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The currentness of person-centred practice

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Contemporary society is characterised by at least three fundamental shifts. The first is an economic-technological shift, which becomes manifest in direct transactions on a global scale that are being made possible by advanced communications and information technology. The second is a relational shift that becomes visible in the rise of the networked society. Organisations develop into open and flexible network systems, which take on a more democratic character and in which power and influence are connected to relationships more than to positions. The third development is a cultural-spiritual shift. A 'revolution from within' is going on that is characterised by an increased interest in personal experience, new forms of consciousness and creativity (Scharmer and Kaufer, 2013, p 125). These changes concern all spheres of life: labour; education; living and recreation; and health and social care. They offer opportunities to live, learn and work in a more meaningful and humane way, but they also bring many uncertainties and the risk of emptiness, in economic, sociocultural and existential terms. When looking at the domain of health and social care, we see that costs and scope have ballooned in recent decades as a result of economic and technological-medical developments, the growing number of older people and people with a chronic disease, and the increasing complexity of healthcare needs. The most important challenge within care and cure now is how to provide high-quality care with fewer resources and less manpower. This special issue of the *International Practice Development Journal* puts forward an important perspective from which to do this: person-centered practice.

Person-centeredness is not a new concept in healthcare (see the introduction to this issue, *Person-centredness: the 'state' of the art*). Originally based in the humanistic psychology of Carl Rogers, it has become a movement of reform in healthcare since the 1990s. Kitwood's early definition of person-centredness as 'a standing or status bestowed upon one human being by others in the context of a relationship' (Kitwood, 1997, p 8), emphasises a key characteristic of person-centred care – that it entails a relationship that is experienced as meaningful and empowering to the persons involved. More recently, 'care' has been broadened to include learning and working relationships, resulting in the concept of person-centered practice and person-centred cultures in workplaces. Person-centred practices and their development are characterised by participation, openness, engagement and reciprocity in learning. This dialogical perspective transforms the dominant cultures of bureaucracy, distancing and instrumentality in many healthcare practices. All papers in this issue demonstrate the dialogical nature of care and/or research practice, whether intrapersonal, interpersonal, social, cultural or even spiritual, and each paper contributes a small piece to this puzzle of establishing and legitimising person-centred practice as an approach to creating high-quality and cost-effective care. Moreover, these contributions show the importance of participatory, creative and interactive methodologies alongside the more standard research methods for fostering as well as measuring person-centred outcomes. However, practices are not static, but continuously changing, influenced by new policy decisions and legislation. The solutions put forward by policymakers and umbrella

organisations to deal with the challenge of 'costs and quality' in health and social care raise new and interesting questions for person-centred practice too.

First of all, technological innovations are seen as an opportunity to strengthen persons' self-determination regarding their life choices and health, to offer better quality care that is more transparent and collaborative, and to reduce the costs of healthcare. A lot of research is still needed to determine whether technology can bring the desired changes, but what is clear is that it changes the relationships within health and social care practices (Pols, 2012). From the perspective of person-centeredness, we can consider whether these changes help persons to feel seen, respected and develop their own life projects, thereby enhancing their health and wellbeing.

Second, we see a shift from 'care' to 'self-management' and from institutional to community care. Linked to the value of self-determination and based on a positive notion of health (Huber et al., 2011; Galderis et al., 2015), self-management is promoted among care providers and care receivers. Instead of having their needs and problems cared for by professionals, people will be encouraged to manage their own health and life within their home environment, supported by professionals, family, neighbours and friends. Again, we see that relationships change dramatically: the care relationship becomes a coaching relationship and the care setting is now a sociocultural community and physical neighbourhood. This raises the question of how to implement person-centeredness within these new practices: what do community care and support look like in terms of fostering the empowerment and health of persons?

Both the above shifts bring a third challenge: new forms of professionalism are needed. Health and social care professionals will become coaches of clients' self-management, and coordinators of care and assistance within the home environment, using new technological devices and apps in doing so. They will also increasingly become initiators of improvements in the workplace or care networks, as pioneers of transformation (Frenk et al., 2010). Being compassionate and thoughtful is not enough, dialogical and transformational leadership skills are also needed.

Person-centred practice stands at the forefront of these developments and is simultaneously encouraged by these changes to transform itself. These developments do not occur at the same speed or have the same importance in all countries or areas across the globe. This requires adaptability to changing and diverse contexts, and resilience in the light of the insecurity this can bring. It also means that there is never a single or final definition of person-centred practice. We must maintain this ongoing dialogue and collaborative process of learning and transformation. The Person-centred Practice International Community of Practice is at the beginning of its work and we aim to make a significant international contribution to person-centred practice research in multiple ways, as the papers in this special issue so articulately demonstrate.

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