The politics of patient-centred care

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Abstract

Background Despite widespread belief in the importance of patient-centred care, it remains difficult to create a system in which all groups work together for the good of the patient. Part of the problem may be that the issue of patient-centred care itself can be used to prosecute intergroup conflict.

Objective This qualitative study of texts examined the presence and nature of intergroup language within the discourse on patient-centred care.

Methods A systematic SCOPUS and Google search identified 85 peer-reviewed and grey literature reports that engaged with the concept of patient-centred care. Discourse analysis, informed by the social identity approach, examined how writers defined and portrayed various groups.

Results Managers, physicians and nurses all used the discourse of patient-centred care to imply that their own group was patient centred while other group(s) were not. Patient organizations tended to downplay or even deny the role of managers and providers in promoting patient centredness, and some used the concept to advocate for controversial health policies. Intergroup themes were even more obvious in the rhetoric of political groups across the ideological spectrum. In contrast to accounts that juxtaposed in-groups and out-groups, those from reportedly patient-centred organizations defined a 'mosaic' in-group that encompassed managers, providers and patients.

Conclusion The seemingly benign concept of patient-centred care can easily become a weapon on an intergroup battlefield. Understanding this dimension may help organizations resolve the intergroup tensions that prevent collective achievement of a patient-centred system.

The politics of patient-centred care

A growing international movement champions patient-centred care (PCC), which has been recognized as an important element of quality in its own right and a potential contributor to other desirable outcomes.[1] Of the numerous definitions of PCC, many focus on the point of

care (stressing humanistic values and/or shared decision making), some on services and systems (describing services that revolve around the patient and/or are designed with patient input) and a few on broader policy considerations.[2–8] Despite these differences in emphasis, the literature suggests a general consensus on the essence of PCC:

> 'In the broadest terms, patient-centered care is care organized around the patient. It is a model in which providers partner with patients and families to identify and satisfy the full range of patient needs and preferences' (Frampton et al., 2008, p. 4).[9]

What is lacking is evidence on how to actualize this vision. While some studies have assessed interventions to promote patient-centred clinical consultations,[10] the evidence base on how to achieve PCC at the *organizational* level is very limited. There is a widespread understanding that becoming patient centred requires not merely the adoption of various interventions, but 'culture change'. But what does this entail?

Complicating the picture is the finding that out in the real world, different stakeholder groups talk about patient-centred care in very different ways.[11] Goodrich and Cornwell found that 'the concept of 'patient-centred care' is changeable; it means different things to different people, and is defined in ways that reflect and reinforce, rather than transcend the division between the various tribes in health care – the doctors and managers, the doctors and nurses, the clinical versus the non-clinical' (p. 4).[5] The present article will take this analysis a step further by revealing how the discourse of patient-centred care is actively used to prosecute intergroup conflict. Managers, professionals, policymakers and even patient groups can be found to deploy claims about what (and who) is patient centred as weapons on an intergroup battlefield. Understanding this dimension is essential to resolving the intergroup tensions that prevent the collective achievement of a patient-centred system.

Methods

This *discourse analysis* investigates how different groups engage with the concept of patient-centred care. The technique of discourse analysis uncovers how people use language to accomplish various actions, such as justifying or blaming.[12] An inquiry into how *groups* use language demands, in addition, a theoretical frame that explicates intergroup relations. As elucidated in a recent review,[13] the *social identity approach* (SIA, which comprises social identity theory[14] and self-categorization theory[15]) offers a broad, multifaceted framework that accommodates the insights of diverse traditions. Founded in the recognition that group memberships form a crucial part of individuals' self-concepts, the SIA highlights the importance of *social structure* (groups compete for status and power) and *identity content* (members uphold and protect group-defining attributes and values). Whereas early social identity research concentrated on internal processes, the literature has increasingly expanded to address the public performance of social identities.[16] Studies have used discourse analytic techniques to investigate how communicators construct and manipulate social categories to advance group interests or ideologies,[12,17–19] and current scholarship identifies 'crafting a sense of us' as a core component of effective leadership.[20] Within the health-care field, although few discourse analytic studies have explicitly cited social identity theory,[21,22] several have shown how discursive constructions are used for ingroup enhancement, intergroup differentiation and/or the advancement of group interests[23–25]; other studies have, without using discourse analysis *per se*, explored how social identities are constructed in talk or text.[26–29] The present analysis examines the presence and nature of social identity constructions within the discourse on patient-centred care.

I conducted a systematic search for English-language reports that engaged with the concept of PCC and/or the question of how to achieve it. The intent was not to assemble a complete body of relevant literature, but to derive a

sample of reports reflecting the main perspectives from which PCC has been addressed. In the interests of focus and manageability, I restricted the search to 'patient-centred care' and its synonyms (not related concepts such as 'medical humanities' or 'patient engagement'); included only literature on PCC within clinical care in general, excluding the subliteratures on mental health, dementia, paediatrics, and provider groups other than medicine and nursing; and used only reports from North America, Australasia and the UK. (It is worth noting that the large literature on person- or client-centredness in mental health raises several important issues– from the effectiveness of Rogerian therapy to the ethics of involuntary treatment and the question of who defines mental 'health', that would have been impossible to address adequately while maintaining a broad survey of the PCC literature.)

To identify peer-reviewed literature, I searched SCOPUS (which includes full MEDLINE coverage) for articles whose titles featured 'patient centred' or a related term and that were either influential (cited > 10 times) or recent (published since 2009). To identify grey literature (reports, books, documents and websites), I Google-searched 'patient centred' and a variety of related terms and retrieved the top 100–400 hits for each, to the point of theoretical saturation. (See Data S1 for further details on the search strategy and a full list of included reports.) Some additional sources were identified through personal collections, follow-up searching and web links. This process yielded 87 sources, including 55 journal articles, 24 grey literature reports, six websites and two books. More than half the sources (51) came from the United States, 19 from the UK, 10 from Canada and four from Australia; three were international in focus. Four were published during the 1990s, 53 in the 2000s and 30 since 2010.

Data extracted included report characteristics (e.g. year, country, authors, professional and/or organizational affiliation if noted), the groups mentioned (e.g. patients, various types of providers, managers, etc.), the way each group's attitudes and/or behaviour were explicitly or implicitly portrayed as consistent or inconsistent with PCC, and key quotations illuminating this. This phase revealed that intergroup themes, while not universal, were sufficiently prevalent to merit further investigation. I therefore undertook a closer analysis of reports featuring particularly strong (positive and/or negative) statements about various groups.

Results

PCC and intergroup conflict in health care

In a number of cases, the language of PCC has been used to advance the intergroup concerns of managers, professionals and/or patients, and in some cases to attack other groups. The most blatant examples tend to appear in the grey literature, although a number of milder ones occur in peer-reviewed articles. The cited sources most clearly exemplify the use of intergroup language, but are by no means unique. They are highlighted, not to single them out for criticism, nor to dismiss the often thoughtful and valuable proposals that they present, but simply to illustrate the intergroup dimension of the discourse on patient-centred care.

Managers
Reports from a managerial perspective tend to emphasize the service/system level of PCC. These make an important contribution by advocating health-care design that creates a better experience for patients, addressing such issues as access and continuity of care. However, while delivery system redesign *does* show evidence of benefiting patients, there is some concern that when such redesign is equated with patient centredness, the patient becomes invisible.[30] An even greater cause for concern is that *managers* as a group can become invisible; in some sources, the recommended approach is clearly managerialist, yet managers are never recognized as a group with its own interests. Instead, they are able to appropriate the identity of patients to gain ground in an intergroup battle with providers.

A two-part report prepared for a Canadian provincial government draws the battle lines, with patients and (invisible) managers on one side and providers, especially physicians, on the other.[31,32] It introduces PCC thusly:

'A basic foundation of PCC is the notion of service. Many think of contemporary health care as a combination of science and technology deployed by professionals to address health problems. This is of course true, but PCC is based on a simpler premise: health care is a *service* industry…. one concept fundamental to the commercial world is relevant to health care: the customer is always right'. (2009a, p. 2, emphasis original)

Here, the author makes a seamless transition from the idea of service (which many professional groups embrace) to that of a service *industry* in which patients are customers. This extract draws a contrast between a professional-centric and customer-centric view, both implicitly ('science and technology deployed by professionals') and explicitly ('the customer is always right'). In part two of the report, the author recognizes – but dismisses – providers' aversion to the patient-as-customer paradigm:

'Providers – again, physicians in particular – are not inculcated with a culture of service. They see patients as fundamentally different from customers….Their basic question is not, "what does the patient need to have a good experience," but rather "what do I need to do to cope with demands".' (2009b, p. 1)

The implication is that providers who persist in seeing patients as 'fundamentally different from customers' are subordinating patients' interests to their own.

Part one of the report concentrates on recommendations for delivery system redesign and quality management (few of which appear distinctive to PCC). Although never named as a group, managers would presumably be responsible for implementing the prescribed 'financing changes', 'organizational changes', and changes to 'monitoring and accountability'. Part two, which focuses on means of shifting power from providers to patients, features a suggestion that primary care practices be required to 'read patients their Miranda rights' (2009b, p. 6) –

seeming to imply that the physician–patient relationship should be remodelled along the lines of that between police officers and criminals. Although the report acknowledges that 'the strategy should be collaborative, with providers central to (but not dominant in) its development' (p. 4), the expectation seems to be that providers will collaborate, not in *defining* the agenda but in implementing a managerial one.

To many clinicians, turning patients into customers not only attacks professional status but strikes at the dignity and value of the work they do by turning it into a mere commodity.[33,34] As we will see, the managerial groups who undertake such intergroup positioning are far from invisible to health-care professionals.

A discussion paper by the Australian Commission on Safety and Quality in Health Care provides another example of a managerial perspective.[35] Its definition of PCC in terms of 'mutually beneficial partnerships among health care providers, patients, and families' (p. 13) leaves managers invisible, yet most of its recommendations are directed at managers (the remainder at policymakers), suggesting a technocratic paradigm in which managers make all the improvements. Like the preceding report, this one encourages managers to engage staff – but with the clear implication that managers, and not staff, are inherently patient centred.

'Another factor associated with success in patient-centred environments is that employees' behaviour consistently reflects the organization's values. Only when employees' personal values simulate the core values of the organization can the culture transform to a patient-centred model…Directly involving staff in determining the organizational values and defining the behaviours that embody those values fosters a culture of patient-centred care. Making the organization's values visible can remind staff of the patient-centred behaviours expected of them'. (p. 31)

This extract implies that the organization (meaning managers) naturally embodies patient-centred values. Employees' values, in contrast, are thrown into doubt; they may not genuinely converge with the organizational

value of patient centredness, but must 'simulate' it. Furthermore, the emphasis on bringing *personal* values into line with organizational ones implies that the organization is the only relevant collectivity. There is nary a suggestion that the staff body includes groups with a collective commitment to providing excellent and responsive care or that *professional* values (which the report never mentions) might be as relevant as 'personal' ones. It is notable that the authors favour the generic term 'staff' or (less frequently) 'providers', very seldom referring to 'clinicians' or any subgroup thereof. 'Managers' receive relatively few mentions; more than half of these occur in the recommendations section, where assumptions about the respective roles of managers and staff are made plain (e.g. 'executives and managers should develop a shared patient-centred mission that senior leaders continually articulate to staff'; p. 55).

Health-care professionals

Health-care professionals present the aspiration towards patient centredness as grounded in professional identity, envisioning patient- or person-centred care in terms of humanistic values and partnership, not consumerism and buyer–seller relationships. Indeed, they can lead the charge for patient centredness, understood as a fuller expression of their professional identity.[36] The problem, however, arises when professional groups use this genuine and legitimate aspect of identity content to buttress the claim that they are already patient centred – and others are not.

In a paper by the Canadian Medical Association Working Group on Collaborative Care, the rhetoric of 'putting patients first' is clearly employed to support one profession's agenda, as physicians unite with patients against cost-cutting managers/governments and uppity non-physician provider groups.[37] The authors begin by situating the concept of PCC within medical identity:

> 'The CMA considers patient-centred care to be the cornerstone of good medical practice... As

patient advocates, physicians strive to ensure that their patients receive the best possible care. At the heart of patient-centred care lies the patient-physician relationship, the importance of which cannot be overstated' (p. 1).

The 'politics' of the issue – already hinted at in the term 'patient advocates' (which implies protecting patients' interests from other groups) – are soon addressed head-on:

> 'Too often, governments, other providers and health system managers have used "collaborative care" as a vehicle to achieve objectives and address agendas that are not focused on patient care... constraining health care costs; controlling the medical profession; advancing individual personal and/or professional self-interests...' (p. 4).

Physicians, however, are held exempt from such accusations; the repeated theme is that other stakeholders' demands are group serving, whereas physicians are grounded in what is best for patients.

The report then articulates twelve principles of collaborative care, beginning with 'patient-centred care', 'recognition of the patient-physician relationship', and 'physician as the clinical leader' (pp. 5–6). In elaborating the first of these principles, the authors take the opportunity to differentiate physicians from other providers ('First and foremost, medical care delivered by physicians and health care delivered by others should be aligned around the values and needs of patients'; p. 5). The second principle enshrines the physician–patient relationship as 'the cornerstone of medical care' (p. 6). Arguing that 'every resident of Canada has the right to access a personal family physician' (p. 6) – and expressly excluding nurse practitioners from this category – the report cautions that 'collaborative care should not be seen as an opportunity for governments to substitute one care provider for another simply because one is more plentiful or less costly than the other' (p. 10). By the time the report moves on to principles that connote intergroup harmony (e.g. 'mutual respect and trust'), 'patient-centred collaborative care' has been inextricably linked to medical dominance.

An even more confrontational approach is evident in http://www.patientcenteredcare.net,

the website of an American primary care physician.[38] With the explicit statement that 'U.S. medicine is currently controlled by pharmaceutical manufacturers, government, insurance companies and an inordinate excess of specialists', he pits physicians and patients against the managerial elite, whose agenda of population health and disease management ('a new concept that removes your individuality') is portrayed as contradicting the patient-centred ethos of recognizing the unique patient.

Not only physicians but nurses can mobilize the language of PCC for intergroup purposes. Nursing scholars Lutz and Bowers draw on the concept of person-centredness for ammunition in the fight against physicians.[39] Their discourse centres on intergroup differentiation between nursing and medicine:

> 'Nightingale…considered nursing as distinct from medicine because it focused on the patient rather than the disease….however…even though nursing has a long history that is focused on meeting patients' needs, the philosophical underpinnings of many of the major nursing theories support the authority of the social institution of medicine, with a provider-defined, disease-focused approach…' (p. 170).

The authors urge nurses to throw off medical authority and embrace the distinct, patient-centred heritage of nursing. They present PCC as a source of not only in-group superiority but potential in-group advantage: 'With its long-standing commitment to being patient focused, nursing is in a prime position to lead the research effort [on] patient-centered models of care' (p. 179). Surprisingly, their concept of PCC hinges on 'a philosophical shift…from providing care for patients to providing services to consumers' (p. 173). Whereas professional discourses often reflect an antipathy to managerialism and market language,[33] these authors would apparently prefer to embrace the commercialization of care than to co-operate with medicine.

Patient groups

Obviously, the discourse on PCC should reflect, first and foremost, the views of patients.

However, the reports produced by patient organizations are not entirely unproblematic. Their constructions of patient identity may not represent all patients and may carry various kinds of ideological baggage.

The International Alliance of Patient Organizations (IAPO) offers one of the least political discourses; although it does advance a particular representation of patients (highly active, desirous of customized care), it casts no aspersions on other groups.[1] However, some intergroup bias surfaces when IAPO broaches the topic of how to achieve patient-centred care: Nearly every sentence in the 'possible solutions' section is written in the passive voice (e.g. 'Policies must be designed around the patient. Structures to ensure policies and practice are patient-centred must be built into the healthcare system at every level…'; p. 17). While the report identifies 'the opportunity to work with others to…encourage the practice of the identified elements of patient-centred healthcare' (p. 17), these 'others' are never named, leaving patients/families as the only visible, agentic group.

To more militant patient or citizen groups, managers, policymakers, and sometimes providers become actual targets of resistance. The American organization Health 3.0 eschews the very term 'patient', which, in its view, 'strengthens the traditional medical care system… reinforces the existing power relationships and creates the illusion of control when in fact very little changes'.[40] It urges individuals to put 'the CONTROL and RESPONSIBILITY for making health and health-care decisions back where it belongs – with YOU, the individual. Not with your doctor, health insurer or some government agency'.[41] The Canadian Association for People-Centred Health (CAPCH) likewise avoids the term 'patient'.[42] However, by constructing the category 'people' to distance themselves from the vulnerable identity of 'patient', such groups may marginalize the experience of persons whose illness renders them vulnerable. These reports downplay certain aspects of patient-centred care that are highly valued by patients

and providers alike (humaneness and relationships) and demand a level of control that patients may not always want or be able to exercise. (The implications of advocating patient control and responsibility have been addressed more fully in the literature on chronic disease self-management.[43,44])

Under the banner of 'people-centred health', CAPCH founder Vaughan Glover endorses policies that are not necessarily embraced by all people (or patients). Some of his recommendations are evidence-based (e.g. increased role for non-physician providers and multidisciplinary teams), but others are quite controversial (e.g. increased private delivery and financing of care). Interestingly, although he speaks for patients, Glover belongs to a profession that competes with medicine for status and exists outside Canada's public system: dentistry.

Even when it is not tied to specific policy planks, the idea of patient control can be used to justify governmental withdrawal of resources from health care. One American summit of health-care leaders decided that a 'collaborators in health' scenario – which offloaded much responsibility onto patients and a vaguely defined informal sector – were preferable to an excellent and responsive but costly health-care system, because the latter might remain 'paternalistic' (Bezold *et al.*, 2004, p. 15).[45] (Interestingly, the putatively non-paternalistic alternative involved incentive schemes to control patients' health behaviour.)

PCC and political ideology

The political dimension of PCC is most evident when one examines how the topic is discussed by politicians and activists. To conservatives, PCC means consumer choice exercised in a free market[46]; to liberals, it means universal access which must be ensured through government intervention[47]; to socialists, it takes on the added implication of participatory democracy.[48] However, 'capital-P politics' are not the focus of this inquiry; owing to space limitations, such discourses are discussed in Data S2.

PCC without intergroup conflict

We have now surveyed political discourses that privilege the perspective and interests of a certain group, often at the expense of other groups. Is there another way to talk about PCC?

Researchers who have produced seminal works on PCC tend not to engage with the politics.[7,10,49] This literature is an invaluable resource for defining the construct and determining its evidence base, but does not take us very far down the path of achieving PCC in politically complex organizations. Moreover, readings of PCC that appear neutral may still have political implications; Pulvirenti *et al.*[43] charge that the traditional PCC literature, by restricting its focus to the individual patient and the clinical relationship, precludes the discussion of broader political changes needed to empower people to manage their own health (e.g. those targeting the community environment and social determinants of health).

A more helpful approach may be to examine the discourse produced by organizations that are considered patient centred. Among the articles retrieved, three were written by representatives of organizations that have been cited as exemplars of PCC by a national or international institute devoted to its promotion.[50–52] As the examples below will reveal, these quite explicitly construct a tripartite in-group of patients/families, providers/clinicians/staff and managers/leaders. This is not a homogenized in-group that attempts to unite everyone behind a pre-specified common vision, but a mosaic that highlights the patient-centred identity content of each subgroup. An account from the Dana Farber Cancer Institute, published in a nursing journal, begins:

> 'The idea of patient-centered care resonates particularly well with nurse executives and clinicians, who have long valued the central role of patients and families in the design and delivery of healthcare. Yet even as most professionals in the healthcare arena readily embrace a philosophy of patient-centered care, many underestimate the organizational commitment and related

efforts associated with moving from a traditional organizational model to one that is truly patient-centered'. (p. 82)[50]

The authors address nurses and other clinicians as group members and affirm that a patient-centred philosophy is already part of their identity. The identified target of change is not providers but the 'organizational model', and at no time is this 'traditional' model branded 'provider centred'. Such rhetorical choices suggest that this organization's journey to 'making the patient an integral part of the healthcare team' (p. 82) began with validation of provider identities. In a similar vein, an article by the CEO of a Planetree hospital itemizes the groups that contribute to patient-centred care and criticizes none:

> 'Of course, the most powerful resources available to those of us on a journey of patient-centered care culture change are not manuals or a series of articles; they are the people who make up our organizations: patients, families, staff, medical staff, volunteers, board members and patient and family advisory council members'. (p. 34)[51]

In rare cases, an organization may be able to draw on a single, shared group identity. At the Mayo Clinic, a strong common identity is grounded in physician identity; providers embrace the credo 'the needs of the patient come first' and see no tension between being a physician and doing management.[53] But more commonly, organizations that are known for PCC appear to build a multipartite identity, emphasizing the congruence between each subgroup identity and a patient-centred philosophy. An early book on achieving patient-centred care speaks explicitly of working through the various organizational subcultures instead of attempting to dominate them.[4] The Planetree–Picker improvement guide instructs that culture change must begin with serious, far-reaching engagement of staff, physicians, administrators and patients/families.[9] The language used throughout the report conveys support for all these groups' identity content. Such language appears to facilitate conversations about patient-centred care – or whatever term for this construct resonates most with the groups involved.

Discussion

This article has illustrated how the discourse of managers, health-care professionals, patient organizations and others may reflect the politics of patient-centred care. This does not mean that all discourse on PCC is highly politicized; much of the literature – especially the official, academic literature – is not. Without a complete survey of the literature on PCC, which is far beyond the scope of this article, it remains difficult to estimate how much of the discourse is politicized, or whether some areas are more politicized than others. However, the discovery of intergroup themes in more than a few reports from each health-care group suggests that politicization is widespread enough to merit serious attention. To identify this as a problem is not to imply that statements about various groups' patient centredness (or lack thereof) are invariably expressions of bias or identity-enhancing performances, but merely to suggest that persistent intergroup strife is not conducive to the achievement of patient-centred care.

How could as seemingly benign a concept as patient-centred care become an instrument of conflict? Perhaps the concept's slipperiness makes it easy for groups to appropriate. Stewart observed that PCC 'may be most commonly understood for what it is not – technology centred, doctor centred, hospital centred, disease centred' (p. 444).[49] Yet the common practice of defining PCC negationally allows certain groups to be singled out (implying that their interests clash with patients), while other groups remain hidden (implying that their interests are congruent with patients). Thus, managers can contend that health care must cease to be provider centred, providers can contend that it must cease to be bureaucracy centred, and politicians can contend either or both, depending on their current alliances. Ironically, the purpose of invoking the term 'patient centred' may sometimes be to

rally stakeholders behind a common purpose. In making the case for interprofessional practice, a senior manager of my own health region stated, 'Our health care system is provider centred. It needs to be patient-centred. We're all here for the same goal – to meet patient care objectives'.[54] As we have seen, however, PCC is far from an unproblematic rallying point – especially when it is linked to the idea of de-centring some other group.

The goal of patient centredness *does* have the potential to unite health-care groups – but to do so, it must be understood as congruent with, not contrary to, their existing social identities.[13] To avoid political landmines, those wishing to make an organization more patient centred should strive to see PCC through the 'triple frame' of provider, patient/family and management perspectives. Instead of asking, 'how can we shift the focus away from providers?' they might ask, 'Under what conditions will providers embrace a patient focus, and how can we support them in working towards that goal?' This appears to be the approach taken by the most patient-centred organizations. Of course, assessment of the actual state of intergroup relations within such organizations is well beyond the scope of this article, and it seems unlikely that intergroup tension could be completely abolished in any organization. However, such organizations' inclusive, mosaic-favouring rhetoric suggests a consistent practice of affirming and mobilizing subgroup identities *en route* to developing a shared identity. This practice is consistent with evidence that the first step towards resolving intergroup conflict is to strengthen subgroup identities – not to ignore them or try to subsume them in a unitary identity (either of which can provoke *identity threat* and exacerbate conflict).[29,55] The 'black box' of culture change might be opened to reveal an overall strategy of working with and through existing social identities.

To recommend inclusiveness towards all groups is not to deny the patient–provider, employee–manager and interprofessional power differentials that exist in health care. On the contrary, acknowledging the importance of groups can be a first step towards examining the structure in which these interact and finding ways to mitigate power imbalances and work through competing interests. Organizational approaches that ignore intergroup conflict, or inflame it, are more likely to reinforce the *status quo*.

The Actualizing Social and Personal Identity Resources (ASPIRe) model offers a practical, four-step approach to engaging organizational subgroups.[55] First, surveys and/or consultations are used to determine which groups staff consider relevant (e.g. professional groups, sites, programs, non-work-related groups, etc.). Second, each subgroup discusses the issue separately, defining it in their own terms and using their own language (which may or may not include the term 'patient-centred care'[5]). This is very important if staff groups are to have real ownership of the process and make a meaningful contribution; it is even more important for patients, who have the least power and perceived expertise within the health-care system. Patient/family groups should have a neutral facilitator and not be led (or even frequented) by managers, to avoid the risk of co-optation either by 'the system' in general or by whatever subset of managers happens to run the involvement activity. Third, the subgroups select representatives who come together to develop a common vision and mandate. Finally, this group chooses and spearheads a selection of changes, which may include both measures to meaningfully embed culture change and tangible interventions to make the design and delivery of care more patient centred. Given the large volume of research on patient and staff perspectives, it may be tempting to assume that we already know what various groups will say about patient-centred care. However, it is crucial that they have the conversation, because it is the *process* that leads to change.

While it may be counterproductive to define PCC in terms of taking power or focus *away* from certain groups, it remains very legitimate to talk about putting patients *first*. The proposed 'triple frame' is in accordance with a report from the Institute for Family-Centred

Care, which upholds an agenda of collaboration but is also critical of managers and providers who maintain a narrow-group focus or claim to represent patients.[2] Leaders need to draw on the positive elements of each group's identity content, but should also guide groups towards using this identity content to build bridges, not walls or smokescreens. We may not be able to escape from the politics of patient-centred care, but we can replace the politics of division with the politics of inclusion.

Acknowledgements

Supporting Information

Additional Supporting Information may be found in the online version of this article:
   Data S1. Search and selection process.
   Data S2. Patient-centred care and political ideology.

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