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European hospital managers' perceptions of patient-centred care: A qualitative study on implementation and context

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Oliver Groene, PhD, is Lecturer in Health Services Research at the London School of Hygiene and Tropical Medicine. His interest lies in assessing and improving hospital performance, with a particular focus on patient-centred care strategies. His work involves devising systems for the collection of process and outcomes data for national clinical audit and the statistical analysis of large-scale data bases to inform clinical decision-making and evidence-based health care management. He has 15 years of experience in health services research and public policy.

Structured Abstract:

Purpose – The spotlight has recently been placed on managers' responsibility for patient-centred care as a result of Mid Staffordshire NHS Foundation Trust failings. In previous research, clinicians reported that managers do not have an adequate structured plan for implementing patient-centred care. In this exploratory study we aim to assess the perceptions of European hospital management with respect to factors affecting the implementation of a patient-centred approach.

Design/methodology/approach – 15 semi-structured interviews were conducted with hospital managers (n=10), expert country informants (n=2), patient organisations (n=2), and a user representative (n=1) from around Europe. Participants were purposively and snowball sampled. Interviews were analysed using framework analysis.

Findings – Most participants felt that current levels of patient-centred care are inadequate, but accounted that there were a number of macro, meso and micro challenges they faced in implementing this approach. These included budget constraints, political and historical factors, the resistance of clinicians and other frontline staff. Organisational culture emerged as a central theme, shaped by these multi-level factors and influencing the way in which patient-centred care was borne out in the hospital. Participants proposed that the needs of patients might be better met through increasing advocacy by patient organisations and greater staff contact with patients.

Originality/value – This study is the first of its kind to obtain management views from around Europe. It offers an insight into different models of how patient-centred care is realised by management. It indicates that managers see the value of a patient-centred approach but that they feel restricted by a number of factors at multiple-levels.

Keywords: Patient-centred care, hospital managers, organisational culture, quality improvement, Europe, qualitative

Article Classification: Research paper

Introduction

Management in hospitals has come under the spotlight as a result of significant hospital failings at Mid Staffordshire NHS Foundation Trust, exposed by the Francis Inquiry report (Francis, 2013a; The King's Fund, 2013). Poor quality of care was highlighted as a major issue, which is increasingly regarded as a priority area for the NHS in England (Department of Health, 2008). Quality of care consists of three essential components: effectiveness, safety, and patient-centred care. The Francis Inquiry found that in particular the monitoring, detection and improvement of patient-centred care was lacking (Francis, 2013a). While the Francis Inquiry findings were specific to that NHS Foundation Trust, with European and international calls for patient-centred care (Epstein et al., 2010; World Health Organisation, 2005) the findings and recommendations are relevant to healthcare more widely. European patients have also voiced the need for greater involvement in their healthcare (Coulter and Jenkinson, 2005) but efforts to involve patients and their representatives in quality management functions in European hospitals are currently low (Groene et al., 2014b). Additionally, with the free movement of citizens across Europe, European-wide patient-centred care will become a more important consideration (European Union, 2011), indicating the need for a European focus on patient-centred care research. According to a previous study which surveyed clinicians in Europe, one of the current factors explaining the lack of patient-centred care is hospital managers' failure to establish structured plans to implement interventions aimed at improving patient satisfaction (Rozenblum et al., 2012). The authors of the survey study conclude that there is a chasm between management and frontline clinicians in improving patient satisfaction. However, what managers' roles, views and efforts are with regard to patient-centred care and whether this chasm really exists has been very little explored.

Understanding patient-centred care

Patient-centred care is defined variably and inconsistently (Goodrich, 2009), but broadly describes the shift away from a paternalistic delivery of healthcare where the patients' needs are assumed, to planning and delivering services in a way that recognises patients as experts of their own health (Coulter, 2011). Patient-centredness can be traced back to the Hippocratic Oath, but first became better known in the 1950s in response to the increasing focus on biomedical processes at the expense of the patient experience. Since then there has been growing support for patient-centred care from patients, providers and governments alike.

While patient-centred care has been interpreted to mean increasing patient choice, fulfilling patient *wants* and endeavouring to involve patients in decision-making at all costs, it has been proposed that patients have varying degrees of interest in participating in their health (Thompson, 2007). Being patient-centred may therefore be more about determining the most suitable way to communicate with each patient in order to meet their healthcare *needs*. Thus, patient-centred care can be conceptualised in two different ways: the consumer model, where there is emphasis on 'customers' exercising their rights to choice and voicing *wants* and complaints; and the more democratic model, where users express their *needs* (Thompson, 2007), aligned with the suggestion that patient-centred care is part of a wider effort towards a bottom-up healthcare approach (Bate and Robert, 2007).

Patient-centred care has historically been explored in sociological and political literature as citizen participation and has been described by Arnstein (1969) as a *Ladder of Citizen Participation*. The top rungs of the ladder refer to *Citizen Power*, where citizens fully participate; the middle rungs to *Tokenism*, where efforts to engage with citizens are tokenistic; and the lowest rungs to *Non-participation*. This is a useful model for

understanding how the distribution of power with respect to patient-centred care can be realised in practice in the hospital.

A growing body of evidence supports a patient-centred approach, which includes the improvement of a number of health outcomes, such as patients' knowledge, experience, health behaviour, satisfaction, health status, reduced use of services and lowered costs (Coulter and Ellins, 2007; Doyle et al., 2013; Little et al., 2001; Stewart et al., 2000), and improvements to the care pathway (Groene, 2011). The rationale behind these outcomes is that effective communication and identification of health needs will lead to the correct diagnosis, appropriate prescription, adherence to medication, suitable treatments and care pathway, and also enhance patients' healthcare experiences.

Numerous patient-centred efforts and strategies have been described, which range from informed consent, to patient satisfaction surveys, hospital user representatives, and integration of the patient voice in management and quality improvement decisions. Previous studies found substantial variation in the implementation of patient-centred systems across European hospitals, with specific requirements such as patients' rights and informed consent procedures being more likely met than more advanced approaches to involve patients in care decisions and system design (Groene et al., 2009).

The role of management in realising patient-centred care

Management has been described as dealing with complex but resolvable problems, and leadership as dealing with uncertainty, critical problems and preparing organisations for change (Kotter, 2001). In this article we use 'management' to generally describe the activities of the management interviewees, and use 'leadership' to describe a distinct but complementary system of action.

Management are in a unique position of overseeing the hospital whilst being faced with numerous conflicting macro, meso and micro level challenges, including national and local politics, financial pressures, and quality and safety of care (Chambers, 2011). Leadership by management is suggested to be key to influencing patient satisfaction (Al-Mailam, 2005), consistent with their responsibility for holding the hospital purse strings, setting hospital priorities and therefore determining the hospital's healthcare delivery approach. However, although the role of managers in organisational culture was specifically highlighted as an issue in the Francis Inquiry and the significant role of strong leadership was emphasised, Francis stated that improvements requires the efforts from everyone involved. It has also been posited that hospital systems are highly differentiated, functioning not as one but multiple independent organisations, and that enabling the hospital to function successfully requires the integration and collaboration of all parties involved (Glouberman and Mintzberg, 2001a; Glouberman and Mintzberg, 2001b). The views and roles of clinicians (Mead and Bower, 2000; Storm and Davidson, 2010), nurses (Aasen et al., 2012; Bolster and Manias, 2010; Touveneau et al., 2011) and patients (Coulter and Jenkinson, 2005; Little et al., 2001) have all been researched relatively extensively with respect to patient-centred care, but those of managers have not. Focusing on the perspectives of managers and therefore developing a better understanding of the perspectives and efforts of all involved will offer a better insight into how patient-centred care is borne out in the hospital.

The Francis recommendation is echoed in studies that have looked at management perspectives on patient-centredness. We conducted a literature review specifically on hospital management perspectives on patient-centred care. Our inclusion criteria were views and self-reporting from hospital managers, description of

facilitators and barriers to implementing patient-centred care by management, a high-income country setting, and articles from 2005 onwards. Our objective was to find literature very similar to our own for comparability and which would enable identification of current gaps in a specific area of research. We retrieved four articles from three electronic databases. In these studies, managers reported that they are constrained in their efforts by variable patient interest in engagement, frontline staff resistance, and lack of support and accommodating culture in adopting a patient-centred approach (Davies and Cleary, 2005; Gagliardi et al., 2008; Luxford et al., 2011; Wiig et al., 2013). These views indicate that managers believe efforts from elsewhere are also lacking, and furthermore suggests that they might have genuine perceived reasons relating to their professional priorities for currently inadequate structured plans to improve patient satisfaction. These studies focused on more homogeneous settings; either by looking at high-performing hospitals only (Luxford et al., 2011) or a small number of hospitals in just one region (Davies and Cleary, 2005; Gagliardi et al., 2008) or country (Luxford et al., 2011; Wiig et al., 2013). As yet, no study has explored this topic in a broad setting to gain exploratory and heterogeneous data. Heterogeneity allows for the exploration of multiple perspectives, for broad comparison and categorisation, the reflection on diverse contexts of such perspectives, and through deviant cases enables refinement of theory (Pope et al., 2000). Europe is a politically relevant unit of analysis and an ideal setting for obtaining rich and varied accounts from management.

Rozenblum et al. found that clinicians reported that management did not have an adequate plan to improve patient satisfaction. Clinicians and managers have historically not seen eye-to-eye (Davies and Harrison, 2003; Montoute, 2012) and patient-centred care may specifically be "actively used to prosecute intergroup conflict", with different professional groups stating that they are patient-centred while others are not (Kreindler, 2013). Clinicians and management may also have different experiences and perceptions of the same tasks, with managers in one case study of a quality and safety task identifying greater improvements to culture in the organisation, and frontline staff identifying improved timeliness to the delivery of care (Parand et al., 2011). These different perceptions appear to reflect both groups' professional priorities, and suggests that they may not have a shared experience or language (Atun, 2003) with regards to patient-centred care, even if their efforts and vision are shared and equal. In order to obtain a more complete picture of why clinicians reported that managers do not have an adequate plan to improve patient satisfaction, a qualitative and in-depth exploration of the views of managers will be valuable.

Aim

Further research is required to understand the views of European hospital managers with regard to their patient-centred care efforts. With European patients' calls for greater involvement in their care and European clinicians suggesting that managers have inadequate plans for implementing it, there is a need to hear the voice of managers. Specifically, this study will explore European managers' perceived patient-centred efforts and their perceived facilitators and barriers to realising patient-centred care. Exploring the views of hospital managers will contribute to our understanding of how patient-centred care is realised in hospitals and will allow for harnessing of this knowledge to ensure that the needs of patients are being met.

This study is exploratory and aims to obtain a range of diverse and disparate perceptions from European managers as well as expert country informants and patient-centred care organisations. The diversity of

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participants may provide useful lessons beyond current thinking and conceptualisation from one country or hospital setting alone.

Methods

Study design and setting

A qualitative research approach was chosen in order to explore the participants' own generation of views and themes. This study was conducted as part of the wider Deepening Our Understanding of Quality Improvement in Europe (DUQuE) project, which has aimed to investigate the effectiveness of quality management systems throughout Europe (Secanell et al., 2014). Participants were drawn from countries within the European geographical region.

Data collection

In-depth, semi-structured interviews were conducted between June and August 2013 by AT. All interviews were carried out in English, except for one hospital manager who had an amateur interpreter present. Participants were interviewed via telecommunication (Skype or telephone). Video was not used for Skype interviews in order to ensure consistency. Interviews were conducted from a quiet, private office setting. In one interview, another member of the hospital management joined in towards the end without prior notification. This did not appear to affect the direction or the responses of the interview. Recordings of all the interviews were made using a Dictaphone. Interviews lasted between 43 and 62 minutes. Short field notes were made in order identify key points during the interview and to facilitate analysis. All interviews were transcribed ad verbatim by AT.

The interview guide was informed by previous studies on hospital management views on the implementation patient-centred care (Davies and Cleary, 2005; Gagliardi et al., 2008; Luxford et al., 2011; Wiig et al., 2013) and sought to address perceptions on 5 key areas: (1) Views (specifically on benefit or drawback) and understanding of patient-centred care; (2) Current patient-centred care implementation (level of, and strategies planned and implemented); (3) Facilitators and barriers to patient-centred care; (4) Monitoring and evaluation of patient-centred care; and (5) Patient-centred governance (national policy and legislation). The interview guide supported a semi-structured interview and included broad questions as well as specific probing questions in response to participants' reports. The interview probing questions were slightly adjusted iteratively to reflect emerging themes. We intentionally did not define patient-centred care as a concept or the associated strategies in our interviews in order to allow the participants to express their own understanding and for us to therefore gain insight into how they perceive patient-centred care is borne out in the hospital. Transcripts were sent to participants for member checking to improve clarity. They were given instruction to only amend spelling or incorrectly transcribed words in order to prevent participants from revising meaning. Only one participant edited a small number of words.

Sampling and participants

Purposive sampling was initially used, followed by snowball sampling, a sampling combination which allows for a small selection of relatively hard-to-reach participants to increase in number (Potter, 1996). OG purposively contacted expert country informants known to him in order to help recruit hospital managers from their respective countries via snowball sampling, and to recruit some of the expert country informants

themselves. We were careful to try to interview participants from a range of countries. Therefore, the countries from which the expert country informants were selected are based on the number of hospital managers already recruited for that country. In total, 25 prospective participants were specifically approached, either by AT or a recruiter, as indicated in Figure 1. Expert country informants were included to obtain expert country-wide understanding of background and current policy themes regarding patient-centred care. Patient organisations were contacted by AT by email and telephone and interviewed in order to obtain a broader understanding of patient-centred care implementation. The European and International patient organisations were contacted specifically in order to obtain their respective broad geopolitical perspectives. One manager agreed to the interview but cancelled due to illness, three did not reply, and six managers responded at the end of data collection and were therefore not interviewed. Four 'recruiters' were unable to recruit any hospital managers due to language issues. Correspondence with all of the prospective participants was followed up by AT via email.
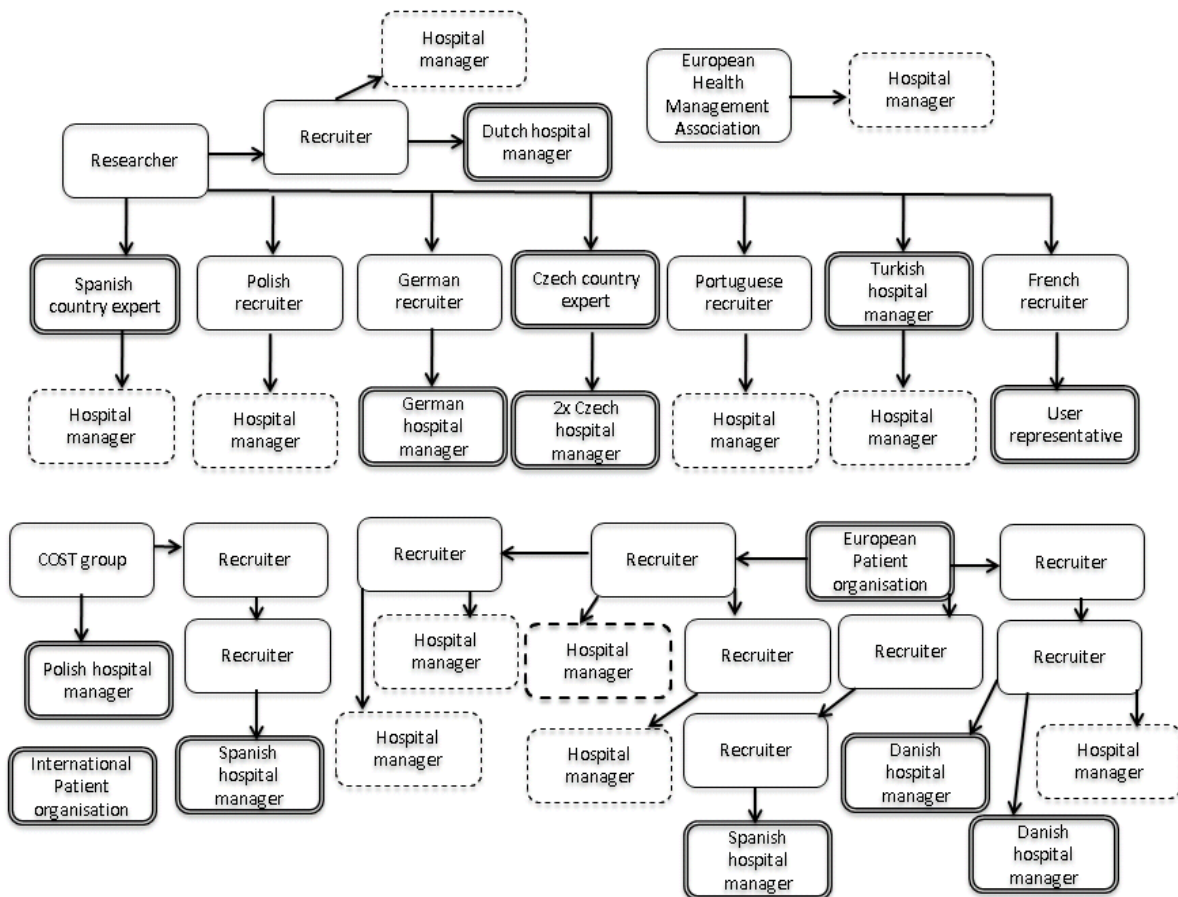

Figure 1 Flow chart of sampling strategy. Double-line boxes indicate participants who were interviewed, dashed boxes indicate participants who could not be interviewed, and single-line boxes indicate people who helped to recruit new participants.

Analysis

Data were analysed using Framework Analysis, a methodological orientation developed for applied social policy (Ritchie and Spencer, 1993). Data were open-coded to allow for the emergence of themes. A thematic framework was developed throughout the data collection process, which included major codes, such as 'management', and associated sub-codes such as 'leadership/management style' and 'decision-making'. Themes

are grounded in the data but are very similar to the key topic guide areas. Indexing was achieved using numerical codes in the margins of the transcripts. Data were charted by creating tables of themes for comparison, with a description and example of each theme for each participant. The constant comparative method was used throughout to compare, contrast, review and revise data iteratively. Analysis was conducted by AT. Software was not used to organise the data due to the manageability of the data volume and the risk of over-extracting with the use of software. No further data were collected on achieving thematic saturation. The study is reported in line with COREQ guidelines (Tong et al., 2007).

Ethics

All participants received an information sheet stating the purpose of the research and signed a consent form before commencing the interview. They were briefed again on ethics before formally commencing the interview and were also given an opportunity to ask questions. Ethics approval was obtained by the London School of Hygiene and Tropical Medicine in April 2013

Results

15 participants were interviewed in total, which included 10 hospital managers, 2 expert country informants, 2 patient organisations, and one user representative, as shown in Table 2. 5 participants were sampled purposively and 10 were snowball sampled, as indicated in Figure 1.

[Insert Table 1 here]

In keeping with our aims and framework analysis approach, our results firstly describe managers' perceptions of current patient-centred care implementation, their management role, and perceived barriers and facilitators to these efforts,.

Current implementation of patient-centred care

All but one hospital manager believed that current levels of patient-centredness were insufficient or that more could be done in their hospitals and more widely. One of the patient organisations and the user representative also stated that implementation is currently inadequate.

> *We in our hospital have learned in the last three years that there is much more we can do to be more patient-centred with shared decision-making and more focus and a lot of other aspects. I must admit there is a long way to go. (Hospital manager 1, Denmark)*

These views indicate the current lack of patient-centredness, as well as the participants' awareness and consideration of the issue. This was also reflected in their reports of patient-centred strategies implemented in the hospitals. Strategies tended to be the collection of satisfaction surveys or informed consent rather than more developed and mature patient-centred systems, where patient voice is an integral part of management decisions. Additionally, for many of the hospitals, strategies did not seem to be part of a structured plan but appeared to be individual efforts. For example, in one hospital strategies included having a longer stay to avoid multiple return

visits, a toilet and shower in each room, spiritual care, employee communication training, and a satisfaction survey, all of which do not seem to fall under a cohesive plan. There was also some variation in the understanding of the concept of patient-centred care and the reported maturity of implementation amongst hospitals. The two Czech managers, the Polish manager and Turkish manager indicated that the concept was relatively new to their countries, and this was to some extent reflected in the more under-developed patient-centred systems that they reported, bar the private Turkish hospital. For example, two of the participants spoke of patients' rights instead of patient-centred care, which is considered to be a basic EU requirement. The two Danish and the Dutch hospitals reported more mature systems of patient-centred care in their hospitals than the others and also demonstrated an understanding of sophisticated patient-centred care strategies, which included regular management consultation meetings with patients, and managers' efforts to experience the patient pathway.

The role of management

All managers stated the importance of strong leadership in improving patient-centredness in hospitals. This suggests that they take a high degree of responsibility for this.

> *Managers are so important because they're the decision-makers and they're the champions. (Hospital manager, Turkey)*

> *I think [my role as CEO is] extremely important because in the organisation you have to be really engaged in ensuring patient rights on a high level. (Hospital manager, Poland)*

These responses show a clear understanding of the role of the manager and their responsibilities with respect to patient-centred care. Many participants described the role of the manager more specifically, detailing their need to create a vision, secure and provide resources, and set strategic patient-centred goals. Interestingly, one of the patient organisations and the user representative allied themselves more with the managers than the clinicians and described how managers are sympathetic towards patient-centred care.

> *We have very good relations with the hospital directors. They will probably pick up the telephone to answer a phone call from me more rapidly than they would for a doctor or a doctor on their hospital board. They understand that the users represent the general public in a certain sense and that it's important because it's a public hospital system. (User representative, France)*

Differences in management style also emerged, with some managers describing a more 'top-down' approach and others with a more 'bottom-up' style. The former approach appeared more practised in the Czech Republic, Poland and Turkey, and the latter approach in the Danish and Dutch hospitals, which could possibly be reflected in each country more widely. The more shared management style also appeared to go hand-in-hand with the belief that culture change is necessary to achieve a patient-centred system, and that culture change within the hospital was a hospital-wide effort and not down to management alone.

> *These programmes, as you know, are bottom up, they are not from the top. And a chief executive is no-one in these policies because you need first a culture that promotes, that fosters the participation of*

patients. I think the position of the chief executive is very important, the managers are very important, but you alone cannot make changes. (Hospital manager 2, Spanish)

There's not a lot of hierarchy in the Danish hospitals, so we see ourselves as the leaders that try to make it possible for the clinicians to do what is right for the patients. (Hospital manager 1, Denmark)

Challenges to achieving a patient-centred system

While most participants felt that patient-centred care was beneficial, a number of participants described how its value was compromised by other hospital priorities and a number of challenges that they faced. They felt that these challenges explained the current insufficient levels of patient-centredness. These included a number of macro level factors such as the economic climate and resulting budget constraints, more meso level factors such as culture change, and micro level factors such as staff resistance, as shown in Table 2.

[Insert Table 2 here]

Culture appears to be a central theme to many of the barriers provided in Table 2. It seems that national-level culture influences the level of supply and demand for a patient-centred approach, as described by the Spanish, Turkish and Czech participants. Additionally, it appears to affect cultures of power played out between frontline staff and patients, as reported by participants. Culture was further revealed to be an important feature to participants when they were probed on their views on national-level patient-centred policy and governance. Most of the participants made it clear that although it is generally useful to set national targets, policies and legislation, without everything in place within the hospital to make change, such as a supportive culture, this is either not useful or would be damaging to the local setting.

The macro level climate of politics, history and culture appears to influence the nature of two key components of care: supply and demand. From the managers' accounts, political and cultural histories seem to shape the demand side; namely the patients' own expectations, the population health literacy and general levels of education. This, in part, determines the level of patients' engagement with their own health care. Patients who perhaps are less confident in their own knowledge in the consulting room or those who are used to a more hierarchical relationship with clinicians may be less likely to voice their health needs. From the supply side, frontline staff perceptions of patients and their willingness to provide a patient-centred style of care also appear to be shaped by these macro level factors. Clinicians used to being in positions of greater power or more educated than their patients may be less likely to engage with their patients to address their health needs.

A number of participants described or alluded to culture as a barrier. One of the Spanish hospital managers reported that Catalan culture prevented people from being forthcoming in their interaction with clinicians and in their healthcare demands. The Czech expert country informant described how a history of communism in the Czech Republic has affected the power balance between state and service user.

I think in the Czech Republic or the Eastern block it's also caused by the past because between 1948-89 during the communist regime, the wellbeing of the nation was put in front of the wellbeing and rights of an individual, so basically the provider had all the power of the patient, and the patient had almost no powers. (Expert country informant, Czech Republic)

These wider political, cultural and historic challenges were implicitly echoed by the two Czech managers and Polish manager and explicitly by the Turkish manager, the latter participant who was probed on why they felt that "patient rights are very new in Turkey".

> *I think it's cultural. I mean, the Turkish medical system is just now coming to a point where it's more of a dialogue between the doctor and the patient. It was very authoritative, hierarchical up until this point. (Hospital manager, Turkey)*

Several managers reported the resistance of frontline staff to implementing a patient-centred approach, six of which specifically related to clinicians, and two to nurses. Reasons for this resistance were proposed by the participants, including impatience with patients' lack of medical knowledge, clinicians' own priorities, such as research, and resistance to a shift in power balance.

> *We are trying to convince especially the nurses but also the physicians that this is not a battle for power but that we have to help each other. I think the barriers [to patient-centred care] are in the staffs' mind[s]. We have been growing up in a culture where the doctors and nurses took all the decisions and this change [towards patient-centred care] is not easy. (Hospital manager 2, Denmark)*

The user representative described how staff in the hospital have their own interests, leading to the neglect of patient-centred care. However, the user representative stated that hospital managers have a "much more ethical interest" and that they are unable to implement patient-centred care due to various pressures.

> *The problem is that they [hospital managers] are subjected to all sorts of pressures from the different lobbies. In the hospital the lobbies are the medical professions, the different professions. You also have the public-private lobby, you have the pharmaceutical company lobby... (User representative, France)*

The economic situation and budget constraints were frequently mentioned as challenges that prevented further patient-centred efforts. The participants were asked what their patient-centred care vision is, and two participants stated that they simply needed to survive as hospitals, echoed by the Czech expert country informant. In one case, the hospital abandoned most patient-centred efforts because of significant budget constraints.

> *We stopped it [the survey] because we found it showed big problems and there was no money to change it. Every year this survey showed that they [the patients] want the physicians to speak more with them. We have no response for that, we can't do anything. We don't have the money for it. It is a struggle or a fight every day. (Hospital manager, Germany)*

> *I think in the Czech Republic right now there is so much financial tension, especially in hospitals. I think the general managers of the hospitals are preoccupied with totally different problems, which is not about*

providing care efficiently, but actually surviving with the budget they have. (Expert country informant, Czech Republic)

Knock-on effects of budget constraints had led to staff cuts and time constraints in a number of hospitals. It was evident from participant responses that the economic crisis and general levels of funding for healthcare in Europe have had a significant effect on the participants' hospitals. This had shifted management priorities more acutely towards making sure that patients were seen at all, let alone be treated in a patient-centred way.

Finally, when probed on the usefulness of national patient-centred targets, policies and legislation, while most participants expressed that they could be beneficial to some extent, a few feared that hospitals would begin to pay lip service due to the inability to adequately implement a patient-centred system

Of course it is important that they [national policy and legislation] are in place. But that they are in place is not the important thing because the important thing is that the managers on every level focus on that, and it can take many years to change it really. (Hospital manager 2, Denmark)

Things [in the hospital] are always organised the same, so to make changes in the routine is very difficult. Routine is very complex. (Expert country informant, Spain)

Reported facilitators for achieving a patient-centred system

A range of diverse facilitators to improving patient-centred care were reported. Frequently reported facilitators were advocacy from patient organisations and more opportunities to hear the patient voice, where managers have clinical duties or where there are opportunities through meetings or workshops for patients to provide feedback or share their experiences with managers.

I asked her [the patient] to give a story of quality through a patient's eyes. She did it and it was so wonderful. After that we heard a lot of medical specialists or doctors say, "Well, I thought it was only important that the operation was fine, but this is what patients see, what they see and what they think." (Patient-centred care manager, Netherlands)

Hearing the patient's voice for managers and clinicians, according to managers, seems to act as a reminder or increase awareness of the patient's voice and their experience within the hospital. Additionally, one of the patient organisations felt that patients will increasingly demand greater involvement in their healthcare in the future and that this will affect patient-centred practice.

People are becoming more informed about healthcare and how these things work, so they are able to actually have valid discussions about what they want, what they need, what they think is good practice; without it just being, "We want this, we want this, we want this. Give it to us or I'll find you responsible". (Patient organisation, International)

The participant believes that as service users become more informed, they shift from demanding *wants* to voicing *needs*, and that this shift leads to the implementation of patient-centred care. This shows that the participant anticipates that changes to the way that service users engage with healthcare will contribute to a shift within the hospital.

Another reported facilitator was private management or ownership of hospitals. Both private managers felt that there is more money available to them, and greater emphasis on patient satisfaction helps to attract more patients. One of the private managers also referred to patients at times as 'customers', reflecting the more visible transaction that takes place between service users and the hospital in a private setting. In contrast, the user representative suggested that private healthcare companies are more likely to reduce the implementation of patient-centred care in public hospitals.

Patient-centred policy and legislation was also reported as a facilitator, as shown in Table 3 although, as previously described, this was generally conditional on culture change.

There was a fair amount of heterogeneity in reported facilitators, which could reflect the context-specificity of facilitators, in contrast with greater shared reported barriers.

[Insert Table 3 here]

Discussion

Key findings from the study are that managers are generally aware of the currently insufficient levels of patient-centred care, they realise their responsibility for creating a patient-centred vision, but report that there are a number of factors that hamper improvement efforts, including economic and time constraints and frontline staff resistance. A central finding is that according to participants, national-level and hospital-level culture appeared to be a determinant of the way in which patient-centred care was realised in each of the European hospitals.

Managers' awareness of current insufficiency in their hospitals is an important finding and is to some extent consistent with Rozenblum et al.'s (2012) responses from clinicians who state that most hospital managers do not have a structured plan in place to improve patient satisfaction. There is clearly a great deal more to be done about patient-centredness and managers interviewed here appear to be are aware of this.

Managers reported a number of barriers they face in implementing patient-centred care, which they suggest restrict their efforts and explain current patient-centred care levels. The reported barriers were very much in agreement with previous studies (Davies and Cleary, 2005; Gagliardi et al., 2008; Luxford et al., 2011; Wiig et al., 2013), which also found that staff resistance was an issue, as were financial and time constraints, culture change and variable patient interest. Some of these reported barriers appear unique to management, such as awareness of organisational culture, and economic and financial barriers. Managers are in a position of dealing with resource issues, where prioritisation is essential and where a broader view of hospital operations is required. Clinicians, in contrast, are charged with making medical decisions for individual patients. It is possible that the clinicians in the Rozenblum et al. study (2012) illustrate the differences in both groups' professional priorities, echoing another study which found that clinicians and managers identified different aspects of a quality and safety intervention (Parand et al., 2011). It is also likely that due to the survey design of the team's study it was not possible for them to probe into the complexity of why current patient-centred care plans are

inadequate. This study is able to add clinicians' reports that management do not have an adequate plan to improve patient satisfaction by offering a more nuanced picture, as will be discussed in more detail.

It is also important to note that several managers felt that frontline staff were resistant to patient-centred efforts. This study was able to probe and hear of some managers' views on issues relating to this resistance. These included the relinquishing of power and the perception of patients as being uneducated or unknowledgeable. These observations could possibly echo the "intergroup conflict" identified elsewhere (Kreindler, 2013) . More importantly, however, it suggest that patient-centred care achievements from management and frontline staff, as reported by many of the participants themselves, are currently inadequate, and therefore actual differences between both professionals are less marked than previously reported (Rozenblum et al., 2012). Furthermore, it suggests that hospitals require all staff to work towards a shared patient-centred approach, which was also explicitly stated by some managers. How to further involve patients exactly remains an important question (Groene et al., 2014a; Groene et al., 2014b).

Culture emerged as a key theme in relation to the way in which patient-centred care is conceptualised and borne out in the hospital, according to managers. Most of the other themes raised by the participants also seem to converge on culture, as will be discussed here. It appeared to be important to the clinician-patient relationship (micro level), to management and leadership style and organisational culture within the hospital (meso level), and also seemed to be related to wider structural factors and political power (macro level). The picture that emerged is a spectrum of different patient-centred care models, or rungs of the *Ladder of Participation*, each illustrated by the participants' accounts. The Polish and Czech accounts seem to position their hospitals at the lower rungs of the ladder, described by Arnstein as *Non-participation*. One of the participants spoke about the power balance between patient and state in the Czech Republic, and two other Czech participants indicated that they have somewhat traditional hierarchies in the hospital. The Polish hospital manager said that patient-centred care is a Western concept that is "not widely used" in Poland, and that they have a "different kind of attitude". These accounts suggest a somewhat complex picture of how political histories and culture play out in the hospital, where, historically, political power is positioned more towards the state rather than towards the service user. The role of management and their adopted style of leadership could reflect this wider context and shape culture towards service users within the hospital. In contrast, the Danish and Dutch hospital managers' accounts seemed to position their hospitals closer towards *Citizen Power*. They placed emphasis on a "shared vision", spoke of managements' facilitation of "flat" hierarchies within the hospital and reported slightly more mature levels of patient-centredness. Historically, there has been greater engagement of the citizen in Denmark and the Netherlands, which could be reflected in the hospital culture. The suggestion elsewhere (Bate and Robert, 2007) that patient-centred care is part of efforts towards a more bottom-up approach to healthcare seems to be evident in the participants' reports, and could suggest the important role that management has in facilitating this. The two private hospital managers suggested they place emphasis on a high level of patient satisfaction and offer patient choice, which may position their hospitals on the higher rungs of the ladder. However, service users were described as "customers", a term increasingly used in the United Kingdom, but which could suggest a transaction rather than an engagement. Furthermore, the emphasis on choice and fulfilling *wants* could indicate a level of *Tokenism*, as also suggested by one of the patient organisations. Arnstein's framework helps to understand how the distribution of power between patient and provider can be realised in different hospital

settings. Some of the barriers reported by the participants, such as economic and time constraints, appear to be widely shared, but the constellations of cultural factors appear to be more unique and rate-determining.

Further data collection and analysis are certainly required to explore these different conceptualisations and conclusions certainly cannot be drawn, but what emerges from this study is the different ways in which managers conceptualise patient-centred care. It suggests that although there are currently inadequate structured plans by management to improve patient-centred, there is variation in how this is borne out in the hospital in different settings, not found in previous literature. It also suggests that these different models across Europe are culturally, historically and politically engrained, and that shifts in the hospital organisational culture may therefore be challenging. Priorities are currently clearly focused on keeping costs low and getting by with the economic climate, and it is clear this has had a significant impact on the prioritisation of patient-centred care around Europe. However, culture change and its numerous associated factors have surfaced as a deeper issue for consideration and will be key to realising a patient-centred system. The Francis Inquiry stated that culture change is not easy: "Quite how the required common culture is delivered is less than easy to discern, given the mixed success met with by previous attempts at cultural change, but it is clearly a co-ordinated combination of factors that must be looked for, rather than some simplistic solution"(2013b). Culture is also something that is complex, messy and not easily grasped, but comes from the interactions within and between staff and patients. As also reiterated by the King's Fund (2013): "It follows that nothing less than a transformation of systems, leadership and culture at all levels is needed if the lessons of the Francis Inquiry are to be learned and acted on." Reassuringly, managers appear to be aware of a number of the "co-ordinated combination of factors" for consideration, which may be one step towards creating this cultural shift.

Existing conceptual frameworks on patient-centred care currently do not articulate the roles and strategies of managers to improve patient-centredness (Mead and Bower, 2000). Our study adds to this literature by presenting managers' perspectives and highlighting their importance in the development of future frameworks.

While macro level economic and political factors may be difficult to challenge within the hospital, other meso and micro level barriers may be overcome slightly more feasibly, facilitated by managers themselves. Their role is clearly crucial to implementing patient-centred care in the hospital. As stated by participants, managers have a role to play in creating a vision, and strategies to improve communication of this vision as well as establishing more shared forms of leadership could help to engage all staff in working to realise patient-centred care. This may benefit the manager-clinician working relationship in particular. Support for the vision could be strengthened, as reported by some participants, by joining forces with user representative and patient organisations, and arranging for more staff opportunities to hear the patient voice. Additionally, managers can help to communicate to staff the value of a genuine patient-centred approach and the associated improvements to outcomes. This cultural shift will require cooperative efforts from all staff within the hospital. Lastly, managers may benefit from greater shared learning from their European neighbours on how to catalyse this culture shift, whilst being sensitive to their local context.

This study suggests that a chasm in patient-centred efforts does not exist between management and clinicians; that patient-centred care is a concern of hospital management and that they play an important role in realising this vision; and that there are shared, complex and nuanced reasons for the current lack of patient-centred systems in European hospitals.

Research limitations

Language presented as a problem for many potential and recruited participants. Recruitment of participants was restricted to English speakers, which may have introduced some selection bias. Those who were interviewed struggled at times with the English language, which made language a less nuanced point of analysis for the study. However, interviewing participants in English may have allowed for greater veracity of responses and less social desirability bias than if participants spoke in their native language with an interpreter present. Obtaining views from across Europe posed these practical issues, but which might be outweighed by the rich and diverse data that was collected.

This study was exploratory in nature and attempted to obtain a range of views that would allow for broad comparison and identification of key themes and issues. In doing so, depth of exploration and analysis for each hospital was not possible. Such focus could be usefully explored in another study using ethnography and interviews in a local context. Breadth of views does seem to reveal different applications of patient-centred care in different settings, but trends cannot be concluded from a small number of qualitative interviews and, without further in-depth analysis or use of a survey design, such differences can only be suggestive

Conclusion

We find in this study that despite increased calls for involving patients in their healthcare, managers from diverse hospital settings across Europe admit that more could be done. Managers reported that they felt restricted in their efforts by a number of macro, meso and micro barriers, including political-historical factors and clinician-patient power dynamics. Central to these was hospital organisational culture, which appears to determine the way in which patient-centred care was borne out in practice. Three models of *Non-participation*, *Tokenism*, and *Citizen Power* emerged as important but tentative findings to illustrate the way in which patient-centred care was conceptualised and practised in the participants' hospitals. These models have important implications for cross-border care, suggesting that patients may experience healthcare very differently in hospitals throughout Europe. These models also help to suggest that resource constraints are not the only barrier to patient-centredness, and that while budgets are certainly limiting, hospital culture is likely a much more important consideration. Managers tended to see the value of patient participation and the importance of strong leadership in its development, but these models suggest that in a number of hospitals there may be some way to go before it is realised.

This study adds to the literature by presenting managers' views from a range of countries and settings for the first time and contributing their voice to the patient-centred care debate. This exploratory research has provided a broad picture of current conceptualisation and implementation of patient-centred care by management, and yields a number of new and outstanding questions. Specific questions that would be useful to consider are how does organisational culture determine models of patient-centredness, what is the role of the manager in effecting change towards a patient-centred approach, and what can we learn from focusing on hospitals 'positioned' on specific rungs of the Ladder of Citizen Participation. Further adding the managers' voice and improving our understanding of their role to discourses on patient-centred care will allow us to take a step closer to meeting the needs of patients.

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