INTRODUCTION
In recent decades, there has been a shift from physician-focused to more patient-centred care in Western countries (Mead and Bower, 2000; Bensing, 2000). The concept of patient-centred care was introduced to address excessive paternalism in health care (Coulter and Dunn, 2002; Richards and Coulter, 2007). Following this new approach, individual patients’ preferences and needs should be the central focus of care services (Castro et al., 2016; Balint, 1969). The need for adopting a more patient-centred approach has been increasingly recognized worldwide (Kitson et al., 2013; IOM, 2001) due to its potential to:

- reduce the demand for health services (Ekman et al., 2011; Bertakis and Azari, 2011);
- enhance the quality of care (Roumie et al., 2011);
- improve patients’ health outcomes (Mead and Bower, 2002; Stewart et al., 2000; Ulin et al., 2015);
- improve quality of life (Kinmonth et al., 1998; Ulin et al., 2015); and
- improve patients’ satisfaction (Lewin et al., 2001).

Patient involvement has been put forward as one way to place the patient in the centre of care. Various initiatives have been undertaken to involve patients in health-related decision-making processes. At an individual level, more responsibility is given to patients for controlling their own care (Guadagnoli and Ward, 1998) through, for instance shared decision-making (Charles et al., 1997; Elwyn et al., 2003; Elwyn et al., 2010) and self-management (e.g. Coulter and Ellins, 2006; McCorkle et al., 2011). At a collective level, patients have been invited to join decision-making processes regarding strategic topics such as the organization of care. For example, initiatives have been set up to involve patients in the assessment of the quality of care (e.g. Cleary and McNeil, 1988; Teunissen et al., 2013), the development of clinical guidelines (e.g. Boivin et al., 2010; van der Ham et al., 2016; Serrano-Aguilar et al., 2015; Pittens et al., 2015), improvement measures (e.g. Millett and Adams, 1999; Boivin, 2012) and self-management tools (e.g. Funnell and Anderson, 2004; Stellefson et al., 2010; Warsi et al., 2004). Including patients’ perspectives has been suggested as a way to increase the quality of health-related decision-making through greater legitimacy and accountability (Gordon, 2005), thereby contributing to improved implementation of health-related innovations and policies (Grit et al., 2008; van de Bovenkamp and Trappenburg, 2009).

By involving patients in health care decision-making, patients’ unique experiential knowledge about care services is included. This experiential knowledge is obtained by experiencing the disease and care process, and is complementary to health professionals’ knowledge (Caron-Flinterman et al., 2005). Although patients’ experiential knowledge is increasingly acknowledged as a legitimate source of information (Jouet et al., 2010), studies show variable progress regarding patient involvement (Ocloo and Fulop, 2012). In addition, many cases of tokenism in which such involvement is a box-ticking exercise rather than having real influence, are reported (Supple et al., 2015; Ocloo and Matthews, 2016). The attitudes of health professionals and the absence of appropriate methods are among factors that have limited the adequate involvement of patients in health-related decision-making (Gagliardi et al., 2008).
Obtaining successful patient involvement at both the individual and collective level requires a ‘meaningful’ dialogue between patients and health professionals (Forbat et al., 2009) in which patients act as partners in knowledge co-creation processes. Knowledge co-creation comprises of three phases: making patients’ knowledge explicit (knowledge articulation), integrating patients’ knowledge with health professionals’ (and other stakeholders’) knowledge (knowledge integration), and implementing the integrated knowledge in health services and innovations (knowledge embedment) (Pittens, 2013). By involving patients in knowledge co-creation processes, a patient-centred approach could be further facilitated (Shaller, 2007; Luxford et al., 2011), leading to patients’ increased empowerment (Holmström and Röing, 2010; Anderson and Funnell, 2010). At an individual level, a dialogue between patients and health professionals can create conditions for patients to become willing and able to take an active role in their own care (Fumagalli et al., 2015; Aujoulat et al., 2007; Dowling et al., 2011; Small et al., 2013). Empowered individuals are thought to have healthier behaviour and more control over their lives than less empowered individuals (Beresford, 2003; Wallerstein, 1992). At a collective level, patient empowerment means that patients become willing and able to play an active role in health care-related decision-making processes (Tritter, 2009). As a result, patients’ representatives will be able to take actions such as advocating patient groups’ needs.

Involving patients in knowledge co-creation processes has, however, posed challenges (van der Ham et al., 2014; Boivin, 2012; Pittens, 2013; Shippee et al., 2015). Involvement is also an attribute of empowerment (Shearer, 2007), and the empowerment of patients is expected to be helpful for supporting successful partnerships in which knowledge is co-created (Holmström and Röing, 2010; Anderson and Funnell, 2010). Patients’ empowerment level depends among other factors on the patient-empowerment strategies implemented by health professionals (Spence Laschinger et al., 2010), amongst other factors. Health professionals could provide information and tools that enable patients’ empowerment by increasing their capacities (Aujoulat et al., 2007; Hibbard, 2003; Chatzimarkakis, 2010). Educating patients and involving them in shared decision-making could, for instance, enable patients to self-manage their illnesses and make decisions on their care processes (Holmström and Röing, 2010; Fumagalli et al., 2015). In order to empower patients to be involved in health-care decision-making requires health professionals to take on new roles and attitudes (Gagliardi et al., 2008; de Wit et al., 2015). To become confident in these new roles, health professionals could themselves benefit from empowerment (Légaré et al., 2008b). Limited empowerment of health professionals due to issues like a lack of perceived meaningfulness, resources or skills, could impede patients being successfully involved in decision-making processes (Gagliardi et al., 2008).

While the importance and relevance of the concepts of patient-centred care, patient involvement and empowerment have been widely acknowledged in academic research, the exploration of the relationships between these concepts has been limited. Therefore, this thesis aims to obtain insights into the processes of knowledge co-creation and empowerment to enhance patient-centred care.
1.1 | THESIS OUTLINE

After this introductory chapter (Chapter 1) presenting the scope and main aim of this thesis, Chapter 2 will describe the main concepts of patient-centred care, patient involvement in knowledge co-creation processes and (patient and professional) empowerment. Chapter 2 will also elaborate on the relation between these concepts and introduces the overarching conceptual framework of the thesis. Subsequently, the research design, approach and methods are described in Chapter 3, including the validity and ethical considerations concerning the research undertaken for the thesis.

Chapters 4–8 describe five case studies. The first case study (Chapter 4) articulates parents’ experiences with the quality of care and their needs to become more empowered to ensure that the care is more centred on the needs of their children with Congenital Diaphragmatic Hernia. In the second case study (Chapter 5), women’s perspectives on maternity care are articulated to provide recommendations on how to achieve client-centred care. In addition, ideas on how clients’ empowerment could play a role in ensuring these improvements were discussed. Chapter 6 presents the third case study which provides insights into how patient involvement in co-creating care-pathway management can be meaningfully implemented. The case study described in Chapter 7 provides insights into the development of an empowering educational intervention using participatory research in which patients and health professionals co-created patient information. In the last case study (Chapter 8), patients and health professionals’ needs to address sexual health are explored. Based on this understanding an empowerment tool that is aligned with such needs was co-developed through a participatory approach. These chapters each present an article that has been published in or submitted to an international peer-reviewed journal.

Finally, Chapter 9 presents a general discussion based on the lessons drawn from the different case studies. This chapter also reviews the validity of the findings and explores clinical and theoretical implications and opportunities for future research.