

A Qualitative Study on Patient-Centered Care and Perception of Nurses in Primary Healthcare Practice

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Research

Keywords: Patient-centered care, perception, nurses, Primary Health Care, Nursing care, and Healthcare services

Posted Date: October 15th, 2020

DOI: <https://doi.org/10.21203/rs.3.rs-91573/v1>

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Abstract

Background: Patient-centered care (PCC) approach has continued to gain recognition globally as the key to providing quality healthcare. However, this concept is not fully integrated into the management of primary health care (PHC) in existing nursing practice due to numerous challenges. Among these challenges is the perception of nursing on PCC in the Primary Health Care system. This study seeks to present the results of qualitative research performed at various selected PHC centers on nurses' perceptions in PCC practice.

Aim: This study aims at exploring the perception of nurses on PCC.

Method: A qualitative research approach was adopted for this study. This study involved thirty local government PHC centers located in Osun State of southwest Nigeria. The sample comprised 28 female nurses and 7 male nurses. Data were collected through a semi-structured interview schedule in different sessions that were conducted on a one on one basis. Thereafter, data analysis was performed using thematic analysis and NVivo 12 software to generate themes, subthemes, and codes.

Results: The findings of the study revealed a number of perceptions on PCC that were categorized into positive and negative themes. The negative themes include: Poor approach by the nurses and lack of enforcement agency. The positive themes that emerged include: Outcome-driven healthcare, valued care provider, communication to sharpen care, and driven healthcare service. In addition, the findings established a positive correlation between perception and years of working experience. 68.5 % of the participants, who had working experience in the range of 12 – 31 years, expressed a mixed perception of PCC practice. The remaining 31.5 % of the participants interviewed who had working experience in the range of 2, 6 – 11 years, expressed positive perceptions on the provision of PCC.

Conclusion: From the findings of this study, there is a need for the government to enforce the utilization and provision of PCC in the PHC setting. This should be done through the provision of an enabling environment in the PHC setting. In addition, the government should provide regulations and monitoring mechanisms in the PHC institutions. Enforcement agencies should also offer opportunities for continuous training to enhance the nursing care skills of nurses to stimulate and sustain improved healthcare services. Lastly, the government should remunerate and promote nurses based on merit as another means of supporting improved healthcare service delivery by the nurses.

Background

Patient-centered care (PCC) was developed in the 1950s by Carl R. Roger, an American humanist psychologist in what he referred to as client-centered therapy [1-3]. Today, PCC is widely recognized and acknowledged as a core value in medical practice [4, 5]. This has led to positive outcomes that include a reduction in malpractice complaints, improved patients satisfaction, improved consultation time, patient's emotional state, and medication adherence [6-8]. In addition, Newell & Jordan [9] reported that PCC is an essential and fundamental ethics in promoting quality healthcare. This is in the understanding that patients are fundamentally human, leading to the promotion of the concept of PCC even with personhood, but not without its complexities [10]. Historically, the concept of PCC has been explored through theoretical proposals and practical approach since the earliest Geneva conference that followed a process that allowed the acquisition of experience concurrently [11-13]. In essence, the experience is a crucial aspect of the identity and existence of any institution that connotes the value of delineating institutional journeys, evaluating and recognizing PCC development.

PCC concept is a comprehensive approach to healthcare service delivery [14, 15]. This innovative concept in policy and practice moving to a conceptual optimal routine clinical practice is pivotal [16-19].

In developed countries such as the United Kingdom, United States of America, Australia, and Germany, among others, PCC has been in paper through policies leading to this statement, “*liberating the NHS: No decision about me without me*” [20, 21]. Even though the trend of this concept is clear in research and theoretical conceptualization, it is, however, fuzzy, elusive, and even poorly implemented in medical practice [22-24]. Since its inception, several studies on PCC such as [8, 12, 25-28] have described the various dimensions and models of PCC to show its importance in the healthcare system. In addition, several research findings on the challenges experienced in realizing and practicing PCC have been presented in [29], among others. The results of these findings also reveal that PCC has been taken for granted by healthcare providers and other stakeholders in primary health care.

Implementation of the PCC concept is a necessity in order to achieve sustainable healthcare coverage for all in Nigeria, where it has been accepted for incorporation into the existing healthcare system. This means that it is feasible at the grassroots level of the healthcare system provided that the stakeholders work in collaboration with the nurses in its implementation and practice. Thus, the aim of this study was to explore the perception of nurses on PCC.

The impact of perception on PCC

There has been an increased need for PCC globally since its identification by the Institute of medicine of United States of America National Academies of Science as the leading contributor in the provision of quality PHC [30]. PCC is aimed at understanding the illness experiences from the patient’s viewpoint. The International Alliance of Patients Organization (IAPO) declared that PCC as a service is based on placing the patient at the center and around the patient’s needs [31].

In professional nursing circles, PCC is perceived to be an awareness of the importance of patient healthcare culture, family and friend’s involvement, incorporation of values of love and respect, and communication in all facets of patient’s care leading to accountability to the patient [32, 33]. In South Africa, PCC is endorsed in the second amendment Act No 3 of 2003, which states that all South African citizens have a right to effective quality healthcare free from harm [34]. The South African PCC has established on an eight-point “*Batho Pele*” principle that introduces a concept to service delivery putting people first, and the stated values of public service in the Republic of South Africa [34].

The role of nurses in delivering PCC in public hospitals and other healthcare facilities has become an imperative study for researchers since it is necessary to evaluate the knowledge and understanding of the nurses. In the findings by Terry in [35], nurses were found to be enthusiastic about sharing their perceptions with regards to PCC and what they perceived it to encompass. It is interesting to note that the perception of humane treatment was evident from the nurses. The components of human emotional aspects such as psychological, social, spiritual, and emotional aspects that greatly influence an individual’s health was presented. For instance, the awareness of the patient’s cultural background and how to integrate the culture of a patient into the management of a patient and treatment plan were seen to be associated with PCC.

Therefore, in order to effectively render PCC, the nurses have to demonstrate cultural awareness [36]. Culture is known to be multifaceted and dynamic, making it an important subject for the health practitioner’s especially nurses, to understand for quality and effective healthcare service in the PHC [37-39]. To improve healthcare outcomes in PCC model, there has to be a demonstrated aptitude for cultural competence [40]. However, there are many challenges and barriers, but none is more influential than institutional and cultural-based on individual ethnocentrism [41]. This is responsible for the current socialization of young healthcare professionals leading to the perpetuation of negative attitudes, stereotype behavior towards vulnerable and culturally diverse populations [42].

The involvement of the family in crucial patient's health decisions is a vital component of PCC and has been evident in research findings presented in [43, 44]. The similarities and differences have been identified in order to define and describe the level of family involvement in delivering PCC. In a systematic review of nine different models and frameworks in which PCC was defined, family and friend's involvement was found to be 60 % [45, 46]. The values of love and respect for patients were seen to be the other aspects of PCC. This is seen as incorporating a holistic PCC when interacting with patients and family members. Dowling in [47], reports that nurses perceive love in nursing as going beyond the traditional duty of patient care and the willingness and commitment to the good of a patient before themselves. In [48], it was found that treatment with love and respect among patients included aspects of listening and trusting in a patient. This makes the patients feel valued besides having a sense of control of their own healthcare process, thus helping in their recovery efforts. The display of these values of love, respect, and dignity was seen as integral to PCC and was perceived so by the nurses.

One way of expressing perception is through verbal and non-verbal communication. Nurses should be aware of the different methods of communication that should be adopted when handling patients. In [49], it is reported that communication skills form a fundamental component of PCC. Evidence has demonstrated the impact of PCC in healthcare. These include patient satisfaction, adherence to recommended treatment, and management of chronic diseases [50, 51]. However, PCC lacks clear measurement tools to clearly show its effectiveness as presented in [52].

Methods

Study design

A qualitative action research approach was used with a purposive sampling technique. Individual interviews were used to collect data from nurses in PHC environments. Data were collected through a semi-structured interview schedule in different sessions that were conducted on a one on one basis.

Sample size

The sample comprised 28 female nurses and 7 male nurses on reaching data saturation. The qualitative study data sample size was based on the principle of theoretical saturation. It follows the process of gathering and analyzing data until it reaches a point of no new idea or information is observed [53, 54]. A saturation level was reached with the total sample population of 35 participants. The average age of the participants ranges between 30 and 61 years.

Study Setting

The study was in 13 local government areas (LGAs) with thirty PHC centers located in Osun State, southwest Nigeria. The PHCs were distributed, as shown in Table 1.

Table 1: PHC distribution in southwest Nigeria

LGAs	No. of PHCs
Ede-North	6
Ede-South	2
Ife-Central	4
Ife-South	2
Ife-East	1
Oshogbo	2
Ifelodun	2
Ejibo	3
Ifetedo	2
Olorunda	2
Irepodun	1
Irewole	1
Egbedore	2

The Federal Republic of Nigeria is divided into six geopolitical zones, namely: North East, North West, North Central, South East, Southwest, and South-South zone. South West zone comprised of the following 6 States: Lagos State; Oyo State; Ogun State; Osun State; Ekiti State, and Ondo State. This study was conducted in Osun State. Osun State has a population of 4,705,589, according to the 2016 census [55]. This population size provides an adequate sample size for such a study.

Data collection and data analysis

Individual interviews were used to obtain data from the participants. An interpretative data analysis approach, according to [56, 57], was employed for data analysis. The interviews were transcribed verbatim and coded to extract relevant information. The coding process involved organizing the data in different containers based on the research questions and relevant information. Then codes were developed into themes and sub-themes using thematic analysis and software NVivo 12.

The trustworthiness of the study

The term trustworthiness is used to explain the validity and reliability in qualitative studies [58, 59]. This refers to the rigor of the data and the degree to which the researcher could influence the readers that the study is worthy of the data [60, 61]. The four criteria that qualitative researchers considered in maintaining the trustworthiness of their studies, as proposed by Guba is employed in this study, according to Shenton. These are credibility, dependability, conformability, and transferability [62].

Credibility: It refers to the accuracy with which the data provided by the participants were interpreted [61, 63]. This technique was achieved in this study. To ensure the credibility of this study, an individual in-depth interview was adopted to obtain information from the participants. This instrument was not only used to get information but also to

authenticate the information to be gathered. The individuals' in-depth interviews lasted between 15 to 30 minutes per participant. All interviews were taped recorded.

Confirmability: This is the extent to which the data collected from the participants were analyzed objectively. If another researcher examined the same data, they would get the same results [60, 61]. The analysis of the data presented in this study is not our view about the study instead is a neutral reflection of the interpretation of the data obtained from participants. Confirmability standard was ensured through the audio-recording and verbatim transcription of interview sections. Thus, the confirmability of this study was provided.

Dependability: This refers to the stability and consistency of data obtained and the extent to which this data is dependable over time and conditions. To ensure dependability, a comprehensive description of the study setting, the technique for data collection, and data analysis were presented.

Transferability: The ability of the findings to be applied to a similar situation and still yield similar results [58, 64]. Thus, transferability in this study was ensured by providing adequate data description, study setting, and socio-demographic characteristics of the participants. This could enable the public to evaluate the applicability of the data to other contexts.

Results

Both negative and positive perceptions of PCC, as described by the nurses, emerged from this study. Participants' perceptions were categorized as described in Tables 2, 3, and 4, respectively.

Table 2
The themes, sub-themes, and codes, with meaning based on negative perceptions

THEMES	SUB-THEMES	CODES	MEANING
Poor approach by the nurses	Sentimentalism of the Nurses	<i>...Patient-centered care consumes time, for me to treat patient holistically it consumes time..</i>	Participants reported poor approach towards accessing the healthcare system, which is associated with nurses attitude toward the patients due to many factors such as stress, workload, personal opinion, and misconception
	Uncaring Approach	<i>We look at the time for our patient...we don't have enough time to listen to them, for the patients to say what they want to say. So aspect of the nursing care which is the counselling that this patient really need is not there any more</i>	
Lack of enforcement agency	lack of commitment from the management	<i>This country! I can't say if we will ever achieve it. If it is private hospital, yes. But for Primary Health Centre that is owned by government it is not achievable</i>	This transformation of quality service is yet to be fully implemented in the PHC setting. The national interest to enhance the quality of health care service delivery to the people is poorly addressed.
	Low empowerment	<i>I am a community health nurse who had first degree in nursing and knows the importance of a community centered care... the people will respond back base on what you do, whether is a quality care or a poor care. But the patients are too much for the staff. So, I think it might be a bit difficult...</i>	

Table 3
Themes, sub-themes, and codes with meaning based on positive perceptions

THEMES	SUB-THEMES	CODES	MEANING
Outcome driven healthcare	1. Being compassionate and caring	<i>I think is a positive concept with good strategy which should be implemented...It will make health care delivery appropriate for client so I think is a good concept.</i> <i>It is very good if we can integrate it in the service, especially at the primary health care center</i>	Nurses revealed it committed as a healthcare provider to patients to give holistic healthcare services geared towards helping the community member to contribute their healthcare and collaborate.
	1. Enrich nursing care	<i>It will give a better outcome in the care that is been given to the clients and enhance the practice of nursing</i>	
Valuable care provider	a) Increase information sharing	<i>... This will be great for the nurses and the community because both of them will benefit from it</i>	Participants reported increase advantage by the quality of care for patients through deliberate changes in caring for patients to bring better health outcomes
Driven healthcare service	1. Compel to do the normal thing	<i>It will be reminding us that these are the things we need to do...So, I think it will be very helpful, it will be very helpful and it will tailor the way we interact with our patient</i>	The importance of PCC knowledge was reported by the participants to be able to interact well with patients. Although the concept is good but the majority of them are aware of it.
	2. Acceptance of usefulness	<i>PCC is necessary because taking care of patient or a client especially in primary health care center, it will be good to create more awareness to people generally...</i>	
Communication to sharpen care	1. Understanding information	<i>To me, I think PCC in the PHC is relevant because it will improve the quality of care when you allow clients, to participate, to talk to you freely and listen to her, you know we will work together because they will see us as friendly</i>	Participants acknowledged the importance of listening to patients' expressions and understand them as they pour their emotions and anger during care. Effective communication was revealed from nurses to improve healthcare.
	2. Interpersonal relationship	<i>You need to made the people feel important because I am also a human being you know when we treat patients with respect. I think we need to improve on that</i>	

Table 4
Characteristics of the participants and their perception in percentage

Participants ID	Frequency	Working experience	Percentage (%)	Perception
P1	1	2	2.9	Positive
P2-P11	10	6-11	28.6	Positive
P12-P31	20	12-18	57.1	Mixed
P32-P35	4	19-31	11.4	Mixed

Discussion

The utilization and provision of PCC in nursing healthcare remain a challenge in the PHC setting. This is in spite of the fact that a significant number of the nurses interviewed indicated the usefulness of PCC to nursing practice as it compelled nurses to practice ideal healthcare service delivery. As a result, the performance of nursing care and the quality of services in the health system was still low. Therefore, there is a need for enhanced support from policymakers, institutions, and health professionals in the provision of improved quality healthcare and services. Additionally, the need for further studies on the challenges experienced in the implementation and practice of PCC in PHC environments is necessary in order to provide possible mitigation measures. As such, this study seeks to provide qualitative research on the perception of nurses on PCC for improved utilization and provision of PCC in the PHC setting.

Out of the 35 nurses interviewed, 20 nurses that represent 57.1% with a working experience of 12–18 years had mixed perceptions. 4 nurses that represent 11.4% of the participants with a working experience of 19–31 also had mixed perceptions. 11 nurses that represent 28.6% and 2.9%, given a total of 31.4% of the participants with a working experience of 2, and 6–11 years of working experience expressed positive perceptions about PCC. These results are summarized in Table 4.

The findings revealed both the positive and negative perceptions of the utilization and provision of PCC in nursing practice at the PHC settings. A number of the participants reported an uncaring approach among the nurses as a hurdle to the utilization of PCC among the negative perceptions. The uncaring approach from the nurse was reported as due to the nurses' sentiments that PCC was an exaggerated way of healthcare delivery service. Also, during the study, the nurse said that they lacked adequate time to deliver quality healthcare through the PCC approach since it required a considerable amount of time in practice. For instance, this recording confirms this complaint from one of the nurses interviewed: *"We look at the time for our patient...we don't have enough time to listen to the patients to say what they want to say."*

This study revealed several factors that contributed to the nurses' negative perception of PCC utilization and provision. Among these factors are socioeconomic factors, political factors, and poor working environment. From these findings, the PHC health system is subject to political influence and management in Nigeria. Additionally, the political climate and socioeconomic factors surrounding the PHC health system in Osun State, Nigeria, also influenced the nurses' perception of the utilization and provision of PCC at the PHC settings. Lastly, the existing disparity in remuneration among nurses working in the local government compared to the State hospitals and federal hospital nurses is great. This, in turn, affects the perception of nurses on PCC negatively.

The majority of the nurses who expressed full support to the implementation of PCC in the PHC had a Bachelor degree in Nursing education and were aged between 30–35 years with quite a handful holding a diploma in nursing. This can be attributed to the fact that nursing education at these levels covered theoretical concepts on PCC, thus providing these nurses with the necessary knowledge and PCC expectations. However, these research findings reveal the lack of emphasis on PCC education in nurse training institutions generally. These findings are similar to the results presented in other settings [65–67].

This study shows that the foundation for better quality healthcare provision to the patient is good communication and interpersonal relationship between nurses and patients. Excellent and effective communication plays an essential role in patient full healthcare service, and this responsibility falls mostly on the nurses. It is also crucial for patients to understand the information provided by the nurses. Such a strategy improves nurses' performance, increases patient's input on health matters, reduces misunderstanding between nurses and patients, and increases awareness on preventive healthcare, and increases better healthcare outcomes. However, misconception and negative perceptions hinder the nurses from an effective nurse-patient relationship. This study is identical to findings from these authors [68–70].

Several nurses that were interviewed indicated using the PCC approach in their nursing practice. However, this was not observed at the various PHC under study. Thus, it could be due to a misunderstanding about the PCC concept and principles at the PHCs. In addition, these nurses who claimed to have been using the PCC approach were found to be lacking the expertise required for PCC provision. As such, this contributed to the negative perceptions recorded from the interviews. This reveals the need to review the nursing curriculum in Nigeria nursing training institutions to incorporate PCC theory and practice. This would ensure that all graduating and registered nurses are well informed, skilled, and knowledgeable in the ideas and practice of PCC in nursing care. As a result, this would lead to the achievement of positive healthcare outcomes. Additionally, the patient will be treated with respect, dignity, value, compassion, and have a sense of satisfaction from the service provided to them. Such training of nurses on PCC will also enable and empower them with the necessary knowledge and skills for improved nursing care in the PHC health system. These findings were found to be similar to those presented in these authors [71–73].

Conversely, nurses have the potential and ability to influence and contribute to improved high-quality healthcare and services. This improvement can be stimulated and sustained through the modernization of the health system in a PHC setting with a focus on patient-centeredness for improved quality of care. In Nigeria's health system, there is a need to support PCC utilization and provision in the PHC setting. It was observed from this study that the current nursing practice in Nigeria has not fully embraced PCC as a means of healthcare service delivery. The reason for this challenge of poor demonstration of PCC in PHC can be attributed to existing knowledge gaps among nurses, lack of enforcement agencies from the national and local governments and inadequate training on the utilization and provision of PCC, among others. This finding is similar to the conclusions of other researchers [74–76]. In addition, valued care providers are required at the PHC to provide quality healthcare services to the people. PCC approach being an evidence-based care, was identified as a necessity in the PHC due to increased information sharing between the healthcare providers and the patients. Hence, promoting participation, collaboration, and involvement of patients in the decision-making process of their healthcare, will inevitably improve cooperation from patients to enable nurses to understand patients' perspectives, explore patient concerns and ideas as well as their experiences regarding their illness [77].

The corporation between nurses and patients through interaction with PCC would drive positive nursing care outcomes, improve performance, enhance community experiences on healthcare, and increase patients' satisfaction [78]. Thus, promoting quality healthcare services through significant community involvement is ensured when PCC is integrated into the PHC system. The patients will be provided with full support and assistance to understand what is required of them when accurate and precise information is provided through effective partnership and collaboration. This will lead to a shift from the traditional authoritarian nursing care for the benefit of the patient and, at the same time, will promote healthcare beliefs with positive values towards wellness [78].

Conclusion

From the findings of this study, there is a need for the government to enforce the utilization and provision of PCC in the PHC setting. This should be done through the provision of an enabling environment in the PHC setting. In addition, the government should provide regulations and monitoring mechanisms in the PHC system. Enforcement agencies should also provide opportunities for continuous training to enhance the nursing care skills of nurses to stimulate and sustain improved healthcare services. Additionally, the quality of healthcare provided to the patient will also improve with excellent and effective communication which was observed from the findings to be inadequate. Lastly, the government should remunerate and promote nurses based on merit as another means of sustaining improved healthcare service delivery by the nurses.

Limitations Of The Study

This study involved only primary health nurses in the PHC. As such, the main limitation of this study was that perceptions from the other healthcare professionals and the patients under care at the public PHC were not considered. It is therefore recommended that further studies should be done to include the perception of the other healthcare professionals and patients in the public healthcare system.

Abbreviations

PCC

Patient-centered care; PHC:Primary Health Care;WHO:The World Health Organization; LGAs:Local government areas; and LMIC:Low and middle-income countries.

Declarations

Ethics approval

Humanities Social Sciences Research Ethics Committee, the University of KwaZulu-Natal with Protocol reference number: HSS/1772/018D approved this study.

Consent to participate

Participants' informed consent was obtained, and the research was conducted following research ethics throughout the data collection process.

Consent for publication

Not applicable

Availability of data and material

The data analyzed during this study that supporting our findings are available in the manuscript as supplementary.

Competing interest

The authors declare no conflicts of interest.

Funding

No funding was received from any organization.

Author contributions

AL conceptualised the paper, prepared the draft of the manuscript, and Dr. EM read and reviewed the report. Both authors agreed on the final versions of the document.

Acknowledgment

The authors would like to acknowledge all the participants of this study, the Department of Nursing, School of Nursing and Public Health College of Health Sciences, University of KwaZulu-Natal. The research reported in this publication was supported by the Fogarty International Center (FIC), NIH Common Fund, Office of Strategic Coordination, Office of the Director (OD/OSC/CF/NIH), Office of AIDS Research, and Office of the Director (OAR/NIH), National Institute of Mental Health (NIMH/NIH) of the National Institutes of Health under Award Number D43TW010131. The content is

solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

References

1. Rogers CR. " Client-Centered" Psychotherapy. *Sci Am.* 1952;187(5):66–75.
2. Rogers CR. Psychometric tests and client-centered counseling. *Educ Psychol Measur.* 1946;6(1):139–44.
3. Rogers CR. Significant aspects of client-centered therapy. *Am Psychol.* 1946;1(10):415–22.
4. Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. *The Milbank Quarterly.* 1996;511–44.
5. Nuño R, Coleman K, Bengoa R, Sauto R. Integrated care for chronic conditions: the contribution of the ICC Framework. *Health Policy.* 2012;105(1):55–64.
6. Oates J, Weston WW, Jordan J. The impact of patient-centered care on outcomes. *Fam Pract.* 2000;49(9):796–804.
7. Epstein RM. The science of patient-centered care. *J Fam Pract.* 2000;49(9):805–10.
8. Stewart M. *Patient-Centered Medicine: Transforming the Clinical Method.* 3rd ed. ed. London: Radcliffe Publishing; 2003.
9. Newell S, Jordan Z. The patient experience of patient-centered communication with nurses in the hospital setting: A qualitative systematic review protocol. *JBI Database of Systematic Reviews Implementation Reports.* 2015;13(1):76–87.
10. Mezzich JE, Appleyard J, Botbol M, Ghebrehiwet T, Groves J, Salloum I, et al. Ethics in person centered medicine: Conceptual place and ongoing developments. *International Journal of Person Centered Medicine.* 2014;3(4):255–7.
11. Mezzich JE, Snaedal J, Van Weel C, Heath I. Introduction to conceptual explorations on person-centered medicine. *International Journal of Integrated Care.* 2010;10(5):1–2.
12. Mezzich JE, Snaedal J, Van Weel C, Botbol M, Salloum I. Introduction to person-centred medicine: From concepts to practice. *J Eval Clin Pract.* 2011;17(2):330–2.
13. Botbol M, Lecic-Tosevski D. *Person-Centred Medicine and Subjectivity. Interdisciplinary Applications of the Person-Centered Approach.* New York: Springer; 2013. pp. 73–9.
14. Christodoulou GN. *Psychosomatic Medicine.* ed ed. New York: Plenum Press; 1987.
15. Patwardhan B, Warude D, Pushpangadan P, Bhatt N. Ayurveda and traditional Chinese medicine: A comparative overview. *Evidence-Based Complementary Alternative Medicine.* 2005;2(4):465–73.
16. Miles A, Mezzich JE. Person-centered medicine: Advancing methods, promoting implementation. *International Journal of Person Centered Medicine.* 2011;1(3):423–8.
17. Scholl I, Zill JM, Härter M, Dirmaier J. An integrative model of patient-centeredness—a systematic review and concept analysis. *PloS One.* 2014;9(9):1–9.
18. van Dulmen S, McCormack B, Eide T, Skovdahl K, Eide H. 18 Future Directions for Person-Centred Healthcare Research. *Person-Centred Healthcare Research.* 2017:209.
19. Lewin S, Skea Z, Entwistle VA, Zwarenstein M, Dick J. Interventions for providers to promote a patient-centred approach in clinical consultations. *Cochrane Database of Systematic Reviews.* 2001(4).
20. Department of Health. Putting people at the heart of care 2009 [Available from: https://webarchive.nationalarchives.gov.uk/20130123200554/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_106038].
21. Department of Health. *Liberating the NHS: No decision about me, without me.* London: Department of Health; 2012.

22. Hobbs JL. A dimensional analysis of patient-centered care. *Nurs Res.* 2009;58(1):52–62.
23. van Dulmen S. Patient-centredness. *Patient Educ Couns.* 2003;3(51):195–6.
24. De Haes H. Dilemmas in patient centeredness and shared decision making: A case for vulnerability. *Patient Educ Couns.* 2006;62(3):291–8.
25. Mead N, Bower P. Patient-centredness: A conceptual framework and review of the empirical literature. *Soc Sci Med.* 2000;51(7):1087–110.
26. Mead N, Bower P. Patient-centred consultations and outcomes in primary care: A review of the literature. *Patient Educ Couns.* 2002;48(1):51–61.
27. Stewart MA. Effective physician-patient communication and health outcomes: A review. *CMAJ: Canadian Medical Association Journal.* 1995;152(9):1423–33.
28. Epstein RM, Franks P, Fiscella K, Shields CG, Meldrum SC, Kravitz RL, et al. Measuring patient-centered communication in patient–physician consultations: Theoretical and practical issues. *Soc Sci Med.* 2005;61(7):1516–28.
29. McCormack B, van Dulmen S, Eide H, Skovdahl K, Eide T. *Person-Centred Healthcare Research.* UK: John Wiley & Sons; 2017.
30. World Health Organisation. *People centred health care. A policy framework.* Geneva: WHO Press; 2007.
31. International Alliance of Patients' Organizations. *What is Patient-centred care?* London: IAPO; 2007.
32. Jardien-Baboo S, van Rooyen D, Ricks E, Jordan P. Perceptions of patient-centred care at public hospitals in Nelson Mandela Bay. *health sa gesondheid.* 2016;21(1):397–405.
33. Lawal BJ, Agbla SC, Bola-Lawal QN, Afolabi MO, Ihaji E. Patients' Satisfaction With Care From Nigerian Federal Capital Territory's Public Secondary Hospitals: A Cross-Sectional Study. *Journal of Patient Experience.* 2018;5(4):250–7.
34. South Africa. *White paper on transforming public service delivery (Batho Pele White Paper).* Pretoria: Government Printer; 1997.
35. Terry MJ. *The Impact of Patient-Centered Narrative Interviewing on the Perceptions of Primary Care Clinicians: a Pilot Evaluation.* 2010.
36. Matteliano MA, Street D. Nurse practitioners' contributions to cultural competence in primary care settings. *J Am Acad Nurse Pract.* 2012;24(7):425–35.
37. Van Rooyen D, Jordan P, Brooker C, Waugh A. *Foundations of nursing practice (African edition).* Edinburg: Elsevier; 2009.
38. Chenowethm L, Jeon YH, Goff M, Burke C. Cultural competency and nursing care: An Australian perspective. *Int Nurs Rev.* 2006;53(1):34–40.
39. Hardy S, Titchen A, McCormack B, Manley K, editors. ... *Revealing nursing expertise through practitioner inquiry.* Oxford.: John Wiley & Sons.; Wiley-Blackwell; 2009.
40. Australian Commission on Safety and Quality in Health Care. *Patient-centred care: Improving quality and safety by focusing care on patients and consumers.* Canberra: Biotext; 2010.
41. Blackman R. Understanding culture in practice: Reflections of an Australian Indigenous nurse. *Contemporary Nurse.* 2011;37(1):31–4.
42. Ramsden I. *Cultural safety and nursing education in Aotearoa and Te Waipounamu: Victoria University of Wellington New Zealand;* 2002.
43. Delaney LJ. Patient-centred care as an approach to improving health care in Australia. *Collegian.* 2018;25(1):119–23.

44. Pelzang R. Time to learn: Understanding patient-centred care. *British Journal of Nursing*. 2010;19(14):912–7.
45. Shaller D. *Patient-Centered Care: What Does It Take?* New York: Commonwealth Fund New York; 2007.
46. Mitchell M, Chaboyer W, Burmeister E, Foster M. Positive effects of a nursing intervention on family-centered care in adult critical care. *Am J Crit Care*. 2009;18(6):543–52.
47. Dowling M. Exploring the relationship between caring, love and intimacy in nursing. *British Journal of Nursing*. 2004;13(21):1289–92.
48. Kvåle K, Bondevik M. What is important for patient centred care? A qualitative study about the perceptions of patients with cancer. *Scand J Caring Sci*. 2008;22(4):582–9.
49. Levinson W, Lesser CS, Epstein RM. Developing physician communication skills for patient-centered care. *Health Aff*. 2010;29(7):1310–8.
50. Arora NK. Interacting with cancer patients: The significance of physicians' communication behavior. *Soc Sci Med*. 2003;57(5):791–806.
51. Epstein R, Street RL. *Patient-Centered Communication in Cancer Care: Promoting Healing and Reducing Suffering*. USA: National Cancer Institute, US Department of Health and Human Services, National Institutes of Health Bethesda, MD; 2007.
52. Robinson JH, Callister LC, Berry JA, Dearing KA. Patient-centered care and adherence: Definitions and applications to improve outcomes. *J Am Acad Nurse Pract*. 2008;20(12):600–7.
53. Tay I. To what extent should data saturation be used as a quality criterion in qualitative research 2014 [Available from: Retrieved from <https://www.linkedin.com/pulse/20140824092647-82509310-to-what-extentshould-data-saturation-be-used-as-a-quality-criterion-in-qualitative-research>].
54. Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research: Exploring its conceptualization and operationalization. *Qual Quant*. 2018;52(4):1893–907.
55. National Population Commission and National Bureau of Statistics Estimates. *National Population Estimates 2016* [Available from: <https://africacheck.org/wp-content/uploads/2017/02/Population-Forecasts.pdf>].
56. Miles MB, Huberman AM, Huberman MA, Huberman M. *Qualitative Data Analysis: An Expanded ourcebook*. 2nd ed. ed. London: Sage; 1994.
57. Saldaña J. *The Coding Manual for Qualitative Researchers*. 3rd ed. ed. Washington: Sage; 2015.
58. Leung L. Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine Primary Care*. 2015;4(3):324–7.
59. Noble H, Smith J. Issues of validity and reliability in qualitative research. *Evidence-Based Nursing*. 2015;18(2):34–5.
60. Fawcett J, Garity J. *Evaluating Research for Evidence-Based Nursing Practice*. Philadelphia: F.A. Davis Company; 2008.
61. Korstjens I, Moser A. Series: practical guidance to qualitative research. Part 4: trustworthiness and publishing. *European Journal of General Practice*. 2018;24(1):120–4.
62. Shenton AK. Strategies for ensuring trustworthiness in qualitative research projects. *Education for linformation*. 2004;22(2):63–75.
63. Anney VN. Ensuring the quality of the findings of qualitative research: Looking at trustworthiness criteria. *Journal of Emerging Trends in Educational Research Policy Studies (JETERAPS)*. 2014;5(2):272–81.
64. Polit DF, Beck CT. *Nursing Research: Principles and Methods*. 7th ed. ed. New York: Lippincott Williams & Wilkins; 2004.

65. Santana MJ, Manalili K, Jolley RJ, Zelinsky S, Quan H, Lu M. How to practice person-centred care: A conceptual framework. *Health Expect.* 2018;21(2):429–40.
66. Moore L, Britten N, Lydahl D, Naldemirci Ö, Elam M, Wolf A. Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scand J Caring Sci.* 2017;31(4):662–73.
67. Rosengren K, Danielsson L, Jansson I, Wallengren C. Development of an Academic Course in Person-Centred Care for Students in Higher Education: Teachers' Perspectives. *Education Research International.* 2018;2018.
68. Van den Heever AE, Poggenpoel M, Myburgh CP. Nurses and care workers' perceptions of their nurse-patient therapeutic relationship in private general hospitals, Gauteng, South Africa. *Health SA Gesondheid (Online).* 2013;18(1):1–7.
69. Kourkouta L, Papathanasiou IV. Communication in nursing practice. *Materia Socio-Medica.* 2014;26(1):65–7.
70. Fakhr-Movahedi A, Negarandeh R, Salsali M. Exploring nurse-patient communication strategies. *Journal of Hayat.* 2013;18(4):28–46.
71. Hashim MJ. Patient-Centered Communication: Basic Skills. *Am Fam Physician.* 2017;95(1):29–34.
72. Lateef MA. A qualitative descriptive exploratory study of teaching methodologies utilised by nurse educators in South West Nigeria 2017.
73. Lateef MA, Mhlongo ME. Factors Influencing Nursing Education and Teaching Methods in Nursing Institutions: A Case Study of South West Nigeria. *Global Journal of Health Science.* 2019;11(13):13–24.
74. Boykin A, Schoenhofer SO, Schoenhofer SOB. *Nursing as Caring: A model for Transforming Practice.* London: Jones & Bartlett Learning; 2001.
75. Oluwatolania BO, Philip A. Lack of integration in software systems for health practitioners in Nigeria: The way forward. *Journal of Health Informatics in Developing Countries.* 2010;4(1):47–51.
76. Appelgren M, Bahtsevani C, Persson K, Borglin G. Nurses' experiences of caring for patients with intellectual developmental disorders: A systematic review using a meta-ethnographic approach. *BMC Nursing.* 2018;17(1):51–70.
77. World Health Organization. WHO global strategy on integrated people-centred health services 2016–2026. Geneva: WHO; 2015.
78. Kieft RA, de Brouwer BB, Francke AL, Delnoij DM. How nurses and their work environment affect patient experiences of the quality of care: A qualitative study. *Biomed Central health services research.* 2014;14(249):1–10.