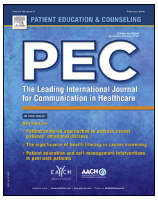
Patient Education and Counseling xxx (2016) xxx–xxx

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou



Review article

Patient empowerment, patient participation and patient-centeredness in hospital care: A concept analysis based on a literature review

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ARTICLE INFO

Article history:
Received 23 February 2016
Received in revised form 14 July 2016
Accepted 16 July 2016

Keywords:
Patient participation
Patient-centeredness
Patient empowerment
Concept analysis

ABSTRACT

Objectives: The concepts of patient empowerment, patient participation and patient-centeredness have been introduced as part of the trend towards a more participatory health care and have largely been used interchangeably. Although these concepts have been discussed for a number of years, their exact meaning in hospital care remains somewhat unclear. This absence of theoretical and conceptual clarity has led to (1) poor understanding and communication among researchers, health practitioners and policy makers and (2) problems in measurement and comparison between studies across different hospitals.
Methods: This paper examines all three concepts through a concept analysis based on the method of Avant and Walker (2005) [1] and the simultaneous concept analysis of Haase et al. (1992) [2].
Results: Through these methods, the antecedents, attributes, consequences and empirical referents of each concept are determined. In addition, similarities and differences between the three concepts are identified and a definition offered for each concept. Furthermore, the interrelatedness between the key concepts is mapped, and definitions are proposed.
Conclusions: It can be concluded that patient empowerment is a much broader concept than just patient participation and patient-centeredness.
Practice implications: The present study may provide a useful framework that researchers, policy makers and health care providers can use to facilitate patient empowerment.

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http://dx.doi.org/10.1016/j.pec.2016.07.026
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1. Introduction

Patient empowerment is a concept that was introduced to allow patients to shed their passive role and play an active part in the decision-making process about their health and quality of life. The concept is rooted in social action and associated with community interests and attempts to increase the autonomy, power and influence of oppressed groups such as the poor, working class residents, women and ethnic minorities [3]. During the 1960s civil rights movement, the concept further expanded by emphasizing the rights and abilities of individuals and communities rather than focusing on their deficits and needs [4]. In the 1970s and 1980s, the idea of empowerment was embraced by the self-help movement [3] and it has continued to grow ever since. Over the last three decades, a series of policy changes paved the way for the international attention patient empowerment currently attracts. Like other supranational organizations, the World Health Organization [5] has developed guidelines that emphasize that patients' voices should be heard [6]. The emphasis is on assisting people in gaining control over the factors that might affect their health. Both individual and collective empowerment are emphasized as critical to patients' ability to control their own lives.

Against the backdrop of this desire to empower patients, a tendency towards more patient participation has developed. At the root of this trend are developments in legislative regulations and policies, and evolutions in society at large and health care [7]. Patients or patient organizations are increasingly invited to take an active role in their own care as well as at more strategic levels, such as the organization of care. Patients have come to be seen as experts on their own bodies, symptoms and situations. Patients' experiential knowledge is now considered to be complementary to professionals' knowledge [8,9] and important for the success of the treatment and improving the quality of care [10–12]. By inviting patients to participate in care decisions, the gap between the professional knowledge and the knowledge by experience can be bridged, while health care becomes more patient-centered [13]. In 1969, Michael and Enid Baling introduced patient-centered medicine in the medical field as "another way of medical thinking". Doctors were required to include everything they knew about their patient in their diagnosis and treatment. The focus was not only on medical-technical aspects but also on emotional, spiritual and relational dimensions [14,15]. Since 2001, patient-centeredness is one of the six improvement goals to enhance quality of care in health care systems listed in Crossing the Quality Chasm: A New Health System for the 21st Century [16]. It is viewed as an approach that respects the individuality, values, ethnicity, social background and information needs of the patient. Although patient-centeredness has for decades been the focus of research and health policy developments, there is no real consensus on its definition.

In research literature, patient empowerment, patient participation and patient-centeredness have been buzz concepts for quite some time now. Despite the popularity of these three terms, existing scientific literature offers no univocal definitions for these concepts [17], and it is unclear how they are related [18,19]. This paper intends to clarify the meaning of the overlapping concepts of patient empowerment, patient participation and patient-centered (ness) by highlighting their interrelationship and distinguishing their antecedents, attributes, consequences and empirical referents, and this with the aim of improving understanding between different groups of health care professionals in hospital care. A second goal of this paper is to suggest a definition as well as a process model for these three key concepts.

A plethora of terms are used in existing literature to refer to the concept of patient empowerment, patient participation, patient-centeredness and the 'users'. For the purpose of clarity, this paper exclusively uses the term 'patient' to refer to users.[1]

2. Methods

2.1. Search strategy concept analysis

The search strategy of this concept analysis included a protocol driven search, combined with a secondary search (snowballing), following the recommendations of Greenhalgh and Peacock [20]. Original articles as well as theoretical and conceptual articles were

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[1] This does not imply that we see patients as passive subjects.

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consulted. We looked at peer-reviewed papers in medical, sociological, psychological and nursing literature. Four databases were searched (Pubmed, Web of Science, Embase and Jstor) with the following keywords entered: 'patient empowerment'; 'patient participation'; 'patient-centered' or 'patient-centeredness'; and this with and without the search term 'conceptual definition'. The search was limited to references published in English; and only articles published in the last 10 years were included. Since this resulted in a large number of articles; the search was limited to articles that listed the search terms in their title.

2.2. Eligibility criteria

Publications with a conceptual definition or framework of patient empowerment, patient participation or patient-centeredness were included in the literature study. Definitions or frameworks were considered to be conceptual if they specified 'what needs to be assessed in empirical evidence' [21].

First, titles and abstracts were screened to exclude irrelevant records. Second, full text articles were retrieved for all selected records. Third, the full texts were screened to see whether they fulfilled the inclusion criteria. Articles that showed how these concepts were understood, described and operationalized were included. Articles that were retrieved by applying the snowball method and those considered as seminal papers whether they were published more than 10 years ago or not were also included. Literature on nursing home or residential or aged care was excluded because this did not fit within the scope of this study. As the aim was to identify a broad range of conceptual definitions used in the literature, no further assessment of the validity or quality of the full text was conducted. This selection process continued until a saturation point was reached in terms of breadth of understanding and descriptions. When no new information emerged after three papers, the search was ceased. Finally, all the definitions were screened by two peers from the same research unit who evaluated the definitions' appropriateness. The result was that 20 definitions of patient empowerment, 13 definitions of patient participation and 20 definitions of patient-centeredness were included (Appendix A). Fig. 1 shows the flow diagram detailing the search process and inclusion of papers in this review.

2.3. Concept analysis

Concept analysis is widely viewed as a process that informs theory development and facilitates communication [22]. "After a brief comparative study of different approaches, a combination of Walker & Avant [1] and the simultaneous concept analysis (SCA) of Haase et al. [2] seemed the most appropriate approach to identify unique characteristics and relationships of ambiguous concepts. The strength of the method of Walker & Avant is that it provides a structural guideline [23]. In combination with SCA the method offers the advantages of clarifying all concepts simultaneously and distinguishing between their characteristics, leading to mutually exclusive definitions as the basis of a theoretical process model. Moreover it reflects diverse perspectives of concepts to obtain a generic view of those concepts. SCA is an extensive method leading to an in-depth analysis as it includes continuous validation of the concepts during the analysis. Therefore it offers greater understanding of the meaning of individual concepts and the processes that may underlie their characteristics." The analysis was comprised of the five steps shown in Fig. 2.

3. Results

3.1. Patient empowerment

3.1.1. Definitions

Patient empowerment is a very complex and paradoxical concept: it is situated at several levels (micro, meso and macro), can be approached from several perspectives (the patient, the health care provider or the health care system) that lead to different interpretations (a theory, a process, an intervention, an outcome, a feeling or a paradigm) and surfaces in several areas (e.g. (mental) health and welfare) and disciplines (psychology, sociology, nursing and social work). Different definitions, each with a different emphasis, are consequently in use [24].

3.1.2. Antecedents

A dialogue between health care providers and patients is the first antecedent to patient empowerment. Health care providers should communicate effectively [25–27]. The focus should be on

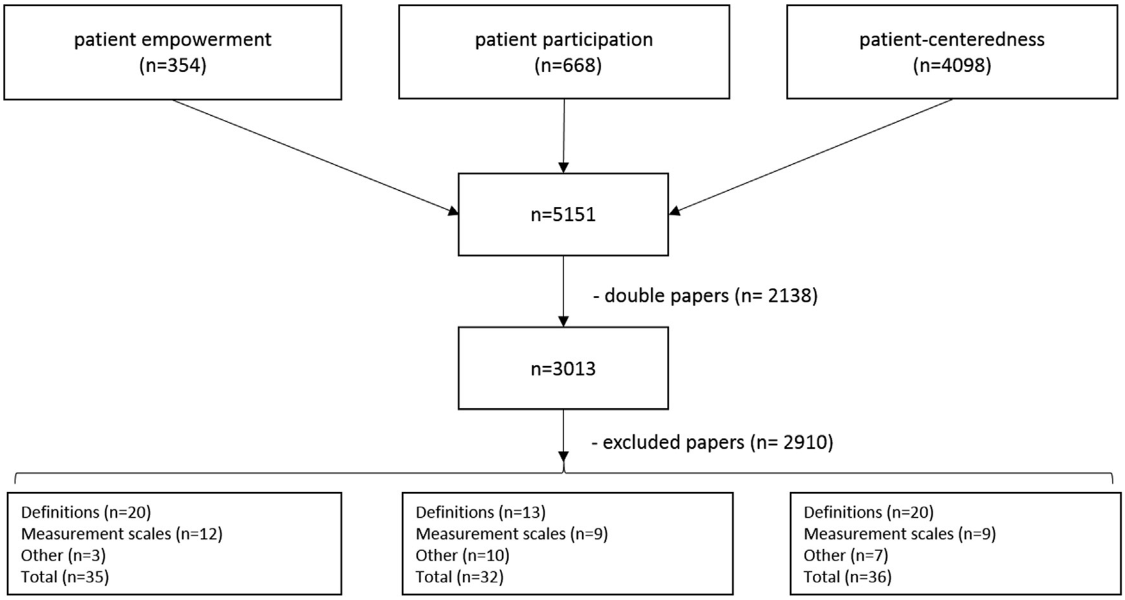

Fig. 1. The search process and inclusion of papers.

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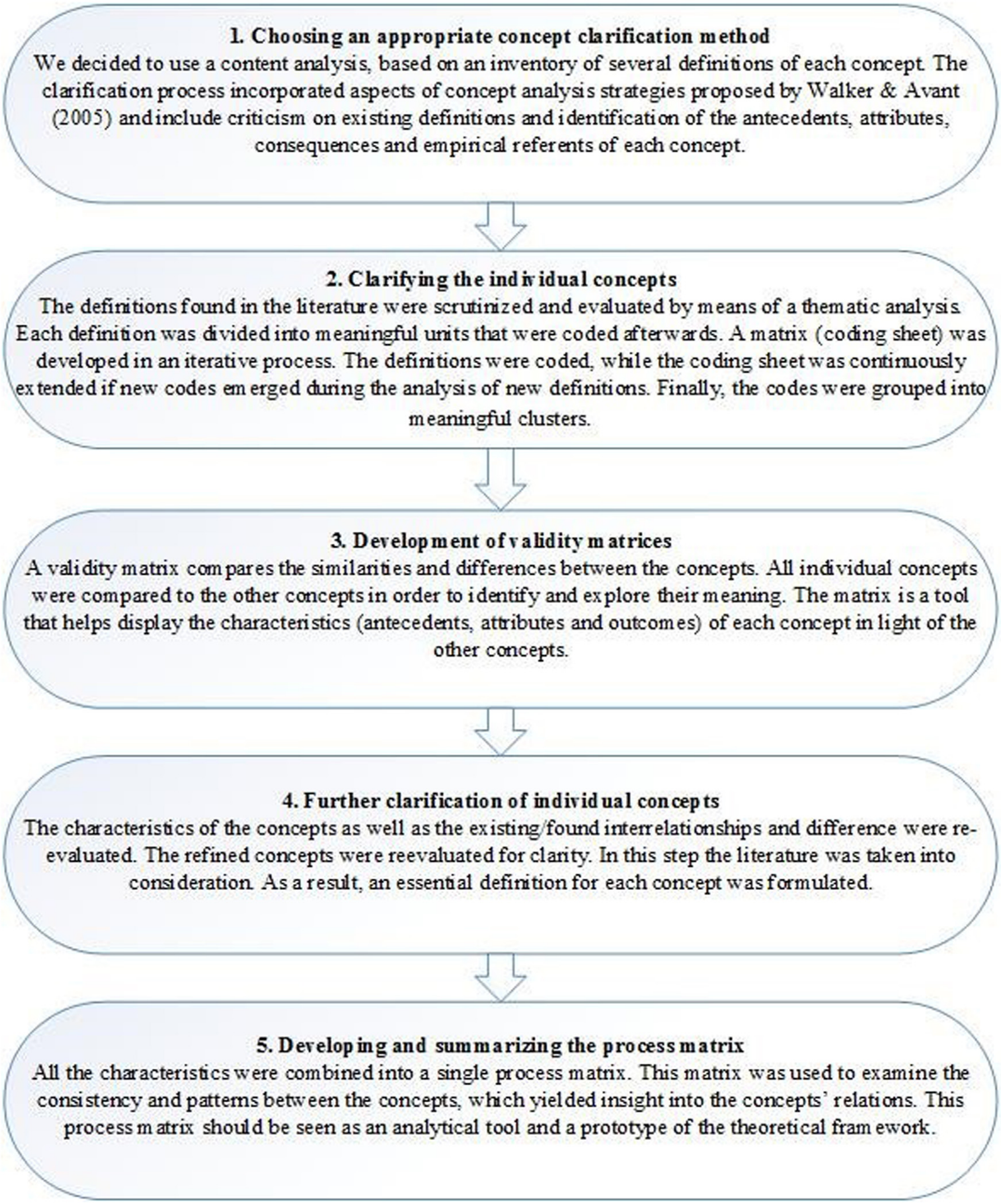

1. Choosing an appropriate concept clarification method
We decided to use a content analysis, based on an inventory of several definitions of each concept. The clarification process incorporated aspects of concept analysis strategies proposed by Walker & Avant (2005) and include criticism on existing definitions and identification of the antecedents, attributes, consequences and empirical referents of each concept.

2. Clarifying the individual concepts
The definitions found in the literature were scrutinized and evaluated by means of a thematic analysis. Each definition was divided into meaningful units that were coded afterwards. A matrix (coding sheet) was developed in an iterative process. The definitions were coded, while the coding sheet was continuously extended if new codes emerged during the analysis of new definitions. Finally, the codes were grouped into meaningful clusters.

3. Development of validity matrices
A validity matrix compares the similarities and differences between the concepts. All individual concepts were compared to the other concepts in order to identify and explore their meaning. The matrix is a tool that helps display the characteristics (antecedents, attributes and outcomes) of each concept in light of the other concepts.

4. Further clarification of individual concepts
The characteristics of the concepts as well as the existing/found interrelationships and difference were re-evaluated. The refined concepts were reevaluated for clarity. In this step the literature was taken into consideration. As a result, an essential definition for each concept was formulated.

5. Developing and summarizing the process matrix
All the characteristics were combined into a single process matrix. This matrix was used to examine the consistency and patterns between the concepts, which yielded insight into the concepts' relations. This process matrix should be seen as an analytical tool and a prototype of the theoretical framework.

Fig. 2. Method concept analysis.

the co-creation of knowledge rather than just a transference of knowledge [28].

A patient-centered approach is the second antecedent to empowerment. In the literature, it is even seen as a prerequisite for the empowerment process [14,17,29]. This approach calls for customization of care according to individual needs, desires and circumstances of patients [16]. The concept of "patient-centeredness" is discussed later in this paper.

The third antecedent concerns the enhancement of patients' competences so that they own the necessary knowledge, skills and attitudes to make choices on issues they define as important. According to Aujoulat [25], health care professionals can promote these competences by supporting and strengthening their patients. Promoting a sufficient level of health literacy [24,30] seems to be essential to this.

As a core aspect of patient empowerment, active participation is the fourth antecedent [26]. Participation is seen as a crucial dimension as it is often used interchangeably with patient empowerment (e.g. Anderson & Funnell [17]). Without patient participation, it is impossible to promote patient empowerment in hospital care. Hence, patient empowerment is a personal process that one completes independently; health care providers can only support this process by involving patients in decisions that affect their quality of life [14]. They can act as coaches by providing condition specific information, helping patients to develop change

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skills, promoting behavior change strategies and encouraging patients to develop self-confidence [31,32].

3.1.3. Attributes

Several authors define patient empowerment as an enabling process [19,27,33]. By providing tools, techniques and support as in for instance self-management interventions, the enabling process can be facilitated [19,34].

A second attribute of patient empowerment is achieving personal change in relation to others. Feste and Anderson [35] stated that the empowerment philosophy is based on the assumption that in order to be healthy, people must be able to effect changes. This is not only true of their personal behavior, but also of their social environment and the organizations (e.g. hospitals) that influence their lives.

The third attribute is self-determination as most definitions of patient empowerment include some conceptualization of self-determination [25,28,35]. Since the underlying philosophy of empowerment-based interventions is that people have the right and ability to make their own choices, self-determination is a guiding principle of empowerment-based interventions [36]. Moreover, many authors cite self-determination theory as the underlying theory for patient empowerment implying that patients are self-determining agents who have the ability for autonomy. This is in contrast to the paternalistic concepts such as adherence and compliance [33].

3.1.4. Consequences

A successful empowerment process can occur when patients come to terms with their threatened sense of security and identity [36]. Therefore, an integrated self is the first consequence of patient empowerment. Through interaction with their peers or health care providers, patients can develop new perspectives by reframing and reinterpreting their illness, which in turn leads to better adjustment to their long-term condition [24]. A sense of inner strength and the development of a renewed and valuable sense of the self can be another result [26,28].

Lack of medical knowledge and loss of control over one's body are seen as the main factors behind patients' feelings of powerlessness [36]. Conversely, patient empowerment is seen as a process that results in patients' gaining more control over their lives [25]. Therefore, the second consequence is a sense of mastery and control. Three types of patient control can be distinguished: cognitive control, decisional control and behavioral control [33].

Achieving self-management is one of the most frequent consequences associated with patient empowerment [27,28,37–39]. Sometimes the term self-management is even used interchangeably with patient empowerment [19,40]. Self-management refers to "the individual's ability to manage symptoms, treatment, physical and psychosocial consequences and life style changes inherent in living with a chronic condition and to affect the cognitive, behavioral and emotional responses necessary to maintain a satisfactory quality of life. Thus, a dynamic and continuous process of self-regulation is established" [41]. It can be seen as an aspect of a sense of mastery and control. It has been defined in various ways but all existing definitions go beyond simply following medical advice: patients are encouraged to attain self-management in order to achieve mastery over their lives as well as maximum health and wellness [34]. Moreover, patients that view themselves as managers of their own health, are more likely to engage in healthy behaviors [31].

Finally, improved quality of life is a long-term consequence of patient empowerment [24].

3.1.5. Empirical referents

There is no universally accepted generic measurement instrument for patient empowerment. Most of the existing measurement scales focus on particular conditions such as diabetes [42] and cancer [43], or on specific contexts such as rehabilitation [44] or primary care [45]. The Health Care Empowerment Questionnaire [46], the Patient Enablement Instrument [45] and the Patient Activation Measure [47] are examples of generic validated instruments. Questionnaires differ depending on the framework and the constructs used [33]. The measured outcomes are therefore limited to one aspect of patient empowerment such as 'activation levels' [47], self-management [48] or self-efficacy [49]. Barr et al. [24] recently identified a range of constructs that have been operationalized in patient empowerment questionnaires. They stated that patient empowerment was differently conceptualized across the included measurement scales and found 38 distinct constructs in 19 measurement scales. They classified the constructs into four domains: patient states, experiences and capacities; patient actions and behaviors; patient self-determination within the health care relationship and patient skills development.

Based on our concept analysis, we found nine different empirical referents related to patient empowerment. Some of these empirical referents are presented in Table 1. They were derived from their associated measuring scale and linked to their corresponding dimension. This is not an exhaustive list.

Fig. 3 presents an overview of antecedents, attributes, consequences and empirical referents of patient empowerment.

3.1.6. Proposed definition of patient empowerment

In line with the Ottawa Charter on Health Promotion [6], patient empowerment has an individual and collective component. Based on the above analysis, the following comprehensive definition of patient empowerment is proposed:

- Individual patient empowerment is a process that enables patients to exert more influence over their individual health by increasing their capacities to gain more control over issues they themselves define as important.
- Collective patient empowerment is a process that gives groups the power to express their needs and take action to meet those needs and improve their quality of life.

Table 1
Patient empowerment: empirical referents and their associated measuring scale.

Empirical referent	Measurement scale
Enablement (primary care)	Patient Enablement Instrument [41]
Process of growth	Nederlandse Empowerment vragenlijst [46]
Coping and decision making	Patient Empowerment Scale [39]
Control (decisional control, cognitive control, emotional regulation) and hope	Genetic Counseling Outcome Scale [30]
Self-management	Partners in Health Scale [47]
Self-efficacy	Diabetes Empowerment Scale [38], The Empowerment Scale [40]
Patient education	The Health Education Impact Questionnaire [48]
Patient knowledge, patient control, patient participation	Sustains [49]
Activation	Patient Activation Measurement [50]

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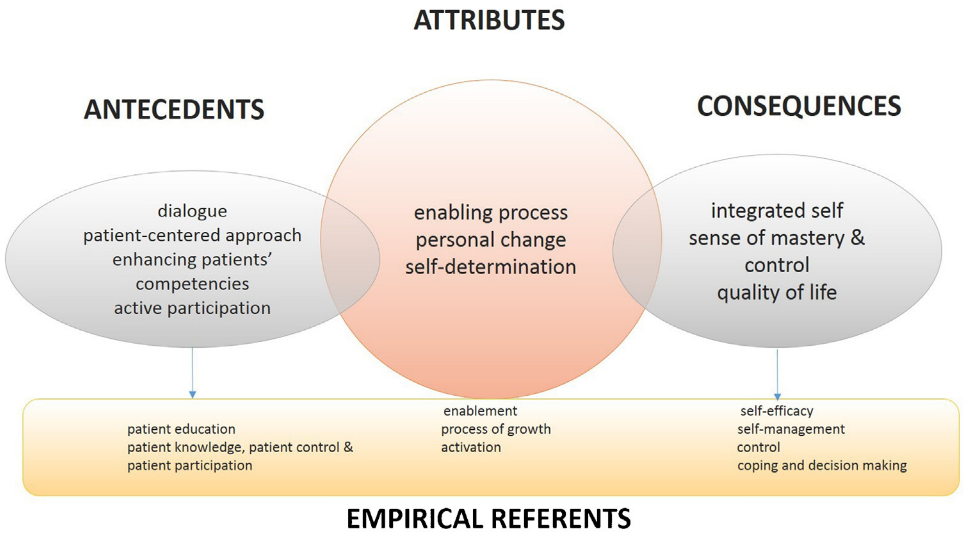

Fig. 3. Overview of antecedents, attributes, consequences and empirical referents of patient empowerment.

3.2. Patient participation

3.2.1. Definitions

The term patient participation seems to be used interchangeably and synonymously with patient involvement, user participation and user involvement. The first framework of participation, the well-known participation ladder of Arnstein [50], shows the different degrees of influence, from manipulation to citizen control, the highest rung on the ladder. The degree of influence increases as one ascends the ladder.

Just like patient empowerment, the concept of patient participation is used at different levels: micro (individual care), meso (service development; planning, delivery and evaluation of care; education and training of health care providers) and macro (policy). Each level is associated with a range of types and activities of participation. Tritter [51] distinguished between five different types of participation: (1) individual patient participation in treatment decisions, (2) involvement in service development, (3) integration of user perspectives in the evaluation of services, (4) participation in education and training and (5) participation in research activities. For each type of participation, several definitions can be found in the literature.

3.2.2. Antecedents

The first antecedent, being informed, is an obvious one [7,52–56] The information that is exchanged has to be meaningful, understandable and individually adapted [57].

Education and support for patients and health care providers is the second antecedent. Both are crucial to a successful participation process as both groups need to have the right skills, knowledge and attitudes [7,53,58].

A facilitating management and supportive care environment should be in place. Sufficient resources are often mentioned as a requirement. Both time and financial resources should be available to ensure successful patient participation [7]. Formal structures and processes (e.g. clear guidelines) similarly need to be developed and institutionalized to provide ongoing, systematic opportunities for patients to participate in decision making [7].

Health care providers need to develop a positive attitude towards patient participation. Patient participation requires responsiveness to the patient and valuing of his strengths and expertise. It requires professionals to see patients' knowledge as equal and complementary [7,56,57,59].

3.2.3. Attributes

Patient participation is characterized by the involvement of patients at different participation levels in the decision making process that affects their lives [18,58]. Participation in decision-making is understood as partaking in decisions related to patients' condition (through informed consent or a therapy plan) and decisions related to more strategic levels such as service development.

Patient participation revolves around active engagement in a mix of activities [27,54,56,60,61]. Throughout all aspects of the participation process, participation requires activation of both the health care provider and patient. This engagement includes several types of action and several methods (e.g. shared decision making, taking part in focus groups, representation in official bodies).

Many authors stress the importance of working in partnership to successful patient participation [55,56,61]. In order to achieve a partnership, the patient's view as an expert must be considered important [7]. In dialogue, a bilateral exchange of experiences and knowledge between patients and health care providers should take place [59]. This partnership entails mutual trust and respect [53,57].

3.2.4. Consequences

Several initiatives that have implemented patient participation suggest its effects on quality of care are positive with higher accessibility [62–64], increased patient safety [65] and increased patient satisfaction [53,64]. Health care providers appear to have more empathy and better communication skills [66], which in turn result in better informed and empowered patients [67,68].

3.2.5. Empirical referents

Instruments that measure patient participation at the individual level, and more specifically shared decision-making, are the ones most commonly used in the literature. Examples are: the Observing Patient Involvement in Decision Making Scale (OPTION) [69] and the Shared Decision Making Questionnaire [70]. A systematic review of reliable and valid tools for measurement of patient participation in health care [71] found four scales that measure 'the patient as an expert of his or her own care needs': e.g.

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the Patient Participation Emergency Department Questionnaire [72]. The literature did not produce generic validated measurements that specifically capture the impact of patient participation in shaping health and social care services [73]. Particularly in the field of mental health, the Consumer Participation Questionnaire [74] measures consumer involvement in the planning, management and evaluation of mental health services, and the attitudes of mental health workers towards consumer participation. Based on our concept analysis, we found four different empirical referents related to patient participation (Table 2). They were derived from their associated measuring scale and linked to their corresponding dimension. This is not an exhaustive list.

Fig. 4 presents an overview of antecedents, attributes, consequences and empirical referents of patient participation.

3.2.6. Proposed definition of patient participation

Following the results of the concept analysis, the following definitions for patient participation are proposed:

Individual patient participation revolves around a patient's rights and opportunities to influence and engage in the decision making about his care through a dialogue attuned to his preferences, potential and a combination of his experiential and the professional's expert knowledge.

Collective patient participation is the contribution of patients or their representing organizations in shaping health and social care services by means of active involvement in a range of activities at the individual, organizational and policy level that combine experiential and professional knowledge.

3.3. Patient-centered(ness)

3.3.1. Definitions

Depending on the context, terms as client-centered, consumer-centered, user-centered, person-centered or family-centered are often used interchangeably. This array of concepts leads to confusion. Many definitions of patient-centeredness and a variety of models describing its dimensions can be found in the literature. In addition, several concept analyses have attempted to clarify what patient-centeredness means [75–78]. Despite these efforts, a broad heterogeneity in definitions and conceptualizations continues to exist, so that patient-centeredness remains a fuzzy concept.

3.3.2. Antecedents

Several authors consider individual patient participation to be a crucial antecedent in patient-centeredness [76,77,79–84]. As active partners and experts on their own situation and needs, patients should actively participate in determining their preferred outcomes.

Communication between the patient and caregiver is regarded as another central antecedent of patient-centeredness [16,18,81,82,85]. Several definitions consequently focus on patient-centered communication [86,87]. Most interventions in this field similarly focus on enhancing caregiver-patient communication [88,89] by improving health care providers' general communication skills, e.g. verbal and non-verbal behavior [82].

A caring environment has great impact on the operationalization of patient-centeredness [77,90,91]. An organization culture that respects everyone's values and choices is a crucial antecedent. It is determined by the attitudes and behaviors of the organizational management and has to support the committed-to vision of patient-centeredness [90]. Hence, a patient-centered care climate has a positive influence on the health care provider's competencies (attitude, skills and knowledge) [90]. Examples are: being empathic, respectful, compassionate and non-judgmental [56,82].

Finally, the literature review shows the importance of coordination and continuity of care [82,92,93]. This implies good and interdisciplinary teamwork [80,94].

3.3.3. Attributes

The first attribute, according to several published concept analyses, is the biopsychosocial perspective [78,82,95]. A perspective combining biological, psychological and social dimensions is regarded as necessary to account for the full range of problems patients might experience. Providing care that considers the biopsychosocial perspective means exploring both the disease and illness experience, something that is also referred to as 'holistic care' [90].

Treating the patient as a unique person is the second attribute. Patient-centeredness is generally described as an approach to care that tries to see through the eyes of the patients and understand patients' expectations, perceptions and experiences. It is generally seen as an approach that meets the specific needs, values and beliefs of patients [16,78,87]. Several authors referred to it as 'individualized care' [79,82,90]. The valued and essential characteristics of patient-centered care are empathy, listening and treating patients with dignity and respect, and regarding them as individuals [82,94].

In the analyzed literature, the sustainable and genuine patient-caregiver relationship is described as an essential attribute to achieving patient-centered care [76,78,82,90,91,96–98]. Patient-centeredness is based on mutually beneficial partnerships between the patient, his family and the health care provider, and is characterized by open communication of knowledge. There is an exchange of experiential knowledge and clinical knowledge. Ridd et al. [99] characterized patients' perspective on the doctor-patient relationship using four components: knowledge, trust, loyalty and regard.

3.3.4. Consequences

A patient-centered approach can improve health outcomes [78,97,100]. Other reported outcomes are improved quality of care, for instance, increased patient satisfaction [101], efficiency and a decrease in health care related costs [12]. Patient-centeredness is also associated with other positive outcomes such as enhanced adherence, improved illness-related knowledge and health behavior, and decreased health care utilization [102].

Table 2
Patient participation: empirical referents and their associated measuring scale.

Empirical referent	Measurement scale
Shared decision making	The Observing Patient Involvement In Decision Making Scale (OPTION) [71] The Shared Decision Making Questionnaire [72] CollaboRATE [77]
Health care provider communication during consultation	The Perceived Involvement Scale [78]
Participation culture	The Patient Participation Culture Tool (Pa2CT) [79]
Involvement in the planning, management and evaluation (mental health)	The Consumer Participation Questionnaire [76]

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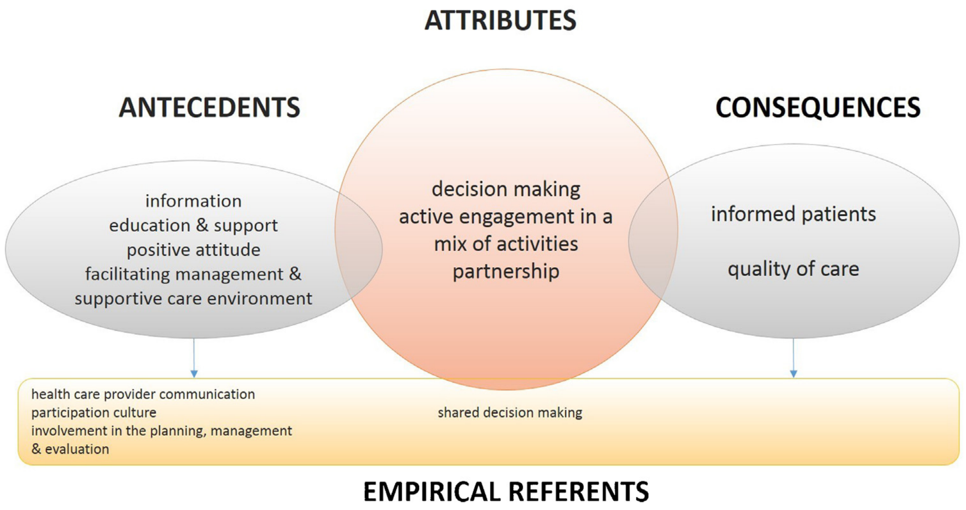

Fig. 4. Overview of antecedents, attributes, consequences and empirical referents of patient participation.

3.3.5. Empirical referents

A review of the Health foundation [103] found five constructs of measurement scales of ‘person-centered care’: patient engagement, empathy and compassion, person-centered communication, supporting self-management and shared decision making. Several instruments are used to measure (aspects of) patient-centeredness. Some scales measure the broad holistic concept of patient-centeredness (e.g. the Individualized Care Scale); others focus on specific subcomponents (e.g. the Person-centered Climate Questionnaire). Based on our concept analysis, we found seven different empirical referents related to patient-centeredness (Table 3). They were derived from their associated measuring scale and linked to their corresponding dimension. This is not an exhaustive list.

Fig. 5 presents an overview of antecedents, attributes, consequences and empirical referents of patient-centeredness.

3.3.6. Proposed definition of patient-centeredness

Based on the analysis above, patient-centeredness is a biopsychosocial approach and attitude that aims to deliver care that is respectful, individualized and empowering. It implies the individual participation of the patient and is built on a relationship of mutual trust, sensitivity, empathy and shared knowledge.

3.4. Similarities and differences

The multidimensional concepts of patient empowerment, patient participation and patient-centeredness all illustrate an important ideological shift from a paternalistic health care to an increasingly participation-based health care. The connecting thread when it comes to patient empowerment, patient participation and patient centeredness is a balance between the power of professionals and patients. Aside from power, interaction, relationship, communication and respecting patients’ voice proved to be key.

Besides the similarities, differences also exist. Empowerment has a political background. Patient-centeredness, unlike empowerment, originated from a medical context, more specifically that of psychology and psychotherapy [14,15]. These differences in origins are also reflected in the different dimensions of the concepts and particularly at the level of their consequences. The consequences of patient empowerment go beyond the medical context [104]. In contrast to the consequences of patient-centeredness, patient participation developed from a combination of the origins described above: a series of social and clinical evolutions such as the increased accessibility of information and the socialization of care.

Another distinction can be made in terms of the organization levels. Patient empowerment and patient participation are multilevel concepts. They are mostly situated at the micro level but can also take place at the meso- and macro level. Patient-centeredness, however, is not a multilevel concept and is situated exclusively at the micro level. In addition, patient-centeredness is an empowering approach [104] related to the caretaker perspective, while patient participation is more associated with the patient perspective as the patient experience is the key driver. Meanwhile, patient empowerment comprises both perspectives.

3.5. Process model

In Fig. 6 the interrelationship between the concepts patient empowerment, patient participation and patient-centeredness is shown. We can conclude that patient empowerment is a broader concept than just patient-centeredness and patient participation. It is a philosophy or a framework for thinking, and it can be

Table 3
Patient-centeredness: empirical referents and their associated measuring scale.

Empirical referent	Measurement scale
Individualized care	Individualized Care Scale [109,110]
Empathy	The Consultation and Relational Empathy Scale [111]
Person-centered climate	Person-centered climate questionnaire patient version [112]
Patient-centered care and patient-caregiver relationship	Client-centered care questionnaire (CCCQ) [113]
Quality of the therapeutic alliance	Kim Alliance Scale (KAS) [114]
A patient-doctor relationship	A Patient-Doctor Relationship questionnaire (PDRQ-9) [115]
Interpersonal trust	Stanford Trust in Physician scale (STP) [116]

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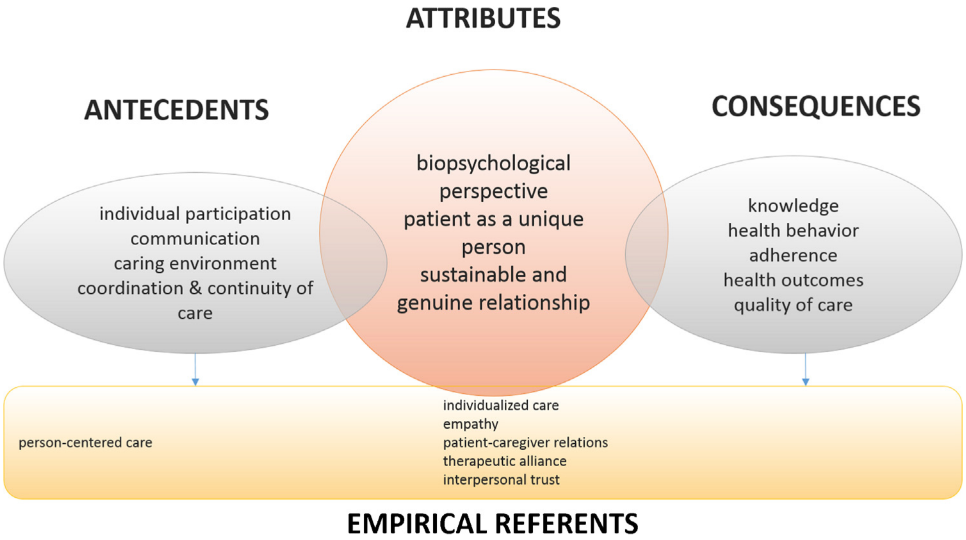

Fig. 5. Overview of antecedents, attributes, consequences and empirical referents of patient-centeredness.

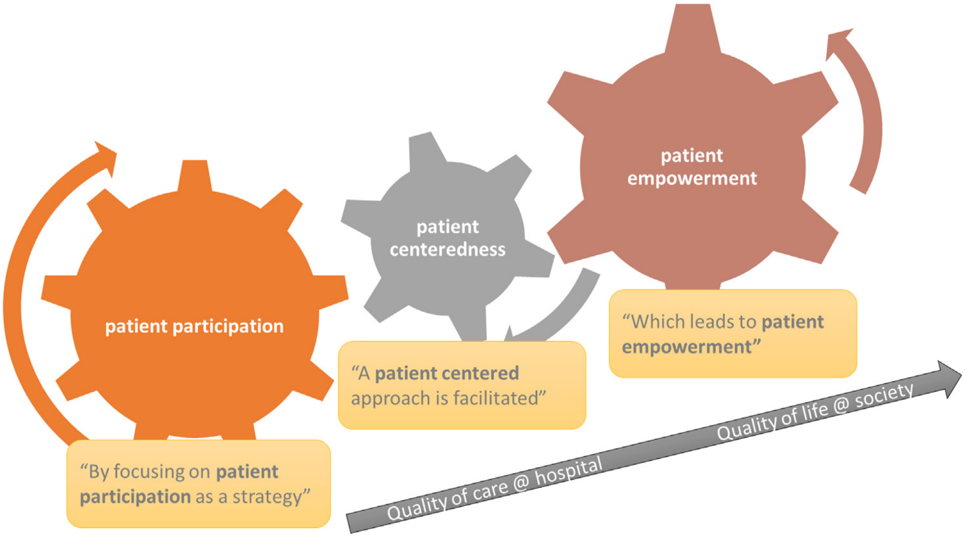

Fig. 6. Process model for concepts of patient empowerment, patient participation and patient-centeredness in health care.

considered as a meta-paradigm that connects more concrete paradigms. Patient-centeredness is an antecedent of empowerment [14,17,29,83] while patient participation is often mentioned as a condition for patient-centered care [80,83,105] and patient empowerment [106]. Patient participation can be seen as a strategy to achieve a patient-centered care, which in turn can promote patient empowerment.

4. Discussion and conclusion

4.1. Discussion

We generally found that use of explicit definitions was limited. Clearly distinguishing and separating the concepts is therefore a complex enterprise, as confirmed by a recent study by Fumagalli et al. [107]. This intricate relatedness reflects the historical roots and evolution of the concepts and can be explained by the close connections between the three concepts: patient participation is a strategy to achieve a patient-centered approach in health care and patient-centeredness seems to be a precondition to facilitating patient empowerment. In line with Barr et al. [24], we found similar principles and approaches for patient empowerment and patient-centeredness. In conclusion, the studied concepts should be seen as interrelated rather than as independent from each other.

In order to distinguish the different concepts from each other the authors had to make several choices. The reasoning behind these choices is described below. First, in contrast to some other concept analyses [82], this study placed patient-centeredness exclusively at the micro level as a precondition for the multilevel concept of patient empowerment. This was a choice the authors deliberately made to clarify the concepts vis-à-vis their theoretical roots. Patient empowerment, however, is a concept that derives from the multilevel concept of empowerment. Studies of empowerment depart from the assumption that people must take actions to improve their quality of life [35]. Not only at the level of their individual behavior, but also with respect to their social environment and the organizations that influence their lives. Empowerment is thus a relational construct that comprises different levels. Moreover, this focus on the individual might even foster the misconception that the patients themselves are the only ones responsible for their outcomes [108]. These arguments call for a vision of patient empowerment that is much broader than just patient-centeredness. Patient-centeredness was furthermore introduced in psychotherapy [109] and in the field of medicine [15] as an interaction process that departed from the point of view of the health care provider. As Mead & Bower [78] state in their well-known conceptual framework, the practitioner-patient relationship is a key one. This concept is therefore exclusively situated at the micro level. The variance in conceptualization may reflect a difference between theoretical and practical definitions. In practice, the micro, meso and macro level are interrelated too.

Second, the authors chose to propose definitions that included both patients' and professionals' perspectives and that could be useful to the various disciplines involved in hospital care. This concept analysis therefore started from a multidisciplinary literature review that examined medical, sociological, psychological and nursing literature. However, some authors have argued that important differences in meaning exist, depending on who is using the concept and what context it is being used in [78,91]. In their view, different (professional) groups focus on different aspects in a reflection of the clinical conditions under which they work [94]. The result is a heterogeneity of measurement instruments. It is therefore not possible to make comparative evaluations of interventions [33,79]. More generic definitions can counter this problem.

A distinction between the individual and collective level can incidentally be made when it comes to patient empowerment and patient participation. As the Ottawa Charter on Health Promotion [6] states, both individual and collective empowerment are key drivers to having control. Individual empowerment means that individual patients take action to improve their life, while collective empowerment refers to patient groups taking action to improve their situation. In line with the WHO, the authors chose to propose separate definitions for individual and collective patient empowerment. Furthermore, both individuals and groups can participate [7,51].

Zimmerman (1995), one of the founders of psychological empowerment, proposed a nomological network of empowerment including intrapersonal, interactional and behavioral components. The behavioral component is about engaging in behaviors to exert control and is related to behavior theories such as the Patient Activation Theory. This theory provides guidance on supporting greater activation which ultimately can lead to effective self-management and better health. By gaining confidence, success experiences and positive emotions patients can go through an upward spiral that is self-reinforcing [31]. Yet we must differentiate between behavior theories and the empowerment approach. First, behavior theories such as the behavior change approach are rather paternalistic [110] because the approach assumes that professionals determine problems and solutions. This might interfere with a patient's autonomy and would be in contrast to the attribute 'self-determination' as the goals chosen by the professionals may not match with those of the patient."

Furthermore, the behavior change approach risks leading to blaming and stigmatization. When professionals only focus on behavior and disregard underlying reasons for the lack of behavior change, they might assume that people themselves are to blame for their problems. Particularly when patients do not adapt their behaviors as recommended. In contrast with the behavior change approach the empowerment approach focuses not primarily on health but on quality of life and the determinants that might affect one's quality of life

As shown by the results of our concept analysis, quality of life is a long-term consequence of patient empowerment. By not only focusing on 'health' but also on the determinants that might affect one's quality of life (e.g. environmental support), the empowerment approach aims a wider range.Thus, even the focus is not specifically on health, facilitating the patients' empowerment might increase patients' health as it considers the determinants of quality of life related health such as the patients' competences [110,111].

This paper aims to bring clarity into the described conceptual vagueness in the literature. We propose three distinct definitions that capture the essential dimensions of the overlapping concepts patient empowerment, patient participation and patient-centeredness. Many definitions and models of the concepts only take into account one or some dimensions including antecedents, attributes, consequences and empirical referents. We consider all of them. Moreover, we propose a process model that shows the relationships between the three concepts. To our knowledge, no study have thoroughly analyzed these three concepts together and their inter-relatedness. This research is part of a study that focuses on the hospital sector and therefore the analysis is limited to the hospital context. But when we compared our results with studies from other sectors (home care, primary care, care for the elderly) we found similar results [112–119]. This might imply that our definitions are generalizable to other sectors and therefore this concept analysis might be a start towards consensus among several disciplines Conceptual models stimulate knowledge expansion and provide research direction. More specifically, the validated concepts and relationships inform theory development. Subsequently, our theoretical model needs to be evaluated by empirically testing and validation by additional studies. First in a pilot or feasibility study, then in controlled studies (e.g. RCT) at several settings. This can lend itself to a meta-analysis in the future.

4.2. Study limitations

First, the subdivision of dimensions into antecedents, attributes and consequences was sometimes subjective and artificial. For example: in the concept analysis of patient empowerment, 'active participation' was seen as an antecedent of patient empowerment, while other authors like Shearer et al. [120] have seen it as an attribute. Secondly, we chose not to include synonyms in the search strategy of the analyzed concepts such as patient involvement, person-centered care or health empowerment, in order to keep the literature review manageable. Finally, we did not conduct a systematic evaluation of the quality of the included research articles. This decision was motivated by the wide variation in literature types and the inclusive nature of this concept analysis.

4.3. Conclusion

This study systematically analyzed the different definitions of patient empowerment, patient participation and patient-centeredness, and described these concepts by presenting the relevant historical perspectives, the defining attributes, antecedents, consequences and empirical referents. As a result, definitions and an integrative process model based on the relationships of these concepts were suggested. It can be concluded that patient empowerment is a much broader concept than patient-centeredness. It is a paradigm that approaches problems in a fundamentally different way. Patient-centeredness can be seen as a precondition for patient empowerment. By embracing patient participation as a strategy, health care can become more patient-centered, which in turn will facilitate patient empowerment.

4.4. Practice implications

The results of this study addressed some of the existing gaps in the literature. First, to our knowledge, these three concepts have

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never been analyzed together before. Such a simultaneous analysis may provide insight into patient empowerment, patient participation and patient-centeredness and the relation between all three. This will promote better understanding and communication about these concepts in practice and in research and policy contexts. Second, this concept analysis contributes to theory development by adding to previous studies, which limited themselves to comparing only a few definitions or solely focusing on one component of the broader concept.

Conflicts of interest

None.

Funding

None.

Acknowledgements

We wish to acknowledge Peter Gielen and Carine Van Wanseele for proof reading this paper. We also acknowledge Frederik Knockaert and My Pham for their support with optimizing the frameworks.

Appendix A. Overview definitions and conceptual framework

Patient empowerment	Definitions/conceptual frameworks
Anderson & Funnel (2010)	Patients are equipped to make informed choices for themselves with sufficient skills and support from the health services.
Anderson & Funnel (2005)	The empowerment process is regarded as an individual's discovery (and development) of their inborn capacity to control and take responsibility for their live.
Anderson et al (2010)	Patient empowerment is a process designed to facilitate self-directed behavior change. The empowerment approach involves facilitating and supporting patients to reflect on their experience of living with diabetes. Self-reflection occurring in a relationship characterized by psychological safety, warmth, collaboration, and respect is essential for laying the foundation for self-directed positive change in behavior, emotions, and/or attitudes.
Aujoulat et al. (2007)	Empowerment may be defined as a complex experience of personal change. It is guided by the principle of self-determination and may be facilitated by health-care providers if they adopt a patient-centered approach of care which acknowledges the patients' experience, priorities and fears. In order to be empowering for the patient, therapeutic education activities need to be based on self-reflection, experimentation, and negotiation so as to allow for the appropriation of medical knowledge and the reinforcement of psychosocial skills.
Aujoulat et al. (2008)	A process of personal transformation which occurs through a double process of (i) "holding on" to previous self-representations and roles and learning to control the disease and treatment, so as to differentiate one's self from illness on the one hand, and on the other hand (ii) "letting go", by accepting to relinquish control, so as to integrate illness and illness-driven boundaries as being part of a reconciled self.
Chatzimarkaki (2010)	Empowerment means enablement, empowered patients need strong partnerships with doctors and caregiver, patient empowerment is a paradigm, not a technique.
Dowling et al. (2011)	An operational definition for empowerment in this context therefore emphasizes equality in the relationship between the health care professional and the client, with the client viewed as an expert.
European Patinet's Forum (EPF) (2015)	Empowerment is "a multi-dimensional process that helps people gain control over their own lives and increases their capacity to act on issues that they themselves define as important." Collective empowerment is "a process through which individuals and communities are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and take political, social, and cultural action to meet those needs.
Feste & Anderson (1995)	The empowerment philosophy is based on the assumption that to be healthy, people must be able to bring about changes, not only in their personal behavior, but also in their social situations and the organizations that influence their lives.
Funnel et al. (2004)	We have defined the process of empowerment as the discovery and development of one's inherent capacity to be responsible for one's own life. People are empowered when they have sufficient knowledge to make rational decisions, sufficient control and resources to implement their decisions, and sufficient experience to evaluate the effectiveness of their decisions. Empowerment is more than an intervention or strategy to help people make behavior changes to adhere to a treatment plan. Fundamentally, patient empowerment is an outcome. Patients are empowered when they have knowledge, skills, attitudes, and self-awareness necessary to influence their own behavior and that of others in order to improve the quality of their lives. Empowerment is a patient-centered, collaborative approach tailored to match the fundamental realities of diabetes care. Patient empowerment is defined as helping patients discover and develop the inherent capacity to be responsible for one's own life.
Gibson (1991)	Empowerment is a social process of recognizing, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives. Even more simply defined, empowerment is a process of helping people to assert control over the factors which affect their health
Holmström & Roing (2009)	The empowerment philosophy is based on the assumption that to be healthy, people must be able to bring about changes, not only in their personal behavior, but also in their social situations and the organizations that influence their lives.
Keleher (2007)	Respect for culture, cultural and local sensitivity of programs, education materials and opportunities examined for their underlying assumptions about race and culture, a sense of community and local bonding, reinforcement of authentic participation, increase people's skills and control over resources, use of lay leaders and helpers, fostering of advocacy and leadership development, time and space to identify structural barriers and facilitators to empowerment interventions, mechanism to overcome structural barriers and facilitators to empowerment interventions, understanding of the role of material and social forces that underpin constraints to good health conditions or personal health skills.
Lau (2002)	Patient empowerment in the health care context means to promote autonomous self-regulation so that the individual's potential for health and wellness is maximised. Patient empowerment begins with information and education and includes seeking out information about one's own illness or condition, and actively participating in treatment decisions.
McAllister et al. (2012)	Patient empowerment is a multi-dimensional construct: cognitive control, decisional control, behavioral control, emotional regulation, hope for the future.

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(*Continued*)

Patient empowerment	Definitions/conceptual frameworks
Mok (2001)	Connectedness, partnership with health care professionals, reinterpretation of the illness, and self-reliance. “Experience of empowerment is a process whereby they have strength, self-reliance and cognitive choices in coping with the illness and the situation they confront.
Piper (2010)	The theme of empowerment suggested patient centered, holistic practice responsive to patient needs involving a reduction in the ‘social distance’ between the patient and the nurse and a move away from compliance based, nurse directed intervention and outcomes
Schulz & Nakamoto (2013)	Spreitzer (1995) identifies four constructs inherent in empowerment—meaningfulness (or relevance), self-efficacy (or competence), self-determination (or choice) and impact. Schulz and Nakamoto adapted this set of measures to the health context. “What is central to this operationalization is that the components all highlight the subjective experience of empowerment and its force as a motivation for action. This distinguishes empowerment from literacy, which focuses on knowledge and abilities to use it”
Shearer (2007)	A process of purposefully participating in health change: the empowerment process is a mutual process in human beings and their environment that generates an ongoing and innovative change.
Small et al. (2013)	An enabling process or outcome arising from communication with the health care professional and a mutual sharing of resources over information relating to illness, which enhances the patient’s feelings of control, self-efficacy, coping abilities and ability to achieve change over their condition. Empowerment is a psychological state that occurs as a result of effective communication in health care, and which acts as a determinant of consequent participation and self-management.
The Lancet (2012)	A widely accepted as a process by which people are helped to use autonomous decision making in order to better self-manage their condition, gain control over their health and remain socially integrated.

Patient participation	Definitions/conceptual frameworks
Sahlsten (2007)	Mutuality in negotiation emerged as the core category for explaining nurses’ perspectives on patient participation in nursing care. It is characterized by four interrelated sub-core categories: interpersonal procedure, therapeutic approach, focus on resources and opportunities for influence. Mutuality in negoti-ation constitutes the dynamic nurse–patient interaction process. Mutuality in negotiation emerged as the core category for explaining nurses’ perspectives on patient participation in nursing care. It is characterized byfour interrelated sub-core categories: interpersonal procedure, therapeutic approach, focus on resources and opportunities for influence. Mutuality in negoti-ation constitutes the dynamic nurse–patient interaction process.
Sahlsten (2008)	An established relationship between nurse and patient, the surrendering of some power or control by the nurse, shared information and knowledge, and active engagement together in intellectual and/or physical activities.
Haywood et al (2006)	An interaction, or series of interactions between a patient and the healthcare system or health care professional in which the patient is active in providing information to aid diagnosis and problem-solving, sharing his/her preferences and priorities for treatment or management, asking questions and/or contributing to the identification of management approaches that best meet his/her needs, preferences of priorities.
Tambuyzer et al (2013)	Participation in decision making, the active character of involvement, involvement in a diverse range of activities, collaboration with professionals.
Forbat et al (2009)	Engagement is further development, referring to working in partnership with service-users having them inform (1) service redesign/improvement, (2) policy, (3) research, (4) their own care/treatment. Engagement involves a collaboration which demands understanding rather than purely an information seeking process.
Millar et al (2015)	An active partnership between service users and mental health professionals in decision making regarding the planning, implementation and evaluation of mental health policy, services, education, training and research. This partnership employs a person-centered approach, with bidirectional information flow, power sharing and access to advocacy at a personal, service and/or societal level
Eldh et al (2010)	Patient participation from the patients’ point of view relates to getting explanations and having knowledge of (a) plans, (b) where to turn for help and (c) what to do in order to feel well. As a result, the general focus on patient participation should be considered in relation to patients acquiring knowledge and having comprehension.
Rise et al (2011)	Patient and public involvement is founded on mutual respect and is carried out through dialogue aiming to achieve shared decision making.
Groene et al (2010)	Patient involvement is understood as the extent to which patients participate in decisions related to their condition (through informed consent, therapy plan or self-management) and contribute to organizational learning through their expert knowledge acquired during illness and hospitalization.
The Institute for Patient- and Family-Centered Care (IPFCC) (2008)	Patient- and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among patients, families, and health care professionals. These partnerships at the clinical, program, and policy levels are essential to assuring the quality and safety of health care. They define 4 core concepts: (1) Dignity and Respect, (2) Information Sharing, (3) Participation, (4) Collaboration
Coulter (2011)	To promote and support active patient and public involvement in health and healthcare and to strengthen their influence on healthcare decisions, at both the individual and collective levels.
Coulter et al (2013)	Patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, and policy making – to improve health and health care.
Lathlean et al (2006)	

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(*Continued*)

Patient participation	Definitions/conceptual frameworks
	An active and equitable collaboration between professionals and service users concerning the planning, implementation and evaluation of series and education.
Tutton (2005)	Dynamic process that changes over time and is integral to the work of nurses and carers. This process is carried out through facilitation, partnership, understanding the person and emotional work. Partnership is seen as an essential process that underpins participation by identifying the values and beliefs on which negotiation is based. Staff may make decisions for patients but these decisions are participatory through this dynamic process.

Patient-centeredness	Definitions/conceptual frameworks
Bauman et al, 2003	Is about interactions and partnerships between health practitioner and patient, based on communication and a focus beyond specific conditions, on health promotion and healthy lifestyles.
Beach et al (2006)	(1) respect for patients' values, preferences, and expressed needs; (2) coordination and integration of care; (3) information, communication, and education; (4) physical comfort; (5) emotional support and alleviation of fear and anxiety; (6) involvement of friends and family; and (7) transition and continuity.
Berwick (2009)	Such care respects the individuality, values, ethnicity, social endowments, and information needs of each patient. The primary design idea is to put each patient in control of his or her own care. The aim is customization of care, according to individual needs, desires, and circumstances. It also implies transparency, with a high level of accountability of the care system to the patient.
European Patinet's Forum (EPF) (2015)	Individual: the extent to which patients and their families or caregivers, whenever appropriate, participate in decisions related to their condition (e.g. through shared decision-making, self management) and contribute to organisational learning through their specific experience as patients. Collective: the extent to which patients, through their representative organisations, contribute to shaping the health care system through involvement in health care policy-making, organisation, design and delivery.
Institute of Medicine, 2001	Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.
Ishikawa et al, 2013	Patient-centered communication should be operationalized as the interaction between the patient and physician considering the specific context, rather than the independent behaviors of each party. In previous communication research, interactional measures of patient-centered communication have been proposed, such as the physician's responsiveness to patient cues and concerns, the extent to which patient illness experience is discussed, and the common ground established between the patient and physician (Henbest and Stewart, 1989, Mead and Bower, 2000a and Stewart et al., 2000). Additionally, the degree to which physicians and patients have shared beliefs, emotions, and values as well as the degree to which they can articulate each other's perspectives can be considered a maker of shared mind (Street & Haidet, 2011).
Leplege et al (2009)	The principles underpinning person-centered care can be summarized as being concerned with treating people as individuals; respecting their rights as a person; building mutual trust and understanding and developing therapeutic relationships.
Little et al (2001)	• There are at least three important and distinct domains of patient-centeredness: communication, partnership and health promotion. • Exploring the experience of disease and illness: patients' ideas about the problem, feelings, expectations for the visit, and effects on function • Understanding the whole person: personal and developmental issues (for example, feeling emotionally understood) and the context (the family and how life has been affected) • Finding common ground (partnership): problems, priorities, goals of treatment, and roles of doctor and patient • Health promotion: health enhancement, risk reduction, early detection of disease • Enhancing the doctor-patient relationship: sharing power, the caring and healing relationship
Longtin (2010)	Conceptual framework
Lusk & Fater (2013)	The provision of care incorporating contextual elements and including the attributes of encouraging patient autonomy, the caring attitude of the nurse, and individualizing patient care by the nurse. Attributes are encouraging patient autonomy, caring attitude of the nurse, and individualizing patient care by the nurse. Antecedents are the need for healthcare intervention and the ability of the patient or significant other to participate in his/her own care. Consequences are self-care ability and patient satisfaction.
McCormack & McCance (2006)	The formation of a therapeutic narrative between professional and patient that is built on mutual trust, understanding and a sharing of collective knowledge.
McWilliam et al (2009)	Lists additional elements from other approaches based on health promotion, accessibility of services, continuity of care and motivation of the patient. The aims are to encourage, enable and support patients to take responsibility for control of management of their conditions and growing patient autonomy in decision making to become 'expert patients.
Mead & Bower (2000)	(1) the caregiver gives attention to biological, psychological and social aspects of patients' health, (2) the caregiver understands the 'patient-as-person', that illness has a personal meaning for each individual, (3) there is a sharing of power and responsibility between healthcare provider and patient, where the healthcare provider strives to be sensitive to, and is able to respond to patients' needs for information and sharing in decision making, (4) there is a therapeutic alliance between healthcare provider and patient, in which common goals of therapy are developed and relationship between

(*Continued*)

Patient-centeredness	Definitions/conceptual frameworks
	healthcare provider and patient is strengthened and (5) there is an awareness that the healthcare provider is also a person, and that the personal qualities and subjectivity of the healthcare provider may influence their practice of medicine.
Millar et al (2015)	5 key attributes: person-centered approach, informed decision making, advocacy, obtaining service user views and feedback and working in relationship.
Morgan & Yoder (2012)	PCC is a holistic approach to delivering care that is respectful and individualized, allowing negotiation of care, and offering choice through a therapeutic relationship where persons are empowered to be involved in health decisions at whatever level is desired by that individual who is receiving the care.
Picker Institute	8 principles: fast access to reliable health advice, effective treatment delivered by trusted professionals, involvement in decision and respect for preferences, clear, comprehensible information and support for self-care, attention to physical and environmental needs, emotional support, empathy and respect, involvement of, and support for family and carers, continuity of care and smooth transitions
Pulivirenti et al (2011)	'Our review of PCC showed it to be understood variously as putting a person's needs at the heath of the system, supporting people to make informed decisions, a focus on the relationship between the practitioner-patient relationship, a partnership approach, a valuing of people's experiences and a process of empowerment.
Scholl et al (2014)	The dimensions patient as a unique person, biopsychosocial perspective, essential characteristics of the clinician and clinician-patient relationship can be seen as underlying principles of patient-centered care. These principles can be implemented by a range of patient-centered activities, i.e. patient information, patient involvement in care, involvement of family and friends, patient empowerment, physical and emotional support. Furthermore, there are certain enablers, which, if present, can be helpful to implement these activities. They are clinician-patient-communication, integration of medical and non-medical care, coordination and continuity of care, access to care and teamwork and team building.
Shaller (2007)	Education and shared knowledge, involvement of family and friends, collaboration and team management, sensitivity to non-medical and spiritual dimensions of care, respect for patient needs and preferences, free flow and accessibility of information.
Stewart (1995)	Patient-centered clinical method: (1) exploring both the disease and the illness experience; (2) understanding the whole person; (3) finding common ground regarding management; (4) incorporating prevention and health promotion; (5) enhancing the doctor-patient relationship, and (6) 'being realistic' about personal limitations and issues such as the availability of time and resources.
The International Alliance of Patients' Organizations (IAPO)	(1) Respect – Patients, families and carers have a fundamental right to patient-centered healthcare that respects their unique needs, preferences and values, as well as their autonomy and independence. (2) Choice and empowerment – Patients have a right and responsibility to participate, to their level of ability and preference, as a partner in making healthcare decisions that affect their lives. (3) Patient involvement in health policy – Patients and patients' organizations have a valuable role to play in healthcare policy-making through meaningful and supported engagement in all levels and at all points of decision-making, to ensure that they are designed with the patient at the centre. (4) Access and support – Access to safe, quality and appropriate services, treatments, preventive care and health promotion activities is needed with a commitment to equity so that all patients can access the appropriate treatments. (5) Information – Accurate, relevant and comprehensive information is essential to enable patients and carers to make informed decisions about healthcare treatment and living with their condition.
Wiig et al (2013)	The term 'patient-centered' has been used to describe an approach in which the therapist 'sees the situation through the eyes of the client', attends to patients' experiences with their illness, empathizes with their feelings and fears, or refers to professionals creating opportunities for and responding to patients' desires for information and participation in treatment decision making.

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Please cite this article in press as: E.M. Castro, et al., Patient empowerment, patient participation and patient-centeredness in hospital care: A concept analysis based on a literature review, Patient Educ Couns (2016), http://dx.doi.org/10.1016/j.pec.2016.07.026

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