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Being Taken Seriously: Patients' Experiences of Participation in Care for Supraventricular Tachycardia—A Phenomenological Study

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ABSTRACT

Aims and Objectives: For patients with a recurring and elusive heart disorder, participation is challenging because of the need for care across the healthcare system. This paper describes how patients with supraventricular tachycardia (SVT) experience participation in their healthcare encounters.

Methodological Design: A descriptive phenomenological design in line with the reflective lifeworld research approach was used. Interviews were conducted with 17 patients, and the analysis was carried out to analyse participation as it evolved from the initial healthcare encounter through various phases of illness and treatment.

Findings: Patient participation in the context of SVT is commonly experienced as limited, inconsistent, and fragmented. These shortcomings contributed to feelings of existential insecurity and led patients to repeatedly seek care. Patients described a lack of continuity, passive or dismissive responses from healthcare professionals, and not being taken seriously—factors that increased their vulnerability and disrupted daily life. Overall, the findings underscore the need to recognise patients' lived experiences and to support their active involvement in diagnostic processes and treatment decisions.

Conclusions: Patients with SVT continue to face challenges in participation in their care due to fragmented care pathways and repeated encounters with multiple healthcare providers. The study underscores the importance of validating intermittent symptoms, providing clear information, and ensuring continuity to support meaningful participation. Improved education for healthcare professionals—focusing on trust-building, communication, and managing uncertainty—is essential. Further research should develop and evaluate interventions that enhance trust and address the informational and existential dimensions of living with SVT.

1 | Introduction

This inductive empirical study examines patient participation from a caring science perspective. Recurrent palpitation, frequently caused by supraventricular tachycardia (SVT), are a

common reason for seeking primary healthcare and secondary healthcare, particularly when the condition is undiagnosed [1–3]. SVT consist of atrial arrhythmias characterised by sudden onset and termination of episodic tachycardia [4]. Because episodes are unpredictable and often difficult to document, patients

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frequently experience prolonged uncertainty and repeated encounters with multiple healthcare professionals (HCPs, in this study, mainly physicians). Each episode raises concerns about severity and prompts patients to seek explanations, treatment guidance, and support. Active patient involvement is therefore essential, and HCPs play a crucial role by providing clear information, encouraging questions, and supporting patients' understanding and self-management [5, 6]. Patients, however, face participation challenges, particularly due to the prolonged time that often elapses before they receive effective diagnosis and treatment, combined with limited knowledge of available treatment options. Management's options range from no interventions to self-care strategies such as vagal manoeuvres (e.g., bending one's head, inhaling deeply, coughing, applying cold water to the face, or straining at an early stage), which may interrupt SVT episodes [4]. Additional treatments include rate-reducing or anti-arrhythmic medication, and, when symptoms are frequent, prolonged, or troublesome, catheter ablation—an invasive, highly effective and low-risk procedure. Self-care strategies may lose effectiveness, and medication may be insufficient or poorly tolerated, making coordinated care essential [4, 7]. Although guidelines recommend catheter ablation as a first-line option [4], significant delays often occur between diagnosis and treatment [7], and it remains unclear whether such delays are influenced by how the patient participates in shared decision-making. Patient participation is an established concept nationally and internationally, and in caring science it comprises learning, a supportive care relationship, and reciprocity [6, 8, 9]. It entails being treated with respect, receiving relevant information, and engaging in reflective dialogue based on individual needs [6]. While participation has been widely studied in other contexts, including atrial fibrillation [10], limited research has addressed how patients with SVT experience seeking care and involvement in treatment decisions. Although clinical knowledge about the management of SVT has expanded in recent years, research illuminating patients' lived experiences of seeking care and participation in treatment decisions remains limited [1, 5, 7]. Existing studies primarily focus on epidemiology, resource utilisation, and treatment outcomes [2, 3], leaving experiential and relational aspects of care largely unexplored. Greater insights are needed into how relational and organisational factors shape patients' opportunities for participation. Insufficient participation can result in feelings of powerlessness, exclusion, and suffering [6, 7, 11]. Patients who navigate between multiple levels of care often perceive the care process as fragmented and poorly coordinated [12, 13]. To our knowledge, no previous studies have examined patient participation across different healthcare levels involving multiple HCPs. Therefore, this study aimed to describe how patients with SVT experience participation in their healthcare encounters.

2 | Methods

This study explores and illuminates the phenomenon of patient participation in healthcare using the reflective lifeworld research (RLR) approach, which is based on phenomenological epistemology [14]. Phenomenological studies focus on lived experiences, providing a non-dualistic, non-reductionist, and holistic perspective that incorporates existential and social context [15]. As an epistemological basis, lifeworld refers to

the study of individuals as embodied subjects—an experiential world that is both common and shared with others but partly unique and personal, encompassing past, present, and future [14]. The interview and analysis focus on the relational aspects, or the “in-between”, exploring how the subject experiences the object within the world [16]. The methodological principles of RLR emphasise openness and flexibility toward the lifeworld descriptions, with a central focus on the studied phenomenon, the things themselves, and their meanings. For researchers, adopting a bridled attitude is crucial for staying attentive and critically examining the phenomenon in relation to their own pre-understanding. It also helps sustain reflective openness throughout the entire research process [14, 16]. Bridling one's pre-understanding involves slowing down the interpretative process, reflecting, and refraining from prematurely defining what is indefinite, thereby expanding the scope of one's understanding [16]. To describe and understand the phenomenon of patient participation, the study examines how it develops from initial healthcare encounters through various phases of illness and treatment. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guided the reporting of the study design, participant selection, data collection, and analysis [17] (see Supplementary File 1).

2.1 | Informants and Data Collection

Patients living in central west Sweden, in the Region Västra Götaland, were recruited from a specialist clinic with referrals from several regional hospitals, between December 2021 and March 2022, and between April 2023 and June 2023. The inclusion criteria were as follows: patients who had undergone catheter ablation for SVT, diagnosed with atrioventricular nodal re-entry tachycardia (AVNRT) and/or atrioventricular re-entry tachycardia (AVRT), aged ≥ 18 years, and able to communicate in and understand the Swedish language. The exclusion criterion was a diagnosis of atrial flutter or atrial fibrillation. Patients were identified in two steps. First, the clinic's medical secretary scheduled SVT ablations based on the planned elective program. Second, the ward coordinator identified patients who had undergone ablation for AVNRT or AVRT, ensuring that the first author (AKN) had not participated in their care. Twenty-seven patients met the inclusion criteria and were sent a formal invitation letter to participate in this study. The first author contacted those who expressed interest in learning more about this study, and nine women and eight men agreed to participate (Table 1).

The patients in this study comprised a diverse sample of adults of various genders and ages, residing in both rural and urban areas. Their education levels ranged from primary to academic school, and were representative of patients treated with catheter ablation for AVNRT and AVRT at a specialist clinic. Primary healthcare provides accessible, first-line services that address common and broadly occurring health needs, whereas secondary healthcare manages more acute, complex, and resource-intensive conditions, likely delivered through specialist clinical expertise [18]. Table 1 shows that some patients had prior experience with both healthcare levels, although a significant proportion had engaged only in secondary healthcare. According to the routine, the patient interactions for both primary and secondary care were primarily with a physician and rarely with a nurse or

TABLE 1 | Sociodemographic and Clinical Characteristics of patients prior to catheter ablation treatment.

Patient	Primary/ Secondary healthcare level	Sex and age (years)	Time from self-rated onset of symptoms (months)	Own strategy to interrupt palpitations	Pharmacological treatment (before ablation)	Diagnosis (after ablation)
P1	Primary Secondary	Female, 65	432	No	No	AVRT
P2	Primary Secondary	Female, 53	84	No	Yes	AVNRT
P3	Secondary	Male, 55	3	No	Yes	AVNRT
P4	Primary Secondary	Male, 59	492	No	Yes	AVRT
P5	Primary Secondary	Female, 53	45	No	No	AVNRT
P6	Primary Secondary	Female, 46	240	No	No	AVNRT
P7	Secondary	Female, 63	14	No	Yes	AVNRT
P8	Primary Secondary	Female, 89	180	No	Yes	AVNRT
P9	Primary Secondary	Male, 63	144	No	Yes	AVNRT
P10	Secondary	Female, 21	96	No	No	AVNRT
P11	Secondary	Male, 35	33	No	No	AVRT & AVNRT
P12	Primary Secondary	Male, 68	144	No	Yes	AVNRT
P13	Secondary	Male, 74	38	Yes	No	AVNRT
P14	Primary	Female, 63	120	No	No	AVNRT
P15	Secondary	Male, 63	360	No	Yes	AVNRT
P16	Secondary	Female, 35	120	No	No	AVNRT
P17	Primary	Male, 55	156	No	No	AVNRT

Abbreviations: AVNRT = atrioventricular nodal reentry tachycardia, AVRT = atrioventricular tachycardia.

biomedical scientist. None of the patients employed specific self-initiated strategies for controlling palpitations beyond abruptly stopping their activities and resting. In total, eight of the 17 patients received pharmacological treatment prior to catheter ablation. The average patient was 56 years old (21–89 years) who had experienced palpitations for an average duration of 13 years (3 months to 41 years) before undergoing catheter ablation. They were diagnosed and treated for AVNRT (14 patients), AVRT (2 patients), or a combination of both (1 patient) (Table 1). A previous study, conducted between December 2021 and March 2022, focused on patients' experiences of being awake during catheter ablation for SVT. The findings revealed a clear need for increased patient participation in healthcare. Against this background, previously unanalysed raw data from that study [19] were included and complemented with five additional interviews conducted between April and June 2023, with an explicit focus on participation. The present study draws on a total of seventeen lifeworld interviews. The inclusion was justified by

the close relevance of the earlier dataset to the current research question on patient participation, as it captures patients' experiences in relation to a specific treatment (catheter ablation for SVT). Since both studies used the same methodological approach (RLR), the same data collection method (lifeworld interviews) [14, 16], and the same context (patients with experience of SVT in healthcare), the material was integrated into a joint analysis [20, 21]. By combining the datasets, a broader and more nuanced understanding of patient participation was achieved, enabling the illumination of variations across time, healthcare contexts, and care interactions. As the interviews were conducted during the COVID-19 pandemic and post-pandemic period, the patient chose the interview locations based on convenience. Seven patients selected face-to-face interviews, and ten patients selected telephone or digital interviews. The audio-recorded interviews lasted between 29 and 93 min, with an average duration of 60 min. The interview guide was developed collaboratively by the co-authors, based on a literature review and their combined

professional and research experiences. Each interview began with information on ethical considerations, including the patient's right to discontinue participation without providing a reason. In the previous data collection phase, the lifeworld interviews started with an open-ended question focused on lived experience, in accordance with the methodological principles [14]: *Can you describe experiences in contact with healthcare when you felt that you had participated in your care?* In the supplementary data collection phase [19], the first question was a broad open prompt: *Would you please tell me about your experiences in interacting with healthcare when seeking care for sudden palpitations?* allowing patients to articulate their experiences in their own words. The interviewer encouraged further reflection through gentle follow-up questions aimed at deepening meanings without steering the content. This conversational, lifeworld-oriented approach facilitated rich descriptions of patients' experiences; however, narrative elicitation was not an explicit methodological aim. Throughout the interview process, the interviewer (first author) maintained a bridled and phenomenological attitude to support depth, variation, and clarity in the patients' descriptions. When the recording had concluded, the interviewer took time to check on the patient's experience of the interview and evaluate any potential support needs. Should the interview have elicited distress or personal concerns, the patient was offered the option of contacting a counsellor. After each interview, the interviewer took reflective notes on their own nonverbal experiences, such as their observations of the patients' emotional state. These notes were considered part of the data. In fact, the research situation—the interview itself—was always more contextually rich than the transcript data. To preserve the sense of the research encounter, the first author conducted and transcribed each interview verbatim [14]. However, during one interview, a technical error occurred with the recorder, but the patient refused to reschedule the interview, stating that they had waited for that opportunity to share their experiences. Therefore, the interview was continued, and the first author took notes throughout. The reporting followed the COREQ checklist throughout the study (see Supplementary File 1).

2.2 | Data Analysis

The data were analysed according to the RLR principles [14]. The analysis followed a descriptive tripartite structure—a movement from the whole to the parts and back to the whole [14]. It began with repeated reading of the full text to develop a sense of the whole, maintaining openness to its meaning. This process included bridling, which involves resisting premature or careless understanding [14, 22], allowing the phenomenon to emerge in a new way [14, 15] and contributing new knowledge. The analysis then shifted to the parts—identifying the meanings of the phenomenon of patient participation in healthcare. These meanings were sorted into clusters based on similarities and differences, with flexibility maintained as long as possible [14]. Furthermore, the phenomenon was examined by contrasting participation (figure) with nonparticipation (background) across clusters to reveal new patterns of meanings [23]. Throughout the analysis process, the author group engaged in repeated discussions to interpret the narratives and explore their meanings, aiming to reach a shared understanding of the essential aspects. In addition, the manuscript underwent per-review

during seminars with other researchers. Nuances and the richness of meanings were integrated into a new whole. Finally, the findings are presented in a structured format, beginning with the phenomenon's essence (key meanings) [14], followed by its constituents. The results are supported by contextual descriptions and anonymised quotations. Quotations were selected to illustrate essential meanings within the findings and to show variation in how patients expressed their lived experiences. All quotations were originally in Swedish; all quotations were translated into English by the authors and cross-checked against the original transcript to ensure accuracy, with close attention to preserve semantic meaning, tone, and the experiential nuances that are central to phenomenological interpretations.

3 | Findings

The essence of the phenomenon of patient participation in healthcare, as experienced by patients with SVT, involves a currency of trust that is hampered by a lack of continuity, leaving patients in an “existential waiting room”—a state characterised by trust in healthcare and a hope for treatment of an unpredictable condition that significantly impacts daily life. Effective participation in their own care allows patients to resume their lives. However, it is hampered by inconsistent involvement. This phenomenon fosters a transition toward a sense of increased existential safety that begins when the patient is believed. Knowledge and a joint struggle to obtain objective evidence and appropriate treatment are crucial. Participation manifests as a sense of trust in being taken seriously as a whole person, which, for patients with SVT, brings hope of help with their unreliable heart. When patient participation is not facilitated, it results in powerlessness and broken trust in the healthcare system, even if suitable treatment is offered.

Thus, the phenomenon has the following constituents: (1) being taken seriously—a joint struggle; (2) trust in an uncertain situation; (3) lack of continuity; and (4) knowledge—a transition to existential safety.

3.1 | Being Taken Seriously—A Joint Struggle

Patients with SVT participate in healthcare when they are taken seriously, receive professional help, and are treated as a whole person. Their need for objective evidence of their condition sometimes involves a joint struggle with HCPs, and for other patients, an individual effort to have their tachycardia documented on an electrocardiogram (ECG) as proof. One patient described their interaction with healthcare as uncertain and ambiguous due to the existential impact of an unclear health situation:

At first, I hesitated to go there, but then, the palpitations increased, and I did not want to die before I could explain my health issues to my kids, so I went in for a check. And so, it went on for several years.
(P 9)

The existential impact of SVT may concern the transience of life, including uncertainty about the future due to the unexplained

and elusive nature of the condition. Reassurance that the condition was not dangerous offered relief, but without information or dialogue about treatment, some patients felt that they were not being taken seriously. One patient articulated their experience of a lack of support during a sustained episode of tachycardia, describing the feeling of being ignored and not respected as a person with a life:

When I told them about this, they responded, “It is not dangerous.” Well, I can say that this is serious for me. Not dangerous?! Sit here and have this tachycardia for several hours, then you will see it yourself.

(P 11)

The patients were able to clearly identify the moment when they began participating, describing their experiences of being treated as a capable individual who actively contributes to treatment decisions. This moment was reflected in interactions with HCPs who made a difference in the continuing care process—who demonstrated commitment and listened to the patient. One patient described frustration followed by relief and the experience of finally being taken seriously:

They told me, “Next time you have the tachycardia, you call 112,” but I do not want to have it that way! I am just over 50 years old; I do not want to deal with it that way. The physician really listened to me and then wrote a referral to the cardiologist.

(P 5)

Additionally, the phenomenon of participation occurs when patients are aware of their treatment options and involved in the decision-making, understanding the significance of their choices for their well-being.

3.2 | Trust in an Uncertain Situation

Patients with SVT experience participation in healthcare as a form of trust amidst an uncertain situation. It is rooted in confidence in the competence of the HCPs but is hindered when patients feel disbelieved, which erodes their overall trust in the healthcare system. Participation can be understood as trusting HCPs and relinquishing responsibility for one’s care, which also requires remaining attentive to the procedure. One patient described this experience during ablation treatment:

I experienced the ablation as quite effortless—I handed over the responsibility for myself to the experts. I do not like pain, but if everything seems normal in the operating room, then I keep cool.

(P 9)

The patients experienced participation as trustworthy when communication with HCPs occurred at a personal level. This means HCPs need to show genuine interest, first, in the patient’s narrative, and to provide knowledge about the condition and how to manage it in daily life. Trust in an uncertain situation

is perceived as particularly difficult because the heart rhythm disturbances are elusive. Patients reported not being taken seriously when the tachycardia episodes suddenly stopped, which led to responses such as “Come back if the symptoms return.” Experiences of being neglected when seeking help in healthcare resulted in broken trust during an uncertain situation and frustration due to their lack of participation and support. Some patients experienced this as hindering their ability to seek care; as such, their next of kin or other significant persons supported them in making another attempt due to the substantial impact of the tachycardia episodes on their daily life.

3.3 | Lack of Continuity

Trust, which is central for participation, fluctuates in interactions with different HCPs and is hindered by a lack of continuity. A lack of participation arises from experiences of being ignored and especially from inconsistent care. This discontinuity disrupts the formation of trusting relationships and contributes to a sense of existential insecurity. Patients describe a feeling of resignation—of quietly giving up—when their efforts to be heard are repeatedly met with unresponsiveness. The need to repeatedly recount one’s medical history becomes not only exhausting but also symbolic of fragmented care that fails to acknowledge the person behind the symptoms. One patient reflected on how they coped with the lack of continuity:

I did not handle it in the end. Just not being believed in ... there was so much other stuff they were good at, but in the end, I did not manage to repeat my story again...

(P 2)

The patients’ insecurity following their nonparticipation in their examination—or the absence of an examination altogether—resulted in their existential fear of a serious condition, experiences of powerlessness, and diminished trust in healthcare, as they knew that something was wrong with them, but they did not know how to manage their symptoms and condition.

3.4 | Knowledge—A Transition to Existential Safety

Participation in healthcare interactions, as experienced by patients with SVT, reflects a desire to regain health and transition toward existential safety. Specifically, it is experienced as a transition toward being securely grounded in one’s knowledge of one’s illness and its treatment, which offers the possibility of reducing one’s existential uncertainty. In this context, participation includes informed knowledge of treatment options and the ability to decide to pursue further treatment when it is supported by HCPs. A patient with previous negative experiences of participation described the turning point as the moment when their need for security became central:

Just to hear what this is about—and they were checking “Do you get what this means?” and “Do you want us to send this referral?” ... I think my need for security

... emerged just by having knowledge and being involved in the decision.

(P 2)

Participation occurs when prior existential uncertainty turns into a need for security, having a diagnosis, and knowing how to manage the episodes. This shift increases opportunities for patients to understand their symptoms and learn tachycardia management, healthcare access, and treatment options. Knowing each option's consequences allows patients to process the information and make informed decisions about the proposed treatment. One patient expressed their frustration and sadness for lost years of a quality life:

Thanks to meeting that physician, it went on well, but having to wait for so many years, I truly think that is a scandal when there is a treatment. I try not to think about it, but it truly bothers me. It has destroyed so much for me these years...

(P 1)

Even after successful catheter ablation and the patient's satisfaction with the treatment, the broken trust leads to a lingering sadness over lost years of quality time in life. Some unanswered questions persist, such as the reason for not being allowed to participate in their care earlier and being involved in the decision-making process for treatment. Through this reflection, the significance of participation in one's own care becomes unmistakably clear.

4 | Discussion

The findings of this study reveal that the phenomenon of patient participation in the context of SVT is often experienced as limited and fragmented, contributing to feelings of existential insecurity and repeated care seeking. Patients described inadequate continuity, passive responses from HCPs, and not being taken seriously, all of which amplified their vulnerability and disrupted their everyday lives. These results highlight the importance of acknowledging the patient's lived experience and ensuring their active involvement in diagnostic and treatment decisions. When patients are believed and provided with clear information about treatment options, their sense of security increases—an effect consistent with previous research on the role of participation and trust in the healthcare encounter [7, 10, 11]. Overall, our findings underscore the need for more compassionate and person-centred care pathways for individuals with SVT. Although situated within the context of SVT, the findings may be relevant to other cardiology patients with episodic symptoms that are difficult to capture objectively. The study shows how elusive symptoms, limited continuity, and restricted dialogue hinder patient participation and create uncertainty. Trust, comprehensible information, and relational continuity emerge as central for enabling person-centred care [6]. The frustration reported by patients—particularly regarding the lack of timely information about treatment with catheter ablation—echoes previous research showing that treatment options are not always discussed [5]. When patient perspectives are overlooked, opportunities for participation and shared decision-making

disappear. The findings reveal wide variation in patient participation. Some patients actively engaged in reflective dialogue and care planning, while others experienced fragmented care and felt unheard. Overall, the study highlights that integrating clinical expertise with patients' experiential knowledge strengthens understanding, fosters trust, and promotes shared decision-making. Consistent with previous research [1, 13], patients described an unstructured and poorly coordinated care pathway that hindered integrated healthcare. A recent study [24] revealed that patients with palpitations suggestive of SVT are often managed conservatively until tachycardia is documented on ECG, a delay that significantly affects both quality of life and healthcare use. In SVT care, where multiple HCPs operate across various levels, fragmentation makes patient participation throughout the care pathway [13]. Cohesive care models that integrate interprofessional collaboration with person-centred approaches are needed [25]. Finally, the question is whether greater attention to patients' perspectives and active involvement in their own care can decline or prevent the existential insecurity many experience.

4.1 | Methodological Considerations

An issue not addressed in the earlier study [19] prompted an in-depth investigation in the present work. This study combined two datasets: Five interviews collected for the current study and twelve interviews from previously gathered but unanalysed data [21], which were used as additional data in the analysis. Both studies were conducted by the same research team, ensuring familiarity with the context and consistency in the data collection methods, which may have reduced bias [21]. Both datasets share a common conceptual foundation—patients' perspectives in healthcare—making secondary analysis appropriate. However, using previously collected data carries certain risks, such as limiting opportunities for follow-up or probing questions in the supplementary dataset. While data-fit challenges can occur, the two datasets shared contextual similarities and were collected within comparable periods. These factors led the authors to conclude that both the combined dataset provided sufficient depth and breadth to address the research aim [21]. Moreover, integrating two datasets strengthened the credibility of the findings by allowing for richer perspectives and enhanced transferability through a broader representation of patient experiences. One strength of this study lies in its ethical, careful attention to patients' narratives about their engagement in care while seeking help for recurrent SVT. Efforts were made to ensure trustworthiness through a transparent analytic process, guided by the principles of RLR [14]. This included maintaining openness and bridling pre-understandings throughout the research process and analysis. During the interviews, the patients' lived experiences of participation in healthcare were further explored and deepened. Consistent with the methodological ethical approach, this resulted in a rich variation of described phenomena [14]. All interviews were conducted by the first author, who was familiar with the data and context, supporting continuity in the reflective process. The author team analysed the data multiple times to gain a deeper understanding of patient participation. To ensure credibility, the authors repeatedly discussed the interview material to agree on its meaning and cross-checked interpretations throughout the analytic process. Additionally, the manuscript was per-reviewed during a seminar with other researchers, further

validating the findings. The quotations included in the findings were selected for their ability to convey the essential meanings and nuances through the RLR approach [14]. In qualitative research, the generalisability of the findings arises from their presentation within a structured framework of meaning and in quotations, emphasising their inherently contextual nature [14, 15]. Regarding ethical concerns, the first author, a nurse at the specialist clinic where the patients were examined and treated with catheter ablation, ensured that their participation in this study did not overlap with their clinical duties involving the treatment of the patients included in the study.

4.2 | Implications for Clinical Practice

The Patient Act [8] aims to strengthen patients' legal status in healthcare, yet limited compliance persists, particularly regarding participation, accessibility, continuity, and coordination [12]. This study highlights the need to reinforce patient participation in SVT care by ensuring that healthcare is not only medically appropriate but also relationally and ethically responsive. Because symptoms are intermittent and trust strongly influences engagement, clinical practice should prioritise relational continuity, validation of patients' experiences, and provision of clear, accessible information [4, 6]. These elements extend beyond specific arrhythmia diagnoses and are fundamental to reducing existential insecurity and enhancing participation among patients with arrhythmia more broadly. Timely access to HCP with expertise in assessment and treatment is essential. Developing care protocols that promote continuity, minimise fragmented encounters, and foster trust may support these goals. Care should be guided by person-centred principles that prioritise human experience, compassion, and dignity as core values [25]. Digital tools, such as patient portals [26], mobile applications, and secure messaging systems, can also enhance communication and support more coordinated, person-centred care. Given that patients in this study primarily interacted with physicians, the specialised competencies of nurses may represent an underutilised resource in SVT care. A recent review of nurse-led arrhythmia care across healthcare levels reported several positive effects but concluded that evidence remains insufficient to determine the magnitude of these outcomes [27]. Further research is therefore needed to establish the effectiveness of nurse-led arrhythmia care with greater certainty. Although ECG documentation is often necessary for diagnostic confirmation, overreliance on ECG may delay referral despite clear patient narratives [1]. Advances in self-monitoring technologies, including smartwatches and other wearable devices, may support patients, facilitate timely assessment, and improve care responsiveness [28]. When combined with strengthened patient participation and broader use of nursing expertise [29], such tools may contribute to more equitable and effective SVT. Finally, because patients often engage with multiple HCPs across healthcare levels, this study reinforces the importance of continuity and patient participation as integral to holistic health from a lifeworld perspective [14].

5 | Conclusions

Participation in healthcare remains challenging for patients with SVT, due to repeated encounters across multiple healthcare levels and interactions with several HCPs. This study highlights

a complex and fragmented care pathway, underscored by the following insights:

- Clinical: Validation of intermittent symptoms, providing clear information, and ensuring continuity of care are key to strengthening patient participation across arrhythmia diagnoses.
- Educational: Training should prioritise trust-building, effective communication, and strategies for managing symptom-related uncertainty to support person-centred care.
- Research: Future research should develop and evaluate interventions that build trust and address both the informational and existential dimensions of patients' experiences, helping to transform the prevailing "existential waiting room" into a more supported and predictable care pathway.

Author Contributions

All the authors were involved in the conceptualisation of the study and contributed to data acquisition for both datasets, as well as the analysis of the combined material. They also participated in drafting and revising the manuscript, and all authors approved the final version.

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In the preparation of this manuscript, Microsoft Copilot was used solely for language improvement. All text was reviewed, edited, and validated by the authors, who take full responsibility for the accuracy, integrity, and scientific content of the manuscript. No artificial intelligence tools were used in data analysis, interpretation of findings, or in drawing scientific conclusions.

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Ethics Statement

The study was approved by the Ethical Review Board in Uppsala, Sweden (Dnr: 2019–03295) and complied with the principles outlined in the Declaration of Helsinki [30]. Each patient provided informed consent to participate.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that supports the findings of this study are available in the [Supporting Information](#) of this article.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** COREQ 32-item checklist.