ARTÍCULO ESPECIAL

1. Obstetrician and Gynecologist, FACOG, President of the Committee on Sexual and Reproductive Rights SPOG, former President of SPOG, former President of the Peruvian Fertility Society, Full Member of the Peruvian Academy of Surgery, Scientific Editor of the RPGO, Honorary Member of 6 Obstetrics and Gynecology Societies in Latin America, former Executive Director of FLASOG, Latin American Master of Gynecology and Obstetrics, Medal of Extraordinary Merit of the CMP, Former Deputy Minister of Health. ORCID: https://orcid.org/0000-0002-2603-3607

Declaration of conflict of interest: The author declares no conflict of interest in this publication.

Funding: the author's own.

Ethical considerations: Since this work is the product of a non-systematic literature review, there was no need for informed consent.

Received: 9 April 2023

Accepted: 16 April 2023

Online publication: 5 July 2023

Corresponding author:
Luis Távara Orozco
luis.tavara@gmail.com

Cite as: Távara Orozco L. Person-centered obstetric care. Rev peru ginecol obstet. 2023;69(2). DOI: 10.31403/rpgo.v69i2512

Person-Centered Obstetric Care
Atención Obstétrica Centrada en la Persona

Luis Távara Orozco[1]

DOI: 10.31403/rpgo.v69i2512

ABSTRACT
The Code of Ethics of the Peruvian Medical Association states that medicine is a scientific and humanistic profession. Person-Centered Care is now recognized as a fundamental component of quality medical care because numerous beneficial outcomes have been observeds for patients, family members and providers. Objective: To explore the arguments for person-centered medicine in order to incorporate it into our specialty and contribute to improving obstetric care. Methodology: Non-systematic review of the literature with selection of 72 references to construct this trial. Results: Over time, women have been attended by other women during childbirth. However, in hospitals around the world continuous support during labor has often become the exception. Currently, women deliver in a private setting with no one to accompany them, a situation to be changed, according to the evidence. The WHO recommends respectful maternity care and refers to care that maintains dignity, privacy and professional secrecy ensures freedom that no harm or abuse is done and allows informed choice and ongoing support during labor and delivery. Conclusion: The literature review shows that person-centered obstetric care improves maternal and perinatal health.
Key words: Person-centered medicine, person-centered care

RESUMEN
El Código de Ética del Colegio Médico del Perú establece que la medicina es una profesión científica y humanística. La Atención Centrada en la Persona ahora es reconocida como un componente fundamental de la atención médica de calidad porque se han observado numerosos resultados beneficiosos para los pacientes, incluidos familiares y proveedores. Objetivo. Explorar los argumentos de la medicina centrada en la persona para incorporarlos a nuestra especialidad y contribuir a mejorar la atención obstétrica. Metodología. Revisión no sistemática de la literatura, con selección de 72 referencias para construir este ensayo. Resultados. A lo largo del tiempo, las mujeres han sido atendidas por otras mujeres durante el parto. Sin embargo, en los hospitales de todo el mundo, el apoyo continuo durante el trabajo de parto a menudo se ha convertido excepcional. En la actualidad, las mujeres tienen su parto en un ambiente privado sin nadie que las acompañe, situación a ser cambiada, de acuerdo con las evidencias. La OMS recomienda la atención materna respetuosa y se refiere que la atención que mantiene la dignidad, la privacidad y el secreto profesional garantiza que no se haga daño ni maltrato, y permite la elección informada y el apoyo continuo durante el trabajo de parto y el parto. Conclusión. La revisión de la bibliografía muestra que la atención obstétrica centrada en la persona mejora la salud materna y perinatal.
Palabras clave. Medicina centrada en la persona, atención centrada en la persona

Introduction

Historically, medicine has been considered the science and art of caring for the sick, and many authors consider medical ethics and morality to be part of the physician's behavior. Since the Roman culture, the concept of complete and honorable dedication of the physician to his patient has been accepted[1]. In Aristotle's book Protrepticus, it is pointed out that medicine is fundamentally dedicated to preserving health and secondarily to caring for the sick, without mentioning diseases[2].

The Code of Ethics and Deontology of the Colegio Médico del Perú (CMP), version 2023, states: 'Medicine is oriented to respect for life, agony and death; as well as, to the achievement of the highest quality of life. It is a scientific and humanistic profession whose mission is to care for both individual and collective health, which implies promoting and preserving it, as well as preventing, treating, rehabilitating, relieving and comforting patients and their relatives, accompanying them respectfully and empathetically'[3].

We note two positions regarding the practice of medicine, the first accepts the biomedical model (positivist) and the second supports the biopsychosocial vision of person-centered care; each has different arguments and characteristics. We postulate that the biopsychosocial model is the most adequate way of understanding the reality of the human being because it does not contradict the biomedical model, but rather complements it[1].

The British physician William Osler states 'A good physician treats the disease; the great physician treats the patient who has the disease'[4].

More than 50 years ago, Karl Jaspers, physician and prominent philosopher, said: 'In modern medicine, everything seems to be in the best order. Day by day great results are achieved. But the astonishing thing is that dissatisfaction is growing among patients and physicians. There are now more high-level scientists and more science than at any other time, but it is also true that never before have there been so many problems and deteriorations in medical care derived from the negative influence of the dark side of technology, added to the persistent commercialization of medicine'[4].

Gregorio Marañón's phrase 'there are no diseases, but sick people' is in truth a biopsychosocial model that considers not only the organic disease but also how the patient lives his own ailment and how it affects both his values and his family and social environment. It surpasses the paternalistic model of Hippocrates[5].

Person-Centered Care (PCC) is now recognized as a fundamental intervention of high-quality health care because it results in numerous beneficial outcomes for patients, families and providers[6]. In addition, the practice of Person-Centered Medicine (PCM) provides solutions to other prevalent problems in health care including cost of services, improved chronic disease care, and legal litigation. Despite its profound ethical content, PCC is not well researched[7].

Methodology

Due to the aforementioned positions, the author carried out a non-systematic bibliographic search on the subject of Medicine/Person Centered Care in various databases of the SciELO, Cochrane Library, PubMed, Scopus indexers, from which primary and secondary sources were collected in number of 1,576, selecting 67 to which 5 of direct access were added. This means that 72 references were finally used to prepare this trial. It was not necessary to request informed consent.

Definition

In Valero Rodriguez's thesis, William Osler's phrase is quoted as saying: 'Variability is the law of life, and just as no two faces are alike, no two bodies are alike, and no two individuals behave alike under the abnormal conditions we know as disease'[8].

There is still no standard definition of PCM. The US National Academy of Medicine defines PCC as 'care that is planned, managed, delivered, and improved on an ongoing basis with the active participation of patients and their family or caregivers, in a manner that integrates the patient's preferences, values, and desired clinical outcomes'[1,9,10].

For WHO, PCC 'is an approach that incorporates the views and perspectives of people with a condition, caregivers, family members, and communities receiving that care. The health system is then organized around the comprehensive needs of people, rather than diseases'[11,12].

PCM is a very old and, at the same time, very current doctrine. It is a worldwide programmatic movement led by the International College of Person-Centered Medicine, based in New York[13-15].

The main objective of PCM is to improve the quality of people's health care[16,17], facilitating scientific and humanistic medical work with a solid ethical foundation[9]. Furthermore, PCM focuses medical action on the individual with a general holistic approach and not fragmented in all its biopsychosocial dimensions[18], stimulates scientific research to generate the best clinical evidence and humanism as the essence of medicine[14], offers care, support and treatment to the individual and the necessary information for the person to participate in his or her self-care[19-22].

History

PCM can be found in ancient Eastern civilizations, such as Chinese and Ayurvedic, as well as Western civilizations, particularly ancient Greece, which understand health broadly and holistically. These traditions are oriented towards health as a whole human being rather than disease[19].

In ancient Greece, the physicians of Cos did not differentiate the disease from the person nor the person from his environment; and those of Cnidus sought to find the patient's picture according to a taxonomy of diseases. During the Renaissance, both schools of thought were expressed through the controversy between the followers of Hippocrates and those of Galen. In the 17th century, the physician Thomas Sydenham constructed a model of objective clinical observations, describing the symptoms, course and outcome of the disease over time and thus created a new nosography. One hundred years later, with the French Revolution, foundational ideas of the modern clinical method appeared[23].

From a very young age, Pedro Laín Entralgo developed an integrative style of the scientific and the humanistic, as well as the treatment of the patient understood as a subject who seeks his or her personal wellbeing. Regarding the ethics between the doctor and the patient, he shows his commitment to the recovery of a professional with a soul. C. Gustav Jung advised health professionals: 'know all the theories, master all the techniques, but when touching a human soul, be just another human soul'[10].

Carl R. Rogers incorporated several disciplines related to the human being: social sciences, medicine, organizational psychology, economics, ecology, philosophy of science, theology, ethics, sports, art, culture, and race[24,25]. The term 'patient-centered medicine' was introduced by the British psychoanalyst Michael Balint in 1970, who contrasted it with 'disease-centered medicine'[5,26]. In recent years, in the face of increasing technology and specialization, the concept of person-centered medicine has been introduced, which emphasizes individual attention to the sick as subjects with a holistic, general, non-fragmented approach, analyzing the person in all his/her biopsychosocial dimensions[27]; it rescues Ortega y Gasset's expression "I am I and my circumstances"[26]. PCM has become a worldwide movement led by the International College of Person-Centered Medicine founded by the Peruvian psychiatrist Dr. Juan Mezzich. It has only recently entered Latin America[14,28].

PCM has developed predominantly in psychiatry and especially in family medicine[29] and seeks to apply a personalized, integrated, and contextualized model of clinical practice, so that the biomedical approach and technological advances can be delivered to patients within a humanistic planning[30].

In recent years, interesting national, Latin American and world events have been held with the purpose of promoting this new current in the practice of medicine. Mezzich points out that the WHO has already convened several international conferences to deal with the obvious: people-centered medicine[31]. In our country, the National Academy of Medicine has conducted several events on the subject, including a Latin American meeting that was followed by an important pronouncement. The Peruvian Association of Medical Schools (ASPEFAM, for its acronym in English) indicates that this approach not only seeks to place the human person at the center of health care, but also to continue humanizing the doctor-patient relationship[32]. This pronouncement is extremely important to ensure the training of human resources who can apply the new orientation of medicine[33], different from the one that Abraham Flexner gave it and that he himself remarked years later that 'intensely cultivating a scientific medicine brought with it the risk of losing the best judgment and the broad culture of previous generations'[34]. It will first be necessary to train teachers to impart teaching-learning of this current of medical thought, given that 'no one can give what he does not have, since in order to teach how to be a person one must first be a person'[13].

We have stated that PCM has been developed in psychiatry, in family medicine -particularly in primary care- and has been extended to surgery, and we obviously aspire to its application in the specialty of obstetrics and gynecology[35,36].

How do we understand PCM?

According to the National Academy of Sciences, Engineering and Medicine of the United States, PCM is understood as 'the medical practice that is based on the respect and monitoring of the

patient's preferences, needs and values, elements that should guide all clinical decisions',[37]. It should consider the patient's cultural traditions, personal preferences and values, family situation and lifestyle[38].

JM Ceriane tells us: 'we are in an era of medicine in which biological science, information, no tolerance for uncertainty, commercialism, scarce empathy, utilitarianism, and technology predominate. These aspects displace humanism, one of the pillars of medicine since time immemorial. Doctors and patients are dissatisfied'[39]. There are patients who show the same symptoms, and even the same laboratory tests, but their ailments are very personal to each one, depending on the circumstances surrounding them[40].

Characteristics

Mezzich summarizes the 8 essential characteristics of CCM[18]:

a. Ethical commitment

b. Holistic framework

c. Cultural sensitivity and responsiveness

d. Communicative and relational focus

e. Individualization of the clinical care program

f. Establishment of common ground between clinicians, patient and family for understanding and action

g. Organization of integrated, person- and community-centered services; and

h. Person-centered medical education and scientific health research.

The PCM emphasizes individual care of the sick as subjects, with a holistic, general - and not fragmented - approach to the human being in all its dimensions"[18].

Cárdenas, in his doctoral thesis, found that the most frequent violation of the Code of Ethics was 'careless, superficial, incomplete care'. Such a finding justifies one of the many reasons why the practice of PCM should be encouraged in Peru within a strict adherence to ethical aspects[41].

With Alvarez-Romero we can add that this paradigm understands the person from five factors: biological, psychological, sociological, ecological, and spiritual. He adds: 'Doctors are useful, not because they make us swallow all kinds of harmful substances, but because they correspond to a psychic need of the patient and his relatives, the eternal need for hope, sympathy and help that only a suffering being is capable of experiencing' (Leo Tolstoy)[20].

Finally, we can say that the South London Health Innovation Network states that 'PCC includes: - Respecting people's values - Taking into account people's preferences and needs - Coordinating and integrating care - Working together to be sure there is good communication, information and education - Being sure the person is physically comfortable and safe - Giving emotional support - Involving family and friends - Being sure there is continuity within services - Ensuring that people have access to care when they need it'[43].

Advantages[1,4,7,33,43,45,46]

- Contributes to improving the quality of available services
- Helps people to obtain health care
- Helps people become more active in self-care
- Reduces some of the pressure on health services
- Can help reduce health costs
- Improves wellness
- Increases adherence rates to care plans
- Reduces complications
- Improves professional attitudes
- Increased respect for ethics
- Enhanced reputation of professionals and facilities
- Patient satisfaction
- Lower rate of lawsuits.

Barriers

- Lack of human resources
- Lack of training
- Poor infrastructure
- Excess demand for services in higher level facilities
- Administrative demands to attend a greater number of patients
- Time constraints for care
- Interventions by third parties in health services.

Woman-centered obstetric care

Obstetrics and gynecology provides care for women throughout their lives, including pregnancy and childbirth, as well as diagnosis and treatment for diseases of the female reproductive organs[9]. Professor Mamhoud Fatalha proposed in 1997 to change the name to Women's Health. In Latin America there is evidence on the humanization of gynecological-obstetric care, but the studies report from the review of compliance with WHO recommendations to the assessment of inadequate care[47].

Traditionally, women have been attended and supported by other women during childbirth. Today, in hospitals around the world, continuous support during childbirth is often the exception. Currently, women deliver unaccompanied in a private setting, a situation that needs to change according to the evidence[48]. WHO recommends maternal care that respects dignity, confidentiality, ensures no harm and no abuse, and proposes informed choice and continuous support during labor and delivery[49].

A study in Ireland on person-centered obstetric care found that respect, participation in decisions, communication, educational impact, continuity of service, continuity, availability and competence of staff, genuine choice, promotion of autonomy, individualized care, and organization of practice improve outcomes[50].

A paradigm shift is essential to provide care that is more inclusive of the needs and priorities of pregnant women in different aspects of their health. PCC respects gender equity by involving women in self-care, tailoring care to their needs and values, and eliminating discrimination of all kinds[51]. Poor quality maternity care leads to delays in care and adverse outcomes for the pregnant woman and newborn, including perinatal mortality. A quasi-experimental study in India showed that PCC improved outcomes[52].

Woman-centered prenatal care (WCP)

This section is based on the author's experience, the Clinical Practice Guide Prenatal Control with Patient-Centered Care, Mexico DF[53], the National Guidelines for Comprehensive Sexual and Reproductive Health Care of the Ministry of Health, Peru[54] and several other references.

WCP is a set of actions based on a series of visits by the pregnant woman to the health facility and medical consultation with the aim of managing the pregnancy, detecting risks, preventing complications, and preparing her for childbirth, motherhood, and child rearing. WHO considers maternal care a priority that is part of public policies as a strategy to optimize pregnancy outcomes and prevent maternal and perinatal mortality. WCP provides a wide range of health services in health promotion and disease prevention, including nutritional support, vaccination, among others.

The APN starts with the use of the perinatal health record (PHR) in which the following should be considered:

- Health promotion
- Disease prevention and major interventions each quarter
- Detection of pathologies
- Recommended medical interventions
- Management of comorbidities
- Relevant health education
- Breastfeeding promotion
- Family planning counseling.

Emphasis is placed on the quality of the consultation and not its number. It means adopting an empathic behavior, giving affection, accompanying, paying attention to possible ailments, exploring the psychic, emotional, family, and social sphere, facilitating communication with the pregnant woman and the companion she chooses, explaining and requesting authorization (consent) for each procedure, respecting her decisions, and giving her enough time for complete attention. PCC is promoted and in the family, creating alliances between health professionals, the woman's partner and the family that lead to improve the quality and safety of health care.

The diet is important since obesity in the pregnant woman is a risk factor for various complications. A systematic review found that obesity is associated with adverse maternal and infant outcomes. Gestational diabetes, preeclampsia, gestational hypertension, depression, instrumental and cesarean delivery, and infection were more frequent. It is also associated with an increased risk of preterm delivery, large-for-gestational-age babies, fetal defects, congenital anomalies, and perinatal death. The frequency of breastfeeding initiation is lower and there is an increased risk of breastfeeding cessation[55].

Providers should train pregnant women and their families to identify warning signs and symptoms during pregnancy, delivery, and puerperium. Regular exercise in low-risk pregnant women is beneficial because it increases their sense of well-being. Dental evaluation and vaccination are also beneficial. It is advisable to identify prenatal depression, which is a risk factor for postpartum depression. Offer the pregnant woman an ultrasound examination in each trimester, for which trained personnel should be available.

Measuring the uterine fundus is a first resource to detect alterations in fetal growth. Auscultate the fetal heart rate at each PNC, as well as record fetal movements. Women who report reduced movements may benefit from non-stressed and stressed fetal well-being tests or ultrasound studies to measure amniotic fluid, biophysical profile, estimated fetal weight.

Pelvic examination during pregnancy is used to detect clinical conditions such as anatomical abnormalities, vaginal infections, assess pelvic size (clinical pelvimetry) and evaluate clinical conditions of the cervix for signs of cervical incompetence.

Provide women and couples with information, education, and appropriate contraceptive options for an informed choice of the method that best suits their needs and preferences. Also, education and promotion of breastfeeding. Provide information about:

- Labor and when to go to the emergency room.
- Pain and identification of uterine contractions.
- Care to be taken in the puerperium, emotional changes and risk situations.
- Newborn care.
- Refer the pregnant woman to a higher level when complications that cannot be managed at the level of origin are detected.

Person-centered childbirth care

Humanized childbirth care provides care to pregnant women with the aim of providing a happy occurrence of labor, delivery, and the immediate postpartum period. Woman-centered care means that the health care user is truly the center of care. Their participation should be achieved by allowing them to express their opinions and preferences, to make their views known about the different ways of managing their delivery and to listen to what they have to say. The aim of this behavior is to ensure that the care provided by the physician is permanent at the pregnant woman's side and ensures her greater and more active participation, taking care that it is carried out in an atmosphere of affection, transparency, accompaniment, and respect[9].

To speak of humanization in the quality of clinical care is to put the best competencies of its human resources at the service of women[56]. Humanization is an ethical issue, which has to do with the values that guide our conduct in the field of obstetrics. The humanization of childbirth implies a confrontation between two different cultures: on the one hand, a culture that favors the value of efficiency based on the results of knowledge, technology, and management, and on the other

hand, a culture that favors respect for the individual, for his autonomy and the defense of her rights[57].

The laboring woman should be admitted to a facility with health professionals trained and skilled in PCC, who should perform a comprehensive review of the PHC and a complete clinical examination. Then, arrange for the most comfortable position that the woman wishes to adopt, without the need for venoclysis, enema or shaving. Incorporate the partogram with warning curves into the follow-up of labor. The woman can decide to take oral fluids and choose the position for expulsion[48,54].

There is no doubt that the accompaniment by the professional and the person chosen by the laboring woman increases the benefits for the woman and her baby. A Cochrane systematic review found higher frequency of spontaneous vaginal deliveries, shorter labor duration and reduction of cesarean deliveries, instrumented vaginal delivery, use of any analgesia, use of regional analgesia, low Apgar score at five minutes and negative outcome on birth experiences[48]. Another systematic review of 47 studies of person-centered interventions in birthing centers found that the interventions improved autonomy, social support, health center environment, and dignity[58].

Quality of care during labor and birth reduces maternal and infant morbidity and mortality. Factors such as lack of coordinated care among providers, fragmentation of care, and poor care are reduced in woman-centered obstetric care[59]. Insist on informed consent in all necessary procedures in delivery care[60,61].

The advantages of woman-centered obstetric care are those described in previous paragraphs, to which we can add better satisfaction of women and health care providers, lower cesarean section rate, lower frequency of complications, higher frequency of breastfeeding, lower maternal and perinatal mortality and, in general, better quality in PCC and childbirth[9,48,62,63].

A Peruvian experience, reported by Carbone, in relation to primary care in which PCC was actually applied tells us: 'When the time came, Paulina went to the delivery room of the health post. Paulina had already decided that she wanted to have a vertical delivery. Paulina did not change her clothes, the traditional girdle and *chumpi* for the medical gowns offered to patients. She was accompanied by her family and community. Her husband held her, the midwife soothed her, and the health personnel attended her warmly, speaking to her in her native Quechua. Paulina held on to a rope hanging from the ceiling, and through the natural maneuvers of expulsion a sweet cry filled the room, a cry that delighted Pachamama and the whole community, it was not a cry of pain, but of a new creature opening to life'[64].

This last story is a beautiful expression of the results obtained when person-centered obstetric care is performed. This resulted in greater confidence of the population in the service, a greater influx of pregnant women and zero (0) maternal deaths in the Andean region (Huancavelica), where the intervention was applied.

Recommendations

The following recommendations emerge from this review:

- Change the paradigm in health policies, strengthen the first level of care to rescue primary care in accordance with the conclusions of Alma Ata and provide person-centered care[52,65-68].
- Improve the physical plant and equipment of health facilities to provide adequate, timely and dignified care to pregnant women, women in labor and newborns[9,21,49].
- Build an integral health system, with biopsychosocial, cultural, spiritual, and energetic dimensions duly harmonized and balanced, based on the right to health and with the intersectoral participation of the entire State, building the defense of the health of individuals, the family and the community[13,19].
- Educate health personnel and train tutors in people-centered medicine at the undergraduate, postgraduate, and continuing medical education levels, in order to strengthen attitudes[9,19,32,35,56,69,70,71].
- To build a participative and consensual health, between caregivers and care, with unrestricted respect for the ideas of all[18].

- Use evidence-based medicine to strengthen PCM[14,20,30,30,39,72].
- Promote research on person-centered obstetric care[7,14,18].
- Strengthen family and community involvement in person-centered care[4,12,65].
- Update the National Guidelines for Comprehensive Sexual and Reproductive Health Care[53,54].

References

1. Vargas JL. Medicina centrada en la persona: un llamado al origen. Salud & Sociedad Uptc. 2022;7(2).
2. Aristóteles. Protréptico-Metafísica. Madrid: Ed Gredos, 2014.
3. Colegio Médico del Perú. Código de Ética y Deontología. Lima: Colegio Médico del Perú, 2023.
4. Fernández-Cantón SB. La atención centrada en el paciente: una visión general sobre su enfoque en los servicios de salud. Boletín Canamed. N° 23, México. Marzo-Abril 2019.
5. Suarez-Cuba MA. Medicina centrada en el paciente. Rev Med La Paz. 2012;18(1): 67-72.
6. Bastante C, Wyrwich MD, Boren SA. Atención y resultados centrados en el paciente: una revisión sistemática de la literatura. Med Care Res Rev. 2013;70:351-79.
7. Louw JM, Marcus TS, Hugo JFM. Patient- or person centred practice in medicine? – A review of concepts. Afr J Prm Health Care Fam Med. 2017;9(1):1-7. https://doi.org/10.4102/phcfm. v9i1.1455
8. Valero-Rodríguez A. Evaluación de la integración de la medicina centrada en el paciente en los profesionales de la salud. Tesis para optar especialización en Medicina. Universitat Jaume I. Colombia 2021.
9. Salazar-Hernández AM. Diagnóstico de los estándares de atención centrada en la persona de la organización Planetree: en el servicio de ginecobstetricia del hospital general de Medellín, 2021. Tesis de Auditoría en Salud, 57pp,
10. Burgos M, González AR, Houghton N, Arrighi E, Sureda SA. Las asociaciones de pacientes como promotores de la atención centrada en las personas en América Latina. Reunión para fortalecer el acceso a la salud en América Latina. Policy Wisdom 2018:54pp.
11. WHO . People-Centred Health Care: A policy framework, 2007. Available at: http://www.wpro.who.int/healthservices/peopleatthecentreofcare/documents/ENGPCIPolicyFramework.pdf?ua=1
12. WHO. People-Centered and Integrated Health Services: An Overview of the Evidence. Available at: http://apps.who.int/iris/bitstream/10665/155004/1/WHO_HIS_SDS_2015.7_eng.pdf?ua=1&ua=1
13. Perales A. Medicina Centrada en la Persona: del concepto a la acción [Editorial]. Rev Peru Med Exp Salud Publica 2016; 33(4): 605-6. doi: 10.17843/rpmesp.2016.334.2541
14. Perales A, Mendoza J, Armas R, Cluzet O. Perspectivas latinoamericanas sobre medicina centrada en la persona. Rev Peru Med Exp Salud Publica. 2016;33(4):801-10. doi:10.17843/rpmesp.2016.334.2568
15. International Alliance of Patients' Organizations, a Global Voice for Patients. Declaración de la Asistencia Sanitaria Centrada en el Paciente. IAPO. {En línea}. (09 septiembre de 2014). Available at: http://www.aids-sida.org/archivos/IAPO-Declaracion.pdf
16. Ruelas-Barajas E. Sobre la garantía de la calidad: conceptos, acciones y reflexiones. Gac Med Mex 1994;130:218-26.
17. Beach MC, Inui T. Relationship-Centered Care Research Network. J Gen Intern Med. 2006;1:S3-S8.
18. Mezzich JE. Repensando el Centro de la Medicina: De la enfermedad a la persona. Acta Med Per. 2010;27(2):148-50.
19. Díaz-Bruzual A. Medicina centrada en la persona. Gac Méd Caracas. 2018;126(1):40-51.
20. Álvarez-Romero M. Nuevo Paradigma. Medicina Centrada en la Persona. Bioética y Ciencias de la Salud. 2019;7(2):1-5.
21. New England Journal of Medicine Catalyst. ¿Qué es la atención centrada en el paciente? NEJM, 2017 [PubMed].
22. Brummel-Smith K, Butler D, Frieder M, Gibbs N, Henry M, Koons E, et al. Person-Centered Care: A Definition and Essential Elements. J Am Geriatrics Soc. 2016;64(1):15-8. https://doi.org/10.1111/jgs.13866
23. Freeman TR. McWhinney's Textbook of Family Medicine. 4th edition. New York: Oxford University Press; 2016.
24. Martínez-Miguélez M. Fundamentación Epistemológica del Enfoque Centrado en la Persona. Polis, Revista Latinoamericana. Agosto 2012, URL: http:// journals.openedition.org/polis/4914
25. Rogers C. El proceso de convertirse en persona. Buenos Aires: Ed Paidos, 1961.
26. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. Patient-centered medicine, transforming the clinical method. 3rd edition. London: CRC Press, 2013.
27. Espinosa-Brito AD. La medicina centrada en las personas y la medicina personalizada. Medisur. 2015;13(6):920-4.
28. Alkhaibari RA, Smith-Merry J, Forsyth R, et al. Patient-centered care in the Middle East and North African region: a systematic literature review. BMC Health Serv Res, 2023;23:135. https://doi.org/10.1186/s12913-023-09132-0
29. Mezzich J, Snaedal J, Van Weel C, Heath I. Toward person-centered medicine: From disease to patient to person. Mt Sinai J Med. 2010;77(3):304–6. https:// doi.org/10.1002/msj.20187
30. Miles A, Mezzich J. The care of the patient and the soul of the clinic: Person centered medicine as an emergent model of modern clinical practice. Int J Pers Cent Med. 2011;1(2):207–22. https://doi.org/10.5750/ijpcm.v1i2.61
31. Mezzich JE. The Geneva Conferences and the emergence of the International Network for Person-centered Medicine. J Eval Clin Pract. 2011;17(2):333-6.
32. Asociación Peruana de Facultades de Medicina. La Medicina Centrada en la Persona: un enfoque que busca seguir hu-

manizando la atención de la salud. Lima: Prensa-ASPEFAM 2019:3pp.

33. Hernández-Torres I. Modelo de atención centrada en el paciente. Facultad de Medicina UNAM, México 2021.

34. Coppolillo FE. Cuidados centrados en la persona. Bases epistemológicas para la atención primaria y la medicina familiar. Arch Med Fam y General. 2013;10(1):45-50.

35. González-Blasco P, Ramírez-Villaseñor I, Bustos-Saldaña R, Moreto G. La formación de médicos familiares en Latinoamérica: Timidez académica y liderazgo errático. Arch Med Fam. 2005;7(1):1-4.

36. Pacheco Ojeda L. La cirugía centrada en la persona. Rev Fac Cien Med (Quito). 2018;43(1):7-10.

37. Hatchimonji JS, Sisti DA, Martin ND. Surgical futility and patient-centered care: The effects of human nature in decision making. Bull ACS. 2016;101(11):19-23.

38. Institute for Healthcare Improvement. Patient-centered care for medical/surgical units. 2017. http://www.ihi.org/resources/Pages/Changes/PatientCenteredCare.aspx. Accessed March 2023.

39. Ceriani Cernadas JM. ¿Medicina basada en la evidencia o Medicina centrada en el paciente o ambas? Arch Argent Pediatr. 2018;116(2):90-1.

40. Sacristán JA. Medicina basada en la evidencia y medicina centrada en el paciente: algunas reflexiones sobre su integración. Rev Clin Esp. 2013;213(9):460-4.

41. Cárdenas M. El daño médico: su regulación ética y legal en el Perú. Tesis de Doctorado en Medicina. UNMSM. Unidad de Posgrado. 2016.

42. Cuba MS, Romero Z. El método clínico centrado en la persona y su aplicación en la atención primaria de salud. Rev Peru Med Exp Salud Publica. 2016;33(4):780-4. doi: 10.17843/rpmesp.2016.334.2565

43. Health Innovation Network South London. What is person-centred care and why is it important? www.hin-south-london.org. Consulted March 2023.

44. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. Medicina Centrada na Pessoa: Transformando o Método Clínico. Sao Paulo, Brasil: Artmed, 2017.

45. Dwamena F, Holmes-Rovner M, Gaulden C, Jorgenson S, et al. Intervenciones para la promoción de un enfoque centrado en el paciente por parte de los profesionales en las consultas clínicas. Biblioteca Cochrane, Revisión sistemática 2012.

46. Editorial Team. What Is Patient-Centered Care? Definition and Benefits. Career Development. February 3, 2023.

47. Biblioteca virtual noble. Atención centrada en el paciente: mitos y realidades [consultado Marzo 2023]. Available at: http://asegurados.descargas.nobleseguros.com/download/posts/January2020/Yr U72ZwYb9pdUho10i9u.pdf

48. Bhoren M, Hofmeyr J, Sakata C, Fukusawa R, Cuthbert and Cochrane pregnancy and children group. Continuous support for women during childbirth. Cochrane Date Base Sys Review. 2017 Jul 6;7(7):CD003766. doi: 10.1002/14651858.CD003766.pub6

49. Bhoren M, Tuncalp O, Miller S. Transforming intrapartum care: Respectful maternity care. Best pract res Clin Obstet Gynaecol. 2020;67:113-26.

50. Hunter A, Devane D, Houghton C, Grealish A, Tully A, Smith V. Woman-centred care during pregnancy and birth in Ireland: thematic analysis of women's and clinicians' experiences. BMC Pregnancy Childbirth. 2017;17(1):322. doi: 10.1186/s12884-017-1521-3

51. Dong K, Jameel B, Gagliardi AR. How is patient-centred care conceptualized in obstetrical health? Comparison of themes from concept analyses in obstetrical health- and patient-centred care. Health Expect. 2022;25(3):823-39. doi: 10.1111/hex.13434

52. Sudhinaraset M, Giessler K, Nakphong MK, Roy KP, Sahu AB, Sharma K, Montagu D, Green C. Can changes to improve person-centred maternity care be spread across public health facilities in Uttar Pradesh, India? Sex Reprod Health Matters. 2021;29(1):1-15. doi: 10.1080/26410397.2021.1892570

53. Instituto Mexicano de Seguro Social. Guía de Práctica Clínica Control Prenatal con atención centrada en la paciente. México DF: Dirección de Prestaciones Médicas. 2017:104.

54. Ministerio de Salud. Guías Nacionales de Atención Integral de la Salud Sexual y Reproductiva. Lima-Perú: Dirección General de Salud de las Personas, 2004.

55. Marchi J, Berg M, Dencker A, Olander EK, Begley C. Risks associated with obesity in pregnancy, for the mother and baby: a systematic review of reviews. Obes Rev. 2015;16(8):621-38. doi: 10.1111/obr.12288

56. Santacruz J. Humanización de la calidad en la atención clínica en salud desde la perspectiva centrada en el paciente a partir de la Resolución 13437 de 1991. Rev Univ. Salud. 2016:18(2):373-84.

57. Bermejo-Higuera JC. Humanización en salud. Ejes de la acreditación. [Online]; 2012. [Consultado Marzo 2023] Available at: http://www.acreditacionensalud.org.co/seguridad.php?IdSub=190&IdCat=84

58. Rubashkin N, Warnock R, Diamond-Smith N. Una revisión sistemática de las intervenciones de atención centradas en la persona para mejorar la calidad del parto en un centro. Reprod Salud. 2018;15:169.

59. Sharma G, Mathai M, Dickson KE, et al. Atención de calidad durante el trabajo de parto y el nacimiento: un análisis multinacional de los cuellos de botella del sistema de salud y las posibles soluciones. BMC Embarazo Parto. 2015;15(suplemento 2): S2. [PubMed].

60. Nicholls J, David AL, Iskaros J, Lanceley A. Patient-centred consent in women's health: does it really work in antenatal and intra-partum care? BMC Pregnancy Childbirth. 2022;22(1):156. doi: 10.1186/s12884-022-04493-6

61. Barry MJ, Edgman-Levitan S. Toma de decisiones compartida: pináculo de la atención centrada en el paciente. N Engl J Med. 2012;366(9):T 780–1.

62. Klootwijk A, Bakx P, Franx A, Bijma H, Ernst-Smelt H, Lamain-de Ruiter M, Posthumus A, van Rijn B. Patient-reported outcome and experience measures for quality improvement in pregnancy and childbirth care: a retrospective cohort study. BMJ Open Qual. 2023;12(1):e001922. doi: 10.1136/bmjoq-2022-001922

63. Floris L, Irion O, Bonnet J, Politis Mercier MP, de Labrusse C. Comprehensive maternity support and shared care in Switzerland: Comparison of levels of satisfaction. Women Birth. 2018;31(2):124-33. doi: 10.1016/j.wombi.2017.06.021

64. Carbone-Campoverde FI, Palomino Flores Y. La atención primaria de salud. La experiencia peruana. Rev peru ginecol obstet. 2018;64(3):367-73. DOI: https://doi.org/10.31403/rpgo.v64i2099

65. Esteves Nagem T, Bambini Negozio S. Do método clínico centrado na pessoa à terapia de família relacional sistêmica: Diálogos possíveis. Nova Perspectiva Sistêmica. 2021;30(70):64-76.

66. Cacace PJ, Giménez-Lascano G. Modelos de atención centrados en la persona: evolución de conceptos humanizadores de nuestras prácticas. Rev Mex Med Fam. 2022;9:63-72.

67. Pacheco-Romero J, Távara Orozco L. Preámbulo al simposio de Alma-Ata. Atención primaria de la Salud. Rev peru ginecol obstet. 2018;64(3):359-60. DOI: https://doi.org/10.31403/rpgo.v64i2097

68. Tejada de Rivero DA. La historia de la Conferencia de Alma-Ata. Rev peru ginecol obstet. 2018;64(3):361-6. DOI: https://doi.org/10.31403/rpgo.v64i2098

69. Salinas H, Erazo M, Pasten J, Preisler J, Carmona S, Delia O, et al. Indicadores de calidad de asistencia en obstetricia. Rev chil obstet ginecol. 2006;71(2):114-20.

70. Forrellat M, Calidad en los servicios de salud: un reto ineludible. Rev Cubana Hematol, Inmunol Hemoterapia. 2014;30(2):179-83.

71. Hernando-Robles P. L'atenció centrada en el pacient: moda o actualitat? Butlletí Del Comitè de Bioètica de Catalunya. Febrer 2015.

72. de Mestral E. Medicina centrada en la persona. Rev virtual Soc Parag Med Int. Marzo 2015;2(1):107-12. http://dx.doi.org/10.18004/rvspmi/2312-3893/2015.02(01)107-112