AFRICAN JOURNAL OF HEALTH SCIENCES AND MEDICINE
AJHSM (2024)04:01
http://www.du.edu.et/duj

RESEARCH ARTICLE

Health Professional's Experience in Patient-Centered Care in Gedeo *Zone*, South Ethiopia, A Grounded Theory Study

Getachew Nenko[1*], Negassa Eshete[1], and Jarsso Tadesse[2]

Received: 22 June 2023

Accepted: 27 September 2024

Published: 25 December 2024

DOI:10.20372/ajhsm.v04i01.01

Suggested Citation: Nenko G., Eshete N., and Tadesse J. Health Professional's Experience in Patient-Centered Care in Gedeo *Zone*, South Ethiopia, A Grounded Theory Study. Afri. J. Heal. Sci. Med; 2024, 04(01).

Copyright:©2024 Dilla University. This is an open access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

Background: Patient-centered care (PCC) places the individual patient at the center of healthcare delivery, ensuring that care is provided in a respectful manner. In Ethiopia, the practice of PCC remains limited, and the reasons for its poor implementation have not been explored in a study setting. This study aimed to explore health professionals' experiences regarding PCC in the Gedeo Zone, Southern Ethiopia.

Method: A health institution-based study was conducted using Glasser's (1992) grounded theory approach. Twenty-one participants were recruited via purposive sampling. Semi-structured interviews were conducted with health professionals at Dilla University General Hospital and Yirga Cheffe Primary Hospital. The interviews were audio recorded and transcribed for thematic analysis using Atlas.ti (v.7) qualitative data analysis software. Inductive thematic analysis was employed to identify themes and sub-themes.

Result: Twenty-one health professionals participated in the study, comprising 43% nurses, 33% general medical practitioners, and 24% senior physicians. Fifty-two percent of the participants were from Dilla University General Hospital, while 48% were from Yirga Cheffe Primary Hospital. Participants identified similar experiences that either facilitated or hindered the implementation of PCC, yet most health professionals had not been exposed to the concept. The thematic analysis revealed four major themes: (a) failure to respect patients' preferences; (b) lack of involvement of patients' families; (c) poor patient-provider interaction; and (d) challenges to implementing PCC. Participants discussed barriers and provided recommendations to improve the understanding and implementation of PCC in healthcare.

Conclusion: This study demonstrated that patient care is primarily delivered from a traditional provider-centered approach focused on episodic curative services, with PCC largely absent in the study setting. However, the support of the hospital senior management team is essential to create an environment that fosters the implementation of PCC and enhances its value among health professionals.

Keywords: Grounded theory, Health professionals, Patient-centered care, South Ethiopia

*Correspondence: freegetch01@gmail.com
[1]School of Public Health, College of Health Sciences & Medicine, Dilla University, Dilla, Ethiopia.
Full list of author information is available at the end of the article

1 Introduction

1.1 Background

Patient-centered care (PCC) is increasingly recognized as a crucial aspect of healthcare quality. The Institute of Medicine has highlighted PCC as one of the six most important dimensions of healthcare quality [1], defining it as care that is respectful and responsive to individual patient preferences and needs, ensuring that patient values guide all clinical decisions [2]. This principle has become a guiding tenet in healthcare delivery. According to the World Health Organization (WHO), the implementation of PCC at all levels of health facilities should encompass harmonization, reduced patient waiting times, efficiency and effectiveness of health services, and the maintenance of patient safety, ethics, and professionalism [3].

In Ethiopia, PCC is a component of the compassionate, respectful, and caring (CRC) agenda outlined in the Health Sector Transformation Plan since 2015. Although the inclusion of PCC as a quality dimension in healthcare delivery dates back to 2010, a common understanding of PCC remains lacking in practice [4]. While health systems aim to deliver patient-centered care, health professionals often focus excessively on providing episodic curative services based on a disease-focused approach. In contrast, PCC suggests concrete activities for implementation, including providing information to patients, engaging them in their healthcare, involving patients' families, and empowering patients [5].

The implementation of these activities has been associated with more positive health outcomes [6,7]. Understanding the domains of PCC often depends on the definitions provided by health professionals and the social context. Nevertheless, there is a consensus among various professional groups regarding the core elements of PCC, such as addressing the psychological needs of patients and promoting patient empowerment. However, the focus and emphasis placed on these elements may vary among different health professionals [8].

According to the WHO, health systems prioritize the treatment of individual diseases, leading to an investment in and efficient utilization of health resources based on a medical model of service delivery rather than on patient-centered care. Thus, primary healthcare is designed to mediate between PCC and the provision of medical model health services [9]. This model fulfills the coordination role necessary for patient-centered service delivery, tracking and ensuring the right balance between primary and secondary levels of health service delivery as a whole [9].

Previous studies have found that PCC has the potential to improve health outcomes [10,11] and benefits healthcare systems and providers. Practices that contradict the principles of PCC, such as failing to consider patient preferences in care decisions, have been linked to accusations of malpractice [12,13]. The risks of miscommunication increases when healthcare providers neglect a patient's preferences, needs, and values. Additionally, healthcare systems benefit from PCC by reducing patient waiting times, minimizing unnecessary laboratory investigations and procedures, decreasing out-of-pocket healthcare expenditures, and ultimately improving the efficiency of care [14,15].

The lack of implementation of patient-centered care (PCC) may be attributed to health professionals' insufficient knowledge about how to involve patients in their care and the variability in patient preferences. However, patients are more likely to trust their ability to make decisions regarding treatment and care when they are thoroughly informed [16,17].

Researchers in their field have observed that the Compassionate, Respectful, and Caring (CRC) health workforce—a multi-pronged approach—requires mechanisms to continually remind health professionals of the values and aspirations that led them into the healthcare industry [18]. Unfortunately, this commitment is becoming compromised, as there is a lack of effective service provider-patient interaction and insufficient direct involvement of patients' families in treatment care plans. Moreover, studies on decentralization in Ethiopia often overlook the potential effects of decentralized reforms on patient-centered service delivery models [19].

To date, there are no documented studies exploring health professionals' experiences with patient-centered care in a study setting. These gaps have prompted the researchers to investigate health professionals' experiences with PCC, aiming to provide recommendations for better implementation of PCC in this context.

1.2 Research questions

What experiences do health professionals have about patient-centered care?

2 Methods and Materials

2.1 Study Setting and Period

The study was conducted in the Gedeo Zone, specifically at Dilla University General Hospital and Yirga Cheffe Primary Hospital. This study setting is located approximately 425 km south of the capital, Addis Ababa. The total number of health professionals in the study area is estimated to be around 850. The research was carried out from August to September 30, 2021.

2.2 Study Approach

Health institution-based Glasser's (1992) grounded theory approach was employed.

2.3 Study Population

To elucidate the lived experiences of health professionals directly involved in the health service delivery process, participants were invited to take part in the study. A six-month period was chosen to ensure that eligible participants had sufficient experience without being too short-term in their healthcare roles. Recruitment was based on the participants' expertise related to the concept under inquiry. Paramedical professionals, environmental health professionals, and non-health professionals were excluded from the study.

2.4 Sample Size Determination and Sampling Procedure

The sample size was determined based on data saturation regarding experiences of patient-centered care, and a purposive sampling technique was employed to identify study participants.

2.5 Data Collection Tool and Procedures

A semi-structured questionnaire was designed in English based on a modified two-step theoretical framework model. It included demographic characteristics of the study participants, open-ended questions, and follow-up questions. The questionnaire was then translated back into Amharic.

To collect data from multiple sources, individual face-to-face in-depth interviews were conducted, with audio recordings and field notes taken to capture participants' opinions and viewpoints. A pre-test was conducted with five health professionals at Kabado Primary Hospital, near the study site. During the pre-test, the questionnaire was evaluated for clarity, readability, comprehensiveness, accuracy, and the optimal time required for completing the in-depth interviews. Modifications and amendments to the questionnaire were made based on insights gained from the pre-test.

2.6 Definition of Terms

Health Service Delivery: is the provision of healthcare services to meet health needs of patients in order to improve client satisfaction through strengthening relationships between clients and health service providers [20].

Medical Model Service Delivery: is service delivery model focused on illness and episodic curative services with limited autonomy of patient preference and needs [20].

Health Service Facility: is the point of healthcare service provision in a hospital setting [21].

Patient-Centered Service Delivery Model: is respecting patients' preferences, needs and values to enable multidisciplinary healthcare team to give due attention to patient's concern [22].

Grounded Theory: is a qualitative research approach in which the researchers derive a general abstract theory of a process, action or interaction grounded from the participants viewpoints [23].

2.7 Trustworthiness of the Study

The term "**trustworthiness**" refers to the validity and reliability of qualitative studies [24,25]. It encompasses the rigor of the data and the extent to which the researcher can convey to readers that the study is worthy of their attention [26,27]. In this study, the four criteria for maintaining trustworthiness proposed by Guba, as outlined by Shenton, are employed: conformability, credibility, dependability, and transferability [28].

Confirmability refers to the extent to which the data collected from participants are analyzed objectively. If another researcher were to examine the same data, they would arrive at similar results [26,27]. The data analysis presented in this study reflects a neutral interpretation of the information obtained from participants rather than the researchers' viewpoints. Confirmability was ensured through audio recording and verbatim transcription of the interview sections, thereby establishing the confirmability of this study.

Credibility refers to the accuracy with which the information provided by participants is interpreted [27,29]. This study achieved credibility through individual in-depth interviews, which were not only used to gather information but also to authenticate the data collected. Each interview lasted between 30 to 60 minutes and was audio-taped and recorded.

Dependability pertains to the stability and consistency of the information obtained, as well as the extent to which it remains reliable over time and under varying conditions. To ensure dependability, a comprehensive description of the study setting, data collection techniques, and data analysis methods was provided.

Transferability is the ability of the findings to be applied to similar situations and yield comparable results [24,30]. In this study, transferability was ensured by providing detailed descriptions of the data, study setting, and the socio-demographic characteristics of the participants. This information allows readers to evaluate the applicability of the findings to other contexts.

2.8 Data Processing and Analysis

Filled questionnaires were checked for completeness and consistency, and demographic data were entered into SPSS version 25 for analysis. Qualitative data were categorized and organized into themes and sub-themes that emerged through initial coding, process coding, focused coding, axial coding, and theoretical coding. The transcripts were imported into Atlas.ti (v.7) for further analysis. Regular debriefing sessions were held among the investigators to ensure the accuracy of data coding, analysis, and interpretation.

3 Result

3.1 Demographic Characteristics of the Study Participants

Data were collected from 21 health professionals, achieving a 100% response rate. The average age of the participants was 27.85 years, with the youngest being 25 and the oldest 43. Nearly 52% of the respondents were recruited from Dilla University General Hospital. The majority of respondents (13, or 62%) were female health professionals, and 16 (76%) held a bachelor's degree. The average work experience among the participants in various health service organizations was 6.3 years, ranging from a minimum of 1 year to a maximum of 18 years; however, only 62% (n=13) of the health professionals had less than 5 years of work experience (Table 1).

 DOI:10.20372/ajhsm.v04i01.01 (December 2024)

Table 1 Demographic Characteristics of Participants, Dilla University General Hospital and Yirgacheffe Primary Hospital, South Ethiopia, 2021 (n= 21)

Variables		Frequency	Percentage
Average age		27.85	
Health Facility	Dilla University General Hospital	11	52%
	Yirgcheffe Primary Hospital	10	48%
Gender	Male	8	38%
	Female	13	62%
Level of education	BSc degree	16	76%
	Master's degree	3	14%
	Specialty certificate	2	10%
Professional qualification	Senior physician	5	24%
	General practitioner	7	33%
	Professional nurse	9	43%
Work experience in a year	<5 years	13	62%
	6-10 years	3	14%
	>11 years	5	24%
		n=21	

The following four major themes and twelve sub-themes emerged during data transcription, with direct quotes from study participants providing a rich description of the findings. To maintain confidentiality, participants' ages in years and professional qualifications were used to describe their viewpoints.

Table 2 Major Themes and Sub-Themes

S.N.	Major Themes	Sub-Themes
1.	Failure to respect patient's preference	Information asymmetry
		Physician induced demand
2.	Lack of involvement of patients' family	Patient privacy
		Patient's age
		Patient's medical conditions
3.	Poor service provider-patent interaction	Belief on treatment
		Treatment adherence
		Patient empowerment
4.	Challenges to implement PCC	Work load
		Shortage of medical supplies
		Lack of support from SMT
		Lack of awareness of service providers about PCC

3.2 Patient-centered care

During the data analysis, "patient-centered care" represented how health service providers in the study setting aimed to place patients at the center of their care and deliver quality health services.

3.3 Failure to respect patient's preference

The theme "Aiming to Respect Patients' Preferences" reflects how health professionals in the study setting recognize the low literacy levels of patients, which is linked to the tendency of health professionals to overlook patients' preferences for services, thereby creating additional demand. Within this theme, two subthemes emerged: "Information Asymmetry" and "Physician-Induced Demand".

Information asymmetry

Participants clearly indicated that patient perceptions of health services exist in a healthcare market similar to other consumer goods. The agency relationship is influenced by information asymmetry between physicians and patients, with physicians typically possessing more knowledge about diagnostic and treatment options. Consequently, patients may seek their physician's personal opinions to help them make healthcare decisions. This can lead to the ordering of diagnostic tests or treatments that may not be necessary and might offer minimal benefits to the patients.

One participant noted: "*Low health literacy among patients and a strong doctor-patient relationship can occur in private health facilities, where doctors recommend or encourage patients to use specific health services required for their medical problems*" (A 40-year-old physician).

Physicians induced demand

The doctor-patient relationship is essential to healthcare practice and is central to delivering quality and efficient health services. In the healthcare industry, physicians act as principal agents on behalf of their patients, guiding them to make the best possible treatment decisions. However, physicians' behaviors may be influenced by their desired income levels, and the health system in the private sector often encourages the overutilization of health services to boost revenue in the private healthcare market. Physicians may leverage their knowledge to influence patients, leading to increased utilization of diagnostic tests, imaging services, or screening procedures.

One physician stated: "*As a physician, I have to convince patients and determine the most efficient treatment for their needs, rather than prioritizing patients' voices and needs. In a private setting, physicians may offer more services than optimal for the patient in order to increase the revenue of the private health service organization*" (A 29-year-old physician).

3.4 Lack of involvement of patients' family

Patient-centered care is essential for promoting family engagement in hospital settings when making decisions about treatment plans. However, nurses have varying perceptions of the extent to which family members should be involved in healthcare. Service providers should foster a positive attitude toward patients' families to create a culture of inclusion that supports quality healthcare delivery, family cohesion, and patient safety. Within this theme, three sub-themes emerged: "Patient Privacy", "Patient Age", and "Patient Medical Condition".

Patient privacy

Maintaining patient privacy is of utmost importance during healthcare provision. A well-documented imbalance of decision-making power between service providers and patients' families poses a barrier to engaging family and friends in the treatment process. Furthermore, the apparent transfer of power to the family can impact patient privacy.

One physician noted, "*As a healthcare provider in the obstetrics and gynecology department, I am not comfortable allowing family members and friends to be involved in patients' care processes in the obstetrics unit because I believe it compromises patients' privacy*" (A 43-year-old physician).

Patient's age

In a hospital inpatient unit, involving family members as partners in the care of older patients is critical for improving health outcomes, both

in the hospital and at home following discharge. Although the decision-making power for children under 18 years and unconscious patients is typically held by their parents or legal guardians, study participants noted that these guardians play a crucial role in advocating for clinical decisions and arranging for informed verbal and signed consent.

One nurse stated, "*When the health condition of an older patient is relatively improving, it is better for them to be discharged from the hospital, with care and support provided at home*" (A 28-year-old nurse).

Another argument in favor of involving family members is their important role in patient care, contributing to clinical decision-making and assisting health professionals in providing care. This involvement is facilitated through a genuine commitment to value-based, patient-centered care.

One nurse remarked, "*Patient decision-making is important, but I think the involvement of the patient's family is not essential unless the patient is unable to help themselves, is mentally incapable, or is legally not an adult to make decisions regarding their treatment plan*" (A 32-year-old nurse).

Patient's medical conditions

This sub-theme reflects participants' perceptions of the patient-family relationship and the development of communication patterns prior to the diagnosis of medical conditions. Participants described how family engagement could enhance patients' clinical conditions and motivation to continue with their care, particularly in cases of co-morbidity.

One nurse noted, "*Among the healthcare services provided to patients admitted to the ward, nurses were most likely to seek help from family members or patient attendants for simple daily tasks, such as feeding the patient, maintaining hand hygiene, and providing nail care. However, nurses were less likely to request support from relatives for activities specifically related to skilled nursing roles*" (A 26-year-old nurse).

Study participants expressed concerns about the feelings and worries of elderly patients when their attendants and family members were not allowed to enter specific treatment rooms or stay for extended periods.

3.5 Poor service provider-patent interaction

The skill of service provider-patient interaction is empirically linked to patients' beliefs in modern medicine and their adherence to treatment. Effective communication skills among service providers are a crucial aspect of clinical competence. Three sub-themes were identified concerning poor service provider-patient interaction skills, which hinder and negatively impact patients' health outcomes: "Beliefs on Treatment", "Treatment Adherence", and "Patient Empowerment".

Beliefs on Treatment

Study participants noted that patients who trust their healthcare providers tend to report stronger bonds, greater openness, and shared decision-making power, which fosters respect for the treatments offered. This sub-theme highlights that poor interpersonal relationships between patients and service providers may stem from nurses' attitudes towards patients, influenced by various factors, leading to disappointment when patients do not trust their healthcare providers.

One nurse remarked, "*Sometimes patients perceive a gap in communication skills among service providers, often coupled with language barriers, resulting in misunderstandings. This can lead to a transient poor relationship*" (A 25-year-old nurse).

Conversely, patients also criticized health service providers' attitudes, expressing feelings of disrespect. Some health professionals were reported to insult or embarrass patients during treatment and care. Such incidents tend to spread quickly, deterring patients from seeking treatment at public health facilities. Additionally, patients complained that service providers often disregarded their wishes for relatives to accompany them during hospital visits.

Treatment adherence

Effective service provider-patient interaction positively influences health outcomes by increasing patient satisfaction, leading to a better understanding of health problems and available treatment options, which, in turn, contributes to improved adherence to prescribed treatments. When patients fail to take their prescribed medication as intended, it is often due to poor communication between patients and service providers. A strong patient-doctor relationship and active involvement of patients in the decision-making process are closely linked to medication adherence.

Patient empowerment

Patient empowerment is crucial for shared decision-making with service providers. Feeling involved in their treatment care plans and having a sense of responsibility for their health provides patients with a greater sense of security and control over their future. Patients can learn to address their health problems by utilizing the information and support provided by health professionals. Empowerment begins with the recognition by service providers that patients are capable of managing their own healthcare, which aims to enhance their capacity to think critically, become autonomous, and make well-informed decisions about their health.

Study participants noted that systems for providing information and education in healthcare facilities are in place, but the extent, regularity, and utilization of this information by individual patients are not common practices. They believe that the provision of health information is often non-specific, with most patients typically receiving health information only in the form of counseling during treatment for specific medical conditions.

One physician stated, "*Most of the study participants agreed that providing health information and education to patients is considered a central activity in healthcare facilities to empower them regarding their own health and treatment options*" (A 31-year-old physician).

Another participant pointed out, "*Some patients are not interested in participating actively in their own care due to a lack of understanding. Therefore, most nursing care in a hospital setting should shift from a paternalistic approach to one where patients are considered partners requiring health education*" (A 25-year-old nurse).

3.6 Challenges to implement PCC

This major theme reflects interview participants' experiences regarding the challenges in implementing patient-centered care (PCC) in the study setting, which they identified as a bottleneck to providing quality health services. The majority of participants highlighted four subthemes related to factors that deter the implementation of PCC: "Workload", "Shortage of Medical Supplies", "Lack of Support from Senior Management", and "Lack of Awareness among Health Professionals about PCC".

Workload

This sub-theme pertains to participants' experiences with staffing adequacy and the implementation of patient-centered care. Interviewees identified case-load as a significant barrier to implementing PCC.

Participants described how the availability of staff, the ratio of nurses to patients, and overall workload influenced the implementation of PCC in the hospital. Factors related to staffing, such as having adequate personnel and an optimal nurse-patient ratio, were noted as prerequisites for successfully implementing patient-centered care. Additionally, these factors affect the flexibility of hospital routines, particularly in light of high nurse turnover during off-duty periods.

One respondent from Yirga Cheffe Primary Hospital stated, "*Despite the high patient flow and fast-paced work routines, there is not enough time to implement PCC, making it an uncommon practice. This issue is exacerbated by the limited availability of professional nurses who face high workloads during their shifts*" (A 31-year-old nurse).

Another nurse remarked, "*To treat patients holis-*

tically, patient-centered care consumes time for me" (A 27-year-old nurse).

Shortage of medical supplies

Study participants primarily linked the implementation of patient-centered care (PCC) to the availability of various resources. Shortages of drugs and medical supplies, often attributed to a lack of financial resources, were frequently reported by participants from Yirga Cheffe Primary Hospital.

One participant noted that the shortage of essential medical supplies further compromises the already limited availability of resources, creating an opportunity for patients to seek care in private health facilities. This was identified as one of the most significant resource-related factors hindering the implementation of PCC in hospital settings.

"*The system for delivering medical supplies in the hospital is very slow, from the time of request to procurement and delivery*" (A 27-year-old physician).

Lack of Support from Senior Management

Senior hospital management and leaders who are not directly involved in patient care must feel committed to creating an enabling work environment for health professionals to implement PCC.

"*Hospital clinical directors should offer opportunities for continuous in-service training to enhance the PCC skills of health professionals, thereby stimulating and sustaining improved healthcare services*" (A 35-year-old senior physician).

Additionally, the senior management team should promote and remunerate health professionals based on merit as a means of supporting improved PCC and enhancing health service delivery.

Other participants indicated, "*Patient-centered care has yet to be fully implemented in the hospital setting; however, support from the senior management team is poorly recognized*" (A 35-year-old senior physician).

Lack of awareness of service providers about PCC

Health professionals in the study setting had little awareness of the transformational concept of patient-centered care. Respondents perceived patient-centered care in various ways. Physicians and nurses commonly viewed it as providing quality care to satisfy patients.

One participant expressed this perspective: "*In this hospital, health professionals have the responsibility to provide quality service to satisfy the patient; this is what patient-centered care means to me*" (A 39-year-old physician).

4 Discussion

main finding of the present study is the lack of understanding regarding the core elements of patient-centered care (PCC), as reflected in the data. However, its implementation in the study setting is still lacking, as the majority of health professionals appear to provide care according to a traditional provider-centered and disease-focused approach. Respondents noted a discrepancy between how health professionals interact with individual patients, indicating that only a few health professionals intended to work within the PCC framework, and even then, to varying degrees.

The implementation of the PCC model in the study setting is notably minimal. Challenges to implementing PCC within healthcare facilities and at the individual patient level are influenced by factors at the systemic level. The analysis suggested that a large proportion of health professionals recognized the importance of this new concept for improving patient health outcomes. However, conflicting data indicated that some health professionals did not support the PCC model at all.

Individual characteristics that affect the implementation of PCC—such as empathy and health professionals' attitudes toward the uniqueness of patients and their preferences—can only be partially influenced by the health facility. In

this context, a lack of adequate nursing staff was highlighted as a significant challenge by study participants from Yirga Cheffe Primary Hospital. Another important challenge for implementing PCC at the individual patient level was the professional expertise of staff. Preliminary analysis of the core elements of PCC from the outer setting indicated that health professionals were primarily focused on episodic, curative aspects, which need to be integrated into current PCC concepts.

According to various studies, this approach to care has resulted in improved healthcare quality in Ethiopia and increased patient/client satisfaction. In this study, key issues raised by participants included failure to respect patients' preferences, lack of involvement of patients' families, poor service provider-patient interactions, and challenges to implementing PCC.

Participants noted that a shortage of time restricts the involvement of patients' families in treatment care plans and clinical decision-making processes, suggesting that poor implementation of PCC may compromise patient health outcomes. This finding is comparable to a study conducted in the United States, which highlighted that clinician attitudes and beliefs contribute to lower rates of family engagement, as the task is perceived as time-consuming and difficult [31]. The similarity may be attributed to consistent clinician attitudes and perceptions toward these concepts.

On the other hand, this finding aligns with a study conducted in London by the International Alliance of Patients' Organizations (IAPO), which emphasizes the importance of involving patients' families in clinical care over time. This approach fosters a partnership between service providers and patients' families, ensuring respect for patients' needs, values, and preferences, reflecting similar concerns among study participants regarding these aspects.

Some study participants noted that when patients are aware of their disease conditions, it significantly influences their sense of being taken seriously and receiving appropriate care. This awareness fosters a sense of personal responsibility for their health and appears to establish a foundation for a continuing relationship with their healthcare providers. This finding is consistent with a study reported by the Health Foundation in 2016 from the UK [32], which revealed that patients who are well-informed and confident in managing their conditions, in partnership with service providers, are more likely to engage in positive health-seeking behaviors, potentially leading to better health outcomes. This suggests that practice should prioritize what is most convenient for the patient.

The majority of health professionals viewed patient-centered care as involving an awareness of the importance of patients' cultures, incorporating values and respect, maintaining optimal communication in all aspects of patient care, and ensuring accountability to patients. This finding resonates with a study conducted in central Ethiopia [33], which found that patients who are familiar with their healthcare providers experience better empathic care. This implies that the perceived intimacy between patients and service providers directly influences PCC encounters [34].

Furthermore, all health professionals agreed that a better understanding of patients' preferences and needs could lead to more effective healthcare, ultimately saving both patient waiting time and resources. Interview participants reported that patients' preferences and needs are better understood and respected in hospital settings. A study conducted in a public hospital in the Benishangul Gumuz regional state highlighted that healthcare provider-related factors, such as poor patient-provider interactions, can negatively affect the implementation of PCC [4]. This finding suggests that PCC is facilitated through mutual understanding and positive interactions between service providers and patients. Disparities in PCC implementation may be linked to variations in communication skills among service providers.

5 Conclusion and Recommendation

Patient-centered care is one of the key dimensions of health service quality in the 21st century and has been a focal point for quality improvement in Ethiopia. This study found that patient care is predominantly being delivered through a traditional provider-centered and disease-focused approach. A critical factor for the successful implementation of patient-centered care appears to be the active involvement of the hospital senior management team and decision-makers, who are positioned to support the implementation process effectively.

To validate our findings and identify systematic differences in the applicability of this practice between public and private health facilities, future researchers should consider conducting quantitative studies.

Limitation

The study findings should be interpreted in light of several limitations. First, interviews were conducted solely with health professionals, meaning that the practice of patient-centered care (PCC) was not assessed from the patients' perspective, and the viewpoints of decision-makers in leadership positions were not explored. As a result, any differences in perspective cannot be identified through this study. Additionally, individuals in leadership roles may not provide insights into management-related and resource-related opinions.

Second, our sample may be subject to selection bias. We assume that participants had a higher intrinsic motivation and interest in the research topic, which may make them more likely to engage in patient care.

Acknowledgments

The clinical director of Dilla University General Hospital and the CEO of Yirgacheffe Primary Hospital deserve special credit for their unwavering support throughout the data collection process. The researchers would also like to thank the health professional study participants for taking time from their busy schedules to contribute to the study.

Ethics Approval and Consent to Participate
Ethical clearance was obtained from the Institutional Review Board (IRB) of the Colleges of Health Sciences and Medicine at Dilla University (protocol unique number: 001/17-11). Official letters were submitted to both Dilla University General Hospital and Yirgacheffe Primary Hospital, and permission was granted by the clinical director and CEO of the study settings. Written informed consent was obtained from all study participants.

Participation in the study was voluntary, and those who were unwilling to participate or wished to withdraw at any stage were informed that they could do so without any restrictions. Confidentiality and anonymity were maintained at all levels of the study, and collected data were stored on a password-protected computer accessible only to the research team. Instead of capturing participants' names on the questionnaires, code numbers were assigned to ensure anonymity.

All research methods were conducted in accordance with the ethical standards outlined in the 1964 Declaration of Helsinki and its later amendments.

Provenance and Peer Review: Not commissioned; externally peer reviewed.

Consent for Publication: Not required

Availability of Data and Materials
All data included in this manuscript can be accessed from the corresponding author upon request.

Conflict of Interests: None declared.

Funding
This work was supported by Dillla University Research, Publication, Ethics and Dissemination Office.

Authors' Contributions
(GNY) conceptualized and designed the study, collected, analyzed, and interpreted the data, and drafted the manuscript. (NES) and (JTH) also contributed to the study design, analyzed and interpreted the data, drafted the manuscript, and provided guidance throughout the research process. All authors read and approved the final manuscript.

Authors' Information

GNY: PhD in Public Health. Email: freegetch01@gmail.com. Assistant Professor at Dilla University, School of Public Health:
NES: PhD in Water & Public Health. Email: yeroosaa@gmail.com. Assistant Professor at Dilla University, School of Public Health:
JTH: MD, Email: jarssohirbu@gmail.com. Assistant Professor of Internal Medicine at Dilla University, School of Medicine:

References

1. Ahmed S, Djurkovic A, Manalili K, Sahota B & Santana MJ, 2019: *A qualitative study on mea-*

suring patient-centered care: Perspectives from clinician-scientists and quality improvement experts.

2. Belachew B. 2017: Factors influencing patients' service delivery in public hospitals: A case of Ras Desta memorial general hospital. Addis Ababa, Ethiopa.
3. World Bank, 2018: *Delivering quality health services: a global imperative for Universal Health Coverage. Geneva: World Health Organization, Organization for Economic Co-operation and Development.*
4. Bogale *et al.*, 2017: *Scope of Patient Centered Care Practice in Public Hospitals of Benishangul Gumuze Regional State.* South West Ethiopia.
5. Little P, Everitt H & Williamson I, 2001: Observational study of effect of patient centerdness and positive approach on outcomes of general practice consultations. *BMJ.* Vol. 323.
6. Rathert C, Wyrwich MD & Boren SA, 2013: Patient-centered care and outcomes: A systematic review of literature. *Med Care Res Rev.*Vol. 70.
7. Matthews EB, Stanhope V & Choy-Brown M, 2018: *Do providers know what the do not know? A correlational study of knowledge aacquisition and patient-centered care.* Vol. 54.
8. Timothy *et al.*, 2014: Balancing Demand, Quality and Efficiency in Nigerian Health Care Delivery System. *European Journal of Business and Management.* Nigeria.
9. cMillan SS, Kendall E & Sav A, 2013: *Patient-centered approaches to health care: A systematic review of randomized controlled trials.* Vol. 70.
10. Beckman HB, Markakis KM, Suchman AL & Frankel RM, 1994: *The doctor-patient relationship and malpractice: lessons from plaintiff depositions.* Vol. 154.
11. Coulter A & Dunn N, 2002: *Putting patients at the centre.Cpmentart,Patient centred care: timely, but is it practical*? Vol. 324.
12. Stewart M, Brown JB & Donner A, 2000: The impact of patient-centered care outcomes. Vol. 49.
13. Stone S, 2008: *A retrospective evaluation of the impact of the Planetree patient-centered model of care on inpatient quality outcomes.* Vol. 1.
14. Henderson S, 2003: *Power imbalance between nurses and patients: a potential inhibitor of partnership in care.* Vol. 12.
15. Say R, Murtagh M & Thomson R, 2006: *Patients' preference for involvement in medical decision making: a narrative review.* Vol. 60.
16. FMOH, 2015: *Health Sector Transformation Plan (HSTP) 2015/16-2019/20.* Addis Ababa, Ethiopia.
17. Kassa A & Shael Y, 2013: Integrating all stakeholders: Health service governance in Addis Ababa, Ethiopia.
18. FMOH, 2017: *Leadership, Management and Governance In-Service Training Manual for Health Managers at Hospitals & Health Centers.* Addis Ababa, Ethiopia:
19. National Health Policy, 2017: *Community Development, Gender, Elderly and Children.* The United Republic of Nigeria.
20. WHO, 2018: *Delivering quality health services: a global imperative for Universal Health Coverage.* Geneva.
21. Creswell JW, 2014: *Research Design. Qualitative. Quantitative and Mixed Methods Approaches. 4th* Edition. Los Angeles: SAGE.
22. Leung: Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine Primary Care.* 2015: 4(3):324–7.
23. Noble H & Smith J: Issues of validity and reliability in qualitative research. Evidence-Based Nursing. 2015: 18(2):34– 5.
24. 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.
25. Polit DF & Beck CT: Nursing Research: Principles and Methods. 7th ed. New York: Lippincott Williams & Wilkins. 2004.
26. Fawcett J & Garity J: Evaluating Research for Evidence-Based Nursing Practice. Philadelphia: F.A. Davis Company. 2008.
27. Korstjens I & Moser A: Series: practical guidance to qualitative research. Part 4: trustworthiness and publishing. *European Journal of General Practice.* 2018; 24(1):120.
28. Shenton AK: Strategies for ensuring trustworthiness in qualitative research projects. Education for Information. 2004; 22(2):63–75.
29. Jeroen de *et al.*, 2016: *Patient-Centered Care and People-Centered Health Systems.* Sub Saharan Africa.
30. Sinaiko *et al.*, 2019: *Delivery of patient-centered care in US healthcare system. What is standing in its way*?
31. Terrell SR, 2016: Writing a proposal for your dissertation. Guidelines and Examples. A division of Guilford publications Inc. New York. USA.
32. International Alliance of Patients' Organization (IAPO), 2017: *What is patient-centered Healthcare*? A review of definition and principles. United Kingdom.
33. Frehiwot B, Kiddus Y, Animut A, Dereje A & Nigusie S: Patient-Centered Care and Associated Factors at Public and Private Hospitals of Addis Ababa. *Patients' Perspective.* 2021; 12 107–116.
34. Alharbi T, Carlström E, Ekman I & Olsson L-E: Implementation of person-centered care: management perspective. *J. Hosp. Adm.*. 2014, 3(3):107–120.