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**Patient orientation in public hospitals: A marketing device as compromise
between worlds**

(Patrick Gilbert and Marie-Eve Laporte¹)

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Abstract

The concept of patient centricity has spread for several years in hospitals where, under the expression patient-centered care (PCC), it contributes to introducing a marketing logic in a new environment. However, beyond the intention to transform the patient as an object into a patient as a subject, this concept remains difficult to define. A review of the literature shows a diversity of approaches that are echoed in practice. This article draws on the economies of worth to examine how these conceptions collide but also reconcile. It relies on the study of an

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emblematic case, the orthopedic surgery department of a large Parisian public hospital (3 weeks of observation and 43 interviews). The research shows that PCC is built sequentially in a shared experience involving patients, caregivers and management. The article defines PCC as a marketing device resulting from compromises between different conventions and provides evolution scenarios.

Keywords

Conventions, customer centricity, economies of worth, hospitals, marketing device, patient-centered care, patient centricity

Introduction

Since the end of the 20th century, a marketing strategy has developed with service marketing that consists of centering the organization's action on the individual to whom the offer is addressed at the end of the chain, such as the customer (Lemon and Verhoef, 2016). The hospital world is no exception to this trend. *Patient-centered care* (PCC) has become a major concept in health care, initially in English-speaking countries. According to the Royal College of General Practitioners (2014), PCC comes in response to the aging population and the increase in chronic diseases in order to safeguard an economically fragile health system: by empowering patients, it limits their consumption of care and reduces health costs. At the same time, it addresses the new expectations of patients, at least of those who have access to individualized digital services via "companies such as Apple, Samsung or Google"; this positioning "inexorably changes the relationship between patients and health professionals" (Royal College of General Practitioners, 2014: 3).

The idea of firmly placing the patient at the center of care delivery has spread more recently in France under the influence of public authorities. The French "Kouchner" law, which affirms patients' rights, marked a turning point in 2002 by improving access to medical information and the defense of patient interests. In 2009, the "Hospital, Patients, Health, Territories" law empowered patients by giving them a legislative framework for their therapeutic education. On September 18, 2018, President Emmanuel Macron, during a conference unveiling his plan to reform the French health care system, expressed the need for a single requirement: *"We must completely rethink our health care system by setting a single requirement: to put the patient at the center and guarantee all French people better prevention and access to quality care."*

Patient orientation has brought about a major transformation in French hospitals. They must now encourage collaboration between caregivers and patients and their families, taking into

account their preferences and environment and providing clear and understandable information, education and support in addition to care. The implementation of this approach raises its share of difficulties, as it results in many challenges for caregivers and patients in a context where French hospitals are also faced with strict budgetary and normative constraints. The progressive penetration of customer orientation is leading to the introduction of a marketing logic, where previously the logic of care delivery by experts to patients prevailed. However, the medical community as a whole distrusts marketing (Crié and Chebat, 2013). Similar to the appearance of marketing in the internet world (Busca and Bertrandias, 2020), PCC can be felt as an aggression by caregivers in general and particularly in public hospitals. While it seems difficult to argue against the idea of "putting the patient at the center," PCC is open to multiple interpretations depending on the perspective and situation. However, the parties (patients, caregivers and management) seem to be able to adjust. Based on an analysis of practices, can we arrive at a definition of PCC that will shed light on the issue of patient orientation in public hospitals and its potential evolution?

To answer this question, it is first important to understand what the concept of PCC covers in the literature. If, in principle, PCC generates a certain amount of support, its implementation raises disagreements that we propose to read as oppositions between "worlds" using the framework of economies of worth (Boltanski and Thévenot, 1991). To study how these worlds are inscribed in concrete situations where agreements are reached, we will use the case study of an orthopedic surgery department in a large public hospital to shed light on how PCC is constructed in practice in a *marketing-as-practice* approach (Chautard and Collin-Lachaud, 2019; Skálén and Hackley, 2011). We then turn to the presentation and discussion of the main results. It emerges that the PCC is not a tool to be deployed in a top-down manner but a marketing device initiated by political will, coconstructing a strategy in a shared experience among patients, caregivers and management. PCC is constructed through the confrontation of different conventions that sociomaterial elements manage to bring together to reach agreements. We conclude with theoretical and managerial contributions and with the limits and perspectives of the research.

Patient-centered care, a concept in search of a shared definition

From customer centricity to patient-centered care

A central theme of relationship marketing, customer orientation, which places customer satisfaction at the heart of an organization's marketing strategy, has been mentioned in management and marketing textbooks since the 1950s (Shah et al., 2006). However, it has

only truly taken hold in companies since the 2000s (Lemon and Verhoef, 2016). Historically, companies were focused on what they knew best: their products. In the late 20th century, advances in information systems allowed access to considerable individual customer data (Lemon and Verhoef, 2016). Companies were then able to adopt a customer-centric approach, or *customer centrality* (Shah et al., 2006). In practice, developing such a strategy remains complex because it requires reconsidering the company's culture, organizational structure, processes, and financial metrics (Shah et al., 2006).

Since then, *customer centrality* has spread to many fields. It is part of a fundamental trend that places the individual recipient of the service at the center. Thus, *user-centric* approaches are adopted in the IT sector (Bhargav-Spantzel et al., 2007), *tourist-centric* in tourism (Clergeau and Trinquocoste, 2018), and now *patient-centric* in health care (Palmatier et al., 2019). According to Robbins et al. (2013: 350), "*Patient Centrality* is a dynamic process by which the patient regulates the flow of information to and from him or her through multiple channels to exercise choices consistent with his or her preferences, values and beliefs." The patient-centered approach has long struggled to gain traction for two main reasons: (1) patients are generally not payers, and (2) there is profound information asymmetry between patients and caregivers (Agarwal et al., 2020). This approach has become essential in drug development (Lowe et al., 2016), health care information systems (Paul et al., 2012), cost-effectiveness analyses (Goto et al., 2017), improving patient adherence (Kok et al., 2018), and clinical research (Lamberti and Awatin, 2017). *Patient centrality* can thus be seen as a customer orientation adapted to the health care field.

The hospital prefers the term *patient-centered care* (PCC) to the term used in the pharmaceutical industry. What does it mean? The U.S. National Academy of Medicine (Institute of Medicine, 2001: 6) defines PCC as "*providing care that respects and responds to the preferences, needs, and values of each patient and ensures that the patient's values guide all clinical decisions.*" In the United Kingdom, according to the Royal College of General Practitioners (2014: 4), PCC is "*care that is holistic, empowering and tailors treatment to the priorities and needs of the individual.*" The most important feature of PCC, then, is the focus on patients' needs to tailor treatment according to their priorities. This approach might seem somewhat *top-down*, as if it were a delegation of responsibility from the caregiver to the patient, whereas some definitions of *customer centrality* promote a form of cocreation (see Habel et al., 2020: 27 for a synthesis of definitions in the literature). In all cases, PCC implies the active participation of patients in care decisions. Patients are *empowered* and encouraged to make choices that are best suited to their specific situation (Levinson et al., 2010). This

corresponds to a fundamental trend in the health field, namely, the transformation of the status of the patient from object of care to subject actor in his or her health (Agarwal et al., 2020; Crié and Chebat, 2013; Grewal et al., 2020). At the end of the 20th century, health crises—AIDS, contaminated blood, and mad cow disease—gave rise to the figure of a patient actor on a collective level in "pressure groups to be heard more by health professionals and public health policy makers" (Mougeot et al., 2018: 75). Thirty years later, digitalization and direct access to personalized services have enthroned an emancipated individual patient-actor who intends to occupy a central place (Agarwal et al., 2020).

These developments make PCC seem inescapable and make it all the more important to understand it well. There is a large body of English-language literature on PCC in the public health field, especially in nursing research, but very little in management. Literature reviews are periodically conducted in an effort to more precisely identify what PCC encompasses (see Constand et al., 2014; Hobbs, 2009; Lusk and Fater, 2013; Morgan and Yoder, 2011; Rathert et al., 2013; Robinson et al., 2008). If the concept remains unclear, it is likely because of the polyphony of approaches.

Polyphony of patient-centered care approaches

According to the marketing approach in which we are involved, PCC is close to *patient centrality* and, more indirectly, to *customer centrality* (Table 1).

Table 1. Three parent concepts

| Strategic direction | <i>Customer centrality</i> | <i>Patient centrality</i> | <i>Patient-centered care</i> |
|---------------------|---|--|--|
| Purpose | Focus on customer needs and adapt the marketing mix accordingly to provide the best experience and build customer loyalty | Focus on the needs of the patient and provide personalized medicine that delivers the best patient experience and outcomes | Focus on the patient's needs to tailor treatment to their priorities and environment |
| Key player | Customer | Patient | Patient |

PCC, then, examines the patient as a consumer in the health care environment. It recognizes the patient's ability to make informed choices about health care that balance cost, quality of care, treatment time and other service characteristics (Robinson, 2005). This newly recognized ability of the patient is argued by the greater media coverage of health issues and

the access of all to medical information on the internet. These developments influence the relationship between patients and caregivers, which is now less asymmetrical. Patients are more actively involved in decision-making, using information from multiple sources and expecting the provider to deliver care that meets their wishes. The result is a PCC that can be seen as a supply and demand model of care, as it seeks to balance providers' supply of services with patients' demands. According to Robinson (2005), PCC is thus part of a market-oriented health policy. It is also one of the three pillars of the value-centered marketing model in health care (Agarwal et al., 2020). This model advocates identifying patients' preferences to provide them with precise and personalized care by adopting a patient-centered approach, PCC. This approach "prioritizes patient experience, transparency, reduced patient burden, and privacy" because, like the consumers they otherwise are, "patients want a seamless experience and to be seen as a person whose time, opinions, and data are respected" (Agarwal et al., 2020: 16). It is this marketing approach—as "a specific vision of equitable exchanges involving the creation of value for each stakeholder," according to the definition of marketing given by the French Marketing Association²—that we retain in this research.

However, this perspective, which Robinson et al. (2008: 601) describe as "economic," is not the only one. From their review of the literature, these authors identify three other perspectives that inspire distinct definitions of the concept of PCC: "*public policy definitions*" (based on patient education, participation and respect), "*clinical practice definitions*" (based on self-management of care, family involvement, knowledge of the patient) and "*patient definitions*" (based on patient involvement in treatment, information offered to the patient, communication, duration and accessibility of care).

The choice of perspective is not just a matter of semantics. In practice, the answer to the question "What is PCC?" is by no means self-evident, as stakeholders are not on the same page. There are different viewpoints that clash and yet, in action, often come to a consensus. However, the literature sheds little light on how protagonists reach agreements. Rathert et al. (2013) have proposed a conceptual model that aims to integrate all the approaches, but in so doing erases the differences in conception. However, these differences have their justification. The literature does not, therefore, constitute a theoretical framework for understanding this phenomenon.

² <https://www.afm-marketing.org/fr/content/la-d%C3%A9finition-du-marketing>

Given that the very definition of PCC is the subject of disputes, conflicts and controversies, it seems useful to see how, in practice, PCC takes shape rather than putting forward a theoretical model *a priori*. Indeed, marketing practices have a performative dimension (Araujo, 2007; Araujo et al., 2008; Busca and Bertrandias, 2020), which is essential to take into account in marketing research (Chautard and Collin-Lachaud, 2019; Skålén and Hackley, 2011) alongside theory (Gotteland, 2019; Kumar, 2017). This context led us to use the theoretical framework of economies of worth, compatible with the practical turn in organization theories (De Vaujany et al., 2015), and to integrate material elements, which are resources for action, into the analysis (Busca and Bertrandias, 2020; De Vaujany et al., 2015).

Theoretical framework: Economies of worth

Report on the agreements reached by the actors in situations of uncertainty

The literature says little about the reception of PCC by health actors. It is essentially focused on the strategic aspect and does not focus on the implementation aspects. To fill this gap, we will focus on the difficulties posed by the implementation of this approach, the justifications given by the actors and the methods by which they generally end up agreeing.

It seemed to us that the conventionalist framework of economies of worth (Boltanski and Thévenot, 1991), which studies the ways in which actors manage to cooperate despite divergent interests, was particularly appropriate. Shortly after its conception, the theoretical model of economies of worth was introduced into debates in management science (Livian and Herreros, 1994). In marketing, El Euch Maalej and Roux (2012) demonstrated the fruitfulness of this framework in a qualitative study of loyalty challenges. The theoretical framework of economies of worth seems particularly relevant to us for two reasons. On the one hand, it focuses on the process of confronting disagreements, calming criticism, and how agreement can result. On the other hand, it recognizes the place of objects in the analysis of behaviors: "*we seek to show the way in which people face uncertainty by relying on objects to construct orders and, conversely, consolidate objects by attaching them to constructed orders*" (Boltanski and Thévenot, 1991: 31).

Boltanski and Thévenot did not provide an analytical and operational definition of the situation of uncertainty. However, a reading of their work allows us to identify its contours. Uncertainty arises from the fact that the behavior to be adopted or the decision to be made in the face of a problematic situation may admit several solutions. Its definition is a matter of point of view (i.e., of convention). To remove uncertainty, people make justifications, referring to higher principles from different "worlds."

The seven worlds of economies of worth

In an organization, there are different ways of considering the common good, and each way corresponds to a "higher principle," a term that comes from the sociology of social order. It is around the common higher principle that the agreement between the people of the same "world" is sealed. A world is thus a logic of justification based on a conception of the common good, which is affirmed according to the form of the obvious. These worlds constitute referentials of judgment that clash. For Boltanski and Thévenot (1991), there are six such worlds: the inspired world (creativity), the domestic world (tradition), the world of fame (stardom), the civic world (the fact of all, equality), the market world (interest) and the industrial world (technical rationality, efficiency). Boltanski and Chiapello (1999) added a seventh world, the world of projects (networks). In each world, people are qualified by a state of greatness (see Table 2) and are considered "great" or "small" in the eyes of those in that world because of the higher principle. For example, people who are attached to money, great in the market world, will be judged small in the civic world; those who show flashes of genius, valued in the world of inspiration, will be seen as dangerous in the industrial world. In this theoretical framework, the "greatness" of people is relative to the worlds but also to the "investment formula" of the people belonging to that world, that is, "to a cost or a sacrifice required to access it" (Boltanski and Thévenot, 1991: 99).

Table 2. The seven common worlds

| World | State of size | "Being great" |
|--------------|---|----------------------|
| Inspired | One who creates, escapes the certainties of the technique as well as the reasoning of common sense and habits and gives priority to the singularity | The artist |
| Domestic | One who respects history and customs and contributes to the establishment and maintenance of hierarchies | The chief |
| Fame | One who is recognized, reputed: "fame makes greatness" | The star |
| Civic | One who represents the collective, who subordinates his or her particular and immediate interests to the general will | The elected official |
| Market | One who, driven by desire (his or her own and that of others), confronts competition and seizes opportunities to increase his or her possessions | The seller |
| Industrial | One who, qualified and competent, pursues a quest for performance and masters his or her environment in which he or she is effective | The expert |
| Projects | One who commits himself or herself and coaches by | The project |

It is not necessary to engage in a lengthy exegesis to note that what Robinson et al. (2008) describe as an economic perspective is more specifically inscribed in the market world. It should also be recognized that this convention may not be shared, resulting in disputes, in what could be called a "war of the worlds."

The worlds are in competition and, in an organization, order is based on the reconciliation of the logics of action from the different worlds. However, for the same situation, several decisions or behaviors may appear legitimate insofar as they are justified by different higher principles. We can therefore find ourselves with the simultaneous presence of several higher principles in a decision or an action. These principles are not always compatible. They sometimes give rise to tensions leading either to an agreement or to the continuation of a dispute.

There are three types of agreement: (1) The most durable is the compromise. It occurs when there is a juxtaposition of several worlds in the same situation (for example, when market logic rubs shoulders with industrial logic), and individuals try to associate components, initially referring to different principles, around a common good "*in order to agree on what is right*" (Boltanski and Thévenot, 1991: 183) and to render this association legitimate and lasting. "*The compromise situation remains composite, but the dispute is avoided*" (1991: 337). (2) The second type of agreement that avoids conflict is the arrangement. It is a contingent agreement, "*a transaction for the benefit of the present*" (1991: 408), which requires neither a common good nor a justification. (3) The third type of agreement is relativization, which has only one purpose, to escape from the ordeal by denying its relevance. Relativization serves to "*evade the ordeal*" (1991: 412).

However, when individuals cannot agree, a persistent dispute erupts from the confrontation of worlds. The consequence can be behaviors of exclusion, withdrawal, resignation, etc. Worlds are not immutable attributes of individuals. Individuals can move between worlds and are supposed to be able to change their argumentative logic according to the circumstances.

To study how these worlds fit into PCC in practice and how the actors (patients, caregivers and management) manage to adjust in context, we mobilized a plurality of qualitative approaches to study the service of a large Parisian public hospital recognized as providing PCC.

Methodology

Research field: The orthopedic department of a Parisian hospital providing PCC

We conducted a quasi-monographic study in the orthopedic department of a large public hospital in Paris. By this we mean a detailed and in-depth study of a phenomenon (the implementation of PCC), based on a total immersion and circumscribed in space (a specialized service in a public hospital), with a view to understanding the mechanisms that govern this phenomenon. Such a study is inspired by Weberian comprehensive sociology (Weber, 1971), which is interested in the meaning that people and organizations give to their practices and representations and not exclusively to their behaviors.

The choice of this case was dictated by the research strategy: it is, in fact, an "ideal observation point" (Hamel, 1997) for studying the diffusion of customer orientation in the hospital environment for two reasons. The first is that confrontations are predictable, since the public hospital is a context in which criticism of the market world and tensions between worlds are exacerbated. As a result, the challenges surrounding the need for compromise are more apparent. The second reason why this service was chosen is its recognition as providing PCC. The orthopedic department was awarded the label "Hospitality - Welcoming well for better care," granted for a period of four years by the University Hospital's Patient, Quality and Medical Affairs Department. The voluntary approach is based on a self-diagnosis of the patient's journey by the department, followed by a visit by representatives of users, caregivers and management. These actors evaluate a list of criteria based on an observation grid (coconstructed beforehand by working groups of patients, caregivers and management) and by interviewing patients. The awarding of the label is made public on the hospital's website and on the premises via the display of a logo. Although it is a special case, we felt that this example shed new light on the concept of PCC and enriched the idea of PCC in the literature.

The department studied is a reference center for bone oncology, sepsis and pain. It has 160 medical, paramedical and administrative staff. The department also offers many other services (anesthesia, operating room, social assistance, supportive care, etc.) In total, approximately 200 people work for the department and report to different hierarchies. The department has 75 beds, and approximately 4,000 operations are performed each year. It occupies five floors in the same building. One ward is mainly dedicated to trauma and osteoarticular infections, and two others are dedicated to scheduled operations. One of these wards is a "weekday hospital" (HDS) where patients arrive on Monday and Wednesday morning for surgery on the same day and are normally released on Wednesday and Friday of the same week. The HDS is closed on weekends. A geriatric postoperative unit (Upog) located in an adjacent building is dedicated

to providing care to patients over 75 years of age after their operations. There is also a multidisciplinary ambulatory surgical unit (UCA), including orthopedics, which is run separately at an adjacent site.

Prior approval was obtained from the head of the orthopedic department, the hospital management and all informants (staff and patients). The conformity of the methodology and the purpose of the research were approved by the management of the academic institution and the research laboratory. All data collected were anonymized.

The study was conducted as follows. After multiple contacts, the researchers interviewed the clinical pharmacist in September 2019. The latter then connected them with the department head. The researchers obtained permission to immerse themselves in the environment for three weeks full time in January-February 2020, i.e., just before the outbreak of the COVID-19 crisis at the European level. The investigators were dressed in hospital white coats and introduced by the department head at the morning surgical staff meeting on Monday, January 27, 2020. The field investigation took place over the next three weeks.

Data collection

We multiplied the doors of access to care situations using interviews (individual and collective), observation and documentary analysis.

The fact remains that observation was a central vector of information. Direct observation, by which the researcher himself or herself collects information, is restrictive, and there is a need to guard against naive empiricism, which is a reflexive practice prior to analytical ordering (Arborio et al., 2008). In addition to classic direct observation, we used *shadowing* (Czarniawska, 2007), following a member of the nursing staff as closely as possible during visits, consultations and even in the operating room. We were introduced each time by a member of the health care team, who briefly explained the reasons for our presence.

Despite the establishment of a climate of trust, the field did not give itself up spontaneously to the researchers, who had only limited prior knowledge of the work context. Hence, the interest in indirect observation is accompanied by what ergonomists call "incentive verbalization." This technique is based on the principle that since most mental activity is unobservable, the observer must provoke verbalization on the part of the subjects observed (Hoc, 1984).

In total, we reviewed 294 pages of documents provided by the local informants, conducted 38 individual interviews and 5 group interviews, and carried out 25 hours of observation. Most of the group and individual interviews with medical and paramedical staff and interviews with

some patients were recorded, with the consent of the individuals concerned, and then transcribed, producing 641 A4 pages (11-point font, single-spaced). The nonrecorded interviews and observations were the subject of detailed notes representing 344 handwritten pages. The details of the data collected are summarized in a table in the appendix.

Our sampling was intended to be rigorous, favoring the diversity of statuses, roles and situations, rather than statistical representativeness. The individual interviews were diversified: medical and paramedical staff, patients, and administrative staff. The documents were gleaned throughout the survey. The observations concerned numerous situations involving listening to patients, particularly during consultations and room visits. In total, we were in contact with approximately sixty patients, often accompanied by caregivers.

Data analysis

The situation is the basic unit of analysis. We used benchmarks defined for a given situation according to a five-phase analysis protocol summarized in Figure 1 and detailed below. The starting point of the analysis is the observation of debates, in progress or resolved. The observation shows both the confrontations and their outcomes. In some cases, the researchers arrived "after the battle," when criticism had calmed down. The compromise is institutionalized, inscribed in spaces, objects, and shared statements. The actors' accounts, whether spontaneous or in response to the researchers' requests for clarification, make it possible to reconstruct the criticism between worlds that preceded the emergence of the compromise. The phases are therefore not totally compartmentalized.

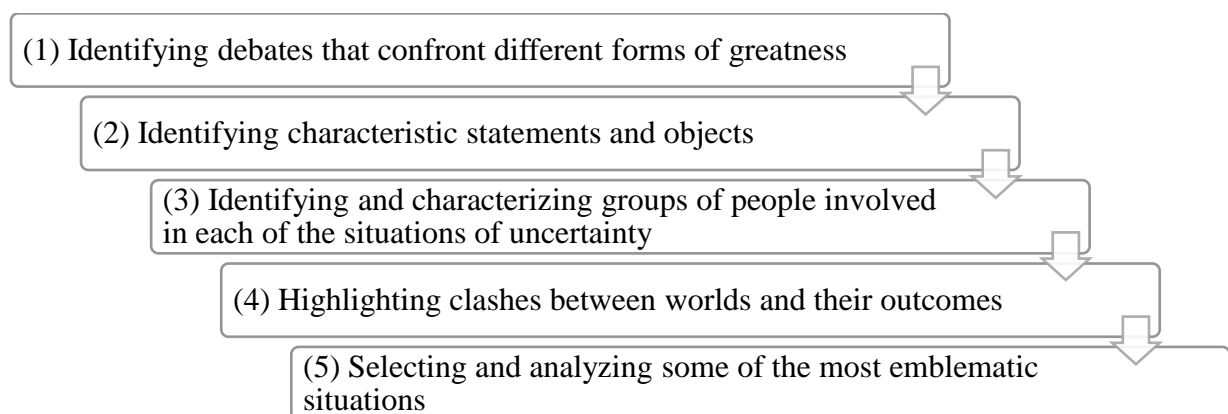


Figure 1: Data analysis protocol.

Identifying debates that confront different forms of greatness. This first step consists of identifying and describing situations in which people clash. These situations may have been

observed directly by the researchers or simply mentioned during interviews. We also try to identify the objects constituting the situations of uncertainty that serve to anchor the arguments specific to the worlds: location of the places and moments to which the statements and objects are attached (care unit, operating room, recovery room, specific meeting, etc.).

Identifying characteristic statements and objects. This involves identifying statements that designate the state of large or small, such as official speeches and *verbatim statements* by which the actors justify (rationalize) the positions and behaviors they adopt. These statements can be summarized by higher principles (patient empowerment, collective interest, science, cost, good functioning, etc.).

Identifying and characterizing groups of people involved in each of the situations of uncertainty. These people have specific shared characteristics and attitudes that bring them closer to the higher principles (hospital management and cost, physicians and science, care support professions and the proper functioning of the orthopedic department, etc.). The common higher principle is the one that unifies the group and defines the most relevant reference world.

Highlighting clashes between worlds and their outcomes. We are not interested in disputes *per se*—disagreements that can occur within the same world and be subject to readjustment—but in disputes between worlds, which are more fundamental disagreements. The aim is to discover the moments when worlds clash (the tests of justification); to describe the clash and the way conflicts are resolved; and to shed light on the controversies between worlds, the way agreements are established and the role played by objects and spaces between worlds initially in conflict.

Selecting and analyzing some of the most emblematic situations. These situations were chosen because people from different worlds frequently referred to them and because they were particularly representative of the criticisms between worlds and the overcoming of these criticisms. Thus, we have identified and will describe situations that illustrate the conflicts between worlds and the elements that contribute to avoiding or suspending disputes and reaching agreements between worlds.

Results

Competing conceptions of patient-centered care

The major worlds. For those who are not familiar with the place, the hospital immediately appears as a mosaic universe, although ordered in different ways. Several orders are juxtaposed. As is classic, a political order sets the medical profession in opposition to the

hospital's management. Moreover, the diversity of professions and the hierarchy of prestige associated with them induce different representations of the patient. These representations guide the behavior toward patients because of the judgments made about the situations and the greatness that inspires them. We note the influence of the domestic and industrial worlds, following Grenier and Oiry (2021), as well as the influence of the civic world, as suggested by Orvain and Angelé-Halgand (2011).

(1) In the domestic world, the relationships between the protagonists of the acts of care are governed by customs and the role of the work community, which is valued: *"It's a team effort and without a team, we're dead"* (a health care executive). Here, benevolence toward the patient takes precedence, as long as the patient assumes the obligations associated with his or her role (accepting prescriptions, submitting to medical and surgical procedures, not being a "difficult patient"). Some patients naturally fit into this domestic world. For example, a 92-year-old patient, who regularly has follow-up visits to the department and is accompanied by her son, confided to us about the care team: *"we feel like we've always known each other, it's nicer than the family"* (in front of her son who accompanied her). The son also felt somewhat excluded: *"the welcome is good, but I'm the odd man out."* One hospitalized patient emphasized how much she appreciated the fact that the head of the department (who had operated on her) came to see her in her room: *"You know, in hospitals, that's not always the case, even in the private sector!"*

(2) In the industrial world, the patient is seen as an object of care that is primarily intended to be effective. Many patients explained that they were referred to this service because it is one of the only ones able to manage certain pathologies. One patient told us that he had lost a considerable amount of time upstream, from one hospital to another, until they realized that they were powerless and had to transfer him: *"At the hospital where I was treated before, they told me: 'we can't do that'".* Another patient, whose state of health makes any operation more complicated, confided that she had seen six different surgeons in different establishments before deciding on this service: *"with him, I knew that I could have the operation, I had confidence."* It should be noted that the definition of efficiency does not enjoy consensus among caregivers and management. If surgeons refer above all to technical acts that conform to a state of the art—performance and the scientific method on which it is based are part of the common higher principles—they are also subject to economic pressure that enjoins them, according to the principles of PCC, to consider the patient as a "care partner," in consideration of indicators that reflect the hospital reform (bed occupancy rate, average length of stay, etc.) according to a managerial rationality.

(3) The civic world is particularly evoked to characterize the public hospital in opposition to the "private" hospital and the commercial grandeur that the latter embodies. Here, the patient is a citizen who has rights and must be treated according to a principle of equality. Some patients and their families negotiate to extend their stay in the hospital, considering that their condition justifies it and that this is the mission of public authorities. Several caregivers (doctors, nurses, orderlies) proudly mention that the service accommodates "homeless people" well beyond the classic duration of hospitalization because their recovery would be compromised if they returned to the street. However, for the staff, this mission to care for everyone is in danger. The private sector appears at all levels as a threat that could intensify in the future: *"There will be those who have enough money to go to the private sector and who will go to the private sector. And then those who don't have the money, who will wait"* (a surgeon); or again: *"If you have the means, we will find you such and such a structure, you will be accompanied. People have money, so they can put in extra resources. So we are no longer in the public service system as we used to be"* (a nursing assistant).

The minor worlds. The other worlds are present, albeit in a minor mode. The world of projects presides over organizational innovations, notably the creation of care units, to which we will return (UCA, HDS, Upog). The inspired world is sometimes evoked by both patients and caregivers when they are ecstatic about the beauty of the surgical technique and the inventiveness of the practitioners. The market world is cited essentially in a critical mode in the comparison made between public hospitals and private clinics. Among patients, this comparison often gives the advantage to the service studied for the quality of care and expertise but in favor of the clinics in terms of comfort and organization. Patients do not hesitate to share their opinions on the internet, either positively (*"excellent service; staff, nurses, interns, surgeon who operated on me at the top"*) or negatively (*"I ended up going to a private clinic (...), the bad reputation of public hospitals is unfortunately well founded"*). These online opinions are still scarce (a few dozen) compared to the number of patients received, but they underline the emergence of the world of opinion. Caregivers are aware of this, and the head of the department recognizes this without any complexes: *"[Patients] don't come to [name of the hospital], they come to see the professor [his name], (...) because I have been working for years, (...) that I pay particular attention to my patients, (...) that I make sure that I do my work well."*

The conceptions of PCC thus appear to be plural, sometimes contradictory between actors but also within the same group of actors. The patients themselves appear torn between the search for recognized medical excellence (the world of industry and fame) and the desire to be

pampered (the domestic world). This position generates different types of agreements, structural in the form of institutionalized compromises or cobbled together between actors in the form of local arrangements.

The different types of agreements around patient-centered care

Structural agreements in the form of institutionalized compromises. As we observed in the hospital wards and in consultations, not all patients are ready to play the PCC game and position themselves as actors in the health system. Some are informed and position themselves as actors in their health, giving their opinion and even their demands in a sometimes authoritarian way. For example, a patient declared to the surgeon during a consultation, "*I want a ceramic prosthesis like my neighbor, not one made of plastic!*" Others adopt a self-effacing, almost submissive behavior, waiting for instructions from the caregivers. The staff unanimously emphasize the existence of these two types of population, one rather young and connected, the other older and vulnerable. One anesthetist goes so far as to speak of a divide between "*those who have mastered the tools and can have information easily, (...) much more accessible to even contradictory discourse (...), [who] benefit [from PCC], indisputably, on the psychological level and adherence to the therapeutic project*" and "*those who do not have access to it: many elderly people, [who] were satisfied with a speech made by a person carrying hierarchical and moral authority.*" In response, the service segmented its patient base, defined targets and positioned its offers differently for each base, without realizing that these were the three steps of strategic marketing. From an operational point of view, this manifests itself in very different locations and languages. The last three care units created are emblematic of this. The UCA (ambulatory surgery unit) and the HDS (weekday hospital) target emancipated patients—strongly in the UCA, slightly less so in the HDS—while the Upog (postoperative geriatric unit) targets the most fragile elderly patients. The very name of these units departs from the "domestic" tradition of naming care units after an illustrious physician.

The UCA, located on a separate plot of land with trees, is characterized by a demedicalized atmosphere (a waiting room with soft tones, light wood, subdued lighting and relaxing music), empowerment of patients who must perform certain procedures at home (preoperative betadine shower, postoperative rehabilitation, etc.), and dematerialized communication (text messages before and after the operation). Patient satisfaction appears to be very high according to the statistics posted on the wall, the interviews conducted and our own observations—smiling and relaxed patients who do not feel like they are hospitalized. For

their part, the medical and paramedical staff of the UCA consider it to be an ideal response both for patients in a hurry and for the hospital ("*the perfect organizational model*" (head of department); "*it makes it easy to get five, six, seven patients on a room in a day*" (surgeon)). However, for others who categorically refuse to work in the UCA, this model is at odds with the mission of the public hospital. It leaves out the most fragile, as illustrated by the words of one orderly, anchored in the civic and domestic world: "*Ambulatory care may be important, but for me it's not beds (...) I wonder about the future of the public hospital, about patient care, about the psychological and physical aspect.*"

The HDS follows the same logic as the UCA but in a less advanced way. It occupies a dedicated wing in the building where the service is located, and demedicalization and patient empowerment are not as advanced. During our fieldwork, there were heated discussions about creating an admissions lounge with robes for patients who would enter the operating room "on their feet" and not on a gurney. This idea was met with outrage by some and enthusiasm by others.

On the other hand, the Upog is aimed at people with limited autonomy who are over 75 years old and suffer from multiple diseases. The head of the department, who initiated its creation, "*knew that this existed elsewhere. I could see that elderly patients were not being treated well. We don't know how to treat them; we're not doctors, we're surgeons!*" Initially, located on one floor of the department, the Upog moved to a neighboring building, which participated, according to the staff, in establishing its status and the holistic care of patients. As the geriatrician in charge of the Upog explained, "*the hyperspecialization of the university hospitals meant that we thought in terms of pathology. Is it broken? It goes to orthopedics. You have a heart attack? You go to cardiology. A lung problem? To pulmonology. And that's where we, geriatrics, are not an organ specialty; our organ is the whole human body.*" Faced with the initial reluctance of management ("*it's very expensive*"), clinical research conducted with geriatricians has demonstrated a faster recovery of patients and, ultimately, a shorter average length of stay: "*We show that patients do much better. This brings more money to the hospital. In terms of coding [of procedures], it makes stays much more expensive, and the hospital earns more money*" (head of department). The Upog includes psychological, social and emotional components for patients that are not found in other services and actively involve caregivers. For example, a room is dedicated to the patient, set up as a comfortable lounge and decorated with care, so that the patient can meet up with his or her loved ones "*just like at home*" (nurse).

Arrangements, expressions of agreements "cobbled together" locally. A space is institutionalized to house the "staff," daily medical meetings (nightly emergencies reviewed at 7:30 a.m.) and weekly thematic meetings (scheduled operations of the upper limb, lower limb, tumors, etc.). The agreements reached by the actors are more like arrangements than compromises because they do not refer to the common good. The patient files are reviewed while the medical images are being projected, and the team discusses the options, taking into account the constraints, before reaching a collective decision. Discussions are sometimes heated between surgeons and anesthesiologists, medical and paramedical staff, or within the same group of actors. These debates concern, in particular, the assignment of patients to one or the other of the care units and the decision of whether to discharge them ("*How come she's still here? There was a request for a center!*"). The mobility of objects plays a key role in the arrangements. Thus, decisions are written on a large white board in full view of everyone and simultaneously transcribed on a computer to be sent by e-mail to the care units as soon as the staff meeting is over. Logistical constraints related to the occupation of beds give rise to arbitration. During the medical discussions, a nurse's aide, who is responsible for the care pathway, juggles the allocation of patients to the beds with the help of cardboard T-sheets of different colors. After the staff meeting, this person circulates between care units to arrange her "ear cards" in the planning boards while explaining the decisions. The debriefing room thus appears to be a place of conciliation, where each person makes his or her point of view heard and where arrangements are made between the worlds of which the protagonists claim to be part.

Relativization agreements aimed at suspending the disputes between conventions. This third type of agreement, relativization, has been less common. It is reflected in the comments of a surgeon when he evacuates the debate on his private patients followed in the public institution: "*It's like traveling by train, there's the one in first and the one in second. They arrive at the same time, except it's a little more comfortable. That's it.*" Avoiding the dispute sometimes leads to rule breaking. For example, the Upog bends the usual hospital rules for the benefit of its patients, such as meal times. As the geriatrician says, "*There are some demented patients who refuse to eat at that time because it is not their habit. And after all, why upset them? We have an organization, of course, but if it can avoid a behavioral disorder with aggressiveness and therefore a crisis management, I say yes.*" To be able to provide care to patients who wander, providers adapt, for example, by giving cakes to a patient because it is "*the only way we have found to settle him to take a blood test. You don't want to hinder patients from walking around. If you stop them, they'll give you a hard time*" (geriatrician).

The Upog allows caregivers to come outside of official visiting hours. We were able to observe that the husband of a patient was present every day from morning until bedtime to give meals to his wife with Alzheimer's disease, which would be inconceivable in the other units of the service.

Summary of results

Although PCC seems to have been imposed on the actors in this public hospital, they have room to maneuver, as the case study shows. The way in which the orthopedic surgery department responded to the constraints of the environment and the injunctions of its supervisory authority was not simply a matter of accepting a closed tool. The health professionals dealt with the prescriptions relayed by the "Hospitality - welcoming well to provide better care" label to give the PCC a form corresponding to the compromises they have reached.

The results highlight the plurality of the worlds and the conceptions of PCC that they inspire. They show the confrontations but also the agreements that may ensue in the form of compromises or arrangements. Relativization, whose aim is to escape the ordeal by contesting its interest, appears only marginally; no doubt, the strong professional identities of the nursing staff lead to the confrontation of greatness rather than to the avoidance of the ordeal.

The results also suggest an articulation between compromise and arrangement. Thus, the "debriefing room" is a space that maintains a compromise on the need for a balance between logics of action and favors local arrangements during the meetings that take place there. The need to cooperate that this space recognizes does not exclude the expression of divergent views.

Discussion

Theoretical contributions

This article aimed to clarify the notion of PCC in the context of *marketing as practice* to promote an actionable definition. Mobilizing the economies of worth, it also sought to understand how this definition takes shape despite diverging points of view. In response, contributions are made both to the characterization of PCC and to the identification of the way in which actors manage to converge to realize this concept.

PCC as a compromise between worlds. Putting the patient at the center of the hospital implies knowing the "needs, uses, desires and aspirations of the various publics" (definition of marketing management by the French Marketing Association³), creating adapted offers and then distributing them. By taking into account the variety of patients and individualizing the responses provided, PCC contributes to building and structuring a hospital care market in the sense of "market-making" (Araujo, 2007). However, this personalization of the offer seems very different from the traditional public service, where users are treated in a uniform manner in the name of equality. In practice, PCC appears to be a collective construction, even if differentiated representations preexist in this construction. By referring to Robinson's four perspectives (2008), we can see that PCC is first and foremost a *public policy issue*, since it is initiated by politicians concerned with the sustainability of health systems. This results in an *economic perspective*, which is in line with the requirements of hospital management. However, this is not in affinity with the status of the patient, mainly because of the financial burden of care. Those whom we have qualified as emancipated patients are more in tune with the *patient perspective*, in line with their expectations of participation, which evokes coconstruction in its counterpart, the customer orientation. The staff in direct contact with the patient (nurses, care assistants) more readily adopt the *perspective of clinical practice*, which implies a good knowledge of the patient and the involvement of his or her family for personalized care. In the sense of economies of worth, PCC thus coconstructed is a compromise that allows the different worlds to cohabit around a common good, "taking care."

PCC as a marketing device. The observation of practices has highlighted the key role of sociomaterial arrangements in the acceptance of PCC by actors, as they solidify the compromise. The joint action of three ingredients, language, spaces and management instruments, makes it possible to reconcile the beliefs and social representations at work behind each of the variables. (1) Language provides the statements that meet the "justification imperative." Invested in actions and interactions, it facilitates coordination within the same world and the obtaining of agreements between rival worlds. (2) The segmentation of spaces objectifies the segmentation of people, both patients and caregivers. This is particularly evident in the contrast between the UCA and the Upog. (3) Management instruments (indicators such as the average length of stay; satisfaction surveys carried out in the UCA; ear cards, etc.), have a mobility that opens up a differentiated appropriation of PCC according to

³ <https://www.afm-marketing.org/fr/content/la-d%C3%A9finition-du-marketing>

the conventions. These instruments act as border objects (Star and Griesemer, 1989), making it possible to cross the barriers erected between the worlds, constituting resources for cooperation. Together, these ingredients help to coconstruct a shared meaning. PCC is shaped by the stakeholders as much as it shapes them, in a dynamic process, the result of the combination of objects and human actors with sometimes divergent visions but who thus find common ground around the patient. From this perspective, PCC crystallizes the provisional balance among the seven worlds present in the hospital. The protagonists agree to converge on the essential care, but the modification of one or the other of the components is likely to call into question the compromise among the worlds by relaunching the controversies. Our research shows that PCC is not a simple tool, conceived in a normative vision, formalized once and for all and subject to the appropriation of more or less consenting actors, but is a management device. More precisely, this research allows us to define PCC as a marketing device:

PCC is a marketing device, the result of compromises, of "provisional and evolving arrangements" (Gilbert and Raulet-Croset, 2021: 92) combining statements and objects, and whose objective is to create value for the patient and other stakeholders.

This device is developed progressively in a series of tests in which the different worlds are brought into confrontation (Figure 2). Taking into account the role of objects and the use of economies of worth sheds light on how PCC can be installed as a marketing device in public hospitals.

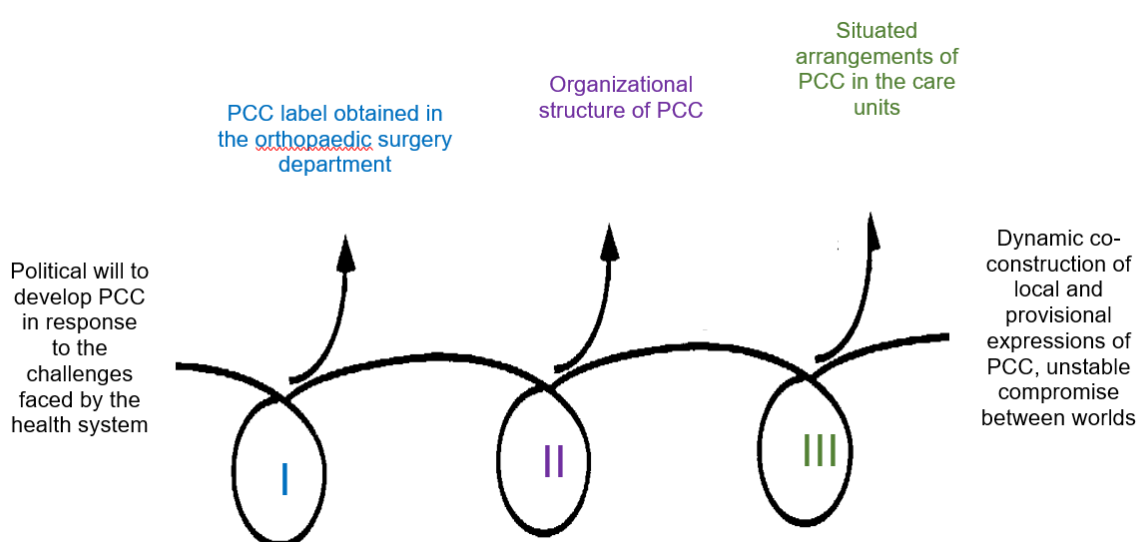


Figure 2: Progressive development of PCC as a device (diagram inspired by Akrich, Callon and Latour, 1988: 21).

Managerial implications

The exploratory nature of this research prevents us from going very far down the path of prescription. However, some courses of action can be deduced from the situations analyzed, identifying how management can contribute to the realization of PCC by stabilizing the compromises.

Encouraging cocreation. As we have seen, PCC is in reality neither top-down (even if it is pushed by the public authorities) nor bottom-up (even if there are many local initiatives): it is built laterally, in a whirlwind fashion. This implies a form of cocreation among management, caregivers, patients and caregivers, as illustrated by the creation of a lounge at the Upog at the request of families so that they can meet their hospitalized loved ones in a private setting or the hiring of a clinical pharmacist who conducts individualized drug reconciliations with patients, allowing them—if they so wish—to be involved in their prescriptions. This cocreation should therefore be facilitated and stimulated to improve the accurate and personalized management of patients and their families, in accordance with the value-centered marketing in health care outlined by Agarwal et al. (2020). However, care must be taken not to add too much mental burden to patients already weakened by their medical situation or to their families, a risk against which Agarwal et al. (2020) warn.

On the staff side, PCC can contribute to enhancing the value of their work by giving them more meaning and autonomy, provided that the different points of view can be expressed. PCC could then be the subject of internal marketing to attract and retain employees and thus constitute a lever of attraction in response to the staff shortage. Implementing a PCC approach, which is the fruit of a marketing strategy but also the unstable result of a marketing system, requires, however, stabilizing—at least temporarily—the worlds.

Stabilizing compromises between worlds. Boisard and Letablier (1989) show that the stabilization of compromises between worlds requires (a) the constitution of composite devices borrowing from the worlds in confrontation and (b) that people translate one world into the other and adapt the procedures of one world to the specific requirements of another. These people must therefore have both the knowledge of one world and the capacity to act in the logic of that world.

These characteristics are perfectly identifiable in our case. First, it appears that PCC ultimately holds together not because the public hospital manages to impose the market

convention—what Robinson et al. (2008) refer to as the economic perspective of PCC—but because of its composite character, which results from the confrontation between worlds. Second, it is indeed possible to identify individuals who translate one world into the other. One obviously thinks of the head of the department, the "manager–surgeon," who is responsible for establishing overall coherence. However, we also note that in the morning meeting of the department, the decisions are made more during the course of the discussions than following his intervention. Other actors, apparently less central, have an important role. For example, the pathway manager does not work solely to meet the logistical imperative of optimizing length of stay, in line with hospital guidelines. If she were not a caregiver, the outcome would likely be quite different, as she would be less legitimate. Knowing the requirements of care staff contributes to cohabitation between worlds.

Overcoming organizational barriers. To move from a *product-centric* to a *customer-centric* approach, Shah et al. (2006) recommend taking into account the potential organizational barriers of culture, structure, processes and indicators. We apply this framework to our results on PCC. Regarding culture, the patient is at the center of care situations for all actors, regardless of the reference conventions. However, the personalization of the responses provided may offend the actors referring to the domestic and civic worlds, which are very present in the public hospital. It therefore seems appropriate to adapt the structure by using smaller, more agile units, defined around the needs of the patients, and by assigning fixed (and not mobile) teams to them while respecting the dimensions to which the actors refer. Each unit can thus come together around its own culture. This is what the service studied is trying to do, between the UCA and the HDS on the one hand and the Upog on the other. This operation could be extended to other patient segments. This segmentation must be materialized by dedicated spaces that are distinct from each other: they institutionalize the compromises (UCA, HDS, Upog) or *at least* allow local arrangements (debriefing room). In terms of process, our research encourages the adoption of a patient pathway logic, which breaks down the stages experienced by the patient throughout his or her care. Thus, one of the reasons for the success of the Upog is the anticipation of discharge from the hospital, by providing, depending on the patient's situation, for admission to a follow-up and rehabilitation center or an adapted return home. Finally, it is important to adopt management indicators linked to patient orientation because they allow the players to appropriate PCC according to their own conventions.

Another course of action, the use of experiments, makes it possible to pacify—temporally at least—confrontations by bringing together individuals from different worlds. Piloted in

parallel with the classic structure, this approach does not call the current organization into question, at least at first. This is how the Upog came into being in the department studied. This approach allows a gradual and gentle acculturation to new practices, with a view to eventually disseminating them more widely if the results are conclusive or to abandoning them without damage.

Conclusion

In view of this analysis, PCC seems inescapable. The scenario of the hospital reverting to its initial positions (the prominence of three worlds: domestic, industrial and civic, as noted in the literature and in our results) is not conceivable because of the pressures of the public authorities and the expectations of patients. Conversely, a sudden shift toward the market world, which would result from the collapse of the values attached to the civic and domestic worlds, is not a conceivable scenario, at the risk of strong resistance from hospital actors. A third scenario seems more likely to us, one that combines the domestic and industrial worlds with the market world. The market world would thus go from being a minor world to a major world, the domestic and industrial worlds would remain major, and the civic world would no doubt become less influential. The other minor worlds would not cease to produce their effects without significantly changing their status. The rise of the world of fame in society, however, can be seen as contributing to the acceptance of the market world carried by PCC, given, as Boltanski and Thévenot (1991: 392) point out, the reinforcement that can be provided by the contribution of "the greatness of a market good" in the public eye. This lasting appeasement of criticism through the personalization of relations with patients is consistent with what Boltanski and Thévenot refer to as a "state of confidence" that allows the development of a market mechanism (Boltanski and Thévenot, 1991: 380).

Despite its contributions, we are aware that this research has certain limitations and consequently leaves room for further study. First, it is a single case study (a public hospital in Paris), which limits the scope of the conclusions. Of course, every case is particular, rooted in a specific environment, but this does not prevent its scope from going beyond its initial object, as we have argued in presenting the methodology. Reasoning from a particular case is part of a long tradition in the social sciences (Yin, 1981; Becker, 2020). Nevertheless, one can legitimately question the representative nature of the situations observed and wonder whether the reception of PCC is not different in other types of hospitals, such as mutualist clinics and *a fortiori* in private clinics. In this respect, it would be interesting to analyze whether there are differences with private clinics and to study the sector's role in the acceptance or otherwise of

patient centrality. Is the appropriation of PCC dependent on a sectoral effect (public/private), or is it intrinsic to the nature of the field (health)? In addition, beyond the public or private hospital, PCC may concern any medico-social establishment that receives patients or vulnerable persons (specialized homes for the disabled, residential establishments for dependent elderly persons. It would be useful to extend the research to these establishments. Within the same institution, we could also examine the differences in specialties as structuring elements of the relationship with the patient by comparing, for example, a surgical department and a medical department ("with doctors," to use the words of the respondents) or surgical specialties with different purposes, such as visceral surgery, "which saves lives," and plastic surgery, "which reconstructs them." Within plastic surgery itself, it would be interesting to compare the reception of PCC according to whether the purpose is aesthetic or reconstructive. Another promising line of research would be to study whether PCC can constitute a differentiating element to reinforce the attractiveness of the territories to health care personnel on the one hand and to the inhabitants on the other, thus placing health at the heart of territorial marketing.

Additionally, one will note that the observations took place over a relatively short period. As a result, they have a quasi-photographic character. To shed more light on the genealogy and dynamics of the compromises, it would be useful to carry out studies of a more longitudinal nature. On this occasion, it would be possible to explore the role of the spatiotemporal anchors that encourage the establishment of compromises. It would then be possible to more precisely identify the factors of the success or failure of PCC.

Economic and social stakes are high in the health sector, and management science research on the implementation of PCC is still scarce. In the past, when hospitals "segmented" patients according to pathologies and not individuals, marketing was probably not truly necessary to address the delivery of care, and even less so in public hospitals. It is the advent of the "market" convention, in conjunction with changing patient expectations (Agarwal et al., 2020; Grewal et al., 2020), that calls for a marketing approach.

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Appendix: Details of data collected

Details of the data collected

| Method | Description | Average time per interview or observation sequence |
|--------------------------|---|--|
| 38 individual interviews | 14 medical staff members from all levels: - 9 orthopedic surgeons (including the head of department on two occasions) - 3 anesthetists - 1 geriatrician - 1 clinical pharmacist | 55 minutes |
| | 18 paramedical and administrative staff of different hierarchical levels: - 6 nurses (3 in the hospitalization room, 1 in the Upog, 1 in the care pathway, 1 in the operating room), - 1 health assistant controlling bed occupancy, - 1 health assistant controlling the occupation of the operating room, - 5 health executives (2 in the hospital room, 1 in the Upog, 1 in anesthesia, 1 in the operating room), - 2 medical secretaries, - 1 social worker, - 1 dietician, - 1 physiotherapist | 57 minutes |
| | 6 patients (4 women and 2 men, ages 55-92): - 5 in an inpatient room, - 1 in postoperative consultation | 21 mn |
| 5 group interviews | 12 paramedical and administrative staff: - 4 nurses in the hospital ward, - 6 health assistants, - 2 health executives (Upog and UCA) | 60 minutes |
| Direct observation | 3 daily meetings of the surgical staff | 2 h |
| | 2 visits to hospital wards (with the nursing staff) | 3 h |
| | 1 "weekly grand rounds" (involving a senior surgeon, medical and paramedical staff) | 1 h |
| | 1 day of consultation with the department head | 1 j |
| | 1 half day with the health assistant controlling bed occupancy | 3 h |
| | 5 surgical operations | 2 h |
| Literature review | Patient Documents: - Brochure: "Pathway of Care: Enhanced Rehabilitation after Surgery" (ERS) - Leaflet: "Preventing the risk of falls: the right shoes" | |

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- Complete file on a scheduled operation (information on hospitalization and anesthesia, admission documents, preanesthetic questionnaire with anxiety assessment, prescriptions, consent form for femoral head donation, application for admission to follow-up care and rehabilitation, application for functional rehabilitation)

Hygiene recommendations before an ambulatory surgical procedure

Leaflet for follow-up care in one of the rehabilitation centers linked to the service

Internal Documents:

- Organization chart of the university hospital group
- Annual Report 2019
- Welcome booklet for the new trainee in the department and procedures
- Description of the care pathway nurse position
- Programming sheet for operations
- Surgical preparation interview (care pathway nurses)

Academic Documents:

- Thesis defended by one of the health executives on the Upog
 - Paper presented at a geriatric conference by the head of the Upog
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