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Science Matters – From Person-Centred Moments to Person-Centred Culture

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Laya Poost-Foroosh, PhD



Many organizations and health care professionals have person-centred aspirations and perceive their model of care to be person-centred. However, the complexities and constraints of actual practice may lead to person-centred *moments*, occurring in spite of health systems that actually impede person-centred care (PCC). As more organizations declare PCC as their preferred model of practice, challenges to effectively deploying PCC start to emerge. These include both organizational challenges that are embedded in the organizational practice culture and individual challenges associated with lack of adequate training. These challenges could impact how PCC is perceived and enacted in different organizations. The following are two examples of encounters that have elements or degrees of PCC, however they result in different outcomes and different care experienced by a patient.

Emily is an 8-year-old girl whose teacher suggested her hearing be tested. Her parents took Emily to see an audiologist. The hearing assessment showed a permanent moderate hearing loss in both ears. When Emily's parents heard the test results and learned that she needed hearing aids, they were shocked. They were also shocked to hear how much the instruments cost and how much commitment and follow-up it would take to manage Emily's hearing needs. They felt the audiologist was kind and thorough with testing; she spent one full hour with them and explained the test results and hearing aid options and why it was important for Emily to use hearing aids. She also provided different hearing aid options. However, all of the options were beyond their budget, so they told the audiologist they needed to think about it. They left the clinic without any

immediate treatment plans.

This scenario has played out differently in another setting. In the second setting Emily's audiologist recommended hearing aids and Emily's parents showed some hesitation to follow up with the recommendation. However, in this scenario the audiologist did not want them to leave without knowing what the source of their hesitation was. The audiologist did not know what the issue was; were the parents shocked with the news and needing more time to process it? Was the issue the stigma associated with wearing hearing aids? Or were there concerns with the cost of the intervention? So, she spent more time to get to know Emily and her family. She learned that there were some concerns with Emily's hearing when she was younger but her parents did not take it seriously because Emily started talking, reading, and writing in line with typical developmental expectations. They also thought the reason that Emily did not socialize in school like other kids her age was because she was shy. They did not attribute Emily's poor academic performance to her hearing because they were never academically strong themselves. Emily's dad works in a bakery and her mom has a part time job with minimum wage. Emily has three siblings ranging in age from 3 to 11 years. After taking the time to get to know the family better, the audiologist realized the reason for Emily's parents' hesitation was a complex mix of guilt, regret, and frustration. While their most tangible concern was the cost associated with getting hearing aids, they also felt regret for not having noticed or acted sooner, and could not help but wonder if Emily had missed out on academic and social development over the years as a result of their own failings. As a result, she counseled them beyond what some audiologists may consider to be within the realm of audiological counselling (but still within her scope of practice), and offered resources and contacts for further support. She also shared the typical audiological information on the benefits and importance of intervention, and potential financial support. The audiologist provided the application forms and information about how to apply for funding for Emily. Meanwhile she suggested fitting Emily with loaner hearing aids until the funding application was processed. Emily was very excited to hear that she would be getting hearing aids and her parents were relieved to know that there was a way to overcome the financial barrier.

Both audiologists in the above scenarios may claim the event as a person-centred encounter; however, the outcome of care is different between the two scenarios. What facilitated a more compassionate enactment of PCC in the second scenario was not merely the motivation of the individual clinician; this level of PCC requires an enabling work setting and training on PCC beyond the popular rhetoric. The clinician in the second example could not be as person-centred if her/his organization did not enable additional time for counselling and additional paperwork, and allow for the provision of loaner hearing aids and time for customizing them for patients. In addition, knowledge of what genuine PCC entails would have helped the first clinician to realize that although providing treatment options to patients and allowing them to choose between the options is in line with the shared decision-making element of PCC, it is not necessarily sufficient to be called PCC.

Research shows that clinicians have preferences for PCC, however, their actions are not as person-centred as they think. What clinicians perceive as being person-centred practice is often person-centred moments that they experience occasionally, and perhaps with certain patients who inspire person-centred moments. PCC has become a buzz word and is claimed to be the model of care by many, however it is not clear if everyone is talking about the same concept and what it actually means to each person. Besides, PCC is not a skill that is learned and maintained indefinitely. Sustaining person-centred care and changing practice from on-and-off person-centred moments to a consistent approach to care entails more than a motivated clinician. Moreover, being unaware of what constitutes a genuine PCC orientation or not knowing the difference between a person-

centred moment and person-centred practice may prevent practitioners from recognizing contextual or systemic barriers and consequently hinder engaging fully in person-centred practice. Contextual factors play an important role in how PCC is operationalized in practice. Embedding PCC in practice requires a sustained commitment not just from individual clinicians but also at the level of the organization. A work culture that supports PCC creates awareness of possibilities and also challenges to practicing PCC, and as a result facilitates effectively overcoming those challenges. How can one overcome barriers if one doesn't know they exist?

In my AMS research I am investigating the barriers in health professional practice for developing and enacting person-centred care. I am finding that organizational culture plays an important role in clinicians' familiarity with PCC and awareness of contextual barriers to PCC. My research is showing that health professionals who have support from their organizations have more opportunities to practice in a person-centred way, rather than performing person-centred moments. I am proposing that to effectively embed PCC in practice, organizations can utilize practice development in which individuals and teams are supported to become aware of the context of their practice and realize how specific features of their context may prevent them from practicing in a person-centred way. Instilling PCC requires an organization to create the work culture that provides learning opportunities through practice, leadership that supports PCC, and a collaborative work environment where PCC is not an individual ambition but a team effort.

Recommended Readings

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http://www.ams-inc.on.ca/ams-healthcare-blog/