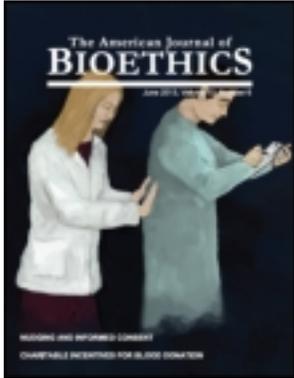


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Treating Patients as Persons: A Capabilities Approach to Support Delivery of Person-Centered Care

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Target Article

Treating Patients as Persons: A Capabilities Approach to Support Delivery of Person-Centered Care

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Health services internationally struggle to ensure health care is “person-centered” (or similar). In part, this is because there are many interpretations of “person-centered care” (and near synonyms), some of which seem unrealistic for some patients or situations and obscure the intrinsic value of patients’ experiences of health care delivery. The general concern behind calls for person-centered care is an ethical one: Patients should be “treated as persons.” We made novel use of insights from the capabilities approach to characterize person-centered care as *care that recognizes and cultivates the capabilities associated with the concept of persons*. This characterization unifies key features from previous characterisations and can render person-centered care applicable to diverse patients and situations. By tying person-centered care to intrinsically valuable capability outcomes, it incorporates a requirement for responsiveness to individuals and explains why person-centered care is required independently of any contribution it may make to health gain.

Keywords: person-centered care, patient-centered care, professional–patient relations, capabilities approach, ethics, quality of care

Health care leaders and patients’ advocates internationally have struggled for decades to improve patients’ experiences of the way health care is delivered. There are various reasons for this. Some reasons relate to practical obstacles, but in this article we focus on ways of thinking about “person-centered care” and associated concepts. Ways of thinking about these concepts can have important implications for how health care staff understand the value and ethical significance of their interactions with patients.

Person-centered care and near synonyms such as patient-, client-, family-, and relationship-centered care refer to forms of care that are intended to correct tendencies for health care to be either (1) too disease-centered (taking an unduly limiting biomedical approach, focusing narrowly on pathologies, and applying disease-standardized and often unnecessarily high-tech “solutions” that give insufficient regard to the subjective illness experiences, particular interests and autonomy of patients), or (2) too system- or staff-centered (being inappropriately oriented to serve the interests of the organizations and/or professionals who provide services, and using one-size-fits-all approaches that again give insufficient regard to the particular interests and autonomy of the people who use services) (Epstein et al. 2010; Gerteis et al. 2002; Hobbs 2009; IAPO 2007; Mead and

Bower 2000; Mezzich et al. 2009; Stewart 2001; World Health Organization 2007).

“Person-centered care” and its near synonyms can refer to an approach that guides the (whole) practice of medicine or health care (Stewart et al. 2003; Mezzich et al. 2009) and/or to an aspect of health care quality (Institute of Medicine 2001). There is sometimes ambiguity about this. A selection of definitions and positive characterizations is presented in Table 1. Each offers useful pointers to key issues and good practice, but with their particular emphases, they variously highlight and downplay potentially important considerations. Each definition or characterization is also open to various interpretations, which can incorporate (often implicitly) a number of other concepts and assumptions.

Despite the differences between the definitions and characterizations of person-centered care and associated terms, several important recurring themes can be identified. We suggest these can all be related to a broad overarching (or underpinning) ethical idea that patients should be “treated as persons.” This idea recurs strongly in studies of what matters to patients about their experiences of health care delivery (Coyle 1999; Entwistle et al. 2012a; Goodrich and Cornwell 2008). It seems that depersonalization—in both the de-humanizing and the (linked) de-individualizing

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Table 1. Some key definitions and identified dimensions of person-centered care

Mead and Bower (2000)	Patient-centered medicine has five distinctive dimensions: (1) a biopsychosocial perspective; (2) patient as person; (3) having power and responsibility; (4) therapeutic alliance; and (5) doctor as person.
Stewart (2001)	Patient-centered care (a) explores the patients' main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patient's world—that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationships between the patient and the doctor.
IOM (2001)	Patient-centered care: respectful and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
IAPO (2006)	To achieve patient-centered health care, health care must be based on five principles: (1) respect; (2) choice and empowerment; (3) patient involvement in health policy; (4) access and support; and (5) information.
Leplege et al. (2007)	The concept of person centeredness has four main meanings: addressing the person's specific and holistic properties; addressing the person's difficulties in everyday life; regarding the person as an expert who should participate actively in their rehabilitation; respecting the person "behind" the impairment or disease.
Mezzich et al. (2009)	Person-centered medicine is dedicated to the promotion of health as a state of physical, mental, sociocultural, and spiritual well-being, as well as to the reduction of disease, and founded on mutual respect for the dignity and responsibility of each individual person.
Berwick (2009)	Patient-centered care is "The experience (to the extent the informed, individual patient desires it) of transparency, individualisation, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care" (w560).
McCormack et al. (2011)	"We define person centred care as an approach to practice that is established through the formation and fostering of therapeutic relationships. . . . [It] is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding."

senses of that term—is what proponents of person-centered care (or similar) are most concerned to avoid. Of course, what it means and what is takes to "treat patients as persons" are complex issues, but the notion is a promising starting point for a fresh attempt to reinvigorate efforts to improve patients' experiences of health care delivery.

In this article we make novel use of ideas from the "capabilities approach," which is now well established in work on international human development and social justice (Robeyns 2011), to explore what it might mean for health services to treat patients as persons. The article is organized as follows. In the next section, we explain how some interpretations of person-centered care and associated concepts can have problematic implications for their delivery. Any fresh thinking in this area should usefully address at least some of these issues. We then outline key ideas relating to the concepts of "treatment as persons" and "capabilities" before using these ideas to develop a novel understanding of "treating patients as persons." Finally, we consider how our novel understanding relates to previous characterizations of person-centered care, highlight its implications for health care practice, and outline the further development work that will be needed to take the idea forward.

SOME ISSUES WITH SOME CURRENT INTERPRETATIONS OF PERSON-CENTERED CARE

From this point on, to facilitate ease of reading, we use the term "person-centered care" to cover "patient-centered care" and other near synonyms as well.

The ways that people (and especially health care staff) think about person-centered care and health care quality more generally can be among the reasons why health services do not consistently deliver the kinds of experiences for patients that proponents of person-centered care aspire to.

Among health care leaders and staff, terms such as "person-centered" are increasingly widely recognized and claimed as positive descriptors. As several previous commentators have recognized, however, these terms are so variously understood that they are sometimes used in confusing or misleading ways (Epstein and Street 2011; Hobbs 2009).

We are particularly concerned that some features of some ways of thinking about person-centered care can tend to obscure its intrinsic value. First, a tendency to think of person-centered care primarily in terms of *processes* encourages a tendency to focus on its value as instrumental. This can be particularly problematic when an appropriate

concern with the *outcomes* of health care is channeled into a narrow focus on the kinds of measurable health status changes that are investigated in studies of the effectiveness of technologies designed to limit disease and/or to lower the risks of disability and death. The processes of person-centered care (or interventions to promote them) cannot (and should not be expected to) “compete” with interventions that are more directly oriented to such health status outcomes when the competition is judged on these kinds of outcomes alone.

Few people would argue that health, even if broadly and positively construed, is the only thing that matters in life. But in the absence of clear and strong reasons to value person-centered care intrinsically (or at least not just for its contribution to health status improvement), its proponents have little scope to argue against health care policies and practices that might undermine it. And some policies and practices do tend to undermine the responsiveness of health care staff to patients as persons, for example, when standardized checklist approaches are used inflexibly to help implement generally effective interventions in the pursuit of measurable aggregate reductions in disease, disability, and death (Rhodes et al. 2006).

Of course, many health care systems do somehow signal that person-centered care or aspects of this are valued. For example, many invest significantly in efforts to monitor aspects of patient experience or satisfaction as indicators of health care quality (AHRQ 2012; NHS Scotland 2010). However, the reasons for valuing positive patient experiences and satisfaction, and the relative priorities between different aspects of experience and satisfaction and in relation to aspects of health, have been largely neglected. Beyond the vague recognition that they are, by definition, positive, and that it can be good for business to demonstrate that a service delivers them, the sources of their value are not widely discussed.

The intrinsic value of person-centered care can also be obscured by some interpretations of the idea that person-centered care is, among other things, somehow responsive to the preferences or choices of individual patients. This idea, which can be identified in most of the definitions and characterizations in Table 1, is not necessarily problematic—indeed, it can be very important. But if, in quick thoughts or casual conversations, health care staff tend to equate person-centered care with doing what patients say they like, the deep value base and intrinsic worth of the concept (as well as its complexity) can be lost (Epstein and Street 2011). An unreflective emphasis on preferences can tend to detach the idea of person-centered care from what is ethically significant—especially when preferences are not well informed, stable, strong, or good, or do not relate to issues of importance (Epstein and Peters 2009; O’Neill 2002). Because other considerations do matter, an uncritical association of person-centered care with patients’ preferences can lead health care staff to think either that person-centered care is unachievable in situations where they do not believe unfettered choice is appropriate (e.g., when patients request antibiotics for simple upper-

respiratory-tract infections) or that it is a nice but ultimately optional extra, or that it is only instrumentally valuable—for example, if it leads to demonstrable improvements in health and/or reduces the costs to health services of achieving such improvements (which takes us back to the problem noted earlier).

Other concerns relating to ways of thinking about person-centered care arise, somewhat paradoxically, from an important set of policies, strategies, and interventions that have been developed in recent decades to facilitate people’s contributions to their own (and family members’) care. In practice, these policies, strategies, and interventions (or particular interpretations or applications of them) can sometimes be problematic for the ways people are treated as persons. Efforts to promote shared decision making, support people’s self-management of their long-term conditions, and involve patients in the pursuit of patient safety have understandably (and often usefully) emphasized the ethical importance of respecting patients’ autonomy. They have stressed that many people can and want to participate and do more for themselves in relation to their health and care than health services have historically encouraged (Coulter 2011). However, some efforts to harness patients’ and family members’ contributions are oriented to serve health service or professional interests, rather than interests that particular patients and family members can recognize and accept as their own. For example, some health professionals “manage” patient involvement to support the achievement of organizationally imposed health indicator targets regardless of individual patients’ life projects and priorities (Shortus et al. 2013). Current definitions and interpretations of person-centered care cannot always differentiate more from less appropriate forms of involvement: they cannot recognize these health professionals’ approaches as less person-centered than the approaches of health professionals who are more responsive to individual patients as persons.

Efforts to avoid inappropriately imposing organizational or professional priorities by emphasizing the need to respect patients’ autonomy can also become problematic in other respects. Patients from various health care settings report feeling unsupported and becoming distressed because clinicians have informed them about treatment options, then insisted they make their own choices. At least some of their reports can be linked to clinicians’ ideas about respecting patients’ autonomous choices and/or recognizing patients’ responsibilities. Although textbook discussions of what respect for autonomous choices might look like in practice sometimes present quite nuanced accounts (Beauchamp and Childress 2009), the ideas that autonomous choices are both informed and substantially free from controlling influences are sometimes interpreted in ways that emphasize a need for clinicians to inform people about health care options, then not “interfere” with their preferences or choices. But an insistence that patients alone should take responsibility for preference-sensitive decisions (see, e.g., McNutt 2004) perhaps reflects unwarranted assumptions about the kinds of preferences people have and

the kinds of “independence” they can achieve. It fails to reflect the various ways in which people’s options and values can be shaped by their (past and present) social situations and relationships, and it can lead to a neglect of the ways in which both family members and health professionals might need to support people to exercise their autonomy and to enable them to engage in and influence their care (Cribb and Entwistle 2011; Ells et al. 2011; Entwistle et al. 2010a, 2012b; Mackenzie 2008; Mol 2008; Walker 2009).

Ideas about autonomous choice that obscure the social aspects of personal autonomy can contribute to a tendency for some of the policies, practical initiatives, and assessments associated with person-centered care to neglect the significance of relationships between health care staff and patients. Although leading writers on person-centered care and associated concepts rightly stress the importance of professional–patient relationships (Beach and Inui 2006; Epstein and Street 2011b; McCormack et al. 2011; Stewart et al. 2003), and patients regard supportive relationships with professionals as significant (Entwistle et al. 2008; 2012a; Little et al. 2001; Wright et al. 2004), policies and interventions often focus more superficially on task-oriented communications such as information provision for choice. The importance of deeper aspects of care relationships, and of continuity within these relationships, is sometimes deemphasized in both attempts to improve efficiency and attempts to assess the quality of care from external standpoints. Policies and practical initiatives sometimes seem to forget that patients’ abilities to participate in their care can depend on appropriately supportive relationships with health professionals and broader services, and that interactions and relationships with health professionals and broader services can have harmful as well as beneficial implications for patients’ contributions to their own care, as well as their identities and broader well-being (Coyle 1999; McLeod 2002; Entwistle et al. 2010a; 2010b; 2012a).

TREATING PEOPLE AS PERSONS: PRELIMINARY CONSIDERATIONS

The concept of “persons” and its implications for how people should be treated have featured in debates in moral and political philosophy for centuries. We provide just a brief overview.

The term “person” is often equated with the term “human,” but can be used in a more technical way to refer to beings (human or otherwise) that (a) have particular (valued) characteristics and/or (b) belong to a group whose members have particular ethical privileges. The characteristics associated with the concept of persons include abilities to reason and communicate, emotionality, abilities to act intentionally, self-awareness, self-regulation, potential to suffer in particular ways, and interests in preserving and developing self and identity (see, e.g., Cassell 2004; Frankfurt 1971; Johnston 1987; Kant 2008 [1788]; Strawson 1962; Watson 1975). Different authors have emphasized different characteristics and generated different implications from these, including in terms of which humans or other beings

they think should count as persons, and (less often) what is due to them and what can be expected of them as such (Chappell 2011). On all accounts, however, persons have a different ethical standing than nonpersons.

There are important concerns, however, about use of the concept of persons when thinking about how human beings should be treated. If the characteristics associated with the concept are understood as criteria for judging which individuals should *count* as persons, those humans who do not clearly and consistently demonstrate them might apparently be excluded from the protection of requirements that they be treated as persons (Chappell 2011). In this article we are committed to developing an understanding of what it means to treat patients as persons that will not have negative implications for anyone who needs health care. We seek an understanding of person-centered care that applies, for example, to babies and young children, people with intellectual or developmental impairments, people who are anaesthetized, and people with dementia.

Tim Chappell (2011) offered an important way to address the potential exclusion problem. He pointed out that we know that humans are the kinds of creatures “likely to display sentience, rationality, self-awareness and the rest of the personal properties” and we rightly treat those humans we meet as persons “in advance of any such displays” (2011, 7), and even if they seem unlikely to be able to put on such displays. Chappell thus advocates that all humans should (somehow) be treated as persons without having to pass any further, individual-level tests.

This raises the question of whether the concept of persons is needed at all. We suggest it remains useful, especially in health care settings, to signal a focus on the ethical aspects of interactions between humans as social beings. Support for this idea can be derived from the widespread recognition that when patients say they were treated not as a person but rather as a lump of meat, a number, or a thing on a conveyor belt (for example), they are making indignant claims to the effect that they were not treated appropriately for the kind of being that they are.

The idea that all humans should be treated in ways appropriate to persons does not require us to deny or ignore the fact that some humans are not particularly good exemplars of the possession of all the characteristics associated with the concept of persons, and it does not require us to assume that all human beings should be treated in exactly the same ways. Chappell (2011) considered the interactions of parents with their young children to illustrate how people can simultaneously recognize that others do not (yet) have or exemplify these characteristics, and interpret and relate to them in ways that enable them to develop those characteristics. Our treatment of others can in some senses support their development as persons, as well as signifying our recognition of their ethical standing as members of the community of persons (Chappell 2011).

Answers to questions about how persons should be treated are, however, complex. They depend in part on our ideas about what is good for persons. While some aspects of life seem important for all human beings (Flanagan 2007;

Nussbaum 2011), the specifics of what is good for individuals vary. In the liberal moral and political philosophy that has shaped much bioethical thinking to date, a strong concern to avoid imposing on everyone a single standard view of what is good is often associated with the idea that what distinguishes individuals, and what determines what is good for them, is their particular preferences or choices. This idea helps explain the emphasis on autonomous choice mentioned earlier. However, important critiques of the idea argue that it obscures both the significance of social relationships for shaping individual preferences or choices and the values that can emerge when we think of humans as socially situated beings who make sense of themselves in part by reflecting on their capabilities and their places in intersecting biographical narratives (Davis 2009; Mackenzie and Stoljar 2000; Sandel 2009). These issues need to be taken into account too. They imply that to treat others as persons we must be sensitive and responsive to their specific characteristics in the particular situations in which we encounter them.

Our reflections on these ideas about persons, together with recent work on what matters about people's experiences of health care delivery (Entwistle et al. 2012a), prompted us to recognize that insights from the capabilities approach might be useful for thinking about the idea of treating patients as persons.

THE CAPABILITIES APPROACH: AN INTRODUCTION

The capabilities approach was developed as a way of thinking about how advantaged or disadvantaged people are, or how the quality of human lives can be assessed. Its roots can be traced to Aristotelian ideas about human flourishing, but it has been developed in more recent times for work on human development and social justice by Amartya Sen, Martha Nussbaum, and others (Nussbaum 2011; Robeyns 2011; Sen 2009). There are now several variants of the approach, but this section summarizes key and widely accepted features.

The main concepts of capabilities thinking are "functionings" and "capabilities." Functionings are doings or ways of being, such as preparing meals for one's family, working as a nurse, being malaria-free, or being literate. Capabilities are the genuine opportunities that individuals have to achieve particular functionings. Capabilities, especially for higher level functionings, are dynamically shaped by interactions between individuals and their environments—including their social relationships. The capability to prepare meals for one's family, for example, depends on having relevant resources (food and tools for cooking it), knowledge and skills, interpersonal proximity, and a position within the family from which sociocultural norms allow one to take on food preparation responsibilities. Some capabilities, for example, to be malaria-free, are more environmentally and socially shaped than actively individually acquired and owned.

The basic idea of the capabilities approach is that what makes for good lives is having capabilities for valued func-

tionings. The approach generally encourages an evaluative focus on the extent to which people are free and able to be and do what they have reason to value being and doing. Leading authors recognize that it can sometimes be more appropriate to assess achieved functionings rather than their corresponding capabilities, but the merits of doing this in specific situations continue to be debated.

Several features of capabilities thinking make it particularly useful for our purposes. First, it opens up a broad evaluative space. The questions of which of the many possible capabilities should count as valued, and how they should be prioritized and assessed, are still open to discussion, although a number of useful options have been published. In principle, however, many capabilities can be recognized as widely valued—some, including for example the capability to be well nourished, because they are deemed essential for human well-being and/or are foundational for many other capabilities. However (second), capabilities thinking is also pluralistic. It can recognize that individuals differ in the value they place on particular functionings, especially the more complex functionings associated with particular ways of life, such as working as a chef or being an athlete or a poet. The capabilities approach emphasizes the importance of opportunity freedom, and when assessments of quality of life focus on people's capabilities rather than their achieved functionings, they avoid imposing particular ideals on everyone. For example, a focus on the capability to be well nourished leaves room to respect the value that some might attach to religious or politically motivated fasting, as well as the value of being well nourished.

Third, the capabilities approach incorporates a relational rather than an individualistic ontology of persons and their capabilities (Smith and Seward 2009). This involves recognizing that a person's capabilities are significantly shaped (and perhaps at least partly constituted) by their environmental and social circumstances—both past and present. As our example of the capability to prepare meals for family members illustrates, situational and relational issues interact dynamically with any particular impairments or talents individuals have been born with or acquired.

The relational ontology of the capabilities approach can extend to capabilities that are often thought of as properties of individuals, including, for example, capabilities to develop refined self-awareness and identities. The capabilities approach is broadly consistent with relational understandings of autonomy that recognize that who we as individuals are able to be, and how we are able to contribute to that for ourselves, depend on our social situations and relationships, as well as on the resources and skills that we might claim for and locate within our individual selves (Entwistle et al. 2010a; Mackenzie 2008; Mackenzie and Stoljar 2000; Meyers 1989; Westlund 2009). The relational ontology of the capabilities approach does not prevent it from taking individual human beings as the ultimate concern of ethical thinking.

There are several ways in which capabilities thinking can be used in relation to health care. Health can be

considered in terms of capabilities as well as in terms of absence of disease, normal functioning, and other aspects of well-being (Law and Widdows 2008; Venkatapuram 2011), and the capabilities approach can offer a helpful frame for relating considerations of justice to considerations of health (Ruger 2010; Venkatapuram 2011). As a number of authors have recognized, consideration of capabilities can also be useful when evaluating the effectiveness and appropriateness of health-related services and interventions because it can encourage an expansive view of outcomes that reflects what people say they value in life and appreciate from service provision (Al-Janabi et al. 2012; Entwistle et al. 2012a; Grewal et al. 2006; Lorgelly et al. 2010). Our primary concern here, however, is to explore how capabilities thinking might support the consideration and delivery of person-centered care.

CONSIDERING THE CAPABILITIES ASSOCIATED WITH BEING (TREATED AS) PERSONS

If we consider person-centered care as a (whole) approach to medicine or health care, or as an approach oriented to promote health in its broadest senses, a very wide range of capabilities can be salient to assess it (as for evaluations of medicine or health care more generally). Here, however, we consider person-centered care primarily as an aspect of health care quality that is talked about alongside effectiveness, safety, and so on. We now use insights from the capabilities approach to develop a new guiding idea for the promotion of person-centered care. In what follows, we explain the basis of this idea, illustrate the kinds of implications this has for health care practice, and explain how it relates to existing definitions and characterizations of person-centered care.

We suggest it may be helpful to identify and focus on a subset of capabilities (and/or their corresponding functionalities) that is particularly associated with the concepts of persons and being treated as persons. This subset could include, for example, capabilities to reason, to feel and respond to emotion, to intend and initiate action, to be self-aware and self-directing, to experience particular kinds of suffering and so on, and capabilities to participate socially in a group or community of beings that recognizes each other as having significant ethical privileges. Almost by definition, these are valued human capabilities. (Of course, suffering per se is not necessarily positively valued, but capabilities to experience emotion, avoid unjust suffering, and/or seek and gain relief from suffering are.)

We call this subset of capabilities—which we acknowledge is still imprecisely defined and underspecified—the “*person-al capabilities*.” We use the unorthodox hyphenation to try to sustain attention to the ethical aspects of the concept of persons.

The person-al capabilities, and especially those associated with being, and not just being treated as, persons are often thought of as attributes of individuals. But while they have some important bases in our bodies, and their emergence and development may be constrained by our particular genetic makeup and bodily characteristics, they also

depend to some extent on our past and current situations and relationships. Relational thinking about capabilities can readily accommodate the idea that there are many important senses in which the ways others treat us enable us (or not) to exhibit the characteristics—as well as to experience the social status—of persons as ethically significant beings.

Recognition that person-al capabilities are socially shaped, and that people can “have” them in various ways and to differing extents, encourages the idea that to treat patients as persons, it will often not suffice simply to stand back and give those in whom the person-al capabilities are already well developed space to exercise them. Treating patients as persons might also entail positively enabling the development of person-al capabilities—and in ways that bestow significant ethical standing upon patients in whom those person-al capabilities are not all always and obviously manifest.

Guiding Idea: What Treating People as Persons Involves

We therefore propose a guiding idea that *treating patients as persons involves recognizing and cultivating their person-al capabilities*. A broader version of the idea—about treating *people* as persons—also has important implications for thinking about how patients might be expected to behave and for how health professionals should be treated by each other and by their employing organizations. For now, however, we focus on illustrating the potential of our idea to guide health care staff as they work with patients.

There are various possible ways of identifying, labeling, and describing person-al capabilities, and various approaches to recognizing and cultivating them. We are keen to avoid overspecification of the person-al capabilities in this preliminary article, but we use a few illustrative suggestions to outline three broad and interlinked implications of our guiding idea for health care practice, and to consider how these relate to previous definitions and discussions of person-centered care. In the final discussion section, we highlight some of the further developmental work that we think is needed to take the idea forward.

Respect and Compassion

Experiences of inclusion (or not) in the community of ethically significant persons arise in the context of interactions with others. If health services and staff are to recognize and cultivate patients’ capabilities to experience inclusion in the community of ethically significant human beings, they must bestow on them the status of people who matter. This will involve interacting with them in ways that signal they are valued and given due consideration (not, for example, left unacknowledged in waiting rooms or on hospital beds, and, in Kantian terms, not treated as means to policy or service ends). This requirement can obviously be associated with the notion of respect that features strongly in many existing definitions and discussions of person-centered care.

“Respect” can have various objects and take various forms (Darwall 1977). As we suggested earlier, concern to

recognize and cultivate person-al capabilities encourages a positively supportive kind of respect for all human beings, not just a distance-keeping or noninterfering kind of respect in the case of those who, for example, say they want to make their own decisions and articulate particular treatment preferences. Our guiding idea may thus be more demanding of health care staff than some other interpretations of person-centered care.

Respectful treatment of patients involves, in part, relating to them within the social norms of interpersonal behavior. These norms vary to some extent across cultures, but meaningful experiences of inclusion depend on more than superficial politeness. Our guiding idea requires that interactions between health care staff and patients reflect relationships of equality–mutuality in terms of entitlement to ethical consideration within and as part of a social group. Differentials of expertise and responsibility need not be denied, but if health care staff engage in communicative demonstrations of superiority that demean patients or undermine their self-perceived ethical status, they will not, on our account, be practicing in a person-centered way because they will be destroying rather than cultivating those patients' capabilities to experience inclusion in the community of ethically significant beings. Something like this kind of equality–mutuality requirement can be found in some (e.g., McCormack et al. 2011; Mezzich et al. 2009) but not all current definitions or characterizations of person-centered care.

A case can probably also be made that health services that recognize and cultivate person-al capabilities will treat people with the kind of compassion that acknowledges their potential to suffer in characteristically human ways—including emotionally and psychologically via threats to their self and identity (Cassell 2004). Health care provision that contributes to human suffering in these domains, for example, by ignoring distress, dismissing concerns, or passing negatively judgemental comment on people who do not conform to service-imposed ideals of health-related behaviors, will thus fall short of treating patients as persons on our account. Again, compassion features in some but not all previous definitions and characterizations of person-centered care.

So far, we hope we have illustrated that our guiding idea can promote the kinds of respect and compassion that avoid depersonalization in the sense linked to the notion of dehumanization as denial of shared humanity. It also, as we now illustrate, has implications for avoiding depersonalization in the linked sense of failing to adequately individualize care provision.

Responsiveness to Subjective Experiences, Unique Biographies, Identities, and Life Projects

The particularity of individuals is part of our humanity. Given the fact of human diversity, a commitment to recognize and cultivate people's capabilities to be self-aware and have interests in self-preservation and self-development (among others) entails working with each patient as a particular someone who has his or her own distinctive perspec-

tive and concerns. Our guiding idea can demand taking each patient's subjective experiences seriously, being attentive and responsive to patients' unique biographies, social contexts, and the relationships that matter to them, and being careful to avoid damaging personal identities that they value. In this respect it is thus broadly compatible with previous definitions and characterizations of person-centered care that encourage: individualizing care in ways that go beyond attention to the particularities of pathology and genes (Epstein and Street 2011); the adoption of biopsychosocial perspectives (Mead and Bower 2000); the seeking of an integrated understanding of the patient's whole person, emotional needs, and life issues (Stewart 2001); the addressing of the person's specific and holistic properties and difficulties in everyday life (Leplege et al. 2007); and so on.

Our guiding idea thus presents person-centered care as (in part) oriented to ensure that services work well for individuals; it encourages considerations of person-specific appropriateness and not just of generally demonstrated effectiveness. It also, as we illustrate next, requires services to take seriously what people can (and should be enabled to) do in terms of *determining* what is appropriate for them.

Support for Capabilities for Autonomy

Persistent concerns about autonomy in bioethics reflect the value that is attached to people being able to live their lives according to their own conception of the good, and the recognition that both illness and health care can undermine this. The idea of recognizing and cultivating capabilities for autonomy in health care might be regarded as a matter of demonstrating appropriate respect and/or of being responsive to individuals. However, respect for a person's autonomy can require more than the kind of recognition of their distinctive perspective and particular concerns that we have just discussed (Mackenzie 2008); we consider it separately here.

As Table 1 illustrates, autonomy is rarely explicitly mentioned in definitions and characterizations of person-centered care. One reason for this is that a narrow understanding of respect for autonomy that is inconsistent with some of the deep concerns of person-centered care lingers in health professionals' thinking (Ells et al. 2011). Relational understandings of autonomy (see earlier discussion) do not have these compatibility problems (Ells et al. 2011; Entwistle et al. 2010).

We assume a relational understanding that recognizes both that the exercise of autonomy requires relevant capabilities and that those capabilities are developed and exercised in relationships with others. We do not attempt here to specify which capabilities are relevant for autonomy (or what autonomy capability consists in). However, the most promising attempts to date (including Mackenzie 2008; McLeod 2002) suggest these could readily be included among the person-al capabilities that person-centered care should recognize and cultivate.

The idea that people can (and should) be supported to develop and use autonomy capabilities can help avoid

several problems that can arise with some ways of thinking about person-centered care. First, it can help ensure that our guiding idea of what it means to treat patients as persons can be inclusive of people who are deemed to have limited competence for decision making, including the intellectually disabled and mentally ill. These people are often excluded from the protection of an ethical principle of respect for patients' autonomy when the focus is narrowed to respect for autonomous choices (Beauchamp and Childress 2009). They are not readily accommodated by consumerist type definitions of person-centered care that place a strong emphasis on information and choice (e.g., Berwick 2009; IAPO 2006). But their capabilities for autonomy can often be recognized and cultivated in some appropriate senses—as they can be among patients who seem unable or disinclined to make their own decisions after being informed about their options. Of course, people will vary in the kinds of support they need to enhance their autonomy capabilities (e.g., help with reasoning, encouragement to discuss what might matter to them, development of self-trust), so various forms of engagement between health care staff and patients might be appropriate to cultivate autonomy capability in health care (Entwistle et al. 2012b; Mackenzie 2008).

Second, the idea that people can and should be supported to develop and exercise autonomy capabilities can usefully limit the kinds of means that service providers who aspire to be person-centered can use in the pursuit of health. This is helpful, for example, when we think of the support that health services give people to self-manage their health conditions outside formal health care encounters, as well as to share in decision making within these (Naik et al. 2009; Walker 2009). Support for self-management is envisaged within the definitions of person-centered care that emphasize support for health promotion (e.g., Mezzich et al. 2009; Stewart 2001) and active participation in rehabilitation (Lepge et al. 2007). The advantages of our emphasis on the need to recognize and cultivate autonomy capabilities include that it can generate demands that health care systems do not allocate patients responsibilities that are misaligned with their supported capabilities for self-management, that health promotion efforts do not undermine or preclude the exercise of patients' self-trust, self-respect, or (other) capabilities for autonomy, and that patients' own views of what is good for them are not neglected.

Third, because the emphasis is on cultivating autonomy capability, our guiding idea can discourage the problematic mandating of patient choice-making in the name of autonomy (Davies and Elwyn 2008). A concern to recognize and cultivate autonomy capability will require that patients' personal preferences be taken seriously, but in a nuanced and situation-sensitive way. It does not imply that health care staff should simply do whatever patients might say they like and want, as some choice-focused interpretations of person-centered care (e.g., Berwick 2009) can seem to imply. Our guiding idea can demand active work on the part of health care staff to ensure their recognition of a patient's autonomy capability is accurate and justified. It can also, by explicitly advocating the cultivation of autonomy capabil-

ity, encourage the forms of interpersonal relationship and professional support that people may need to help them to identify, check, and perhaps refine, as well as to pursue, their own particular interests. It is, therefore, congruent with broader rather than narrower interpretations of shared decision making and clinical support for the self-management of long-term conditions (Entwistle et al. 2012b; Epstein and Street 2011).

DISCUSSION

We have suggested that person-centered care can be understood in terms of a single guiding idea - that it involves recognizing and cultivating patients' personal capabilities. The implications of this guiding idea are far-reaching and congruent with the findings of broad-ranging studies of what matters to people about their experiences of health care delivery (Coyle 1999; Entwistle et al. 2012a; Goodrich and Cornwell 2008). They also often resonate with what thoughtful advocates of person-centered care have aspired to previously. Our guiding idea does, however, have several important advantages over previous definitions and characterizations of person-centered care, including strong potential to help overcome some of the issues with current interpretations of person-centered care that we identified in the second section of the article.

Several advantages derive from the facts that our guiding idea (a) emphasizes what is achieved for patients (recognition and cultivation of their personal capabilities), not just what health professionals do, and (b) is rooted in ethical considerations of what matters for good human lives (valued human capabilities). This ethically grounded ends-oriented approach offers a way of unifying thinking about the various practices or processes that can be associated with person-centered care, and criteria for judging which of these many practices or processes should count as person-centered in which circumstances.

Attention to the impact of health care on personal capabilities can help explain why person-centered care has intrinsic value independently of the impact of health care on disease- or illness-based indicators of health. Personal capabilities, like the broader range of capabilities that health care can support, are theoretically ethically significant and practically widely valued. (And various steps can be taken to ensure that future work to specify more clearly the personal capabilities to be associated with person-centered care can support claims that these capabilities are valued by particular groups of people.)

Consideration of implications of health care interactions for patients' various personal capabilities can help to distinguish between the practices of patient involvement that seem to thoughtful advocates to be more and less congruent with what matters about person-centered care. If health professionals promote treatment or condition-management strategies that are generally effective in relation to some valued health goals but do so in ways that undermine patients' personal capabilities (e.g., by dismissing their reports of side effects, overriding their requests to discuss other

treatment strategies, or otherwise denying the expression or authority of their voice), our guiding idea will say that there is a problem, even if the patient leaves a consultation having agreed to a clinically recommended intervention.

The emphasis that our guiding idea places on what is achieved for patients facilitates consideration of the achievement of person-centered care as a valuable outcome of health care. In principle, person-al capabilities could serve as ethically significant indicators of person-centered care. They could be used to evaluate interventions to promote person-centered care and to monitor progress toward person-centeredness in routine health care provision. Assessments of the extent to which patients' person-al capabilities are recognized and cultivated by health services are (assuming they measure what they are intended to) less likely to "miss the point" than tools that focus on what health care staff do. The tools for such assessments have not yet been developed, and assessment of person-al capabilities and the ways they are recognized and cultivated by health services will be methodologically challenging. It can, however, be supported by ongoing work to develop measures of capabilities more generally.

While our guiding idea might increase attention to the outcome aspects of person-centered care, it does not discourage the attention that still needs to be paid to the processes of health care delivery. As our illustrations of its implications indicated, our guiding idea can in some senses demand more of health services and staff than existing interpretations of person-centered care. In large part, this is because it reflects a relational ontology of person-al capabilities.

The relational ontology behind our guiding idea renders all day-to-day interactions with patients significant for person-centered care. It supports a recognition that commitments to good communication and careful exploration and responsiveness to what matters to each patient are particularly important at key junctures such as treatment decision making, care planning, and goal setting for self-management, but it also encourages us to remember that any communicative behavior can have significant implications for patients' practical identities and person-al capabilities—for their experiences as ethical agents.

The relational ontology behind our guiding idea can also refresh and strengthen thinking about the social aspects of health care interaction. It encourages us to look beyond task-oriented informational transactions and to think in a less "remote" way about interpersonal communication because it leads us to understand that the ways that health services and staff position and relate people in some senses and to some extent *constitute* those people's person-al capabilities.

Our guiding idea demands the kind of flexible responsiveness to individuals that some authors have previously identified as important (Epstein et al. 2005) but that is often lost sight of (or precluded) by attempts to promote person-centered care by "rolling out" particular processes or clinician behaviors. Interventions that promote standardized ways of working with patients will not work to achieve person-centered care on our view because different kinds

of interaction and support will be needed to recognize and cultivate the person-al capabilities in particular people and in particular situations (see also Entwistle et al. 2012a).

Because it discourages unduly simplistic assumptions to the effect that person-centered care can be achieved by having health care staff follow recipe-like guides to communication with patients, our guiding idea must be "implemented" in large part via commitment to its ends, awareness of the range of ways in which these can be achieved, and ongoing development and facilitation of skilfully flexible and virtuous professional behavior. There is, of course, a danger that the "permission" given by encouragement to cultivate person-al capabilities might be interpreted as a warrant for inappropriate paternalism. In principle, safeguards are built into the idea, as inappropriately paternalistic behavior is not consistent with recognizing and cultivating person-al capabilities, but these safeguards may not always be recognized and used in practice.

Our guiding idea can present a creative challenge to health professionals, particularly when it is used, as we hope it will be, to support the promotion of person-centered care for all, including the very young, the intellectually disabled, the delirious, and the demented. The idea discourages the assumption that people who clearly lack some of the person-al capabilities, or seem to have them to only limited extents, can be treated as ethically less significant as a result. It is, however, demanding in its expectation that health services and staff will find individually appropriate ways of recognizing and cultivating what person-al capabilities these people do and can have (including to experience membership of a social group in which all have ethical privileges).

In this introductory article, we have sketched only an outline of the guiding idea and its potential. A number of issues will need much more theoretical, empirical, and methodological exploration. Further questions need to be asked, for example, about the identification and perhaps prioritization of what we are calling person-al capabilities, about how these capabilities can and should be cultivated in different health care contexts and for particular patient groups, and about methods for assessing (health care support for) the relevant capabilities, for example, for quality monitoring and improvement purposes. More attention also needs to be paid to the conceptual and empirical relationships between the person-al capabilities and health, and to the scope of health service obligations and capacity to support both.

Finally, if it is to be of practical use, our guiding idea will need to be introduced and explained carefully to health service leaders and staff, many of whom will be unfamiliar with capabilities thinking. The language in which our guiding idea is currently couched is likely to be challenging. One simpler alternative would be to suggest that person-centered care could be thought of more in terms of "person-supportive care." However, adding yet another label and starting a terminological debate may be unhelpful at this juncture. Whatever the language, it is currently unclear whether and how health service leaders and staff will

be willing to accept the recognition and cultivation of the personal capabilities as part of their remit (or even to recognize a requirement not to undermine them as they work to promote health). However, most health care staff aspire to treat patients well as persons, and given the slow and uneven progress toward the provision of person-centered care to date, it seems worth exploring the potential of focusing on the recognition and cultivation of personal capabilities in person-supportive care. ■

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