Med Health Care and Philos
DOI 10.1007/s11019-008-9131-5

SCIENTIFIC CONTRIBUTION

Types of centredness in health care: themes and concepts

Julian C. Hughes · Claire Bamford · Carl May

Abstract *Background* For a variety of sociological reasons, different types of centredness have become important in health and social care. In trying to characterize one type of centredness, we were led to consider, at a conceptual level, the importance of the notion of centredness in general and the reasons for there being different types of centeredness. *Method* We searched the literature for papers on client-, family-, patient-, person- and relationship-centred care. We identified reviews or papers that defined or discussed the notions at a conceptual level. The reviews and papers were analyzed as text transcripts. *Results* We identified 10 themes that were common to all the types of centredness. At a conceptual level we could not identify thematic differences between the types of centredness. These findings were subjected to a philosophical critique using ideas derived from Wittgenstein. *Conclusion* Different types of centredness are required in different contexts. The differences are justified by their practical utility. The unifying themes of centredness, however, reflect a movement in favour of increasing the social, psychological, cultural and ethical sensitivity of our human encounters.

J. C. Hughes
Northumbria Healthcare NHS Foundation Trust and the Institute for Ageing and Health, Newcastle University, Newcastle upon Tyne, UK

C. Bamford · C. May
Institute of Health and Society, Newcastle University, Newcastle upon Tyne, UK

J. C. Hughes (✉)
Psychiatry of Old Age, Ash Court, North Tyneside General Hospital, Rake Lane, North Shields, Tyne & Wear NE29 8NH, UK
e-mail: j.c.hughes@ncl.ac.uk

Keywords Carer-centred care · Family-centred care · Patient-centred care · Person-centred care · Relationship-centred care · Concept analysis · Wittgenstein

Introduction

Healthcare professionals are exhorted to be centred on those they look after in a variety of ways. There has been a burgeoning literature on client-, family-, patient-, person- and relationship-centred care. In the context of a study of patient-centred care, we were keen to define this notion, which led us to consider alternative types of centredness. In this paper we present the findings from a literature review. We shall characterize the notion of centredness in terms of the themes that have emerged.

Defining any of the individual types of centredness is difficult, but seeing how they relate is more complex still. In this paper we offer a comparative analysis of the various terms from the literature. This should help to clarify our use of the different concepts. We shall offer some philosophical comment to argue that the notion of centredness acts as a corrective to a narrower view. First, however, we need to try to understand why it is that the notion of 'centredness' has become so important, which we shall do by focusing on the idea of 'patient-centredness'.

Why have ideas about patient-centredness become important?

The shift to 're-centring' relations in the clinical encounter reflects longstanding trends in education for health professionals and in research about them. There has been a steady increase in interest in improving the quality and

conduct of professional–patient interactions—and more recently attempts to specify and measure important components of those interactions as they are revealed in everyday practice (May 2007; Heritage and Maynard 2006). This trend towards seeing professional and patient as experiencing subjects is derived from several sources. Three of these are especially important.

(a) Improving communications between patients and professionals has been assumed to improve health outcomes because of improved compliance on the part of the patient, and better comprehension on the part of the doctor (Armstrong 2002).
(b) Including patients in processes of care and decision-making have been assumed to have benefits for patients (and professionals) because the strain caused by asymmetrical relations of power and knowledge are reduced (Strauss et al. 1997).
(c) Sharing responsibilities between professional and patient is a response to social change over the past 50 years. Such change includes objections to both medicalization and medical paternalism, the objectification of experiential aspects of health and illness, along with demands for increased autonomy and choice about the conduct and organization of health care, which arose from the cultural and political shifts of the 1960s (Morris 1998).

Socio-cultural change, therefore, means clinical relationships have been constituted as a particular kind of problem for different professional groups (Armstrong 1983). The social sciences have played an important part in these shifts because they have provided both a vehicle for an external critique and a set of tools that can be employed within medicine to reconfigure and measure clinical practice. Models of 'centredness' in health care invariably contain an implicit appeal to psychological or sociological theories of improved interaction as psychosocial and ethical goods.

There are, first, clinical concepts that were originally developed in general practice to support the ideas of Brackenbury (1935) and Balint (1957), which suggested that effective family medicine relied on revealing the underlying problems that led to the patient's presentation. Here, the doctor–patient relationship has been seen as a therapeutic technology in itself (May 2005).

Secondly, social science research has revealed the importance of open communications and awareness (Strauss 1968) and patient autonomy in terminal and palliative care settings (Hibbert et al. 2003). Here, specific interactional techniques have been constructed as therapeutic technologies for managing patients' experiences (May 1992).

The growth of clinical and academic interest in re-centring the subject of patienthood can thus be explained in terms of clinical interests in communication, inclusion and sharing responsibilities that have been translated from specific settings into general ones. Beyond this, the importance of these notions and the radical growth and proliferation of models of centredness corresponds to the increasing importance of changes in the landscape of epidemiology and policy. In particular, the increasing prevalence of chronic or longstanding conditions (Holman 2006) has led to a model of professional work as disease management over relatively long trajectories (May 2005). Indeed, the patient-centredness or otherwise of a professional can be measured (Roter and Hall 1989; Bower et al. 1998; Mead and Bower 2002) and used—for policy purposes—as a means of defining quality of care (Campbell et al. 2000; Mead et al. 2002).

Patient-centredness and related concepts have become important for ideological and structural reasons as well as for professional and ethical ones. They are part of the body of ideas through which professionals and others make sense of their work and attribute moral meaning and value to it. In this context, such ideas have important practical importance and effects in the daily business of health care. All the more reason, then, to achieve a clearer view of the concepts involved. In doing this we have focused on two questions: What justifies the use of one type of centredness rather than another? What is important about the notion of centredness?

Method

Key papers on client-, family- patient-, person- and relationship-centredness[1] were identified through literature searches (see Box 1).

In view of the large number of papers relating to most types of centredness, we identified narrative and systematic reviews by searching for the word 'review' in the title,

Box 1 Search strategies (1987 to 2006)

Database	Search terms
Medline	Patient[a] adj (centred$ or centered$).ti
CSA Illumina[b]	(Patient AND centered) or (Patient AND centred)
Web of Science	TI = Patient SAME (centred* OR centered*)

[a] The search was repeated for each database using the terms: person, client, family and relationship

[b] Selected databases were: AIDS and cancer research abstracts; ASSIA (Applied Social Sciences Index and Abstracts); CSA Linguistics and Language Behaviour Abstracts; PILOTS database; psycINFO; CSA social services abstracts; CSA sociological abstracts

[1] Other potential types of centredness exist: 'people-centredness' (e.g. Williams and Grant 1998): which is very close to 'person-centredness' but with an emphasis on consumerism; and 'carer-centredness'. However, there is no literature of note to review for these concepts.

abstract or keywords. Two authors (CB and JCH) independently scanned the papers (since there were too few reviews) relating to the concept of relationship-centred care and the abstracts of all the reviews identified for the other types of centredness. Given our interest in understanding the meanings of types of centredness, we focused on papers which defined the terms, identified elements or components of care, critically examined the concepts or reviewed existing work. The papers marked for retrieval were compared and discrepancies discussed until agreement was reached. Additional references were identified through the bibliographies of included papers and citation searches. In addition to academic articles, we also identified relevant UK policy documents by searching the relevant government websites. All retrieved papers were read by two authors (CB and JCH). Papers were analysed as if they were original text transcripts, with all descriptions of the particular type of centredness being noted. This process continued until the point of data saturation was reached (i.e. the inclusion of further papers did not result in the identification of new themes). In this way themes emerged from within the papers and, for a particular type of centredness, they could be grouped. This process was undertaken independently by separate researchers (CB and JCH) and the emergent themes compared. Any discrepancies or disagreements were discussed and consensus was reached. Having noted the themes within individual categories, it was possible to compare the themes emerging in different types of centredness, looking both for concordance and discordance.

Results

The number of papers identified by the searches for each type of centredness is shown in Table 1.

Our summary definitions of types of centredness are shown in Box 2.

The main themes that emerged are shown in Table 2. For any particular type of centredness, all of the main themes were found in the literature. In short, therefore, none of these themes is specific to any particular type of centredness. The themes implied by different types of centredness are by and large the same.

Table 1 Search results by year

Type of centredness	1987–1991	1992–1996	1997–2001	2002–2006	All years	Reviews
Patient	42	165	274	504	985	48
Person	65	63	146	282	556	57
Client	82	75	107	115	379	39
Family	82	202	213	241	738	64
Relationship	0	7	20	22	49	2

Box 2 Types of centredness

Client-centredness: Initially focused on three 'necessary and sufficient' conditions for therapeutic relationships (Rogers 1951)—namely empathic understanding, unconditional positive regard and therapeutic genuineness—but subsequently it has been adopted in other fields, particularly occupational therapy, where its meaning has been broadened to encompass wider aspects of communication, in particular the provision of information to enable clients to make informed decisions (Law et al. 1995).

(Other illustrative references: Patterson 1990; Bott 2001; Falardeau and Durand 2002; Sumsion and Law 2006.)

Family-centredness: Emphasises "mutually beneficial partnerships among health care providers, patients and families" and is relevant to the planning and evaluation of health care as well as to its delivery (Ahmann and Johnson 2000). While this term has been primarily used within paediatrics, family-centred care is seen as applicable to all patient groups. It is linked to the practice of family therapy which draws upon systems theory (Bertalanffy 1968).

(Other illustrative references: Hostler 1991; Nethercott 1993; Allen and Petr 1998; Rosenbaum et al. 1998; Hutchfield 1999; Coleman 2002; Malusky 2005; Regan et al. 2006; Shields et al. 2006.)

Patient-centredness: Stemming in large part from general practice, described by Edith Balint as "understanding the patient as a unique human being" (Balint 1969): the focus has been on fostering joint understanding of illness and its management.

(Other illustrative references: Mead and Bower 2000b; Lewin et al. 2001; Michie et al. 2003.)

Person-centredness: Had its origins in the client-centred psychotherapy of Carl Rogers (1961): but was adopted in other fields, such as dementia care, where Kitwood (1997) used the term to emphasize communication and relationship.

(Other illustrative references: Barrineau and Bozarth 1989; Kitwood and Bredin 1992; Kitwood 1993; Department of Health 2001; Epp 2003; Brooker 2004; McCormack 2004.)

Relationship-centredness: Intended to "affirm the centrality of relationships in contemporary healthcare" (Tresolini and the Pew-Fetzer Task Force 1994): it suggests that the patient-centred model is "not inclusive enough" (Nolan et al. 2001).

(Other illustrative references: Madigan 2001; Frankel 2004; Nolan et al. 2004; Wylie and Wagenfeld-Heintz (2004); Beach et al. 2006; Suchman 2006.)

Table 2 Summary descriptions of themes

Theme	Description
Respect for individuality and values	Recognizes the importance of valuing people as individuals with awareness of differences, values, culture, their unique strengths, needs and rights, including the right to dignity and privacy.
Meaning	Accepts the unique perspective, reflecting the phenomenological and subjective nature of the person's experience, with self-defined goals and a potentially shared understanding of the meaning of illness.
Therapeutic alliance	Involves the possibility of genuine empathy and unconditional positive regard. Therapeutic alliance is based on respect for personhood, with warmth, trust, openness, care, honesty, the instillation of hope and confidence. Non-judgemental relationships should encourage competency, belonging and a shared language, where the professional is a facilitator.
Social context and relationships	Attends to our social nature as people, with an emphasis on relationships, on our situated context of interpersonal, interconnected, mutual interdependence. Hence family and carers' needs are recognized, as is the relevance of roles and life stages. The importance of seeing the network of relationships as a whole is crucial.
Inclusive model of health and well-being	Broader than diagnosis and treatment, with protection and safety for the vulnerable, this theme involves comfort, attachment, occupation, identity and inclusion, with attention to well–being and a biopsychosocial model of the person as a whole. This model includes an integrated *holistic* understanding of the individual's unique world with a recognition of his or her idiosyncratic and broader life-setting. It also includes attention to the prevention of disease, health promotion and the improvement of quality of life.
Expert lay knowledge	The legitimacy of individual's or the family's expert knowledge and experience is recognized. The possibility of consensus through negotiation, compromise and active participation is encouraged. In addition, therefore, there is the possibility of service users contributing to service and professional development.
Shared responsibility	This suggests the sharing of power, responsibility and control, with mutual agreement on plans and reciprocity, with involvement in decision-making, and an orientation towards the individual situated in context, but open to collaboration and partnership. Hence, a type of consumerism, with user involvement and awareness of rights.
Communication	This theme encourages communication with careful, sensitive, interactional dialogue, observational skills and authentic contact, including attentive listening, with the provision of accessible and unbiased information provided in ways that are affirming and useful.
Autonomy	This includes the person's ability to make his or her own decisions, with independence and recognition that individuals and families should be encouraged to live out their lives, make their own choices, in accordance with principles of self-determination, enhancing their control and independence in the process of receiving care.
Professional as a person	The emphasis is on valuing staff as well as service users and on the doctor's or professional's role as a person with emotions, who may need support to enable self-awareness and meaningful partnerships

There are no clear exceptions to these conclusions. However, it is difficult to find the word 'autonomy' in the literature to do with relationship-centred care. Even so, we do find talk of "respect for self-determination" (Tresolini and the Pew-Fetzer Task force 1994). Similarly, the status of the professional as a person is difficult to find explicitly stated in the literature on client-centredness, but there is a heavy emphasis on partnership between the client and the professional, where there is a requirement for the professional to have self-knowledge and to be able to recognize his or her own emotional and value-driven responses to client choice (Law et al. 1995).

Discussion

Our main finding is that different types of centredness contain, at a conceptual level, the same themes. In this discussion we shall: (a) discuss the characterization of centredness; (b) offer philosophical comment on the apparent paradox that there are different types of centredness, which are nevertheless constituted by the same themes; (c) consider the limitations and implications of our study.

Characterization of centredness

We found ten themes that emerged from the literature and which featured in all of the different types of centredness, as shown in Table 2. Of course, it could be argued that there should be more or fewer themes. Brooker (2004), for instance, summarized person-centred care with the acronym VIPS (which implies: the absolute Value of all human lives; an Individualised approach, recognising uniqueness; an understanding of the world from the Perspective of the service user; and a Social environment that encourages well-being). Alternatively, our ten themes could be subdivided into the sub-themes from which they were constructed. We would justify our ten themes by saying that we wished to capture the richness of the data from the

literature in both a meaningful and practical way. However, this begs the question, which precisely concerns how we can argue that our judgements in this regard are justified. To this we shall return.

Conceptual paradox?

We need to see more clearly the apparent paradox that, on the one hand, we have different types of centredness, which can lead to quite different ways of working, whilst, on the other hand, there is no distinction between the types of centredness at the conceptual, thematic level. Two solutions immediately present themselves, but they are both incorrect responses! It is important to see why. First, we might think that the solution is to tighten the definitions of the different types of centredness. Secondly, it might be argued that we should do away with the distinctions altogether.

The case for tightening the definitions is implicit in the attempts to measure centredness, mostly in connection with patient-centredness (e.g. Henbest and Stewart 1989; Winefield et al. 1996; Mead and Bower 2000a; King et al. 2003; Epstein et al. 2005; Dyke et al. 2006; Siebes et al. 2006, 2007). It is not that such measurement relies on there being no overlap between the concepts. It does, however, suggest that the concepts can be pinned down to objective standards. Our analysis suggests, contrariwise, that the concepts are rather poorly circumscribed and this has been reflected in a lack of reliability in some approaches to measuring centredness (Mead and Bower 2000a).

There seem to be two separate problems. One is to do with pinning down and operationalizing concepts. This depends on the idea that there is an essence to these concepts that can be delineated in a reliable way. As we shall see, this sort of essentialism has been powerfully challenged at a philosophical level. Within clinical practice, too, essentialism with respect to diagnosis has been heavily criticized (Scadding 1996).

The second problem is that most measures have addressed only some components of centredness. Thus, whatever is being measured turns out not to be 'patient-centredness' or 'person-centredness', but only a segment of what these concepts represent and, perhaps, just as large a segment of some other concept of centeredness. For example, existing tools for evaluating patient-centredness typically focus on only a small number of the dimensions relevant to this concept. Given the multi-dimensionality of each of the concepts, it would be unrealistic to focus on all aspects of centredness within a particular study; instead the particular type of centredness, and the dimensions within this type of centredness, should reflect the research question(s) and study context.

The second putative solution, that we should do away with the distinctions, is similarly nonsensical. For there clearly is a difference between the way a doctor interrelates with a patient on a one-to-one basis in a clinic and the way a formal carer interrelates with a resident in a home. Both of these are different again if several people are involved; for example, when a family carer is with the person who has dementia, or where the multidisciplinary team is focusing on the wellbeing of a child in the context of a family. So there do seem to be valid distinctions, which we would wish to preserve, in terms of practice. But if the interactions that constitute centredness are to be judged or evaluated, the (common) themes identified in the literature should provide a useful framework. This does not mean, however, that any particular type of centredness is otiose.

A Wittgensteinian analysis

To support these assertions we can point to comments made by the philosopher Wittgenstein (1968). He famously used the word 'game' to argue that there is no hidden essence to what a game is, to which we might point to define the word. Instead, there are just many types of game, all very different (compare a child playing on her own to a game of rugby). The general point—that words do not refer to essences—is apposite to our discussion. There is no essential thing, common to all circumstances, to which we can point and say "This is what relationship-centredness is". Of course, we *can* point to examples of relationship-centred care in the same way that we can point to games of rugby. And for various reasons we might pick out for emphasis particular aspects of relationship-centred care. But the Wittgensteinian idea (confirmed by the empirical analysis of the literature) is that we cannot pick out one *single* thing that *is* relationship-centred care.

Wittgenstein later talks about the concept of 'number':

> "And we extend our concept of number as in spinning a thread we twist fibre on fibre. And the strength of the thread does not reside in the fact that some one fibre runs through its whole length, but in the overlapping of many fibres" (Wittgenstein 1968, § 67).

Once again this seems very relevant to our discussion of centredness. To be person-centred is to see the person as an individual; it is to try to understand what the illness means for the particular person; it is to understand the broader social and psychological context; it is to listen to the person's point of view; it is to try to understand their needs and values and to attempt to share responsibility with them, and so on. But it is not just one of these things. Each of these components is a fibre running through the concept and giving it strength. Part of the strength comes from the way in which the fibres twist or interconnect. Seeing the

person as an individual, for instance, makes one more inclined to try to understand his or her individual needs and values. These sorts of thing tend to go together. But we do not deny that someone is person-centred simply because they overlook one component of the concept. Being person-centred, therefore, is not a concept that can be clearly delineated, but it is none the less useful.

Given that concepts do not refer to discrete essences, the way is opened for a good deal of overlap between the concepts. This also carries the implication that one thread might contain contrasting fibres. Thus, for example, it might seem at first blush as if 'autonomy' and 'social context and relationships' should not go together. But, at least in the cultural context we are considering, these both constitute authentic ways of being a person, a patient, a client, or an individual situated in a family or relationship. The philosophical analysis draws out and explains this apparent paradox. Furthermore, we know from our own lives that we can have, at one and the same time, a predilection for autonomy and an appreciation of our socially situated context.

Hence, the fibres that run through the concept 'person' also run through the concepts 'patient' or 'client'. Patients and clients are, after all, just persons in particular circumstances. And given that the concept of 'person' cannot avoid the notion of 'relationship' and that 'relationship-centred care' implies 'persons-in-relationship' and often families, it should not be at all surprising that empirically the concepts as revealed in the literature should include similar fibres shared between them. The broader the concept, the more fibres to give it strength.

What happens, however, is that, for different purposes the interaction with the person is seen in different lights: in this case as person-centred care, in some other case as an example of relationship-centred care. Elsewhere Wittgenstein says, "Our talk gets its meaning from the rest of our proceedings" (Wittgenstein 1979, § 229). Thus, in the context of a hospital, specialist consultation, it might make perfect sense to talk about patient-centred care. But this would seem meaningless if the conversation were between a carer and someone with mild forgetfulness in a residential home talking about teatime, where the paradigm of person-centred care would seem to be more fitting. Alternatively, in a conversation about advance care planning, involving the person with dementia, his or her children and the general practitioner (GP), who has known the family for some years, the concept of family- or relationship-centred care would seem to be most apt. The rest of the proceedings give meaning to our concepts, or make them seem out of place. Still, the concepts themselves can contain, as we have seen, the same or similar fibres with, perhaps, a particular component seeming to be more prominent in one context compared to another.

Limitations

With the exception of family-centredness, the process of our review indicated much variability of definitions and themes *within* types of centredness. For example, client-centredness originally consisted of three core conditions relating to the counselling relationship (Patterson 1990), but its meaning has been broadened as the term has been applied to other disciplines (e.g. occupational therapy). Our themes represent the broadest content of types of centredness, based on a range of definitions of each concept. Any single paper relating to a type of centredness is unlikely to encompass all of these themes.

Although we continued to review papers until the point of data saturation was reached, in view of the diversity of definitions, it is possible that additional themes are contained in other papers. A further limitation relates to the subjective nature of the identification of themes. Other authors might have combined or interpreted the themes in different ways. This is an unavoidable aspect of this type of research. However, we are confident that, in terms of content, our themes do characterize the literature on centredness, albeit an alternative characterization might have been possible.

Even if there were an alternative characterization, however, it would be sufficient that our themes were acknowledged to have validity at some level. A consequence of our analysis is that the concepts retain their strength even if their fibres were somewhat differently constituted. What cannot be denied, we believe, is that these fibres exist. Whether they are themselves deconstructed to reveal microfibres, or reconstructed to form larger threads running through the whole, is not really a matter of great importance, certainly not in practical terms. The key thing is that the concepts work as they do because of the interconnecting and interrelating nature of the fibres running through them.

Implications

The first implication of our study is that the justification for our thematic characterization of the different types of centredness depends merely on its usefulness for a given purpose. If the purpose is to present people with a handy mnemonic, then it should be memorable (Brooker 2004 VIPS for example). Our own characterization in terms of 10 themes is intended to highlight the main fibres running through the concept of centredness. The validity of this characterization depends on its ability to catch the depth and breadth of the types of centredness without too much redundancy or overlap. The justification comes from the literature and the process by which the themes were developed. There is no alternative justification, as if we

could support these concepts by some further conceptual findings. The important thing is the *practice* from which the themes emerged and the *practice* within which the themes might actually be used.

This also allows us to answer one of our initial questions concerning the justification for using one type of centredness rather than another. Once again, the justification is embedded in the practice. For instance, family-centred practice makes sense in the context of child health and welfare. Once we have seen how concepts work—both by the overlapping of many fibres and in the context of the rest of our proceedings—we can become more tolerant of the different types of centredness. We can learn to recognize their different strengths and weaknesses in different circumstances and in different social and political environments.

A benefit that derives from the different types of centredness is that the tension set up by the apparent paradox cautions against complacency in using any particular model. Family-centred practitioners need to recall that there is still an individual patient at the heart of the system who deserves attention. Client-centred therapists need to recognize the influence of relationships and the importance of the therapist's own emotional life. Furthermore, the different types of centredness have emerged from different backgrounds. Their different histories (e.g. client-centred therapy developing from the work of Rogers (1951) and relationship-centred therapy from the work of the Pew-Fetzer Task Force (Tresolini and the Pew-Fetzer force 1994)) define their difference even if at the level of content they significantly overlap.

This provides an answer to our second question concerning the importance of the notion of centredness. The emphasis on interrelationships is a clue. The different types of centredness represent a corrective to a more blinkered approach to how professionals should interrelate with their patients or clients. The move is to a more humanistic view, one that sees the individual person as situated in a context of relationships, which also pays attention to emotions and inner significance. From different historical backgrounds, various types of centredness encourage the move from a limited biomedical perspective to a broader biopsychosocial and spiritual view of people (Hughes 2001). The importance of centredness, therefore, is that it encourages this broader view of people interrelating with those who care for them. Advocating any form of centredness, therefore, is to encourage the view that care must be seen as a mutual endeavour (Oeseburg and Abma 2006). In the field of chronic degenerative conditions, the importance of the broader view is paramount as a corrective to an approach that would tend otherwise to stigmatize people and emphasize frailty or deficiency, rather than the possibility of maintaining citizenship and enhancing quality of life (Downs et al. 2006; Sabat 2006).

Conclusion

Our analysis of the notion of centredness, on the basis of the literature that describes its different types, has led to ten themes, which could be used to characterize any particular type of centredness in health and social care settings. The anti-essentialist stance and the ideas derived from Wittgenstein—concerning the many fibres that make up a particular concept and the way in which concepts are understood in the context of practices in which they have a use—have allowed us to answer the two questions with which we started. The different types of centredness are required by different contexts. The differences are justified (conceptually) by the practical utility of each type of centredness. Meanwhile, the notion of centredness itself, which—as we have seen—emerges in the unifying common themes, reflects a movement in health and social care, away from the narrower biomedical view, in favour of the broader view, which involves increasing the social, psychological, cultural and ethical sensitivities of our human encounters.

Acknowledgements This paper stems from a research project entitled 'Improving patient-centred care for people with dementia in medical encounters', which was funded by the BUPA Foundation. We acknowledge this support with thanks, as well as the encouragement of our collaborators: Dr Ruth Briel, Dr Eileen Kaner, Dr Louise Robinson, Professor John Spencer and Dr Paula Whitty. We are also grateful to the journal's reviewers for their comments.

References

Ahmann, E., and B.H. Johnson. 2000. Family-centered care: Facing the new millennium. *Pediatric Nursing* 26 (1): 87–92.

Allen, R.I., and C.G. Petr. 1998. Rethinking family-centred practice. *American Journal of Orthopsychiatry* 68 (1): 4–15.

Armstrong, D. 1983. The fabrication of nurse–patient relationships. *Social Science and Medicine* 17 (8): 457–460.

Armstrong, D. 2002. *A new history of identity: A sociology of medical knowledge*. Basingstoke: Palgrave.

Balint, M. 1957. *The doctor, his patient, and the illness*. London: Pitman.

Balint, E. 1969. The possibilities of patient-centred medicine. *Journal of the Royal College of General Practitioners* 17 (82): 269–276.

Barrineau, P., and J.D. Bozarth. 1989. A person-centered research model. *Person-Centered Review* 4 (4): 465–474.

Beach, M.C., T. Inui, and the Relationship-Centered Care Research Network. 2006. Relationship-centered care: A constructive reframing, *Journal of General Internal Medicine* 21 (Supplement 1): S3–S8.

Bertalanffy, K.L. von. 1968. *General system theory: Foundations, development, application*. New York: George Braziller.

Bott, D. 2001. Client-centred therapy and family therapy: A review and commentary. *Journal of Family Therapy* 23: 361–377.

Bower, P., L. Gask, C. May, and N. Mead. 1998. A review of comparative approaches to modelling the consultation in primary care. *Patient Education and Counseling* 34: S17.

Brackenbury, H. 1935. *Patient and doctor*. London: Hodder and Stoughton.

Brooker, D. 2004. What is person centred care? *Reviews in Clinical Gerontology* 13 (3): 215–222.

Campbell, S.M., M.O. Roland, and S.A. Buetow. 2000. Defining quality of care. *Social Science and Medicine* 51(11): 1611–1625.

Coleman, V. 2002. The evolving concept of family-centred care. In *Family-centred care: Concept, theory and practice*. eds. L. Smith, V. Coleman, and M. Bradshaw, 3–18. Basingstoke: Palgrave.

Department of Health. 2001. *National service framework for older people*. London: Department of Health, 23–40.

Downs, M., L. Clare, and J. Mackenzie. 2006. Understandings of dementia: Explanatory models and their implications for the person with dementia and therapeutic effort. In *Dementia: Mind, meaning, and the person*, eds. J.C. Hughes, S.J. Louw, and S.R. Sabat, 235–258. Oxford: Oxford University Press.

Dyke, P., P. Buttigieg, A.M. Blackmore, and A. Ghose. 2006. Use of the measure of process of care for families (MPOC-56) and service providers (MPOC-SP) to evaluate family-centred services in a paediatric disability setting, child: Care. *Health & Development* 32(2): 167–176.

Epp, T.D. 2003. Person-centred dementia care: A vision to be refined, Canadian Alzheimer Disease Review (April): 14–18.

Epstein, R.M., P. Franks, K. Fiscella, C.G. Shields, S.C. Meldrum, R.L. Kravitz, and P.R. Duberstein. 2005. Measuring patient-centered communication in patient–physician consultations: Theoretical and practical issues. *Social Science & Medicine* 61(7): 1516–1528.

Falardeau, M., and M.J. Durand. 2002. Negotiation-centred versus client-centred: Which approach should be used? *Canadian Journal of Occupational Therapy* 69(3): 135–142.

Frankel, R.M. 2004. Relationship-centered care and the patient–physician relationship. *Journal of General Internal Mediciine* 19(11): 1163–1165.

Henbest, R.J., and M.A. Stewart. 1989. Patient-centredness in the consultation. 1: A method for measurement. *Family Practice* 6(4): 249–253.

Heritage, J., and D.W. Maynard. 2006. Problems and prospects in the study of physician–patient interaction: 30 years of research. *Annual Review of Sociology* 32: 351–374.

Hibbert, D., B. Hanratty, C. May, F. Mair, and A. Litva. 2003. Negotiating palliative care expertise in the medical world. *Social Science and Medicine* 57(2): 277–288.

Holman, H.R. 2006. Chronic illness and the healthcare crisis. *Chronic Illness* 1(4): 265–274.

Hostler, S.L. 1991. Family-centered care. *Pediatric Clinics of North America* 38(6): 1545–1560.

Hughes, J.C. 2001. Views of the person with dementia. *Journal of Medical Ethics* 27(2): 86–91.

Hutchfield, K. 1999. Family-centred care: A concept analysis. *Journal of Advanced Nursing* 29(5): 1178–1187.

King, G., M. Kertoy, S. King, M. Law, P. Rosenbaum, and P. Hurley. 2003. A measure of parents and service providers beliefs about participation in family-centered services. *Children Health Care* 32(3): 191–214.

Kitwood, T. 1993. Towards a theory of dementia care: The interpersonal process. *Ageing and Society* 13: 51–67.

Kitwood, T. 1997. *Dementia reconsidered: The person comes first*. Buckingham: Open University Press.

Kitwood, T., and K. Bredin. 1992. Towards a theory of dementia care: Personhood and well-being. *Ageing and Society* 12: 269–287.

Law, M., S. Baptiste, and J. Mills. 1995. Client-centred practice: What does it mean and does it make a difference? *Canadian Journal of Occupational Therapy* 62(5): 250–257.

Lewin, S.A., Z.C. Skea, V. Entwistle, M. Zwaeenstein, and J. Dick. 2001. Interventions for providers to promote a patient-centred approach in clinical consultations (Review): Cochrane database of systematic reviews. Issue 4 Art. No. CD003267. doi: 10.1002/14651858.CD003267.

Madigan, M.M. 2001. Relationship-centered care: What do the Fetzer institute and physician well-being have to do with it? Michigan Medicine (May/June): 36–38.

Malusky, S.K. 2005. A concept analysis of family-centered care in the NICU. *Neonatal Network* 24(6): 25–32.

May, C. 1992. Individual care? *Power and Subjectivity in Therapeutic Relationships, Sociology* 26(2): 589–602.

May, C. 2005. Chronic illness and intractability: Professional–Patient interactions in primary care. *Chronic Illness* 1(1): 15–20.

May, C. 2007. The clinical encounter and the problem of context. *Sociology* 41(1): 29–45.

McCormack, B. 2004. Person-centredness in gerontological nursing: An overview of the literature. *Journal of Clinical Nursing* 13(3a): 31–38.

Mead, N., and P. Bower. 2000a. Measuring patient-centredness: A comparison of three observation-based instruments. *Patient Education and Counseling* 39(1): 71–80.

Mead, N., and P. Bower. 2000b. Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science and Medicine* 51(7): 1087–1110.

Mead, N., and P. Bower. 2002. Patient-centred consultations and outcomes in primary care: A review of the literature. *Patient Education and Counseling* 48(1): 51–61.

Mead, N., P. Bower, and M. Hann. 2002. The impact of general practitioners' patient-centredness on patients' post-consultation satisfaction and enablement. *Social Science and Medicine* 55(2): 283–299.

Michie, S., J. Miles, and J. Weinman. 2003. Patient-centredness in chronic illness: What it is and does it matter? *Patient Education and Counseling* 51(3): 197–206.

Morris, D.B. 1998. *Illness and culture in the postmodern age*. Berkeley: University of California Press.

Nethercott, S. 1993. A concept for all the family. Family-centred care: A concept analysis. *Professional Nurse* 8(12): 794–797.

Nolan, M., J. Keady, and B. Aveyard. 2001. Relationship-centred care is the next logical step. *British Journal of Nursing* 10(12): 757.

Nolan, M.R., S. Davies, J. Brown, J. Keady, and J. Nolan. 2004. Beyond person-centred care: A new vision for gerontological nursing. *Journal of Clinical Nursing* 13(3a): 45–53.

Oeseburg, B., and T.A. Abma. 2006. Care as a mutual endeavour: Experiences of a multiple sclerosis patient and her healthcare professionals. *Medicine, Health Care and Philosophy* 9: 349–357.

Patterson, C.H. 1990. On being client-centered. *Person-Centered Review* 5(4): 425–432.

Regan, K.M., C. Curtin, and L. Vorderer. 2006. Paradigm shifts in inpatient psychiatric care of children: Approaching child- and family-centered care. *Journal of Child and Adolescent Psychiatric Nursing* 19(1): 29–40.

Rogers, C.R. 1951. *Client-centred therapy*. Boston: Houghton Mifflin.

Rogers, C.R. 1961. *On becoming a person*. London: Constable.

Rosenbaum, P., S. King, M. Law, G. King, and J. Evans. 1998. Family-centred service: A conceptual framework and research review. *Physical & Occupational Therapy in Pediatrics* 18(1): 1–20.

Roter, D.L., and J.A. Hall. 1989. Studies of doctor–patient interaction. *Annual Review of Public Health* 10: 163–180.

Sabat, S.R. 2006. Mind, meaning, and personhood in dementia: The effects of positioning. In *Dementia: Mind, meaning, and the person*, eds. J.C. Hughes, S.J. Louw, and S.R. Sabat, 287–302. Oxford: Oxford University Press.

Scadding, J.G. 1996. Essentialism and nominalism in medicine: Logic of diagnosis in disease terminology. *Lancet* 348(9027): 594–596.

Shields, L., J. Pratt, and J. Hunter. 2006. Family centred care: A review of qualitative studies. *Journal of Clinical Nursing* 15: 1317–1323.

Siebes, R.C., M. Ketelaar, L. Wijnroks, P.E. van Schie, B.J. Nijhuis, A. Vermeer, and J.W. Gorter. 2006. Family-centred services in the Netherlands: Validating a self-report measure for paediatric service providers. *Clinical Rehabilitation* 20(6): 502–512.

Siebes, R.C., L. Wijnroks, M. Ketelaar, P.E. van Schie, A. Vermeer, and J.W. Gorter. 2007. Validation of the Dutch Giving Youth a Voice Questionnaire (GYV-20): A measure of the client-centredness of rehabilitation services from an adolescent perspective. *Disability and Rehabilitation* 29(5): 373–380.

Strauss, A. 1968. *Anguish: The case history of a dying trajectory*. San Francisco: The Sociology Press.

Strauss, A., S. Fagerhough, B. Suczek, and C. Wiener. 1997. *Social organization of medical work*. London: Transaction.

Suchman, A.L. 2006. A new theoretical foundation for relationship-centered care: Complex responsive processes of relating. *Journal of General Internal Medicine* 21(Supplement 1): S40–S44

Sumsion, T., and M. Law. 2006. A review of evidence on the conceptual elements informing client-centred practice. *Canadian Journal of Occupational Therapy* 73(3): 153–162.

Tresolini, C.P., and the Pew-Fetzer Task Force. 1994. *Health professions education and relationship-centered care*. San Francisco, CA: Pew Health Professions Commission.

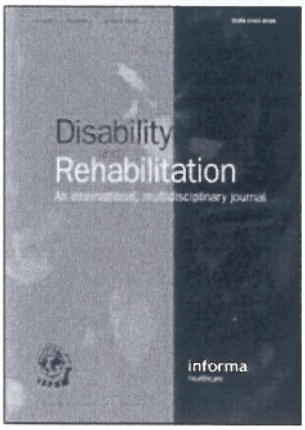
Williams, B., and G. Grant. 1998. Defining people-centredness: Making the implicit explicit. *Health and Social Care in the Community* 6(2): 84–94.

Winefield, H., T. Murrell, J. Clifford, and E. Farmer. 1996. The search for reliable and valid measures of patient-centredness. *Psychology and Health* 11(6): 811–824.

Wittgenstein, L. 1968. *Philosophical investigations*, 3rd edn. Oxford: Blackwell.

Wittgenstein, L. 1979. On certainty. In eds. G.E.M. Anscombe and G.H. von Wright (trans: Paul, D. and G.E.M. Anscombe). Oxford: Blackwell.

Wylie, J.L., and E. Wagenfeld-Heintz. 2004. Development of relationship-centered care. *Journal for Healthcare Quality* 26(1): 14–21 and 45.



Disability & Rehabilitation
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713723807

Health behavior change models and theories: contributions to rehabilitation

Els R. Nieuwenhuijsen [a]; Eric Zemper [b]; Kathleen R. Miner [c]; Marcy Epstein [c]
[a] Department of Physical Medicine and Rehabilitation, University of Michigan Health System, Ann Arbor, MI
[b] Applied Public Health, Emory University, Atlanta, GA
[c] Department of Physical Medicine and Rehabilitation, University of Michigan Health System, Ann Arbor, MI, USA

Online Publication Date: 01 March 2006
To cite this Article: Nieuwenhuijsen, Els R., Zemper, Eric, Miner, Kathleen R. and Epstein, Marcy (2006) 'Health behavior change models and theories: contributions to rehabilitation', Disability & Rehabilitation, 28:5, 245 - 256
To link to this article: DOI: 10.1080/09638280500197743
URL: http://dx.doi.org/10.1080/09638280500197743