


## REVIEW

# Patients' experiences of patient-centred care in hospital setting: A systematic review of qualitative studies

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### Abstract

**Background:** Patient-centred care (PCC) has been proposed as an appropriate approach for addressing current shifts in healthcare needs. Although the importance of PCC is generally recognised, PCC is poorly understood by patients in the hospital settings.

**Objectives:** To identify patients' experiences of PCC in hospital settings.

**Methodological design:** This systematic review followed the Joanna Briggs Institute's (JBI) guidance for systematic reviews of qualitative evidence and the PRISMA checklist for reporting systematic reviews. The search strategy included peer-reviewed qualitative studies published after 2010 in English or Finnish. The databases searched were SCOPUS, MEDLINE, CINAHL and Medica. Unpublished studies and grey literature were searched in MedNar. Ten qualitative studies were included, and their quality was assessed by two independent reviewers using JBI quality assessment criteria. The data were analysed using thematic analysis.

**Setting and participants:** Studies were included if they had explored adult patient experiences of PCC in hospital settings.

**Results:** A thematic analysis produced 14 subthemes which were grouped into five analytical themes: the presence of the professional, patient involvement in care, receiving information, the patient–professional relationship and being seen as a person.

**Conclusions and implications:** This review suggests that the implementation and provision of PCC in hospitals is incomplete and patients' involvement in their own care should be in the focus of PCC. The majority of patients experienced receiving PCC, but others did not. The need for improvement of patient involvement was strongly emphasised. Patients highlighted the importance of professionals being present and spending time with patients. Patients felt well-informed about their care but expressed the need for better communication. Meaningful patient–professional relationships were brokered by professionals demonstrating genuine care and respecting the patient as an individual. To improve the implementation of PCC, patient experiences should be considered in the development of relevant hospital care strategies.

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In addition, more training in PCC and patient–professional communication should be provided to health care professionals.

#### KEYWORDS

hospital, literature review, patient experiences, patient-centred, qualitative research, systematic review

## INTRODUCTION

The populations of developed countries are ageing, driving higher rates of multipathological conditions and increased demand on healthcare services. These services should offer high levels of quality, efficiency, equity and appropriateness [1, 2]. Patient-centred care (PCC) has been proposed as an appropriate approach for addressing current shifts in health care needs [2]. The Institute of Medicine described PCC as one of the principles for high-quality care in the 21st century, alongside safe, effective, timely, efficient and equitable care [3]. Since then, PCC has been on the healthcare agenda across the globe [4]. In Europe, WHO has identified ensuring PCC within health systems as one of the aims of Health 2020 [5]. PCC has been considered a core dimension of high-quality health care [4, 6, 7] and is integral to how patients are treated and medical care is practiced [8]. PCC represents a shift from disease-centred approaches towards those that integrate patient's needs, experiences and perceptions into the development and practice of healthcare [9].

Despite widespread agreement on the significance of PCC, there is still no universal definition of it [6, 10]. Patient-centred care can be defined in relation to five dimensions: the biopsychosocial perspective, the patient-as-person, shared power and responsibility, the therapeutic alliance and coordinated care. The biopsychosocial perspective can be described as practicing holistic care, and seeing the patient-as-person underlines each patient's uniqueness. Shared power and responsibility has been described as shared decision-making and ensuring empowerment as a way of fostering better patient participation. The therapeutic alliance can be seen as valuing the relationship between patient and professional. Lastly, coordinated care means that patients experience continuity in their care and have a hassle-free experience [6]. Recently, the concept of person-centred care has emerged as a further development of PCC. In the literature, these are often treated as similar concepts, although they differ in their goals. However, both concepts involve empathy, respect, engagement, relationship, communication, shared decision making, holism, individualised focus and coordinated care [8]. Patient-centred care has been described using an array of other terms, such as family-centred care, relationship-centred care, personalised care

and client-centred care [4]. The terms 'patient-centred', 'people-centred', 'person-centred' and 'relationship-centred' are used side by side or interchangeably within healthcare and research [11]. In this research, we use the term 'patient-centred care' to also cover person-centred care.

Patient-centred care is associated with positive outcomes such as patient satisfaction, engagement in care and increased quality of life [12, 13]. However, PCC is poorly understood and implemented [8]. There are many barriers to adopting PCC, including negative attitudes and beliefs among health professionals, the absence of a universal definition, methodological challenges with measuring PCC and limited understanding of patients' perspectives [12]. Factors that enable PCC include successful interaction between patients and professionals, delivery of effective interventions, patients playing an active role in their care and free flow of information [2]. Patient-centred care has been most fully described within long-term care and dementia care, but also described in acute care and other settings [14].

Although the importance of PCC is generally recognised, professionals' and patients' perceptions of PCC differ. Variation in experiences of PCC may be explained by such variation in perceptions of PCC among professionals and patients [15, 16], limited understanding of the concept [16], attitudinal problems [12], or lack of prioritisation given to PCC by managers [15]. To improve health outcomes, it is important to understand the uniqueness of an individual's perceptions and experience of a phenomenon [17]. Patient experience can be defined as a measure of PCC. Understanding patient experience is central to improving the environmental, organisational, social and cultural influences that contribute to positive patient experiences [18]. Patient-centred information and patient experiences have an important role to play in improving health services and assessing their quality and safety [19]. Understanding of PCC can be enhanced by taking patients' perspectives into account [20]. Patient-centred care is poorly explored within hospital settings [1]. Arakelian et al. [21] explored the meaning of PCC in perioperative nursing and found that patients wanted to be recognised as unique individuals, who should be treated with dignity and respect. Patients expected professionals to give them the time and space to express their personal wishes and

consider them as a resource. More research is needed to develop a wider understanding of PCC.

We conducted a preliminary search of PROSPERO, MEDLINE, the Cochrane Database of Systematic Reviews and JBI Evidence Synthesis, and there were no current or in-progress systematic reviews covering patient experiences of PCC in hospital settings. The aim of this systematic review was to identify patients' experiences of PCC in hospital settings. The research question was: what kind of experiences do patients have of PCC in hospital settings?

## METHODS

This systematic review was conducted in accordance with the Joanna Briggs Institute (JBI) methodology for systematic reviews of qualitative evidence [22] and the PRISMA statement [23].

### Search strategy

The search strategy aimed to locate both published and unpublished studies. A three-step search strategy was used. First, an initial limited search of MEDLINE (Ovid) and CINAHL was undertaken, followed by analysis of text contained in the title and abstract, and index terms (i.e. MeSH). The search strategy, including all

identified keywords and index terms, was adapted for each information source included (Table 1). A second search was conducted in January 2022, which included the MEDLINE (Ovid), CINAHL and SCOPUS databases and the Finnish database Medic. Unpublished studies and grey literature were searched for in MedNar in June 2022. The search strategy was developed in cooperation with an information specialist. Finally, the reference lists for the studies included were screened for additional studies.

Studies published in English and Finnish and between 1/2010 and 12/2021 were included in this review. The time limitation was based on the assumption that most studies investigating patient experience of PCC would have been carried out since 2010, as this phenomenon is relatively recent [4].

### Study selection

The search strategy was defined using PICOs (participants, phenomena of interest, context and study type; Table 2). All identified citations were collated and uploaded into the bibliographic management system Covidence (version 2.0), and duplicates were removed. Titles and abstracts were screened by four independent reviewers (TH, SK, EL and OK) and assessed against the inclusion criteria. Potentially relevant studies were

**TABLE 1** Search strategies in searched databases and their results.

Databases	Search strategy	n
CINAHL	((MH 'Patient Centred Care') OR ('patient-cent*') OR ('person-cent*')) AND ((patient OR patients) N2 (experienc* or perception* or view*)) AND ((MH 'Hospitals') OR (MH 'Inpatients') OR (hospital* or 'acute setting*' or inpatient* or ward))	1976
SCOPUS	(TITLE-ABS-KEY('patient-cent*' OR 'person-cent*') AND TITLE-ABS-KEY(patient OR patients W/2 experienc* OR perception* OR view*) AND TITLE-ABS-KEY(hospital* OR 'acute AND setting*' OR inpatient* OR ward)) AND PUBYEAR >2010 AND (LIMIT-TO (DOCTYPE,'ar'))	1268
MEDLINE (Ovid)	(Patient-Centred Care/ or ('patient-cent*' or 'person-cent*') and ((patient or patients) adj2 (experienc* or perception* or view*)) and (exp Hospitals/ or exp Inpatients/ or (hospital* or & 'acute setting*' or inpatient* or ward))	1097
Medic	potilaskeskeinen hoito asiakasläh* AND potila* AND kokemu* näkemy* ajatuk* AND sairaala*	10
MedNar	('patient-cent*' OR 'person-cent*') AND (patient OR patients) AND (experienc* OR perception* OR view*) AND ('health care' OR healthcare OR nurs* OR medic*)	445

Note: Searched conducted 3 June 2022, limited to English or Finnish and published from 2010 to 2020.

**TABLE 2** PICOs describing inclusion and exclusion criteria.

	<b>Participants (P)</b>	<b>Phenomena of interest (I)</b>	<b>Context (Co)</b>	<b>Study type (s)</b>
Inclusion criteria	Adult patients (18 years of age or older) who have been admitted as inpatients to a hospital	Studies that explored patient experiences of PCC. All studies concerning patients' experiences, perceptions and views were included	Hospital settings. This includes any somatic ward including acute settings	Studies that focused on qualitative data including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research
Exclusion criteria	Paediatric, dementia and mental health patients	Experiences of other than patient themselves	Primary healthcare settings, medical homes, outpatient care and psychiatric wards	Studies that focused on quantitative data

retrieved in full. The database search identified 3352 studies after removing duplicates. A total of 3323 articles were excluded based on their titles and abstracts and the full texts of 29 articles were reviewed. Of these, 20 were excluded, meaning that nine studies were included for final critical appraisal. The reference lists of all the studies included were manually searched for additional studies ( $n=1$ ). Full-text studies that did not meet the inclusion criteria were excluded. Any disagreements that arose between the reviewers were resolved through discussion or with the help of a third reviewer. The results of the search are presented in a PRISMA flow diagram [23] (Appendix 1).

### Assessment of methodological quality

Eligible studies were critically appraised by two independent reviewers (TH and SK) for methodological quality using the standardised JBI critical appraisal checklist for qualitative research [22]. Any disagreements that arose between the reviewers were resolved through discussion, or with the help of a third reviewer. All studies were included in the analysis, and they scored 6–9/10 (Table 3).

### Data extraction

Data from the included studies were extracted by two independent reviewers. The extracted data included specific details about the citation and language of the article, study objective, participants, context, study design, methodology, key findings and quality assessment (Table 4). Only findings relevant to this systematic review's research

question were extracted. The relevant information was presented in the form in which it appeared in the original studies.

### Data synthesis

Thematic analysis was used to synthesise the results [24]. This synthesis included line-by-line coding of the findings, organising initial codes ( $n=301$ ) to construct descriptive themes ( $n=37$ ), and subthemes ( $n=14$ ) and finally develop analytical themes ( $n=5$ ). An overview of the coding and theme building is presented in Table 5.

First, free line-by-line coding of the findings of primary studies was conducted, enabling the translation of concepts from one study to another. Next, these free codes were organised into related areas to construct descriptive themes. Finally, descriptive themes were grouped into subthemes and used to develop analytical themes.

## RESULTS

Through this process, five analytical themes about patient experience were identified. These related to (1) the presence of the professional, (2) receiving information, (3) being involved, (4) the patient–professional relationship and (5) being seen as a person.

### Study characteristics

The studies included ( $n=10$ ) were conducted in Sweden ( $n=3$ ), Australia ( $n=2$ ), Iran ( $n=1$ ), Denmark

**TABLE 3** Critical appraisal results for included studies using the JBI-Qualitative Critical Appraisal Checklist.

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Alharbi et al. (2014)	N	Y	Y	Y	N	N	Y	Y	Y	Y
Esmaili et al. (2014)	Y	Y	Y	Y	N	N	Y	Y	Y	Y
Jensen et al. (2013)	Y	Y	Y	Y	N	N	Y	Y	Y	Y
Laird et al. (2015)	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Marshall et al. (2012)	Y	Y	Y	Y	N	N	Y	Y	Y	Y
Naldemirci et al. (2017)	N	Y	Y	Y	N	N	Y	Y	Y	Y
Nyhof et al. (2019)	N	Y	Y	Y	N	N	Y	Y	Y	Y
Rahman et al. (2019)	N	Y	Y	Y	N	N	Y	U	Y	Y
Sharp et al. (2014)	N	Y	Y	Y	N	N	Y	Y	Y	Y
Wolf et al. (2017)	Y	Y	Y	Y	N	N	Y	Y	Y	Y

*Note:* Q1: Is there congruity between the stated philosophical perspective and the research methodology? Q2: Is there congruity between the research methodology and the research question or objectives? Q3: Is there congruity between the research methodology and the methods used to collect data? Q4: Is there congruity between the research methodology and the representation and analysis of data? Q5: Is there congruity between the research methodology and the interpretation of results? Q6: Is there a statement locating the researcher culturally or theoretically? Q7: Is the influence of the researcher on the research, and vice-versa, addressed? Q8: Are participants, and their voices, adequately represented? Q9: Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body? Q10: Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Abbreviations: N, No; U, Unclear; Y, Yes.

( $n = 1$ ), the United Kingdom ( $n = 1$ ), Canada ( $n = 1$ ) and Pakistan ( $n = 1$ ). The year of publication ranged from 2010 to 2020. The number of participants ranged from 10 to 35. The data were collected using semi-structured interviews ( $n = 7$ ), interpersonal interviews ( $n = 1$ ), narrative interviews ( $n = 1$ ) and individual in-depth interviews ( $n = 1$ ).

## Presence of the professional

The theme related to the presence of the professional comprised two subthemes: the professional spending time with and for the patient and the professional being attentive.

### Professional spending time with and for patient

Patients appreciated the time and effort they received from professionals, even though not all professionals acted in the same way [25]. Patients highlighted the importance of professionals spending time with them [24, 26, 27], being attentive [28] and present [26, 29]. Some patients experienced that active participation in specific care activities and interaction with professionals justified the needs of getting help [26]. The professional spending time with patients had a positive impact on their experience: professionals being available and reliable increased patients' comfort [26, 30, 31], sense of worth [29, 30],

confidence and efficiency and created no time pressure [30].

In general, patients experienced prompt support with their care, without pressure [31]. Professionals' patience during discussions made patients feel listened to and cared for [32], and their willingness to listen attentively was considered to demonstrate respect [27]. Nevertheless, expressed a desire for professionals to spend more time with them and meet their needs better [28]. In particular, the system of allocating a named nurse to a patient was valued [26]. The absence of accompanying care caused patient disempowerment [30], and being rushed by a professional made patients feel isolated and upset [33].

### Professional being attentive

Professional attention contributed to patients' experience of being helped and made comfortable [26]. Patients associated fast response times with feeling of being important, while delayed response times made patients feel that they were wasting professionals' time, and was sometimes attributed to staff shortages [30]. Patients experienced that nursing staff adopted an attentive and participatory attitude when they did not face time pressure [26]. Care was provided in a caring and close manner, when the professional was there for the patient [31]. Professionals' inattention to patient needs was seen as a barrier to good quality care, and patients felt insulted by such behaviours [29].



TABLE 4 Data extraction.

Authors (year) country of origin, language	Objective	Participants, context
Alharbi et al. (2014), Sweden, English	To investigate whether patients did in fact perceive the intentions of partnership in the new care model (Gothenburg person-centred care model) 1 year after its implementation	16 patients with previous hospital experience who had received care for at least 2 days in medical wards
Esmaeili et al. (2014), Iran, English	To explore cardiac patients' perception of patient-centred care	Eighteen cardiac patients (10 women and 8 men) having a hospitalisation length of at least 3 days in hospital coronary care units
Jensen et al. (2013), Denmark, English	To explore the patients' experiences of receiving patient-centred personal body care and to document changes compared to the patients' experiences in previous hospital stays	Nine female and 2 male patients diagnosed with moderate-to-severe COPD. Two different departments of a university hospital. The department of respiratory diseases and department of endocrinology and internal medicine
Laird et al. (2015), United Kingdom, English	To illuminate the experiences of patients of care received in hospital wards during the intervention phase of a program to develop person-centred practice	Twenty-six patients and 4 family-carers in four different hospital sites in one healthcare organisation, focusing on patients who were admitted to the nine wards/unit
Marshall et al. (2012), Australia, English	To explore patients' understanding and conceptualisation of patient-centred care and link it to existing literature on the topic	Ten patients in hospital surgical ward
Naldemirci et al. (2017), Sweden, English	To analyse deliberate and emergent strategies adopted by healthcare professionals to overcome barriers to normalisation of a specific framework of person-centred care (PCC); and secondly, to explore how the recipients of PCC understand these strategies	Eighteen researchers and 17 practitioners who adopted a model of PCC on four different wards and 20 patients who were cared for in one of these wards
Nyhof et al. (2019), Canada, English	To gain insight on how to achieve patient-centred care for ductal carcinoma in situ	Thirty-five women aged 30 to 86 treated for DCIS from five hospitals
Rahman et al. (2019), Pakistan, English	To examine and compare the perspectives of health care providers and patients regarding best practices of PCC	Eighteen health care providers (nurses, consultant doctors, residents, radiologists and physiotherapists) and 18 patients in free private hospital
Sharp et al. (2016), Australia, English	To examine acute nursing care from the perspective of the person receiving the care, and then to interpret the meaning of this care in relation to the concept of person-centred care (PCC)	Ten former patients of a regional health service in public hospital
Wolf et al. (2017) Sweden, English	To explore the realities of partnership as perceived by patients and health professionals in everyday PCC practice	Sixteen health professionals based at hospital wards or primary care centres delivering person-centred care, and 20 patients admitted to one of the hospital wards

Study design and methodology	Key relevant findings	Critical appraisal
Semi-structured interview. A directed deductive content analysis	Patients felt listened to and seen as individuals. Respondent had different experiences of involvement; Some felt included and able to participate in their care. Some patients appearing not to have been exposed at all to the PCC. Some patients were not interested in participating and playing an active role in their own care	7/10
A descriptive qualitative content analysis study with conventional approach. Personal face-to-face semi-structured interviews. Qualitative content analysis	Participants described patient-centred care as the removal of their uncertainties about the process of care through information, and having flexibility in care delivery, empathising with patients, and having the right to make independent decisions. Therapeutic communication was an essential component of patient-centred care	8/10
Observation of body care sessions with the patients, followed by individual in-depth interviews. Qualitative outcome analysis	Patient-centred care had a significant impact on participants' experience of being an active part of the body care activities	8/10
A narrative enquiry study. Narrative interviews. Structural narrative analysis	Participants placed value on the readiness of the staff team for their arrival and on the preparedness to provide explanations. Patients experienced misalignments in systems, care processes and nurses' responses. Patients felt denied an active role in reaching decisions	9/10
Qualitative research study grounded in phenomenology. Interpersonal interviews. Thematic analysis based on Giorgi's step by step approach to phenomenological analysis	Participants were unfamiliar with the concept of patient-centred care, for them it meant being involved, being attentive and connectedness	8/10
Semi-structured interviews. Data from these interviews were first coded inductively and emerging themes are analysed in relation to normalisation process theory	Patients felt sense of ease and being listened, inter-professional congruity, non-hierarchical communication	7/10
Qualitative descriptive approach. Semi-structured focus groups informed by the McCormack et al. PCC framework, constant comparative technique	Participants experienced absence of desired information or behaviour to achieve the PCC. Variety in terms and lack of education caused frustration and not being able to fully engage in own care. Participants also desired more involvement	7/10
Exploratory study. Focus group interviews, using a semi-structured interview guide. A deductive approach was used primarily to analyse the data, according to three domains of Scholl's framework. The deductive approach was complemented with constant comparison analysis	Providers were committed to maintaining an effective patient-provider relationship. Family involvement and offering necessary information was seen as a key indicator in decision making for patient. Spending time emerged as an important indicator of patient-centeredness	6/10
Semi-structured interview. Thematic analysis	Compassionate care was seen as the catalyst for patient empowerment and participation in the care. Therapeutic nurse-patient relationship is a fundamental aspect of care	7/10
Qualitative study employing a thematic analysis of semi-structured interviews	Available and reliable professionals increased patients' comfort, many patients felt listened to and acknowledged. Patient took part in developing a health plan, but few mentioned goals. Patients felt they contributed in various ways	8/10

**TABLE 5** An overview of descriptive themes, subthemes and analytical themes.

Descriptive themes ( <i>n</i> = 37)	Subthemes ( <i>n</i> = 14)	Analytical themes ( <i>n</i> = 5)		
Patient appreciating the time received	Professional spending time with and for patient	Presence of the professional		
Impact of professional's presence				
Patient expectation of professional's Advocacy				
Professional's patience	Professional being attentive			
Professional's attitude towards patient's Needs				
Importance of response time	Experience of being informed	Receiving information		
Expressed importance of being informed				
Impact of communication quality				
Receiving information about care	Professional as educator			
Lack of information				
Patient expressing need for information				
Paying attention to educational needs				
Means of improving understanding				
Being able to take an active role			Patient role in own care	Being involved
Comfortable with passive role				
Given opportunity for involvement			Being involved by professional	
Given opportunity for discussion				
Patient decisions respected			Collaboration with professional	Patient–professional relationship
Feeling of not being involved by professional				
Authoritarian action by professional				
Interpersonal relationship with Professional				
Recognising the difference in expertise				
Prioritising the patient's needs				
Professional generating receptive atmosphere				
Professional recognising patient distress				
Lack of emotional support	Emotional support from professional			
Providing comfort and compassion				
Professional's interest in personal Situation	Personal inquiry	Being seen as a person		
Value of personal inquiry				
Lack of individual inquiry	Recognising individuality			
Lack of individual care				
Professional generated an acknowledging atmosphere				
Recognition of patient's individuality	Being ignored			
Not being noticed by professional				
Professional's dependence on technology	Being respected			
Importance of being listened to				
Providing care with respect				

## Receiving information

The receiving information theme included two subthemes: the experience of being informed and the professional as educator.

### Experience of being informed

Patient-centred care was understood as receiving information [29]. Patient-centred care entailed patients receiving

information concerning their treatment [25, 26, 29], condition, discharge and future care needs [29, 31], which helped them to make informed decisions [29]. Information helped patients to understand the purpose of a treatment [33] and prepared them for the subsequent medical outcomes [27]. Sufficient information also increased patients' understanding of their own capability [26], enabling them to take control of [27] and better deal with their illness [31]. Being informed generated a sense of security [25, 26] and being cared for [25] and reduced the sense of vulnerability [30] and uncertainty [29]. Poor communication caused a sense



of being ignored and neglected [29], and professionals' use of unclear terminology confused patients and caused misunderstanding [33], while respectful communication increased their confidence and comfort [29].

The absence of information-sharing made patients feel isolated [30], frustrated and unprepared to manage their own health [33]. Examples of poor information-sharing included issuing discharge papers, which lacked relevant information, failing to discuss side effects [27], and creating health plans which did not include clear goals or were described in purely medicalised terms which focused on discharge requirements rather than the patient's perspective [31]. When patients felt unprepared to manage their own health they found it difficult to engage in relevant discussions with professionals and to advocate for their own needs and preferences [33]. The uncertainty of 'not knowing' was perceived as a threat and resulted in feelings of fear [32].

### Professional as educator

Patients expressed the need for information and education [32, 33] that would prepare them for involvement in their care [33]. Some patients were more prepared than others to ask questions [32], and they were able to engage in discussions with professionals to understand their own illness [25]. Sharing information required professionals to pay attention to the patient's educational needs and their family's concerns [29, 33] and be ready to provide explanations while giving patients opportunities to ask questions [30, 33]. Where professionals were committed to giving information this reassured patients that they were dedicated to their care [33]. Patients expressed desires for better, multidirectional communication, enabling both participants to be aware of each other's opinions and actions [28]. Patients felt that a doctor should articulate the options for treatment so that patients could come to an informed decision [27]. Patients' understanding improved when clinicians took the time to explain and repeat information [33].

### Being involved

Being involved comprised two subthemes: the patient's role in their own care and being involved by the professional.

#### Patient role in their own care

Patients differed with regards to their desire for involvement in their own care [25]. Some wanted to be actively

involved in their care [25, 28] and take responsibility for their own body and health [25]. These patients wanted to participate as much as they were able to [26, 31], and participation was described in terms of informed discussion, acceptance and mutual agreement [31]. Being able to take part made them feel self-sufficient [26]. Others were comfortable adopting more passive roles [25, 31], and participated by listening to the professional, agreeing to [31] and accepting decisions made by the professional [25, 31].

#### Being involved by the professional

Patients felt that they were given opportunities to participate in developing their care plan [25, 26, 31] and in decision-making processes [26, 28–30]. Involving family members was felt to be important when patients were unable to express themselves verbally [27]. Patients were given the opportunity to discuss care plans and treatments [25, 31]. Patient participation was enhanced by opportunities to question and decline treatment, contribute to discharge planning and evaluate what assistance they needed [26, 31]. Patients were motivated to play an active role where they were given the tools to be involved in care planning [25]. In most cases, patients had experience of their decisions being respected [26, 28, 29], although in some cases they were denied involvement in such decisions [30].

In some cases, patients did not feel invited to participate and did not have opportunities to express themselves [25]. Some patients were not involved in decision making [25, 33], and decisions were made without informing them [25]. Lack of patient involvement in decision-making process led to worsening health status [25] and patients feeling obliged to comply with professionals' decisions [33].

### Patient–professional relationship

The patient–professional relationship included three subthemes: collaboration with professionals, the professional's receptiveness and emotional support from the professional.

#### Collaboration with the professional

A meaningful patient–professional relationship was brokered through gestures of genuine care and respecting the patient as an individual [27, 30]. Patients highlighted the importance of professionals being friendly and showing mutual respect [26]. The nurse–patient relationship

was seen as central to patient care and experienced as important to relieving stress [29]. A family-like atmosphere contributed to a sense of belonging [30]. Professionals' thoughtfulness and openness increased patients' sense of security and trust. It helped patients to feel confident and comfortable and that they were treated as equals [31]. Elements of informality in the patient-professional relationship fostered environments in which it became possible for patients to ask questions [31] and take part in discussions [34]. Working in collaboration with staff developed into comforting interpersonal relationships [26]. In contrast, there were some cases in which patients experienced vertical hierarchy in their relationships with staff and dependence on the professional. When doctor acted in authoritarian ways, this diminished patients' willingness to be involved [25]. Indifference on the part of professionals also caused dissatisfaction [29].

### The professional's receptiveness

Patients expressed the need to be treated as equals, the implication being that they possess their own expertise and experience of their illness, body and needs, while professionals bring their medical expertise to the care process [28].

Patients described positive feelings towards the receptiveness of staff and atmosphere on the ward [27, 31, 34]. Nurses who approached their work in a person-centred way were described as prioritising patients' needs over other tasks and prescribed duties [32]. In such instances, patients felt that the professional wanted to care for them [32, 33], were ready for the patient's arrival and committed to their work [30]. Efficient professionals evoked a sense of confidence among patients, and the feeling of being cared for generated a sense of ease [30]. Open minded and appreciative nursing staff became the foundation for further support [26]. Nurses' competence and expertise was seen as a prerequisite for PCC [29], and trust in professionals' competence gave patients a sense of security [26, 33].

### Emotional support from the professional

Compassion was considered to be vital ingredient in experiences of PCC: Providing compassionate care increased patients coping ability, comfort and hope [32]. Reassurance from staff supported a sense of belonging [30]. In some cases, patients experienced a lack of emotional support: for instance, a physician not acknowledging the patient's emotional reaction, and few of them referred patients to supportive care or gave patients information about disease-specific resources. In cases where

interaction was abruptly terminated patients felt isolated and unsupported [33]. In another study, nurses were perceptive to patient distress and compassionately moved to mitigate it [27]. The role of body language was highlighted [25, 33]; sitting beside the patient at the same level conveyed a sense of caring, while talking down to the patient made them feel insignificant [33].

### Being seen as a person

Being seen as a person comprised four subthemes: personal inquiry, recognising individuality, being ignored and being respected.

#### Personal inquiry

Patients valued any time professionals spent inquiring after them on a personal level [33]. Conversations in which professionals took an interest in people's lives apart from their disease conveyed the feeling of being known [25, 32]. Professionals focused on patients' abilities and resources for managing their illness [25]. In some cases, personal information was elicited but not used in defining relevant goals [32]. Some conversations focused on the disease rather than the patient [25], and professionals did not inquire about the socio-economic status of the patient [27]. Taking time to get to know patients reduced their anxiety and made them feel more comfortable to engage in discussions [33]. It resulted in patients feeling that they were listened to and known personally [25, 31].

#### Recognising individuality

Patients had experience of professionals establishing an atmosphere of acknowledgement and mutual understanding about their needs [26]. Individualised care was seen to express professionals' recognition and acceptance of the patient's situation [26, 30, 32] and opinions [26], seeing patients as people rather than focusing on their disease and placing themselves in the patient's shoes [25]. Recognition of patients' individuality was considered to be the foundation of good care [25, 26, 32]. Patients recognised that PCC tries to satisfy their needs and expectations and protect them from harm [29]. Where nurses acknowledged a patient's basic needs and the personal impact of their illness, this reinforced the patient's feelings of being important, having more autonomy, greater ability to cope and compliance with care [32]. Patients felt listened to, acknowledged

and known personally [31]. Being known was a source of trust and confidence in their care [31]. In contrast, some patients felt that they were treated using a protocol rather than being seen as an individual, undermining their relationship with staff and ability to raise medical concerns [25].

### Being ignored

Some patients reported that professionals ignored what they had to say [25, 32] and that professionals talked among themselves but not with the patient. Some professionals relied on medical technologies to convey information to patients, at the expense of talking to them. This created the sensation of being invisible and irrelevant. [25]

### Being respected

Patients highlighted the importance of being respected as a person who could contribute to their care [28], be given an opportunity to express feelings [23] and whose feelings and opinions were worth hearing. [25, 26, 31]. Patients expressed the desire to have their personal preferences taken into consideration [25].

## DISCUSSION

This systematic review identified how patients experienced PCC in hospital settings. A thematic analysis produced five themes which describe the importance of the professional's presence, patient involvement, receiving information, being seen as person and the patient-professional relationship. Sladdin et al. [12] found quite similar themes in their research into patient perceptions of PCC in dietetic consultations. According to their study, patients wanted to maintain caring relationships with professionals, receive individualised care, be involved in care processes and take an active role in their own health. A caring relationship meant professionals taking an interest in developing a holistic understanding of the patient's situation.

The presence of the professional constituted them giving time, being available and being attentive. The presence of nursing staff had a positive impact on patient experiences and their expressed feelings of being important and cared for, sense of security and comfort. The importance of nurses' presence has been recognised in other studies. For example, Mohammadipour et al. [35] found that patients identified the continual

presence of nursing staff as the most important factor for their sense of security. Continual presence was seen as essential to enabling good communication and information-sharing, recognising patients' individuality and participation. In this review, presence was experienced as an expression of full concentration on the part of the professional and attentiveness to patients, while frequent check-ups conveyed a feeling of being cared for. Prerequisites for professionals to be fully present include their competence, self-actualisation and openness to experience, as well as a supportive working environment [35].

According to this review, most patients felt well-informed about their treatment, condition and care plan. This helped them to understand and be prepared for their treatment. Nonetheless, patients still expressed the need for further information that would help them to participate better. Lack of information was experienced as a threat. Sharing information required professionals to pay attention to the patient's educational needs and communicational skills. Previous studies highlight the role of patient information as one of the most important dimensions of PCC [36]. This suggests that there is still a need for better information and more understanding about the type of information needed. Meeting this need would increase patient satisfaction and is essential to informed decision-making on their part [37, 38].

Valuing patients' right to participate and providing opportunities for shared decision-making are fundamental principles of health care. As stated earlier, providing the information that patients need is a crucial element of this [39]. This review has identified that patient preferences regarding involvement differ. Most patients wanted to take an active role in managing their own health and making decisions, but others were comfortable with playing a more passive role and relying on professionals' decisions. The latter may reflect patients' presumption that doctors know best [40], or a sense that they should play a different role in a hospital context than elsewhere [41]. There were also variations in terms of involving patients. In most cases, patients were given the opportunity to discuss their care and their decisions were respected, but in some patients did not feel invited to participate or felt that they were denied a role in reaching decisions. Involving patients in their own care has many benefits including increased patient satisfaction, patient empowerment, higher quality of life and reduced anxiety. Patient involvement in decision-making can be shaped by many factors including the patient's personal characteristics and those of the disease, the professionals and the health care settings in question [39].

In earlier research, the patient–professional relationship has been described as an interaction that impacts on both subjects [42]. In this review, the patient–professional relationship was specifically associated with care and was brokered by professionals respecting patients' individuality and making gestures of genuine care for the patient. Professionals being receptive and friendly generated positive feelings such as comfort. Patients reported differences in professionals' behaviour: Some seemed to be more compassionate and ready to consider patients' needs than others. A caring nurse–patient relationship has been characterised as involving active listening, respect, being present and available, empathy, acceptance and cultural sensitivity [42]. The quality of the patient–professional relationship has a direct impact on the quality of care, and professionals' support, empathy, care and good relationships with patients have a decisive role in shaping patients' participation and attitudes [41]. The difficulty of involving patients has been recognised by previous studies and may be related to the time that is available to professionals [15].

In this review, the importance of being respected as a person and receiving individual care was highlighted. Individual care was seen to involve recognising and understanding the patient's situation and acknowledging their needs. Such care generated patient experiences of being important, having more autonomy and reduced anxiety. By contrast a lack of individual care led to weaker relationships and patients feeling invisible. A previous study found that patients in integrated care also expressed prominent expectations of being seen as whole, unique individuals [43]. Seeing patients as persons and individuals is central to patient- and person-centred care. It involves recognising and cultivating individuals' personal capabilities. PCC can be demonstrated through respect and compassion, responsiveness to an individual's subjective experiences and supporting their autonomous capabilities [44].

## Limitations

The limitations concern the search strategies used in the databases, the heterogeneity of the selected studies and the synthesis of findings. Selecting the search terms was problematic because of the broad use of different terms relating to PCC. The time limitation may also have ruled out some relevant studies. There is a possibility that some relevant studies might have been missed because only peer-reviewed research articles were included, and the language of the studies was limited to English and Finnish. Data analyses were finalised by discussion between all the authors, supporting the trustworthiness.

## CONCLUSIONS AND IMPLICATIONS

Patients' experiences of PCC in hospital settings varied. This review suggests that the implementation and provision of PCC in hospitals is incomplete and patients' involvement in their own care should be in the focus of PCC. There is variation in patient experiences across nearly all of the themes identified, with some patients receiving PCC and others not. This may be explained by variation in perceptions and understandings of PCC or by actual differences in healthcare management. Patients highlighted the importance of professionals being present and spending time with patients. Patients felt informed about their care but expressed the need for better education. The need for patients' involvement in their own care was strongly emphasised even though it varied for different reasons, including both their own willingness to get involved and professionals' behaviours. A meaningful patient–professional relationship was experienced through gestures of genuine care and receptiveness by staff. Patients felt that their individuality was recognised, and this was seen as key aspect of good care. Receiving PCC was related to positive feelings such as security and comfort, while lack of PCC was related to negative feelings such as being ignored and wasting professionals' time. The findings identified themes that are linked together, requiring patient involvement and reflecting actual patient experiences of PCC. Patient involvement should be considered better in hospital practice.

The results may be useful for improving PCC, for instance, by including patients' experiences in designing measurement instruments and implementing PCC. Taking patient experiences of PCC into account can help professionals to better provide PCC in practice while fostering deeper understanding of the concept. Healthcare professionals need more training in PCC and patient–professional communication. Further research involving both qualitative and quantitative data is needed.

## AUTHOR CONTRIBUTIONS

TH, EL and OK were responsible for the study design, TH, SK, EL and OK collected the data, TH and SK performed the data analysis and all authors drafted the manuscript. All authors critically reviewed and approved the final version of this manuscript.

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**CONFLICT OF INTEREST STATEMENT**

The authors declare that there aren't conflict of interests.

**DATA AVAILABILITY STATEMENT**

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

**ETHICAL APPROVAL**

Not applicable.

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**APPENDIX 1**  
Prisma flow diagram

