BMJ Open Quality

Pedagogical value of a hospitality awards programme

Gérard Reach,[1,2] Sophie Bentégeat,[3] Isabelle Mounier-Emeury,[3] Brigitte Le Cossec,[3] Sadiyé Yesilmen,[3] Vincent Hirsch,[1] Yohann de Oliveira Granja,[1] Audrey Minetti[1]

To cite: Reach G, Bentégeat S, Mounier-Emeury I, *et al*. Pedagogical value of a hospitality awards programme. *BMJ Open Quality* 2019;**8**:e000576. doi:10.1136/bmjoq-2018-000576

Received 7 November 2018
Revised 8 August 2019
Accepted 29 August 2019

[1]Direction Qualité, Accueil du Patient, et Opérations, Groupe Hospitalier Hôpitaux Universitaires Paris-Seine Saint-Denis, Assistance Publique-Hôpitaux de Paris, Bobigny, France
[2]Laboratoire Éducations et Pratiques de Santé, EA 3412, Université Paris 13, Sorbonne Paris Cité, Bobigny, France
[3]Direction Patients, Usagers et Associations, Assistance Publique-Hôpitaux de Paris, Paris, France

Correspondence to
Professor Gérard Reach; gerard.reach@aphp.fr

ABSTRACT

Objective Assistance Publique-Hôpitaux de Paris (AP-HP), the leading university hospital in France, proposed to offer its services to candidate on a voluntary basis for a hospitality award, certifying compliance to a 240-item home-made questionnaire designed by healthcare providers and patients' representatives. It combined an objective examination of the services and patients' questionnaires, covering seven domains: reception and information from admission to discharge; cleanliness, comfort and environment; proposed services (eg, access to Wi-Fi); culture, relaxation and well-being; meals; linen and relationship quality with hospital staff. The procedure was completed in two steps: an initial self-evaluation to detect improvable deficiencies, followed by an awarding visit. A service received the hospitality award if at least 80% of the reference criteria were met during this second evaluation. Here, we describe the construction of this hospitality awards programme and present a comparison of the scores obtained during the two steps.

Design and methods Retrospective comparison by usual statistical tests.

Setting AP-HP, grouping 39 university hospitals (21 000 beds, 8 million annual patient visits).

Participants The 211 services from 29 different hospitals engaged in the procedure (2017–2019).

Results Only one service did not get the award (self-evaluation 83%, visit score 79%). The score was higher during the awarding visit (89.0%±5.6%) than during self-evaluation (85.5%±4.3%, n=211, p<0.00001), with increased scores for the following domains (p<0.005): patient reception and information; cleanliness, comfort and environment; proposed services; culture, relaxation and well-being.

Conclusion (1) Internal self-evaluation is feasible. (2) By diffusing criteria of hospitality, the procedure had a pedagogical value leading to rapid and significant improvements. (3) This quality assessment procedure results in an award that can be posted in the departments. By appealing to pride, this procedure should promote hospitality in hospitals.

INTRODUCTION

The concept of hospitality is difficult to define in a hospital setting. Intuitively, hospitality encompasses two distinct domains: material (such as comfort of the room, food or Wi-Fi access) and immaterial (ie, the quality of relationships with staff). Whatever the connotation, hospitality has become a natural expectation of patients when hospitalised. In addition to high quality and safety of care, people now want to be considered not only as patients but also as active individuals who deserve treatment in a humanised framework focusing on quality, respect, responsibility and transpersonal care.[1] Therefore, hospitals need to consider hospitality a core value[2–4] representing an extension in hospitals of the concept of person-centred medicine.[5 6] Evaluating patient satisfaction has become an indispensable part of quality assessment.[7–10]

Hospitality in hospital settings may seem evident, but its actual implementation is jeopardised by the fact that it requires adequate time and resources. In practice, these are often lacking owing to economic constraints with reductions in hospitalisation durations, nurse/patient ratios and space. There is also a tension in the need to organise vast patient flows while maintaining high levels of individualised care. The multidisciplinary nature of modern care and restructuring of hospitals into mutualised organisations has increased anonymity in care, meaning that patients may not know whom to identify as their host. Thus, it is not surprising that the hospital setting has been paradoxically described as a 'merciless world'.[11]

Assistance Publique-Hôpitaux de Paris (AP-HP) is a university hospital trust operating in Paris and surroundings regions. It comprises 39 hospitals and is a major European hospital system, with >21 000 beds and >8 million annual patient visits. Being aware of the importance of promoting hospitality as a value, AP-HP decided to tackle this aspect of hospital care. This led to the development of a programme, in which services may engage on a voluntary basis to certify their compliance to a home-made questionnaire, leading to the attribution of an award. This article describes the development of this hospitality awards programme and demonstrates its pedagogical value.

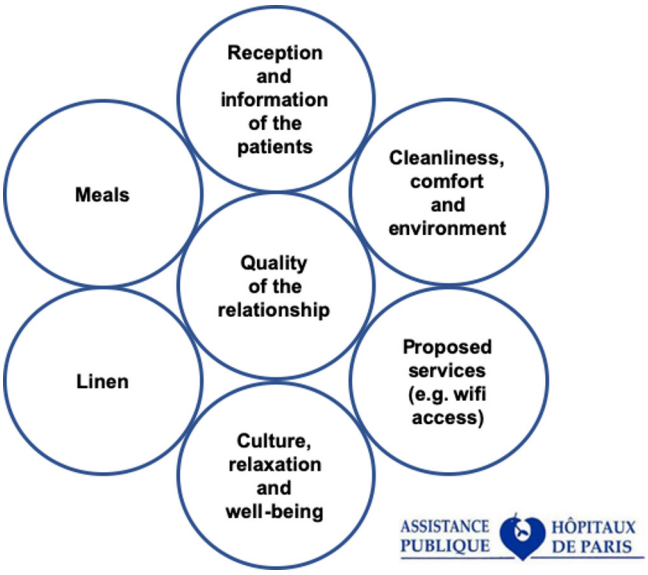

Figure 1 Assistance Publique-Hôpitaux de Paris's seven domains of hospitality.

METHODS

Development of the hospitality awards programme

In 2012, AP-HP formed a task force aimed at defining the concepts and needs in this field.[12] Subsequently, from 2014 to 2016, seven working groups, comprising healthcare professionals and patient representatives of AP-HP, elaborated on reference items that could be used to evaluate the different aspects of hospitality. Each group explored one of the following seven domains (figure 1): (1) reception and information for patients from admission to discharge; (2) cleanliness, comfort and environment; (3) proposed services; (4) culture, relaxation and well-being; (5) meals; (6) linen and (7) relationship quality with hospital staff. More than 120 people worked for 2 years to develop a high-granularity questionnaire that could be used in different hospitals of AP-HP.

The hospitality questionnaire

Given that patients may have their own perception of hospitality, any meaningful evaluation must combine objective observation with patient questionnaires. Indeed, it is this subjective perception that is most relevant. The hospitality awards programme was therefore based on a two-part questionnaire. First, assessors performed an objective evaluation of >160 criteria covering different aspects of hospitality. For example, the bed linen was evaluated according to the following criteria: (1) The equipment of a bed must comprise two sheets or one sheet and one mattress; (2) one pillowcase, one pillow, one cover; (3) the laundry is without holes; (4) the laundry is clean; (5) the laundry is without moisture and (6) the laundry is odourless. At this level of granularity, assessors were asked to appreciate different common areas of the service (such as waiting room, corridors and public toilets). Further, three to six patient rooms were evaluated depending on the size of the service.

Box 1 Assessment of relationship quality

1. Do you feel welcomed as a person and not as a number?
2. Do you feel welcomed with politeness?
3. Do you feel welcomed with kindness?
4. Does the dress code of professionals seem correct and appropriate?
5. Do the professionals who look after you introduce themselves?
6. Do you feel considered as a responsible adult?
7. Do you feel welcomed with no assumptions about you?
8. Do you feel that your expectations are considered?
9. Does the staff seem available if needed?
10. Do you feel that special situations happening during your hospitalisation are considered?
11. Do you feel that the staff has appropriate behaviours and words?
12. Do you feel that your privacy is respected?
13. Do you consider that the decisions concerning you are made with your agreement?
14. When there is disagreement or conflict, do you feel that the staff attempts to understand your perspective?
15. Do you feel that trust has been established with the healthcare team?
16. Do you feel that the staff ensures you understand what you have been told?
17. Do you feel that professionals understand what you are telling them?
18. Do you have opportunities to express yourself and ask questions?
19. Do you have opportunities to express yourself without being interrupted?
20. Do you feel that the gestures of care are accompanied by explanations?
21. Are you asked if you need additional information?

For the second part of the evaluation, questionnaires were provided to three to six patients depending on the size of the service. The questionnaire covered 71 questions that took 20–30 min per patient and examined all seven domains of hospitality. For example, relationship quality in standard hospital care was assessed with the 21 questions shown in Box 1. They were consistent with some general principles of patient education and person-centred medicine.[5 6 13–15]

Finally, this generic material was customised to specific hospital settings, such as standard hospital care, day hospitalisation, outpatient visits, rehabilitation services, long-stay care and palliative care. Table 1 shows the number of items that were applied in each hospitality domain for the objective observation and the patient questionnaire, respectively, in the case of standard hospital care.

The hospitality awards programme

In September 2016, AP-HP opened its services to the possibility of candidating for a hospitality award that would be attributed to services found complying with the criteria in the questionnaire. The hospitality awards programme comprised two steps. First, self-evaluation was locally organised to assess whether 80% of the reference items for the hospitality criteria had been met or if improvements were possible to reach this threshold. Then, if this

Table 1 Number of items in each hospitality domain for a standard hospital care

Hospitality domain	Objective observation	Patient questionnaires
1. Reception and information of the patients from the entrance to the exit of the hospital	27	5
2. Cleanliness, comfort and environment	94	5
3. Proposed services	11	7
4. Culture, relaxation and well-being	12	6
5. Meals	7	21
6. Linen	16	6
7. Quality of the relationship with the healthcare providers		21
Total	167	71

The questionnaire is customised for specific settings (such as standard hospital care and outpatient visits). The example of standard hospital care is given.

criterion was met, a visit was organised within 2–3 months by the AP-HP headquarters. A service received the hospitality award if at least 80% of the reference criteria were met during this second evaluation.

Objectivity

The same questionnaire was used during the self-evaluation and awarding visits. Both visits were performed by two assessors who were asked to be as critical as possible and to agree for each questionnaire answer. Self-evaluation was performed by staff members of the service assisted by a trained member of the hospital's quality direction. The awarding visit involved a trained non-physician member of the AP-HP headquarters (Patient, Customers and Association's Direction) and a trained patients' representative from the institution. These two assessors had access to the evaluation chart filled during the self-evaluation step to allow them to detect eventual discrepancies or improvements.

Score calculation

Answers were scored as 1 (Yes) or 0 (No); if a question was irrelevant, assessors were asked to record the response as 1 in a non-applicable (N/A) box. A pondering factor, 2 for important or 3 for very important, was attributed by the working groups to each item of the questionnaire. For each of the seven hospitality domains, a computerised spreadsheet was used to calculate scores, considering both the assessors' and patients' answers, as well as the N/A questions, and using the items' pondering factors. Scores were given as the percentage of a maximal value that would be obtained if a positive answer was given to all applicable questions. Finally, a global hospitality score was calculated as the mean of the seven specific domain scores. All data used in this study are available with AP-HP headquarters, and the spreadsheet file used for calculations is available with the first author.

Immediately after the self-evaluation, scores were communicated to the teams with suggestions for improvement. When a team considered that it was likely that the 80% threshold would be met, if necessary after having achieved these improvements, the awarding visit was organised within 2–3 months. The hospitality award was attributed to a service if the global score was ≥80% during this visit, and this was followed by an awarding ceremony. Figure 2 shows the award given to the team to be displayed in the service. It is granted for a period of 4 years.

Statistical analysis

There were no missing data. StatPlus Mac LE V.6.9.94 was used to compare data obtained during the two visits using two-tailed paired Student *t*-tests and Pearson correlation (r) test to detect correlations.

Ethics

This study was based on the data gathered during quality surveys that represent standard investigations in any institution and thus did not require, according to French law, a formal approval by an ethical review board. The aim of the

Figure 2 The hospitality award to be displayed in the hospital service. AP-HP's hospitality award. Bien accueillir pour mieux soigner: Better welcome for a better care. The French word 'label' refers to an official distinction attesting that a product, service or site complies with a certain number of quality standards defined by regulation. AP-HP, Assistance Publique-Hôpitaux de Paris.

Table 2 Characteristics of the 211 candidate services for hospitality award

	N	Number of beds (standard hospital care) and places (day hospitalisation)
Standard hospital care, medicine	60	1542
Standard hospital care, surgery	18	740
Day hospitalisation, medicine	37	335
Day hospitalisation, surgery	6	58
Intensive care unit	9	239
Emergency room	2	NA
Rehabilitation services	17	618
Long-stay care	6	441
Palliative care	5	55
Outpatient visits, medicine	26	Total: 4028
Outpatient visits, surgery	15	
Imaging and other technical services	10	
	Total: 211	

survey (investigating and promoting hospitality in hospitals) was explained to patients who were asked to give their written informed consent. Their individual answers were entered during the visits into a spreadsheet table and were not communicated to their healthcare providers.

RESULTS

Participants

Table 2 shows the characteristics of the 211 candidate services for the AP-HP hospitality award from February 2017 to June 2019. Concerning the hospitalisation services, this represents more than 4000 beds (out of AP-HP's 21 000 beds), and we estimated that this sample represents 20% of the services eligible for the procedure.

Global hospitality score

Figure 3 shows the global hospitality scores calculated from the scores obtained for each domain during both self-evaluation and the awarding visit. Among the services with a self-evaluation score ≥80%, only one (self-evaluation score=83%) achieved an awarding visit score below the threshold (79%) and did not get the hospitality award. Of note, 30 services that had not met the 80% threshold during self-evaluation had improved enough to receive the hospitality award.

As shown in figure 3, the score obtained during the awarding visit was higher than that obtained during the self-evaluation procedure in 147 instances (69.6%) and

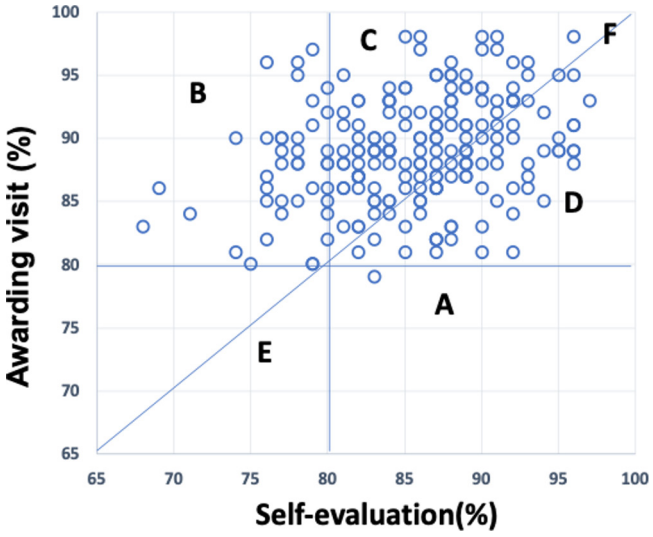

Figure 3 Global hospitality scores obtained during self-evaluation and awarding visit. Awarding visit (AV) and self-evaluation scores (SE). Zone A (n=1): SE >80% and AV <80% (this service did not get the award). Zone B (n=30, 14.2%): SE <80% and AV >80%. Zone C (n=117, 55.4%): AV and SE >80% and AV >SE. Zone D (n=53, 25.1%): AV and SE >80% and AV <SE. Zone E (n=0): SE and AV <80%. F (n=10, 4.7%): AV and SE >80% and AV=SE. It should be noted that B+C (n=147, 69.7%) is more than twice as high as D+F (n=63, 29.8%).

lower or equal to that obtained during the self-evaluation procedure (while remaining higher than 80%) in 64 instances (30.3%). Consequently, the mean±SD global hospitality score was significantly higher during the awarding visit (89.0%±4.3%) than during the self-evaluations (85.5%±5.6%; p<0.00001). A correlation was also apparent between the two evaluation scores of a given service (r=0.29173, p<0.00002)

Analysis of the seven hospitality domains

For each of the seven hospitality domains, table 3 shows the scores obtained during the self-evaluations and the awarding visits and the respective correlation. Compared with the self-evaluation scores for domains 1 (reception and information of the patient), 2 (cleanliness, comfort and environment), 3 (proposed services) and 4 (culture, relaxation and well-being) but not for other hospitality domains (meals, linen and relationship quality), the mean awarding visit score was significantly higher (p<0.005). Notably, for this last domain (relationship quality), the score was already >90% at the self-evaluation step, and even for this high baseline score, a correlation was observed between the two scores obtained by each service.

DISCUSSION

Principal findings

We developed a two-step hospitality awards programme using a questionnaire jointly elaborated by healthcare professionals and patients' representatives of a hospital institution. Self-evaluation was shown to be a feasible method of assessment, with only one case giving a

Table 3 Hospitality score for each domain at self-evaluation and at the awarding visit

	1 (n=211)		2 (n=211)		3 (n=211)		4 (n=211)		5 (n=154)*		6 (n=142)*		7 (n=211)	
	SE	AV	SE	AV	SE	AV	SE	AV	SE	AV	SE	AV	SE	AV
Mean	80.6	89.4	90.9	93.6	77.8	82.4	65.5	75.8	83.3	84.5	95.6	95.0	94.4	94.3
SD	10.8	9.5	7.3	5.7	21.5	18.9	28.6	23.8	8.9	8.2	5.5	5.6	8.3	5.7
P value (*t*-test)		**<0.0001**		**<0.0001**		**0.004**		**<0.0001**		0.149 NS		0.334 NS		0.89 NS
r (Pearson)		0.33811		0.24967		0.35035		0.64932		0.27847		0.08673		0.18024
P value (Pearson)		**<0.0001**		**0.00024**		**<0.0001**		**<0.0001**		**0.00005**		**0.30 NS**		**0.0009**

1 = reception and information of the patients from the entrance to the exit of the hospital; 2 = cleanliness, comfort and environment; 3 = proposed services; 4 = culture, relaxation and well-being; 5 = meals; 6 = linen; 7 = quality of the relationship with the healthcare providers; P values are given for Student's t-test and Pearson correlation coefficient r between the data obtained during the two visits. See text for the calculation of the score, expressed as a percentage of the maximal possible value.
Bold values are statistically significant.
*N is lower because there are services where these criteria are not applicable (for instance, day hospitalisation, outpatient visits and imaging).
AV, awarding visit; NS, not significant; SE, self-evaluation.

self-evaluation score above the award threshold while the actual awarding visit score being lower (ie, 83% and 79%, respectively). In 70% of the 210 services that were granted the hospitality award, the score obtained during the awarding visit was higher than that obtained during self-evaluation; in the cases where it was lower, it still met the criteria and remained ≥80%. In particular, the awarding visit score improved in four domains: reception and information of the patient; cleanliness, comfort and environment; proposed services, culture, relaxation and well-being.

Further, the investigation aimed to determine whether self-evaluation was sufficiently objective to predict success in the awarding visit. Indeed, we recognised that it was possible for scores obtained during locally organised self-evaluation to be overestimated and that this could cause discrepancies with the results of the awarding visit, leading to a refusal representing a disappointment to the teams. This situation was observed in only one case.

Implications for clinicians and policymakers

Hospitalisation is a complex situation that can lead to emotional distress. In previous research, we showed that the hospital experiences of patients were multidimensional.[16] Similarly, the concept of quality of care in a hospital is complex by nature and cannot be restricted to its technical and safety aspects. A third dimension—namely hospitality—should be individualised as a new domain that reflects the evolution in patient expectations. Therefore, any modern hospital institution needs to tackle this issue and implement it as a core value along with quality and safety of care. Clinicians may use this procedure to improve their practice and care, and policymakers may find it useful to prioritise investments to enhance the quality of patients' receptions in hospitals.

Therefore, we propose that a procedure leading to an award, such as that developed by AP-HP, may facilitate the promotion of hospitality in hospitals. The questionnaire used comprised approximately 240 items to be compared with the usual number of items (mean 45, range 15–72) from previous questionnaires used to assess hospital patients' perceptions of care.[17] With such a high-granularity assessment of different domains of hospitality and by involving objective examination and patients' questionnaires, precisely detecting areas that require improvements is feasible. Indeed, we observed the existence of a significant improvement in four domains of hospitality from the time of self-evaluation to the awarding visit. A key rationale for launching a two-step procedure was that it may give pedagogical value to the programme: distributing the reference criteria could open the eyes of hospital staff to patients' expectations. Indeed, as the French poet and essayist Charles Péguy (1873–1914) stated,[18] 'We must always tell what we see. Above all, and this is more difficult, we must always see what we see.'

A strength of this study is that it illustrates how the fields studied by the questionnaire are diverse, coming under different responsibilities (such as management,

physicians, nurses, contracts for household and meals). This indicates how the hospital functions as a whole or a system, while the organisation is compartmentalised. Integration may indeed be difficult owing to the frequent subcontracting of ancillary activities, for example, household, which makes this integration problematic because of the mobility of the contract staff. Using the questionnaire can therefore be an integrative tool.

Patient and public involvement

Patient representatives were involved in the seven working groups who designed the hospitality questionnaire and participated as assessors in the awarding visits. AP-HP communicates on a regular basis on the progress of its hospitality programme, and the results of this study will be published on its website.

Strengths and weaknesses of the study

This awards programme launched by AP-HP showed originality in terms of its focus on hospitality using a high-granularity questionnaire dedicated to this domain of quality. Quality assessments are available in hospitals that take into account various non-clinical and patient-centred aspects of care, including 'hotel services' in healthcare. However, these are more generic, dealing mainly with the quality and safety issues, such as in the Medicare Hospital Compare system.[19] Focus on hospitality can be advantageous in that it can emphasise the importance of new patient expectations among healthcare providers. Moreover, this programme was well received by healthcare professionals, particularly nurses, who may see it as recognition of the essence of their profession. Here, we demonstrated the pedagogical value of this awards programme, as evidenced by significant improvements in certain domains of hospitality, based on a study of 211 participating hospital services in 29 of the 39 hospitals of AP-HP, representing approximately 20% of the institution (eg, 4028 of >21 000 beds).

This study has certain limitations. First, this homemade questionnaire remains to be formally validated. Moreover, although assessors received training on the questionnaire, inter-rater reliability between assessments may not be warranted. However, the data may have some consistency because an interim analysis performed in July 2018 (n=118) provided similar data (awarding visit, 88.8%±4.3%, self-evaluation, 84.7%±5.7%) to those presented herein (June 2019, n=211, 89.0%±4.3% vs 85.5%±5.6%). Second, given that service enrolment in the programme was on a volunteer basis, it is not possible to conclude that the good hospitality scores that were observed can be generalised. In the same vein, unhappy customers may be perhaps less likely to complete questionnaires and return feedback. However, we explained the aim of this study to those who accepted to participate and asked them to be as critical as possible. Third, the correlation between scores could have been affected by the assessors having access to the self-evaluations; however, the fact that a correlation was observed even for scores higher than >80% indicates that the hospitality evaluation had at least some quantitative significance and robustness. Fourth, the attribution of the hospitality award relied on a global score that was calculated as a mean from seven different fields, which may be a questionable approach. However, given that the perception of hospitality by patients is a composite outcome, this may best reflect reality. Finally, the long-term durability of the observed improvements remains to be demonstrated. However, the hospitality award is given for a period of 4 years, and the teams that receive the award are encouraged to ensure that there is no drift during this period. We hope that raising awareness regarding the diverse requirements of hospitality through the questionnaire will be an important step towards ensuring its sustainability.

CONCLUSION: AN AWARDS PROGRAMME FOR PROMOTING QUALITY IN THE FIELD OF HOSPITALITY

In the procedure described herein, services volunteered to enrol in the procedure. Unlike accreditation and certification, whose primary objective is often, at least in France, to control the quality of care, leading to an authorisation, this procedure set up by AP-HP leads to an award. The teams welcomed this approach in a positive way; receiving the award to be displayed in their departments was seen as an object of pride, and they understood it as a recognition of their continuing efforts to provide the best possible human care to hospitalised patients. This pride felt by teams that received the hospitality award can encourage other hospital departments to imitate them and join the programme.

This approach uses awards as an incentive to improve quality in hospitals. This approach has been recognised by numerous organisations that assess quality in hospitals, such as the European Foundation for Quality Management in Europe[20]; there are at least 14 hospital awards in the USA.[21] In his analysis of the psychosocial value of awards,[22] Frey pointed out that '…when the outside intervention is perceived to be controlling, people react by reducing their intrinsic motivation (motivational crowding out). In contrast, when people perceive the outside intervention to be supporting, their intrinsic motivation increases (crowding in). Awards are typically perceived as a gesture of support, rather than of control, and are therefore likely to have a positive, rather than a negative, effect on performance'. Awards inspire pride, that is, a positive emotion, which can reinforce the promotion of hospitality as a core value of a hospital; this may be relevant to any aspect of quality. According to Spinoza 'Desire arising from pleasure is, other conditions being equal, stronger than desire arising from pain'.[23]

Therefore, we expect that the very existence of a hospitality awards programme in a hospital, such as that described herein, can encourage services to collaborate in improving the general quality of care within a framework of person-centred medicine, where both patients and healthcare providers are considered as persons. Indeed,

both of them are hosts in a hospitality relationship and are interested in the quality of care.

Acknowledgements We are grateful to the members of the initial task force on hospitality (2012–2014) and of the seven working groups, which included patient representatives (2014–2016) for their commitment during the conception of reference criteria for hospitality awards, as well as to the professionals and the patients' representatives involved in the awarding visits. We are also grateful to Prof Isabelle Durand-Zaleski and Prof Sadek Béloucif for their productive comments.

Contributors GR, SB, IME, BLC and SY participated in the design of the hospitality awards procedure. GR, IME, BLC, SY, VH, YOG and AM participated in some of the self-evaluation and awarding visits. GR designed the evaluation described herein, performed data analysis and wrote the paper, which was approved by all authors. GR, the lead author and manuscript's guarantor, affirms that the manuscript is an honest, accurate and transparent account of the study being reported; that no important aspects of the study have been omitted and that there is no discrepancy from the study as planned. He has the right to grant on behalf of all authors a non-exclusive licence on a worldwide basis to the BMJ Publishing Group Ltd to permit this article to be published in BMJ editions.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests All authors have completed the Unified Competing Interest form and declare no support from any organisation for the submitted work. In the section 'Other relationships or activities that could appear to have influenced the submitted work', they indicated that they are employees of Assistance Publique-Hôpitaux de Paris who registered a patent on the hospitality labelling procedure.

Patient consent for publication Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request.

REFERENCES

1. Galán González-Serna JM, Ferreras-Mencia S, Arribas-Marín JM. Development and validation of the hospitality Axiological scale for humanization of nursing care. *Rev Lat Am Enfermagem* 2017;25:e2919.
2. Hepple J, Kipps M, Thomson J. The concept of hospitality and an evaluation of its applicability to the experience of hospital patients. *Int J Hosp Manag* 1990;9:305–18.
3. Kelly R, Losekoot E, Wright-StClair VA. Hospitality in hospitals: the importance of caring about the patient. *Hospitality & Society* 2016;6:113–29.
4. Royse D. A touch of hospitality: treating patients as guests proves revolutionary. *Mod Healthc* 2016;46:H2–4.
5. Entwistle VA, Watt IS. Treating patients as persons: a capabilities approach to support delivery of person-centered care. *Am J Bioeth* 2013;13:29–39.
6. Reach G. Hospitalité: pour l'avènement à l'hôpital d'une bientraitance ordinaire. *Revue du Praticien* 2017;67:371–9.
7. Hung K-Y, Jerng J-S. Time to have a paradigm shift in health care quality measurement. *J Formos Med Assoc* 2014;113:673–9.
8. Bjertnaes OA, Sjetne IS, Iversen HH. Overall patient satisfaction with hospitals: effects of patient-reported experiences and fulfilment of expectations. *BMJ Qual Saf* 2012;21:39–46.
9. Heidegger T, Saal D, Nübling M. Patient satisfaction with anaesthesia - Part 1: Satisfaction as part of outcome - and what satisfies patients. *Anaesthesia* 2013;68:1165–72.
10. Isaac T, Zaslavsky AM, Cleary PD, *et al*. The relationship between patients' perception of care and measures of hospital quality and safety. *Health Serv Res* 2010;45:1024–40.
11. Compagnon C, Sannié T. *L'hôpital, Un monde sans pitié, Paris, L'Editeur*, 2012.
12. Report on hospitality by the Ad hoc Task Force of the AP-HP "Commission Médicale d'Établissement", 2014. Available: http://cme.aphp.fr/sites/default/files/CMEDoc/cme-10-06-2014_rapport_hospitalite.pdf
13. Reach G. Linguistic barriers in diabetes care. *Diabetologia* 2009;52:1461–3.
14. Reach G. Simplistic and complex thought in medicine: the rationale for a person-centered care model as a medical revolution. *Patient Prefer Adherence* 2016;10:449–57.
15. Reach G. Patient education, nudge, and manipulation: defining the ethical conditions of the person-centered model of care. *Patient Prefer Adherence* 2016;10:459–68.
16. Reach G, Fompeyrine D, Mularski C. Understanding the patient multidimensional experience: a qualitative study on coping in hospitals of assistance Publique-Hôpitaux de Paris, France. *Patient Prefer Adherence* 2015;9:555–60.
17. Castle NG, Brown J, Hepner KA, *et al*. Review of the literature on survey instruments used to collect data on hospital patients' perceptions of care. *Health Serv Res* 2005;40:1996–2017.
18. Available: https://thinkinthemorning.com/channeling-charles-peguy/
19. Available: https://www.medicare.gov/hospitalcompare/Data/Data-Updated.html
20. European Foundation for Quality Management. *Eight essentials of excellence – the fundamental concepts and their benefit*. Brussels: EFQM Representative Office Brussels, 1999.
21. Poku MK, Blum AB, Sharfstein JM. Us Hospital awards and community health improvement. *Am J Public Health* 2017;107:1076–7.
22. Frey BS. Giving and receiving awards. *Perspect Psychol Sci* 2006;1:377–88.
23. Spinoza B. Ethics, 4, proposition 18.