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FROM HUMAN SCIENCE TO MEDICINE

Defining and disambiguating patient-centredness

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Introduction

Today, we are coming to recognise that patient-centredness is fundamental to the nature of medicine. It was integral to medical practice prior to the scientific era, but its loss began in the move towards technical practice that started in the 17th century and the professionalisation of the social roles of physician and surgeon in the 18th century onwards. A century later, its loss became evident and it began to emerge again (Putnam, 1899), boosted by the development of nursing but struggling to cope with reductionist approaches in science and the rapid development of technology. In the latter half of the 20th century, with an expansion of identity-politics, patient-centredness was rediscovered as an equally essential aspect of medicine rather than as an alternative to quasi-scientific medical practice. What is patient-centredness, what is it not, and what is its potential? Our conclusions in this paper are based on a critical review of much of the literature on patient-centredness, of which the appended Bibliography forms a small sample with some key references.

Reviewing these sources, it becomes clear that the literature on patient-centredness itself rarely uses a patient-centred perspective and that, in practice, patient-centredness continues to be defined largely in physicians' terms and framed by the characteristics of national, professional, or financial systems: for example, the (American) Institute of Medicine's 2001 report is a review limited to commercial approaches within a physician-centred model of medicine. Similar problems are evident with reports from the UK's King's Fund (Goodrich and Cornwell, 1998). Such approaches presuppose that the definition of patient-centredness changes according to the system in which it is expressed. This is itself a key problem, as the system defines and interprets patients' needs according to the systems' own needs first. It is only within the past few years that patient-centredness has started to be defined purely in terms of the patient's needs and from the patient's perspective, independent of any given system and unfiltered by any profession. This is the approach that we take in this discussion-paper.

At the Tuke Institute, we believe that the needs of all of us as patients must be the starting point of any definition and interpretation of what patient-centredness is, regardless of the expression it may find in any given system. It is on this basis that we have developed and disambiguated the concept as follows and we believe that—in the best tradition of scientific knowledge—the necessary methods of operationalisation of those principles should emerge from the principles themselves.

What patient-centredness is not¹

Before specifying what patient-centredness is, it is useful to identify its boundaries by saying what it is not. In this section, we distinguish it from many of the things it has been conflated or confused with and from the extraneous purposes to which it has been put over recent decades. All the examples below have occurred in one or more of the authors' direct experience as patients and/or professionals.

Firstly, patient-centredness is not the same as physician-centred medicine, which is its polar opposite and the model that underlies current systems of Western medicine. This latter model is still sometimes called the "medical model", although, from a patient-centred perspective, that label is incorrect because it presupposes that medicine is defined by what physicians do rather than what patients need. The two models are distinct: not only is what physicians do often more than they are competent to do—which is diagnostic biology, pharmacotherapy, and surgery—but it is also less than patients need to get well and stay well. To claim that physician-profession alone is entitled to define medicine means that it is physicians alone who are entitled (and competent) to define what patients need to get well and stay well.

In physician-centred medicine, medications and surgery are the only interventions that are considered 'treatments', which are applied in a standardised fashion to standardised diagnoses: true to the theory of logical positivism, ideally, one pill fits all instances of a given, objectively identified disease, and true also to the theory of reductionism—itsself obsolete since the 1950s—all illness can be explained by the physical disease, regardless of who has the disease and in what social context. In patient-centredness, as in reality, 'illness' can not be reduced to biomarkers of disease, such as viral load or blood-sugar levels, nor is 'health' simply the absence of those biomarkers. Chronic illnesses are not reducible to the biological disease and they are not treated the same way as acute conditions, if repeatedly. Mental, behavioural, and social issues are not seen as irrelevant or trivial to the onset, duration, or resolution of illness, nor are they discarded in assessment and treatment-planning. Similarly, while public health is distinct, it is not separated from medicine, just as community-based health-services are not separated from clinical health-services.

In the physician-centred model, treatment for HIV in a 55 year-old man with drug-dependence and severe social marginalisation who is sexually active on the commercial gay scene is the same as it is in a 20-year old immigrant, African woman with genital mutilation, infected

¹ It should be noted that all the problems of physician-centred medicine exist in other professions' approaches to health-service; thus, it is not a problem of the physician-profession *per se* but of professional power. We study the physician-centred model as it is dominant and pervasive.

with HIV by her first, deceased husband to whose brother she was then forcibly married. Both receive the same anti-HIV medication and are expected to become 'well' with it, since their illness is defined by HIV. Yet, scientific research has confirmed repeatedly that we are not as simple as this: patients' needs are far more complex—human—than what clinical biology can address. This is especially true in chronic conditions, which are obviously biopsychosocial, not just biological, and which typically require more from the patient than from the physician to resolve. It is this disjunction between physician-centred medicine and patients' needs that is arguably the prime cause of the social and financial failure of health-services world-wide, with spiralling financial and social costs and dwindling health-effectiveness in the face of chronic conditions. The physician-centred definition of 'medicine' persists for social reasons alone. For the 21st century, patient-centredness construes 'medicine' differently, with the intention of an alternative vision.

Similarly, in patient-centredness, services are not designed firstly around physician's specialties, with the consequence of today's hierarchical and balkanised services. 'Treatment' is not defined in terms of physician-controlled services or products such as pharmaceuticals, where other interventions are merely 'supportive' of patients or physicians' treatments regardless of their relative efficacy in creating good health-outcomes. Treatment is also not more significant than prevention or health-management, and is not distinct from rehabilitation; diagnosis is not a substitute for case-formulation, and length of life is not more inherently important than health—which is itself sometimes conflated with its distinct consequent, "quality of life". Through a lack of relevant critical education in the social and behavioural sciences in relation to medicine, not enough clinicians or commissioners understand these differences or translate them into service-design, yet they are crucial.

Patient-centredness is also not about encouraging amateurism and other unethical practices by, for example, permitting physicians (for example) to give opinions in areas where, as such, they hold no relevant qualifications—such as in mental, behavioural, or social aspects of a patient's illness, or in nursing, behavioural medicine (Henderson and Baum, 2001), social medicine, medical science, public health, or medical policy. It is also not about creating an unreal distinction between medical services and 'health-services', or between "medical" and "allied health" professions. Given that healing and health require more than what physicians alone are competent to provide, physicians are also not considered inherently to be the best qualified, most competent, most important, central, or necessary to the delivery of medical services. Nor are the other medical professions 'ancillary' (lit. "servant-girls"), where only the physician is a 'doctor'—even when holding only an undergraduate degree, as in the UK—while the typically female nurses, psychologists, and clinical social workers can be referred to routinely as 'the girls', even when holding doctorates. Patient-centredness is also not about the problems consequent to this model,

such as an inability on the part of many physicians to collaborate in multiprofessional teams as equals, with their needing typically to be the lead or refusing to engage when they are not. Patient-centredness is equally not about involving clinicians of any sort as “stakeholders” or privileging their opinions for political purposes related to social status rather than competence.

Patient-centredness is also not about maintaining the paternalism and sexism of the physician-centred model and a dehumanising bureaucracy of managed “care” that maintains this model while mimicking the wider social conditions that lead to ill-health and prevents the patient from assuming authorship of his or her own health-narrative. It is, therefore, not about physicians’ beliefs having primacy over patients’ beliefs, nor the physician being the authority on the individual patient’s illness—including the moral authority. Patients with behavioural factors contributing to illness are not stigmatised as ‘bad’—e.g., sexual infections, smoking-related lung-disease, eating-related obesity and diabetes, drug-use, teenage pregnancy—nor are they stigmatised as ‘difficult’ if they are assertive or autonomous, if they are passive yet ‘fail to get well’, if they are non-adherent to prescribed treatments, or if their expectations can not be ‘managed’ (i.e., reduced); nor are they stigmatised as ‘malingerers’ or dismissed as psychiatric ‘cases’ if no physical basis to their illness can be identified, nor is their condition considered non-‘medical’ if it is primarily mental and they are “just worried well” (even when self-harming, for example). It is not about distrusting patients’ opinions and disbelieving patients on principle, nor is it about expecting patients to show gratitude for services they have paid for.

Patient-centredness is also not about teaching physicians manners and better communication-skills so that they can seem nicer to patients, nor is it about maintaining the physician-centred model by adding a “patient-centred” veneer. Not least for reasons of scientific validity and good psychometrics, it is also not about creating good “patient-experience” or maximising “patient-satisfaction”, since neither determines nor measures services’ health-effectiveness.

Patient-centredness is not about interpreting ‘professionalism’ in terms of the autonomy, monopoly, and non-accountability of the profession, rather than in terms of health-effectiveness of practice, nor is it about perpetuating systems of professional training, apprenticeships, qualifications, titles, trade-practices, or status—and thus political power—by appealing to tradition rather than evidential reason. It is also not about allowing the medical professions alone to define quality and standards in terms of any one profession’s practices regardless of the health-consequences for the patient—where a physician can say in all seriousness that “the surgery was successful but the patient died”. It is also therefore not about allowing the medical professions to define malpractice according to their solipsistic professional values and standards, nor calling malpractice ‘negligence’ because it is less unpalatable to the professions. It is not about defining

services from the perspective of the provider or in the providers' interests, nor about rationalising those choices by saying "that's the way the system is" and therefore has to be (while avoiding thereby the issue of how the physician-centred system came to be in the first place). In patient-centredness, there is no excuse for unethical service and each clinician's duty is not obviated—nor is an abuse of privilege rationalised—by consequentialist or pseudo-utilitarian ethics.

Equally, patient-centredness is not about managerial ideologies or technocracy, replacing clinical expertise with content-free managerialism, subsuming patients' needs to managers' needs (cf. the "Francis Inquiry": Francis, 2013). It is not about designing services according to managerial principles first or about measuring services' effectiveness by their outputs, rather than outcomes, and by services' short-term financial costs alone. It is not about managerialism that doesn't know differently than to pay for the most—and unduly—expensive clinician (i.e., physicians) because they are considered to be indispensable, regardless of relative health-effectiveness. Nor is it about finding the least-qualified (and therefore cheapest) clinician to do a job, also regardless of health-effectiveness.

Patient-centredness is not about political ideologies or beliefs such as consumerism, as in promoting patient-preferences, or business-ideologies such as patient-'leadership' (Dept Health, 2005; Fitzpatrick, 2005). It is not about increasing 'engagement' of the patient as a consumer to increase 'market'-share but therefore, paradoxically, increasing usage of services, which are then designed to address only common needs, for the purposes of cost-efficiency, rather than the diversity of all patients' needs. It is not about using methodologically inappropriate but ideologically consonant business-techniques such as market-research and focus-groups to demonstrate "engagement", or rubber-stamping initiatives through similar commercial and tokenistic practices. It is also not about cherry-picking isolated ideas, such as "patient-choice", in the ill-evidenced belief that they will create systemic change. It is not about protecting a nationalised health-system like the British National Health Service that fails to be adaptive, sustainable, or accountable, or one that can lead again to a Shipman Inquiry, a Bristol Inquiry, an Alder Hey Inquiry, or, indeed, a Francis Inquiry. It is also not about ensuring a system that has to be provided by commercial corporations, to maintain or replicate, for example, the failures of American health-services and America's low standards of public health with its pervasive inequalities and inequities.

Fundamentally, patient-centredness is not about disrespect, be that for patients, for other medical professions, for fields lying outside a manager's or a clinician's competence, for expertise itself, for illness and disease, or for the health-effectiveness of services.

Although this specifies here what patient-centredness is not about, it continues to be misconstrued and misused in these ways, which subverts the meaning of patient-centredness and

injures its potential for creating progress in medical systems in extreme need of change. People with significant experience as patients might recognise many of these characteristics in the current systems of medicine or ‘healthcare’, as identified in both the Bristol and Francis Inquiries by the UK government. It would be difficult for an informed person not to become dispirited at the magnitude and systemic nature of the problems, not least because it is these problems that are the primary obstacles to the creation of patient-centred health-services. Simply put, medicine and health-services are not construed first and foremost in the interests of patients in themselves and as members of society—whereas, in patient-centredness, they are.

Defining patient-centredness and patient-centred services

Patient-centredness is about delivering services and products that help people get well and stay well, about the characteristics of those services and the values that underlie them; these values and characteristics are distinct but inextricable aspects of this model of medicine.

Health-effective

Patient-centredness defines ‘health’ or ‘wellness’ according to the World Health Organization’s definition: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1946). This means that patient-centredness defines ‘medicine’ as a service that helps to remedy illness, and create health, in each person’s body and mind in social context. This entails a comprehensive or ‘biopsychosocial’ approach. In patient-centredness, any and all clinicians who help patients to get well and stay well are in fact practising medicine—be they nurses, psychologists, social workers, physicians, physical therapists, nutritionists, etc.; this obviates the need for two terms—medicine and “healthcare”—for often-identical practices carried out by different professions. The patient-centred definition of medicine moves on from the current, obsolete framework and has fundamental social and legal ramifications for medical training, as well as the definition of medicine and malpractice, in the 21st century.

Since patients use health-services to get well and stay well, patient-centredness is about ‘health-effectiveness’ first and foremost. For services to be health-effective, they must help to create positive and comprehensive health-outcomes in accordance with the WHO’s definition of health, enabling sustainable health by addressing the larger social and mental determinants of illness and recovery as well as the relevant diagnoses and treatments.

Patient-centredness addresses the entire spectrum of health and illness through services that integrate prevention, diagnosis, treatment, and rehabilitation. As part of its comprehensive

approach, patient-centredness looks at patients' internal and external assets that are related to health, such as cognitive capacity and instrumental social support, and engages these resources through the patient to maximise and consolidate health. Compared to the current model of medical services, the delivery of such comprehensive and integrated services requires very different service-designs in order to co-create the outcome of long-term, sustainable health.

Health-efficient

In patient-centred services, efficiency requires that only those components that help to deliver health-effective services are included in the service—and any aspects that impede health-effectiveness are removed. In patient-centredness, health-efficiency is defined as “the most efficient way to create optimal and sustainable health-outcomes”. It is achieved by a variety of means, not necessarily by minimising processes of delivery, and, above all, health-efficient services make the process of getting well and staying well as easy as possible—for patients, not providers. Thereby, it also redefines a health-service as a service while rejecting consumerist and managerial methods unless they can be shown scientifically to increase health-outcomes more than other approaches².

In patient-centredness, ‘costs’ are construed in terms of personal costs and social costs, the latter including but not limited to the financial costs to the service, the payor, and society, which is consistent with the WHO’s definition of health. This requires a more sophisticated method of accounting than the usual today—similar in principle to environmental accounting—and includes the use of total costs in health-economic analyses. Analyses of cost-efficiency are determined firstly by how health-efficient a service is, not whether it is financially cheaper than an alternative service. If services are truly health-services, it is not possible for them to be cost-efficient if they are not firstly health-effective. Thus, providers of commercial services that are geared therefore towards financial profit can not logically or honestly be called providers of health-services but, rather, “medical traders” and ethically, based on their delivery- and accounting-methods, should be prevented from misrepresenting themselves. Today, that would include most American and European health-services.

Efficiency means that access to health-services is as easy as possible and that all removable barriers to health-services are, indeed, removed. Not least, this fulfils the providers’ duty to safeguard the universal human right of access to health-services as defined by the UN General Assembly in 1948 (Whitaker, Westin, & Pitt, 2013). Not only are medical records and informational resources integrated and readily accessible to patients and clinicians, with communication-technologies that are easy to use, but the more important social, geographic, and economic barriers

² We have been unable to find any scientific evidence of patient-choice directly maximising health-outcomes, let alone in a more effective and efficient way than alternative methods.

to access are also removed. Removing such barriers is part of a patient-centred health-service itself, as patient-centredness addresses the contextual factors that affect health, including inequalities and inequities. Similarly, a patient-centred health-service itself is delivered in a context that is healthful and healing.

In patient-centredness, efficiency also means integration. Patients' needs are already integrated within the patient and patient-centred solutions to those needs are therefore also integrated. The removal of barriers to access includes ensuring the maximal co-location of services, both physically and temporally, as referrals between physician-centred services often fail.

For truly acute and isolated, minor illnesses, it is obvious that a minimal level of service-integration is necessary. For major illnesses and especially chronic illnesses—which already form the majority of conditions that health-services address—it is most health-efficient when each patient's health-needs are assessed comprehensively and in an integrated manner, his or her service-needs are formulated at one time, the personalised plan for service-delivery is also formulated at one time and then delivered in an integrated manner through the use of teams, with iterative revisions to the formulations over time. This method also allows clinical health-services to be integrated with community-based health-services with much greater continuity.

For the purposes of efficiency as well as accountability (see below), one clinician is in charge of overseeing assessment, formulation, and colleagues' service-delivery. That same clinician is responsible for assessing service-delivery for effectiveness and efficiency; in line with the requirements of effectiveness as well as ethics around qualified competence (see below), this clinician is a nurse who is senior in competence, as nursing is the only fully biopsychosocial medical profession. This also means that patient-centred services are nurse-led, even though the central member of that team is always the patient—after all, it is the patient who actually does the healing. This means that consumerist and managerial approaches to services, with replaceable clinicians and devalued clinical relationships, are rejected in favour of dedicated, named clinicians with responsibility for ensuring effective and efficient services.

Ethical

For services to be both health-effective and health-efficient, each service is provided by a professional who is fully qualified and competent to provide that service. For example, just as a psychologist should not prescribe or advise the choice of antibiotics for a genital infection, a physician should not provide a behavioural intervention or advice over how that genital infection was contracted and can be prevented in the future. For a professional to act outside his or her area of expertise in such a way is unethical because, for example, a physician's failure to competently assess the behavioural and mental issues that relate to a genital infection has a risk of injury to the

patient, as would a psychologist's failure to competently assess the nature of the genital infection, thereby prescribing an inappropriate antibiotic. Neither of the bodies of expert knowledge underlying these clinical acts is trivial; to act as if they were is disrespectful to the patient as well as of the other profession's earned competence and reflects a neglect of duty of care to the patient driven by over-confidence. Ethical, respectful, health-effective, and health-efficient services require qualified expertise to do a given job.

An example lies in the unnecessarily repeated and increased severity of infections in attendees of sexual-disease clinics. It should not be necessary to treat the sexual acquisition of Hepatitis C for a fourth time in a person of normal cognitive ability, as occurs now with physician-centred medicine. The curing of a sexual infection is not in itself evidence of a health-effective—and therefore ethical—service if it fails to address the behavioural and social issues that underlie the reason why the patient contracted the infection initially. In this instance, that requires qualified competence in behavioural and social medicine. Addressing these wider determinants of illness prevents resolvable conditions from recurring, which prevents both the “revolving-door” problem of sexual-disease clinics and reduces the incidence and severity of chronic conditions. This is in patients' interests as well as health-services' and society's wider interests, which an ethical service must prioritise.

Collaborative

In patient-centredness, a multi-disciplinary team addresses each patient's needs, which lie within a properly constituted team's “circle of competence” and which don't within a physician's alone (cf. ethics, above). In addition to the patient and his or her social network-members, the team can include any therapists necessary, such as nurses, psychologists, physicians, social workers, physiotherapists, occupational therapists, etc. The composition of a team varies with the patient's needs, but the primary clinicians (i.e., the nurse-lead plus the most qualified within each medical domain, such as psychologist, social worker, physician or physiotherapist) remain constant. The team works to find the best ways for the patient to achieve and maintain optimal health, collaborating on delivering the most meaningful and effective prevention, treatment, and maintenance or palliative services for the patient.

Patient-centredness entails treatment of the patient around difficult tasks such as behavioural change and self-management in chronic conditions. Collaboration makes self-management less difficult, more meaningful, and better enabled, which enhances therapeutic alliances within the team and congruence between the goals of the team's members, reducing non-implementation of prescribed treatments by patients. Patients' knowledge and experience is viewed as a potential asset to guiding prevention and treatment (Nesta, 2013; p.5) and feedback is

welcomed as an essential source of information on relevance and efficacy, used to refocus or redesign services.

Collaboration also increases emotional and instrumental support from members of the patient's social network, thereby increasing the effectiveness of interventions as well as enabling collateral interventions such as health-literacy and prevention in the patient's social network. Collaboration is also construed to extend beyond the clinical team to community-based organisations, patient-advocacy groups, and participative governance- and policy-groups (Whitaker, 2010). This approach joins clinical health up with its wider social contexts and determinants, while joining medicine up with public health (Whitaker, Sleiter, Verma, 2013).

Meaningful

For services to be health-effective, they must be personally relevant and meaningful to the individual patient and his/her health-narrative, which enables the services to be tailored to the individual. Defining what 'health' means to an individual patient requires a process of collaborative and mutual education with the team-lead in order to identify a personally relevant set of goals and configure the necessary services. Providing partially relevant services in an 'efficient' manner is not health-effective and therefore neither efficient in actuality nor patient-centred. Similarly, delivering health-effective services in an inefficient manner renders them less health-effective, due, for example, to patients' disengagement from services. The definition and assessment of an individual's health would include a collaborative and continuing discussion of positive concepts within the definition of health that give life meaning, such as happiness, safety, autonomy, and emotional connection, and how those are affected by life-activities. Where clinically appropriate, this can be explored further with the team-psychologist for refining health-goals and adjusting both case-formulation and service-formulation, as well as measuring personalised health-outcomes.

The personalisation of services does not contradict evidence-based practice but goes beyond it to recognise and address the patient's needs as an individual rather than as an embodied exemplar of a disease. Personalisation allows practice-guidelines to be guidelines rather than 'tick-box' requirements for practice and it entails the use of clinicianship rather than just technicianship, which is a problem for many clinicians today. Like factory-farming, factory-medicine based on tick-lists and throughput is health-inefficient and -ineffective, since the quality of the outputs are relatively low and not designed to create sustainable health-outcomes. Patient-centredness understands that population-derived, scientific knowledge requires translation to each individual's unique situation, paralleling the distinction between public health and medicine, and acknowledges with humility that not only do we have insufficient scientific knowledge for purely

evidence-based practice that is constrained by guidelines, but that such a reductive, technocratic approach is counter-productive when working with real, whole people.

Empowering

Creating optimal and sustainable health-outcomes, especially in chronic conditions, depends significantly on what the patient does in his or her daily life. A lack of empowerment in daily life relates directly to illness-promotion and poor resilience to illness through an experienced lack of control and decisional latitude in daily life, and to the onset of chronic illnesses such as coronary heart-disease, the intensity of illness-experiences such as pain, and the risk of mortality. For services to be health-effective, the development of patients' inner resources and empowerment to create meaningful health-outcomes has to be prioritised, starting in the patients' interactions with health-services and leading towards a skilled and responsible self-sufficiency and autonomy in daily life. It has pervasive social effects, such as the reduction of stigmatisation and discrimination, both of which are injurious to health. Empowerment enables patients to provide feedback, to the mutual benefit of the health-service and the patient.

Empowerment is developed through the patient's development of knowledge, through facilitated participation (e.g., in mutual education with clinicians and through negotiated, clinical decision-making, for example), as well as through enabled but autonomous health-behaviours. As the patient's behaviours are essential to health-services' success, empowerment is an outcome mostly of treatments based in behavioural medicine, including but not limited to self-management interventions, but it also requires the synergistic context of a pervasively patient-centred service for it to be effective.

Trustworthy

For services to be health-effective and health-efficient, they must be fundamentally trustworthy. If a patient can trust a health-service and each clinician they encounter in that service, he or she is able to focus on the decisions and actions needed to co-create and maintain health. The evidence of the inadequacy of the physician-centred model has been paralleled by a justified and pervasive loss of trust in clinicians and their services due, not least, to the continued abuse of their assumed authority. Trust entails reliability and integrity, shown by consistency, responsiveness, openness, accountability, honesty or 'transparency', and demonstrated values such as respect, fairness, humility, and scrupulousness. These characteristics are communicated through a level of emotional intelligence and a set of interpersonal skills that demonstrate active listening, empathy, compassion, and caring, leading to a resilient and health-effective rapport. Trust entails holding individual clinicians responsible for their actions and their influence on patient's health-outcomes.

Only through mutual trust can patients and clinicians work collaboratively with the mental, behavioural, and social aspects of illness, healing, and health. Patient-centred medicine can be seen in the operationalisation of values-based services in a fully transparent system that privileges patients' personal well-being above all else.

Creating patient-centred health-services

Creating patient-centred health-services requires understanding how to create a system from which these characteristics naturally emerge, as opposed to veneering physician-centred services with selected aspects, as happens today. A necessary, first step is to use the principles above to create patient-centred standards for health-services, which should also specify how these principles can be operationalised and measured, and how they relate to patient-centred service-designs. These standards should be accompanied by a toolkit and educational programmes for patients, service-commissioners, service-managers, and clinicians.

Given that everything else in patient-centredness follows on from health-effectiveness, an essential clinical step in creating patient-centredness is to measure a person's health as defined by the WHO. Currently, there are thousands of ways of measuring various aspects of disease and of health, but there is no single clinical tool to scope or measure an individual's comprehensive health, despite the WHO's established taxonomy called the International Classification of Functioning, Disability, and Health (World Health Organization, 2002). Such a scoping-tool could be elaborated by more specific clinimetrics, translated by methods for patient-centred case-formulation and service-formulation, as well as be used for audit by the personalised benchmarking of health-outcomes.

To create fully patient-centred health-services, it is also necessary to assess the variety of methods of patient-participation, including those of monitory democracy and participative audit that ensure that health-effectiveness is kept as the primary goal of any health-service. This would help to identify the relative health-effectiveness of the methods of participation, while disambiguating effective methods from the ineffective, including concepts such as "involvement" and "engagement". For instance, having picnics for children with haemophilia was used in audit by one major London health-service as a demonstration of patient-involvement, yet it has no value in terms of health-effectiveness since patients are not actually participating in their health-services or in significant health-behaviours. For non-specialists, including most clinicians and commissioners, the concepts of patient-participation and empowerment are often as difficult to grasp as that of the larger concept of patient-centredness. An analysis of methods of patient-

participation, in conjunction with the patient-centred standards, should describe how and why such methods could be implemented, and it should also lead to a toolkit and educational programmes for patients, service-commissioners, service-managers, and clinicians.

Identifying those providers whose focus is no longer primarily on health-outcomes makes it possible to maintain services' health-effectiveness but it requires methods of generating patient-based evidence with which to review the health-effectiveness of services in a manner that shows transparency and enables accountability (Whitaker, 2010). It is necessary to create methods for assessing health-services against an Index of Health-Services' Effectiveness (e.g., www.tukeinstitute.org/ihse) in order to promote and protect the quality of services, which can be folded into other methods promoting patient-empowerment as well as health-literacy.

A related issue of concern to services addressing chronic conditions is that of the rights and responsibilities of patients in their health-services and health-behaviours. The circumstances in which patients have rights and responsibilities remain to be explored and rationalised in terms of ethics and health-effectiveness, as these are central to enabling patient-centred services. What is required of health-services to protect patients' civic and human rights and to empower their responsibilities (Whitaker, Westin, Pitt, 2013)? What is required of patients to safeguard their rights and be responsible to themselves and others, and when? Clarity of principles and operationalisation are needed, as with patient-centredness, supported by toolkits and educational programmes for patients, service-commissioners, service-managers, and clinicians.

Conclusion

It is claimed and assumed that all health-services aim to be patient-centred and that they consider the patient's needs to be the driver of services. This is not true, for, if it were, the social movement towards patient-centred services would not be seen to be as radical or disruptive as they are and there would not be the concerted effort there is to co-opt the concept of patient-centredness for use by the existing, physician-centred system, not least by efforts to coat the latter with a tangibly increased sense of concern for patients. One does not need to read critical social theory or systems' theory to know that such co-optation is to be expected, as it invalidates patient-centredness and can be used to show that it holds nothing new or helpful in addressing what ails the current system of health-services, while maintaining the current system. Yet, ironically, it is true that patient-centredness holds little that is new, but most of it has been forgotten and it can also now be construed more specifically than ever before. Patient-centredness is a radical old idea.

We know now that patient-centredness does not happen if individual aspects of it are extracted and applied as a veneer over the current system. This raises the question of what is necessary and what is sufficient to create a patient-centred system of health-services. We have identified above the characteristics that are necessary, given the overarching purpose of creating the optimal health-outcomes for the patient—as opposed to treating disease, maintaining professional dominance, or achieving financial cost-offsets. These necessary characteristics, well operationalised, are also likely to be sufficient to create patient-centred health-services and therefore services that are demonstrably health-effective, health-efficient, and sustainable. Patient-centredness privileges patients' health, considering everything else as secondary—including the imperishable self-regard and the ideologies of providers—and it re-envisages health-services from the patient forward. After all, it is, as patients, our lives and our health.

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