and most papers were from other specialty disciplines and tertiary care (table 1).

The most common terms to qualify ‘centredness’ were patient (59 papers), person (38 papers), and family (33 papers), with family mostly limited to the papers from paediatric settings (table 2). The Dutch (six papers),<sup>36 68 70 82 85 98 160</sup> Belgian (one)<sup>98</sup> and German (three) authors only used ‘patient’ centredness and did not use any other preceding word.<sup>47 48 73</sup>

Most papers described centredness from the perspective of a discipline or healthcare organisation. The patient perspective was represented in 15.7% of the papers (25 papers, table 2). There were 13 papers reporting on centredness from a non-Western perspective

**Table 2** The number of papers with each qualifier, justification, values, perspective represented; total papers n=159

	n (%)
Qualifying word	
Patient	59 (37.1)
Person	38 (23.9)
Family	33 (20.8)
Client	9 (5.7)
Relationship	3 (1.9)
Other	17 (10.7)
Level of analysis	
Provider	30 (18.9)
Team	24 (15.1)
Discipline	58 (36.5)
Organisation	47 (29.6)
Justification	
Efficiency	34 (21.4)
Humanistic/moral	44 (27.7)
Patient satisfaction	34 (21.4)
Improved health outcomes	90 (56.6)
Underpinning values	
Respect	104 (65.4)
Equity	22 (13.8)
Social justice	35 (22.0)
Cultural practices	11 (6.9)
Autonomy	41 (25.8)
Who’s perspective?	
Academic	132 (83.0)
Patient/person	25 (15.7)
Healthcare provider	27 (17.0)
Policy-makers	8 (5.0)

using a specific cultural lens (online supplemental table 1).<sup>12 15 35 43 57 64 81 87 126 134 135 139 155</sup>

We found nine major categories of elements of centredness described across the different papers (table 3). From the initial coding tree (informed by Mead and Bower plus the Langberg review), we added access and continuity of care as major categories. We also added a number of more specific, but related categories to the existing coding frame, including compassion, emotional engagement, person as part of a collective, spirituality, strengths based, social determinants of health, professional clinical responsibilities and advocate for the patient (table 4).

Regardless of the preceding word, and healthcare discipline, the most frequently described elements of centredness across the papers were: Sharing responsibility; therapeutic relationship; and, patient as a person. Papers reporting from an organisational level of centredness generally had a greater focus on co-ordination,

**Table 3** Elements of centredness described in the paper; total papers 159; note: each paper can have multiple elements described within the same paper

	n (%)
1. Sharing power*	46 (28.9)
a) Seen as equals*	50 (31.4)
b) Empowerment	56 (35.2)
2. Sharing responsibility	103 (64.8)
3. Therapeutic relationship/bond/alliance	129 (81.1)
a) Compassion	27 (17.0)
b) Emotional engagement	38 (23.9)
4. Patient as a person	125 (78.6)
a) Person as part of a collective	79 (49.7)
b) Spirituality, cultural needs	25 (15.7)
c) Comprehensive care	52 (32.7)
d) Strengths based	38 (23.9)
5. Biopsychosocial	33 (20.8)
a) Social determinants of health	16 (10.1)
6. Provider as a person	42 (26.4)
a) Professional clinical responsibilities	27 (17.0)
b) Advocate for the patient	15 (9.4)
7. Co-ordinated care	52 (32.7)
8. Access	39 (24.5)
9. Continuity of care	41 (25.8)

See Table 4 for an explanation of each category.

\*Papers were only coded to 'Sharing power' if they used the word power; other papers that included a similar concept, but without using the word power were coded as 'Seen as equals'. Please see Table 4 for a fuller explanation of each element.

access and continuity than those with a different level (provider, team, discipline). Papers written after 2003 did not mention the 'provider as a person'.

For the justification for centredness, we focused on four items—efficiency, patient satisfaction, improved health outcomes, the moral imperative of humanistic values—based on the justification given by the Institute of Medicine.<sup>1</sup> The most frequent justification for focusing on centredness was improved health outcomes (table 2).

Some of the values reflected in the papers included respect, equity, social justice, cultural practices and autonomy. Many authors did not report the values that underpinned their work, but for those that did, respect for patients was the most frequent underlying value (table 2).

## DISCUSSION

We identified nine core elements of centredness across the literature with the most common being sharing responsibility, therapeutic relationship and patient as a person. There were many qualifier terms used in the literature, but we found little difference in the elements of

centredness no matter what the preceding word. There were few papers that explicitly included the patient perspective in their analysis. By using a complex systems approach, we were able to identify the justification and values that underly conceptualisations of centredness.

We found there were few descriptions of centredness in the published literature that used anything other than a Western perspective. The 13 papers that did use a specific cultural or ethnic group often had a different way of bringing together the elements of centredness, but still the elements were similar to the majority of papers. For example, a description of Maori centred nursing practice used an image of two hands to explain how nursing practice and Maori practice interacted in the nurse's work.<sup>81</sup> The papers from more culturally diverse perspectives had a stronger emphasis on the person as part of a collective, that is seeing people as part of their family, community or wider society.

Access and continuity of care were the two major elements that were added to our initial list drawn from Mead and Bower and the Langberg review. These two additions, both based on the elements described in the literature, transform the list into one that resonates strongly with the 'four Cs of primary care' described by Starfield as comprehensiveness, first contact of care (or access), co-ordination and continuity of care.<sup>168</sup> Many in our team have been, or are, involved in primary care research and synergies between the four Cs and this list of nine elements left us reflecting on the central place of centredness as an overarching principle in the provision of high-quality (primary) healthcare.

It is important to reflect on the justification and values that are driving the quest for centredness in healthcare. The most common justification for centredness was to improve health outcomes for patients, while the most common underlying value was respect for patients. We are left with a question as to whether centredness is an outcome in itself, or only part of the process to achieve better health outcomes? Is centredness a recognition of the right of patients to be involved in their own care or is it simply an organising principle intended to deliver greater care efficiency and better health outcomes? Is it possible (and morally acceptable) to have healthcare that is centred on the person/patient/client, when we are primarily interested in it as a means to improve outcomes (an instrumental purpose)? Perhaps further reflection on the values would assist in implementing care that better reflects the core elements of centred healthcare.

These reflections require the acknowledgement of the lack of the perspective of the patient in the vast majority of papers. This appears to be in direct conflict with the stated intentions of those interested in increasing centredness and leaves us wondering, whom is at the centre? When the patient perspective is not explicitly included, the void is filled by the perspective of academics, clinicians and other interested stakeholders. Future research on centredness should not proceed without the explicit and intentional inclusion of the patient perspective.

This review is unique as we included all healthcare disciplines and settings. Strength lies in the rigorous screening

**Table 4** Description and explicit coding rules for the elements of centredness identified in the scoping review

Element of centredness	Description	Explicit coding rules (if relevant)
1. Sharing power	Between the patient/client and the practitioner	Only coded if the word 'power' is used
a) Seen as equals	Balance in the consultation; not 'paternalistic'; reduced medical authority; symmetrical relationship; mutual participation—have similar meaning, but the word 'power' is not used	
b) Empowerment		Only coded if the word 'empowerment' is used
2. Sharing responsibility	Between the patient/client and the practitioner, includes collaboration, working together on tasks, each person having their own tasks to be responsible for	
3. Therapeutic relationship/bond/alliance	Includes factors of empathy, respect, trust, rapport	
a) Compassion		Only coded if the word 'compassion' is used
b) Emotional engagement	Specifically recognises the emotional needs of the individual including emotional support, attending to the emotions of the patient	
4. Patient as a person	Concerned with understanding the individual's experience of illness; seeing the patient as more than just their 'disease' or problem; includes the personal meaning that people bring to illness; the importance of eliciting each patient's expectations, feelings and fears about the illness; strive to understand the patient as an idiosyncratic personality within their unique context	
a) Person as part of a collective	Recognising that an individual is part of a larger community—for example, family, community, cultural group—and that this impacts management	
b) Spirituality, cultural needs	Recognising that the patient has spiritual needs that should be considered, these could be related to religious, cultural or other practices	
c) Comprehensive care	Includes care of the 'whole person', including 'holistic care'	
d) Strengths based	Recognising and building on the strengths of the individual/family/focus of care	
5. Biopsychosocial	Considering the complete picture of biological, social and psychological issues; it is about the issue that the patient/person is presenting with, rather than about its management	Only coded if the word 'biopsychosocial' is used
a) Social determinants of health	Factors such as housing, employment, poverty and minority status influence both the disease and the participation in treatment	
6. Provider as a person	The influence of the personal qualities of the provider; recognising that the practitioner is also a person with multiple facets	
a) Professional clinical responsibilities	The clinician involved in the encounter has a set of professional responsibilities that need to be integrated into the approach to the patient	
b) Advocate for the patient	The clinician has a role outside the consultation to advocate for the needs of the patient	
7. Co-ordinated care	Care provided by a broader team that requires coordination	
8. Access	This is the ability of the patient to access care and will have different specifics depending on the level of analysis (person/practice/discipline/system): could include physical access to care; appointment systems (level of the practice); consultation specific issues, for example, language and translation	
9. Continuity of care	care provided by a clinician/team/system that is familiar with the patient's story; includes longitudinal care, care provided over time	

process and, importantly, our multidisciplinary, multinational team that includes consumer representation as described in our methods. We view our team as a strength due to its ability to bring diverse perspectives to the understanding of centredness which is particularly important when focusing on a conceptual research question. Unfortunately, we were only able to include papers written in English and this means we would have missed concepts in other languages. We also only had two extractors for 50% of the papers, and while we ensured we had regular meetings and an agreed codebook, this lack of a second extractor for the second half of the papers represents a limitation. As our research question was based on peer-reviewed literature so we did not include grey literature. Therefore, concepts outside this body of work will not be included.

This scoping review provides reassurance that there are few discrepancies among the definitions of various types of centredness from varied disciplinary perspectives. Further work in the field of centredness would be worthwhile if it included strong patient perspective and/or the examination of centredness from more diverse cultural perspectives. We intend to further explore the elements of therapeutic alliance, sharing power, and ‘attending’ to the person. A central thread for framing these explorations is the varying contexts of healthcare and the influence of context on how the elements of centredness are enacted.

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**Contributors** EAS and MS conceived of the concept, EAS, AP, LR, LB, LH, SL, DV, GR and MS all contributed to the methods, SL performed the search, EAS, AP, LR, LB, LH, SL, TLC, GR and MS all contributed to the review of articles, EAS, AP, LR, LB, LH, TLC, SL extracted data, all authors were involved in the analysis. EAS and AP wrote the draft manuscript AP developed table 1, TLC referenced the paper, and all authors contributed to the final manuscript. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted.

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