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SHORT REPORT

Person-centred care: looking back, looking forward

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An interdisciplinary group of clinical and non-clinical academics in Sweden created a research centre for the study of person-centred care (PCC) in long-term illness: the University of Gothenburg Centre for Person-Centred Care (GPCC). The GPCC steering committee formulated a position paper with three 'simple routines' to initiate, implement, and safeguard PCC in daily clinical practice. The *EJCN* accepted this position paper for publication in 2011. This brief review seeks to present how PCC, as defined in the position paper, has been used in research and published in *EJCN* during the past 5 years (2016–20). Clinical implications and future research in PCC are also suggested.

Keywords Person-centred care • patient-centred care • patient-centered care

Background

Healthcare systems need to be re-organized to provide high-quality care without increased costs to an ageing population with a high prevalence of chronic and long-term disorders.

At present, patient engagement and satisfaction with the care process are less than optimal. Different solutions have been proposed to recognize the patient in health care, including person-centred care (PCC) initiatives.

Researchers and clinicians noted that PCC, emphasizing patient-professional partnerships, was not implemented into the healthcare practice to any appreciable extent. Thus, in 2010, intending to test and implement PCC, an interdisciplinary group of clinical and non-clinical academics in Sweden created a research centre for the study of PCC in long-term illness: the University of Gothenburg Centre for Person-Centred Care (GPCC).[1,2]

The GPCC steering committee formulated a position paper with three 'simple routines' to initiate, integrate, and safeguard PCC in daily clinical practice. The *EJCN* accepted this position paper for publication in 2011.[3]

The first routine serves to initiate a partnership by eliciting the patient narrative, defined as the sick people's account of their perception of the illness and impact on their life.

It captures the people's suffering in the context of their daily life world, in contrast to medical narratives that reflect the process of diagnosing and treating the disease. The second routine serves to implement the partnership principle using a commonly agreed personal health plan, so that professionals, patients, and their relatives work together to achieve commonly agreed goals. The third routine serves to safeguard the partnership by documenting the health plan accessible to both professionals and patients. This plan is often documented in the patient record. These three routines represent clinical tasks to be embarked upon by the professional as well as everyday goals undertaken by the patient/relatives. This distinctive model of PCC differentiates from other models by incorporating the wishes and capabilities of the patient and be supported by the care team. Such an approach is rooted in the philosophical literature.[4–6]

This brief review seeks to present how PCC, as defined in the position paper, has been used in research and published in *EJCN* during

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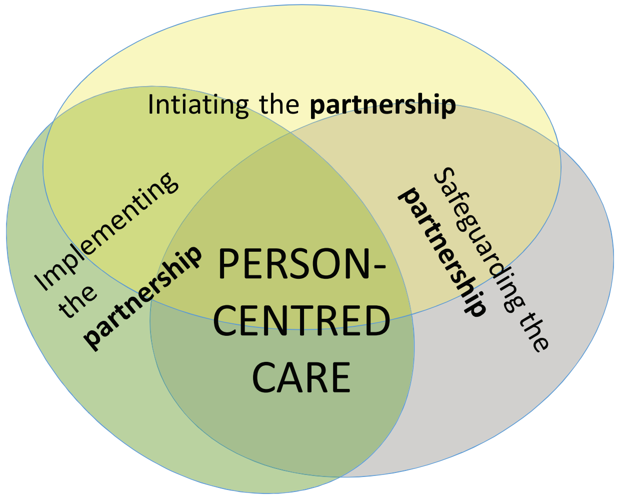

Figure 1 The three routines are integrated and together create PCC.

the past 5 years (2016–20). We will also suggest clinical implications and future research in PCC.

Results

Routine one: initiating the partnership by listening and eliciting the narrative of patients

Routine one: initiating the partnership by listening and eliciting the narrative of patients was explored in three studies seeking to understand their expectations, meanings, feelings, and fears.[7–9] Data were collected using individual in-depth interviews from patients and close relatives. Such an approach provided a detailed narrative of experiences and descriptions of the social context. The starting point in these studies was to listen to patient and relative narratives and ask questions to identify their experiences of acute coronary syndrome symptoms, participating in cardiac rehabilitation or experiences of medication use. For example, patients' descriptions of their expectations of medications, which are largely unknown, may affect how they choose to manage medications. The studies also described reactions and feelings when patients were told that there was no treatment for the condition or they were judged ineligible for advanced surgical interventions, or they were excluded because their symptoms could not be medically explained.[7–9] Improved listening and communication by professional healthcare providers may bolster patients' self-efficacy, resolve feelings of resignation, and improve patients' ability to manage medications.

Routine two: implementing the partnership by co-creation of health plans

The starting point in these studies was to partner with patients through listening to their narratives and asking questions to identify their resources, capabilities, and potential for self-care.[10–12] Another departure point is to examine the opportunities in the patient's home and social network. Based on this partnership, a personal health plan could be drawn up.

To take the time to listen carefully and then agree on a personal health plan, seem to patients that had been judged ineligible for advanced surgical procedure to help them maintain and restore hope and gain control over symptoms.[8] Correspondingly, working with person-centred health plans with patients with a low socioeconomic background that are less likely to participate in their cardiac rehabilitation could prevent attrition and encourage participation.[10] Equal access to cardiac rehabilitation can only be attained if both physical and psychological needs and resources of the patient and family are met by tailoring care and therapy.[9] Discharge processes can also be improved by involving the patients at an early stage during hospitalization and inviting them to tell their story and together formulate a roadmap for a person-centred discharge plan.[13]

Routine three: safeguarding the partnership by documenting the mutually agreed on health plan

The content of person-centred health plans documented at three healthcare levels for patients with acute coronary syndrome found that, according to the patients, the most frequently reported goal for better health was increased physical activity, followed by social life/leisure activities, and return to paid professional work.[14] To achieve their objectives, patients identified their external resources such as family and social support and the healthcare system. The most commonly reported internal resource was motivation. A mutually agreed on health plan was especially beneficial in patients with low educational level.[10] For patients with chronic heart failure, formulating person-centred health plans via telephone or online showed promise to reduce self-reported fatigue. More precisely, the 'reduced motivation' dimension was significantly improved in the PCC group compared with the usual care group.[11] Concerning PCC health plans, patient goals in traditional care and treatment plans often comprise behavioural changes devised solely by health professionals. In contrast, when patients identify their own goals and resources with the help of professionals, they include maintaining social relationships and being able to return to important activities of daily living, including work duties.[14] The completed PCC health plans reflect the available patient goals, capabilities, and healthcare resources.

Implications for practice and future research

PCC in practice

Include all three routines in care and treatment. For example, listen and be open to patients with alternative health beliefs, expectations about prescribed medication, care, and rehabilitation.

- Listen and be open to patients with alternative health beliefs, expectations about prescribed medication, care, and rehabilitation.
- Encourage the patient (often with relatives) to formulate their health plan by themselves.
- Offer contact outside normal working hours and at a distance (e.g. chat functions, social media, etc.).
- Consider specific requirements, i.e. public transportation, suggest locations not requiring long commutes, use telephone or other digital meeting opportunities.
- Use the European standard; Patient involvement in health care - Minimum requirements for person-centred care to ensure quality improvement in PCC.This document specifies minimum requirements for patient involvement in health care services with the aim to create favourable structural conditions for PCC. It is applicable for use also on a strategic level for quality assurance and quality improvement, for procurement, educational and supervisory purposes.[15]

Future research on PCC

Micro level

- What characterizes a person-centred dialogue?
- Describe and evaluate different forms of health plans, including those recorded and written only by patients and relatives.

Meso level

- What characterizes a culture where all patients receive PCC and the medical staff is satisfied with their work?

Macro level

- How can steering documents, respectively, hinder or help implementation towards more person-centred care?
- **All levels**
- The European standard; Patient involvement in health care - Minimum requirements for person-centred care ref is applicable as a guiding document for research and development projects in the field of intervention and implementation of person-centred care.[15]

Conflict of interest: none declared.

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