Philosophical knowledge is warranted for the successful implementation of person-centred care

Maria Andersson

Abstract
One potentially restrictive environment of person-centred care might be the intensive care unit (ICU) where RNs working in ICUs on a daily basis are caring for critically ill patients in a highly technological and stressful milieu. Nursing care for critically ill patients at the ICU is described as task-oriented and mainly based on the patient’s medical needs. The purpose of this contemporary issue paper is to suggest that a photograph of the patient could be used as a tool to support RNs working in ICU in applying person-centred care and their understanding of the philosophical underpinnings for person-centred care. I additionally propose that philosophical understanding and knowledge among RNs working in ICU are an essential part of clinical practice if person-centred care implementations are to be sustainable.

Keywords
advanced nursing practice, intensive care, professional development, person-centred care, quality of care

Accepted: 12 January 2021

Introduction
The care environment has the potential to support or to restrict registered nurses’ (RNs) possibilities to act in a person-centred manner and successfully provide nursing care according to person-centred care (PCC) models. One potentially restrictive environment of nursing care might be the intensive care unit (ICU) where RNs working in ICUs (ICU nurses) on a daily basis are caring for critically ill patients in a highly technological and stressful milieu. The purpose of this contemporary issue paper is to suggest that a photograph of the patient could be used as a tool to support ICU nurses in applying PCC and their understanding of the philosophical underpinnings for PCC. I additionally propose that philosophical understanding and knowledge among ICU nurses are an essential part of clinical practice if PCC implementations are to be sustainable.

Person-centred care
First, it is important to address the concept of PCC. Person-centred care is defined as an approach to practice that is established through the formation and fostering of therapeutic relationships among all health professionals, patients and relatives. However, a review of the literature revealed that a universal definition of PCC was missing, although there were similarities among the components that encompass PCC, such as establishing a therapeutic relationship, shared power and responsibility, getting to know the person, empowering the person, and promoting trust and respect and communication. Person-centred care highlights the importance of knowing the person behind the patient and is described by the World Health Organization as a key attribute of the quality of care.

Sometimes the terms PCC and patient-centred care are used interchangeably. Håkansson Eklund and colleagues concluded in their systematic literature review that the difference between PCC and patient-centred care lay in the goals. The goal of PCC was a meaningful life whilst the goal of patient-centred care was a functional life. Others stated that the difference lies in that patient-centred care departs from a purely biomedical perspective, whereas PCC departs from a humanistic and holistic perspective.

Person-centred care has been described as bringing the person back into care and has become a key of quality of care in many developed countries and is explicitly referenced in healthcare polices. Organizations and healthcare systems worldwide are currently implementing PCC models as a means to improve their health systems performance. In Sweden, PCC is proposed to be one of six standards of nursing care. The foregoing is all very well but, though it...
is a strongly promoted concept, it still lacks a variety of frameworks for PCC available with practical guidance on how to successfully implement PCC. The implementation of PCC might also be additionally challenging in highly technological environments such as ICUs.

**PCC in the environment of the intensive care unit**

Nursing care for critically ill patients at the ICU is described as task-oriented and mainly based on the patient’s medical needs. This is not strange as the primary goal of intensive care is to prevent further physiological deterioration while the underlying diseases or injuries are treated and resolved in one or more organ systems. For the ICU patient, life has changed dramatically and participation in their own care might be challenging because of their health conditions. However, patients in the ICU desire to participate in communication and in their own care as soon they perceive that they can. Even if ICU nurses want to attend to patients at a personal level, the highly technological environment in ICUs might outmanoeuvre the patient. In a recent systematic literature review, including a synthesis of qualitative studies, the findings implied that ICU nurses experienced that technology sometimes appeared to be more important than the patient. In the highly technological environment of ICUs, the notion of PCC might be especially challenging.

It takes time to integrate models of PCC into clinical practice. I would like to put forward that it is counterproductive in healthcare services to practise PCC in an easy-to-use way with little knowledge of the philosophy behind the concept. There is always a risk that implemented PCC models will have minor or no impact on clinical practice if the healthcare professionals have a limited understanding of the philosophical ideas underlying those models. Unfortunately, few discussions about philosophy and PCC are clearly located within a particular philosophical theory. This might have implications for how ICU nurses are expected to respond to an ethical demand and for providing nursing care that is person-centred. I would like to propose that for a successful and sustainable implementation of PCC models in ICUs, there is a need to understand the philosophical underpinnings of PCC.

**Proposed philosophical underpinnings of PCC**

To understand PCC and implement this approach within the ICU, it needs to be considered from a philosophical perspective that lies in the healthcare principle of recognizing self-fragility and coherence in life. In this paper, I will discuss PCC starting out from philosopher Paul Ricoeur’s ‘the striving of the good life, with and for others in justice institutions’. In my understanding, it means a personal way of approaching, connecting with patients and families that builds on social and interpersonal skills as well as professional skills. This approach is hereinafter referred to as person-centredness, a term which can be conceptualized as denoting an ethical, humanistic and holistic perspective on nursing care. Person-centredness builds on a fundamental respect of subjectivity, agency, capability and personhood. From here on, and by using own research as an illustration, I will address my initial proposition i.e. the importance of anchoring PCC philosophically by the simple means of sharing one ICU nurse’s citation about how a photograph affected the ICU nurse, while starting out from the philosophy of Ricoeur.

**The transition from relating to patients as objects towards relating to them as persons**

Photographs helped the ICU nurses to relate to the patients as persons. The transition was described thus by an ICU nurse: ‘an older woman, whom I could not think could be active. The photo showed her in action with her dogs . . . I realized that she was very active and could be so again’. From the perspective of Ricoeur, this might be explained as a transition that requires a shift of focus from patient-centred care’s bio-medical perspectives to PCC’s holistic perspectives. The photograph gave a ‘voice’ to the unconscious older woman and described who the person was. The citation illustrates how the photograph helped the ICU nurse to gain an insight into the patient’s life and the photograph became the narrative link between ‘idem’ (what something is) and ‘ipse’ (who someone is). Through the photograph, the patient spoke to the ICU nurse ‘this is me’, had truth claims, ‘believe me’, and finally, ‘if you do not believe me ask anyone else’. The photograph describes the patient as a person, with a unique background, relationships, capabilities, resources, strengths and limitations. By starting out from the philosophy of Ricoeur, the transition between patient and person becomes understandable. This transition is complicated based on the prevailing medical paradigm in the ICU with objective signs that is characterized by Descartes’s dualistic view of humans, where body and soul are separate. On the other hand, through a dialectic approach that links the hermeneutic and medical paradigms, it becomes more possible to centre the person (who) and integrate the patient (what).

**The transition — a presumption for an authentic meeting**

When the ICU nurse saw the older woman (ipse) and did not only see the older woman in her role as a patient (idem), it opened up possibilities for moving into a greater closeness, an authentic meeting characterized by mutuality. From the perspective of Ricoeur, the ethical nature of nursing care is about wishing the other well, and mutuality might be understood as a form of giving and taking that rests on the recognition of the other as a unique person. Ricoeur’s philosophy and his dialectical approach to mutuality contrast with Lévina’s idea of care where the initiative for authentic meetings always rests on the caregivers. When Lévina emphasizes care as a duty, Schuster interprets Ricoeur’s ethic that care is to dare to meet the other in his or her suffering. The photograph displayed at the bedside was the voice for the unconscious older woman and gave the ICU nurse a glimpse of what was important in the older woman’s life and who she was.

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118 Nordic Journal of Nursing Research 41(3)
The difference between the photograph and the older woman in the bed was a reminder of life’s vulnerability and the ICU nurse showed an emotional response by reflecting on the older woman’s earlier life situation and the possibility of recovery. This emotional response showed the ICU nurse’s ability to be affected by the patient’s suffering, which is a prerequisite for mutuality. My own research used as an illustration for this paper showed that photographs could motivate and engage ICU nurses as well as other ICU professions in caring for the patient. However, the photograph could also threaten the care because the ICU nurses perceived that they sometimes come too close to the ICU patients. This reflects ICU nurses’ commuting between authentic meeting and distance in relation to the ICU patient. The philosophical interpretation of the ICU nurse’s description, ‘an older woman, whom I could not think could be active. The photo showed her in action with her dogs… I realized that she was very active and could be so again’, might give the image of a movement from distance to an authentic meeting. Schuster describes these two different approaches as the neutral nurse and the mutually oriented nurse. The neutral nurse expresses the importance of keeping the personal and professional apart. In order not to get too close to the patient, the personal room is closed and authentic meeting fails. The mutually oriented nurse, on the other hand, occupies the personal space of the professional meeting and results in committed care. In mutuality, there is an existential assumption that people become who they are together with others. However, in life and death situations, ICU nurses’ distance and lower level of person-centredness, for example, to enable patients to participate in their own care, might be a necessity for delivering safe and effective nursing care, because of the prioritizing of medical tasks and measures.

The transition — a presumption for balancing the asymmetric relationship

The patient–person transition and authentic meetings might balance the asymmetric relationships between patients and ICU nurses. The asymmetric relationship in healthcare exists because of patients’ threefold disadvantage. The threefold disadvantage consists of the institutional disadvantage, meaning the patients are in a foreign environment; the existential disadvantage, meaning that the patients are weak and worried; and the cognitive disadvantage, meaning that patients have a lack of knowledge. The patients’ threefold disadvantage results in a strengthening of the hierarchical structure in the ICU between objective signs and subjective symptoms. Objective signs, analysed with technology, are considered as the truth and outweigh the patients’ narrated subjective symptoms. Person-centred care has the opportunity to influence the asymmetric relationship and avoid the dichotomization of objectivity and subjectivity. The ICU nurse quoted here made that connection and realized that the former hierarchical structure, with objectivity as the only truth, was not enough to know the patient. Using photographs might be one method, but in order to be able to know the patient as a person, it is important to use different methods and approaches, such as listening to relatives’ stories about the patient.

Summing up

There is always a risk that good intentions of improving healthcare services will not be fully implemented because of healthcare professionals lacking knowledge of the ideas underpinning the intentions. This contemporary issue paper proposes that a citation from an ICU nurse describing how a patient photograph affected her could be a useful tool to describe and an attempt to explain the underpinnings of PCC. Knowledge of the philosophical underpinnings of PCC is essential for the successful and sustainable implementation of PCC models and, in the long run, for person-centredness to become an integral and natural part of ICU nurses’ professional care.

Conflict of interest

The author declares that there is no conflict of interest.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. The Department of Health Sciences at Karlstad University supports the author with time for the development of research competencies.

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