

Person-centred care in clinical assessment

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Symptoms and signs

That symptoms play a vital role for people's well-being is well established. Not only do symptoms signal that something is wrong but they can also predict re-admission and mortality among patients with myocardial infarction^{1,2} as well as functional status among patients with cancer.³ Moreover, symptoms predict long-term survival better than clinical signs after chronic heart failure (CHF)⁴ and depressive symptoms increase the risk of being affected by myocardial infarction.⁵

Symptoms are defined as subjective experiences of *illness*.^{6,7} When a symptom is experienced, body awareness is altered and a function that has previously been automatic is now brought to attention requiring conscious effort. The habitual equilibrium has been disturbed, which is interpreted as a bodily message.^{8,9} How symptoms are perceived and a person's response to them is based on their reality⁶ and includes physiological, psychological, behavioural and sociocultural components.¹⁰ An effort to capture this broader view on symptoms is the basis of the biopsychosocial approach: psychological and social factors influence the illness experience and, by extension, how individuals experience their symptoms.^{11,12} It is not uncommon for symptoms to appear in clusters, clusters that trigger and reinforce each other.^{13,14}

In contrast to symptoms, signs are defined as biological changes caused by *disease* and possible to identify and see through different procedures (e.g. imaging, biomarkers and x-ray). Signs are seen as objective and therefore viewed as more reliable to establish a diagnosis than symptoms, which can only be identified through patients' narratives.^{6,7,15} The current predominant theoretical framework assumes that symptoms are signals of basic underlying

disordered somatic processes (i.e. measurable or not yet measurable signs).^{7,16} This view is held by many despite the apparent difficulty in determining the link between biological factors and symptoms.^{4,17} Physicians and registered nurses (RNs) have a different but overlapping focus in their clinical assessment. Physicians are trained to assess different objective markers of *disease* (such as biomarkers, imaging and x-ray) and diagnose and prescribe treatment.¹⁸ In the current paradigm the primary task of the physician is to decode the patients' symptoms to their biological referents to diagnose a disease entity.^{7,16} For their help they have symptom sorters to guide them to the most likely diagnosis.¹⁹ In contrast to this are disease severity and pathophysiological changes that are often poorly correlated with the suffering caused by symptoms.^{4,17} In CHF, for instance, a low ejection fraction is not related to quality of life (QoL) or severity of symptoms.²⁰ RNs, on the other hand, prefer to centre on patients' subjective experiences: *illness* and how it affects well-being and daily life. These different views are probably related to the content in the respective professional education and research traditions and have sometimes led to an unfortunate polarisation between physicians and RNs. Such mutual opposition is detrimental to care and is likely to cause some conflict within the professional team. Neither profession has the

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Figure 1. The difference between symptoms (black) and signs (white) is not always clear (black and white), they are both interpretations but equally important.

goal of seeing only part of the picture; however, training and professional responsibilities, together with fragmentation of care, have led these two groups to concentrate on different aspects of the same goal. Both symptoms and signs are valid and need to be considered to optimise care. They should be viewed as complementary rather than as either contradictory or belonging to separate spheres.

The division between symptoms and signs and its consequences

Symptoms and signs are often assumed to be dichotomous, with symptoms representing the subjective and personal illness experience, and signs representing objectively measurable pathological changes.¹⁵ The separation of symptoms and signs was a result of the scientific development and the dualistic division of mind (identity) and body, which, together with the objectiveness of signs, have been increasingly questioned.¹⁶ Malterud,¹⁵ for instance, suggests that it is impossible to distinguish between objective medical signs and subjective symptoms because both are interpreted through the medical gaze. Instead, the author contends that symptoms and signs are essentially the same but are assigned different values and thus credibility. There is a hierarchy of signs. The division between signs and symptoms and their intrinsic values involves the expectation that healthcare professionals can interpret what is important and what is not. Diseases that lack medical signs and are based on symptom experience have lower status than diseases which can be technically measured. Examples of this are myocardial infarction and unexplained chest pain: both are common diagnoses in cardiac wards but they are often viewed differently. The latter condition is not life-threatening and the patient should not worry about it. From the patients' point of view, however, the fear of

death is often as high as for those patients diagnosed with myocardial infarction. Patients presenting with medically unexplained symptoms that do not fit into the diagnostic matrix run the risk of being discredited and subsequently blaming themselves for the unnecessary use of scarce healthcare resources. The separation of symptoms and signs discredits the personal illness experience and reinforces the subordinate position of the patient in the healthcare system.¹⁵ The perspectives need to be integrated to bring about a healthcare system committed to putting patients first and trying to understand their condition and thereby relieve their discomfort (see Figure 1).

The integration of symptoms and signs

Nowadays, symptoms are not fully integrated into the healthcare setting and, as we have shown, this has direct consequences for the quality, safety and effectiveness of care. Progress has been made to integrate patients' views in the form of patient-reported outcome measures (PROMs);^{21,22} however, these are often focused on health-related QoL. Furthermore, they are outcome measures that are used to evaluate care and not seen as an integrated part of the care process. The emphasis in clinical assessments still often focuses on visible signs (blood pressure, blood tests, etc.) but there is a need to put equal emphasis on symptoms and patients' narratives in care. Although there are different models about what influences symptom perception, their consequences and how they should be managed share many similarities.^{10,23} The perception of symptoms is influenced by both biological and psychosocial factors, including factors such as demographic background, personality traits, culture and civil status. Symptom experience is also influenced by symptom characteristics, what value or importance a symptom is assigned, and personal responses to the symptom. Models vary in how much emphasis they place on social, psychological and biological factors. Yet, all of these factors must be addressed to achieve optimal symptom management. Symptom management should be a collaboration between the patient, healthcare professionals and, if appropriate, the patient's family.^{24,25} The models emphasise that symptom management should take its starting point in the personal illness experience, but they fail to address the consequences of the intrinsic value difference between signs and symptoms, and the effect this has on clinical care.

Person-centred care (PCC)

Although these models attempt to show how symptoms should be managed, they fail to demonstrate how symptoms could be integrated into clinical practice. One reason for this failure may be that the models presume the existence of a dichotomy between symptoms and signs. Rather, we believe that the end to this polarity is a key

aspect in the possibility of integrating symptoms into clinical practice. The way we propose to do this is through PCC. We choose the PCC approach because the patient's narrative is central in combination with the results from medical examinations and tests. PCC has its basis in ethics, focusing on the health and resources of patients rather than only on disease and limitations due to disease. Stressing health, while still being aware of the patient's needs and biological markers of disease, has the potential to unite the different directions of RNs and physicians and therefore create healthcare provision that is more consistent and less contradictory. Clinicians (physicians and RNs) must be able to listen to and understand the patient's perspective of the situation. Such an understanding attitude implies elevating the patient as a full partner, sharing his or her experiences and expertise in relation to the condition. PCC and treatment require ethics as a basis and a partnership approach to the patient and family. Such an ethical view can very briefly be formulated as follows: To aim for the good life, *with* and for the patient in just institutions.^{26,27} In practice this means to listen to the patient's story and to reach a common agreement (with and for the patient) on how to proceed with the care within an institution (hospital, care setting, etc.) that cares and treats all patients (and staff) equally. This ethical definition is a guiding principle in which the moral and practical dilemmas that are constantly faced in clinical practice must be resolved.

Different academics have proposed different models for PCC, but they all share the same core perspective, regardless of whether they describe PCC with three, four or more core dimensions.^{26,28,29} In common for all the models is that they start with a patient narrative. This is an exploration of the patients' view of their illness and health. The professional seeks to understand the patients' experiences of the condition and daily life in relation to it. Hence, it is an illness narrative and not a complete life story.^{30,31} Several studies have shown that healthcare professionals' assessment of health and the patients' view of their condition often disagree. We need to listen carefully to obtain a reliable picture of the condition.^{4,32,33} It is sometimes misconceived that PCC requires that healthcare professionals address all aspects of a patient's life; rather, the intention is to focus on illness, symptoms, and how they affect life with the life situation taken into consideration. Health-promoting care can be accomplished when biomedical aspects of disease and the patient's perception of illness are integrated. If clinicians maintained a solely objective stance in relation to patients, an unacceptable insensitivity to human suffering would be achieved. A common agreement on care and treatment between the patient and healthcare professionals should be formulated. Here, in the commonly formulated health plan the interpretation of signs (mainly made by professionals), together with the interpretations of symptoms and signs (made together by professionals

and the patient and family), is made. The focus should be on defining the patient's resources and problems, establishing goals and identifying the roles to be assumed by the patient and healthcare professionals. This approach presupposes changes in the mindset of the clinicians, who need to acknowledge the patient's capacities and sense of responsibility without diminishing the important role of support and care they need to deliver. A central component in PCC is the partnership between patients and healthcare professionals based on the co-creation of a personal health plan. This approach employs resources identified in each patient's illness story in order to tailor care in a way that directly addresses his or her needs and preferences. In contrast to simply convincing and increasing patients' knowledge about the disease and indicating that a given behaviour will lead to a beneficial outcome, PCC builds on a partnership and factors related to the patients' perception of their ability to manage their illness. Resent research has shown that patients with lower levels of education who participate in cardiac rehabilitation programmes may feel excluded and even stigmatised by healthcare professionals.³⁴ In a study comparing the effect of PCC in patients with either high or low levels of education after an event of acute coronary syndrome, the PCC intervention was significantly more effective in patients with low levels of education.³⁵ Partnership requires mutual trust and confidence, including an aspiration for equity in health opportunities. Finally, the integration of symptom into clinical practice is critically important. PCC has shown to improve self-efficacy to control symptoms after acute coronary syndromes³⁶ and we believe it offers a viable framework not only to integrate symptoms into clinical practice but also to foster a collaborative culture in fair institutions.

Declaration of conflicting interests

The authors declare that there is no conflict of interest.

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