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Views on patient-centred care for hospital patients in Peru: A Q methodology study

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ABSTRACT

Background: Patient-centred care (PCC) is considered a core framework for improving quality of care. Evidence on which PCC aspects are most relevant remains limited in Latin America, where health system fragmentation, inequalities, and constraints in access to services may shape priorities.

Objective: To identify and describe viewpoints among patients and healthcare professionals in Peru on the most important aspects of PCC.

Methods: Q methodology was used to examine viewpoints on PCC among patients and healthcare professionals in Lima, Peru. Participants ranked 30 statements reflecting the eight dimensions of PCC of the Picker Institute framework and available studies on PCC in low- and middle-income countries, and explained their ranking. Factor analysis was used to identify distinct viewpoints, which were interpreted based on composite rankings and qualitative data from the interviews.

Results: Four viewpoints on PCC were identified. Across viewpoints, dignity and respectful treatment were consistently prioritised. Three viewpoints emphasised organisational and professional dimensions of care, particularly access to essential medication and equipment, timely responses to pain and treatment-related complications, and coordination and continuity of care. A fourth viewpoint prioritised relational dimensions, placing particular importance on emotional support and family involvement.

Conclusion: Strengthening PCC in Peru may require attention to both relational and organisational dimensions of care. Dignity and respectful treatment emerged as shared foundational priorities, while access to essential medication and equipment and improved coordination and continuity across services were central to several viewpoints. These results differ from studies in Western countries and underline the importance of context-sensitive strategies for PCC.

1. Introduction

Patient-centred care (PCC) has been considered as a core framework leading to higher quality healthcare, and it is integral to how patients are treated, and medical care is practiced (Håkansson Eklund et al., 2019). PCC is typically defined through a focus on understanding the patient as a person, the patient–healthcare professional relationship, and the coordination of care across the healthcare system, among other aspects (Langberg et al., 2019). This approach has demonstrated benefits in managing chronic diseases, acute conditions, and mental health disorders by improving patient engagement, adherence to treatment, and overall health outcomes (Elkefi & Asan, 2023; Mead & Bower, 2000; OECD, 2023). Similarly, previous studies have acknowledged that PCC can contribute to an improved quality of life and wellbeing of patients and has been associated with improved patient outcomes in several

healthcare settings (Rathert et al., 2013).

The dimensions of PCC and their relevance have been widely described. For instance, the Picker Institute framework outlines eight dimensions of PCC: respect for patients' preferences, physical comfort, coordination and integration of care, emotional support, access to care, continuity and transition, the provision of information and education, and the involvement of family and friends (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993; Gerteis, Edgman-Levitan, Walker, et al., 1993). These dimensions have been used widely to conceptualize and evaluate PCC within different healthcare settings but have primarily been investigated in developed countries (Janerka et al., 2023) and for certain health conditions (Cramm et al., 2015; Crompvoets et al., 2022).

Despite increasing interest in improving healthcare quality, explicit research on PCC remains comparatively limited in Latin America (LA). Recent studies show that in the region, elements consistent with PCC,

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such as access, communication, continuity of care, and patient experience are generally addressed but are rarely conceptualised or evaluated within established PCC frameworks (Klimesch et al., 2023). Instead, research has largely focused on expanding healthcare coverage and addressing structural health system challenges, reflecting longstanding regional priorities in health system strengthening (Guanais et al., 2018). Consequently, there is limited evidence regarding how patients and healthcare professionals prioritise different dimensions of PCC within Latin American health systems.

In LA, where accessibility to health care and social inequalities in health and access to healthcare remain important challenges (De la Mata, 2024), relatively little research has explicitly examined these issues through a PCC perspective (Klimesch et al., 2023). Although access to and the quality of health care services vary across LA, recent research has demonstrated that PCC, while unevenly implemented, can lead to better health outcomes, with evidence showing that not all PCC aspects contribute equally to better quality of care and that the most influential domains vary between countries and populations (Guanais et al., 2018). Particularly, studies in the LA region often address aspects such as accessibility, patient preferences, emotional support, or coordination of care without explicitly framing these elements as PCC. This suggests that the relative importance of different PCC dimensions may vary across contexts, populations, and health system conditions, highlighting the need for context-specific evidence.

Within established PCC frameworks, access to care, for instance, is recognized as one of its core dimensions, such as in the Picker Institute model adopted in this study. Still, previous studies suggest that a clear operationalization of PCC in the LA context is needed (Bravo et al., 2017). For instance, legislative efforts on PCC are limited and PCC usually is not mentioned explicitly in Clinical Practice Guidelines (Aguirre Sánchez et al., 2018; World Bank, 2024). Likewise, initiatives to adopt patient-centred approaches or to generate evidence about which PCC dimensions are most important in specific local health systems contexts remain limited (Alarcón-Yaquette et al., 2022). This highlights the need for more in depth research on what patients and healthcare professionals find relevant in the context of PCC in LA (Leslie et al., 2022).

In this regard, Peru represents a relevant setting for a study on PCC from both country-specific and regional lenses. The Peruvian health system is characterised by a fragmented organisational structure, with multiple subsystems operating under different governance, financing, and delivery arrangements, which has posed ongoing challenges for service coordination and quality of care (World Bank, 2023, 2024). Moreover, it has been marked by significant reform dynamics, deep remaining inequalities, and a population with diverse cultural and geographic contexts, characteristics that are also present across many other LA health systems (Bancalari et al., 2023; OECD, 2025).

This study therefore addresses two important gaps in the literature. First, it provides one of the first empirical explorations of how patients and healthcare professionals prioritise different dimensions of PCC in Peru, where explicit PCC research remains scarce. Second, rather than assuming that internationally developed PCC frameworks reflect local priorities, this study uses Q methodology to identify distinct viewpoints on what constitutes PCC. By revealing both shared priorities and preference heterogeneity, these findings contribute evidence to support the development, measurement, and implementation of PCC in Peru and may also inform future research in other Latin American health systems facing similar structural challenges.

Understanding how patients and healthcare workers prioritise different dimensions of PCC can support context-sensitive improvements in the quality of care by identifying priorities in care delivery and highlighting areas where services could be better aligned with local needs and expectations. Hence, this study aims to examine what Peruvian patients and health care workers consider the most important aspects of PCC. The learnings from this study in Peru can provide building blocks for health scholars who seek to further explore the merits of PCC

in developing countries in general, and LA countries in particular.

2. Methods

We used Q methodology to identify views of patients and healthcare professionals on PCC because it is well suited to explore and describe subjective perceptions of complex and value-laden topics in a systematic manner (Watts & Stenner, 2012) and has been used for this purpose before (Berghout et al., 2015; Cramm et al., 2015; Cromptvoets et al., 2022; Galekop et al., 2019; Kuipers et al., 2020). Q methodology combines quantitative and qualitative techniques to study subjective opinions, focusing on identifying the main viewpoints held on a topic within a population, and consensus and disagreement between them (Baker et al., 2006).

In a Q study, participants are asked to rank a set of opinion statements according to an instruction (e.g., level of agreement or importance) and to motivate their ranking, thus revealing their individual view on the topic. The collected ranking data is analysed using by-person factor analysis to identify groups of participants with similar ranking patterns. These factors are then interpreted as distinct viewpoints on the topic of study based on weighted average rankings of the statements per factor and the qualitative data of participants associated with each factor (Watts & Stenner, 2012). We followed the checklist for reporting Q studies by Dieteren et al. (2023), which covers four phases: study design, data collection, data analysis, and presentation of the findings.

2.1. Study design

2.1.1. Development of a statement set

To capture the views on a specific topic, a Q study should include statements that comprehensively reflect the subject of interest (Cross, 2005; Watts & Stenner, 2012). As in previous Q and other studies on patient-centred care (Cramm et al., 2015; Cromptvoets et al., 2022; Havana et al., 2023), the eight dimensions of PCC developed by the Picker Institute served as the primary conceptual framework for this study. In addition, we considered studies using PCC to address inequities in healthcare quality (Filler et al., 2020) as well as those conducted in LA settings (Klimesch et al., 2023) and other low- and middle-income countries (Doubova et al., 2016, 2021; Doubova & Pérez-Cuevas, 2021). Based on these sources, an initial set of 44 statements was drafted by two of the authors (KTJ, JE) (see Table S1 in Supplementary Material). This initial set was reviewed by the other authors and a first round of discussions within the research team resulted in a draft set of 42 statements.

Next, pilot interviews were conducted with six patients and two healthcare professionals (one oncologist and one endocrinologist) to assess the comprehensiveness and clarity of the statement set and the feasibility of the exercise for the target population of participants. This confirmed that the statements were relevant and comprehensive to capture participants' views on PCC and that the statements and other study materials generally were clear, but some were identified as ambiguous or not suitable to the Peruvian context. Based on this feedback, the research team revised several statements to improve clarity or contextual relevance, removed 12 statements to avoid redundancy and reduce participant fatigue (see details on this process in Table S2 in Supplementary Material), and achieved consensus on a final set of 30 statements (see Table S3 in Supplementary Material). In addition, minor adjustments were made to the instructions to provide clearer guidance to participants for completing the exercise.

2.1.2. Participants

We used convenience sampling to recruit patients aged 18 years and older receiving hospital care for their diabetes or cancer. These two groups of patients were selected to capture a broad range of perspectives on PCC shaped by the different challenges of managing complex chronic

and acute conditions. Cancer patients often undergo intensive, frequent treatments, while diabetes patients focus on long-term management. Together, these patients provide a rich context for exploring how care can be personalised and improved to meet varying patient needs and preferences. Healthcare professionals were included as participants to complement the patients' perspectives from their broad experience with these patient groups.

Patients were recruited through two patient associations, representing the two disease groups included in the study (diabetes and cancer), while healthcare professionals were recruited from three hospitals in Lima. A total of 35 respondents were included: 27 patients, one mother and long-time informal caregiver of a patient with diabetes, with extensive knowledge of the disease and experience with care, one representative of a patient association for cancer patients, with many years of experience in supporting and accompanying patients affected by this condition, and 6 healthcare professionals (two endocrinologists, two oncologists and two nurses in diabetes and cancer care).

During data collection, the caregiver, who also had diabetes and cared for an adult patient, attended in place of the recruited patient, and a representative of one of the patient associations also participated. These participants were not initially targeted in the recruitment process, but their Q-sorts were retained as they provided additional perspectives relevant to the study aim.

This is a common sample size for Q studies (Dieteren et al., 2023). Participant characteristics are provided in Table S4 in Supplementary Material.

2.2. Data collection

Data collection took place in September 2025 in Lima, Peru. The Research Ethics Review Committee of the Erasmus School of Health Policy & Management approved the study protocol (case number

ETH2425-0856). Participation was voluntary, and participants were free to withdraw at any time. Informed consent was obtained from all participants. They received a financial compensation of 40 Peruvian soles (approx. 10€) to acknowledge their time and contribution to the research.

Patients were invited to participate in one of five in-person walk-in sessions, scheduling small groups of four to six patients per session. Upon arrival, each participant was introduced to the study and guided through the ranking process individually by one of the three researchers present during the sessions.

Participants were asked to read the set of 30 statements related to PCC, which were presented in random order, and to categorize them as ‘important’, ‘neutral (don’t know)’ or ‘unimportant’ for patient-centred care. Then, they were asked to rank the statements from each category using a grid ranging from 1 (least important) to 9 (most important) (see Fig. 1) according to the question “How important do you consider these aspects for patient-centred care?”. The grid was designed with a relatively flat distribution to accommodate the number of statements and to allow sufficient flexibility in expressing perceived importance.

After completing the ranking exercise, each participant was interviewed by the researcher who introduced them to the study, guided by an interview protocol. These interviews aimed to explore the reasoning behind their ranking of the statements and to elicit broader reflections on the topic. The interaction was audio recorded (with permission of participants) and notes were taken during the interviews by the researchers. The ranking task and interview together lasted between 40 min and 1 h.

The interview with the six healthcare workers took place in three hospitals. The approach to the interviews was similar to those conducted with patients. The interviews after the ranking differed in terms of length and type of questions due to their role as healthcare provider and time constraints inherent in hospital settings. These interviews lasted

¿Qué considera importante para el cuidado centrado en el paciente?

MENOS IMPORTANTE										MÁS IMPORTANTE	
1	2	3	4	5	6	7	8	9			

Fig. 1. Sorting grid.

approximately 30 min in total.

2.3. Data analysis

The data was analysed using the software package KenQ Analysis Desktop Edition – KADE (Banasick, 2019). By-person factor analysis (i.e., centroid factor analysis followed by varimax rotation) was conducted to identify clusters of respondents whose rankings of the statements were highly correlated. The maximum number of factors that the data supported was 5 factors. We inspected 2, 3, 4 and 5 factor solutions (see correlation matrix in Fig. S1 of the Supplementary Material) and, based on the statistical properties and initial interpretations of the factors, we selected the 4-factor solution, which was more comprehensive in covering the interviews than the 3-factor solution. The 5-factor solution represented a further subdivision of the same four substantively distinct viewpoints into five factors, with some overlaps, resulting in reduced interpretability and therefore a less succinct representation.

3. Results

The four factors explained 47% of the variance in the ranking data, with Factor 1 accounting for 24%, Factor 2 for 7%, Factor 3 for 6%, and Factor 4 for 10% of the explained variance. Factor arrays, representing the weighted average ranking of statements by participants associated with the factor, are shown in Table 1. For instance, the statement “Healthcare professionals treat patients with dignity and respect” received scores of 8, 9, 7, and 9 in Viewpoints 1–4, respectively, showing that all four viewpoints considered this aspect highly important for PCC, despite differing in view on other aspects of PCC. Initial interpretations of the factors as viewpoints on PCC were based on these factor arrays. For each viewpoint, the statements ranked as most important (i.e., factor rank scores 8 and 9) and least important (i.e., scores 1 and 2) and the distinguishing statements (i.e., those ranked statistically significantly higher or lower than in other viewpoints) were inspected. Eight participants were statistically significantly ($p < .05$) associated with Viewpoint 1, seven with Viewpoint 2 and Viewpoints 3, respectively, and six with Viewpoint 4. Participants from multiple categories were represented across the viewpoints; however, subgroup sizes were too small to examine associations between participant category and viewpoint membership. The qualitative data were used to verify and refine our interpretation of the viewpoints. Quotes were extracted and added as examples to clarify the interpretation in the words of respondents. Details on participant composition across the viewpoints, as well as the respective factor loadings, are presented in Tables S5 and S6 in Supplementary Material, respectively.

3.1. Viewpoint 1: accessible, safe and respectful care

This viewpoint is mainly characterised by the importance attached to statements pertaining to the ‘Access to Care’, ‘Patients’ Preferences’, and ‘Physical Comfort’ dimensions of PCC. Central to this perspective on PCC is the understanding that the healthcare system should provide adequate access to services, the necessary conditions for treatment, and care that respects patients’ needs and comforts them. Therefore, first of all, hospitals must have the necessary equipment (st.17:9; i.e., statement 17 had rank score 9 in this factor) and medication (st.18:9). As one participant associated with this factor explained, “The hospital that receives us must be well equipped and have the necessary medicine to offer treatment. Medicine is not cheap outside” (Participant PID PC13). Another noted, “People die every day because they don’t have access to medication. I’ve lost friends due to that reason (PID PC2). A third participant added, “If I’m going to offer a health service, it must have at least what the patient needs, and it should not end with a single consultation. You can’t run a health centre with shortages; that is the foundation for implementing any healthcare service” (PID PC1). These comments underline how health centers’ preparedness and access to timely treatment are viewed as essential for

Table 1

Statement rank scores per factor (with * indicating statistically distinguishing statements at $p < .01$).

Dimensions	Statements	Viewpoint			
		1	2	3	4
Patients' preferences	1 Health care professionals treat patients with dignity and respect.	8	7	9	9*
	2 Healthcare professionals are focused on improving patients' health.	5*	8	7	8
	3 Healthcare professionals involve patients in decisions about their care.	3	2	5*	2
Physical comfort	4 Healthcare professionals support patients with pain management.	8	6	5	8
	5 Healthcare professionals ask patients about their need for support with normal daily activities.	4	4	4	5
	6 Patient areas in the hospital are clean and comfortable.	7	8	2*	5
Coordination of care	7 Healthcare professionals know patients' medical history.	6	5	8*	2*
	8 Patient care is well coordinated between healthcare professionals.	2*	7	7	5*
	9 Healthcare professionals act on complications or adverse effects of treatment.	8*	5	7	4
	10 Patients have a primary contact in the hospital for questions about their condition or treatment.	6*	3	3	3
Emotional support	11 Healthcare professionals work as a team.	3	5	8	6
	12 Healthcare professionals take into account patients' worries about their health	6	4*	6	7
	13 Healthcare professionals involve family in providing emotional support to the patient.	6*	3	3	9*
	14 Healthcare professionals refer patients to services for emotional support.	5	1*	5	6
	15 Healthcare professionals take into account patients' worries about the impact of their health on their family.	1	3	4*	8*
Access to care	16 The hospital is accessible for all patients.	4	8*	5*	4
	17 The hospital has all necessary equipment and supplies for treatments.	9	9	9	4*
	18 The hospital has all necessary medication.	9	9	8	4*
	19 It is easy for patients to make an appointment.	7	7	6	3*
	20 Patients can communicate with healthcare professionals in their own language.	7	6	2*	5
Continuity of care	21 When patients are discharged from hospital, they receive information about care and support at home.	5	4	7	7
Information and education	22 Patients receive information about all aspects of their care.	7	6	6	6
	23 Patients have access to their medical history.	1	6	2	2
	24 Patients decide about the care they receive.	2	5	3	1*

(continued on next page)

Table 1 (continued)

Dimensions	Statements	Viewpoint			
		1	2	3	4
Family	25 Patients and healthcare professionals talk openly about the options for care.	3	1	4	3
	26 Patients can inform the hospital about how they experienced their care.	3	4	1	1
	27 Healthcare professionals are able to communicate clearly with patients.	5	7	6	6
	28 The hospital provides accommodation for patients' family in or near the hospital.	4	2	1*	3
	29 Healthcare professionals involve family in decisions about treatment, when needed.	4	2*	4	7
	30 Healthcare professionals take into account the worries of the family about the health of the patient.	2	3	3	7*

PCC.

Those with this viewpoint also value that healthcare professionals treat patients with dignity and respect (st. 1:8) and are responsive to pain and complications (st. 4:8 and st. 9:8*). Professional competence and humane care, where staff acts promptly, communicates clearly, and safeguards patients' comfort and safety, are seen as essential to PCC. As one participant explained, *"Patients should be treated with dignity and respect, because they are in pain and come seeking help. Sometimes we lose focus and see the disease instead of the person"* (PID END2). Another highlighted the importance of timely clinical action: *"If a patient has an adverse effect and there's no doctor available, those minutes of waiting can lead to a fatal outcome"* (PID PC2). Together, these reflections underscore that PCC involves both clinical responsiveness and treating each patient with dignity and respect by seeing the person, not just the illness.

Less importance is attached to aspects related to access to medical information (st. 23:1), patients' family-related concerns (st. 15:1), family involvement (st. 30:2), and patient autonomy (st. 24:2). Within this viewpoint, these elements seem to be understood as secondary to the professional and institutional responsibilities of care, with PCC framed primarily as a commitment by healthcare professionals and hospitals to provide accessible, safe, and respectful care.

3.2. Viewpoint 2: accessible, comfortable and coordinated care

Similar to Viewpoint 1, this viewpoint emphasises Access to Care, Physical Comfort, and aspects of Patients' Preferences as central to PCC. Essential equipment and medication (st.17:9 and st. 18:9) are considered crucial *"for interventions such as surgeries, it is essential that the hospital has all necessary equipment"* (PID PD2) and *"after an operation, the hospital lacked one of the medications I needed, and since then I've had to keep my own stock, which is very expensive outside the hospital"* (PID PD9). Likewise, treating patients with dignity and respect (st. 1:7) is perceived relevant in this context: *"Nowadays, I observe a lack of respect, dignity, and compassion in hospitals, where patients in pain are left unattended. That is why respectful treatment is important to me"* (PID PD2). PCC begins with the health system's capacity to provide timely and appropriate care.

In contrast to Viewpoint 1, this viewpoint places greater emphasis on broader patients' preferences, access conditions and system-level arrangements that enable patients to reach care, rather than on individualised interactions within the care process. For instance, focusing on improving patients' health (st. 2:8) is acknowledged as crucial for PCC. Similarly, hospital accessibility (st. 16:8* and st. 19:7), is seen as integral to PCC, with one participant highlighting: *"The hospital must be accessible because many people do not have money, and treatments are very costly"*

(PID PD2). Physical comfort also ranks highly, specifically for clean and comfortable patient areas (st. 6:8): *"Hospital areas must be clean and comfortable, especially because people have to wait for many hours to be attended"* (PID PD9). Moreover, the fact of healthcare professionals being able to communicate clearly with patients is recognized as important (st. 27:7), which was remarked by a participant *"Communication is a major barrier. There should be at least one person who is able to speak Quechua or another local language, because otherwise it becomes very difficult for patients to ask questions or understand what is happening. This can directly affect the care and treatment patients receive"* (PID PD9). Together, these aspects indicate that PCC is understood not only in terms of healthcare access, but also through the conditions that enable patients to reach the hospital and receive care that they otherwise cannot afford.

This viewpoint also recognises a role that information and education can play in PCC. For instance, patients having access to their medical history as well as deciding about the care they receive (st. 23:6 and st. 24:5) are considered relevant in comparison to the other viewpoints. A participant noted *"Having access to one's medical history is extremely important to understand how the illness is progressing and what stage it is in. For instance, I only learned that I was in stage 3B after my mastectomy, after months of requesting medical information that was never clearly provided"* (PID PC7). Moreover, within the dimension of coordination of care, one aspect was primarily considered relevant in this viewpoint, and concerns a good coordination among healthcare professionals (st. 8:7). Like in Viewpoint 1, emotional support services (st. 14:1) and family provided emotional support (st. 13:3) are considered less central to PCC. One participant noted, *"some people go through the treatment process alone, and including more people is not necessary"* (PID PC7). In addition, open discussion of care options (st. 25:1) is viewed as secondary to clinical expertise: *"taking the patient's concerns into account is less important because physicians are the ones trained, and many patients do not know how to handle their illness"* (PID PD2).

Overall, this viewpoint frames PCC primarily as accessible, founded on a healthcare system that pays attention to fulfilling basic and necessary components for patients' care coupled with an inclusive treatment that take into account communication barriers and proper coordination among healthcare professionals.

3.3. Viewpoint 3: accessible, respectful and well coordinated care

This viewpoint shares similarities with both Viewpoints 1 and 2, particularly in its emphasis on respectful care, access to essential resources and the professional organisation of care as central components of PCC. As in Viewpoint 1, being treated with dignity and respect ranks among the most important aspects (st. 1:9*), remarking the role of respectful interactions in shaping care experiences. As one participant explained, *"Dignity and respect are fundamental; a good relationship with the patient begins there"* (PID ONC1). Another highlighted that respectful treatment provides a sense of safety: *"From the moment a person arrives, they feel calmer and more secure if they are treated with dignity"* (PID PC10). Moreover, similar to Viewpoints 1 and 2, access to essential resources is also central, with equipment (st. 17:9) and medication (st. 18:8) ranked among the most important features of PCC. As one participant remarked, *"The hospital should have the equipment, supplies and medication to treat the patient. Many patients cannot pay; no one has that amount of money"* (PID PC4). Together, these similarities indicate a shared understanding of PCC as grounded in respectful care and health system preparedness. Likewise, as in Viewpoint 2, participants associate PCC strongly with how healthcare professionals organise and deliver care, rather than with emotional or family-related support.

In contrast to Viewpoint 1, this viewpoint places greater emphasis on the role and coordination by healthcare professionals. Aspects related to professional organisation are highly ranked, including knowing the patient's medical history (st. 7:8*) and working as a team (st. 11:8). One participant stated: *"If there is good organisation, the team will know how to refer the patient; all aspects and interactions must be integrated so patients*

reach the right specialist" (PID ONC1). Moreover, health care professionals acting towards complications and adverse effects is also valued for PCC (st.9:7) within this viewpoint, with participants remarking "I feel this is essential when treating someone, because care must always be adapted to the patient's condition and to how the treatment is affecting them" (PID PD4), "Reacting to patients adverse effects of treatments is critical. For instance I kept vomiting after starting treatment, but it was treated as a psychological issue. Only much later they did realise my body could not tolerate the medication and changed it" (PID PD8). Continuity of care and patients' involvement on their care decisions are also considered more relevant within this viewpoint (st. 21:7 and st. 3:5*), in contrast to Viewpoints 1 and 2, with a participant emphasizing "Although some patients are heard, treatment decisions are often already made. Even when you explain what works better for your body, the doctor tells you they can not change the medication" (PID PC4). This viewpoint positions PCC primarily as effective professional coordination across services, in which healthcare professionals integrate clinical information, respond to treatment-related complications, and ensure continuity of care beyond individual encounters and hospital boundaries.

Aspects related to physical comfort, communication accessibility, and family involvement are considered less important for PCC in this viewpoint. Clean and comfortable patient areas (st. 6:2*), the ability to communicate in one's own language (st. 20:2*), hospital accommodation for families (st. 28:1*) and access to medical history (st.23: 2) are ranked among the least important aspects. As one participant explained, "access to the medical history benefits the doctor more than the patient when making decisions" (PID ONC1). Others felt that providing accommodation lay outside the hospital's primary role, noting that "accommodation for families may generate expenses that could be used for other things" (PID PD4) and that such services would belong to "a more paternalistic system; cases from far away are occasional in this hospital and there are shelters available in others" (PID ONC1). Overall, Viewpoint 3 reflects an understanding of PCC that, while closely aligned with viewpoints 1 and 2 on aspects like accessible and respectful care, is distinct by its stronger focus on professional coordination, continuity of care and patients involvement in their care.

3.4. Viewpoint 4: support patient and family

This viewpoint places particular emphasis on treating patients with dignity and respect and on the provision of emotional support to patients and their family as central components of PCC. Treating patients with dignity and respect is ranked as one of the most important aspects (st. 1:9*), indicating that respectful interpersonal interactions are seen as foundational to care. As one participant stated, "It is meaningful when health professionals explain things, treat you with respect and pays you attention" (PID PC5). In addition, this viewpoint prioritises that healthcare professionals focus on improving patients' health (st. 2:8), support them with pain management (st. 4:8), and pay attention to patients' and families' health-related concerns (st. 12:7; st. 15:8*; st. 30:7*). Within this viewpoint, PCC is understood as care that recognises patients' emotional vulnerability and seeks to provide reassurance and trust. As one participant mentioned, "Every patient arrives carrying the burden of what they face due to the illness, and we must help strengthening their health, so they feel calmer. When patients are listened to in their own words, they feel more confident" (PID NUR1). Another indicated, "The emotional aspect should not be neglected; making patients feel like at home helps them cope with their situation and the stress of illness. They should be treated as human beings who want to move forward, and not in a discouraging way" (PID PD12). This viewpoint, therefore, does not conceptualize PCC as shared decision-making or patient autonomy in care processes. Instead, care is perceived as a process that should be guided by healthcare professionals, with trust placed in their expertise and judgement. This perspective is reflected in the following statement: "A person with diabetes is more vulnerable to certain medications; one might help, but another might cause harm, so the doctor is the one best qualified to

decide and prescribe" (PID PD5).

Another defining feature of this viewpoint is the importance attached to family involvement as a source of emotional support. In contrast to the other viewpoints, family involvement in emotional support is ranked highest here (st. 13:9*), alongside involvement in treatment decisions (st. 29:7). This highlights a relational understanding of PCC in which care extends beyond the individual patient to include family members as an integral part of the care process. In this sense, family involvement and emotional support is much more important in Viewpoint 4 compared to other Viewpoints. This orientation is further reflected in the relatively low importance attributed to patient autonomy and informational participation, including deciding about care (st. 24:1*), informing the hospital about care experiences (st. 26:1), access to medical history (st. 23:2), and open discussion of care options (st. 25:3). Similarly, having a primary contact person (st. 10:3) or being actively involved in decision-making (st. 3:2) was not viewed as central to PCC. This viewpoint also places more importance to consider the need of support of patients with their daily activities and referring them to services of emotional support (st. 5:5, st.14:6) than the other viewpoints. Similar to Viewpoint 2 continuity of care is recognized as important here (st. 21:7), and a participant remarked: "Patients should be given clear information and support for care at home, particularly when they are discharged in a vulnerable condition" (PID NUR1). Likewise, in line with the previous viewpoints, importance is given to clear communication between healthcare professionals and patients (st. 27:6).

PCC in this viewpoint is understood as emotionally attentive, professionally guided care in which patients adopt a more dependent role in decision-making, feel supported, reassured, and protected by doctors and their family.

Although Viewpoints 1–3 share an emphasis on access and respectful care, the distinguishing statements reveal important differences in their relative priorities. Viewpoint 1 assigns comparatively low importance to coordination between healthcare professionals (st. 8:2*), whereas Viewpoint 2 places particularly high importance on hospital accessibility (st. 16:8*) and low importance on referral to emotional support (st. 14:1*). Viewpoint 3, in turn, places greater importance on professional coordination (st. 8:7) than Viewpoint 1, but comparatively lower importance on hospital accessibility (st. 16:5*) and communication in the patient's own language (st. 20:2*). These differences show that the viewpoints share some broad PCC priorities but differ in the relative importance assigned to specific aspects of care.

4. Discussion

In light of the limited empirical research on PCC in Latin America, this study provides an empirical contribution by examining what Peruvian patients and healthcare professionals consider the most important aspects of PCC. Four main viewpoints on elements that are important for PCC were distinguished. Together, these viewpoints illustrate the diversity of opinions of what matters for PCC, while also revealing shared priorities across perspectives.

Viewpoint 1 represented a system oriented interpretation of PCC, centred on access to services, availability of essential resources, and respectful clinical practice. This viewpoint prioritised health system preparedness and professional responsiveness as the foundations of PCC. **Viewpoint 2** conceptualised PCC primarily in terms of access to care, physical comfort, and system-level conditions that enable patients to obtain timely and appropriate treatment. Respectful treatment remains important and PCC is mainly associated with hospital accessibility, availability of equipment and medication, clean and comfortable environments, and clear communication that helps overcome linguistic and financial barriers. Moreover, information provision and coordination among healthcare professionals are seen as relevant as they support effective delivery of care. **Viewpoint 3** framed PCC as accessible and respectful care delivered through strong professional coordination and continuity across services. While sharing the emphasis on dignity and

resource availability found in Viewpoints 1 and 2, this perspective distinguishes itself by prioritising teamwork, knowledge of patients' clinical histories, responsiveness to treatment related complications, and selective patient involvement in care decisions. **Viewpoint 4** represented a relational interpretation of PCC, centred on dignity, emotional support, and family involvement. In contrast to Viewpoints 1–3, this viewpoint placed more weight on professionally guided care that offers emotional support to both patients and families. Continuity of care and clear communication were valued as they contribute to a supportive and protective care relationship.

Dignity and respectful care emerged as central and unifying elements of PCC in all viewpoints of this study. This aligns with previous studies, including palliative care professionals and volunteers in the Netherlands, patients with obesity, and patients with end-stage renal disease, where “*dignity and respect*” similarly appeared as consistently salient elements across viewpoints (Cramm et al., 2015; Crompvoets et al., 2022; Galekop et al., 2019). This pattern mirrors established PCC frameworks that position respect for patients' values and preferences as a core PCC dimension (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993; Gerteis, Edgman-Levitan, Walker, et al., 1993; Mead & Bower, 2000).

Beyond this shared priority, our findings highlight context-specific interpretations of PCC likely shaped by health system conditions. In three of the four viewpoints, access to care and the availability of essential resources, particularly medication and equipment, were central to how PCC was understood. This emphasis contrasts with PCC studies conducted in high-income settings, where such elements are often implicit. Instead, those studies tend to foreground autonomy, shared decision-making, and informational participation as defining features of PCC (Bombard et al., 2018; Siebinga et al., 2022). The prominence of resource availability and health system preparedness in our findings reflects the realities of health system constraints in Peru –and possibly more generally in other countries in LA and the rest of the Global South– where shortages, fragmentation of care provision, and inequality in access continue to shape care expectations. These findings resonate with previous research highlighting how structural constraints and health system limitations shape patients' priorities in low- and middle-income settings (Guanais et al., 2018; Kruk et al., 2018).

Viewpoints 1–3 share important similarities, particularly their emphasis on access and respectful care. Yet, they differ in the relative importance assigned to specific aspects of PCC. These differences are relevant for practice and policy, as the viewpoints point to different priorities for improving PCC, ranging from responsiveness to patients' clinical needs in Viewpoint 1, to conditions enabling access to care in Viewpoint 2, and the organisation and coordination of care in Viewpoint 3.

The viewpoint prioritising emotional support and family involvement diverged most clearly from the other viewpoints by conceptualising PCC primarily as a relational practice. Emotional attentiveness and family participation were central, whereas autonomy-related aspects and patient control over decision-making were given lower priority. This perspective was consistent with PCC frameworks that position PCC in clinician–patient relationships and psychosocial support, particularly in contexts of vulnerability or serious illness (Mead & Bower, 2000; van der Eijk et al., 2011). Importantly, emotional support was not valued uniformly across viewpoints, reflecting findings from previous Q methodology studies in which psychosocial dimensions differentiate perspectives rather than constituting universal priorities (Crompvoets et al., 2022; Dieteren et al., 2023).

The comparatively lower importance given to emotional support and family involvement in several viewpoints may partly reflect the broader conditions in which care is received. In contexts where access to care and infrastructure are not always well-established, as remains the case in Peru and other Latin American health systems, more immediate aspects of care may become relatively more salient (Alarcón-Yaquette et al., 2022; Klimesch et al., 2023). This interpretation is also consistent

with studies on PCC in Latin America, in which emotional support has been less prominently represented than dimensions such as patient information, involvement, access, and coordination (Klimesch et al., 2023). The lower ranking of emotional and family support in some viewpoints should therefore not necessarily be interpreted as these dimensions being unimportant, particularly as Viewpoint 4 clearly prioritised both aspects.

A primary strength of this study is providing first insights in perspectives on PCC in a region where empirical evidence is still very limited. This approach enabled the systematic exploration of subjective viewpoints and captured nuanced perspectives that might be overlooked by conventional survey based methods. Including both patients (with different –chronic and acute– health conditions) and healthcare professionals further strengthened the analysis by incorporating a broad range of perspectives within the health system. Furthermore, by situating PCC within a health system characterised by fragmentation, inequality, and resource constraints, this study provides insights into PCC priorities in Peru that differ from findings in high-income countries and highlights the need for similar research in other LMIC settings.

Our study also has some noteworthy limitations. The identified viewpoints were based on rankings of the statement set. If important elements of PCC were missing in that set, this may have influenced our results. To mitigate this, we asked participants about the clarity and comprehensiveness of the statement set during the pilot study. They found the statements clear and no important elements were missed according to them, which increases trust in our results. During the main study, also none of the participants indicated to miss an important aspect of PCC in the statement set. Secondly, some participants tended to evaluate statements based on their current experiences within the health system rather than on their perceived importance for PCC, as instructed. Although the research team provided clarification and support during the ranking process, this different focus may have influenced how some participants interpreted and ranked the statements. Moreover, despite the identified viewpoints reflected shared understandings of PCC that cut across disease categories and professional positions, and although appropriate for Q methodology in terms of sample size, the limited number of healthcare professionals, the focus on participants from only the capital city Lima and not other regions of the country (e.g., the highlands or the Amazon areas), and the inclusion of only two –albeit very distinct– patient groups may have constrained the range of perspectives captured. Recruitment through patient associations may have resulted in the participation of patients who were relatively more informed or engaged in their healthcare and who may share some experiences or perspectives associated with their involvement in these organisations. This should be considered when interpreting the viewpoints identified in this study. Future studies could extend this work by including additional clinical conditions or a larger number of healthcare professionals to further explore how views on PCC may vary across care contexts.

Future research could build on these findings in different ways. Replications of this study in other regions of Peru and in different LA countries could help determine the extent to which these viewpoints are transferable across health systems with similar structural challenges. Furthermore, future studies could examine how different PCC viewpoints relate to patient experiences, satisfaction, or health outcomes, thereby strengthening the link between perceived importance and practical impact. Research focused on verifying PCC priorities with larger groups of citizens could also help to know the relative prevalence of the identified viewpoints, which would be particularly relevant for policy makers when allocating resources to address distinct care priorities, such as those reflected in the viewpoint emphasizing emotional and family support. For this purpose, the viewpoints could be included in survey research (Baker & van Exel, 2022). Moreover, future studies could extend this work by including additional clinical conditions or a larger number of healthcare professionals to further explore how views on PCC may vary across care contexts. Finally, while this study identifies

what aspects of PCC are considered important, it does not assess satisfaction with the existing 'status quo' care delivery. Future research could therefore explore the extent to which highly valued PCC dimensions, such as dignity and respectful treatment, are perceived as adequately implemented or in need of further improvement.

The findings of this study have several implications for health policy and system improvement in Peru and comparable contexts. Across all viewpoints, treating patients with dignity and respect, ensuring access to essential medication and equipment, and providing timely clinical responses to pain and complications were consistently ranked as highly important across the different viewpoints. These elements point to PCC being closely tied to basic service reliability, safety, and respectful professional conduct, rather than to more complex organisational innovations. From a policy perspective, this suggests that strengthening PCC in Peru may first and foremost require ensuring minimum standards of respectful care and system preparedness across hospitals, particularly in contexts characterised by resource constraints and service fragmentation.

Viewpoints emphasizing access-focused conditions highlighted the importance of hospital accessibility, physical comfort, and clear communication, including linguistic accessibility. Policies targeting these priorities could focus on improving physical infrastructure, reducing financial and geographic barriers to care, and strengthening communication capacities, particularly in multilingual settings. Effective communication in patients' preferred languages is essential for understanding care, navigating services, and adhering to treatment. Policies that promote the availability of bilingual healthcare staff, particularly for Indigenous languages such as Quechua, could strengthen PCC and contribute to more equitable PCC among linguistically under-represented groups of the populations. In contrast, the viewpoint centred on professional coordination and continuity of care underscored the need for improved information sharing, teamwork, and responsiveness to treatment-related complications. This suggests policy relevance for investments in interoperable health information systems, clearer referral pathways, and coordination mechanisms across services and care transitions.

Given the different priorities identified across viewpoints, implementation of PCC could also be supported by incorporating it explicitly into the education and continuing training of healthcare professionals. Training could focus not only on the principles of PCC, but also on communication, recognition of different patient priorities, and adaptation of care to individual needs (Moore et al., 2021).

The lower emphasis placed on shared decision-making and patient autonomy in the viewpoints identified in this study points to the importance of contextualising participatory approaches within existing health system capacities and sociocultural expectations. Rather than interpreting this finding as resistance to patient participation, it suggests that patients may prioritise professional responsibility and system reliability when access to care is uncertain. This aligns with previous studies where structural limitations shape how PCC is understood and enacted (Cole et al., 2025; Guanais et al., 2018). Providing patients with clear and accessible information about their condition and care could support their understanding and engagement in care, particularly by helping them navigate services and follow treatment recommendations (Fitzpatrick, 2023).

The variation observed across viewpoints also highlights that PCC implementation may require policy approaches that account for different interpretations of patient-centredness. While some perspectives emphasised professional coordination and system-level organisation, others prioritised access-related conditions or emotional support and family involvement. This suggests that PCC policies may benefit from a flexible approach that allows adaptation to different patient needs and expectations, rather than adopting a single standardised model of care. Such flexibility may be particularly relevant when patients have more complex care needs, as complications and comorbidities can increase both physical and emotional care needs and reinforce

the relevance of tailored PCC approaches (Hopman et al., 2016).

The viewpoint perspectives prioritising emotional support and family involvement highlights the importance of relational and supportive dimensions of care for some patients. This suggests that PCC policies should allow flexibility for care models that integrate family members and emotional support, particularly for patients experiencing chronic illness or heightened vulnerability. At hospital level, this could include identifying patients who require additional emotional support, establishing clear referral options for psychological or counselling services, and facilitating family involvement when this corresponds with patients' preferences and needs. Rather than mandating identical PCC practices across settings, policy frameworks could enable adaptive implementation of PCC, allowing services to respond to different patient and professional needs while maintaining core standards of respectful and safe care delivery.

The viewpoints identified in this study provide novel insight into how patients and healthcare professionals in Peruvian hospitals understand and prioritise PCC, revealing both shared elements, such as dignity, respect, and access to essential resources, as well as distinct elements emphasizing different priorities for quality of care. Recognising these communalities and differences across perspectives can support context-sensitive implementation of PCC, as some patients and healthcare professionals prioritise system reliability and professional coordination, while others prefer emotionally supportive and family-oriented care arrangements.

CRediT authorship contribution statement

Karen Trujillo Jara: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Doroti Cuestas Bernuy:** Writing – review & editing, Conceptualization. **Mónica Seminario Gutiérrez:** Writing – review & editing, Data curation. **Niek Mouter:** Writing – review & editing, Methodology, Conceptualization. **Werner Brouwer:** Writing – review & editing, Methodology, Conceptualization. **Jane M. Cramm:** Writing – review & editing, Methodology, Conceptualization. **Job van Exel:** Writing – review & editing, Supervision, Methodology, Formal analysis, Data curation, Conceptualization.

Ethics approval and consent to participate

The study protocol was approved by the Research Ethics Review Committee of the Erasmus School of Health Policy & Management (case number ETH2425-0856).

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

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