European Journal of Cardiovascular Nursing (2024) **23**, e161–e163
https://doi.org/10.1093/eurjcn/zvae052

EDITORIAL

Person-centredness in cardiovascular care: the need for a whole-systems perspective

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Published 24 April 2024

Introduction

Major developments in cardiovascular disease (CVD) management have resulted in more people living longer with CVD[1]; however, survival can be accompanied by increased risk for multiple complex chronic conditions requiring holistic, individualized care. Person-centred care can address this need and has been consistently shown to improve health outcomes, enhance patient engagement in their care, and promote positive patient and family/carer experiences.[2] However, the conceptualization, definition, and measurement of person-centred cardiovascular care have been the subject of ongoing academic debate because of inconsistent and often unclear characterization of the breadth of person-centred care.[3] In this editorial, we surface some challenges associated with conceptualizing person-centredness (vs. patient-centredness) in cardiovascular care, including the need to consider all domains including the attributes of the practitioners, practice environment, and wider macro-context in which all cardiovascular care is embedded.

The problem with the lack of conceptual clarity

Cardiovascular care and research, like many fields in health care, often fail to make a crucial distinction between *patient-* and *person-*centred care, using these terms interchangeably, as if they mean the same. This lack of definitional and conceptual precision reflects a limited understanding and the stage of scholarship of person-centred practice in the cardiovascular field, contributing to inadequate adoption and implementation. For instance, in 2023, the American Heart Association (AHA) released a Scientific Statement based on a scoping review of person-centred models for cardiovascular care.[4] *Person-centred* models were identified based on their stated use of evidence-based guidelines, clinical decision support tools, systematic evaluation processes, and inclusion of the patient's perspective. Whilst the authors had clear inclusion criteria for models of care selected for review, the extent to which they are *person-centred* in focus is largely unclear. The models included in this review and the guidelines referred to in the review predominantly adopted a *patient-centred* perspective. The ongoing lack of clarity with what constitutes person-centred care in the cardiovascular field results in a wide variety of methodological approaches, outcome measures, and care processes used across studies.

Patient- vs. *person*-centred cardiovascular care

Both *patient*-centred care and *person*-centred care are philosophies in healthcare that aim to improve the quality of care delivery. These two concepts share some key similarities, including shifting focus from being disease-centred to emphasizing the active role of the individual in their care and ensuring the provision of respect and dignity. However, fundamental conceptual differences require thoughtful distinction.

Patient-centred care emphasizes the role of the individual as a recipient of care in interactions occurring in healthcare settings, where patient choice is often mediated through a professional lens and whilst shared decision-making may be included, in most cases, the power and authority for decision-making remain with the clinician.[5] Person-centred care, on the other hand, strives to share decision-making and includes patients, their families, and other carers outside of professional boundaries. Person-centred practice is defined as 'an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives' (p3).[2] Conceptually, *person-centred care* includes *all persons in the care continuum*, not only the patient and their family/carers but also the health care team, leaders, and policymakers, that impact the quality of care that the patient receives. For this reason, person-centred care treats all persons around the patient as *equally important*. At the core of person-centred care is a

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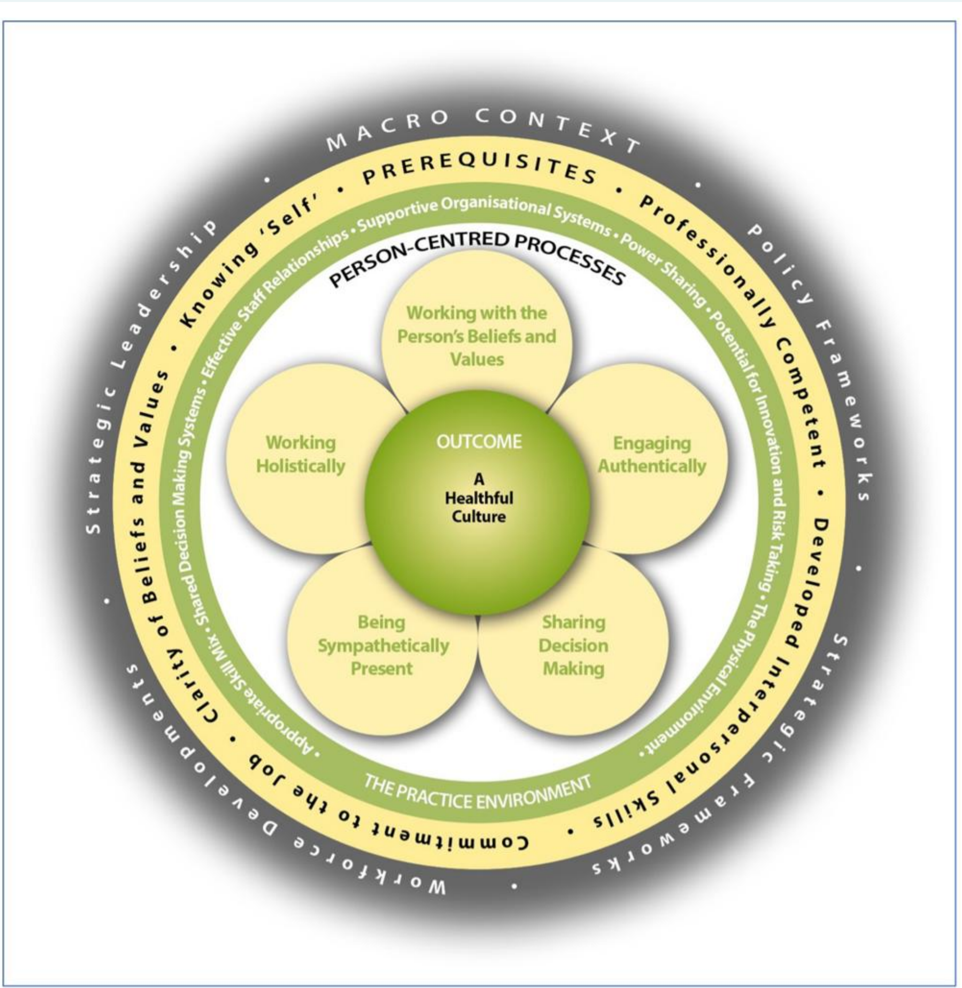

Figure 1 Reproduced with permission from McCance, T and McCormack, B (2021) The Person-centred Practice Framework, in McCormack B, McCance T, Martin S, McMillan A, Bulley C (2021) Fundamentals of Person-centred Healthcare Practice Wiley, Oxford.

healthful culture where clinicians are empowered to work in person-centred ways within a person-centred system, underpinned by mutual respect and understanding.[2]

Existing recommendations for person-centred cardiovascular care

Clinical practice guidelines offer evidence-based recommendations for managing CVD and associated risk factors that include person-centred concepts, such as shared decision-making. For instance, the European Society of Cardiology (ESC) strongly recommends (Class I) optimization of shared decision-making and patient involvement as part of integrated care for patients with atrial fibrillation.[6] Similarly, the AHA identified that person-centred models require a health plan co-designed by the patient and clinician.[4] Advocacy groups such as the British Heart Foundation also promote supporting people to make informed decisions about their care that is personalized to their needs.[7] Indeed, in a review of research published in the European Journal of Cardiovascular Nursing from 2016 to 2020, Ekman[8] identified three processes to integrate person-centred care in practice also known as the Göthenburg model of person-centred care[9]: (i) initiating the partnership by engaging with the patient and listening and eliciting patient narratives, (ii) implementing the partnership by co-creation of health plans, and (iii) safeguarding the partnership by documenting the mutually agreed health plan. This model has been successfully implemented and evaluated in several clinical trials showing positive health outcomes for patients. However, the extent to which this evidence captures the full dimensions of person-centred practice beyond that of patient partnership is limited and requires a more comprehensive consideration. Shared/informed decision-making systems are no doubt crucial for advancing person-centred cardiovascular care but are only one component of person-centredness and arguably insufficient for sustaining person-centred practice in healthcare systems.

The person-centred practice framework

Person-centred practice extends beyond the patient and their interactions with clinicians within the practice environment and considers the crucial role of the larger context in which all cardiovascular care occurs. The person-centred practice framework (*Figure 1*) is a widely standardized and globally translated model that includes shared

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decision-making but identifies 16 additional constructs important for person-centred practice. These constructs address five domains: (i) the *macro context* that identifies strategic and political factors that influence the development of healthful cultures, (ii) *pre-requisites*, which relate to clinician attributes and skills, (iii) the *practice environment* or context in which healthcare is experienced, (iv) *person-centred processes* that are necessary to create connections between persons, and (v) *healthful culture* as outcome. These domains (and the 17 constructs involved) include the importance of having an environment conducive to person-centred practice, an understanding of required personnel attributes or pre-requisites, and person-centred processes—all of which are essential to the adoption of a whole-systems approach to the provision of person-centred care to patients. Mapping the existing evidence base for cardiovascular care against these person-centred domains in their entirety would expand the current understanding of the field and identify gaps for future evidence building.

One of the domains that is poorly addressed and often overlooked is *pre-requisites*, which refers to the attributes and skills of clinicians such as their cultural and professional identity, attitudes and beliefs, and socio-political values. Addressing pre-requisites might hold the key to the development of a person-centred culture within which person-centred practice can be developed, implemented, and sustained. The core curriculum for nurses and allied professionals developed by the ESC Association of Cardiovascular Nursing & Allied Professions supports core clinical skill advancement with a patient-centred care focus that partially addresses this lack of attention towards pre-requisites in CVD care models and guidelines.[10] Similarly, the AHA recognizes the need to identify clinician competencies that must be available or developed given the increasing complexity of cardiovascular care. However, such development would only be of value in fostering person-centred care if, indeed, person-centred principles are included.[4] The current CVD models also lack adequate appreciation of the macro context—the socio-political context in which care is delivered. Any future person-centred models of cardiovascular care must emphasize the need to identify the strengths and weaknesses of health policies, organizational systems, and their interrelationships within the wider cultural and political context of cardiovascular care provision.

Conclusion

Distinguishing between patient-centred care and person-centred care does not simply imply fidelity to the terms used but rather reflects an understanding of the conceptual differences between these two models of care. The field of cardiovascular care needs to build on the successful work of putting patients at its core and go beyond that to consider the attributes of the practitioners, the practice environment, and the wider macro-context as the key to achieving truly person-centred outcomes for patients, families, carers, staff, and healthcare organizations.

Conflict of interest: none declared.

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