Philosophy of Care
Person-Centered Care: An Overview

A paradigm shift is occurring in healthcare and long-term services and supports movement away from a clinician-disease ethos to a person-centered one. In 2001, the Institute on Medicine (IOM) issued a seminal report, *Crossing the Quality Chasm*, in which healthcare in the United States was described as impersonal and fragmented. The report called for a healthcare redesign shifting away from the traditional medical-disease model of care to a patient-centered one. However, healthcare is only one aspect of well-being since humans are *bio-psycho-social-spiritual* beings. To achieve optimal health and well-being, care needs to address this holistic condition. Since the term ‘patient-centered’ speaks only to the medical/clinical dimension, the term ‘person-centered’ has evolved to better describe and encompass the holistic nature of health and well-being. Person-centered care has become accepted as the gold standard.

Person-centered values and practices emerged from humanistic psychology and the influential work of Carl Rogers and Abraham Maslow. Person-centeredness refocuses care to the choices, goals for care, and preferences of the “person” rather than on efficiencies of the provider of services or supports. Care emphasizes and recognizes each person’s self-determination, choices, worth, and unique set of values, views, histories and interests (Koren, 2010; Doty, 2008; McCormack, 2004). Fully employed, person-centered care is a life-affirming, satisfying, humane, and meaningful experience.

**Nursing Home Residents Who Have Dementia**

Nursing home residents who have dementia are one of the most vulnerable populations—as their cognitive condition diminishes, their ability to communicate and to assert clearly their own choices, preferences, and needs diminishes, too. Ninety percent of people who have dementia experience some form of behavioral disturbance such as agitation, restlessness, and anxiety during the course of the illness (Corbett, 2012); we refer to these behaviors as Behavioral and Psychological Symptoms of Dementia (BPSD). A medical model of care supports responding to these behaviors by using antipsychotic medications which further diminishes the person’s life-affirming experience. A person-centered model of care identifies the root causes of the behavior expression. For example, BPSD may stem from the person becoming overstimulated, environmental factors such as noise and not recognizing where they are, a need to rest, and pain, among other causes. People trained in person-centered care recognize that behaviors expressed by people who have dementia often communicate unmet needs. Psychosocial-related factors such as noise disturbance and feeling lost are not resolved by medications; the medication only serves to quiet the person, which is neither humane nor satisfying.

Someone whose dementia has progressed to the stage where they cannot communicate their needs is unable to provide articulated insights about the experience of person-centered care. The following quote from someone with a mental health disorder makes the critical point, however: “Nothing they did cost extra money or required intensive training, but the fact that they saw me as a person—and treated me like one—helped transform my life” (Clayton, 2013). Person-centered care affirms life and meaning.
References


