Person-centred care: more than just improving patient satisfaction?

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This editorial refers to ‘Effects of person-centred care in patients with chronic heart failure: the PCC-HF study’, by I. Ekman et al., on page 1112

Health policy has increasingly signalled a move away from an emphasis on specific organs and disease, towards placing the ‘whole’ person at the centre of medicine.1 The health professional must try to understand what the illness means for the individual, within a social and psychological context. This necessitates listening to that particular person’s point of view, with the ultimate goal of sharing responsibility with them.2 Clinicians should learn to ask not only ‘what is the matter?’, but ‘what matters?’ In other words, what are the patient’s interests, concerns, and fears about the specific conditions, symptoms, or treatment options?3 This moves us from the strictly biomedical view to a broader bio-psycho-social and spiritual view, with power shared between the healthcare professional and the patient.4

Despite widespread pressure for a move from the paternalistic ‘doctor knows best’ approach, progress has been rather slow. All agree that improved communication between patients and professionals is a legitimate goal, but a survey across several developed countries has reported that the majority of patients are not asked for their ideas or opinions about treatment.5 This is particularly troubling as disease management shifts towards chronic rather than acute disease.

Many factors influence how person-centred the interactions between a healthcare professional and a patient may be, including the characteristics of the patient and the professional, the context of the interaction, and the nature of the consultation (Figure 1).

Primary care physicians are typically more enthusiastic about person-centred care than specialist physicians. They tend not merely to focus on the successful treatment of a specific disease, but to work towards a joint understanding of illness and its management.7 Perhaps it is not surprising that cardiologists have been slower to embrace this approach—much of their work relates to very specific pathology and its treatment. Of course, a very directive approach may be appropriate and appreciated for a simple physical complaint due to an easily treatable acute condition, but too often this approach is also applied to the much more complex situation of ill-health related to a number of diseases, most of which are chronic.

Clinical guidelines in cardiology are largely silent about the person-centred approach, other than to state or imply that the clinician must consider how best to apply the evidence base to their patient. In the guidelines for chronic conditions (such as heart failure) the multidisciplinary approach is strongly supported, with professionals working together (with the patient and family) in a co-ordinated manner.8 An explicit discussion of the person-centred approach is not given, but rather indicators of which ‘type’ of patients might or might not benefit from specific interventions. This approach is still directive—the application of what the professionals consider the best treatment—without a fuller discussion of the issues on a more equal basis. Two key components of person-centred care are collaborative goal setting and action planning; agreeing on what, when, where, and how often specific actions are required and the barriers to such actions for that individual patient.9 Such an approach helps foster self-efficacy and may assist the person in moving from a position of dependence to that of being an ‘expert’, if that is what they wish.10

Some may fear that the person-centred approach runs contrary to evidence-based medicine (EBM), but Sackett himself considered EBM as an integration of the best research evidence with clinical experience and patient values: ‘the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient’.11

There is a need for more robust research on the impact of adopting a person-centred approach on outcomes, which should include the traditional ‘end’ points of mortality and hospitalization, in addition to patient satisfaction, quality of life, health status, and healthcare utilization. Most of the published literature on the effect of a person-centred approach in healthcare reports the impact on patient satisfaction, but few studies assess health behaviour, health status, or healthcare system process measures.12

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Ekman and colleagues\textsuperscript{13} are to be congratulated for conducting a before-and-after comparison of the effect of moving from the traditional ‘directive’ approach to a person-centred approach for patients admitted with heart failure to five wards within one hospital over a 2 year period. A total of 123 patients in the usual care group were compared with 125 patients in the person-centred care group. There was a trend towards a reduction in the primary endpoint of length of stay: this reduced by 1 day from a median of 9.2 days ($P = 0.16$). Importantly, 40% of the patients in the person-centred approach were not managed according to the jointly agreed plan throughout the admission. The per-protocol analysis suggested that if the person-centred approach was adopted during the duration of the admission the reduction in length of stay was substantially greater (2.5 days, $P = 0.01$).

Interestingly, there was no evidence that health-related quality of life at 3 months after discharge was different in the two time periods. Despite a shorter length of stay, the readmission rate in the following 6 months was no different, allaying fears that care would in some way be compromised during the shorter index admission.

The study may be criticized for being non-randomized, but this is not unusual for testing of complex healthcare interventions, where implementing a new approach is very likely to affect how staff treat other patients in their care. The results of a cluster-randomized study in many hospitals would be more robust, but would require a much larger and more expensive study. Sixty per cent of eligible patients declined participation in the study, perhaps because they were overwhelmed by their condition, or did not wish to complete multiple study questionnaires. Although true for all trials, this means that an estimate of effect size if the approach was adopted more generally in the heart failure hospitalized population is difficult to determine. However, a similar person-centred problem-solving approach has been described in a randomized trial in one hospital in North London,\textsuperscript{14} with post-hoc analysis suggesting a reduction in both mortality and heart failure readmission rate at 12 months, albeit limited to patients who were admitted for the first time. Ekman and colleagues have also conducted a before-and-after comparison of person-centred care for patients admitted with hip fracture, with a 50% reduction in length of stay ($P$, 0.001), compared with the 30% reduction in the per-protocol analysis in the heart failure study.\textsuperscript{15} Perhaps the simpler agreed targets for rehabilitation after hip fracture lend themselves to a greater effect size.

Further studies are needed, but Ekman’s study suggests that adopting a more person-centred approach is likely to reduce length of stay without compromising subsequent readmission risk or quality of life for people with heart failure. As healthcare moves in the person-centred direction at the policy level, and attention is focused on maximizing the appropriateness and value of any hospitalization, it is essential that the cardiology community rises to the challenge of providing evidence that such an approach does more than just increase patient satisfaction.

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**References**


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**CARDIOVASCULAR FLASHLIGHT**

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**Lines of Zahn in coronary artery thrombus**

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A 46-year-old female presented with troponin-positive acute coronary syndrome and lateral ischaemic changes on electrocardiograph. Coronary angiography revealed a critical stenosis distal to the bifurcation of the intermediate coronary artery, with a crescentic lesion tethered to its distal end suggestive of a thrombus (Panel A, white inset, white arrow). Aspiration of the thrombus was performed using an Export catheter (Medtronic) and a sickle-shaped thrombus was retrieved (Panel A, yellow inset). Angioplasty of the stenotic segment was performed with insertion of a drug-eluting stent (Boston Taxus*, 2.75/12 mm).

Macroscopically, the thrombus consisted of alternating white and red bands typical of Lines of Zahn (Panel B). This feature was also demonstrated on histology examination of the specimen (Panel C). Lines of Zahn are characteristic of thrombus formed at the site of rapid arterial blood flow, with laminations produced by successive deposition of platelets and fibrin (pale layers) alternating with red blood cells (dark layers). This thrombus was likely to be associated with high-velocity blood flow produced by the upstream stenotic lesion.

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