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Perspectives on Patient Experience: Findings from Healthcare Providers in a Web-Based Cross-Sectional Study Within a Healthcare Network in Brazil

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Abstract

The perceptions of healthcare providers regarding patient experience are essential for enhancing healthcare services and improving the overall patient journey. This study aimed to analyze patient experience efforts across six dimensions within a network of private hospitals in Brazil, leveraging insights derived from the perspectives of healthcare providers. A web-based survey was conducted, including questions about the following dimensions: (1) Governance and Leadership; (2) infrastructure and access; (3) staff and provider engagement; (4) Patient & Family Engagement; (5) Policy & Measurement; and (6) Quality & Clinical Excellence. All dimensions were classified as "making progress," except for the "Staff & Provider Engagement" dimension, which was classified as "getting started". Professional experience did not influence perceptions of any dimension. A comparison of scores between physicians and nursing staff revealed the largest mean difference among the professional categories ($p < 0.001$). The key dimensions for implementing and developing patient experiences were positively identified by professionals of the multidisciplinary team in the study context. Healthcare professionals' engagement has emerged as the primary factor identified as an opportunity to improve patient experience.

Keywords

patient experience, healthcare providers, multidisciplinary team, engagement

Introduction

A paradigm in which every patient deserves a positive care experience is fundamental to modern healthcare. Patient experience extends beyond individual satisfaction, acting as a key metric for evaluating and improving quality, governance, and accountability in healthcare.[1] Patient experience, as defined by The Beryl Institute, refers to all interactions influenced by an organization's culture that shape patient perceptions during care.[2] This definition underscores four vital themes intrinsic to comprehending patient experience: personal interactions, organizational culture, patient and family perceptions, and the care continuum. Furthermore, patient experience acts as a valid indicator and metric of patient-centered care (PCC), representing one of the principal domains of healthcare quality.[3] It fundamentally encapsulates human experience within healthcare services, extending far beyond the previous emphasis on technical competencies.[1]

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The direct involvement and responsibility of healthcare providers are pivotal in ensuring that patient care adequately addresses needs within their family and community frameworks. Healthcare providers' perceptions and attitudes toward patient experiences are fundamental to enhancing healthcare services and improving patient journeys. Engaging healthcare staff, fostering their commitment, and understanding their unique perspectives are pivotal to evaluating and advancing patient-centered care, ensuring that care delivery aligns with patients' needs and expectations. Studies have indicated that healthcare providers who are sensitive to the cultural, familial, and community contexts of their patients are more likely to foster patient trust and satisfaction, leading to better health outcomes.[3] Few studies have explored the perceptions of healthcare professionals in multidisciplinary teams regarding PCC in hospital settings.[4,5] Their direct interactions with patients provide valuable insights that complement patient perspectives, highlighting opportunities to address both systemic challenges and relational aspects of care. Engaging healthcare providers remains an essential strategy for fostering patient-centered care and enhancing the quality of healthcare services.[6]

However, accurate measurement and analysis of patient experiences remain challenging. The scientific literature highlights the importance of using a framework to better understand and improve patient experience, departing from traditional approaches to improvements that rely on anecdotes or isolated events.[7] There is a pressing need to develop a comprehensive, multidimensional instrument that is thoroughly validated and applicable across geographically diverse regions, particularly in low- and middle-income countries, where cultural barriers can substantially influence assessment outcomes. Organization-wide patient experience assessments are essential for identifying strategic opportunities to promote experience excellence.[7] It is equally important to incorporate the perspectives of healthcare professionals who directly interact with patients. This study aimed to analyze patient experience efforts across six dimensions within a network of private hospitals in Brazil, on the basis of insights from a national survey conducted from the perspective of healthcare providers.

Methods

This quantitative observational cross-sectional study was conducted in a private healthcare network in Brazil. A web-based survey was conducted between January 2 and February 2, 2024. Healthcare providers were contacted and invited to complete a web-based questionnaire. Participation in the study was voluntary, and after agreeing to participate in the research and with their anonymity guaranteed, the participants completed the questionnaire electronically. Communication took place via the intranet as a strategy to maximize the percentage response rate. This communication channel was chosen to foster awareness among healthcare personnel, leaders, and managers in various hospital departments of the importance of the subject and the focus and objectives of the study. Subsequently, participants were allowed to complete the instrument online.

The study population consisted of professionals working in sixty-nine private hospitals in Brazil, distributed across four Brazilian macro-geographic regions: North, Northeast, Central-West, and Southeast. A total of 69 hospitals were included because they constituted the entire subset of institutions in our private healthcare network. We developed a web-based survey that aimed to capture the perceptions of healthcare providers about patients' experience dimensions,[7] including (1) Governance and Leadership; (2) infrastructure and access; (3) staff and provider engagement; (4) Patient & Family Engagement; (5) Policy & Measurement; and (6) Quality & Clinical Excellence. The questionnaire was developed in Portuguese (Supplementary Table 1).

The participants completed the questionnaire in an anonymous online form. This system design enabled the healthcare personnel to complete the survey at their preferred locations and times. Hospital participation was voluntary. Once a hospital agreed to take part, all healthcare professionals in that facility were invited to complete the survey, ensuring that every staff member had the opportunity to respond. No selection procedure or sampling technique was applied at the individual level, thus allowing for a broad and inclusive representation of perspectives from each participating hospital. Apart from identifying the

Table 1. Level, Descriptions, and Scoring Ranges for Each Item of the Questionnaire and the Dimensional Score.

Level	Description	Scoring ranges
Excelling	Organizations at this stage are ensuring a coordinated, targeted, and sustained effort throughout the experience landscape, continuously working to maintain and enhance their outcomes. Despite observing consistent results, these organizations do not consider their experience efforts fully successful; instead, they acknowledge the ongoing need for focus and action.	Each item: average score 1.0–2.5 Dimensional score: average score 6.0–15.0
Making progress	Organizations at this level are making significant strides across all aspects of the experience landscape and are seeing sustained results in a large portion of their experience effort.	Each item: average score >2.5–3.5 Dimensional score: average score >15.0–21.0
Getting started	Organizations at this level are beginning to see some level of progress across all areas of their experience effort and are starting to realize some consistent results in their efforts.	Each item: average score >3.5–4.5 Dimensional score: average score >21.0–27.0
Needs attention	Organizations at this level are in the early stages of many of their experience initiatives or are revisiting and reengaging in experience efforts. They may only be starting to observe the initial impact of their actions.	Each item: average score >4.5–5.0 Dimensional score: average score >27.0–30.0

hospital name, no information that would reveal the survey respondents was collected. The respondents were not able to change their previously given answers. It was not possible to pause the completion of the questionnaire and continue it later.

For the final analysis, we exclusively considered the fully completed questionnaires. This report adheres to the Checklist for Reporting Results of Internet E-Surveys (CHERRIES) guidelines.[8] All procedures involving human participants were performed in accordance with the ethical standards of the institutional and/or national research committee, as well as the tenets of the 1964 Declaration of Helsinki and its later amendments, or comparable ethical standards.

Survey Development

The Experience Framework of the Beryl Institute and its dimensions were used as a reference for the development of our experience questionnaire.[7,9] The initial pool of survey items was developed by the first author to reflect the six dimensions of patient experience proposed for the investigation in this study. The study team members then reviewed and selected the most appropriate items, refined the wording of some items, and eventually reduced the pool to 36 items for use in the first round of pilot testing. On the basis of the constructs, a total of 36 items were elaborated with a five-point Likert-type answer scale (Supplementary Tables 1 and 2). In this study, content validation was assessed based on relevance. To verify content validity, the questionnaire was submitted for appraisal by the judges (n = 09), who were considered qualified to assess the clarity, content, objectivity, and understanding of the questionnaire. The selection criteria of the judges were as follows: being a healthcare professional with a master's degree (PhD) completed at least one year ago or having postgraduate education related to quality, safety, and patient experience. These judges received an explanatory letter and a questionnaire that included 36 questions with a five-point Likert-type scale that assessed the header, layout, scope of items, clarity, content, and objectivity of the items. The experts were requested to critically review each domain and provide scores on each item independently. The 36 items were categorized into six dimensions. During the content validation stage, two analytical processes were undertaken: the item-level content validity index (I-CVI) was calculated for each item, while the scale-level content validity index (S-CVI) was assessed using the average calculation method (S-CVI/Ave).[10] Items with an I-CVI value of $\geq$0.78 were retained, and those with I-CVI between 0.70 and 0.78 were revised. In addition, the expert panel's recommendations were taken into consideration in revising some of the wording and phrasing of items.

The dimensions evaluate current efforts and associated strategies to improve the experience.[7,9] The questionnaire comprises 42 items, including six questions about the respondent's characteristics (occupational category, professional experience, and experience at the hospital's current position) and 36 questions about patient experience. Patient experience-related answers were graded on a Likert-type scale, indicating the degree of agreement from "totally disagree" to "totally agree". Each item could have a maximum score of five points (strongly agree), and each dimension, consisting of six questions, could achieve a maximum score of 30 points. Scores for each item are based on the following scoring ranges: "needs attention" (average score 1.0-2.5), "getting started" (average score >2.5-3.5), "making progress" (average score >3.5-4.5), and "excelling" (average score >4.5-5.0). The average of all the

Table 2. Dimension Scores According to Time Since Employment at the Hospital and, Time Since Completion of Professional Training.

Experience at current position			
Dimension	Less than 1 year Mean (SD)	1 year or more Mean (SD)	Cohen's d - Mean difference estimator (IC 95%)
Governance and Leadership	24.99 (3.59)	25.04 (3.51)	−0.01 (−0.03; 0.01)
Infrastructure & Access	23.65 (4.11)	23.73 (4.03)	−0.02 (−0.04; 0)
Staff & Provider Engagement	21.63 (5.68)	22.19 (5.36)	−0.1 (−0.12; −0.08)
Patient & Family Engagement	24.74 (3.58)	24.69 (3.54)	0.01 (0; 0.03)
Policy & Measurement	23.82 (4.07)	23.93 (3.94)	−0.03 (−0.04; −0.01)
Quality & Clinical Excellence	24.17 (3.7)	24.22 (3.62)	−0.01 (−0.03; 0)
Years of experience			
Dimension	Less than 1 year Mean (SD)	1 year or more Mean (SD)	Cohen's d - Mean difference estimator (IC 95%)
Governance and Leadership	25.24 (3.45)	25 (3.55)	0.07 (0.04; 0.1)
Infrastructure & Access	24.26 (3.75)	23.64 (4.09)	0.15 (0.12; 0.18)
Staff & Provider Engagement	22.82 (5.1)	21.85 (5.54)	0.18 (0.14; 0.21)
Patient & Family Engagement	24.9 (3.45)	24.69 (3.57)	0.06 (0.03; 0.09)
Policy & Measurement	24.4 (3.73)	23.83 (4.02)	0.14 (0.11; 0.17)
Quality & Clinical Excellence	24.59 (3.44)	24.16 (3.67)	0.12 (0.09; 0.15)

*The magnitude of the effects was defined by the Cohen's d method to estimate the mean difference (MD) and its 95% confidence intervals (CI).

items within a dimension was calculated to determine the dimensional score. The scores for each dimension were based on the following scoring ranges: "needs attention" (average score 6.0-15.0), "getting started" (average score >15.0-21.0), "making progress" (average score >21.0-27.0), and "excelling" (average score>27.0-30.0) (Table 1). Finally, the average of the scores from the dimensions enables an overall assessment of the healthcare provider's perception of patient experience, allowing the identification of strengths and systemic improvement opportunities concerning knowledge, resources, and solutions.

Statistical Analysis

This was a nonprobability sample comprising all eligible staff present or on duty at the hospital during the data collection period. Personnel from various departments of the hospital were invited to participate, and data were collected electronically. By applying the formula $n = Z^2 \cdot p \cdot (1-p)/E^2$, where n represents the sample size, Z is the Z-score corresponding to the desired confidence level (95%), p is the estimated population proportion, and E is the margin of error (2%), the minimum sample size required for each hospital was calculated. The minimum total sample required was 42,754 participants. All healthcare providers were invited to respond to the survey.

The Fleiss' kappa (FK) test was used to confirm the content validity of the questionnaire. Agreement among the judges (ideal $\geq 0.75\%$) was analyzed according to Landis and Kock,[11] with FK values showing slight agreement ($0 \leq FK \leq 0.20$), weak agreement ($0.21 \leq FK \leq 0.40$), substantial agreement ($0.61 \leq FK \leq 0.80$), and almost perfect agreement ($FK \geq 0.81$). The correlation between the items ($r \geq 0.40$) and Cronbach's alpha (ideal $\geq 70\%$) was also verified[12,13] a Cronbach's alpha value of 0.7–0.9 implies adequate internal consistency.[14] To analyze the structural validity, a correlation matrix between the dimensions and all the items was used.

Differences in scores based on employment duration and training completion are presented with 95% confidence intervals. The magnitude of the effects was defined by using Cohen's d method to estimate the mean difference (MD) and its 95% confidence interval (CI). A value of ≤ 0.2 represents a small effect size, and a value of ≥ 0.8 represents a large effect size.[15] All multiple comparisons between dimensions were conducted using the Tukey's Honest Significant Difference (Tukey's HSD) method. All analyses were conducted using R software (version 4.1.2; R Foundation for Statistical Computing). Statistically significant results are indicated by P values less than 0.05.

Results

In total, 47,711 responses were analyzed. The completion rate was 89%. Completing the entire questionnaire took an average of 30 min (range: 11-90 min). Of these, 64% (30,520/47,711) were from the southeast region, 25% (12,004/47,711) from the northeast, 7% (3392/47,711) from the central-west and 1% (557/47,711) from the south (Supplementary Figure 1). The lower proportion of respondents in the South and Northeast regions (1% and 7%, respectively) correlates with the overall staffing distribution in those areas. In addition, 46% (21,990/47,711) of healthcare providers had been working in their respective organizations for five years or more. Overall, physicians accounted for 13% (6171/46,158) of the respondents, whereas nursing staff accounted for 54% (21,469/46,158) (Supplementary Table 3). The representative work units included inpatient units (17%; 7231/42,975), intensive care units (21%; 9069/42,975), surgical centers and obstetric centers (13%; 5651/42,975), and emergency units (13.5%; 5821/42,975).

The questionnaire items showed substantial agreement (Supplementary Table 4) regarding clarity, content, objectivity, and validity. Cronbach's alpha coefficients for the dimensions was 0.90 (0.88–0.92). High correlations were observed between the dimensions "Patient & Family Engagement" versus "Quality & Clinical Excellence" (0.82) and "Policy & Measurement" versus "Quality & Clinical Excellence" (0.80). The correlations observed were moderate to strong (0.64–0.82) (Supplementary Figure 2). The estimated correlation matrix for all the items is presented in Supplementary Figure 3. The content validity of the questionnaire was

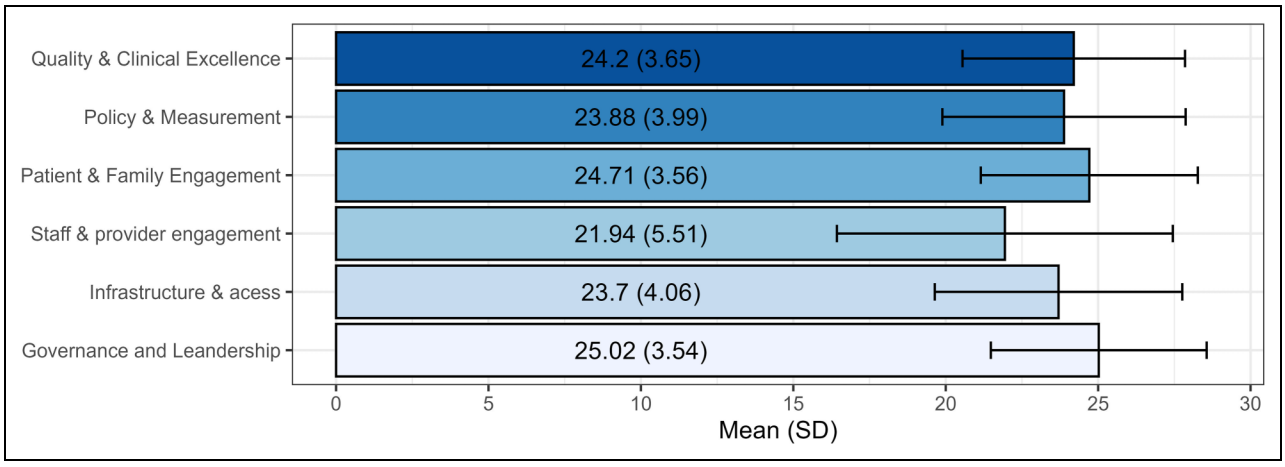

Figure 1. Healthcare providers' perspectives on patient experience through 06 dimensions. Mean (Standard Deviation).

evaluated at both the item and scale levels. The item-level content validity index (I-CVI) ranged from 0.78 to 1.00 across all items, with an overall I-CVI of 0.91. At the scale level, the scale-level content validity index (S-CVI) was calculated using the average calculation method (S-CVI/Ave) and ranged from 0.89 to 0.98 across dimensions, with an overall S-CVI/Ave of 0.95 (Supplementary Table 5).

The total average score across all the dimensions (36–180) was 143.45 (SD 21.3). The participant hospitals in the study and the mean scores obtained are shown in Supplementary Figure 4. Figure 1 presents the scores obtained for each dimension. "Governance and Leadership" achieved a score of 25.02 (SD 3.54), "Infrastructure & Access" scored 23.07 (SD 4.02), "Staff & Provider Engagement" obtained achieved 21.94 (SD 5.51), "Patient & Family Engagement" achieved 24.7 (SD 3.5), "Policy & Measurement" received 23.8 (SD 4), and "Quality & Clinical Excellence" scored 24.2 (SD 3.6). All dimensions were classified as "making progress," except for the "Staff & Provider Engagement" dimension, which was classified as "getting started". The largest

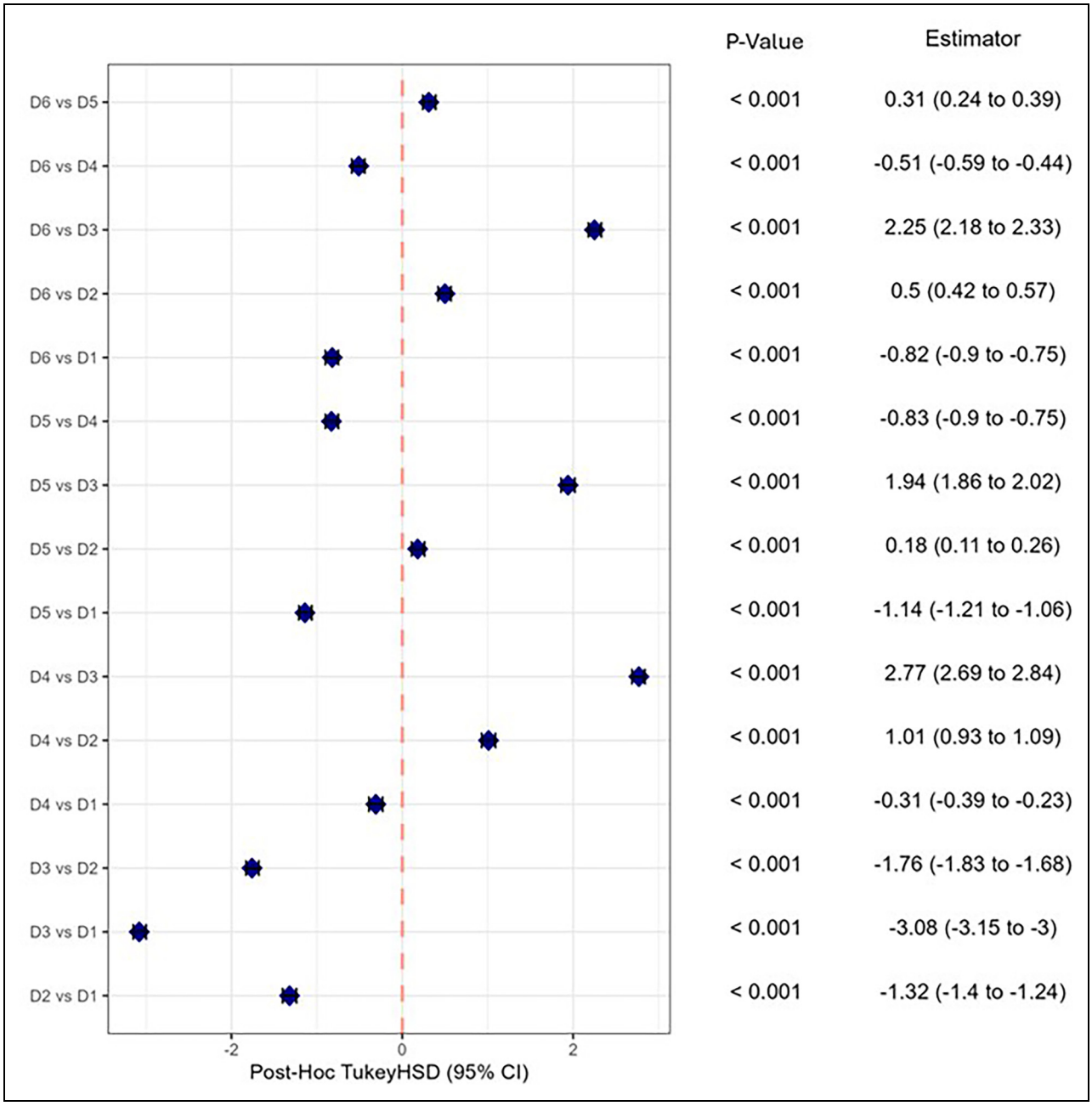

Figure 2. Comparison between dimension scores. Mean difference (estimator), confidence intervals 95% and the adjusted p-values for all possible pairs (Tukey's HSD method). Abbreviations: (D1) Governance and Leadership, (D2) Infrastructure & access, (D3) Staff & provider engagement, (D4) Patient & Family Engagement, (D5) Policy & Measurement, and (D6) Quality & Clinical Excellence.

mean difference was observed between 'Staff & Provider Engagement' and other dimensions ($P < 0.001$) (Figure 2).

Professionals employed at the hospital for less than one year accounted for 44% (21,071 of 47,711) of the sample. When compared with professionals who had more than one year of employment, no significant differences were observed in scores across any of the dimensions, as indicated by small effect sizes (Cohen's $d \leq 0.2$). Furthermore, professionals with less than one year of total professional experience comprised 9% of the sample, and similarly, their scores did not differ significantly across dimensions (Cohen's $d \leq 0.2$) (Table 2).

Among professional categories, nursing staff exhibited the lowest scores across the evaluated dimensions (Supplementary Table 6). A detailed comparison revealed that physicians had a higher mean score (147.44; SD 23.08) than nursing staff (138.09; SD 24.75), with the largest mean difference observed between these groups being 9.3 points (95% CI 6.3-12.0, $p < 0.001$) (Supplementary Figure 5). These results highlight a significant difference in perceptions across professional categories, particularly between physicians and nurses, while professional tenure and overall experience appeared to have a minimal influence on the scores.

Discussion

This questionnaire was developed to gain a deeper understanding of healthcare professionals' perspectives on the dimensions that influence patient experience. Following its validation, its implementation across a network of private hospitals in Brazil revealed that the primary challenge in improving patient experience was related to "Staff and Provider Engagement", which received the lowest scores among the domains evaluated. In other words, motivating and engaging professionals are essential for improving patient experience. A systematic review of patient experiences revealed that most studies primarily have focused primarily on patients, aiming to understand their needs and perspectives to improve patient-centered care (PCC).[16] While identifying and addressing patients' unmet needs are critical for effective PCC, the care process inherently requires two-way communication between patients and healthcare providers. Therefore, concentrating solely on the patient's viewpoint offers an incomplete understanding of how to enhance the PCC. It is equally important to incorporate the perspectives of healthcare providers, who interact directly with patients.

Studies have focused on a better understanding of the specific roles and interactions of users involved in the patient experience.[16–18] According to the patients, the key factors were the functional aspects of the service, such as professionalism, continuity, and comprehensiveness, including respect for patients' psychological needs and protection of their privacy.[19,20] In contrast, healthcare providers emphasize the structural aspects of the service, including efficiency, as well as the quality of their relationship with patients, leading to a dual focus on both the hospital system and the environment, and the ability to form positive relationships with patients. This difference in perspectives between the two groups may not be immediately apparent to either side; however, a deeper understanding could foster better relationships, improve communication about treatment, and increase patient participation in decision making and treatment adherence.[17] Notably, our survey did not indicate that "Governance and Leadership", "Infrastructure & Access", "Patient & Family Engagement", "Policy & Measurement", and "Quality & Clinical Excellence" were considered significant efforts and sustained outcomes. The dimension "Staff & Provider Engagement" dimension is still considered to be in the early stages of more effective actions, with few consistent results achieved thus far. Supporting care providers and reaffirming their purpose is essential for achieving positive patient experiences.

Constant analysis of the workload is also crucial. Healthcare professionals need a proper balance between work demands and available time to ensure the quality of patient care. Work overload can lead to fatigue and a decrease in the quality of care, directly affecting patients' experience. There is a strong correlation between leadership quality at all levels and team engagement and performance.[21] While everyone in the organization plays a crucial role in promoting a healthy environment, it is the leadership responsibility to evaluate working conditions related to structures and workload to ensure that professionals find satisfaction and joy in their work environment.[21] The Institute for Healthcare Improvement advocates shifting the focus from "burnout" to "joy in work." This distinction is more than merely a matter of terminology. As health encompasses more than the mere absence of disease, joy encompasses more than the mere absence of burnout.[22] Experiencing joy in the workplace fosters intellectual, emotional, and behavioral commitment to meaningful and fulfilling work.[23] Substantial evidence indicates that management practices aimed at cultivating a joyful and engaged workforce led to lower burnout rates, fewer medical errors, and enhanced patient experience.[24,25] Additional benefits included improved teamwork, reduced waste, increased customer satisfaction, and increased employee productivity.[26,27]

A previous survey demonstrated that differences existed among subspecialties when their viewpoints on elements relevant to the PCC were assessed. The perception of care coordination clearly varies across departments, whereas teamwork among healthcare professionals in delivering patient care, as well as continuity and transition, is considered significantly more important for PC.[5] Another study that characterized the perceptions of person-centered practice among a multidisciplinary team of healthcare professionals working in an internal medicine inpatient unit revealed that participants' professions significantly influenced their perceptions of commitment to the job.[4] Notable differences were observed between the perceptions of physicians, nurses, and physical therapists, although professional experience had no influence on the perceptions of any dimension. Our results align with these findings, as we found that the

comparison of scores between physicians and nursing staff revealed the largest mean difference among professional categories. This scenario is likely due to differences in educational background, understanding of PCC concepts, and the nature of work relationships with healthcare institutions and patients.

Limitations

This study has several limitations. First, the use of a convenience sample exclusively from private healthcare facilities restricts the generalizability of the findings. Second, the unique socioeconomic landscape of Brazil[28] may introduce bias in the interpretation of the results. Third, the high scores across the different constructs raised the question of whether the participants' responses reflected an idealized version of their practice or their actual current perception of daily care. Fourthly, although this study sheds light on healthcare providers' perspectives regarding patient experience, the absence of systems and standardized measures for capturing patient-reported data during the same study period presents a notable limitation. Finally, although the study was conducted within the specific context of a private healthcare network, which limits the generalizability of the findings to other care settings or populations, the inclusion of a representative sample of healthcare professionals is a mitigating factor. Future studies that characterize the cultural and organizational structures of healthcare settings could offer deeper insight into the relationships between patient-experience dimensions and the complex factors that either facilitate or hinder them. Additionally, it is crucial to examine how the values and customs of different countries and socioeconomic contexts influence efforts to improve the patient experience.

Conclusion

The key dimensions for implementing and developing patient experiences were positively identified by professionals of the multidisciplinary team in the study context. Caring for those delivering and supporting the delivery of care and reaffirming a connection to meaning and purpose are fundamental to the successful realization of a positive experience. In conclusion, health care professionals' engagement emerged as the primary factor identified as an opportunity to improve patient experience. Promoting a better experience for healthcare professionals should be a focus in people management, which includes appreciation and recognition, promotion of well-being policies and joy in the work environment, implementation of guidelines for stress measurement and reduction, and elimination of a punitive culture to address adverse events. Such measures are essential for building a culture of patient experience in healthcare systems.

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Author Contributions

All authors have made significant contributions to the manuscript in various capacities, which include data collection, interpretation, statistical analysis and preparation of the manuscript. All authors have reviewed and approved the manuscript, attest to the validity and interpretation of its data, and agree to its submission (AL). The first two authors contributed equally to this work and share first authorship.

Data Availability Statement

Data are available upon reasonable request.

Declaration of Conflicting Interests

The authors declare no competing interests. All authors had full access to all data pertaining to this investigation, approved the final version of the manuscript, and accept responsibility to submit it for publication.

Ethics Approval

Ethical approval was obtained from the Hospital São Luiz & Rede D´or and Affiliated Teaching Hospitals Research Ethics Board for publication of this report (protocol # 6.842.932, assent CEP 79836124.0.0000.0087). Additionally, this study complied with the Resolution 466/2012 of the Brazilian National Health Council.

Ethics Statements

Patient consent for publication is not required.

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Supplemental Material

Supplemental material for this article is available online.

References

1. Oben P. Understanding the patient experience: a conceptual framework. *J Patient Exp*. 2020;7(6):906-10.
2. Almohaisen NA, Alsayari NM, Abid MH, et al. Improving patient experience by implementing an organisational culture model. *BMJ Open Qual*. 2023;12(2):e002076.

3. Carter N, Valaitis RK, Lam A, et al. Navigation delivery models and roles of navigators in primary care: a scoping literature review. *BMC Health Serv Res*. 2018;18(1):96.
4. Vareta DA, Oliveira C, Família C, et al. Perspectives on the person-centered practice of healthcare professionals at an inpatient hospital department: a descriptive study. *Int J Environ Res Public Health*. 2023;20(9):5635.
5. Berghout M, van Exel J, Leensvaart L, et al. Healthcare professionals' views on patient-centered care in hospitals. *BMC Health Serv Res*. 2015;15(1):385.
6. Lillie HM. Healthcare Providers' resilience communication: a new type of patient-centered communication. *J Health Commun*. 2024;29(8):514-23.
7. The Beryl Institute. Experience Framework, 2024. https://theberylinstitute.org/experience-framework/ (accessed 27 September 2024).
8. Eysenbach G. Improving the quality of web surveys: the checklist for reporting results of internet E-surveys (CHERRIES). *J Med Internet Res*. 2004;6(3):e34.
9. The Beryl Institute. Defining patient experience, 2020; 1-1. https://theberylinstitute.org/defining-patient-experience/.
10. Alexandre NMC, Coluci MZO. Validade de conteúdo nos processos de construção e adaptação de instrumentos de medidas. *Cien Saude Colet*. 2011;16(7):3061-8.
11. Landis JR, Koch GG. An application of hierarchical kappa-type statistics in the assessment of majority agreement among multiple observers. *Biometrics*. 1977;33(2):363-74.
12. Cronbach LJ. Coefficient alpha and the internal structure of tests. *Psychometrika*. 1951;16(3):297-334.
13. Henson RK. Understanding internal consistency reliability estimates: a conceptual primer on coefficient alpha. *Meas Eval Couns Dev*. 2001;34(3):177-89.
14. Bland JM, Altman DG. Statistics notes: Cronbach's alpha. *Br Med J*. 1997;314(7080):572-572.
15. Baguley T. Standardized or simple effect size: what should be reported? *Br J Psychol*. 2009;100(3):603-17.
16. Kim E-J, Koo Y-R, Nam I-C. Patients and healthcare Providers' perspectives on patient experience factors and a model of patient-centered care communication: a systematic review. *Healthcare*. 2024;12(11):1090.
17. Hong H, Oh HJ. The effects of patient-centered communication: exploring the mediating role of trust in healthcare providers. *Health Commun*. 2020;35(4):502-11.
18. Santana MJ, Manalili K, Jolley RJ, et al. How to practice person-centred care: a conceptual framework. *Health Expect*. 2018;21(2):429-40.
19. Steele BJ, Fairie P, Kemp K, et al. Drivers of paediatric inpatient experience: retrospective analysis of casemix factors for the Alberta paediatric inpatient experience survey in Alberta, Canada. *BMJ Open*. 2022;12(5):e048207.
20. Di Lodovico L. La révolution du rapport soignant-soigné. *Soins Psychiatr*. 2023;44(345):10-3.
21. Sinsky CA, Biddison LD, Mallick A, et al. Organizational evidence-based and promising practices for improving clinician well-being. *NAM Perspect*. 2020;2020:10.31478/202011a. doi:10.31478/202011a.
22. Grandfield EM, Schlotzhauer AE, Cramer E, et al. Relationships among nurse managers' job design, work environment, and nurse and patient outcomes. *Res Nurs Health*. 2023;46(3):348-59.
23. Owens KM, Keller S. Exploring workforce confidence and patient experiences: a quantitative analysis. *Patient Exp J*. 2018;5(1):97-105.
24. Maseko L, Myezwa H, Adams F. User satisfaction with primary health care rehabilitation services in a South African metropolitan district. *J Patient Exp*. 2024;11:23743735241261222. doi:10.1177/23743735241261222.
25. Kinsella C, Dunphy A, McCormack S, et al. Experiences of parents and caregivers of children who underwent gastrostomy tube insertion. *J Patient Exp*. 2024;11:23743735241272225. doi:10.1177/23743735241272225.
26. Perlo J, Feeley D. Why focusing on professional burnout is not enough. *J Healthc Manag*. 2018;63(2):85-9.
27. Gierlinger S, Barden A, Giammarinaro N. Impact of a patient experience leadership structure on performance and engagement. *J Patient Exp*. 2020;7(2):146-50.
28. de Oliveira Lima H, da Silva LM, de Campos Vieira Abib A, et al. Coronavirus disease-related in-hospital mortality: a cohort study in a private healthcare network in Brazil. *Sci Rep*. 2022;12(1):6371.