

Review article

“Same same or different?” A review of reviews of person-centered and patient-centered care

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ABSTRACT

Objective: To provide a synthesis of already synthesized literature on person-centered care and patient-centered care in order to identify similarities and differences between the two concepts.

Methods: A synthesis of reviews was conducted to locate synthesized literature published between January 2000 and March 2017. A total of 21 articles deemed relevant to this overview were synthesized using a thematic analysis.

Results: The analysis resulted in nine themes present in person-centered as well as in patient-centered care: (1) empathy, (2), respect (3), engagement, (4), relationship, (5) communication, (6) shared decision-making, (7) holistic focus, (8), individualized focus, and (9) coordinated care. The analysis also revealed that the goal of person-centered care is a meaningful life while the goal of patient-centered care is a functional life.

Conclusions: While there are a number of similarities between the two concepts, the goals for person-centered and patient-centered care differ. The similarities are at the surface and there are important differences when the concepts are regarded in light of their different goals.

Practice implications: Clarification of the concepts may assist practitioners to develop the relevant aspects of care. Person-centered care broadens and extends the perspective of patient-centered care by considering the whole life of the patient.

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1. Introduction

Patient-centered care and/or medicine has been on the healthcare agenda for several decades, as opposed to the previously prevailing bio-medically oriented and paternalistic view of healthcare. The original definition of “patient” was “someone who suffers” [1]. A patient can also be defined as a person who is receiving medical, surgical, or other forms of treatment for a disorder or illness [2]. Vulnerability and dependence are characteristics in the definition of being a patient [3]. The development of patient-centered care can be understood as a response to earlier perceived limitations of biomedical traditions [4] pointing to problems related to the biomedical tradition. A biopsychosocial perspective alone is not sufficient to understand the patient’s problem and experience of illness [5,6]. Michael and Enid Balint, for example, launched the concept of patient-centered medicine as “another way of medical thinking” in 1969, when they held seminars on psychological problems in general practices [4]. Today, the literature advocating patient- and/or person-centered healthcare is widespread. Despite the concepts being significant in healthcare, there is little consensus on the meaning of these concepts.

A patient-centered perspective requires that a carer holistically take into account what is known about the patient and understand the patient as a unique human being before forming a diagnosis of the patient’s illness [4]. In 1977, the World Health Organization advocated that patients participate in their healthcare [7]. Further, in the “Vienna Recommendations on Health Promoting Hospitals,” the WHO recognized the necessity of an active and participatory role for patients to improve both the quality and efficiency of healthcare [8]. Since then, patient-centered care has been regarded as good medicine, yet remains poorly understood and implemented [9]. Stewart [10] described patient-centered care as care that (1) explores the patients’ reason for the visit and concerns, (2) seeks a holistic understanding of the patients’ world, (3) finds common ground about the problem in question and agrees on management, (4) enhances prevention and health promotion, and (5) enhances a continuing relationship between the patient and the health care professional. The benefits of patient-centered care have not been conclusive, but important aspects such as patient satisfaction, greater enablement, greater improvement in symptom burden, and positive health outcomes have, however, been reported [11–14]. Different coding-systems of consultations have been developed to measure the degree of patient-centeredness, see e.g. Sabee et al. [15]. However, already in 1997, Lambert et al. pointed out that patient-centered care might not be enough, and that a *person-centered* approach was needed [16].

In recent years, the concept of *person-centered* care has been launched [17], as a development of patient-centered care. The

concept of person originates from philosophy and denotes what is most important about humans that distinguish them from everything else. The most common definition is that a person is characterized by rationality in the wide sense of the term (e.g. self-consciousness, free will, capacity to communicate) and thus deserves a special moral status that it can claim for itself and acknowledge in others [18]. The concept has been used in discussions about the ethics of abortion, euthanasia, and human uses of animals [19]. The philosophical perspective of personalism articulates ideas akin to those in person-centered care and emphasizes the person as subjective, absolutely unique, and in a self-actualizing relation to other persons [20]. In clinical settings, the person-centered care concept originated from the care of older people. Kitwood [21] developed the theory of person-centered care in the context of dementia care, underscoring the psychosocial needs and of “seeing the person.” Also, the framework by Nolan [22] in elderly care settings is used as a theoretical base that underscores the importance of feeling valued and recognized through satisfying relationships. McCormack [23] has launched a concept of person-centered practice for older persons, and thereafter published several papers along the same train of thought. Ekman et al. [17], in their works at the University of Gothenburg Centre for Person-Centered Care, depart from the philosophy of Ricoeur and take an ethical perspective, underscoring the need to know the person behind the illness, in order to engage the person in his/her own care. To achieve this, Ekman et al. [17] propose the need to establish routines that initiate, integrate, and safeguard person-centered care. In brief, a person-centered approach to care puts persons in the centre with their context, their history, their family, and individual strengths and weaknesses. It also means a shift from viewing the patient as a passive target of a healthcare system to another model where the patient is an active part in his or her care and decision-making [17,24]. Positive effects of person-centered care have been reported by, for instance Edvardsson et al. [25] and Olsson et al. [26]. In addition to the concepts of patient- and person-centered care, there are many other forms of centeredness. For instance, Hughes et al. [27] reviewed the literature from 1987 to 2006, and strived to answer what justifies the use of relationship-, patient-, person-, client-, and family-centered care. They found no thematic differences on a conceptual level between the different types of centeredness but concluded that different types of centeredness were required in different contexts.

McCormack et al. [28] point to the importance of nurses having an in-depth understanding of the concept of personhood, so as not to lose the inherent humanistic values of person-centered care. Yet, recent papers on person-centered care often underpin their reasoning with references to patient-centered care [26,29].

Personhood and the patient-role are far from similar, as described above. This raises the question whether there is a true difference between person-centered and patient-centered care, or if they are two sides of the same coin. We believe this question can be powerfully addressed in a synthesis of articles that have already covered large parts of the field of person- and patient-centered care. Therefore, the aim of the present study was to provide a synthesis of the already synthesized literature on person-centered care and patient-centered care in order to identify similarities and differences among the two concepts.

2. Methods

2.1. Search methods

The literature review was performed according to the seven stages described by Pluye and Hong [30]: (i) formulating the review question; (ii) defining the eligibility criteria; (iii) applying the search strategy; (iv) identifying relevant studies; (v) selecting relevant studies; (vi) appraising quality; and (vii) synthesizing results from the included studies. Because step (vi) (appraising quality) as formulated by Pluye and Hong [30] primarily applies to empirical studies, not systematic reviews, we replaced this step with the alternate quality assessments described in the next section.

A librarian specialist developed and ran the specific searches for each database (Cinahl, Cochrane, Medline, PsycInfo, Scopus, and Web of Science) to identify relevant studies: (1) terms “person cent*” or “patient cent*” in the title, (2) systematic review, (3) peer reviewed, (4) in English, and (5) published January 2000–March 2017 (n = 515). Nine additional articles were found through other sources.

2.2. Data collection

All identified articles (n = 524) were imported into EndNote and duplicates were removed (n = 416). We selected articles with the following criteria: (1) “person-centred/ered care” or “patient-centred/ered care” in the title, (2) generating a novel theoretical result about the concept, content, or meaning of person-centred/ered care or patient-centred/ered care based on systematic reviews or other types of reviews (e.g., narrative, integrative) or concept analyses, in (3) all contexts of healthcare.

Quantitative studies (e.g. estimates of effect size) and systematic reviews with results that did not concern person- or patient-centered care per se (for instance concerning *antidepressant use* from a patient-centered perspective rather than concerning *patient-centered care* in the field of antidepressant use), were excluded. Theoretical articles lacking a result about the concept of person-centred/ered care or patient-centred/ered care based on a systematic review, were also excluded.

Titles and abstracts were read by two authors (MSM, JHE) to exclude articles that were not eligible. The two authors independently appraised the full text of retained papers to identify potentially eligible articles. All authors participated in discussions about the selection process at research group meetings, which served as a part of the quality assessment together with the above-described selection criteria.

2.3. Included studies

The search strategies identified 524 references, whereof 108 duplicates. Out of the 416 remaining articles, 363 were excluded after reading the abstract and finding they did not meet the inclusion criteria described in Section 2.2. Then 53 full-text articles were screened by the same criteria and a further 32 articles were excluded. The selection process resulted in 21 articles for inclusion in the analysis. Ten of these articles were about person-centered

care and eleven about patient-centered care. For an overview of the search process and included studies, see Fig. 1 and Table 1.

2.4. Analysis

The analysis was based on thematic analysis according to Braun and Clarke [31], but consideration was given to the unusually high abstraction level of the included data. A consequence of the high abstraction level was a relatively large number of themes. All nine authors participated in the analysis. Initially, everyone read all the included articles to generate ideas regarding codes. Codes are characteristics of the data that appear to fit the aim of the study. Codes with similar content were grouped into potential themes and sub-themes of person-centered and patient-centered care. Each theme and sub-theme was reviewed to reflect the associated codes and the authors repeatedly checked and updated the list of themes and sub-themes by reading the articles. Through this iterative process, the authors could determine whether a theme or sub-theme was present or not in an article (coded as “yes” or “no”). Table 2 shows examples from some of the articles of codes and sub-themes on the theme of empathy.

3. Results

3.1. Themes

The analysis generated 34 sub-themes used in the articles to describe person-centered and patient-centered care. The thematic analysis allowed us to group these sub-themes into 13 themes. For example, the three sub-themes “coordination across the health system,” “interprofessional collaboration,” and “coordination over

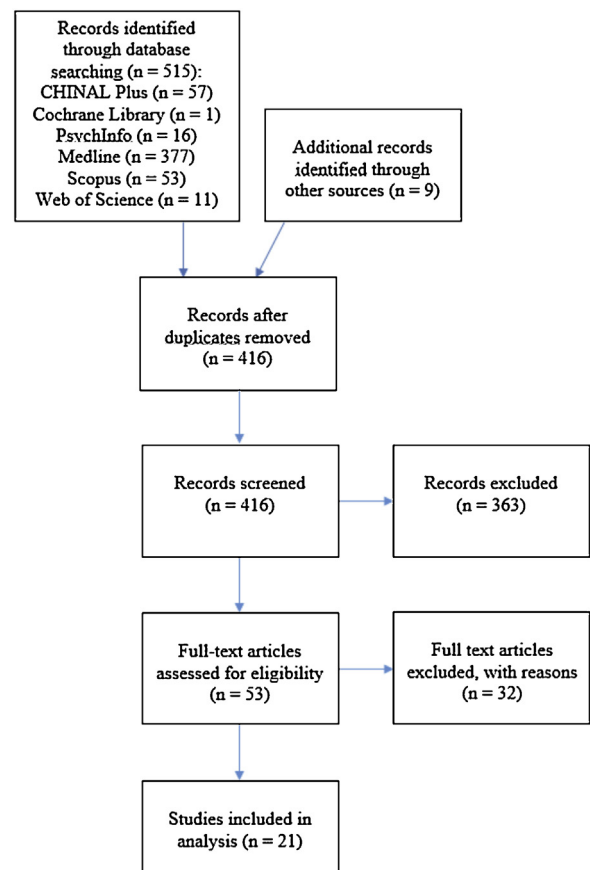


Fig. 1. Data search and selection process.

Table 1
Characteristics of the included articles (n=21).

Article	Discipline	Method	Author location	Patient/person-centered
Castro et al. (2016)	Medicine, nursing, sociology, psychology	Concept analysis (Avant & Walker, 2005) and simultaneous concept analysis (Haase et al., 1992)	Belgium	Patient
Edvardsson et al. (2008)	Nursing/medicine, people with Alzheimer's disease, dementia	Literature review	Sweden	Person
Gabrielsson et al. (2014)	Psychiatric nursing	Evolutionary approach to concept analysis	Sweden	Person
Jayadevappa & Chhatre (2011)	Medicine/nursing	Comprehensive review	USA	Patient
Hobbs (2009)	Nursing	Conceptual analysis/dimensional analysis	USA	Patient
Hudon et al. (2012)	Family medicine	Thematic analysis (Sandelowski, 2000, 2010)	Canada	Patient
Jakimowicz & Perry (2015)	Critical care, intensive care	Concept analysis Walker & Avant (2011)	Australia	Patient
Kitson et al. (2013)	Health policy, nursing, medicine	Narrative review and synthesis	Australia	Patient
Kogan et al. (2016)	Gerontological nursing	Literature review	USA	Person
LePlege et al. (2007)	Rehabilitation	Conceptual and historical analysis	France	Person
Lusk & Fater (2013)	Nursing and interprofessional literature	Concept analysis (Walker & Avant, 2011)	USA	Patient
McCormack (2004)	Gerontological nursing	Literature review and philosophical and conceptual literature exploration	UK	Person
McCormack & McCance (2006)	Nursing	Framework-development Mid-range theory	UK	Person
Mead & Bower (2000)	Medicine	Literature review	UK	Patient
Morgan & Yoder (2012)	Nursing	Concept analysis (Walker & Avant, 2005)	USA	Person
Pelletier & Stichler (2014)	Nursing	Literature review	USA	Patient
Scholl et al. (2014)	Psychology	Systematic review and content analysis	Germany	Patient
Sharma et al. (2015)	Nursing	Overview of reviews with thematic summaries	Canada	Person
Sidani & Fox (2014)	Nursing	Integrative review	Canada	Patient
Slater (2006)	Nursing	Evolutionary concept analysis (Rodgers, 2000)	Australia	Person
Wilberforce et al. (2017)	Social welfare, older people	Literature-based concept synthesis (Walker & Avant, 1995)	UK	Person

Table 2
Examples of codes and sub-themes on the theme of empathy.

Article	Code	Sub-theme	Theme
Morgan & Yoder 2014, person-cent.	C* considers needs and concerns	C is	Empathy
McCormack & McCance, 2006, person-cent.	C is sympathetically present	com-	
Castro et al. 2016, patient-cent.	C is compassionate	passionate	
Hudon et al. 2012, patient-cent.	C has compassion		Empathy
Gabrielsson et al. 2014, person-cent.	C supports the patient as person	C gives emotional support	
Wilberforce et al. 2017, person-cent.	C supports the P***s needs		
Scholl et al. 2014, patient-cent.	C gives emotional support		Empathy
Jakimowicz & Perry 2015, patient-cent.	C gives emotional support		
Edvardsson et al. 2008, person-cent.	C enters the person's world	C	
Slater 2006, person-cent.	C understands the world of the person	understands	Empathy
Sidani & Fox 2016, patient-cent.	C understands P	P	
Jaydevappa & Chhatre 2011, patient-cent.	C understands from P's perspective		

*C = carer, **P = person or patient.

time" were grouped into the theme "coordinated care" (see Table 3).

Among the 13 themes, nine were found in all the articles about person-centered and patient-centered care. According to the analysis, person-centered and patient-centered care both involve (1) empathy, (2) respect (3), engagement, (4), relationship, (5) communication, (6) shared decision-making, (7) holistic focus, (8), individualized focus, and (9) coordinated care.

3.1.1. Empathy

The theme of empathy means to enter into the person's or patient's world, to put yourself "in the shoes" of the person, and includes the sub-themes *compassion*, *emotional support*, and *understanding* (see Table 3). For example, according to Jakimowicz and Perry [32], "the compassionate presence of the nurse is significant in patient-centred nursing" (p. 1510). LePlege et al. [33] stated that in person-centered care "one should listen to the person

with empathy, pay attention to the person's thoughts and enter into the person's world" (p. 1557).

3.1.2. Respect

The theme means the person or patient is approached with a respectful attitude, which includes the sub-themes *respects beliefs*, *respects values*, and *supports dignity* (see Table 3). For instance, Sidani and Fox [34] found "respecting patients' choices" (p. 138) to be central to patient-centered care. In their analysis of person-centered care, Morgan and Yoder [35] considered being respectful as "the driving force behind this concept" (p. 9).

3.1.3. Engagement

This theme means to give of one's time to the person or patient, but not only the allocation of time in an objective sense, but also to be present and committed (see Table 3). For instance, Jayadevappa and Chhatre [36] concluded in their review of patient-centered

Table 3
Themes and sub-themes of person-centered and patient-centered care identified in the articles.

Theme	All articles (21)	Person-centered articles (10)	Patient-centered articles (11)	Sub-themes
Empathy	100%	100%	100%	C* is compassionate C gives emotional support C understands P**
Respect	100%	100%	100%	C respects beliefs C respects values C supports dignity
Engagement	100%	100%	100%	C allocates time C is present C is committed
Relationship	100%	100%	100%	C builds partnership There is mutual trust between C and P There is a therapeutic relationship between C and P
Communication	100%	100%	100%	Communication between C and P C and P exchange information
Shared decision-making	100%	100%	100%	Empowerment Autonomy P is involved in treatment
Holistic focus	100%	100%	100%	Biopsychosocial perspective Nonmedical issues are considered relevant The context has an impact
Individualized focus	100%	100%	100%	C sees specific aspects of P's life P's preferences are considered relevant
Coordinated care	100%	100%	100%	Coordination across the health system Interprofessional collaboration Coordination over time
The goal is to live a meaningful life	48%	90%	9%	The goal is to have meaning in life The goal is to live a good life The goal is wellbeing
The goal is to live a functional life	52%	10%	91%	The goal is to function The goal is symptom reduction
C defends P	43%	30%	55%	C defends the P's rights in the system C deviates from rules
C is self-reflective	24%	10%	36%	C is aware of own thoughts C is aware of own emotions

*C = carer, **P = person or patient.

care that “physicians must spend the necessary time to listen to and understand the patient needs and preferences” (p. 18). Sharma, Bamford, and Dodman [37] see “being accessible” as an aspect of person-centered care (p. 113).

3.1.4. Relationship

The theme of relationship means relationship in a more general sense than specific forms of relationships, such as being friends or relatives. The theme includes the sub-themes of *partnership*, *mutual trust*, and *therapeutic relationship* (see Table 3). For example, Kitson et al. [38] found a “relationship between the patient and the health professional” to be one of the three main themes of patient-centered care (p. 11). According to Castro et al. [39], “patient-centeredness is based on mutually beneficial partnerships” (p. 7). Edvardsson, Winblad, and Sandman [40] suggested as a core component of person-centered care for people with severe Alzheimer's disease to “prioritise the relationship to the same extent as the care tasks” (p. 363). In the same vein, Gabriëlsson, Sävénstedt, and Zingmark [41] suggested that person-centered care is “characterized by its relational quality” (p. 558).

3.1.5. Communication

The theme of communication means a two-way interaction between the carer and the patient where information is being conveyed and shared. The theme includes the sub-themes of *communication* and *exchange of information* (see Table 3). For example, Scholl et al. [42] see “clinician-patient communication” as a dimension of patient-centered care (p. 5). McCormack and McCance [43] acknowledged the importance of communication in person-centered care: “This must involve a process of negotiation

that takes account of individual values to form a legitimate basis for decision-making, the success of which rests on good processes of communication” (p. 476).

3.1.6. Shared decision-making

The theme of shared decision-making means that the person or patient actively participates in his or her care. This theme includes the sub-themes *empowerment*, *autonomy*, and *involvement in treatment* (see Table 3). For instance, Mead and Bower [44] considered “shared power and responsibility” to be one of the five main dimensions of patient-centered care (p. 1087). Slater [45] concluded: “Recognising the person as the centre of care should encourage staff to respect and support the person's decisions” (p. 140).

3.1.7. Holistic focus

The theme of holistic focus refers to a tendency to acknowledge the person's or the patient's whole life. The theme includes the sub-themes *biopsychosocial perspective*, *nonmedical issues are considered relevant*, and *the context has an impact* (see Table 3). For example, Scholl et al. [42] sees a biopsychosocial perspective with “recognition of the patient as a whole person in his or her biological, psychological, and social context” as a dimension of patient-centered care (p. 5). Kogan, Wilber, and Mosqueda [46] found “holistic, whole-person care” to be one of the most central elements of person-centered care (p. 5).

3.1.8. Individualized focus

The theme of individualized focus can be understood in relation to the theme of holistic focus. An individualized focus involves

seeing something particular in the person's or patient's life. Sub-themes are *C sees specific aspects of P's life* and *P's preferences are considered relevant* (see Table 3). Lusk and Fater [47], stressed in their concept analysis of patient-centered care, the importance of "individualizing patient care" (p. 94). According to Wilberforce et al. [48], "person-centred approaches demand a heterogeneous response set, even to apparently homogeneous disorders and disabilities" (p. 90).

3.1.9. Coordinated care

The theme of coordinated care means that care is planned and coordinated across carers, situations, and time. The theme includes the sub-themes of *coordination across the health system*, *inter-professional collaboration*, and *coordination over time* (see Table 3). For instance, Pelletier and Stichler [49] concluded that patient-centered care is "integrated and coordinated across a continuum of services, providers, and settings" (p. 474–475). Similarly, Hudon et al. [50] view coordination as central to patient-centered care: "The physician must coordinate care" (p. 173). Kogan, Wilber, and Mosqueda [46] found coordination to be one of the most central elements of person-centered care: "Care is coordinated, integrated across the health system, medical and supportive services" (p. 5).

3.2. Different goals

While person-centered and patient-centered care have much in common, the two types of centeredness also seem to differ in important respects. The analysis indicated that the goal of patient-centered care is a functional life for the patient while the goal of person-centered care is a meaningful life for the person (see Table 3). There seems to be more of a functional dimension to patient-centered care than to person-centered care. For example, Hobbs [51] emphasizes in functional terms that the consequences of patient-centered care are that the "level of suffering experienced by the patient is reduced" and that any "needs that propelled patient to seek help are met" (p. 57). On the other hand, in his article about person-centered care, McCormack [52] emphasizes "the importance of having a clear picture of what patients and others important to them really value about their life" (p. 35).

3.3. Themes found in a minority of the articles

The themes *C defends P* and *C is self-reflective* were found in a minority of the person-centered as well as the patient-centered articles (see Table 3). *C defends P* includes the sub-themes *C defends the P's rights in the system* and *C deviates from the rules*. For example, in her analysis of patient-centered care, Hobbs [51] described a "willingness to deviate from established norms to customize care for patients" (p. 58). According to Wilberforce [48], person-centered care involves "acting as the guardian of the service user's best interests" (p. 92).

C is self-reflective includes the sub-themes *C is aware of own thoughts* and *C is aware of own emotions*. Mead and Bower [44] described how "emotions engendered in the doctor by particular patient presentations may be used as an aid to further management" (p. 1091). McCormack [52] discussed the importance of the carers "knowing their own views and being aware of how these can have an impact on decisions made by the patient" (p. 475).

4. Discussion and conclusion

4.1. Discussion

The analysis resulted in nine themes present in person-centered as well as patient-centered care. Thus, there seems to be a considerable overlap between the two concepts and the disturbing

question has to be asked: Is person-centered care the same thing as patient-centered care under a new name? Patient-centered care was launched as an effort to acknowledge the individual in opposition to paternalistic biomedicine. It thus seems logical that concepts central to patient-centered care, such as empathy, communication, and holistic focus should gain prominence. Person-centered care is a different concept and developed to put less focus on the sick-role and more on the unique individual with an illness or impairment [16]. But could it be that it fulfils much the same function as patient-centered care although in a different historical context? That is, could the main meaning of the two concepts be to acknowledge the individual in a medical context where psychosocial aspects are taken into consideration? In this interpretation, the concepts could have very much the same meaning since their historical contexts differ. This interpretation is also in line with the findings of Hughes et al. [27] about different forms of centeredness in healthcare.

However, the analysis of the present study also showed that the goals of the two concepts tend to differ. All the person-centered articles, except one, described the goal of person-centered care to be a meaningful life and all the patient-centered articles, except one, described the goal of patient-centered care to be a functional life. This is in line with the conclusion by Lambert et al [16], that patient-centered care still might be labelled as a model of bio-medical care. This also caused us to ask further questions regarding the relation between the two concepts: Could it be that the similarities found in the analysis are simply nothing but an artefact of the method used? In the present study, the primary data consisted of descriptions that were already highly abstract. Further, the codes were typically formed as singular abstract concepts and could thus be suspected to account only for a portion of the context they were referring to. Finally, because of the aforementioned abstractions, there is a substantial risk for overly subjective interpretations in the formation of the themes. There is, in conclusion, a clear risk that such a method misses important nuances and differences in the material. However, we have taken measures to lessen this risk as much as possible. For example, the group has read, analyzed, and discussed the data and evaluated the appropriateness of the codes on several occasions.

In order to address the possibility that we have missed important differences between the two concepts, we did a more interpretative reading of the primary data. We found indications that there were in fact qualitative differences between the themes depending on whether they belonged to patient- or person-centered care. When investigating three of the nine themes more thoroughly they were found to differ in subtle but conclusive ways in line with the difference in goals. The same words are used in person-centered and patient-centered care but they seem to carry different meanings.

For example, while empathy is a theme of both person-centered and patient-centered care, there is also a clear difference. In patient-centered care, where the goal is for the patient to function, empathy typically means to infer the patient's specific feelings. For instance, according to the article by Scholl et al. [42], a dimension of patient-centered care is "recognition of the patient's emotional state and a set of behavior that ensures emotional support for the patient" (p. 5). But in person-centered care, where the goal is for the person to live a meaningful life, empathy typically means to see beyond the person's specific feelings in the present moment to the life he or she is living. In person-centered care, empathy means not only to understand that the person is fearful, joyful, or sad in the present moment as in patient-centered care, but also to see from the person's perspective the purposes that gives the person's life extension and structure. For instance, in the article by Edwardson et al. [40], person-centered care involves "entering their world and assuming there is meaning in all behavior, even if it is difficult to interpret" (p. 363).

A second example of diverse meanings for the same concept is the theme of communication. In the patient-centered articles, communication is typically described in terms of an exchange of information in an unbiased manner, which leads to a common ground of understanding and effective cooperation between the carer and the patient. For instance, Sidani and Fox [34] emphasized the importance in patient-centered care of “sharing information in a complete, accurate and timely way to facilitate patients’ effective participation in decision making” (p. 138). Contrary to the above effective and accurate sharing of information, the person-centered articles put more emphasis on the multifaceted aspects of communication with dialogue and narrative as key elements to clarify what really matters to the person. Rather than being subordinated to decision-making, in person-centered care, communication is viewed as an integral part of the whole caring encounter. For instance, according to McCormack and McCance [43], in person-centered care communication processes, the carer acquires “a clear picture of what the patient values about their life” (p. 476).

A third example of diverse meanings for the same concept is the theme of holistic focus. In patient-centered care, the holistic perspective is additive in nature. It typically means pronouncing the benefits of adding the psychological and social dimensions to the biological dimension. Mead and Bower [44], for instance, state that a “combined biological, psychological and social perspective is regarded as necessary to account for the full range of problems presented in primary care” (p. 1088). In person-centered care, the holistic perspective emphasizes the interdependence between dimensions rather than being additive. Here the severe disadvantage of not taking a holistic perspective is underlined. For instance, according to Morgan and Yoder [35], care “that focuses on biological illness without considering the psychological or social impact hampers healing and contributes to poor outcomes” (p. 8).

It may seem that we have placed ourselves in a dilemma: on the one hand, the two orientations appear to be very much the same, but, on the other hand, they also show themselves to be quite different. We would argue that the present analysis points to the conclusion that the two orientations are *similar* at a surface level but *different* when regarded on a deeper level in light of their different goals. Thus, they are “same same but different”.

4.2. Strengths and limitations

The literature search was conducted in all contexts of health-care, but the majority of articles that turned out to meet the inclusion criteria, were in the nursing context. The search generated only a few medical articles meeting the criteria. Thus, the inclusion of a small number of medical articles was not a deliberate choice but an unintended consequence of the inclusion criteria. This literature review was limited to a thematic analysis of previous reviews, and we did not analyze any empirical data directly, which might have contributed to a shortage of medical literature. Many medical studies were excluded due to being quantitative studies (for example estimates of effect size) that did not concern the nature of person- or patient-centered care per se. However, the bias towards nursing articles and the inclusion of only a few medical articles is still a limitation important to be aware of when interpreting the findings.

To ensure the analysis and the rigor of the present study, the themes derived were reviewed by all the authors. Reflexivity was used by the researchers to identify and become aware of preconceptions that might have an influence on the analysis. This means to have an open and critical stance, while reflecting on the process of analysis and descriptions made. Thematic analysis means to be closely engaged in the analysis, and researchers must reflect on the process. In contrast to single researchers, multiple researchers can strengthen the analysis and give supplementary

views [53]. To follow the process of analysis is no guarantee for trustworthiness in itself, and reflexivity is needed. Also, although several researchers participated in the analytical process, the grouping of sub-themes into themes can still be regarded as somewhat subjective. In a thematic analysis, there are always several possible ways of understanding and relating the themes to each other [31]. However, this is a problem that faces every researcher with the ambition to analyze the themes of a concept, especially at higher levels of abstraction as in a review of reviews.

It should be noted that the literature review was conducted within the context of research and not within the context of clinical practice. The purpose was simply to clarify the similarities and differences between the concepts used by researchers. Although the results of the present study may ultimately be of importance to clinical practice, the interrelations between the two orientations are more complex and intertwined in real life. To address this issue would require another type of study in which direct empirical data from clinical practice would be analyzed.

4.3. Conclusion

The present study addresses an existing gap and confusion regarding the two concepts of person- and patient-centered care in the literature. There were a number of reviews and meta syntheses of person-centered care as well as of patient-centered care, but no meta synthesis comparing the two concepts seemed to have been done. The present study revealed that at the same time as there are numerous similarities between the two concepts, the goals of person-centered and patient-centered care differ in a decisive way. With an interpretative reading of these differences, we conclude that the concepts are similar on a surface level but different on a deeper level in light of their different goals. Both patient- and person-centered care are important alternatives that can and should coexist in clinical practice. However, it is important to acknowledge and respect the deeper and more subtle differences between the two concepts when applying them to clinical practice.

4.4. Practice implications

Although patient-centeredness has been compared and discussed in relation to, for instance, patient empowerment [24], the relationship between patient-centeredness and person-centeredness has not previously been clarified. Clarification of the contents of person-centered care and patient-centered care may assist practitioners and researchers to develop and measure the relevant aspects of care.

Today there is a move toward using “person-centered,” rather than “patient-centered” care, to address the patient as a person with needs and preferences beyond just the medical perspective [24]. Both concepts have the potential to improve the quality of care, and the experiences and outcomes of care on the level of patients’ interactions with their healthcare providers, as opposed to bio-medically oriented care. Even though person- and patient-centered care have been researched for many years, still these concepts remain hard to operationalize and there are challenges and barriers for putting them into practice [17]. The implementation of person- and patient-centeredness has been stressed to require changes in norms and expectations for most healthcare systems [54]. Thus, developing person- and patient-centered care involves a shift in cultures [55] and is a complex task. Routines and strategies are needed on how to instill and establish a new culture in health care, safeguarding values and attitudes contributing to person- and patient-centered care.

This study may help in the development of guidelines and tools needed for researchers, health providers, and educators. We have identified nine themes that need to be considered when implementing

either of the two orientations. Further, the study has revealed two different goals, which can be used to select which of the two orientations on which to focus. The study indicates that a deeper conceptual understanding of each of the two orientations is necessary to implement and use them in a coherent and trustworthy way. That is, to implement the nine themes in light of the goal one currently chooses to focus on. However, it is important to stress that the practice of person-centered care does not mean to abandon the goals of patient-centered care. A functional life is often very important to the individual and part of a meaningful life. In that sense, there is no opposition between practicing person-centered care and practicing patient-centered care. Person-centered care broadens and extends the perspective of patient-centered care by considering the whole life of the patient.

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Conflict of interest

None.

Contributions

Study design: JHE, IKH, MSM; article search: JHE, IKH, JH, EK, TK, KS, AJS, MSM; analysis: JHE, IKH, EC, JH, EK, TK, KS, AJS, MSM; drafting of the article: JHE, IKH, EC, JH, EK, TK, KS, AJS, MSM.

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