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Commentary

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

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ABSTRACT

Over the last centuries, the field of medicine has evolved from a disease-oriented model where individuals were seen as simple hosts for diseases, to a patient-centered approach where health professionals actively try to engage their patients in treatment decision-making. This deep change in models of care acknowledges that patients are important actors in health fulfillment. Even though this change in models of care was a major step forward for medical practices and treatment success, patient-centered care medicine (PCCM) has brought its own limitations. In this brief comment, the concept of PCCM will be defined and the benefits of this model of care will be highlighted. The limitations inherent to PCCM will also be summarized. A discussion on how PCCM can move forward will be undertaken using evidence-based knowledge on positive approaches to health. Finally, an encompassing perspective (*i.e.* the salutogenic perspective) will il lustrate how the PCCM model of care can help to operationalize major health conceptual frameworks worldwide.

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

The benefits of PCCM

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

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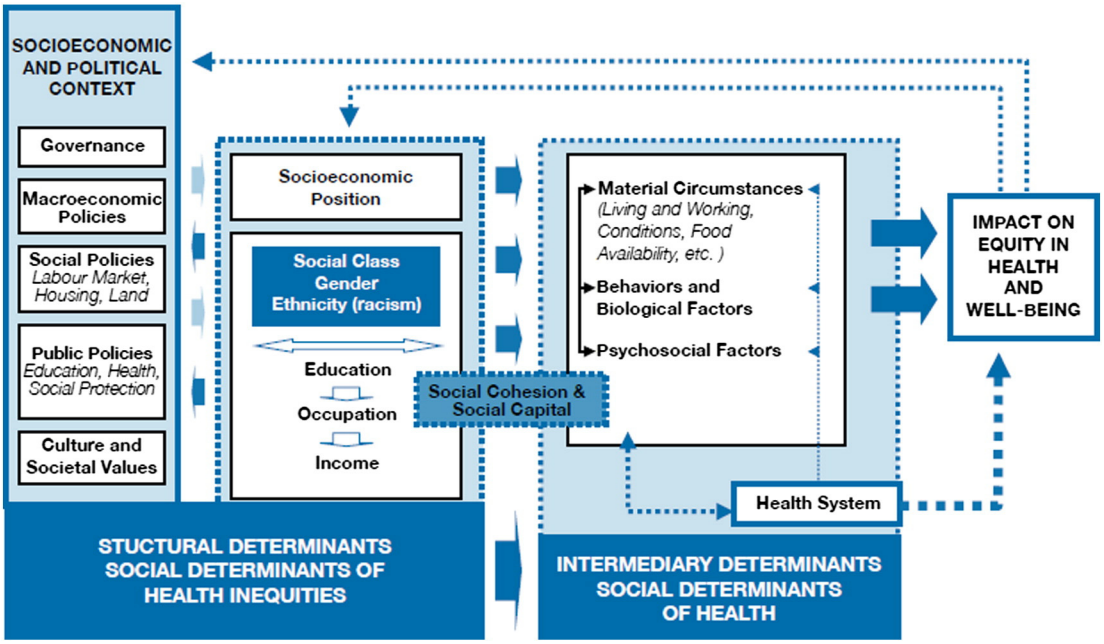

Fig. 1. The World Health Organization Commission on Social Determinants of Health conceptual framework.

also leads to a **decrease** in the average **length of stay** of patients in hospital, to **lowered costs** of care, and to improved **satisfaction with healthcare systems** (Meterko et al., 2010).

The limitations of PCCM

Despite these benefits, PCCM also has limitations. These are mainly related to contextual reasons, patients' health literacy, and to emphasis placed on disease rather than health. As **interactions** between health professionals and patients become increasingly **hurried**, **miscommunication** can occur. This situation can lead to a bad differential diagnosis, suboptimal treatment, and complicate the implementation of this model of care (Stewart et al., 1995). With respect to patients' health literacy (*i.e.* the ability to identify, understand, and use relevant information to make decisions leading to health), there is an **ever-evolving body of medical evidences** that many patients do **not know what to ask** to their health professionals (or even how to ask it). Other patients find it **difficult to discern important** from irrelevant issues. Patients can also fill their mind with **inappropriate** information. These limitations related to patients' health literacy tend to be more commonplace among vulnerable groups (Vaughan, 2009), and this has the potential to widen health inequalities. Additionally, PCCM **emphasizes disease** rather than health. Although patients generally consult health professionals for diseases (or unhealthy states), these appointments must also serve to discuss the state of their health and to empower them in various ways to improve their overall well-being. A growing number of health professionals provide clinical preventive medical practices such as immunization, counseling, and/or screening tests. Nevertheless, these practices are directed toward disease prevention rather than health promotion. Consequently, PCCM as a model of care is still embedded within a disease paradigm.

How PCCM can address its limitations using positive approaches to health

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

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

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

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

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

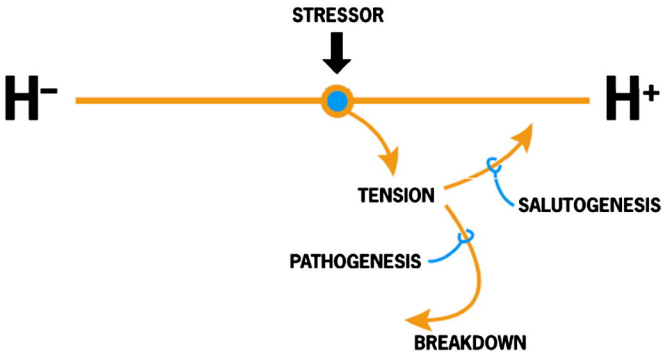

Fig. 2. Aaron Antonovsky health ease-disease continuum.

who was studying people who were able to stay healthy despite extreme life events (Antonovsky was working with Holocaust survivors) (Lindstrom and Eriksson, 2010). According to his researches, stress was pervasive in life and under its influence people experience tension. Antonovsky's showed that peoples either fall prey to this tension or overcome it by learning how to cope (Antonovsky, 1987). Conceptualizing health along a continuum (the health ease-disease continuum; Fig. 2), Antonovsky's theory contains three main concepts: 1) sense of coherence, 2) stressors, and 3) generalized resistance resources (Lindstrom and Eriksson, 2010). The **sense of coherence** captures the progression towards the health end on the ease-disease continuum (Fig. 2). A stronger sense of coherence was predictive of salutogenesis (or production of health) (Eriksson et al., 2007). Tensions are represented by **stressors** whereas **generalized resistance resources** are the available determinants for coping with stressors (Antonovsky, 1987). In other words, generalized resistance resources are moderators in the associations between stressors and sense of coherence. Antonovsky frequently used this theory throughout his career to highlight the limitations of interventions directed toward diseases, and the potential for interventions looking for resources, conditions, and factors underlying the production of health (Lindstrom and Eriksson, 2010).

Using a salutogenic perspective within the actual PCCM model of care may help to produce health by activating major health conceptual frameworks worldwide. When applied to the *WHO Commission on Social Determinants of Health* framework (Solar and Irwin, 2010) (Fig. 1), a salutogenic perspective within PCCM may provide health professionals relevant tools to work with. These professionals are then more likely to supply, or to assist their patients in their search for generalized resistance resources. These patients will then be better equipped to cope with stressors, and to maintain (or even increase) their own sense of coherence. Even if the answer to patients' needs involve only one prescription of medication, which might be a temporary solution, health professionals should use this moment to introduce a salutogenic dialogue with this patient. Across a therapeutic trajectory involving more than one appointment with the health professional, patients will feel more comfortable and respected in theirs needs, wishes, and preferences. Health professionals should capitalize on this opportunity to pave the road for alternative solutions of promoting health.

The salutogenic perspective, as an empowering process within PCCM, affects both the social determinants of health, and the structural determinants of inequalities. This serves individuals, institutions, and societies. Using a salutogenic perspective within the actual PCCM model of care will indeed favor a shift in the entire distribution toward better health, rather than solely acting on groups with higher risks of diseases. By introducing such perspective into health professionals' offices, we think that PCCM will increase its efficiency, and its effectiveness. It may even become a key factor in the production of health. The introduction of a salutogenic dialogue between the patient and its health professional was first discussed in 2000 by Hollnagel and Malterud (Hollnagel and Malterud, 2000). These authors stated that the biomedical model of healthcare largely underestimates healing and prevention resources that patients have in their possession. Using patients' perspective, we have access to various generalized resistance resources (*i.e.* motivation, meaningfulness of life, wishes, hopes, and understanding of disease).

Conclusion

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

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Conflict of interest

The authors declare there is no conflict of interest.

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