



# Patient-Centered Care in the Middle East

Hana Hasan Webair

## Contents

Introduction .....	2
Why Patient-Centered Care? .....	2
Defining Patient-Centered Care .....	2
Principles of Patient-Centered Care .....	3
Patient-Centered Care in the Middle East .....	4
The History of Patient-Centered Care in the Middle East .....	5
Principles of Patient-Centered Care in the Middle East .....	7
Barriers to Patient-Centered Care in the Middle East .....	10
Conceptual Framework of Patient-Centered Care in the Middle East .....	12
Conclusion .....	14
References .....	15

## Abstract

Patient-centered care (PCC) is care that is responding to patients' preferences, values, and needs. The concept was developed in the late 1960s. In 2001, the National Academy of Medicine announced PCC as one of the six main goals of healthcare. PCC is culture-sensitive. Although there is a large amount of literature in Western countries in this regard, much less work has been done in the Middle East. This chapter discusses the history of PCC in the Middle East, the concept of PCC, and barriers against its application and finally draws a conceptual framework for PCC in the Middle East.

## Keywords

Patient-centered care · Middle East

---

H. H. Webair (✉)  
Hadhramout University, College of Medicine, Mukalla, Yemen  
e-mail: [hhwebair@gmail.com](mailto:hhwebair@gmail.com)

## Introduction

### Why Patient-Centered Care?

People generally prefer to make their own decisions themselves. What if the decision is about their own health, the most precious thing they have? Therefore, human nature necessitates that the patient is central to the healthcare journey. Patients should be empowered adequately for this role. Despite the widespread emphasis on patient-centered care (PCC) in healthcare, some professionals and organizations still struggle to involve their patients and to learn from their experiences (Groene et al. 2009; Moore et al. 2017).

In its 2001 *Crossing the Quality Chasm* report, the National Academy of Medicine (NAM) concluded that incorporating PCC as one of its six healthcare aims was ethically the right thing to do since it provided better clinical outcomes for patients and was unavoidable given the quantity of medical information now available to patients on the Internet. The WHO reported that people-centered healthcare has a positive impact on patient safety, adherence to care plans, treatment and health outcomes, satisfaction with care, and quality of life, as well as provider satisfaction (World Health Organization 2007). Studies have also shown that PCC is associated with the following positive outcomes:

1. Better recovery from discomfort and concerns (Oates et al. 2000; Rathert et al. 2013)
2. Better emotional health (Oates et al. 2000; Rathert et al. 2013)
3. Fewer diagnostic tests and referrals (Oates et al. 2000)
4. Fewer emergency department admissions for older patients (Jackson et al. 2013)
5. Better care processes, especially preventative services (Jackson et al. 2013)
6. More self-management and adherence (Robinson et al. 2008; Rathert et al. 2013)
7. Modest improvement in staff experience (Jackson et al. 2013)

There is insufficient evidence to comment on direct clinical benefits and on the impact of any economic outcomes (Oates et al. 2000; Jackson et al. 2013; Rathert et al. 2013). However, the impact of PCC on clinical outcomes is expected to be indirect (Epstein and Street 2011), for example, through improving adherence and self-management which is known to improve clinical outcomes especially in case of chronic diseases.

### Defining Patient-Centered Care

Patient-centered care – along with similar terms like person-centered, consumer-centered, personalized, and individualized care – encompasses qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient (Institute of Medicine 2001). Michael and Enid Balint coined the term “patient-centered medicine” in 1969. They emphasized that patients should

be understood as unique human beings; their illness is an incident or part of them that is better understood within the context of the whole patient (Balint 1969).

Patient-centeredness or patient-centered care (PCC) has been studied for several decades. Numerous definitions have emerged since 1969; unfortunately, there is no universal definition of PCC (International Alliance of Patients' Organizations 2006), though research has shown that a reliable definition must incorporate the patient's perspective (Peschel and Peschel 1994). Among the most useful definitions of PCC are those adopted by the National Academy of Medicine (NAM), the International Alliance of Patients' Organizations (IAPO), the Institute for Patient and Family-Centered Care (PFCC), and the World Health Organization (WHO).

In 2001, the NAM identified PCC as one of the six main goals of healthcare (Institute of Medicine 2001). It defined PCC as "care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient's values guide all clinical decisions." The other five goals of healthcare highlighted by the NAM are safe, effective, timely, efficient, and equitable care.

However, some medical professionals argued that it might be impractical to make decisions based on patients' preferences, which are not always appropriate (Berwick 2009). Thus, the IAPO created a definition in 2006 that limited patient input based on appropriateness and cost-effectiveness: "The essence of patient-centered healthcare is that the healthcare system is designed and delivered to address the healthcare needs and preferences of patients so that healthcare is appropriate and cost-effective" (International Alliance of Patients' Organizations 2006).

The WHO in 2007 suggested a more comprehensive approach, extending the definition of PCC to include all people involved in the healthcare system – from patients, families, and community members to healthcare providers. This approach reaches people outside of the clinical setting, before they become patients, helping them to promote their own health and prevent diseases. The WHO calls this a people-centered approach (World Health Organization 2007).

In summary, the PFCC in 2012 adopted a broader definition of PCC by incorporating the concept of family centeredness. PCC is not sufficient to adequately describe the PFCC's innovative approach to healthcare. The PFCC promotes "an innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. Patient- and family-centered care applies to patients of all ages, and it may be practiced in any health care setting" (Johnson and Abraham 2012).

## Principles of Patient-Centered Care

Most of these dimensions are based largely on the Picker Institute's eight principles of PCC. In 1986, research was conducted by the Harvard School of Medicine, on behalf of the Picker Institute and the Commonwealth Fund, using a wide range of focus groups and a literature review. The research identified seven dimensions of PCC. In 1987, the dimensions were named the Picker Principles of Patient-Centered Care, and the eighth principle – access to care – was added (Picker Institute). The

development of these principles was traced and documented by Peschel and Peschel (1994) in the book *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care*. The principles are:

1. *Respect for patients' values, preferences, and expressed needs*
2. *Coordination and integration of care*
3. *Information, communication, and education*
4. *Physical comfort*
5. *Emotional support and alleviation of fear and anxiety*
6. *Involvement of family and friends*
7. *Transition and continuity*
8. *Access to care* (Peschel and Peschel 1994)

The IAPO, PFCC, and other organizations adopted similar principles with more emphasis on patient empowerment and participation in the healthcare system (International Alliance of Patients' Organizations 2006; Bechtel and Ness 2010; Johnson and Abraham 2012). The IAPO set five principles: respect, choice and empowerment, patient involvement in health policy, access and support, and information (International Alliance of Patients' Organizations 2006). The National Partnership for Women & Families added comprehensive care and coordination and identified four principles, whole-person care, coordination and communication, patient support and empowerment, and ready access (Bechtel and Ness 2010), while the PFCC defined four core principles including respect and dignity, information sharing, participation, and collaboration (Johnson and Abraham 2012).

These principles are considered the general dimensions of PCC, though patient perspectives may differ according to care setting, culture, and illness. Numerous studies have been conducted to explore patients' needs and their expectations in defined settings, as in cancer care, fertility care, and primary care. These areas are beyond the scope of this chapter.

---

## **Patient-Centered Care in the Middle East**

The Middle East encompasses the countries around the southern and eastern sides of the Mediterranean Sea, from North Africa to the Arabian Peninsula. Though the specific area of the Middle East is defined differently by different sources, the United Nations identifies 14 countries in the Middle East: Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Oman, Qatar, Saudi Arabia, the Syrian Arab Republic, the United Arab Emirates, Yemen, and Palestine (World Tourism Organization (UNWTO) 2018). The WHO has a slightly different list which includes Afghanistan, Djibouti, Tunisia, Iran, Morocco, Pakistan, Somalia, and Sudan (World Health Organization 2018). All of these countries share some cultural and religious features; they have been heavily influenced by Islam, Judaism, and Christianity, as well as numerous other belief systems. Arabic is the most widely spoken language in the region.

During the Islamic Golden Age, which extended from the eighth to the thirteenth century, most Middle Eastern countries were caliphates, led by an Islamic steward called a caliph, and subject to the rules and regulations of Islamic law. Even after the decline of the caliphates and during the Ottoman conquest of the Middle East, Islam remained the main religion in the region. Thus, the history of medicine in the Middle East cannot be discussed without considering the history of Islamic medicine (Shanks and Al-Kalai 1984; Majeed 2005).

## The History of Patient-Centered Care in the Middle East

### The Medieval Period

PCC refers to patient care provided in the context of a healthcare system. Therefore, the history of PCC began with the origin of healthcare systems, specifically hospitals. Although medicine originated with early humans, the establishment of well-structured hospitals was an outstanding contribution of Islamic medicine; the earliest Islamic hospital was built in Baghdad in 805, and hospitals flourished in the region throughout the Abbasid caliphate (750–1258). The relationship between Islamic hospitals and the centers for the poor and sick (found in Christian monasteries as early as the Middle Ages) has not been fully explained. However, the medieval Islamic hospital was a structured institution, operated within a well-developed system and with a wider range of functions than the monastic relief centers.

Medieval Islamic hospitals were called *bimaristan* or *maristan*, and most were located in the Middle East (U.S. National Library of Medicine; Nagamia 2003). Treating the ill – whether male or female, civilian or military, adult or child, rich or poor, Muslim or non-Muslim – is a moral imperative of Islam. Islam also prohibits destruction and stresses the importance of learning, cleanliness and personal hygiene, respect for authority, autonomy, and tolerance for other religions. These principles were largely reflected in medieval Islamic hospitals, which were clean institutions located in large urban structures. They provided all services free of charge, and upon discharge, patients received sums of money to support themselves until they could return to work (U.S. National Library of Medicine; Syed 2002; Majeed 2005). Islamic hospitals were financed from the revenues of *waqf* (endowments) and were also part of the state budget. Wealthy men, especially rulers, donated property – which included shops, mills, caravansaries, or even entire villages – as endowments whose revenue was used to build and maintain hospitals (U.S. National Library of Medicine).

Given the importance of moral values in Islam, ethics were recognized as an essential requirement for Islamic physicians. Only qualified doctors were allowed to practice medicine, and in 931, Caliph Al-Muqtadir ordered all physicians to take an examination in order to qualify for a license to practice medicine. The licensing examination became compulsory from that time on. Furthermore, the Hippocratic Oath, a code of medical ethics, became mandatory for all medical practitioners (Syed 2002). Throughout most of the medieval period, a portion of medical textbooks also focused on medical ethics (Amine and Elkadi 1981).

One of the main achievements of the Islamic Golden Age was the ninth-century book *Ethics of a Physician*, written by the Arab physician Ishaq bin Ali al-Rohawi. It discussed topics related to medical ethics, including the faith and loyalty of physicians, problems of responsibility, ethical dilemmas in patient-physician relationships, issues that physicians must avoid, topics related to visitors, medical aspects of people's moral values, and harmful habits. All these topics fall within our modern definitions of PCC; thus, PCC is clearly not a new concept in the Middle East (Al-Ghazal 2004). Unsurprisingly, *Ethics of a Physician* was translated into English in the 1960s (Al-Ruhāwī and Levey 1967).

The high level of healthcare in Middle Eastern countries during the medieval period resulted from high-quality hospitals and the careful preparation of physicians, especially in terms of ethics and licensing, and providing financial assistance and comprehensive care to patients, regardless of age, gender, or religion. Middle Eastern countries were leaders in healthcare and shared their knowledge of medical science with the Western world. Although the concept of PCC had not yet been defined, it was already being partially practiced in the Islamic world by the tenth century.

### **The Contemporary Middle East**

After the medieval period, the flow of scientific and technological knowledge from the Middle East to the West slowed gradually and then reversed (Bulliet 2004). This was reflected in the level of healthcare in Middle Eastern countries. The WHO report published in 2000 revealed that only 8 out of the 22 countries in the Middle East were ranked among the top 50 in overall health system performance (WHO 2000). In 2018, Bloomberg Health Care Efficiency ranked 6 of these countries among the top 50 based on 2015 data (Miller and Lu 2018). Generally speaking, the level of healthcare in the Middle East is not the best today when compared to other regions in the world. Although some countries in the region ranked among the best in the healthcare system, the majority are still behind. In many of these countries, there is little financial support for healthcare from governments; patients may have to contend with high out-of-pocket expenses, inequitable access to care, inconsistent and poor quality of care, long wait times, and high absenteeism rates among providers (Yazbeck et al. 2017). Moreover, the health systems suffer from inadequate documentation, lack of well-designed, updated population databases, and very low biomedical publication rates (Mathers et al. 2005; Maziak 2005). All these issues work against PCC and lead to extreme variations in PCC within the region.

In reality, there is great variation in the quality of healthcare in the region. At one end of the spectrum are oil- and gas-rich countries that offer good healthcare services to the majority of their local population; at the other end are poor countries that are unable to provide even the basic minimum required healthcare services to their people (Qidwai et al. 2012). Despite these variations, Qidwai et al. (2013) found that the majority of physicians in select Middle Eastern countries prefer a PCC approach, while half of the patients in these countries prefer a mixed approach of PCC and physician-centered care. Unemployment and low educational level are associated with patients' preference for physician-centered care (Qidwai et al. 2013).

Promisingly, there are many possible applications for PCC in the region. Psychiatrists in the Middle East have followed a patient- and family-centered approach for several decades – before the introduction of the term PCC (El-Islam 2017) – in addition to the culture and religion of the Middle East which are conducive to PCC. Strong religious beliefs, a strong family network, and social support for patients among families, friends, and the community all favor the application of PCC in the region (El-Islam 2017).

## **Principles of Patient-Centered Care in the Middle East**

Very few publications about PCC have been produced in Middle Eastern countries compared to countries in other regions. Moreover, all of the definitions shared in the introduction of this chapter – and most of those in the existing literature – are based on the experience of patients from outside the Middle East. A study to define PCC in terms of fertility care in the Middle East was presented by Webair et al. (2017). They were, however, unable to develop a comprehensive definition of PCC from the perspective of infertile Arab patients, though such a definition had already been developed from the perspective of European patients, with a validated questionnaire to measure patient centeredness in fertility care (Webair et al. 2017). Current literature search has also failed to find such a definition from the Middle Eastern perspective. The time has come now to comprehensively define PCC from the perspective of patients in the Middle East in order to improve the quality of healthcare in the region. This chapter will discuss only some of the principles of PCC from the perspective of Middle Eastern patients.

### **Communication**

Communication is a central principle of PCC. Communication skills are key to understanding patients' needs, values, and preferences. However, communication is culture-sensitive, and it is one of the common barriers to PCC in the Middle East. What is considered good communication in the Western world may be perceived negatively in the Middle East; thus, the definition of communication in the context of PCC could be different from a country to country.

A study on the definition of good communication surveyed medical students from three different countries: the United Kingdom, India, and Egypt (Mole et al. 2016). Although there were commonalities in their views on good communication, there were also many differences. All of the students shared the view that good communication is extremely important for patients and involves trust and compassion on the part of medical professionals. The students also identified a feeling of disempowerment among medical professionals when working with highly educated patients. Patients' increasing power was, to some extent, perceived negatively by the students.

The Egyptian students emphasized the importance of considering care for both the family and the patient (family centrism) as part of positive communication; they viewed patient-centrism, without a focus on the patient's family, as inappropriate. In contrast, the British students preferred patient-centrism.

The Egyptian respondents also felt that care tailored to the patient's gender was a good communication approach, while the British respondents valued gender blindness, considering gender largely irrelevant to patient care and communication. In the same vein, the British respondents thought that communication should remain professional and detached, rather than emotive and familiar. Appropriate physical touch was also considered positive by Egyptian students but perceived negatively by the British students.

This study on good communication indicates that there is no universal definition for good communication for medical professionals; communication is impacted by culture and religion. Briefly then, in the Middle East, good communication is marked by trust and compassion, caring for the patient and family together (family centrism), following a gender-specific approach, and touching the patient with empathy and affection when appropriate.

### **Information**

Another important area of PCC that differs across cultures is the disclosure of information to patients (Silbermann et al. 2013). Silbermann et al. (2013) found that the majority of Middle Eastern medical professionals preferred not to disclose a serious diagnosis or prognosis to a patient; this runs counter to the universal approach in the USA, where both patients and medical practitioners place a high value on individual autonomy. American doctors fully disclose all medical information to patients, even if their prognosis is poor. Likewise, the fear and stigma associated with some diseases in the Middle East, which often lead patients to wait to visit the doctor until a disease has advanced, can affect disclosure of information and communication between patients and medical professionals (Silbermann et al. 2013).

### **Dignity**

Dignity is understood differently in different parts of the world. There are significant differences between Russian and Arab caregivers in Israeli nursing homes (Bentwich et al. 2017). Arab caregivers prioritized the concept of dignity, regardless of the norms of the institutional setting (Bentwich et al. 2017). The Arab caregivers supported their patients' dignity by referring to them by name, avoiding insulting or disparaging them, treating them affectionately, giving them as much help as possible, dedicating time to them, respecting their families, and avoiding silencing them. They also preferred to treat only patients of their same gender. The collective approach of multi-person households, which respects their different preferences, is common in Middle Eastern societies. This approach creates a supportive environment for both family members and the community. Such an environment leads to care that emphasizes the dignity and worth of the patient.

### **Cultural Competence**

Many of the elements of PCC, like communication preferences, differ across cultures and even between patients of the same culture. Cultural competence means learning relevant attitudes, values, beliefs, and behaviors of different cultural groups (Epner



and Baile 2012). It helps care providers to anticipate some issues, but it is also extremely important that they not make assumptions about a patient's preferences and needs based solely on his or her culture. Cultural competence when applied with PCC is expected to help overcome cultural challenges and meet patient satisfaction (Epner and Baile 2012). The key principles of patient-centered cultural competence were summarized by Epner and Baile (2012). Eight of these principles are listed below, based on the literature about PCC in the Middle East.

1. A skillful consultation is a golden tool. It provides a medical professional with information about the patient's needs, values, and expectations. In order to encourage the patient to speak openly from the beginning, the medical professional should encourage the patient to explain the purpose of the visit. He or she should then explore the patient's ideas, concerns, and expectations and therefore discover the purpose for the visit. This exploration will also alert the medical professional as to how much the patient wants to know and what information the medical professional should disclose. The medical professional should take a full medical history of the patient in order to reach a diagnosis and/or promote health and prevent diseases. Social history also helps to establish the doctor-patient relationship.
2. Family is an extension of the patient (Epner and Baile 2012). Most people have a profound love for and loyalty to their family. Asking a patient about his or her family, especially family members living with the patient, opens a window into his or her life and has diagnostic and therapeutic value (Epner and Baile 2012). The family could be a contributing factor to the patient's illness, as in cases of domestic violence, but it could also be a tool for healing. Families can support patients and help them adhere to their management plan. Watching how the patient interacts with family members could also give the medical professional clues about whether the patient prefers to disclose information related to the illness in front of some or all family members.
3. Words can harm or heal (Bedell et al. 2004). How the medical professional responds to the emotions of the patient and his or her family builds trust and rapport (Epner and Baile 2012). It is important to provide information in a way that the patient and family members can easily understand, avoiding medical jargon, and breaking bad news appropriately to lessen their painful effect.
4. Physical touch is a powerful tool that can be destructive or healing (Epner and Baile 2012). A medical professional should avoid greeting patients of the opposite gender by extending a hand unless the patient extends his or her hand first. A simple smile and nod indicate sufficient respect. It is essential for a medical professional to act with propriety when touching a patient during a physical exam (Epner and Baile 2012).
5. Nonverbal signals are powerful (Epner and Baile 2012). People convey as much or more information through nonverbal cues as through words (Epner and Baile 2012). A medical professional must use these cues effectively especially while exploring the patient's preferences and agenda.

6. Spirituality is extremely important (Epner and Baile 2012). Faith and religion often strengthen a patient during times of illness and weakness. The medical professional must treat the patient's faith respectfully. Offering prayers to a religious patient could have a healing effect (Epner and Baile 2012). Medical professionals must remember that a patient may refuse some procedures or treatments because of his or her religious beliefs or may need to consult with a religious scholar before making a decision. The medical professional must give the patient the time to make a decision and avoid pressing the patient to accept treatment that is prohibited by his or her religion. The medical professional can best help the patient by explaining all available care options.
7. The patient and his or her family are the center of the healthcare process (Epner and Baile 2012). The care provider should permit the patient and his or her family to control the consultation as much as possible, focusing on their agenda and priorities when reasonable (Epner and Baile 2012).
8. Familiarity and empathy should not interfere with professionalism. Patients usually prefer to be dealt with in an emotive, familiar way by their care providers, especially when they are vulnerable. This treatment will make a patient more open and could have a healing effect in stressful healthcare situations. However, it should not interfere with the medical professional's goal to help the patients conquer their illness and improve their health.

## **Barriers to Patient-Centered Care in the Middle East**

There are still significant challenges for PCC in terms of implementation, even in developed countries (Ekman et al. 2011; Mezzich et al. 2011). Studies undertaken in Bahrain, Egypt, Iran, Iraq, Jordan, Pakistan, and Saudi Arabia have found barriers to PCC at multiple levels within Middle Eastern healthcare systems – among healthcare institutions, providers, and patients (Anoosheh et al. 2009; Farahani et al. 2011; Qidwai et al. 2013, 2015; Esmaeili et al. 2014). Some of the barriers to PCC in the Middle East are summarized in Table 1; most are related to communication and team coordination.

Fortunately the literature on PCC available in the Middle East offers possible corrective measures that healthcare institutions can implement to overcome seven identified barriers: lack of a definition of PCC, time constraints, financial constraints, cultural beliefs, communication, dysfunctional healthcare systems, and patient behavior (Qidwai et al. 2012, 2015; McMillan et al. 2013; Elkhammas and Mahmud 2014; Esmaeili et al. 2014). First, in order to address the lack of a comprehensive definition and holistic view of PCC, institutions should survey patients and their family members, as well as healthcare professionals, to develop a country- or region-specific definition of PCC that encourages patient autonomy while respecting their patients' unique cultural and religious perspectives. Institutions should also use PCC as a quality indicator. Second, by reducing the number of patients that each healthcare provider sees in a given time period, institutions can help to alleviate providers' time constraints. Third, by accepting the increased costs of improving the

**Table 1** Barriers to patient-centered care in the Middle East from the perspective of physicians, nurses, and clients

Physicians	Nurses	Clients
1. Patients desire to allow doctors to decide for them	1. Having contagious diseases	1. Time constraints
2. Cultural reasons	2. Heavy nursing workload	2. Doctors feeling of being superior
3. Increased cost	3. Hard nursing tasks	3. Lack of doctors training
4. Religious reasons	4. Lack of welfare facilities for nurses	4. Having contagious diseases
	5. Clients’ misunderstanding manifested by the repeated question-asking	5. Sex differences between nurses and patients
	6. Lack of collegiality between physicians and nurses	6. Lack of empathy
	7. Cultural reasons	7. Lack of respect for patient privacy and confidentiality
	8. Lack of team coordination	8. Use of medical jargon or giving unclear or inaccurate messages
	9. Lack of organizational support	9. Differing languages between patients and healthcare providers

quality of patient care and by making health insurance available for all patients on appropriate terms, institutions can address financial constraints. Fourth, healthcare systems and providers can both respect and embrace patients’ cultural beliefs by educating community leaders about PCC and its benefits and by increasing patients’ capacity to engage with healthcare professionals. Fifth, medical professionals can overcome communication barriers by consciously avoiding the use of medical jargon when communicating with patients and showing empathy. Healthcare institutions can also apply information and communication technologies to improve communication between health facilities and patients. Sixth, to address the barriers caused by dysfunctional healthcare systems in many parts of the Middle East, the highest authority can implement family practice, ensure adequate healthcare coverage for the population, conduct research to develop and test primary care models to positively change healthcare delivery, and encourage patient and community participation in the healthcare system. Finally, and perhaps most importantly, in order to address patient behavior – as well as time constraints, financial constraints, cultural beliefs, and communication barriers – healthcare institutions should improve patient education about PCC and provide training for healthcare professionals to enhance their consultation and communication skills.

## Conceptual Framework of Patient-Centered Care in the Middle East

### Levels of the Healthcare System

A conceptual framework for PCC should be based on the healthcare system. This chapter adapts the four-level model of the healthcare system developed by Ferlie and Shortell, with some modifications (Ferlie and Shortell 2001; Reid et al. 2005). The healthcare system is divided into four interactive levels:

1. The **client level** refers to an individual patient (and his or her family) who is seeking medical help for either preventative or therapeutic purposes.
2. The **healthcare team level** refers to healthcare providers – including physicians, nurses, technicians, and all other professionals involved in the patient’s care. Caregivers from the community and patient advocates should also be included at this level.
3. The **organizational level** refers to hospitals, clinics, and other healthcare facilities within which the patient receives healthcare services. The institutions at the organizational level provide the required support for healthcare teams through infrastructure and complementary resources. Patient and community representation is encouraged at this level.
4. The **environment level** refers to the environment outside the healthcare organization, within which the patient, healthcare team, and organization are embedded. It provides political and economic regulatory services (e.g., finances, payment regimes, and markets). It includes all possible environmental support sources, including people surrounding the patient, community leaders, and local and international bodies.

### Concept of PCC

Unfortunately, there is no existing definition of PCC in the Middle East. Most definitions in the literature are based on studies that focus on patients outside the Middle East. Because the cultural and religious background of the Middle East is reflected in the healthcare preferences of its population, these factors must be kept in mind when drawing the framework for PCC in the region. In order to enhance PCC in the Middle East, healthcare authorities must engage community representatives in planning, implementing, and evaluating the healthcare system at the organizational and environmental levels. These representatives should communicate the preferences of patients and their families and help institutions determine how to design a healthcare system that is responsive to their needs. Community representatives can also play a significant role in the evaluation and modification of the healthcare system to ensure that it is working with the community hand in hand, to achieve PCC.

There are two factors that are essential to a Middle Eastern-specific definition of PCC: family and religion. PCC begins with the patient and his or her family. In the Middle East, the patient cannot be separated from his or her family (Loving 2012). Moreover, because most Middle Eastern patients are religious, their religion will also heavily impact on their care. Some religions have written forms like holy or sacred

books, which clarify the religion's principles and guide its followers (Bonney 2004). Many adherents believe that they must follow all of the rules given in these books. It is impractical to argue with a patient about a treatment that runs counter to the rules of his or her religion. Instead, the care provider should discuss alternative options with the patient when available.

Another important point to be considered is the degree of physician participation. About half of the respondents in a survey of Middle Eastern patients indicated that they preferred a mixed model of care, with both PCC and physician-centered care rather than just PCC (Qidwai et al. 2013). Middle Eastern patients feel more satisfied when their physicians actively participate in their care; some still believe that physicians are next to God. Mixing both PCC and physician-centered care models empowers the patient with the particulars about their condition and the treatment options, helping – but not guiding – the patient to express his or her preferences, needs, and expectations (Lewis and Pignone 2009). There must be a two-way flow of information and queries between the patient, his or her family, the healthcare team, possibly the organization, and maybe even the environment. It is not fruitful for a medical professional to use a consultation as a lesson or to adopt a one-way flow of information (from the provider to the patient only). Instead, the consultation must be interactive, including all levels of the healthcare system as needed. A mixed model of care means sharing treatment decisions rather than leaving it to the patient to decide alone about what he or she wants.

### **Examples of Applying a Middle Eastern PCC Conceptual Framework**

The following clinical situations help to illustrate how to apply a Middle Eastern PCC Conceptual Framework. For some clinical scenarios, there is only one clearly superior decision, and patient preferences play little or no role. For example, acute appendicitis must be treated with emergency surgery. Still, it is of paramount importance to fully inform the patients and their families so that they understand that surgery really is the only option. For many other clinical scenarios, however, more than one treatment option exists, and there are different combinations of possible therapeutic effects and side effects. Decisions about therapy for the induction of labor in post term pregnancy or for the treatment of irritable bowel syndrome are good examples. In such cases, patient and family involvement in decision-making adds substantial value. The process of sharing decision-making should take place at the level of healthcare providers; it can also be extended to include discussions with healthcare organizations, or possibly the environment, arranged through the care provider to achieve the highest possible quality of care. An example is when a care provider encounters a child with frequent asthma attacks despite proper medical management. It is helpful to search for triggers that might be the cause behind that. Common triggers can be found in the school environment, especially if the attacks occur more frequently during school days. In such a case, the care provider communicating with the school to both diagnose possible causes and put corrective measures in place to help the child is extremely helpful. In this way, the maximum healthcare benefit is expected to be achieved for both the patient



**Fig. 1** Conceptual drawing of patient-centered care in the Middle East

and the health system using the available resources, with the least cost, shortest time, and maximum satisfaction. Figure 1 illustrates the conceptual drawing.

## Conclusion

PCC in the Middle East still lags behind healthcare provided elsewhere in the world. There is no comprehensive Middle East-specific definition of PCC that takes the cultural and religious values of the region into account. However, the literature does define some PCC principles from the perspective of Middle Easterners. In the Middle East, good communication is marked by trust and compassion, caring for the patient and family together (family centrism), maintaining patient dignity, following a gender-specific care approach, and touching the patient only when appropriate. Good communication is emotive and familiar. Many healthcare providers in the Middle East believe that the disclosure of serious diagnoses and prognoses to the patient is unacceptable. However, healthcare providers should not

make assumptions about the patient's preferences based on culture alone. They must ask the patient what he or she prefers to know and involve his or her family in the decision-making based on patient's preference. Applying cultural competence and PCC together is helpful in this regard. Fear and stigma associated with diseases are also common in the Middle East, and medical professionals should consider these factors and deal with them appropriately when communicating with their patients.

There is a need for PCC in the Middle East, but many barriers still exist. These barriers include the lack of a comprehensive definition and holistic view of PCC, time and financial constraints, cultural beliefs, patient behavior, lack of appropriate communication, and the existing dysfunctional healthcare system in the Middle East. Nonetheless, Middle Eastern culture and religious adherence could be used to positively enhance PCC in the region. During the medieval period, religious values and culture were used to improve the quality of healthcare and patient satisfaction. The suggested conceptual framework of PCC includes the four levels of healthcare systems: client, care team, organization, and environment. It focuses on engaging the patient and his or her family and community as members of the healthcare system, facilitating informed decision-making, and encouraging the patient and healthcare provider to share decision-making, across all levels of the healthcare system.

---

## References

- Al-Ghazal SK (2004) Medical ethics in Islamic history at a glance. *J Int Soc Hist Islam Med* 3:12–13
- Al-Ruhāwī IA, Levey M (1967) Medical ethics of medieval Islam with special reference to Al-Ruhāwī's "practical ethics of the physician". American Philosophical Society, Philadelphia
- Amine ARC, Elkadi A (1981) Islamic code of medical professional ethics. *J Islam Med Assoc N Am* 13:108–110
- Anoosheh M, Zarkhah S, Faghihzadeh S, Vaismoradi M (2009) Nurse–patient communication barriers in Iranian nursing. *Int Nurs Rev* 56(2):243–249
- Balint E (1969) The possibilities of patient-centered medicine. *Br J Gen Pract* 17(82):269
- Bechtel C, Ness DL (2010) If you build it, will they come? Designing truly patient-centered health care. *Health Aff* 29(5):914–920
- Bedell SE, Graboys TB, Bedell E, Lown B (2004) Words that harm, words that heal. *Arch Intern Med* 164(13):1365–1368
- Bentwich ME, Dickman N, Oberman A (2017) Dignity and autonomy in the care for patients with dementia: differences among formal caretakers of varied cultural backgrounds and their meaning. *Arch Gerontol Geriatr* 70:19–27
- Berwick DM (2009) What "patient-centered" should mean: confessions of an extremist. *Health Aff* 28(4):w555–w565
- Bonney R (2004) Reflections on the differences between religion and culture. *Clin Cornerstone* 6(1):25–33
- Bulliet RW (2004) *The case for Islamo-Christian civilization*. Columbia University Press, New York
- Ekmán I, Swedberg K, Taft C, Lindseth A, Norberg A, Brink E, Carlsson J, Dahlin-Ivanoff S, Johansson I-L, Kjellgren K (2011) Person-centered care – ready for prime time. *Eur J Cardiovasc Nurs* 10(4):248–251
- El-Islam MF (2017) Person centered psychiatric medicine. *Arab J Psychiatry* 28(2):127–130

- Elkhammas EA, Mahmud SM (2014) Towards patients-centered medicine in Libya: an ethical perspective. *Ibnosina J Med Biomed Sci* 6(1):42–43
- Epnor DE, Baile WF (2012) *Patient-centered care: the key to cultural competence*. Oxford University Press, Oxford
- Epstein RM, Street RL (2011) The values and value of patient-centered care. *Ann Fam Med* 9(2):100–103
- Esmaili M, Ali Cheraghi M, Salsali M (2014) Barriers to patient-centered care: a thematic analysis study. *Int J Nurs Knowl* 25(1):2–8
- Farahani MA, Sahragard R, Carroll JK, Mohammadi E (2011) Communication barriers to patient education in cardiac inpatient care: a qualitative study of multiple perspectives. *Int J Nurs Pract* 17(3):322–328
- Ferlie EB, Shortell SM (2001) Improving the quality of health care in the United Kingdom and the United States: a framework for change. *Milbank Q* 79(2):281–315
- Groene O, Lombarts M, Klazinga N, Alonso J, Thompson A, Suñol R (2009) Is patient-centredness in European hospitals related to existing quality improvement strategies? Analysis of a cross-sectional survey (MARQuIS study). *Qual Saf Health Care* 18(Suppl 1):i44–i50
- Institute of Medicine (2001) *Crossing the quality chasm: a new health system for the 21st century*. National Academies Press, Washington, DC
- International Alliance of Patients' Organizations (2006) What is patient-centred health care? A review of definitions and principles. Retrieved 20 Oct 2014, from [www.patientsorganizations.org/pchreview](http://www.patientsorganizations.org/pchreview)
- Jackson GL, Powers BJ, Chatterjee R et al (2013) The patient-centered medical home: a systematic review. *Ann Intern Med* 158(3):169–178
- Johnson B, Abraham M (eds) (2012) *Partnering with patients, residents, and families: a resource for leaders of hospitals, ambulatory care settings, and long-term care communities*. Institute for Patient-and Family-Centered Care, Bethesda
- Lewis CL, Pignone MP (2009) Promoting informed decision-making in a primary care practice by implementing decision aids. *N C Med J* 70(2):136–139
- Lovering S (2012) The crescent of care: a nursing model to guide the care of Arab Muslim patients. *Divers Equal Health Care* 9(3):171
- Majeed A (2005) How Islam changed medicine. *BMJ* 331(7531):1486–1487
- Mathers CD, Fat DM, Inoue M, Rao C, Lopez AD (2005) Counting the dead and what they died from: an assessment of the global status of cause of death data. *Bull World Health Organ* 83(3):171–177
- Maziak W (2005) Global voices of science. *Science in the Arab world: vision of glories beyond*. *Science* 308(5727):1416–1418
- McMillan SS, Kendall E, Sav A, King MA, Whitty JA, Kelly F, Wheeler AJ (2013) Patient-centered approaches to health care: a systematic review of randomized controlled trials. *Med Care Res Rev* 70(6):567–596
- Mezzich JE, Snaedal J, Van Weel C, Botbol M, Salloum I (2011) Introduction to person-centred medicine: from concepts to practice. *J Eval Clin Pract* 17(2):330–332
- Miller LJ, Lu W (2018) These are the economies with the most (and least) efficient health care. Retrieved 27 Feb 2019, from <https://www.bloomberg.com/news/articles/2018-09-19/u-s-near-bottom-of-health-index-hong-kong-and-singapore-at-top>
- Mole TB, Begum H, Cooper-Moss N, Wheelhouse R, MacKeith P, Sanders T, Wass V (2016) Limits of “patient-centredness”: valuing contextually specific communication patterns. *Med Educ* 50(3):359–369
- Moore L, Britten N, Lydahl D, Naldemirci Ö, Elam M, Wolf A (2017) Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scand J Caring Sci* 31(4):662–673
- Nagamia HF (2003) Islamic medicine history and current practice. *J Int Soc Hist Islam Med* 2:19–30



- Oates J, Weston WW, Jordan J (2000) The impact of patient-centered care on outcomes. *Fam Pract* 49(9):796–804
- Peschel RE, Peschel E (1994) Through the patient's eyes: understanding and promoting patient-centered care. *JAMA* 271(2):155–156
- Picker Institute. Clarification of the history of the Picker Institute's eight principles of patient-centred care. Retrieved 16 Oct 2014, from <http://www.strategicprojectseoe.co.uk/uploads/files/Picker%20Institute%20Principles%20of%20Patient%20Centre%20Care%20history.pdf>
- Qidwai W, Ashfaq T, Khoja TAM, Rawaf S (2012) Access to person-centered care: a perspective on status, barriers, opportunities and challenges from the Eastern Mediterranean Region. *Middle East J Fam Med* 10(6):4–13
- Qidwai W, Nanji K, Khoja T, Rawaf S, Al Kurashi NY, Alnasir F, Al Shafae MA, Al Shetti M, Bashir M, Saad NES (2013) Are we ready for a person-centered care model for patient–physician consultation? A survey from family physicians of East Mediterranean Region. *Eur J Pers Cent Healthc* 1(2):394–404
- Qidwai W, Nanji K, Khoja TAM, Rawaf S (2015) Barriers, challenges and way forward for implementation of person centered care model of patient and physician consultation: a survey of patients' perspective from Eastern Mediterranean countries. *World Fam Med J: Inc Middle East J Fam Med* 99(2125):1–8
- Rathert C, Wyrwich MD, Boren SA (2013) Patient-centered care and outcomes: a systematic review of the literature. *Med Care Res Rev* 70(4):351–379
- Reid PP, Compton WD, Grossman JH, Farniang G (2005) Building a better delivery system: a new engineering/health care partnership. National Academies Press, Washington, DC
- Robinson JH, Callister LC, Berry JA, Dearing KA (2008) Patient-centered care and adherence: definitions and applications to improve outcomes. *J Am Acad Nurse Pract* 20(12):600–607
- Shanks NJ, Al-Kalai D (1984) Arabian medicine in the Middle Ages. *J R Soc Med* 77(1):60
- Silbermann M, Epper DE, Charalambous H, Baider L, Puchalski CM, Balducci L, Gultekin M, Abdalla RF, Daher M, Al-Tarawneh MR, Smith TJ (2013) Promoting new approaches for cancer care in the Middle East. Oxford University Press, Oxford
- Syed IB (2002) Islamic medicine: 1000 years ahead of its times. *J Int Soc Hist Islam Med* 2:2–9
- U.S. National Library of Medicine. Islamic culture and the medical arts: hospitals. Retrieved 15 Mar 2018, from [https://www.nlm.nih.gov/exhibition/islamic\\_medical/islamic\\_12.html](https://www.nlm.nih.gov/exhibition/islamic_medical/islamic_12.html)
- Webair HH, Ismail TAT, Ismail SB (2017) Review. Patient-centered infertility care from an Arab perspective: a review study. *Middle East Fertil Soc J* 23(1):8–13
- WHO (2000) The world health report 2000 – health systems: improving performance. Retrieved 20 Feb 2019, from <https://www.who.int/whr/2000/en/>
- World Health Organization (2007) People-centred health care: a policy framework. Manila, WHO Regional Office for the Western Pacific
- World Health Organization (2018) Regional Office for the Eastern Mediterranean. Retrieved 14 Mar 2018, from <http://www.who.int/about/regions/emro/en/>
- World Tourism Organization (UNWTO) (2018) Middle East members. Retrieved 14 Mar 2018, from <http://www2.unwto.org/members/middle-east>
- Yazbeck AS, Rabie TS, Pande A (2017) Health sector reform in the Middle East and North Africa: prospects and experiences. *Health Syst Reform* 3(1):1–6