

PATIENT-, CLIENT-, PERSON- OR PEOPLE-CENTRED CARE

in General Health Care and Hearing Care

A CRS White Paper



**AMPLIFON CENTRE FOR
RESEARCH AND STUDIES**

amplifon

PATIENT-, CLIENT-, PERSON- OR PEOPLE-CENTRED CARE

in General Health Care and Hearing Care

A CRS White Paper - May 2022

Mark Laureyns

CRS – Amplifon Centre for Research & Studies – Milan – Italy

Thomas More

University College – Department of Audiology – Antwerp – Belgium

Amplifon Centre for Research and Studies - Via G Ripamonti, 133 – 20141 Milan – Italy - www.crsamplifon.com

In the “World Report on Hearing” (ref 128), published by the World Health Organization on the March 3, 2021, the use of Person-Centred Care (PCC) is highly recommended.

Putting the user in the driver seat and ensuring freedom of choice in the interest of the user are the fundamental pillars of person-centred care (PCC), and they are reported to lead to higher satisfaction, increased use, and to result in greater quality-of-life improvement with professional hearing care.

This white paper discusses the history of Person-Centred Care, and offers a brief overview of existing studies and reports which focus on patient-, client-, person- or people-centred health care and hearing care.

When searching for research papers, articles and other references on patient-centred care, we come across the terms client-centred, people-centred and person-centred care. Depending on the fact if it’s American or British English, “centered” or “centred” is used. Please note that all citations are cited exactly in the original spelling, i.e. “centered” or “centred”.

We carried out a search for research papers, articles and other references on patient-centred care. This was complemented by a duplicate search using the US spelling (“centered”). This highlighted the existence of multiple terms in relation to this concept: client-centred, people-centred and person-centred care. All of these were included in our search (and will be discussed in this white paper). This yielded over 120 articles, reports and research theses.

CONTENTS

	Page
Introduction	2
Patient-Centred Care: a historical overview	3
Patient-, Client-, Person- and People-centred health care	5
What can we learn from scholarly articles such as systematic reviews and meta-analyses, on patient-centred care? Have such publications demonstrated that patient- or person-centred healthcare leads to better results, higher satisfaction, or other outcome measures?	5
Which definition, aspects, and dimensions of patient- or person-centred healthcare are covered in these systematic reviews, publications and reports?	7
How much is patient- or person-centred healthcare used and do all patients/persons prefer it?	10
Patient-centred, Client-centred, Person-centred and People-centred hearing care	12

Historical overview of Patient-Centred care



The oldest known ethical code for health care practitioners is most likely the Hippocratic Oath (ref 11), of which the oldest fragment found dates back to the year A.D. 275. As we can imagine, there are no references to patient-centred care in this Oath.

The 1849 reprint of Percival's book on medical ethics (ref 4) offers statements which stand in stark contrast with Patient-Centred Care, such as: *"The choice of a Physician or Surgeon cannot be allowed to hospital patients, consistently with the regular and established succession of medical attendance."* One of the most striking statements is no doubt *"No man censures a Physician for deceiving a patient too much dejected, by expressing good hopes of him, or by denying that he gives him a proper medicine which he is foolishly prejudiced against : the patient afterwards will not reproach, him for it."* Percival's position and wording were used widely in the codes of conduct adopted by the American Medical Association up to 1980.

After nearly two centuries of the paternalistic "Beneficence Model" (ref 9), there was a gradual shift towards the "Autonomy Model", which, among other things, called for securing patient consent. At the beginning of the 20th century, the act of securing consent was mostly motivated by a desire to prevent or have evidence in the event of any medical malpractice claims (ref 9).

In 1946, in *"Significant Aspects of Client-Centered Therapy"* (ref 5), Rogers introduces the term Client-Centred Practice in psychotherapy, which he claims to have been using in his practice since 1939. In a later publication in 1961 (ref 6), he states that, to that date, more than 40 studies had been published on this topic. Among other things, he introduced the notion of patient sovereignty: *"The foundation of client-centered practice rests not on method but rather on the therapist's respect for and personal openness to the client as a sovereign being of inexhaustible depth and meaning."*

After the Second World War, in 1947, the Nuremberg Code (ref 7) clearly declared that the *"voluntary consent of the human subject is absolutely essential"* in medical experiments.

The first known reference of the term "informed consent" can be found in the *"Salgo v. Leland Stanford Jr. University Board of Trustees"* court decision in 1957 (ref 12). The plaintiff, a patient named Mr Salgo, won a medical malpractice lawsuit, since neither he nor his family had been informed of the details and risks associated with a medical procedure which ultimately resulted in Salgo's permanent paralysis⁷.

Years later, Kiresuk & Sherman (1968) designed the “Goal attainment scaling (GAS): A general method for evaluating comprehensive community mental health programs” (ref 2). Their framework relies on “Goal setting” with patients, taking their lifestyle, preferences and aspirations into account, all of which offer an opportunity for deriving a patient-generated outcome.

		Example of a Goal Attainment Scale – GAS		
Achievement		Goal 1	Goal 2	Goal 3
		_____	_____	_____
+2	Much more than expected			
+1	More than expected			
0	Expected result			
-1	Less than expected			
-2	Much less than expected			

Fig 1. Example of a GAS (Goals Attainment Scale)

In 1973, the American Hospital Association published the Patient's Bill of Rights (ref 1), which stated that “The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment”.

In 1977, Engel published “The need for a new medical model: a challenge for biomedicine” (ref 39). He introduces the “Biopsychosocial Model”, whereby health care providers are required to take a holistic approach and focus on the whole person with a disease, as opposed to the traditional “Biomedical Model”, where the key focus is the disease.

At the end of the 1980s, there was a gradual shift among health care providers around the world towards a “New Public Management in Health Care” model, where the patient is seen as a consumer in search of the best care, and such metrics of personal autonomy, hospitality and patient satisfaction were introduced (ref 40).

Patient-, Client-, Person- and People-centred health care

According to the World Health Organisation, the term “*people-centred health care*” should not be confused with *patient-centred health care*. Indeed, the *People-centred health care*, is an “*umbrella term which better encapsulates the foremost consideration of the patient across all levels of health systems*” (ref 91). The latter, patient-centred care, would therefore be a subset within people-centred health.

Wikipedia describes person-centred care in health care as when “*patients actively participate in their own medical treatment in close cooperation with the health professionals. Sometimes relatives are also included in creating the health plan. The person-centred model of health care is used both for in and out-patients, emergency care, palliative care as well as in rehabilitation*” (ref 86).

The World Health Organization states that “*Person-centred care addresses individuals’ health and social care needs rather than being driven by isolated health conditions or symptoms. A person-centred, integrated approach also embraces the context of individuals’ daily lives, including the impact of their health and needs on those close to them and in their communities*” (ref 89).

According to the International Alliance of Patients’ Organizations (IAPO) “*Declaration on: Patient-Centred Healthcare*” (ref 47), “*The essence of patient-centred healthcare is that the healthcare system is designed and delivered to address the healthcare needs and preferences of patients so that healthcare is appropriate and cost-effective. By promoting greater patient responsibility and optimal usage, patient-centred healthcare leads to improved health outcomes, quality of life and optimal value for healthcare investment.*”

In addition to this overarching definition, IAPO provides an overview of the dimensions impacted by such a patient-centred healthcare approach: respect; choice and empowerment; patient involvement; access and support, and information.

What can we learn from scholarly articles such as systematic reviews and meta-analyses, on patient-centred care? Have such publications demonstrated that patient- or person-centred healthcare leads to better results, higher satisfaction, or other outcome measures?

Stewart (1995) ran a review on “*Effective physician-patient communication and health outcomes*” (ref 76) across 21 studies meeting the inclusion criteria: randomized controlled trials and analytic studies of physician-patient communication with outcomes on patient health. She concluded that “*Most of the studies reviewed demonstrated a correlation between effective physician-patient communication and improved patient health outcomes*”

Mead and Bower (2002) issued a review of previously published literature on “*Patient-centred consultations and outcomes in primary care*” (ref 60). They came to a much more nuanced conclusion, stating that “*although the current evidence base may be suggestive of a relationship between patient-centred consulting behaviour and patient outcomes, the case has not been made definitively, since the pattern of associations was not clear or consistent*”. They also commented on the difference between their conclusions and the earlier study by Stewart (1995), explaining that this was due to the difference in design and inclusion criteria, but mostly to the fact that the earlier review focused on “*general communication skills*” and not on explicitly “*patient-centred*” behaviour.



Griffin et al. (2004) carried out a systematic review of trials on the “Effect on health-related outcomes of interventions to alter the interaction between patients and practitioners” (ref 42). Based on the 35 trials included, they somewhat cautiously conclude that *“Successful interactions between patients and their practitioners lie at the heart of medicine, yet there are few rigorous trials of well-specified interventions to inform best practice. Trial evidence suggests that a range of approaches can achieve changes in this interaction, and some show promise in improving patients' health”*. Highlighting the heterogeneity of study populations, design, settings and measures, with only one study explicitly linking intervention through process to outcome measures, this study brought to light the need for a more rigorous approach in order to clearly establish positive correlations with health outcomes.

Doyle et al. (2013) conducted “A systematic review of evidence on the links between patient experience and clinical safety and effectiveness”(ref 37). Based on the 55 studies included in this review, the authors concluded that *“patient experience is positively associated with clinical effectiveness and patient safety, and support the case for the inclusion of patient experience as one of the central pillars of quality in healthcare.”*

Rathert et al. (2013) offered a systematic review on “Patient-Centered Care and Outcomes” (ref 69). Their literature review analysed a total of 40 articles, and they found *“mixed relationships between PCC [Patient-Care] and clinical outcomes. Some studies found significant relationships between specific elements of PCC and outcomes but others found no relationship.”*The authors conclude that the two most-significant improvement variables achieved thanks to patient-centred care were patient satisfaction and patient self-management.

Kelley et al. (2014) studied “The influence of the patient-clinician relationship on healthcare outcomes” (ref 49). Through a systematic review and meta-analysis of randomised controlled trials. Based on 13 randomised controlled studies on this topic they concluded that *“the patient-clinician relationship had a significant positive ($p=0,02$) impact on the healthcare outcomes.”*

Barrio & Gual (2016) published a systematic review of randomised “Patient-centered care interventions for the management of alcohol use disorders” (ref 18). A total of 40 studies were included, reporting on more than 16,000 patients. They found that studies based on single sessions of motivational interviewing showed no clear benefit; studies based on multiple sessions of counselling showed mixed results, many showing the benefit of the patient-centred care (PCC) interventions. The most positive outcome was found in pharmacologically supported PCC interventions. The authors posit that *“PCC-based interventions may be beneficial for reducing alcohol consumption in people with alcohol use disorders.”*

Davis et al. (2020) conducted a systematic review on “The relationship between patient-centered care and outcomes in specialist drug and alcohol treatment” (ref 33). They identified 25 articles on the topic, but only five articles had included patient centred indicators other than satisfaction. Their results show that *“although often of a small magnitude, the existence of significant positive relationships between indicators of patient centered care and improved outcomes was largely consistent.”*



To conclude on existing systematic reviews on patient-centred care, the more recent publications show cautious yet positive conclusions. They do however show the need for further research, and that moving forward, a more precise definition of the scope of patient-centred care is needed, as well as more studies with a quality design.

Which definition, aspects, and dimensions of patient- or person-centred healthcare are covered in these systematic reviews, publications and reports?

Mead & Bower (2000) carried out a review of existing empirical literature on “Patient-centeredness” (ref 59), and developed a conceptual framework based on the five main dimensions they identified:

1. biopsychosocial perspective (much wider than only the medical aspects)
2. patient-as-person (the person in the unique context)
3. sharing power and responsibility (ensure greater patient involvement)
4. therapeutic alliance (develop the emotional context in healthcare)
5. doctor-as-person (self-awareness of emotional reactions and subjectivity)

They state that since there is some inconsistency in the findings, specifically when related to the patient’s health status and satisfaction, further research is needed.

In a report titled “Improving Care for Older People. A Policy for Health Services” (ref 82), The Australian Victorian Government Department of Human Services (2003) defined person-centred care as *“treatment and care provided by health services [that] places the person at the centre of their own care and considers the needs of the older person’s carers.”*

The Australian National Ageing Research Institute (ref 62) produced a 111 page literature review titled “What is person-centred health care?” (2006). This review was commissioned by the Australian Victorian Department of Human Services, as part of an overarching strategy for Improving care for older people. They identified the following principles of person-centred care, which are all driven by the idea of partnership:

1. *getting to know the patient or client as a person*
2. *sharing of power and responsibility*
3. *accessibility and flexibility*
4. *coordination and integration*
5. *having an environment that is conducive to person-centred care*



Hughes et al. (2008), in “Types of centredness in health care: themes and concepts” (ref 46), conducted a literature review on client-, family-, patient-, person- and relationship- centred care. They conclude that *“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.”*

Pelzang (2010) published a literature review on “Time to learn: understanding patient-centred care” (ref 68). The author identified seven dimensions of patient-centred care:

- 1) *Respect for patients’ values, preferences and expressed needs (accept patient as person, involve patients, listen and value patient needs, respect confidentiality)*
- 2) *Coordination and integration of care (multidisciplinary, wide scope of care, involve patient and family)*
- 3) *Information, communication and education (accurate and understandable information, active listening to patient and family, provide therapeutic advice)*
- 4) *Physical comfort (promote quality environment, manage symptoms and support normal body functions)*
- 5) *Emotional support and alleviation of fear and anxiety (listen with full attention, provide quality information and care with empathy)*
- 6) *Involvement of family and friends (provide information, respect their support in care)*
- 7) *Transition and continuity of care (discharge planning, clear information and education, referring appropriately)*

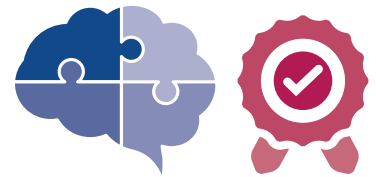
In addition to outlining the dimensions of patient-centred care, they list the knowledge and skills required for implementing such an approach:

Knowledge:

- *Clinical practice*
- *Principles of practice*
- *Clinical problems (disease conditions)*

Skills:

- *Data gathering or patient assessment skills*
- *Procedural skills (Including attention to patient comfort and dignity)*
- *Communication skills (Ability to communicate with patient, family and professionals, including attentive listening)*
- *Relationship skills (Ability to develop and maintain the helping or professional relationship, including empathy, mutual respect and joint participation)*
- *Reporting and recording skills (Ability to maintain and communicate the details of patient clearly, completely and concisely)*



They conclude with the following key points:

- *Patient-centred care places the patient at the centre of the healthcare system*
- *It considers the patient as a whole person with physical, psychological and social needs*
- *The provision of a supportive environment that promotes recovery is recognised as a critical role of the healthcare profession, and health professionals need to have the skills to provide supportive, holistic care*
- *Implementation of PCC requires adequate and appropriate education on PCC, with a planned and coordinated approach*

The Australian Commission on Safety and Quality in Healthcare published a very comprehensive 104-page report (ref 16) titled “Patient centred care: Improving quality and safety through partnerships with patients and consumers” (2011). The report states that “*Patient-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers. The widely accepted dimensions of patient-centred care are respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers, and access to care.*”

This comprehensive report covers a wide range of topics:

1. *What is patient-centred care?*
2. *Drivers, approaches and initiatives for patient-centred care*
3. *The relevance of patient-centred care to the Australian health system*
4. *Current jurisdictional and other activities in Australia*
5. *Making progress on patient-centred care in Australia*

Vahdat et al. (2014) conducted a review on “Patient Involvement in Health Care Decision Making” (ref 80). Of the original 100 articles and five books included in the study, only 30 articles and two books met the inclusion criteria after further screening. Based on their findings, they were able to identify six relevant categories:

1. *definition of participation,*
2. *importance of patient participation,*
3. *factors influencing participation of patients in healthcare decisions,*
4. *method of patient participation,*
5. *tools for evaluating participation, and*
6. *benefits and consequences of patient participation in health care decision-making*

In 2016 the UK Royal College of Physicians published a special issue of the “Future Health Journal” on “Person Centred Care” (ref 44) covering a range of themes:

- Health coaching training for clinicians;
- Legal, ethical and professional considerations for Person-Centred Care;
- How such approaches apply to long-term conditions;
- Personal experiences of practitioners.

In particular, the report highlights the challenges of expanding such an approach in a system under considerable stress, and the need for a two-fold approach: identifying patients' health goals and expectations in times of healthcare service provision.

Santana et al. (2018) produced a narrative review of the person-centred care (PCC) literature, for their article: "How to practice person-centred care: A conceptual framework" (ref 70). Based on their review, they developed a very clear and structured framework. Overall, they identified the three different levels of person-centred care: structural (healthcare system and organization); process (patient & healthcare provider); and outcome (patient, health care provider and healthcare system). For each of these levels, they further identified a number of domains.

Structural level:

1. *Creating a PCC culture (core values, philosophy and defining PCC);*
2. *Co-designing the development and implementation of educational programs (a standardized PCC training) ;*
3. *Co-designing the development and implementation of health promotion and prevention programs (empowering patients and organisations in the development of the program) ;*
4. *Supporting a workforce committed to PCC (ensure there are enough resources available) ;*
5. *Providing a supportive and accommodating PCC environment (the health care facility and the services need to be PCC designed and need to promote PCC) ;*
6. *Developing and integrating structures to support health information technology (e-health platform for health information exchange) ;*
7. *Creating structures to measure and monitor PCC performance. (framework to measure, monitor and evaluate).*



Process level:

1. *Cultivating communication (listen to patients, share information and discuss care plans with patients);*
2. *Respectful and compassionate care (responsive to preferences, needs and values);*
3. *Engaging patients in managing their care (designing care plans);*
4. *Integration of care (information sharing across the full care timeline).*

Outcome level:

1. *Access to care (timely access, availability, financial access);*
2. *Patient reported outcomes (outcome measures, experiences and adverse outcomes).*

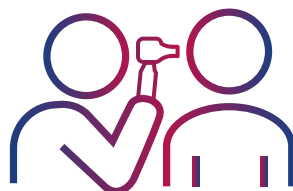
Most systematic reviews on the topic cover the following five key dimensions of patient-centred care: sharing – patient involvement; patient as person; assessing patient needs and values; coordination, integration, environment, structures for PCC.

Secondary dimensions include : biopsychosocial perspective and culture; emotional context; doctor as person; accessibility, information – communication.

A range of other topics are addressed in a non-systematic way in these reviews and reports, such as: involving family and friends; transition and continuity of care; patient reported outcome; and lastly, education and training.

▶ See table 1 on page 15 for the overview.

How much is patient- or person-centred healthcare used and do all patients/ persons prefer it?



Stewart (2001) wrote a very interesting editorial on “Towards a global definition of patient centred care. The patient should be the judge of patient centred care” (ref 78). He states that not every patient prefers a person-centred approach, and it may even be counter-productive or unwise in some cases. He argues that, in fact, patient-centred means that professionals should take an individualised approach in order to take into account the patient’s preference for information and for their desired level of shared decision-making.

In 2006, Langewitz et al. conducted a survey on “Hospital patients' preferences for involvement in decision-making” (ref 52), on 1,040 patients from a Swiss university hospital. The researchers found that 79% of respondents agreed that “*One should stick to the physician's advice even if one is not fully convinced of his ideas*”; 66% agreed that “*It should completely be left to physicians to decide on a patient's treatment*”; and 96% agreed that “*Even when the news is bad the patient must be informed*”. This survey demonstrates that not all patients prefer shared decision-making in healthcare, but also that honest information is essential.

In 2007, Bastiaens et al. published a study on “Older people’s preferences for involvement in their own care: A qualitative study in primary health care in 11 European countries” (ref 19). The authors interviewed 460 primary care patients aged between 70 and 96. They conclude that people over 70 do want to be involved in their care but their definition of involvement is more focussed on the “caring relationship”, “person-centred approach” and “receiving information” than on “active participation in decision-making”. Given the diversity of responses, the main takeaway is that patient involvement needs to be individualised, particularly so for the older age groups.

The WHO-European Office report (2013) “Towards people-centred health systems: An innovative approach for better health outcomes” (ref 89), states that “*To accelerate gain in health outcomes and reduce health inequalities, health systems must be financially viable, fit for purpose, people-centred and evidence-informed.*” The report also highlights the extent to which shortcomings and structural weaknesses of certain European health systems hinder the development of an inclusive, evidence-informed and people-centred approach which covers the entire life span. Moreover, it stresses that the lack of systematic quality improvement schemes across the European region for service delivery, results in care that is not always evidence informed and rarely patient centred.

In 2016, the Care Quality Commission (CQC) in the UK published a report on “Better care in my hands. A review of how people are involved in their care” (ref 32). The report assesses the level and quality of people’s involvement in their health and social care, based on the evidence from CQC’s national reports and inspection findings, national patient surveys and a literature review.

The report offered interesting insights, categorised into types of care:

- Acute care: to the question *“Were you involved as much as you wanted to be in decisions about your care and treatment?”*, 57% responded *“yes”*; 34% responded *“yes, to some extent”*; and 10% responded *“no”* (2014 survey). The report also offers the breakdown of survey responses from 2005 till 2014, showing this to be very stable over the years.
- Mental health care: to the question *“Were you involved as much as you wanted to be in agreeing with what care you will receive?”*, 56% patients responded *“yes”*; 37% responded *“yes, to some extent”*; and 7% responded *“no”* (2015 survey). The report also offers the breakdown of survey responses 2010 till 2014, with very stable results over the years.
- Primary Care (General Practitioner – GP): to the question *“How good was that GP at involving you in decisions about your care?”* 39% responded *“very good”*; 35% responded *“good”*; 13% responded *“neither good nor poor”*; 3% responded *“poor”*; 1% *“very poor”*; and lastly 9% responded *“doesn’t apply”* (2016 GP survey). The report also offers the breakdown of survey responses from 2005 till 2014, with very stable results over the years.
- Adult Social Care (Personal Social Services Adult Social Care Survey 2014/15): for this particular category, the results were less positive. To the question *“How much control do you have over your daily life?”* 33% responded *“as much as I wanted”*; 44% responded *“adequate control”*; 18% responded *“some control, but not enough”*; and 5% responded *“no control”*. The report also offers the breakdown of survey responses from 2010 till 2014, with very stable results over the years.

The final recommendation of the report stresses the need for: *“providers and commissioners of services, and voluntary sector organisations to work together to ensure that health and care services consistently involve people throughout their care, and that staff are supported to communicate with and support people and their families to be involved in their care in the ways they wish.”*

Turner & Archer (2020) published *“Patient-centred care: The patients’ perspective – A mixed-methods pilot study”* (ref 79), a study conducted in South Africa. Including articles which are from other regions of the world can shed a different light on the regional/cultural differences in patients’ perspectives. The responses the authors collected from a survey conducted among 120 people offer interesting responses on statements related to empathy:

- *“The doctor tries to make me feel comfortable”*: 7% not important; 8%, neutral; 85%, important
- *“The doctor is interested in my feelings and worries”*: 10%, not important; 12%, neutral; 78%, important
- *“The doctor includes me in decision-making”*: 14%, not important; 13%, neutral; 73%, important
- *“The doctor tries to understand the way I see things”*: 14%, not important; 21%, neutral; 66%, important.

The authors conclude the Western constructs for empathy also play an important role in other regions/ cultures and that the health care system should implement simple strategies to improve empathic communication within public healthcare clinics so as to ensure patients feel recognised and respected.

Patient-centred, Client-centred, Person-centred, People-centred health care is more and more widespread and, as the various reviews demonstrate, multiple aspects are perceived as very positive by health care receivers, and at the same time, they need to be fully involved in deciding which parts of such an approach they want to be involved in.

Patient-centred, Client-centred, Person-centred and People-centred hearing care

The first publications on patient-centred hearing care emerged in the late '80s and early '90s. The main milestones in this paradigm shift were: the evaluation of how hearing care (audiology) can implement the WHO of impairment, disability and handicap (CFI) concept in 1991; the introduction of the Client-Oriented Scale of Improvement (COSI) in 1997; the establishment of the Person-Centered Hearing Network (PCHN) in 2019 by the IDA institute; and the focus of the WHO World Report on Hearing on Person-Centred Hearing Care in 2021.

Demorest & Erdman (1987), in "Development of the Communication Profile for the Hearing Impaired (CPHI)", developed a framework to assess the environmental, behavioural, emotional, and attitudinal factors contributing to communication problems in the hearing impaired. The CPHI assesses the rehabilitative needs of hearing impaired adults, and consists of 145 items, divided into 19 subscales. The CPHI was developed at the Walter Reed Army Medical Center, where they ran a three-year pilot test, involving 827 patients.

When Stephens & Héту (1991) published "Impairment, disability and handicap in audiology: towards a consensus" (ref 125), they evaluated how to implement the WHO classification of impairment, disability and handicap (CFI) in audiology and stated that such an approach could present many benefits, if the specific aspects of the effects of hearing loss on the everyday life of people are included. This marked the introduction of the biopsychosocial model of care in audiology.

In 1997, Dillon et al. introduce the "Client Oriented Scale of Improvement (COSI)" (ref 104), which is a Goal Attainment Scale (GAS) applied in hearing care. Engel (2005), mentions this scale as a key element in person-centred hearing care. She states that "Being patient-centered means to attend carefully to those 'problems of living' and provide help to reduce those problems. In audiology, we use this approach when we relate all treatment to self-reported patient concerns, using a self-assessment scale such as the Client Oriented Scale of Improvement (COSI) or other self-assessments. The treatment addresses the problems of living with hearing loss, not the audiogram."

Client Oriented Scale of Improvement – COSI

My specific personal auditory goals	Change	Final Ability
• Goal 1: _____	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
• Goal 1: _____	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
• Goal 1: _____	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
• Goal 1: _____	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>

Figure 2. Example of a COSI (Client Oriented Scale of Improvement), the amount of change and final ability are rated on a 5-point scale.

A 2007 issue of the Seminars on Hearing dedicated to Ethics in Audiology featured an article by Clark on "Patient-centered practice: aligning professional ethics with patient goals" (ref 102), one of the first to discuss patient-centred practice in relation to audiology practice. Based on three scenarios, the author opposed the code of ethics in the American Academy of Audiology's scope of practice, to

“allow for the proper discharge of audiologists responsibilities to those served” against the patients’ perspective and preferences in a patient-centred model. The author encourages audiologists to listen attentively to patients and move towards a patient-centred approach.

In 2010, Laplante-Lévesque et al. published “A Qualitative Study of Shared Decision Making in Rehabilitative Audiology” (ref 119). Given the contemporary lack of empirical data and publications on rehabilitative-audiology decision-making, they propose instead that the patient (the client), their family and the health care providers be decision-making actors. The proposed decision-making process goes through the following steps: *“getting the full picture”*, *“getting the options to decide”*, *“being informed”*, *“deliberating”* and finally *“understanding and getting the time to reflect”*.



Von Hapsburg & Tjørnhøj-Thomsen (2012) introduced “The Encounter Model and Audiological Clinical Encounters” (ref 113), a framework designed to assess and take adequately into account – in the meeting between the audiologist, the patient and the patients’ family and significant other – the multiple factors that influence the outcomes for clients and audiologists, such as the cultural, political, and economic context. This can be achieved, they argue, through a more in-depth case history, but also by interacting differently with patients, so they get the chance to share their experiences and personal stories. The authors conclude that *“The Encounter Model also affords clinicians valuable insight that will enable them to reflect on their clinical encounters and adapt their practice to achieve a patient-centered focus.”*

Manchaiah et al. (2014) in “Audiologists’ preferences for patient-centredness: a cross-sectional questionnaire study of cross-cultural differences and similarities among professionals in Portugal, India and Iran” (ref 121), used a modified version of the Patient-Practitioner orientation scale (PPOS) in order to offer an audiology-focused model. This new version of the scale consisted in a questionnaire made up of 18 statements that patients evaluate on a six-point scale (strongly agree, agree, tend to agree, tend to disagree, disagree, totally disagree). In 15 of the 18 statements, rating 1 was the least-patient-centred, whereas in the remaining three, this rating was used for the most-patient-centred. This does beg the question of why this was not more balanced, so the same amount of statements were positive and negative towards patient-centredness. The outcome was that Audiologists in Portugal were more favourable to patient-centredness, compared to audiologists in India and Iran. This was true for both the full scale and the “sharing” and “caring” subscales. There was no significant difference between the scores of audiologists working in India and in Iran, who, in the author’s estimation, share a similar cultural profile. It would be interesting to run a comparable study on patient preferences.

Grenness et al. (2014) published “Patient-centred care: a review for rehabilitative audiologists” (ref 111). Their goal was to inform audiologists about the relevance of patient-centred care for audiological rehabilitation. They conclude that *“Patient-centred care has received much less attention in audiology than it has in other areas of healthcare and more research is required to optimise patient-centred care in audiological rehabilitation.”* The researchers further stress the importance of defining patient-centred hearing care in concrete, relevant and measurable terms.

Boisvert et al. (2017) state, in “Decision-Making in Audiology: Balancing Evidence-Based Practice and Patient-Centered Care” (ref 100), that health care models have moved from a practitioner-centred towards a patient-centred model. Interestingly, in their introduction, they offer a graph representing the percentage of mentions of the terms “evidence-based practice” and “patient-centred care” either in the title, the abstract or keywords across a total of 6,152 audiology articles published between 1995 and 2015. Both terms started at 0% in 1995, and in 2015 “evidence-based practice” had reached 14%, and “patient-centred care”, 3%.

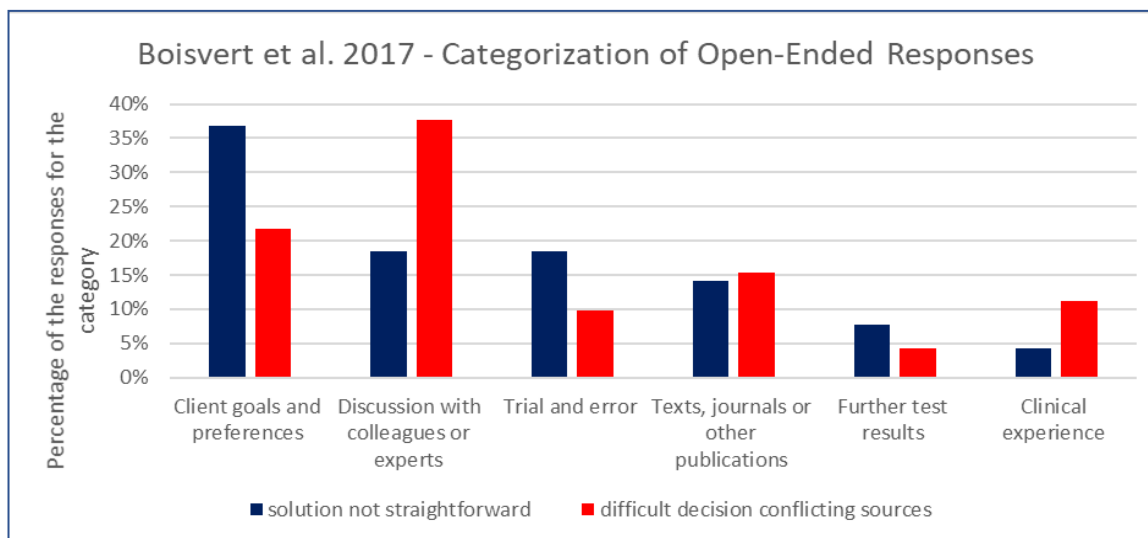


Figure 3: Graph showing the result of the categorization of Open-Ended Responses on the question related to “solution not straightforward” (blue) and “difficult decision and conflicting sources” (red).

For this study, a total of 96 audiologists completed a questionnaire based on the “survey of Australian audiologists’ decision-making” that was developed by Doyle in 1989.

The authors conclude that the three most important information sources for decision-making in hearing health care are: “audiometric test results”; “clinical experience”; and “client opinion” – although this last variable was ranked more important than reliable.

A recent article by Bennett et al. (2021) on “Identifying the approaches used by audiologists to address the psychosocial needs of their adult clients” (ref 99) identified seven clusters of approaches used by audiologists. A total of 66 audiologists from six countries participated in a brainstorming session and later completed an online grouping activity independently, placing 93 statements on how audiologists address the psychosocial needs of their clients into clusters they themselves were to name.

Three of these clusters are highly related to person-centred care.

1. “Client empowerment”
2. “Personalising the rehabilitation programme”
3. “Promoting client responsibility”

Since the objective was to address psychosocial needs, it is not so surprising that a lot of approaches were person-centred.

The Ida Institute established the Person-Centered Hearing Network (PCHN) in 2019 and hosts a website (ref 127) which provides tools, training courses, videos, publications, and other materials focusing on Person-Centred Hearing Care. This website offers very relevant materials, and this should be applauded, but we would prefer to also see a more critical view towards PCHC, since many reviews, such as Grenness et al (2014) conclude that “more research is required to optimise patient-centred care in audiological rehabilitation” (ref 109).

More recently, the 2021 WHO “World Report on Hearing” (ref 126) has played an important role in promoting “person-centred ear and hearing care”.

We can conclude that Person-Centred Hearing Care needs to be an essential part of Audiology education, but more quality research and systematic reviews need to be conducted to further develop and improve this very promising approach. And last but definitely not least, we must remember to fully involve the user (client, person, patient, etc.) in the process and in decision-making process for choosing the most appropriate type of hearing care while being well informed.

	TOPIC	Mead & Bower (2000)	Victorian (2003)	Pelzang (2010)	Vahdat <i>et al.</i> (2014)	Santana <i>et al.</i> (2018)
1	sharing power - patient involvement	sharing power and responsibility (ensure greater patient involvement)	sharing of power and responsibility	Respect for patients' values, preferences and expressed needs (accept patient as person, involve patients, listen and value patient needs , respect confidentiality)	<ol style="list-style-type: none"> 1. definition of participation, 2. importance of patient participation, 3. factors influencing participation of patients in healthcare decisions, 4. method of patient participation, 5. tools for evaluating participation, and 6. benefits and consequences of patient participation in health care decision-making 	Engaging patients in managing their care (designing care plans) Co-designing the development and implementation of health promotion and prevention programs (empowering patients and organisations in the development of the program)
2	patient as person - assessing patient needs and values	patient-as-person (the person in the unique context)	getting to know the patient or client as a person	Respect for patients' values, preferences and expressed needs (accept patient as person , involve patients, listen and value patient needs, respect confidentiality)		Respectful and compassionate care (responsive to preferences, needs and values)
3	coordination and integration		coordination and integration	Coordination and integration of care (multidisciplinary, wide scope of care, involve patient and family)		Integration of care (information sharing across the full care timeline)
4	environment and structures		having an environment that is conducive to person-centred care	Physical comfort (promote quality environment, manage symptoms and support normal body functions)		Providing a supportive and accommodating PCC environment (the health care facility and the services need to be PCC designed and need to promote PCC) - Developing and integrating structures to support health information technology (e-health platform for health information exchange) Creating structures to measure and monitor PCC performance. (framework to measure, monitor and evaluate)
5	biopsychosocial perspective and culture	biopsychosocial perspective (much wider than the medical aspects only)				Creating a PCC culture (core values, philosophy and defining PCC)

	TOPIC	Mead & Bower (2000)	Victorian (2003)	Pelzang (2010)	Vahdat <i>et al.</i> (2014)	Santana <i>et al.</i> (2018)
6	emotional context	therapeutic alliance (develop the emotional context in healthcare)		Emotional support and alleviation of fear and anxiety (listen with full attention, provide quality information and care with empathy)		
7	doctor as person	doctor-as-person (self-awareness of emotional reactions and subjectivity)				
8	accessibility		accessibility and flexibility			Access to care (timely access, availability, financial access)
9	information - communication			Information, communication and education (accurate and understandable information, active listening to patient and family, provide therapeutic advice)		Cultivating communication (listen to patients, share information and discuss care plans with patients)
10	involve family and friends			Involvement of family and friends (provide information, respect their support in care)		
11	transition and continuity of care			Transition and continuity of care (discharge planning, clear information and education, referring appropriately)		
12	patient reported outcome					Patient reported outcomes (outcome measures, experiences and adverse outcomes)
13	education and training					Co-designing the development and implementation of educational programs (a standardized PCC training) Supporting a workforce committed to PCC (ensure there are enough resources available)

Table with an overview of aspects of Person Centred Care in different systematic reviews

References:

HISTORICAL OVERVIEW OF PATIENT-CENTRED CARE.

1. American Hospital Association. The Patient Bill of Rights 1973. Retrieved at: <http://platospress.com/patient-s-bill-of-rights-aha-1973.html>
2. Kiresuk TJ, Sherman RE. Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. *Community mental health journal*. 1968 Dec;4(6):443–53.
3. Moeke D, van Andel J. Historical analysis of personal autonomy for prospective healthcare. *International Journal of Person Centered Medicine*. 2016 Jul 13;6(2):91–7.
4. Percival T. *Medical Ethics; or a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons*. Manchester, England: S. Russel; 1803. 1–210.
5. Rogers CR. Significant aspects of client-centered therapy. *American Psychologist*. 1946 Oct;1(10):415.
6. Rogers, CR. *On becoming a person*. Boston: Houghton Mifflin. (1961). Retrieved at: https://www.academia.edu/20184763/Rogers_Carl_1961_On_Becoming_a_Person
7. The Nuremberg Code (1947). *British Medical Journal* No 7070 Volume 313: Page 1448, December 1996. Retrieved at: https://media.tghn.org/medialibrary/2011/04/BMJ_No_7070_Volume_313_The_Nuremberg_Code.pdf
8. Witty, Marjorie. (2007). Client-Centered Therapy. Chapter in Kazantzis, Nikolaos & L'Abate, Luciano. (2007). *Handbook of Homework Assignments in Psychotherapy: Research, Practice, and Prevention*. 10.1007/978-0-387-29681-4. p. 35–50. Retrieved at: https://www.researchgate.net/publication/226947646_Client-Centered_Therapy
9. Will JF. A brief historical and theoretical perspective on patient autonomy and medical decision making: part I: the beneficence model. *Chest*. 2011 Mar 1;139(3):669–73.
10. Will J. A Brief Historical and Theoretical Perspective on Patient Autonomy and Medical Decision Making Part II: The Autonomy Model. *CHEST* 2011; 139(6):1491–1497
11. Wikipedia. Hippocratic Oath. Retrieved at: https://en.wikipedia.org/wiki/Hippocratic_Oath
12. Wikipedia. Salgo v. Leland Stanford Jr. University Board of Trustees. Retrieved at: https://en.wikipedia.org/wiki/Salgo_v._Leland_Stanford_Jr._University_Board_of_Trustees

PATIENT-, CLIENT-, PERSON- AND PEOPLE-CENTRED HEALTH CARE

13. Adams JR, Drake RE. Shared decision-making and evidence-based practice. *Community mental health journal*. 2006 Feb;42(1):87–105. doi: 10.1007/s10597-005-9005-8. PMID: 16429248.
14. Ahmad N, Ellins J, Krelle H, Lawrie M. *Person-centred care: from ideas to action*. London: Health Foundation; 2014 Oct. p1-100. Retrieved at: <https://www.health.org.uk/publications/person-centred-care-from-ideas-to-action>
15. American Medical Association. *Improving Communication—Improving Care. An Ethical Force Program™ Consensus Report (2006)* 144p. Retrieved at: https://idainstitute.com/fileadmin/user_upload/documents/PCC_Resources/PCC_Definitions/AMA_Improving_Communication_Improving_Care_01.pdf
16. Australian Commission on Safety and Quality in Healthcare (2011), *Patient centred care: Improving quality and safety through partnerships with patients and consumers*, ACSQHC, Sydney. 104p. retrieved at: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/patient-centred-care-improving-quality-and-safety-through-partnerships-patients-and-consumers>
17. Australian Commission on Safety and Quality in Healthcare (2012). *Review of patient experience and satisfaction surveys conducted within public and private hospitals in Australia*. Sydney, NSW: ACSQHC;2012.
18. Barrio P, Gual A. Patient-centered care interventions for the management of alcohol use disorders: a systematic review of randomized controlled trials. *Patient preference and adherence*. 2016;10:1823.
19. Bastiaens H, Van Royen P, Pavlic DR, Raposo V, Baker R. Older people's preferences for involvement in their own care: a qualitative study in primary health care in 11 European countries. *Patient education and counseling*. 2007 Sep 1;68(1):33–42.
20. Berry LL, Seiders K, Wilder SS. Innovations in access to care: a patient-centered approach. *Annals of internal medicine*. 2003 Oct 7;139(7):568–74.
21. Bieber C, Müller KG, Blumenstiel K, Hochlehner A, Wilke S, Hartmann M, Eich W. A shared decision-making communication training program for physicians treating fibromyalgia patients: effects of a randomized controlled trial. *Journal of psychosomatic research*. 2008 Jan 1;64(1):13–20.
22. Bridge E, Law MP, Narushima M. Using patient value statements to develop a culture of patient-centred care: a case study of an Ontario, Canada hospital. *Patient Experience Journal*. 2016;3(2):87–98. Available at: <http://pxjournal.org/journal/vol3/iss2/14>
23. Bolognesi M, Nigg CR, Massarini M, Lippke S. Reducing obesity indicators through brief physical activity counseling (PACE) in Italian primary care settings. *Annals of behavioral medicine*. 2006 Apr;31(2):179–85.
24. Borrell-Carrió F, Suchman AL, & Epstein RM. The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. *Ann Fam Med*. 2004 Nov-Dec;2(6):576–82. doi: 10.1370/afm.245. PMID: 15576544; PMCID: PMC1466742. (2004).

25. Burd H, & Hallsworth M. Spreading change-A guide to enabling the spread of person-and. community-centred approaches for health and wellbeing. The Health Foundation (2016) 30p. Retrieved at: <https://www.health.org.uk/publications/spreading-change>
26. Burd H, & Hallsworth M. Supporting self-management. A guide to enabling behaviour change for health and wellbeing using person- and community-centred approaches. The Health Foundation (2016) 29p. Retrieved at: <https://www.health.org.uk/publications/supporting-self-management>
27. Cals JW, Butler CC, Hopstaken RM, Hood K, Dinant GJ. Effect of point of care testing for C reactive protein and training in communication skills on antibiotic use in lower respiratory tract infections: cluster randomised trial. *Bmj*. 2009 May 5;338. b1374. 10.1136/bmj.b1374
28. Chassany O, Boureau F, Liard F, Bertin P, Serrie A, Ferran P, Keddad K, Jolivet-Landreau I, Marchand S. Effects of training on general practitioners' management of pain in osteoarthritis: a randomized multicenter study. *J Rheumatol*. 2006 Sep 1;33(9):1827–34. Epub 2006 May 15. PMID: 16724375.
29. Christian JG, Bessesen DH, Byers TE, Christian KK, Goldstein MG, Bock BC. Clinic-based support to help overweight patients with type 2 diabetes increase physical activity and lose weight. *Archives of Internal Medicine*. 2008 Jan 28;168(2):141–6.
30. Cooper LA, Roter DL, Carson KA, Bone LR, Larson SM, Miller ER, Barr MS, Levine DM. A randomized trial to improve patient-centered care and hypertension control in underserved primary care patients. *Journal of general internal medicine*. 2011 Nov;26(11):1297–304.
31. Coulter A, Oldham J. Person-centred care: what is it and how do we get there?. *Future hospital journal*. 2016 Jun;3(2):114–116. doi: 10.7861/futurehosp.3-2-114. PMID: 31098200; PMCID: PMC6465833.
32. Care Quality Commission. Better care in my hands: a review of how people are involved in their care. 2016 p.1-34. Retrieved at: https://www.cqc.org.uk/sites/default/files/20160519_Better_care_in_my_hands_FINAL.pdf
33. Davis EL, Kelly PJ, Deane FP, Baker AL, Buckingham M, Degan T, Adams S. The relationship between patient-centered care and outcomes in specialist drug and alcohol treatment: A systematic literature review. *Substance abuse*. 2020 Apr 2;41(2):216–31.
34. de Silva D. Helping measure person-centred care. A review of evidence about commonly used approaches and tools used to help measure person-centred care. The Health Foundation (2014) 80p. Retrieved at: <https://www.health.org.uk/publications/helping-measure-person-centred-care>
35. deBronkard D. From patient centred to people powered: autonomy on the rise. *Bmj*. 2015 Feb 10;350. doi:10.1136/bmj.h148
36. Dixon A, Robertson R, Appleby J, Burge P, Devlin NJ. Patient choice: how patients choose and how providers respond. King's Fund; 2010. ISBN: 9781857175967. p1–215. Retrieved at: <https://www.kingsfund.org.uk/sites/files/kf/Patient%20choice%2020101.pdf>
37. Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ open*. 2013 Jan 1;3(1):e001570. doi: 10.1136/bmjopen-2012-001570
38. Elwyn GL, Edwards A, Kinnersley P, Grol R. Shared decision making and the concept of equipoise: the competences of involving patients in healthcare choices. *British journal of general practice*. 2000 Nov 1;50(460):892–9.
39. Engel GL. The need for a new medical model: a challenge for biomedicine. *Science*. 1977 Apr 8;196(4286):129–36.
40. Engel GL. The clinical application of the biopsychosocial model. In *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 1980 Jan 1 (Vol. 6, No. 2, pp. 101–124). Oxford University Press.
41. Girgis A, Cockburn J, Butow P, Bowman D, Schofield P, Stojanovski E, D'Este C, Tattersall MH, Doran C, Turner J. Improving patient emotional functioning and psychological morbidity: evaluation of a consultation skills training program for oncologists. *Patient education and counseling*. 2009 Dec 1;77(3):456–62.
42. Griffin SJ, Kinmonth AL, Veltman MW, Gillard S, Grant J, Stewart M. Effect on health-related outcomes of interventions to alter the interaction between patients and practitioners: a systematic review of trials. *The Annals of Family Medicine*. 2004 Nov 1;2(6):595–608. doi: 10.1370/afm.142. PMID: 15576546; PMCID: PMC1466743.
43. Hashim MJ. Patient-Centered Communication: Basic Skills. *Am Fam Physician*. 2017 Jan 1;95(1):29–34. PMID: 28075109.
44. Health Foundation (Great Britain). Person-centred care made simple: what everyone should know about person-centred care. Health Foundation; 2016.
45. Herman SM. The relationship between therapist–client modality similarity and psychotherapy outcome. *The Journal of Psychotherapy Practice and Research*. 1998;7(1):56.
46. Hughes JC, Bamford C, May C. Types of centredness in health care: themes and concepts. *Medicine, Health Care and Philosophy*. 2008 Dec;11(4):455–63.
47. IAPO (International Alliance of Patients' Organizations) declaration 2016 – Patient-centred care. Retrieved at: https://www.iapo.org.uk/sites/default/files/files/IAPO_declaration_ENG_2016.pdf
48. Moulton B, King JS. Aligning ethics with medical decision-making: the quest for informed patient choice. *Journal of Law, Medicine & Ethics*. 2010;38(1):85–97. Available at: https://repository.uchastings.edu/faculty_scholarship/325
49. Kelley JM, Kraft-Todd G, Schapira L, Kossowsky J, Riess H. The influence of the patient–clinician relationship on healthcare outcomes: a systematic review and meta-analysis of randomized controlled trials. *PloS one*. 2014 Apr 9;9(4):e94207. doi: 10.1371/journal.pone.0094207. Erratum in: *PLoS One*. 2014;9(6):e101191. PMID: 24718585; PMCID: PMC3981763.
50. Krupat E, Rosenkranz SL, Yeager CM, Barnard K, Putnam SM, Inui TS. The practice orientations of physicians and patients: the effect of doctor–patient congruence on satisfaction. *Patient education and counseling*. 2000 Jan 1;39(1):49–59.
51. . doi: 10.1016/s0738-3991(99)00090-7. PMID: 11013547.

52. Langewitz W, Nübling M, Weber H. Hospital patients' preferences for involvement in decision-making. A questionnaire survey of 1040 patients from a Swiss university hospital. *Swiss Medical Weekly*. 2006 Jan 1;136(3-4):59-64. PMID: 16633947.
53. Lau DH. Patient empowerment--a patient-centred approach to improve care. *Hong Kong Med J*. 2002 Oct;8(5):372-4. PMID: 12376717.
54. Lavoie JG, Wong ST, Chongo M, Browne AJ, MacLeod ML, Ulrich C. Group medical visits can deliver on patient-centred care objectives: results from a qualitative study. *BMC health services research*. 2013 Dec;13(1):1-0. 155
55. Lin CH, Tzeng WC, Chiang SL, Chiang LC. Clinical outcomes: the impact of patient-centered care. *Hu Li Za Zhi*. 2012 Dec 1;59(6):104. (Chinese article)
56. Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, Ferrier K, Payne S. Preferences of patients for patient centred approach to consultation in primary care: observational study. *BMJ* 2001 Feb 24;322:1-7.
57. Mako T, Svanäng P, Bjerså K. Patients' perceptions of the meaning of good care in surgical care: a grounded theory study. *BMC nursing*. 2016 Dec;15(1):15-47.
58. Marshall A, Kitson A, Zeitz K. Patients' views of patient-centred care: a phenomenological case study in one surgical unit. *Journal of advanced nursing*. 2012 Dec;68(12):2664-73.
59. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. *Social science & medicine*. 2000 Oct 1;51(7):1087-110. doi: 10.1016/s0277-9536(00)00098-8. PMID: 11005395.
60. Mead N, Bower P. Patient-centred consultations and outcomes in primary care: a review of the literature. *Patient education and counseling*. 2002 Sep 1;48(1):51-61.
61. Milrod B, Leon AC, Busch F, Rudden M, Schwalberg M, Clarkin J, Aronson A, Singer M, Turchin W, Klass ET, Graf E. A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. *American Journal of Psychiatry*. 2007 Feb;164(2):265-72. 10.1176/appi.ajp.164.2.265.
62. National Ageing Research Institute (2006). What is person-centred health care? A literature review. 111p. retrieved at: <https://www2.health.vic.gov.au/about/publications/researchandreports/What-is-person-centred-health-care-A-literature-review>
63. O'CONNOR SJ. Building the knowledge base for patient-centred care: improving the use of qualitative study findings through meta-analysis and systematic reviews. *European Journal of Cancer Care*. 2009 Sep;18(5):433-436.
64. Ogden K, Barr J, Greenfield D. Determining requirements for patient-centred care: a participatory concept mapping study. *BMC Health Services Research*. 2017 Dec;17(1): 780.
65. Ørngreen R, Nielsen J, Levinsen KT. Client Centred Design: A case study on collaboration with clients, in community interaction and learning design.. 2004, INF Workingpaper series. Retrieved at <https://research.cbs.dk/en/publications/client-centred-design-a-case-study-on-collaboration-with-clients>
66. Parker DM. An exploration of client-centred practice in occupational therapy: perspectives and impact (Doctoral dissertation, University of Birmingham). p1-435. Retrieved at: <https://etheses.bham.ac.uk/4432/>
67. Patient Friendly Billing® Project Report - Consumerism in Health Care: Achieve a Consumer-Oriented Revenue Cycle – 2006 - 17p. - retrieved at <https://www.hfma.org/topics/article/1037.html>
68. Pelzang R. Time to learn: understanding patient-centred care. *British journal of nursing*. 2010 Jul 21;19(14):912-7.
69. Rathert C, Wyrwich MD, Boren SA. Patient-centered care and outcomes: a systematic review of the literature. *Medical Care Research and Review*. 2013 Aug;70(4):351-79.
70. Santana MJ, Manalili K, Jolley RJ, Zelinsky S, Quan H, Lu M. How to practice person-centred care: A conceptual framework. *Health Expectations*. 2018 Apr;21(2):429-40. doi: 10.1111/hex.12640. Epub 2017 Nov 19. PMID: 29151269; PMCID: PMC5867327.
71. Schoot T. Misvattingen over patientgerichte zorg (Misconceptions about patient-centered care). *Vakblad voor opleiders in het gezondheidszorg onderwijs*. N°6 – 2012 p 8-12
72. Schoot T, Proot I, Meulen RT, de Witte L. Recognition of client values as a basis for tailored care: the view of Dutch expert patients and family caregivers. *Scandinavian journal of caring sciences*. 2005 Jun;19(2):169-76..
73. Schoot, C. M. (2006). Client-centred care : balancing between perspectives of clients and nurses in home care. (Thesis) Datawyse / Universitaire Pers Maastricht. P1-231. <https://doi.org/10.26481/dis.20061020cs>.
74. Soklaridis PhD S, Adler Nevo MD FRCPC G, PRCPC LM. Relationship-centred care in health: A 20-year scoping review. *Patient Experience Journal*. 2016;3(1):130-45.
75. Stark S, Worm L, Kluge M, Roos M, Burggraf L. The patient satisfaction in primary care consultation—Questionnaire (PiC): An instrument to assess the impact of patient-centred communication on patient satisfaction. *PLoS one*. 2021 Jul 16;16(7):e0254644. <https://doi.org/10.1371/journal.pone.0254644>
76. Stewart MA. Effective physician-patient communication and health outcomes: a review. *CMAJ: Canadian medical association journal*. 1995 May 1;152(9):1423-33. PMID: 7728691; PMCID: PMC1337906.
77. Oates J, Weston WW, Jordan J. The impact of patient-centered care on outcomes. *Fam Pract*. 2000 Sep;49(9):796-804.
78. Stewart M. Towards a global definition of patient centred care: the patient should be the judge of patient centred care. *Bmj*. 2001 Feb 24;322(7284):444-5.
79. Turner RE, Archer E. Patient-centred care: The patients' perspective-A mixed-methods pilot study. *African Journal of Primary Health Care and Family Medicine*. 2020 Jan 1;12(1):2071-2928
80. Vahdat S, Hamzehgardeshi L, Hessam S, Hamzehgardeshi Z. Patient involvement in health care decision making: a review. *Iranian Red Crescent Medical Journal*. 2014 Jan;16(1) e12454. 10.5812/ircmj.12454

81. VanPuymbrouck LH. Promoting client goal ownership in a clinical setting. *The Open Journal of Occupational Therapy*. 2014;2(2):3. <https://doi.org/10.15453/2168-6408.1087>
82. Victorian Government Department of Human Services. Improving Care for Older People. A Policy for Health Services. 2003.
83. Wade DT. Goal setting in rehabilitation: an overview of what, why and how. *Clinical rehabilitation*. 2009 Apr;23(4):291-5. doi: 10.1177/0269215509103551. PMID: 19293289.
84. Weston, Tony (2011) The Clinical Effectiveness of the Person-Centred Psychotherapies: The Impact of the Therapeutic Relationship. Doctoral thesis, University of East Anglia,. P1–360. Retrieved at: <https://ueaeprints.uea.ac.uk/id/eprint/33506/>
85. White P, Bishop FL, Prescott P, Scott C, Little P, Lewith G. Practice, practitioner, or placebo? A multifactorial, mixed-methods randomized controlled trial of acupuncture. *Pain*. 2012 Feb 1;153(2):455–62.
86. Wikipedia. Person-centred care. Retrieved at: https://en.wikipedia.org/wiki/Person-centered_care
87. Wildevuur SE, Simonse LW. Information and communication technology-enabled person-centered care for the “big five” chronic conditions: scoping review. *J Med Internet Res* 2015 2015 Mar 27;17(3):e3687.
88. Williams JG, Cheung WY, Chetwynd N, Cohen DR, El-Sharkawi S, Finlay I, Lervy B, Longo M, Malinovsky K. Pragmatic randomised trial to evaluate the use of patient held records for the continuing care of patients with cancer. *BMJ Quality & Safety*. 2001 Sep 1;10(3):159–65. <https://doi.org/10.1136/qhc.0100159>.
89. WHO. Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care. 2019 p 1–87. Retrieved at: <https://www.who.int/publications/i/item/WHO-FWC-ALC-19.1>
90. WHO. Towards people-centred health systems: An innovative approach for better health outcomes. (2013) p 1-34. Retrieved at: <https://www.euro.who.int/en/health-topics/Health-systems/public-health-services/publications/2013/towards-people-centred-health-systems-an-innovative-approach-for-better-health-outcomes>
91. WHO. People at the centre of care. Retrieved at: https://web.archive.org/web/20180119121053/http://www.wpro.who.int/health_services/people_at_the_centre_of_care/definition/en/
92. Womack JL. The relationship between client-centered goal-setting and treatment outcomes. *Perspectives on Neurophysiology and Neurogenic Speech and Language Disorders*. 2012 Apr;22(1):28–35.
93. Xie B, Wang M, Feldman R. Preferences for health information and decision-making: development of the Health Information Wants (HIW) Questionnaire. In *Proceedings of the 2011 iConference 2011 Feb 8 (pp. 273–280)*. <https://doi.org/10.1145/1940761.1940799>
94. Youssef A, Wiljer D, Mylopoulos M, Maunder R, Sockalingam S. “Caring About Me”: a pilot framework to understand patient-centered care experience in integrated care-a qualitative study. *BMJ open*. 2020 Jul 1;10(7):e034970. doi: 10.1136/bmjopen-2019-034970
95. Zandbelt, L.. “Patient-centred communication in the medical specialist consultation.” (2000). Doctoral Thesis. University of Amsterdam. P 1–170. Retrieved at: <https://www.semanticscholar.org/paper/Patient-centred-communication-in-the-medical-Zandbelt/c9d7bde4c40f264188f6a1b4f3a1702e4803fa18>
96. Zolkefi Y. Evaluating the concept of choice in healthcare. *The Malaysian journal of medical sciences: MJMS*. 2017 Dec;24(6):92–96.

CLIENT, PATIENT, PERSON CENTRED HEARING CARE

97. Adamovich S. Clinical Supervision Student-Centered Learning Meets Patient-Centered Care. ASHA (American Speech Language Hearing Association) 2018 retrieved at <https://www.asha.org/Articles/Clinical-Supervision-Student-Centered-Learning-Meets-Patient-Centered-Care/>
98. Bennett RJ, Barr C, Cortis A, Eikelboom RH, Ferguson M, Gerace D, Heffernan E, Hickson L, Van Leeuwen L, Montano J, Preminger JE. Audiological approaches to address the psychosocial needs of adults with hearing loss: perceived benefit and likelihood of use. *International Journal of Audiology*. 2021 Jul 22;60(sup2):12-9. doi: 10.1080/14992027.2020.1839680. Epub 2020 Nov 11. PMID: 33176511.
99. Bennett RJ, Barr C, Montano J, Eikelboom RH, Saunders GH, Pronk M, Preminger JE, Ferguson M, Weinstein B, Heffernan E, Van Leeuwen L. Identifying the approaches used by audiologists to address the psychosocial needs of their adult clients. *International Journal of Audiology*. 2021 Feb 1;60(2):104–14. doi: 10.1080/14992027.2020.1817995. Epub 2020 Sep 17. PMID: 32940093.
100. Boisvert I, Clemesha J, Lundmark E, Crome E, Barr C, McMahon CM. Decision-making in audiology: balancing evidence-based practice and patient-centered care. *Trends in hearing*. 2017 Jul;21:2331216517706397. doi: 10.1177/2331216517706397. PMID: 28752808; PMCID: PMC5536381.
101. Clark JG, English KM, Montano JJ. Heightening our vigilance towards patient well-being. *International Journal of Audiology*. 2021 Jul 22;60(sup2):4–11. doi: 10.1080/14992027.2020.1834632. Epub 2020 Nov 4. PMID: 33143471.
102. Clark JG. Patient-centered practice: Aligning professional ethics with patient goals. In *Seminars in hearing 2007 Aug (Vol. 28, No. 03, pp. 163–170)*.
103. Demorest ME, Erdman SA. Development of the communication profile for the hearing impaired. *Journal of Speech and Hearing Disorders*. 1987 May;52(2):129–43.
104. Dillon H, James A, Ginis J. Client Oriented Scale of Improvement (COSI) and its relationship to several other measures of benefit and satisfaction provided by hearing aids. *Journal of the American Academy of Audiology*. 1997 Feb 1;8(1). 27–43.

105. Ekberg K, Schuetz S, Timmer B, Hickson L. Identifying barriers and facilitators to implementing family-centred care in adult audiology practices: a COM-B interview study exploring staff perspectives. *International Journal of Audiology*. 2020 Jun 2;59(6):464–474. doi: 10.1080/14992027.2020.1745305. Epub 2020 Apr 4. PMID: 32248721.
106. Ekberg K, Timmer B, Schuetz S, Hickson L. Use of the Behaviour Change Wheel to design an intervention to improve the implementation of family-centred care in adult audiology services. *International Journal of Audiology*. 2021 Jul 22;60(sup2):20–9. doi: 10.1080/14992027.2020.1844321. Epub 2020 Nov 11. PMID: 33174791.
107. English K. Get ready for the next big thing in audiologic counseling. *The Hearing Journal*. 2005 Jul 1;58(7):10–5.
108. Erdman S., Wark D. and Montano J. Implications of service delivery models in audiology. *Journal of the Academy of Rehabilitative Audiology* Vol 27 (1994) 45–60.
109. Ferrari D, Bundesen LL. A person-centred approach to telehealth. *ENT and Audiology news*. 2017;26(1). p 76–78.
110. Gagné JP, Jennings MB. Incorporating a client-centered approach to audiologic rehabilitation. *The ASHA Leader*. 2011 Aug;16(8):10–3.
111. Grenness C, Hickson L, Laplante-Lévesque A, Davidson B. Patient-centred care: A review for rehabilitative audiologists. *International Journal of Audiology*. 2014 Feb 1;53(sup1):S60-7.
112. Grenness C, Hickson L, Laplante-Lévesque A, Davidson B. Patient-centred audiological rehabilitation: Perspectives of older adults who own hearing aids. *International Journal of Audiology*. 2014 Feb 1;53(sup1):S68–75.
113. von Hapsburg D, Tjørnhøj-Thomsen T. The encounter model and audiological clinical encounters. In *Seminars in Hearing* 2012 Feb 33, 24–34).
114. Hickson L, Meyer C, Lovelock K, Lampert M, Khan A. Factors associated with success with hearing aids in older adults. *International journal of audiology*. 2014 Feb 1;53(sup1):S18-27. doi: 10.3109/14992027.2013.860488. Epub 2014 Jan 21. PMID: 24447233.
115. Hickson L, Worrall L, Scarinci N. A randomized controlled trial evaluating the active communication education program for older people with hearing impairment. *Ear and hearing*. 2007 Apr 1;28(2):212–30.
116. Hickson L, Worrall L, Scarinci N. A randomized controlled trial evaluating the active communication education program for older people with hearing impairment. *Ear and hearing*. 2007 Apr 1;28(2):21233, 24–3430. doi: 10.1097/AUD.0b013e31803126c8. PMID: 17496672.
117. Knudsen LV, Nielsen C, Kramer SE, Jones L, Laplante-Lévesque A. Client labor: Adults with hearing impairment describing their participation in their hearing help-seeking and rehabilitation. *Journal of the American Academy of Audiology*. 2013 Mar;24(03):192-204. <https://doi.org/10.3766/jaaa.24.3.5>
118. Laplante-Lévesque A, Hickson L, Worrall L. Promoting the participation of adults with acquired hearing impairment in their rehabilitation. *Journal of the Academy of Rehabilitative Audiology*. 2010;43:11–26.
119. Laplante-Lévesque A, Hickson L, Worrall L. A qualitative study of shared decision making in rehabilitative audiology. *Journal of the Academy of Rehabilitative Audiology*. 2010 Jul;43:27–43.
120. Laplante-Lévesque A, Hickson L, Grenness C. An Australian survey of audiologists' preferences for patient-centredness. *International journal of audiology*. 2014 Feb 1;53(sup1):S76-82. doi: 10.3109/14992027.2013.832418. Epub 2014 Jan 21. PMID: 24447231.
121. Manchaiah V, Gomersall PA, Tomé D, Ahmadi T, Krishna R. Audiologists' preferences for patient-centredness: a cross-sectional questionnaire study of cross-cultural differences and similarities among professionals in Portugal, India and Iran. *BMJ open*. 2014 Oct 1;4(10):e005915. doi: 10.1136/bmjopen-2014-005915
122. Ryall A, Jenstad LM, Pumford J, Howe T, Grosjean G. Counseling During Real Ear Measurements: The Clients' Perspective. *Journal of the American Academy of Audiology*. 2021 Feb;32(02):107–15. doi: 10.1055/s-0040-1718930. Epub 2021 Feb 15. PMID: 33588514.
123. Saunders GH, Vercammen C, Timmer BH, Singh G, Pelosi A, Meis M, Launer S, Kramer SE, Gagné JP, Bott A. Changing the narrative for hearing health in the broader context of healthy living: a call to action. *International Journal of Audiology*. 2021 Jul 22;60(sup2):86–91. Doi: 10.1080/14992027.2021.1905892.
124. Smith SL. Promoting self-efficacy in patient-centered audiology rehabilitation for adults with hearing loss. *Perspectives on Aural Rehabilitation and Its Instrumentation*. 2014 May;21(1):24–32.
125. Stephens D, Héту R. Impairment, disability and handicap in audiology: towards a consensus. *Audiology*. 1991 Jan 1;30(4):185–200.
126. Wallhagen MI, Strawbridge WJ, Tremblay K. Leveraging the age friendly healthcare system initiative to achieve comprehensive, hearing healthcare across the spectrum of healthcare settings: an interprofessional perspective. *International Journal of Audiology*. 2021 Jul 22;60(sup2):80–5. doi: 10.1080/14992027.2020.1853263. Epub 2021 Jan 8. PMID: 33415999.
127. WHO – Policy brief: Integrated people-centred ear and hearing care. 8p – retrieved at: https://cdn.who.int/media/docs/default-source/documents/health-topics/deafness-and-hearing-loss/world-report-on-hearing/wrh-policy-brief-en.pdf?sfvrsn=cff40649_20
128. WHO – World Report on Hearing (March 2021) 225p – retrieved at <https://www.who.int/publications/i/item/world-report-on-hearing>
129. Website Ida Institute. Overview of Person-Centered Care. Web-based Training - Retrieved at: https://idainstitute.com/tools/supervisor_kit/get_started/person_centered_care/