“I Think That It Could Work But...”: Tensions Between the Theory and Practice of Person-Centred and Relationship-Centred Care

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Abstract

Person-centred care places the person at the center of health care decisions, focusing on strengths and abilities rather than weaknesses and disabilities. Relationship-centred care expands upon person-centred care, emphasizing not only the inclusion of the person but also relational aspects, including family and others who support the person in coping with a disability. Eleven therapeutic recreation specialists were interviewed to explore their perspective of how person-centered and relationship-centred care were put into facility-wide practice. An interpretive framework and thematic analysis were used to compare the philosophy of each institution with current practice as reported by the TRSs. Findings indicate that person- and relationship-centred care are given prominence in the institutions’ mission and philosophy statements but that tensions exist when implementing these philosophies into professional practice at these institutions.

Keywords: Person-centred care, relationship-centred care, therapeutic recreation practice, thematic analysis, inter professional practice
Person-centredness is becoming increasingly prominent in both research and practice related to health care. Emphasizing a holistic approach to care, placing the person at the center of all interventions and decisions, patient-, client-, or person-centred care has been used in a range of care environments, including long-term care (Henderson & Vesperi, 1995), rehabilitation (Nolan, Booth, & Nolan, 1997), community mental health (Williams & Grant, 1998), and dementia care (Kitwood, 1997). It is in the latter area, following the pioneering work of Kitwood (1997) and Kitwood and Benson (1995) at the Bradford Dementia Centre, that person-centred care (PCC) has been most fully explored.

Although the bulk of the research related to PCC has emerged in the nursing literature, the concept is particularly relevant and consistent with the foundations of the allied health profession of therapeutic recreation (TR). TR is a systematic process that uses recreation and leisure services to bring about favorable changes in the persons served (Carter & Van Andel, 2011). This specialized application of recreation interventions is based on the individualized assessment of client needs, strengths, and goals, focusing on maintaining or improving health status, functional abilities, and ultimately the quality of life of individuals who have physical, mental, social, or emotional limitations that impact their ability to engage in meaningful leisure experiences. At its core, TR embraces a holistic approach to care and is based on the concept of collaboration between the therapeutic recreation specialist (TRS) and the client, emphasizing not disease or disability but rather health promotion and individual strengths and abilities (Austin & Crawford, 2001).

Although TR is rarely mentioned in the literature on PCC, as a profession, TR is optimally positioned to embrace the philosophy of PCC and to translate this philosophy into practice. The current study, therefore, explores the experience of PCC by TRSs, to draw attention to the consistencies and inconsistencies between the philosophy of health care organizations and the practice of PCC.

**Relevant Literature**

The purpose of this literature review was to serve as a basis for theoretical sensitivity (Strauss & Corbin, 1990) in the design and implementation of an interpretive study of the experience of PCC and relationship-centred care (RCC) in health care facilities. To enhance the theoretical sensitivity, the researcher identified sensitizing concepts that provided initial ideas for this study. These concepts also acted as points of departure in guiding the development of research questions, interview questions, and data analysis. PCC, RCC, and the practice of TR are examined to support the rationale for this study.

**Person-Centred Care**

Within health care, PCC is an “oft quoted but ill-defined concept that has nevertheless exerted a considerable influence on the policy, practice and academic literatures, particularly in nursing” (Nolan, Davies, Brown, Keady, & Nolan, 2004, p. 46). Although Kitwood’s (1997) ideas have been instrumental in providing a sense of direction and purpose for practitioners, some have begun to doubt if PCC can actually be achieved and question whether it is simply an evangelical ideal (Packer, 2000). PCC is perceived to be an important part of health care
practice, yet not much literature has been included from outside the field of dementia that is generally considered to be the foundational knowledge underpinning the development of PCC (McCormak, Karlsson, Dewing, & Lerdal, 2010).

In a recent review of the literature on PCC, Edvardsson, Winblad, and Sandman (2008) described the defining characteristics of PCC, including (a) acknowledging the individual as an experiencing person despite the disease; (b) using the person’s history and biography in care; (c) focusing on abilities rather than disabilities; (d) supporting individual rights, values, and beliefs; (e) offering and respecting client choices; (f) maximizing potential and providing shared decision making; (g) interpreting all behavior as meaningful; and (h) providing unconditional positive regard. These authors provided evidence that PCC contributes positively to the lives of individuals with Alzheimer’s disease. Similarly, outcomes of PCC include improved interaction and relationships with caregivers, positive changes in mood and behavior, increased feelings of well-being, and improved self-determination (Bosman, Bours, Engels, & De Witte, 2008; Edvardsson et al., 2008).

Despite these promising findings, Mansell and Beadle-Brown (2005) suggested that PCC is “scarcer in reality than it is in rhetoric” (p. 23). Conflicting traditions underpinning health care contribute to confusion about the nature of caring, both philosophically and in practice. For example, the scientific or Hippocratic approach to the provision of health care tends to ignore the uniqueness of each individual and to focus on the management of disease. This approach suggests that all diseases follow a pattern, and once that pattern is identified, management plans can be followed (MacLeod & McPherson, 2007). By contrast, an Asklepian approach, predating the Hippocratic approach, stresses the healing of the person rather than curing of disease/pathology. In this tradition, healing comes from within the person, clearly contrasting with modern medical care with its emphasis on evidence-based practice, protocols, technological advance and a “right way of dealing with things.” (MacLeod & McPherson, 2007, p. 1589)

When health care professionals develop care plans and goals, they need to ensure they are addressing the person’s plans and not their own plan. This remains an issue in practice today. Overall, evaluations of PCC in practice indicate that despite shifting philosophies in health care, patients still do not consistently receive PCC in practice (Coyle & Williams, 2001).

One avenue that has been explored to explain the lack of uptake of PCC in practice is the impact of PCC on health care providers. Although few studies have examined this impact, recently Edvardsson, Fetherstonhaugh, McAuliffe, Nay, and Chenco (2011) found that PCC provision explained nearly half of the variation in job satisfaction for providers in long-term care in Australia. If health care professionals are to be receptive to the emotional response of people with dementia, they need access to support
and supervision that addresses the emotional impact that they experience (Berg, Hansson, & Hallberg, 1994). If staff are not valued in the new culture, they cannot deliver PCC (Woods, 2001). Where job satisfaction is higher, quality of care is also better (Gilloran, Robertson, McGlew, & McKee, 1995). This suggests that both the culture and the context of care can be transformed to better achieve the positive outcomes associated with PCC.

In this respect, practitioners and researchers have begun to critically reflect upon the principles of PCC and have suggested that limitations persist in how PCC is conceptualized in dementia care (Kontos, 2005; Nolan et al., 2004; O’Connor et al., 2007) and translated into practice (McCormack, 2004). Some researchers have suggested the gap between philosophy and practice persists because of negative perceptions of dementia that practitioners hold (Brodaty, Draper, & Low, 2003; Kontos & Naglie, 2007), insufficient investment in education for practitioners delivering dementia care (Cohen-Mansfield et al., 2005; Sung, Chang, & Tsai, 2005; Testad, Aasland, & Aarsland, 2005), and a lack of appropriate knowledge translation methods for health care practitioners (McCormack, 2004; Kontos & Poland, 2009). This has led to the development of indicators and checklists for the delivery of person-centred practice that measures dimensions of caring and environmental factors contributing to PCC (Edvardsson, Sandman, & Rasmussen, 2009; Fossey & James, 2008; McCance, Slater, & McCormak, 2008). The focus, however, has generally been limited to the exploration of the nurse–client relationship and on nurse–physician collaboration (Hall, Weaver, Gravelle, & Thibault, 2007). Critics of this approach have suggested that interprofessional collaboration is key to improved efficiency, job satisfaction, and continuity of care (Hall et al., 2007). Limited attention, however, has been paid to the role of PCC in interprofessional care.

**Relationship-Centred Care**

Consequently, MacDonald (2002) asserted health care professionals should subscribe to a relational view of the concept of PCC, conceiving of human beings as belonging to a network of social relationships within which they are deeply interconnected and interdependent. McCormack (2001) advocated a similar stance, suggesting an individualistic view of autonomy be replaced with one based on interconnectedness and partnership, emphasizing both uniqueness and interdependence among individuals. This relationship-centred approach to care espouses that relationships exist at many levels, including among patients, their families, staff from all disciplines, and the wider community (Nolan et al., 2004). These concepts are not new, although less prominent than PCC in health care policy. A U.S. task force in the early 1990s was formed with the goal of promoting the closer integration of such concepts into the educational preparation of all professionals working within the health care system. As a result of these deliberations, the task force proposed a new model for health care delivery that they termed relationship-centred care, which reflected the importance of interactions among people as the foundation of care (Tresolini, 1994).

According to the tenets of RCC, “interactions between differing disciplines are only likely to thrive when partnerships based on ‘mutual respect
and self-determination’ are created so that reciprocal, complementary and symmetrical relationships result” (Nolan et al., 2004, p. 47). PCC, which focuses on individuals and their needs, or person-centred nursing, which focuses on the nurse–patient relationship, is unlikely to promote such interprofessional relationships (McCormack, 2004). Rather a milieu is needed in which all participants are meaningfully involved and that reflects the existence of multiple environments of care.

**Theoretical Framework**

The profession of TR itself is inherently holistic in its philosophy and approach to practice. This person-centred approach to practice has often positioned TR at odds with the dominant medical model. The quantitative measurement of the experience of leisure is challenging, particularly given the individualized approach to care that is espoused in the TR profession. This further marginalizes TRSs as health care professionals, and they struggle to achieve credibility on the interdisciplinary team. Qualitative research and evaluation techniques have been used to more fully understand the experience of person-focused TR practice (Pedlar, Hornibrook, & Haasen, 2001). Boyatzis (1998), for example, suggested an inductive, data-driven approach to thematic analysis enhances the researcher’s ability to bring forward and recognize previously silenced voices or perspectives.

This study of PCC and RCC in practice, therefore, benefits from the use of the interpretive paradigm, with an emphasis on understanding how meaning is constructed within health care systems. Theorists working within the interpretive paradigm search for culturally derived and historically situated interpretations of the social world (Crotty, 1998). Interaction between the individual and his or her social environment, including the family system and the broader social structure, has been recognized. Thoughts, emotions, attitudes, and behaviors are constructed based on the individual’s own interaction with his or her environment. The focus is on the making of meaning as individuals integrate information from
the internal processes of their minds and the externally available processes of the social world (Daly, 2007). They interpret and attempt to make sense of competing values systems within their social environment. Interpretations and explanations of these thoughts, emotions, attitudes, and behaviors reflect the integration and influence of multiple social realities, including those of the researcher, the participants, and their social networks. In using an inductive thematic analysis within the interpretive paradigm (Boyatzis, 1998), the researcher attempted to interpret and make sense of the experience of PCC and RCC as constructed by TRSs. This interpretation was based not only on the participants’ interactions with their social worlds, but also on the interaction between the participants and the researcher (Guba & Lincoln, 1989).

Method

Through this interpretive, qualitative study, the philosophies of practice at 11 health care institutions in Ontario and Quebec in Canada were examined. Specifically, from the perspective of the TRS employed at each institution, the experience of PCC and RCC is examined to explore the consistencies and inconsistencies between the philosophy and the practice of PCC and RCC.

Sample and Participant Selection

TRSs were recruited using purposive sampling to ensure TRSs who worked with a diverse array of clientele were included. To achieve this diversity, snowball sampling was employed within the provinces of Ontario and Quebec in Canada. Eleven TRSs participated in the study, seven from Quebec and four from Ontario. All participants were women, which is representative of the population of TRSs in Ontario and Quebec generally. Participants worked mainly with older adults and adults, and two TRSs worked with children. Among client groups, an equal distribution of TRSs worked with clients with physical and cognitive disabilities.

Data Collection

All procedures were carried out in accordance with the Human Research Ethics Committee at Concordia University that reviewed and approved this study. To explore participants’ understanding and experience of PCC, semistructured interviews were conducted individually with each TRS. Participants were asked to (a) describe the organization for which they worked and discuss the organization’s mission, vision, and values; (b) explain their understanding of both PCC and RCC; (c) discuss how PCC and RCC were part of the philosophy and practice within their organization; and (d) reflect on the benefits and challenges of implementing PCC and RCC in their practice as TRSs. Interviews were audio recorded and then transcribed verbatim.

As a researcher with strong beliefs in social constructionism, I recognize that my values, actions, and even
approach to research are strongly influenced by my own life experiences and my social world. I acknowledge that my interest in PCC is influenced by my previous experience as a TRS in a geriatric hospital, as well as through my interactions with my own family and their experiences with the health care system in Canada. I have had positive experiences in both arenas and believe in the capacity of TRSs to enhance quality of life for the clients with whom they work. I have also witnessed and experienced, however, the systemic challenges associated with implementing PCC and RCC, especially in an interdisciplinary setting. Like Schutz (1970), I recognize it is important to not impose my values on the research and the research participants. I do not believe, however, it is possible to completely bracket these values during the research process. Consequently, it was important to make my values known and be conscious of the co-construction of reality that occurred between the research participants and myself. This was important throughout the research process, from the formulation of the research questions to the analysis and presentation of the findings. Reflexive journaling was an important tool that allowed me to acknowledge my own co-construction of the interviews and the ensuing analysis. Because I was careful not to impose preconceived ideas or beliefs on the study participants, the interview questions acted only as a guide to me as I interviewed each participant. Through the process of semistructured interviewing, the interview questions developed according to the issues that the participants indicated as important to their experience and understanding of PCC and RCC.

Data Analysis

Based on Boyatzis’ (1998) approach to thematic analysis, the researcher engaged in inductive, data-driven coding and analysis. Inductive thematic analysis was used on each interview to analyze and compare both within and between participants. This method comprises constant comparative processes to generate knowledge about common patterns and themes (Thorne & Paterson, 2000). Although the researcher was sensitized to the theory of PCC and RCC, as outlined in the literature review, the researcher constructed the codes and themes from the interview data themselves, rather than deductively imposing predetermined codes and themes onto the data. This approach is useful in comparative analyses of multiple people, groups, or organizations (Boyatzis, 1998). In this respect, the researcher compared each TRS’s experience with the mission statements of the organizations within which they were employed. Consistencies and inconsistencies between the overall philosophy of the organization and the current practice within the organization were identified. These codes were given labels throughout the interview transcript and were compared within the transcript to identify patterns within each TRS’s account of her experience. For example, codes such as frustration, not feeling supported by management, and disconnect between theory and practice were combined into the theme of systems, structures, and policies, which was one subcategory of the overarching category of tensions between philosophy and practice.

Once that comparison was complete, the researcher then compared these results (i.e., congruence between philosophy and practice) across the
entire sample between each of the participants. At this point, similarities and differences were identified across the entire sample to theorize about the patterns that were created (Boyatzis, 1998). This resulted in two categories: clear commitment to PCC philosophy and tensions between philosophy and practice.

Memo writing (Lofland & Lofland, 1995) throughout the analysis elucidated and refined the emergent themes. In one memo, the researcher reflected upon the breadth and strength of the mission and philosophy statements of the organization:

A very strong connection to PCC philosophy is observed e.g., phrases such as “fostering partnerships to facilitate the inclusion of all people.” Fewer organizations addressed RCC, but some were deeply committed to a relational approach e.g., “We value our extended family network as they are an important partner for caring for our users.” These statements suggest a strong commitment to the philosophies of PCC and RCC.

Patton (2002) suggested:

The qualitative analyst owns and is reflective about her or his own voice and perspective ... the researcher’s focus becomes balance—understanding and depicting the world authentically in all its complexity while being self-analytical, politically aware, and reflexive in consciousness. (pp. 494–495)

Reflexive journaling, therefore, was also an integral aspect of the analysis because it provided me with an opportunity to track and critically reflect upon myself as an instrument in the analysis. This helped to ensure the analysis best represented the experience of the participants rather than my own experiences, both as a researcher and as a TRS.

Findings

Each of the 11 health care facilities espoused a clear commitment to PCC or RCC in some way in their mission and philosophy statements. Additionally, using thematic analysis, the researcher concluded that although the TRSs demonstrated a clear commitment to the embodiment of PCC in their practice as TRSs, they also experienced a number of tensions related to the practice of PCC at their respective health care facilities. There were substantial inconsistencies between the philosophy of PCC and the health care practices evident in the various facilities. The TRSs were well equipped to embrace PCC in their own practice but were constrained by the practices of their health care facilities and other health professionals with whom they worked. The TRSs experienced these tensions in three key areas: (a) between person-centred practice and the systems, structures, and policies of the organizations; (b) between opportunities and challenges in their disciplinary roles within the organizations; (c) in appropriately shifting from PCC to RCC by engaging families in relationship-centred practice. Each of these themes will be discussed in detail below.
Clear Commitment to PCC Philosophy

All of the organizations drew on principles of PCC in their mission, vision, and values statements. They articulated the importance of achieving excellence in providing quality care based on the needs of the clients and the community. Keywords and phrases common to most organizations included care/compassion, respect, teamwork/collaboration/partnerships, innovation, and accountability. These statements clearly exemplified the importance of a person-centred approach to their practices.

Five of the 11 organizations moved beyond PCC, and principles of RCC were articulated in their statements. For example, they wrote specifically of partnerships with families and communities; some even identified “patient and family-focused care” centrally in their statements. Two organizations held these relationships in particularly high esteem and wrote of being allies and partners with families who shared with them the “care of their loved ones.” These statements centrally positioned the importance of a strong commitment to relationships with patients, families, and health care partners and among staff within the organizations themselves.

Relating specifically to the practice of TR, the TRSs stated that they felt that as a profession they were well suited to bring a person-centred approach to their practice. Emphasizing the importance of client input and choice, one TRS stated:

For recreation, it’s looking at what they actually enjoy doing rather than what we think they should be doing. So instead of fitting them into our programs, it’s about trying to find programs or one-to-ones that fit with them and with input from them throughout the process, and with our expertise trying to come up with some kind of common ground to achieve it because the only way the goal is going to get achieved is if they have some stake and say in it.

Tensions Between Philosophy and Practice

Although all of the organizations strongly espoused PCC and/or RCC in their mission, vision, and values statements, ongoing tensions emerged for the participants in how this philosophy was translated into practice. Despite many examples of compassionate care in their practice, the participants overwhelmingly felt challenged in fully realizing the level of person-centredness that they felt was appropriate in their practice. These tensions existed in three key areas for the TRSs: (a) between person-centred practice and the systems, structures, and policies of the organizations; (b) between opportunities and challenges in their disciplinary roles within the organizations; and (c) in appropriately shifting from PCC to RCC by engaging families in relationship-centred practice.

Systems, structures, and policies. All participants shared experiences of their interactions with their clients that clearly exemplified a strong commitment to care. They generally agreed the clients were respected and were provided with good care. For example, one TRS said, “I think that there really is a compassionate, respectful part of our care.”
Another TRS highlighted the parallels between the vision of her organization and the philosophy of TR practice:

I actually think [organization’s] mission, vision, and values are actually very in tune with TR from what they say. Whether they’re being practiced that way is a different issue because they are all about being client-centred, about respect, choice, autonomy, being creative ... So, you know, using creative approaches and finding out the best care possible, so I think all that relates into what we’re taught to do in TR.

As emphasized in this quote, however, there was a sense that there was tension between theory and practice in all of the organizations. Small changes were implemented to enhance PCC in practice, but practitioners faced many structural barriers in their efforts to practice PCC. Scheduling, particularly around eating, sleeping, and bathing, were frequently noted as one of the biggest impediments to the implementation of PCC. One TRS spoke about her organization’s implementation of a new “milieu de vie,” a more person-centred model of care, and pointed out the tensions:

That’s still very scheduled. I know they keep talking about milieu de vie and doing it a different way, and they’re in the process of doing workshops on milieu de vie, but when it comes down to it, they’re still not doing it. They’re still not doing it. Meals are at a certain time because the kitchen has to make it at a certain time, baths are at a certain time. The one thing that they changed was that they’re not going to get their meal on a tray anymore. They did this about a year ago. Now we’re going to get everybody together and everybody that can go to the dining room, here is where we’re going to eat, so that they’re all going to eat together now. So instead of getting breakfast on your tray in your bed at seven o’clock, now you get it at seven-thirty in the dining room where you’re all corralled together. So that was their rendition of milieu de vie: “We’re going to change breakfast.” And it’s a little change; more changes are coming, but, I mean, it’s a start.

These tensions were extremely frustrating for the TRSs, as many felt more significant changes could be made if staff were more open to a change in their approach. For example, one TRS reflected:

I’m thinking to myself, what’s the reason for the mealtimes being at that hour? Is it because every person that lives at the hospital likes to eat supper at four, or is it because the kitchen staff wants to finish at a certain time and the nurses have to give meds? So it just seems to be a backwards approach to it. That’s just one example of so many different things within these systems where it just seems to be coming from the wrong place. It’s not coming from a personalized approach at all,
you know; there’s not a lot of flexibility in certain things. Whereas I think that it could work but … people will say, “Oh but it would be crazy if everyone ate at different times; we’d never have time to do this and that,” but I don’t think it would. I think you just would need to change the way you do things; that’s all. It’s not like there’s not enough hours in the day for it; it’s just that you would have to structure things a little bit differently.

Two of the organizations had made significant policy changes in this respect and no longer abided by such a strict schedule. For example, one TRS explained:

If there’s a resident who wants to get up a little bit later, it’s no longer obligatory for them to eat breakfast at whatever it is, seven-thirty or eight-thirty. If that person wants to miss breakfast, if they get up at eleven and it’s just before lunch but they maybe need a piece of toast and a yogurt, they should be given it.

Additionally, some changes in the accreditation process were seen to be moving in the direction of PCC, as noted by this TRS:

So some areas were weak at [name of organization]; some areas were not. So their new philosophy now for accreditation, there’s no more meeting the team. That’s something new this year. Before when they met the team, you could’ve bluffed; you could’ve had all your papers written up: “This is my dossier.” Not anymore. Now there’s a paper trail, they [accreditors] want to see with their own eyes, and they want to talk to the patient. So it’s patient-focused now; they really want to get to the patients.

The TRSs recognized the structural barriers, but also took steps to overcome these barriers by making changes in their own practice and implementing programs that more closely aligned with the philosophy of PCC. One TRS gave the following example of such a modification:

Breakfast is at seven-thirty; lunch is quarter to twelve; supper is a quarter to five. So I said, “Okay, if I’m not a morning person, what’s going to happen here?” That’s why I introduced breakfast club. Breakfast club was at eight-thirty. You have to be fully dressed, not eating in your bed on a plastic mug on a tray. It was porcelain dishes, freshly brewed coffee, freshly squeezed orange juice, “Butter your toast, smell the toast burning, smell the jam.” I had a bread maker. That’s what I introduced.

Similarly, another TRS spoke of specific programs that were implemented within her organization that emphasized the importance of respecting the clients and getting to know their individual histories through oral storytelling. She stated:
There’s been several cultural festivals and things in the community where the residents will be asked to attend, and they’ll have a special place for them and people come up and give their respects to them … and there’s a lot of storytelling programs that we do, and everyone seems to be really interested in their experiences.

Additionally, the TRSs often took it upon themselves to initiate interventions that emphasized moving in the rhythms of the clients, both cognitively and physically. One TRS began an initiative of writing letters to a client who had become extremely distressed because she was not getting any mail. The woman was asking staff to escort her downstairs to the mailboxes every day and then became distraught when there were no letters for her. The TRS explained her strategy:

So I asked the staff, I said, “Once a week we’re going to send her a letter.” She knows it’s from the staff; she’s alert enough, so it would be deceptive pretending it’s from someone else … and so she is happy. Every week she gets a letter from us. We just send it internally, so what does it cost you like, nothing … So I have a checklist and I’ll say “Gina it’s your turn,” and she’ll be like, “Ugh,” and I’ll be like, “You know we all committed that once every few months each of us would send a card.” So it’s not very complicated, but sometimes it takes interventions like this where that person now is looking forward to something, instead of being agitated because they’re hoping for something that will never happen.

Other TRSs moved even more deeply into a relationship-centred approach by involving the staff in special interventions and celebrations. This emphasized the feeling of being a part of a family or network and increased staff morale, as illustrated by the following example:

Because it’s a community, I find that it’s important to involve everyone, the staff too. So when it’s birthdays, I put the staff birthdays on the board as well. I hear comments about, “Oh, everyone wished me a happy birthday today; they even knew it was my birthday.” One time, I remember there was a nurse; she didn’t look at the board and she went down for her lunch and everyone sang her Happy Birthday and she was wondering how everyone knew. And then at the end of the day as she left, she realized it was on the board. But she talked about it for a month.

The TRSs all felt the reporting structure and statistics that were used to judge the efficacy of the care that they were providing severely constrained their efforts to provide PCC. These structures were perceived to be the most significant barrier to providing PCC, as evidenced by the following statements: “Is it client-centred or is it because we’re being pushed by these
other stats? What is it you want us to do? Provide quality care or quantity care? We feel like we're being pushed to that quantity.” Additionally, “So that was another big issue with me: quantity or quality. I would always offer quality…. But statistics run the show, and it shouldn't be like that.” This, in turn, affected staff morale when they felt stymied by the reporting structures. One TRS explained:

I would say that the systems, and administration pressures, and pressures from the resources from government and other agencies, I think those are the biggest pressures that push us to the non-patient quality focused care, personally. We feel really trapped as to who advocates for us to the government to say “Okay you've chosen the system to, to collect data; we're working with you on it, but hear us when we say it's not telling you what you really need to know.” It's not allowing us to provide quality care as to our best of our abilities, and that challenges a lot of us as far as feeling that professional satisfaction; it challenges us as far as knowing that we could provide more for our patients than we're giving them, um, and we just don't think it's a fair measurement for quality. Now, you know, in light of economy and everything else, we can understand where that's coming from, but it doesn't give them a true picture.

The TRSs, therefore, were highly attuned to the philosophy of PCC but felt constrained by the systems and policies in implementing PCC to its full extent. Despite these barriers, however, the TRSs worked diligently in their roles to push forward the implementation of PCC in their practices, but still felt they were not fully recognized for their efforts in this area.

Disciplinary opportunities and challenges. A second tension that existed for the TRSs in their efforts to embrace PCC and RCC was the challenge of interdisciplinary teamwork within their organizations. Despite clear person-centred and relationship-centred philosophies and mission statements, a medical model of care was still the dominant paradigm within all of the organizations. This was thought to impede the successful implementation of PCC and RCC. Some disciplines were perceived to be more successful than others in integrating PCC and RCC into their practice, which is evident in this quote from one TRS working in a rehabilitation setting:

I don’t see it translating fully. I find, um, some of the disciplines relate very well to the mission, vision, and values. For the most part, occupational therapists, social workers, TRSs, and sometimes even the psychologists depending on what area they work in. More of your multidisciplinary team fits into it. I find your medical model is a completely different focus, and so there's a lot of working around and almost conflict in trying to get the two together. I find there's a huge gap with bridging the two, especially when you look at a team that's mainly made up of nurses and doctors as
the leads and us [other health professions] trying to do what you want to do, and you get a lot of resistance because you’re giving too much choice to clients.

This was particularly challenging to the TRSs because the philosophy of their profession is strongly centered on the principles of choice and autonomy. They felt the clients appreciated and benefited from this approach, which is illustrated in the following quote:

For the most part, we get very good respect from the clients we work with because they know it’s their choice and it’s self-directed, and if they’re having good and bad days, we’re willing to work around that rather than saying, “Five days a week this is what you’re going to do, and there’s no budging from that.”

Some TRSs used their unique approach to act as role models and educate other staff about the importance of PCC and RCC. This was an ongoing role they played, and they found themselves constantly negotiating with other staff and reminding them that a more holistic approach to care is important, rather than segmenting the client based on the needs and expertise of the specific discipline. One TRS reflected on this role, emphasizing the importance of “how to do team building, how to empower them, how to empower the staff, how to empower the volunteers”:

I bring a different angle that they did not see. For example, the more the human side which they don’t see because they’re just so medical. The physio is doing the Get Up and Go, the OT is the Mini-Mental, the nurse is medication, and so on. I said, “Okay, but what does the patient want in all of this? We’re here for the patient; what does the patient want?” So I bring that to the team, and then they know that it’s true. But you’ve got to keep reminding them of that.

The tensions surrounding disciplinary boundaries often hampered a fully person-centred or relationship-centred approach to care. Although many participants gave examples of innovative collaborations with other members of the interdisciplinary team, underlying disciplinary tensions remained that were perceived as interfering with quality care within their organizations:

We have some big battles with occupational therapy over who’s turf is what. So as a result of that, I think it’s pretty sad that a lot of collaboration is lacking because it’s an all or nothing with either OT doing it or TR doing it, and we don’t come together to do it ... We all are really multidisciplinary. More than interdisciplinary, which is sad. We kind of do our own thing, and then it’s like we come together and give our reports, but there’s not a lot of cases where it’s collaborative work.

More specifically, when discussing RCC, the participants had little contact with the clients’ families. This was often
thought to be the purview of social workers and occasionally physicians and nurses. These disciplinary boundaries were perceived to hamper a more relationship-centred approach to their practice, as evident in the following quote:

I think that people are more like afraid sometimes of stepping on toes or it’s always been this person’s role, you know. But I think that obviously the two could coexist, you know. It doesn’t have to be only one department’s role to speak with families.

Despite the values espoused in the mission, vision, and value statements, and the push toward interprofessional practice, the TRSs overwhelmingly experienced a silo approach to care. Although some successful interprofessional care existed, the majority of the care provided still occurred in a multidisciplinary way rather than an interdisciplinary way. These disciplinary silos reinforced a less holistic approach to the clients themselves.

**Including families.** All of the participants were supportive, in theory, of moving toward a relationship-centred approach to care, including the clients, their families, staff, and volunteers in their practice. Although they recognized the benefits of this type of approach, few organizations had taken concrete actions to move in this direction:

We weren’t doing any education really for families who might be struggling; if they have a family member who’s got dementia and they want to learn how to better visit and make that visit more beneficial for both of them, we weren’t doing any of that, and that’s definitely a gap for us.

Some TRSs took initiative to address this concern and bridge this gap in care. For example, a number of the participants had begun to meet with families to learn their histories, as illustrated in the following quote:

I’ll ask them if I can give them some ideas of what to do with their brother when they come to visit or what to do with their father because they don’t know what to do and they’ll just sit there. And they’re like, “He doesn’t talk to me, so he doesn’t know I’m there.” I’ll say, “You know what, he may not know who you are, but if you have something in your hand always to bring, that helps.” I worked on a family album with the son of a gentleman who’s a resident. He brings the same album three times a week, and I worked on it with him. He said, “Oh isn’t it going to be boring?” I said, “Your dad forgets. Bring this every time; it’s a new activity for him all the time.” He carries this big fat album with him all the time, and he passes it to his siblings who come to visit, and his dad is so happy.... And now there’s conversation from a man whose visit used to consist of “Hi. I’m fine” and that’s all; he wouldn’t talk for forty-five minutes. So now there’s shared activity.
When thinking about involving families in care, the participants repeatedly stressed the importance of keeping the clients’ needs and interests at the forefront. They were concerned that involving families would have the potential to overshadow the preferences and abilities of the clients themselves. The TRSs emphasized the importance of maintaining high standards around confidentiality when involving families in care. One TRS explained:

And as far as sharing information to the family, the confidentiality guidelines and things that we have to respect, that can really limit us. We struggle with that because there are times where we feel that we could really involve family more, but we really need to tread lightly because in some places, some situations it’s not our place to share that information, or certainly we have patients where we know those supports could be there but that patient does not want their family or whomever involved for whatever reasons, and we have to respect that.

Because of these confidentiality concerns, as well as disciplinary boundaries and the challenges to interprofessional care that resulted, the TRSs experienced substantial tensions in their efforts to engage in a more relational approach to their practice.

**Discussion**

Based on the experiences of the 11 TRSs working in diverse care settings in Canada, there continues to be tension in the implementation of person-centred and relationship-centred approaches to care. Although all of the organizations had clearly articulated person-centred philosophies in their mission and vision statements, and even some that espoused a relationship-centred approach, the findings indicate these philosophies are still not being fully integrated into practice.

Consistent with previous research, mainly within the nursing profession, implementing PCC in practice is not straightforward. The concept of PCC has been criticized in the literature as ill defined and idealistic (Brooker, 2004; Nolan et al., 2004). One major challenge to the implementation of PCC has been the foundations of traditional models of service delivery that deny diversity or difference (Dowling, Manthorpe, & Cowley, 2006; Ray, 1999). This supports the experiences of the TRSs in the current study. As individual practitioners, the TRSs felt well equipped to bring PCC to their practice. Their emphasis on strengths, abilities, and health promotion were closely aligned with PCC and RCC. The TRSs perceived that working with other professions that did not bring such a strengths-based approach to their practice hampered the organization’s full ability to embrace PCC. This is consistent with previous research that suggested that one of the biggest barriers to widely implementing PCC was an emphasis on impairment, loss, and dependency rather than ability and/or potential in some settings (Sheard, 2004).

Supporting McCormack et al.’s (2010) meta-analysis of the literature related to PCC from Norway, England, and Ireland, these Canadian health care organizations had care processes that were routinized, staff-centred,
and afforded few opportunities for the development of meaningful relationships among clients, families, practitioners, and volunteers. Bringing the examination of PCC and RCC practices into the study of TR practice, this study found experiences similar to those reported in the nursing literature, indicating that practitioners struggled with the values of PCC versus the realities of routine practices (Brown-Wilson, 2008). Although some organizations have made efforts to change structures and policies, such as flexible mealtimes, care processes remain highly staff centred. Consistent with Duffield et al.’s study (2007), this study has resulted in a continuation of a silo approach to care, with little evidence of interdisciplinary practices. Although the TRSs were prepared to deliver PCC in their practice, they were constrained by disciplinary boundaries as well as the systems and structures within which they worked. It would appear as though a relationship-centred approach cannot be successful without more attention to interprofessional relationships and care.

Organizations appear to have added the label of PCC or RCC without the structural or cultural shift necessary for successful implementation. The TRSs in this study found the systems and reporting structures that were required in the current economic climate extremely constrained their ability to engage in PCC and RCC. This has been noted in the management and nursing literature, suggesting the challenge for health care workers today is how to provide care that values the perspective of the person in an environment that is “overburdened and economically impoverished” (Peek, Higgins, Milson-Hawke, McMillan, & Harper, 2007, p. 173). Specifically, Innes and Kelly (2007) pointed out that integrating PCC into practice may be difficult and that pay and conditions do not reflect the importance of the work carried out. Inadequate resources and staffing have consistently been identified as one of the main barriers to implementing PCC in practice (Dowling et al., 2006). Gladman, Jones, Radford, Walker, and Rothera (2007) in occupational therapy suggested, “An appropriately resourced and constructed specialist service using an adaptive rehabilitation approach aimed at maintaining personhood can deliver good individualized care to people with dementia, but specific and appropriate commissioning for these services is needed to nurture them” (p. 171).

Despite these constraints, the TRSs in this study took individual initiative to model quality PCC and RCC in their practice. This care was based on the holistic, strengths-based foundation to the profession of TR as a whole. Based on their training and experience, they were well equipped to engage in care that was person centred and relationship centred. This quality of care, however, was perceived as continually under attack from reporting structures that based decisions solely on quantitative evidence. This evidence was perceived to undermine the TRSs’ holistic approach to care by segmenting client care and interaction into measurable pieces. Broadening evidence-based practice to include qualitative measures could address this tension and has long been advocated for by nursing researchers (Morse, Penrod, & Hupcey, 2000; Rycroft-Malone et al., 2004; Wylie & Nebauer, 2011). If quality of life measures are not person-centred and only quantity
of care is valued and measured, not quality, practitioners will continue to be discouraged from embracing PCC or RCC in their practice.

Developing an organizational culture of PCC and RCC requires that all members of the organization share their beliefs, values, rituals, myths, and sentiments (Stokes, 2004). To implement change and improve experiences for clients and practitioners alike, a workplace culture must be developed that truly values person-centred practice. The importance of organizational culture on the provision of PCC has been well established, and the importance of core values and principles in delivering PCC is well understood. These principles need to permeate the entire organization, with particular attention to staff being managed in a person-centred way (Brooker, 2007; Ryan, Nolan, Enderby, & Reid, 2004; Sheard, 2004). When staff are empowered, recruitment and retention is improved and PCC is more likely to occur (Stokes, 2004).

Although the social and political system has been recognized as important in supporting PCC and RCC in practice, the current data shed light on the importance of individual agency among practitioners as they strive to bring PCC and RCC to life in their practice. Although a supportive workplace culture is important and essential, individual efforts and actions should be encouraged as part of this shift. It is imperative to shape the attitudes of health care professionals in a manner that emphasizes the importance of PCC and RCC through educational and professional preparation. The TRSs in the current study, with education from a variety of educational institutions, exemplified a profession with a clear and consistent philosophy with a strong foundation in a holistic, person-centred and relationship-centred approach to care. Their solid philosophical foundation in education contributed to a strong commitment to providing PCC and RCC despite the tensions they encountered within the health care system and between other disciplines. While continuing to work toward larger organizational shifts in practice, each health care professional, regardless of discipline, can make efforts to engage in more person-centred and relationship-centred practices. Educators can support this in their teaching, and health care organizations could invest in opportunities to educate and enlighten current practitioners, many of whom have been entrenched in the medical model for many years. For example, drama has been used as a successful intervention in implementing PCC and RCC in practice (Kontos, Mitchell, Mistry, & Ballon, 2010). Shaping positive attitudes in practitioners and supporting these attitudes with systems that encourage and reward PCC and RCC can facilitate the development of a collaborative community of care. This collaborative community encompasses interprofessional collaboration, but equally involves collaboration and relationship building among the client, his or her family, his or her friends, other clients, staff, and volunteers at all levels of the organization.

**Conclusion**

This interpretive, qualitative study expands the scope of understanding of the philosophies of PCC and RCC and shows how these philosophies are being integrated into health care practice from the perspective of TRSs in Canada.
The findings support previous research mainly from within the field of nursing, suggesting challenges in implementing PCC and RCC in practice are ongoing. In exploring this phenomenon within the profession of TR, the author suggests the strong educational and philosophical foundations within the field have encouraged TRSs to be leaders in incorporating PCC and RCC in their practice. Ongoing tensions exist between philosophy and practice, and these tensions must be addressed to encourage a more widespread adoption of PCC and RCC practices. Utilization of qualitative methods, both in research and in evaluation, can deepen understanding of and commitment to the experience of PCC and RCC in practice.

References


