

Patients' Perceptions of Person-Centered Care in Early Rheumatoid Arthritis: A Qualitative Study

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Objective. Most research on patient experiences of rheumatoid arthritis (RA) care is performed with patients who have established RA and less often with patients with early RA. Experiences of and expectations about health care may change over time, which is why the aim was to explore patients' perceptions of person-centered care (PCC) early in the RA disease course.

Methods. Thirty-one patients with early RA were interviewed in this qualitative study. An abductive qualitative content analysis was conducted based on the framework of McCormack and McCance (1,2). The four constructs, prerequisites, care environment, person-centered processes, and person-centered outcomes, constituted the four categories in the deductive part of the study. An inductive analysis generated 11 subcategories exploring the content of PCC.

Results. For patients with early RA, PCC was described in terms of 1) prerequisites including being treated with respect, meeting dedicated health care professionals, and meeting professional competence; 2) care environment including having access to a multidisciplinary team, having access to health care, and encountering a supportive organization; 3) person-centered processes including being listened to, being supported, and being involved in decision-making; and 4) person-centered outcomes including being satisfied with received health care and achieving optimal health.

Conclusion. Genuine PCC is important for patients early in the RA disease course, supporting the implementation of a person-centered approach during all stages in the health care system. This study contributes to information about how to further develop person-centeredness in rheumatology care.

INTRODUCTION

A diagnosis of rheumatoid arthritis (RA) entails frequent visits to a specialist clinic, and a trusting relationship between patients and health care professionals will facilitate high-quality care (3). RA affects 0.5% to 1.0% of the population in the world (2). Early pharmacological treatment is necessary, and a tight disease activity control can lower impact and improve work productivity and quality of life in most patients (5,6). Effective treatment, both pharmacological and nonpharmacological, is important for patients, and their treatment preferences change during the first 2 years, from that of “back to normal” to “mastering a new life situation” (7,8).

Person-centered care (PCC) has been advocated (7,8) for using the patients' resources and strengthening autonomy early

in the disease course of RA. PCC emphasizes the importance of recognizing the patient as an expert on the illness and life situation (11,12). Patient experiences, clinical effectiveness, and patient safety are cornerstones of health care quality, and data from the patients' experiences can identify strengths and weaknesses with the care provided (13). McCormack and McCance's theoretical framework for PCC includes the following four constructs: prerequisites, care environment, person-centered processes, and person-centered outcomes (1,2). Prerequisites refer to professional competence and commitment to the job, clarity of beliefs and values, self-knowledge, and advanced interpersonal skills to enhance communication. Care environment refers to the health care context, including a supportive organization, an appropriate mix of skills, an effective staff relationship, use of shared decision-making

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systems, sharing of power, the potential for innovation, and risk-taking, as well as the physical environment. Applying a person-centered process means focusing on the patient in care delivery, working with the patient's values and beliefs, inviting the patient to share decision-making, engaging authentically, being sympathetically present, and providing holistic care. Person-centered outcomes are the central construct within the framework and represent the expected results of effective PCC (a good experience of care, involvement in care, a feeling of well-being, and the existence of a healthful culture) (1,2). The purpose of the framework is to implement PCC for all patients regardless of context, and it is thus important to gain greater knowledge of patients' experiences of how PCC is expressed in different contexts (14).

Research shows that patients with established RA have multidimensional expectations of health care services. Patients expect PCC, access to rheumatologists and health care professionals, active listening, respectful treatment (15), access to reliable information, shared decision-making, and a good relationship between patients and health care professionals (15,16). Information concerning the experiences of PCC in patients with early RA is scarce. Experiences and expectations about health care as well as patients' illness perception may change over time and might differ between countries and contexts (8,17). This study aimed to explore patients' perceptions of PCC in early RA within the four constructs of the framework by McCormack and McCance.

METHODS

Design and setting. The study had an explorative design based on qualitative content analysis. An abductive approach was used to gain a greater understanding of the patients' perceptions of PCC. The abductive approach entailed moving back and forth between inductive and deductive approaches (18). To ensure trustworthiness, the study is reported following the Consolidated Criteria for Reporting Qualitative Research 32-item checklist (19).

The study was conducted at two university hospitals and two regional rheumatology specialist outpatient clinics in Sweden. In early RA, the patients meet the rheumatologist for determining the diagnosis and treatment initiation, and follow-ups are performed every 3 months during the first year. The rheumatology nurse gives information when starting drug treatment and follows this up after 6 weeks, when the patients also meet the multidisciplinary team, and more meetings are scheduled with team members if needed.

Participants. Patients with early RA (disease duration of ≤ 1 year) who received disease-modifying antirheumatic drug (DMARD) treatment for 3 to 7 months and who were 18 years of age or older were invited to participate in the study. Purposeful sampling was carried out to achieve variation in terms of sex (22 women and nine men), age (ranging from 38-80 years), civil status

Table 1. Sociodemographic and clinical data of the participants (N = 31)

Characteristics	Results
Site of Recruitment, n	
Regional rheumatology specialist outpatient clinic	3
University hospital	28
Sex, female/male, n	22/9
Age, median (range), y	56 (38-80)
Disease duration, median (range), mo	5 (3-9)
RA treatment, n	
csDMARDs	30
bDMARDs	6
Civil status, cohabiting/living alone, n	27/4
Education level, primary school/secondary/university, n	8/15/8
Employment, employed/student/unemployed/retired, n	14/1/3/13
NRS pain, ^a median (range), mm	27 (0-70)
NRS general health, ^a median (range), mm	26 (0-80)
NRS fatigue, ^a median (range), mm	30 (0-95)

Abbreviations: bDMARD, biological disease-modifying antirheumatic drug; csDMARD, conventional synthetic disease-modifying antirheumatic drug; NRS, numerical rating scale; RA, rheumatoid arthritis.

One patient had discontinued all treatments at the time point for the interview.

^a During the past week, range 0-100 (best to worst).

(27 patients were cohabiting and four were living alone), and education (eight patients had finished primary school, 15 had finished secondary school, and eight had a university degree). We aimed at achieving variation not only within but also between the four different clinics. A total of 31 patients with early RA were included in the study (Table 1).

Data collection. Individual interviews were performed by the first and last author (E Landgren and IL) between March 2017 and February 2018 and were conducted in Swedish. The questions were the following: "Can you tell me about how RA affects your everyday life?" "Which consequences of your illness and the antirheumatic treatment are important for you at the moment?" "How do you perceive the early RA health care?" "How do you perceive the encounter with the health care professionals in early RA health care?" "Which expectations do you have for the health care and health care professionals?" "What do the health care professionals do for you to make you feel good?" and "Is there anything you think health care professionals can do better in early RA health care?" The following follow-up probes were used to encourage the patients to elaborate on the answers: "Please tell me more," "How do you mean?" or "What do you have in mind when you say...?". The patients talked about their experiences with health care in relation to their expectations. Two pilot interviews were conducted to test the opening questions, and these interviews were included in the study because no adjustments were deemed to be required. The interviews lasted between 16 and 127 minutes, with a median of 43 minutes and a total interview length of 26 hours and 9 minutes. All the interviews were audio-recorded and transcribed verbatim.

Data analysis. The transcribed data were analyzed using qualitative content analysis (18,20). The abductive analysis was performed in several steps. First, with an inductive approach, the entire text (unit of analysis) was read repeatedly by the first author (E Landgren) to gain a sense of the whole. Meanings of phrases containing information relevant to the study's aim were then identified and extracted in 622 meaning units. These were condensed, abstracted, and coded. Second, with a deductive approach, the codes were sorted into the following four constructs in the PCC framework (1,2): prerequisites, care environment, person-centered processes, and person-centered outcomes. An inductive process was then started again within each of the four constructs, which constituted the four categories. The codes were compared on the basis of similarities and differences and grouped into 11 subcategories. The subcategories reflected the core content of the interviews concerning PCC within rheumatology care for patients with early RA. A discussion and reflection took place continuously between the authors to attain a consensus (18,20). No meaningful data were left out. Although some interviews were short, these patients described their experiences in at least two of the four categories.

Ethical considerations. The study was approved by the Regional Ethical Review Board in Lund, Sweden (2016/618, 2017/205), and conforms to the principles outlined in the Declaration of Helsinki (21). Oral and written information about the study was provided, and written informed consent was obtained from all participants.

RESULTS

The perceptions of PCC of patients with early RA were analyzed within the framework of PCC and its four categories (prerequisites, the care environment, person-centered processes, and person-centered outcome) and generated 11 subcategories (Table 2). There is a variation of both positive and negative perceptions of PCC in early rheumatology care regardless of gender or treatment among the participants. All categories and subcategories described below comprise perceptions from both women and men treated with either conventional or biological DMARDs.

The categories and subcategories are illustrated by quotes from the interviews (Table 3).

Prerequisites. The patients' perceptions of health care in early RA were described by the following three subcategories within the category prerequisites for PCC: being treated with respect, meeting dedicated health care professionals, and meeting professional competence.

Being treated with respect. Being treated with respect was a prerequisite for perceiving PCC, illustrating the importance of being seen as an equal and treated as a person with individual needs by health care professionals, not as a diagnosis or number. Health care professionals who informed them frankly about the consequences of the illness were appreciated, and the patients felt respected when experiencing empathy and understanding concerning the effects of living with a chronic disease. However, perceiving a lack of respect from health care professionals led to feelings of disappointment and despair.

Meeting dedicated health care professionals. Patients described the importance of encountering dedicated health care professionals for perceiving PCC. Meeting dedicated health care professionals was essential for building a trusting relationship and sustained confidence in the health care services. The patients spoke of confidence in finding support from dedicated health care professionals when searching for solutions to their individual needs. Encountering nondedicated health care professionals who gave promises that were never fulfilled was frustrating for patients with early RA. Phone calls, follow-up appointments, and referrals that were never executed resulted in feelings of resignation or insecurity.

Meeting professional competence. Patients with early RA perceived PCC if they encountered competent professionals when attending health care services. The patients described positive perceptions when health care professionals communicated comfort and hope based on their professional competence. Patients perceived competence in health care professionals in rheumatology care, in which there was a mix of staff working together who had long and short work experience,

Table 2. Overview of the categories and subcategories showing patients' perceptions of PCC in early rheumatoid arthritis within the framework of PCC from McCormack and McCance (1,2)

Categories	Prerequisites	The Care Environment	Person-Centered Processes	Person-Centered Outcomes
Subcategories	Being treated with respect	Having access to a multidisciplinary team	Being listened to	Being satisfied with received health care
	Meeting dedicated health care professionals	Having access to health care	Being supported	Achieving optimal health
	Meeting professional competence	Encountering a supportive organization	Being involved in decision-making	

Abbreviation: PCC, person-centered care.

Table 3. Quotes of participants that illustrate perceptions of person-centered care in patients with early rheumatoid arthritis

Categories	Subcategories	Quotes
Prerequisites	Being treated with respect	And it's also important to feel that they care. That one is not only a number or something. (Interview 18, man) I fell between two stools, nobody took responsibility for me and that's dangerous. It didn't feel good and it didn't feel good to say it either but I know that it was like that. (Interview 30, woman)
	Meeting dedicated health care professionals	They've always treated me in a very good way, that I can say, I've always got what I've asked for. I don't have any other expectations, I'm sure that if I ring on a weekday and ask for an appointment to see the doctor then they'll arrange it for me, I feel very safe with the rheumatologists here, it feels good. (Interview 30, woman) "We'll ring you", "You'll get an appointment" and then nothing happens. Then... And I become unsure. (Interview 7, woman)
	Meeting professional competence	I mean, everyone can... give an injection, everyone can administer medication, but how it is done, that's what's important. And we humans are very dependent on those small... that I read about somewhere, on those small things that make the difference, doing it correctly. (Interview 19, man) So they gave me 14 days of real hell. And then I couldn't cope then. Either they should get to know the facts because I don't intend to be like that again and be so ill. Because of... incompetence. I demand it actually. If they're not able to do it properly, no, then they'll get to know the facts. (Interview 16, woman)
The care environment	Having access to a multidisciplinary team	I met a physiotherapist already on the first day and then a social worker, and I got to meet many people and "this is your team now, XX" I just said "shit", I've got my own team now! (laughs). (Interview 23, woman)
	Having access to health care	And they've said if there is something then you can just ring to them and they've said that a couple of times to me. You're not to be afraid of ringing and asking. And I'm really pleased about that. (Interview 31, woman) It hasn't been easy to get in touch with them here (the rheumatology department)... but I wrote a message on their internet page a couple of times and they did call me back. This has worked two or three times, I think. (Interview 18, man)
	Encountering a supportive organization	It works well, they give me an appointment every three months and they send referrals for blood tests home to me and... I don't need to think it's great. Everything is done for me. And that's actually just great. (Interview 20, woman) And then he's missed the point that I wasn't informed that I was to start chemotherapy, I haven't been able to go to the occupational therapist and the physiotherapist, everything that is provided for people with arthritis hasn't been given to me. No. And then my reaction is that I want my doctor to see that nothing is being done. (Interview 30, woman)
Person-centered processes	Being listened to	Then it's a little like that. Which was the positive surprise when I came here that I was able to talk in peace and quiet. And ... I think I had been given an hour for the first appointment with the doctor and it felt more than that. We had time to discuss most things. (Interview 17, man)
	Being supported	Well, that they just took care of me immediately, really saw, all of them saw, but they were really, sort of completely, like this, and then I understand that they have a million other patients but when I'm there it feels as though I'm their only patient, you know. (Interview 23, woman) The physiotherapist says that I won't be able to dance again but I'm determined that I'll be able to do it. (Interview 11, woman)
	Being involved in decision-making	Could help you to find solutions because it's not them who should find the solutions, you should work together to solve a problem, untying a knot sort of. (Interview 26, woman) but I assume that the doctors make this assessment and that they know better than I do because I don't really know anything more than that. (Interview 17, man)
Person-centered outcomes	Being satisfied with received health care	That was what I reacted to on the first occasion, and it felt very relaxing, and that we were carefully examined. And I had my wife with me the first time as well ... she also thought it was very pleasant here. A professional and warm, caring reception, you could say. I'm very satisfied at the moment. With the result and how I feel. (Interview 17, man) That's what I've tried to get them to understand, you must take tests, what's wrong with my body? (Interview 26, woman)
	Achieving optimal health	I'm mainly interested in my health and getting well. (Interview 28, man) Yes, but now I know how it's about, I receive medication that works for me, now I can sort of just live as I did for a year ago. (Interview 23, woman)

giving professional advice when appropriate, and embodying the PCC they expected.

The patients described disappointment, frustration, and worry when they encountered incompetence among health care professionals, which threatened their perceptions of PCC. A lack of preparation, a lack of access to medical records, or a lack of disease-specific knowledge was perceived as incompetence. The patients' perceptions of PCC and competent professionals were summarized by the importance of feeling safe in contact with the health care services.

The care environment. The patients' perceptions of health care within the PCC framework and the category of care environment generated the following three subcategories: having access to a multidisciplinary team, having access to health care, and having a supportive organization.

Having access to a multidisciplinary team. Patients valued early support from the multidisciplinary team and recognized access to them as an important part of the care environment, conveying a feeling of safety. The multidisciplinary team provided

treatment and support for the wide range of symptoms that might occur. Not being offered this possibility had a negative impact on their perception of PCC.

Having access to health care. The patients described PCC as a positive perception when they had early and easy access to health care, including laboratory tests, telehealth, referrals, and continuity of care. The patients perceived a feeling of safety and security once they were admitted to the rheumatology clinic, knowing that access to help was within reach when needed. Neglected telephone calls and prolonged waiting time for an appointment or a referral were concerning because they increased the risk for lifelong side effects due to treatment delay. The patients sometimes described an unsatisfactory struggle with the organization to access health care, and this was perceived as a threat to PCC.

Encountering a supportive organization. Encountering a supportive organization was perceived as an important part of PCC and created a feeling of safety and comfort. The patients appreciated a supportive care environment with structured follow-up systems, such as a “tight control,” in which they perceived that the system had full control of their treatment plan. The organization could also be perceived as unsupportive, for example, when transfers between health care levels were missed or if the information was lost, it became the patient’s task to find solutions and reconnect with the organization, which was exhausting. Some patients described a feeling of not “fitting into the model” and advocated the importance of a supportive organization for the care environment to be person-centered. A feeling of loneliness when trying to master the health care system was expressed.

Person-centered process. The patients’ perceptions of health care within the framework of PCC and the category of person-centered process generated the following three subcategories: being listened to, being supported, and being involved in decision-making.

Being listened to. Being listened to was of importance for the patients and for experiencing a person-centered process when seeking health care. Patients were pleased when health care professionals listened to their narrative about their illness and valued the time spent together during their visits. If the patients’ thoughts and suggestions were not listened to, they perceived themselves to be neglected and felt vulnerable.

Being supported. The patients perceived support from health care professionals in the person-centered process through guidance that was tailored to individual needs. Flexibility, assistance in a swift solution to a specific problem, and a positive attitude from health care professionals contributed to a positive experience of the health care services. Being supported meant feeling unique and receiving full attention from the health care professionals during the visit. The patients experienced that most health care professionals encouraged and supported them to fulfill their life goals, whereas some described unsupportive health

care professionals who contributed to a negative perception of the person-centered process, affecting PCC.

Being involved in decision-making. The patients described positive perceptions of the health care services when they were invited to take part in decisions regarding their treatment. In order to be able to make informed decisions, patients requested tailored information (face-to-face, group discussions, pamphlets, or digital information). The exchange of information was important for a mutual understanding early in the treatment process. Information found elsewhere and not discussed in the clinic could lead to distrust, which could affect the PCC process. The patients wanted to be independent, and being involved in decision-making concerning one’s health was described as being in control of the situation and not just being reliant on others. Dialogue and mutual agreements contributed to PCC, whereas disagreements, lack of commitment, and experiences of being overruled by health care professionals without considering the individual situation were troublesome. There were also patients who did not want to be involved in decisions concerning their treatment and were content in trusting their rheumatologist.

Person-centered outcomes. The patients’ perceptions of health care within the framework PCC and the category of person-centered outcomes included the following two subcategories: being satisfied with received health care and achieving optimal health.

Being satisfied with received health care. Perceiving satisfaction with received health care was described as being pleased when receiving adequate and effective treatment. The patients were satisfied with the prompt pharmacological treatment and quick relief of symptoms and described the outcome as “heaven on earth.” All types of treatment, both pharmacological and non-pharmacological, had an impact on their outcome satisfaction, as well as the inclusion of the next of kin. If there was no treatment response or a need for a change of treatment, the patients described negative perceptions of person-centered outcomes and feelings of being misunderstood, contemplating that early and correct treatment might have provided a better outcome.

Achieving optimal health. Achieving optimal health and feelings of well-being was a person-centered outcome according to patients with early RA. Patients valued the experience of health as a result of effective treatment but were also influenced by a good mutual relationship with the staff. Health and well-being was the ultimate outcome, whether in remission or not. Being able to return to normal life despite RA was an expected person-centered outcome.

DISCUSSION

This study presents the perceptions of PCC of patients with early RA within the PCC framework’s four constructs (prerequisites, care environment, person-centered processes, and person-centered outcome) (1,2). Prerequisites for PCC in the early RA disease course are being treated with respect, meeting dedicated

health care professionals and meeting professional competence. The care environment includes access to a multidisciplinary team, access to health care, and a supportive organization. Person-centered processes are being listened to, being supported, and being involved in decision-making. The person-centered outcomes in early RA are being satisfied with received health care and achieving optimal health.

Studies on patients' perceptions of PCC in the early course of the RA disease are scarce, and we hypothesized that they might differ from those of patients with established RA. However, even if illness perception and treatment preferences change over time, our findings reveal that perceptions on PCC are comparable throughout the disease course.

A prerequisite for PCC that was emphasized was to be treated with respect. Patients with early and established RA expect to be treated with respect and empathy and to be met with understanding attitudes from health care professionals (15,22). All types of communication, verbal and nonverbal, should be taken seriously, and a culture of respect is a measure of quality in health care services (23). Meeting dedicated health care professionals was a prerequisite for building a trusting relationship and for maintaining confidence in the health care services. Encountering professional competence was also a prerequisite for PCC in patients with early RA and in optimal rheumatology care, in which a good relationship between patients and health care professionals has been found (15,16). It is stated in the European Alliance of Associations for Rheumatology recommendations for the management of early arthritis that patients should be cared for by rheumatologists and specialized health care professionals in a multidisciplinary approach (24). Previous research has shown that patients with RA expect to feel confident in health care professionals' capabilities (15). When patients perceive competence in the encounter with health care professionals, it leads to a sense of security and trust (25).

The patients' perceptions of the prerequisites for PCC in early RA conform to the framework except that patients with early RA do not explicitly describe the needs for the health care professionals to know themselves and be aware of their own beliefs and values (1,2).

Patients with early RA spoke of the importance of having access to a multidisciplinary team to ensure holistic and person-centered health care. Identifying the needs of the patients is one of the aims of PCC, and health care professionals with varying qualifications may be required (1,2). Access to multidisciplinary and team-based care is an essential element of high-quality care for patients with early RA (26,27) as well as for patients with established RA (15). The eumusc.net project developed recommendations for patient-centered standards of care in patients with RA in 2014 (28) and is also emphasized in the recently implemented Swedish care process for early RA (29). These included a focus on access to a rheumatologist for early diagnosis and access to specialized health care professionals (28), which concurs with our

findings. It is, however, common that patients with RA experience limited access to a multidisciplinary team (30).

To ensure early and easy access to health care was an important part of the care environment for patients with early RA in PCC. It was perceived as a threat to PCC when patients had to struggle with access to health care. The importance of early access to care for patients with early RA has been emphasized by both patients and health care professionals (26), and better treatment outcomes have been found than for later referrals (31). Previous research shows that perceived delays in referral to a rheumatologist for specialist disease management lead to frustration among the patients (22).

The patients experienced that access to continuity of care was important for PCC. Continuity of care allows patients to develop a relationship with health care professionals (22,25,32,33). Encountering a supportive organization with established routines for both pharmacological and nonpharmacological treatment was important. Patients with chronic diseases request routines, information, and follow-up systems (32), and systems for tight control treatment strategies lead to earlier and sustainable remission for patients with early RA (34,35).

The PCC framework and the construct care environment also include shared decision-making systems, effective staff relationships, power-sharing, a physical environment, and the potential for innovation and risk-taking, which are issues not referred to in this study. However, even though the framework does not explicitly refer to access to specialized care, which was emphasized by the patients with early RA, we decided to map access to care within this construct. McCormack and McCance state that the care environment focuses on the context in which care is delivered (1,2).

Patients with early RA talked of the highly regarded parts of the person-centered process being active listening, support from health care professionals, and involvement in decision-making. Research shows that the most appreciated aspects of person-centeredness among patients with long-term conditions were attention to their personal situation and a focus on what matters to them in order to live a good life (36). Patients with RA highly value when health care providers actively listen to them (15,25) and when they have a sense of feeling "heard" (22,26). Patients' views about their life situation and condition should always be at the center of care in PCC. The patients' narrative captures their experience in an everyday context, in contrast to health care professionals' narratives that reflect the treatment of the disease. The patients' voices must thus be heard because their narrative constitutes the starting point for PCC and is the foundation for a partnership in care (11,12).

Patients with early RA appreciated support from health care professionals in the person-centered process through guidance that was tailored to individual needs. Patients express needs for self-management support including several dimensions (eg, information about the disease, pharmacological and nonpharmacological treatment, physical exercises, and fatigue). Patients need guidance about coping strategies in how to manage RA in daily

life and how to find a balance between activity, rest, and work in order to continue with daily activities and manage a social role (37).

Involvement in shared decision-making and a supportive relationship were important aspects of PCC in early RA, as was also found in patients with established disease (15,16). Patients with RA have a desire to be actively involved in decision-making, to be offered alternative treatment choices, and to have an opportunity to be involved in dialogues with the staff (22). Taking part in decision-making regarding treatment is important for the experience of participation and facilitates patients to be co-actors in health care (25). Patients involved in decisions concerning their treatment will promote a positive experience of the health care services and increase adherence to treatment (38-40). Shared decision-making is thus a process in which health care professionals collaborate with patients to provide high-quality care based on the best available evidence as well as the patients' preferences. Research shows, however, that shared decision-making is not yet fully embedded in rheumatology care (41).

Person-centered processes perceived by patients with early RA correspond to the framework even if this construct in the framework is divided into several parts (1,2).

Satisfaction with received health care was a person-centered outcome in patients with early RA. Core aspects of patients' perceptions of satisfaction with care are aiming for more holistic care, having trust in the health care professionals, and having appropriate communication (26).

A key outcome in PCC was achieving optimal health. Patients with early RA have a desire to regain health and the life they had prior to the diagnosis of RA (8). Health is a multidimensional concept and does not just mean the absence of disease, and patients have different ways of understanding the concept of health (42,43). For patients with established RA, the concept of health means being healthy and free from disease, functioning normally, experiencing well-being, and having a healthy lifestyle (42), and is an important dimension of quality of life (44). Because optimal health is a valued person-centered outcome in rheumatology care for patients with early RA, it would be interesting to explore what optimal health is and how optimal health is conceived by these patients in further research. Person-centered outcomes in early RA comply with the framework, although the construct in the framework is divided into a few more parts (1,2).

A limitation of the study could be the duration of the interviews, wherein some could be considered to be too short, but despite this, the participants with short interview durations described their experiences in two or more of the four categories. However, the median length of the interviews was 43 minutes, and the interview texts are deemed to be rich with a deep variation. We performed a purposeful selection with participants from four different clinics, including variations within the group of patients. In qualitative research, the transferability judgment is left to the readers, who know their own setting (45). A strength is that all the categories and subcategories are described of both

women and men regardless of treatment. The rich description of the setting, the included participants, and the research process enable the reader to assess whether the results of this study are applicable and transferable to patients with other rheumatological diseases or settings (18,20).

In conclusion, for patients with early RA, the prerequisites for PCC are being treated with respect, meeting dedicated health care professionals, and meeting professional competence. The care environment needs to include access to a multidisciplinary team, access to health care, and a supportive organization. The person-centered processes are being listened to, being supported, and being involved in decision-making. The person-centered outcomes for patients with early RA are being satisfied with received health care and achieving optimal health. Genuine PCC is just as important for patients early in the RA disease course as for patients with established RA, supporting the implementation of a person-centered approach at all stages in the organization. This study contributes to information about how to further develop person-centeredness in rheumatology care.

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All authors were involved in drafting the article or revising it critically for important intellectual content, and all authors approved the final version to be published. Larsson had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study conception and design. Landgren, Bremander, Lindqvist, Nylander, Larsson.

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