Commentary

The relevance of positive approaches to health for patient-centered care medicine

Mathieu Roy, Mélanie Levasseur, Yves Couturier, Bengt Lindström, Mélissa Généreux

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Although references to PCCM can be found as far as in Antiquity (i.e. ancient Greece), its implementation, its use, and its widespread teaching in medicine curriculum is relatively new. PCCM is defined as “any form of care responding to individual preferences and needs ensuring that clinical decisions incorporate patients’ values” (Institute of Medicine, 2001). It expands the biomedical disease-oriented model to integrate patients’ subjective experience of disease (i.e. the illness), the psychosocial context in which it happens, and shared decision-making between patients and health professionals (Stewart et al., 1995). This expansion in models of care introduces a comprehensive approach to investigate disease through patients’ psychological, social, and environmental reality. As evidenced by major health conceptual frameworks worldwide (e.g. World Health Organization (WHO; Fig. 1), Institute of Medicine, National Health Services), a biopsychosocial approach of health is now well-spread. Within PCCM, doctors, and other health professionals 1) address patients’ ideas and emotions regarding their experience of disease, and 2) find a common ground with them about treatment and the roles that both will have to assume to recover health (Stewart et al., 1995). The huge step forward with PCCM as a model of care is the acknowledgement that recovering health not only depends on accurate diagnoses but also, and more importantly, on including the patient as an active participant in health fulfillment.

The benefits of PCCM

PCCM has many benefits for patients, health professionals, and healthcare systems. For patients, this model of care respects their needs, preferences, values, and beliefs. Patients become fellow human beings rather than medical cases characterized by a constellation of traditional information including medical history, symptoms, and clinical signs. When patients perceive that they are considered as unique, they concurrently experience better physical and mental health outcomes (Meterko et al., 2010). For many health professionals, the main advantage of PCCM is the creation of a space in which they can develop a partnership with their patients (Beach and Inui, 2006). This partnership usually leads to open communication, trust, and decision-sharing on what is best for both of them (Meterko et al., 2010). PCCM
The limitations of PCCM

Despite these benefits, PCCM also has limitations. These are mainly related to contextual reasons, patients’ health literacy, and to emphasis placed on disease rather than health. As interactions between health professionals and patients become increasingly placed on disease rather than health, there is an ever-evolving body of medical evidences that many patients do not know what to ask to their health professionals (or even how to ask it). Other patients find it difficult to discern important from irrelevant issues. Patients can also fill their mind with inappropriate information. These limitations related to patients’ health literacy tend to be more commonplace among vulnerable groups (Vaughan, 2009), and this has the potential to widen health inequalities. Additionally, PCCM emphasizes disease rather than health. Although patients generally consult health professionals for diseases (or unhealthy states), these appointments must also serve to discuss the state of their health and to empower them in various ways to improve their overall well-being. A growing number of health professionals provide clinical preventive medical practices such as immunization, counseling, and/or screening tests. Nevertheless, these practices are directed toward disease prevention rather than health promotion. Consequently, PCCM as a model of care is still embedded within a disease paradigm.

How PCCM can address its limitations using positive approaches to health

With global aging, the burden of ill-health places an unsustainable strain on healthcare systems and innovation becomes imperative. In addition to interventions aiming to create supportive environments, healthy public policies, and/or tackling inequalities, an effective and constant health-promoting partnership between patients and their health professionals should be developed and maintained. Future medical practices, health curriculums, and health services must evolve toward the production of health and well-being while preserving their current roles in treating and preventing diseases. To move toward this model of care, positive approaches to health must be introduced into the offices of health professionals and be grafted within the actual PCCM model of care.

Positive approaches to health focus on why some people thrive or get healthy as opposed to studying why other gets sick (Lindstrom and Eriksson, 2010). One example of a well-known positive approach to health is the identification of strategies that increase patients’ resilience. This positive approach to health has been applied in many clinical settings and populations. There are however plenty of other positive approaches to health such quality of life, cultural and social capital, social participation, auto-efficacy, connectedness, hardness, and flourishing (Lindstrom and Eriksson, 2010). Each of these approach uses different concepts and measures to operationalize their own theory, but in the end they all aim for the same outcome that is, an increased state of perceived well-being (Lindstrom and Eriksson, 2010). Positive approaches to health are well-suited to address the limitations of the PCCM model of care, particularly those related to patient health literacy and to the emphasis placed on disease rather than health. We think that introducing positive approaches to health within the actual PCCM model of care will not only serve to create health but also, to strengthen the effectiveness of health professionals’ clinical practice (Lindstrom and Eriksson, 2010).

Positive approaches to health may be regrouped under one single encompassing perspective named salutogenic perspective (Lindstrom and Eriksson, 2010). This perspective has slowly but surely taken root in the field of public health over the past decades. It was found to be particularly relevant to operationalize the speech, values, and principles contained in the Ottawa Charter for Health Promotion (World Health Organization, 1986). Introducing a salutogenic perspective into the offices of health professionals go further than actual clinical preventive medicine practices.

Using a salutogenic perspective within the actual PCCM model of care to activate major health conceptual frameworks worldwide

The term salutogenesis means “origin of health” (Lindstrom and Eriksson, 2010). It was created in opposition to pathogenesis (i.e. origin of disease) in the late 70s by Aaron Antonovsky, an Israeli sociologist.
Determinants of Health

By introducing such perspective into health professional care will indeed favor a shift in the entire distribution toward better determinants of inequalities. This serves individuals, institutions, and societies both the social determinants of health, and the structural determinants of inequalities. It may even become a key factor in the production of health. The introduction of a salutogenic dialogue between the patient and its health professional was first discussed in 2000 by Hollnagel and Malterud (Hollnagel and Malterud, 2000). These authors stated that the biomedical model of healthcare largely underestimates healing and prevention resources that patients have in their possession. Using patients’ perspective, we have access to various generalized resistance resources (i.e. motivation, meaningfulness of life, wishes, hopes, and understanding of disease).

Conclusion

PCCM has both benefits and limitations. The benefits of this model are essential for optimal medical practices. However, its limitations are also significant. In this context, we propose some elements to overcome these limitations. We believe that PCCM can take advantage of positive approaches to health (under a salutogenic perspective) to move towards a complementary vision of healthcare that emphasizes health rather than disease. Such evolution will activate major health conceptual frameworks worldwide, and will increase both efficiency and effectiveness of the actual PCCM model of care. It will further help health professionals’ to become, in addition to expertise in diseases and limitations, health promoters. Although this shift represents a huge challenge and that reality is complex and involves pragmatic and financial impediments, it is important to develop such complementary vision of healthcare within the actual PCCM model of care. As the medical field is currently addressing notions such as personalization of healthcare, the contributions of the salutogenic perspective should also be discussed.

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Conflict of interest

The authors declare there is no conflict of interest.

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