PATIENT SATISFACTION WITH HEALTH CARE: RECENT THEORETICAL DEVELOPMENTS AND IMPLICATIONS FOR EVALUATION PRACTICE

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Abstract: Using client or patient satisfaction instruments to assess the quality of services and programs is an integral component of much program research and evaluation. But however methodologically straightforward and programmatically useful, the constructs and theory underlying patient or client satisfaction measures are not particularly simple, and the informativeness and usefulness of these satisfaction measures have been repeatedly called into question. To help program evaluators more effectively incorporate service users’ perspectives into program evaluations, this article reviews major approaches to, and research on, satisfaction theory, including disconfirmation, fulfillment and consumer models, and sociological perspectives, and discusses emerging approaches and implications for evaluation practice.

Résumé: Utiliser des instruments de mesure de la satisfaction des clients ou des patients pour évaluer la qualité des services et des programmes est une composante intégrale de bon nombre de travaux de recherche et d’évaluation de programme. Mais peu importe à quel point ils sont méthodologiquement simples et utiles du point de vue programmatique, les concepts et la théorie qui sous-tendent les mesures de la satisfaction des clients ou des patients sont complexes, et le caractère informatif ainsi que l’utilité de ces mesures de la satisfaction ont été maintes fois remis en question. Afin d’aider les évaluateurs de programme à intégrer plus efficacement les points de vue des utilisateurs aux évaluations de programme, le présent article examine les principales méthodes utilisées ainsi que les travaux de recherche effectués sur la théorie de la satisfaction, y compris les modèles de réfutation, d’exécution, et de consommation, et les points de vue sociologiques, et discute des nouvelles approches et de ce qu’elles signifient pour la pratique de l’évaluation.
Using client or patient satisfaction instruments to assess the quality of services and programs is an integral component of much program research and evaluation. Philosophically, pragmatically, and intuitively, measuring patient or client evaluations of program elements and processes makes sense: it values the consumer voice and potentially empowers service users; can provide structured data on services in a relatively straightforward, cost-effective, and easily developed and administered manner; and has inherent face validity. What could be more obvious than asking for user opinions on service elements to gauge program performance? But however methodologically straightforward and programmatically useful, the constructs and theory underlying patient satisfaction measures are not particularly simple, and the informativeness and usefulness of patient satisfaction measures have been repeatedly called into question (Avis, Bond, & Arthur, 1997; Williams, Coyle, & Healy, 1998).

To help program evaluators more effectively incorporate service users’ perspectives into program evaluations, this article reviews major approaches to, and research on, satisfaction theory, including disconfirmation, fulfillment and consumer models, and sociological perspectives, and discusses emerging approaches and implications for evaluation practice. Canadian researchers have made a small but significant contribution to this research base, and in keeping with the theme of this special issue of the Canadian Journal of Program Evaluation, these contributions will be noted.

SATISFACTION THEORY

Although patient or client satisfaction research has been performed for several decades and many standardized satisfaction instruments and countless ad hoc measures have been developed (with varying but usually weak validity and reliability [Sitzia, 1999]), most research and program evaluation applications have been practical and problem-oriented, and therefore theoretically the area is underdeveloped (Linder-Pelz, 1982; Locker & Dunt, 1978; Sitzia & Wood, 1997; Williams et al., 1998). However, a small but growing body of work from several disciplines and approaches has attempted to clarify the constructs and measures of both satisfaction and expectations, and identify the personal and service-related factors determining expectations and satisfaction. Most theoretical work has been carried out in the health care area, and so this literature will be the focus of the following review.
Satisfaction and Elements of Care

In the majority of studies, patient satisfaction is defined as an evaluation or set of evaluations of the medical intervention on a specific health problem or issue (Sitzia & Wood, 1997; Williams, 1994). Reviews of the large body of patient satisfaction studies have produced a range of potentially relevant dimensions of satisfaction, more properly labelled components or elements of health care (Sitzia & Wood, 1997), that may be evaluated by patients. Table 1 summarizes three of the most comprehensive reviews from different time periods, and shows the many elements used in patient satisfaction measures.

As is evident from the table, there is considerable variation in the specific elements of care that may be considered in studies of patient satisfaction. Although the diverse components of care produced by and used in different studies have been criticized for variability, these may be expected to vary according to the specific care context in which satisfaction is being measured and also according to the individuals and sub-populations measuring them (Avis, Bond, & Arthur, 1995; Like & Zyzanski, 1987; Sitzia & Wood, 1997). However, as may also be seen from the table, there is also considerable overlap in the components of care when these are grouped into broad categories.

Generally, through adoption of the Donabedian quality assurance framework (Donabedian, 1980, 1988), relevant elements of care for any particular medical care context may be categorized according to whether they are related to structure (facilities, personnel), process (technical process, interpersonal process), or outcomes (somatic, psychosocial, and financial) of care (Kravitz, 1996; Pascoe, 1983). In research to date, measures of the dimensions of care have tended to focus on process variables, particularly around the interpersonal manner of the health care professional (Kravitz, 1996; Pascoe, 1983). As well, in addition to dimensions of care, an overall measure of satisfaction is usually taken in patient and client satisfaction research studies either directly through a Likert-scale type question on overall satisfaction with a service or through weighting and summing various ratings on elements of care.

There are several weaknesses in the current conceptualizations of satisfaction and the dimensions of care that are rated. First, the traditional classifications of the components of care related to satisfaction largely have been constructed by service providers and represent service provider concerns or service provider perceptions of client concerns.
TABLE 1

**Reviews of the Literature on Satisfaction with General Health/Medical Care**

<table>
<thead>
<tr>
<th>Ware et al. (1983) (number of studies not indicated)</th>
<th>Components of Health Care</th>
<th>Wensing et al. (1998) (57 studies)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interpersonal manner of health care provider:</strong> concern, friendliness, disrespect, rudeness</td>
<td><strong>Overall satisfaction:</strong> global item or items or composite</td>
<td><strong>Availability and accessibility:</strong> waiting times, flexibility, telephone consultations, physical accessibility, financial accessibility</td>
</tr>
<tr>
<td><strong>Technical quality of care:</strong> thoroughness, accuracy, unnecessary risks, making mistakes</td>
<td><strong>Humaneness:</strong> warmth, respect, kindness, willingness to listen, appropriate nonverbal behaviours, and interpersonal skill</td>
<td><strong>Organization and cooperation:</strong> premises, continuity, cooperation, efficiency, special services available</td>
</tr>
<tr>
<td><strong>Accessibility/convenience:</strong> time and effort required to get to an appointment, waiting time at office, ease of reaching care location</td>
<td><strong>Technical competence:</strong> technical performance and competence definable in traditional medical terms</td>
<td><strong>Medical care:</strong> effectiveness, burden on the patient, competence/accuracy</td>
</tr>
<tr>
<td><strong>Finances:</strong> reasonable costs, alternative payment arrangements, comprehensiveness of insurance coverage</td>
<td><strong>Outcome</strong></td>
<td><strong>Doctor/patient relation:</strong> humaneness, exploring patients’ needs, patients’ involvement in decisions, time for patient care, patients’ privacy</td>
</tr>
<tr>
<td><strong>Efficacy/outcomes:</strong> helpfulness of medical staff in improving or maintaining health</td>
<td><strong>Physical facilities:</strong> aesthetic and functional aspects, parking, and adequacy of equipment and laboratories</td>
<td><strong>Information and support:</strong> informativeness, stimulating self-help, counselling, supporting patients’ relatives</td>
</tr>
<tr>
<td><strong>Continuity:</strong> sameness of provider and/or location of care</td>
<td><strong>Continuity of care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Physical environment:</strong> orderly facilities and equipment, pleasantness of atmosphere, clarity of signs and directions</td>
<td><strong>Access:</strong> convenience, hours, distance, perceived availability, and ease of getting appointments</td>
<td></td>
</tr>
<tr>
<td><strong>Availability:</strong> presence of medical care resources</td>
<td><strong>Amount of information:</strong> explanations of treatment, procedures, or diagnoses</td>
<td></td>
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<td></td>
<td><strong>Cost</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>Bureaucracy/organization</strong></td>
<td></td>
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<td></td>
<td><strong>Attention to psychosocial problems</strong></td>
<td></td>
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</tbody>
</table>
Second, the validity of a global satisfaction construct is in question. In traditional survey research on satisfaction, overall satisfaction with a service is generally found to be very high, often with 85% or more of respondents claiming to be generally satisfied with services. However, if questions are asked on specific dimensions of service or occurrences, much lower levels of satisfaction are found (Avis et al., 1997; Sitzia & Wood, 1997). An explanation for this discrepancy could lie in the conceptualization of satisfaction, or may be due to methodological weaknesses in satisfaction surveys and methods, including inadequate sampling, particularly of program drop-outs (Blais, 1990); social desirability bias; respondent situational bias; poor question wording; inadequate weighting of the various dimensions of care; and so on (Avis et al., 1997; Locker & Dunt, 1978).

Perhaps most importantly, the generally employed, often implicit, models underlying the determinants of satisfaction are simplistic and inadequate. Traditional patient satisfaction theory rests on social-psychological theory, and assumes that the expression of satisfaction is an expression of an attitude (an affective response) that is related to both the belief (expectation) that the care possesses certain attributes (dimensions) and the patient’s evaluation of these attributes (first defined in Linder-Pelz, 1982, drawing upon the Fishbein and Ajzen formulation of attitude [Fishbein & Ajzen, 1975]). Measures of satisfaction, then, potentially provide both a measure of care and a measure of the patient or client who provides the rating (Pascoe, 1983; Ware, Snyder, Wright, & Davies, 1983). This general approach has been called the disconfirmation paradigm (Zegers, 1968). Within this approach, dissatisfaction is hypothesized to increase as the disparity between a standard of care and perceived care increases. Other models of satisfaction include fulfillment theory and consumer or marketing theories. There is also an emerging sociological perspective on satisfaction that places these theories within their interactional contexts. Each of these will be briefly reviewed, and their contributions to satisfaction theory and deficiencies will be discussed.

Disconfirmation Theories of Satisfaction

Theories subsumed under the disconfirmation paradigm include discrepancy theory and equity theory, both of which draw on Lawler’s (1973) work on job satisfaction. Simple discrepancy theory of patient satisfaction is the most widely adopted (Kravitz, 1996; Pascoe, 1983; Sitzia & Wood, 1997) and defines satisfaction as the difference between what is desired or thought to be needed (“I want”/ “I need”)
and what is perceived to occur. There is mixed research support for an association between desires and satisfaction (Kravitz, 1996; Sitzia & Wood, 1997). For example, Like and Zyzanski (1987) found that fulfillment of patient desires by the physician was strongly correlated with visit satisfaction; however, more recent research (Peck et al., 2004) using prospective methods has found no relationship between satisfaction and met or unmet expectations in men visiting their primary health care provider.

Less frequently, discrepancies are measured using perceptions of equity or entitlement (“services should be”/“I deserve”) or as the difference between what is thought to be likely and what actually occurs, that is, a probabilistic approach rather than a value-based one (Kravitz, 1996). While there is some evidence that these two approaches may be relevant to patient satisfaction, the research in these areas is too limited to allow for any firm conclusions (Davis, Albino, Tedesco, Portenoy, & Ortman, 1986; Sitzia & Wood, 1997; Smith & Sanderson, 1992).

In research performed to date, simple discrepancy/disconfirmation theories have not been found particularly successful in explaining variation in satisfaction. Generally, and irrespective of the type of expectation measured (desires, entitlements, or probabilities), the variation explained by discrepancies between expectations and satisfaction, controlling for socio-demographic differences, remains at or under 20% (Williams, 1994).

Fulfillment Theory of Satisfaction

Fulfillment theory is often categorized with discrepancy theories (e.g., Kravitz, 1996; Linder-Pelz, 1982), although it comes from an older tradition in job satisfaction research that posits that satisfaction results from the outcomes of an experience regardless of how much one feels he or she should get and/or wants to receive (see Lawler, 1973; Pascoe, 1983). It is assumed that there is a direct relationship between factors such as pay or promotion and satisfaction. In the job satisfaction and consumer satisfaction research areas, it has been found that both discrepancy and fulfillment factors are predictors of satisfaction (Lawler, 1973; Oliver, 1993). In the health care area, if fulfillment is related to satisfaction, one would expect a direct relationship between satisfaction and outcomes of care, such as improved physical, mental, or social functioning. As noted earlier, most satisfaction research has focused on process measures, and so there is
little information available on the relationship between satisfaction and outcomes of health care. However, one study (Covinsky et al., 1998) of older adult inpatients suggests that there is no association between health status change and satisfaction, once baseline health status is controlled for. Those with higher functioning or outcomes will be more satisfied whether there was improvement during the period of care or not.

Consumer Models of Satisfaction

Both discrepancy and fulfillment approaches to patient satisfaction have been judged logically inadequate (Pascoe, 1983). Fulfillment theory assumes that objective outcomes alone determine satisfaction, while discrepancy theories assume that any deviation from what is expected will create dissatisfaction, whether the outcome is more negative or more positive than was expected. As early as 1983, Pascoe suggested that consumer models of satisfaction might be incorporated into patient satisfaction modelling to take into account the type and degree of discrepancy. Contrast theory suggests that when consumers perceive a discrepancy between expectations and outcome, they will magnify the difference. (So, for example, a car that does not perform to expectations will be perceived as a “complete lemon.”) Assimilation theory (from Festinger’s [1957] cognitive-dissonance theory) suggests that inconsistencies between expectations and outcomes will be decreased or assimilated in order to adjust perceptions of outcomes to be consistent with expectations. The combination of these two models — the assimilation-contrast theory — suggests that a consumer’s satisfaction response will be nonlinear: assimilation will occur within a certain range of discrepancy between expectations and outcome (“the zone of tolerance”), while outside that range, the contrast effect will occur and inconsistencies will be magnified, leading to either dissatisfaction or higher satisfaction than within the assimilation range. There appears to be support for the assimilation-contrast model in consumer research (Oliver, 1997; Pascoe, 1983). In the health care area, however, little if any research has been performed on these models, although some research from a more sociological perspective (discussed in the next section) provides some insights into the concept of a “zone of tolerance” in health care (Edwards, Staniszewsk, & Crichton, 2004).

Finally, one of the most ambitious contributions to social-psychological satisfaction theory comes from work conducted by Oliver (1993, 1997). His model incorporates fulfillment theory, discrepancy and
equity disconfirmation theories, and assimilation-contrast theory in a model of consumer satisfaction. In addition, he adds affect as an explicit component of his satisfaction model. He criticizes most satisfaction theories for being primarily cognitive, when satisfaction is, by definition, and according to research results emerging from consumer theory, part cognitive reaction and part affective reaction. Oliver suggests that, based upon research results, affect is composed of two dimensions, positive and negative, which operate simultaneously. He tested the portion of his model related to affect with automobile purchasers and students evaluating a course, and found (a) that affect comprised separate positive and negative dimensions, (b) that attribute satisfaction and dissatisfaction were significantly related to positive and negative affect, respectively, and (c) that both were related to overall satisfaction.

The newest research on affect and satisfaction extends Oliver’s model of positive and negative affect to incorporate concepts of “delight” and “outrage” (Arnold, Reynolds, Ponder, & Lueg, 2005; Schneider & Bowen, 1999). Schneider and Bowen (1999) move well beyond conventional cognitive modelling to argue that outrage is produced when customers’ fundamental needs of security, justice, and self-esteem are degraded during a shopping experience. Some work in the health care area supports this needs-based approach. Coyle (1999; Coyle & Williams, 2001), in her qualitative work on patient dissatisfaction, has found that patient dissatisfaction results when patient identity is threatened by experiences perceived as dehumanizing, objectifying, disempowering, and devaluing. She proposes the idea of “personal identity threat” as a framework for the development of patient dissatisfaction instruments (Coyle, 1999; Coyle & Williams, 2001).

Consumer-based models of satisfaction appear promising, as they build upon previous research and acknowledge the complexity of the factors related to or determining satisfaction. However, attempts to transfer or apply consumer standardized measures of satisfaction (such as the SERVQUAL instrument) to health care have been only partially successful due to the multiple dimensions of service involved in health care and specific service and cultural contexts (Alden, Hoa, & Bhawuk, 2004; Bowers, Swan, & Koehler, 1994; Carman, 1990; Parasuraman, Zeithaml, & Berry, 1988). As well, there is some philosophical opposition to the notion of health care recipient as a “consumer” in the Canadian context (Deber & Sharpe, 1999; Feldberg & Vipond, 1999). It has also been suggested that while consumer models have begun to address emotional aspects of service
reactions, they neglect the important relationship between health care professional and patient, and other social contexts of health care (Williams, 1994). Sociological perspectives on satisfaction attempt to address these concerns.

Sociological Perspectives on Satisfaction

The final set of emerging theory and research to be reviewed examines the interactional and social aspects of determinants of satisfaction. This sociological research questions the veracity of the direct expectations–satisfaction theoretical link, primarily because social-psychological theory does not recognize the social context of health care or the social influences on health care recipients. For example, although “consumer” perspectives on the health care system have been widely sought recently and consumer models have been applied to patient satisfaction, the supposition that the patient/client necessarily adopts a consumerist role in obtaining medical care has been challenged by critical health researchers (Lupton, Donaldson, & Lloyd, 1991). Consumer models are based on a primarily rational view of patient behaviour that assumes that patients have bargaining power, freedom of choice, the knowledge and the motivation to choose a particular option from available services, and the power to challenge medical authority. However, Lupton and colleagues (1991) found that these assumptions do not necessarily hold at the individual choice level. In a survey of 333 patients attending general practitioners in Sydney, Australia, patients surveyed tended not to think of themselves as consumers who should be wary of the quality of the service offered by doctors; rather, they preferred to trust their doctor, and therefore did not devote effort to actively seeking out information about their doctor or evaluating his or her services. In a subsequent study, Lupton (1997) found that individuals’ personal characteristics (particularly age) influenced the degree to which they wished to act as consumers (as opposed to more passive patients), but that the degree of control patients wanted in the medical interaction also depended upon the medical context.

Two studies were conducted that question whether patients evaluate services at all when not impelled to do so by forced choice surveys, and if they do, how they evaluate services (Avis et al., 1997; Williams et al., 1998). In the first study, Avis et al. (1997) repeatedly interviewed 81 cardiology or respiratory patients to obtain their changing perspectives on satisfaction with their care. Results suggested that patients are uncertain in their expectations; that these may be based on pre-
vious negative experiences, hearsay, and background assumptions about medical care; and that these change over time with expectations becoming more pronounced as experience and knowledge increases. Also, they found that patients tended to excuse poor performance. Avis and colleagues suggest that satisfaction may result from psychosocial aspects of the health care encounter other than expectations, such as relief, gratitude, fear of wasting a physician’s time, or confidence in the health care professional. They also suggest that satisfaction with the health care experience may not be particularly relevant to patients in terms of desired outcome, particularly in situations where patients may learn “bad news” or must cope with debilitating conditions. For example, a recent study demonstrated that more than 75% of cancer patients were satisfied or very satisfied with their overall pain management, despite almost half reporting moderate to severe pain (Dawson et al., 2002).

In the second qualitative study investigating whether and how patients evaluate services, Williams and colleagues (1998) found that mental health clients provided value descriptions of their experience of services; however, these were not value descriptions or evaluations of the service itself. Williams et al. suggest that there are two parts to the move from valuing/judgement of the experience to valuing/judgement of the service: (a) Consistent with expectations theory, it appears that patients have perceptions of the duties of services or personnel. These obligations of services are perceived as what will happen or what should happen, although patients hold these beliefs or expectations with varying degrees of certainty. Most often, service users expressed their expectations with a large degree of uncertainty. (b) The second step in the valuing/judgement of a service itself is the attribution of culpability or blame for a negative experience to the service. Most individuals in the study did not negatively evaluate the service or personnel even if they had a negative experience and the service had “failed” in its perceived duties. Usually, patients found sufficient mitigating circumstances to excuse the service or personnel. For example, a long waiting period for service was excused as “the usual government waiting time” (p. 1355), or the lack of resolution to a mental health problem was explained away because the patient concluded that “that’s down to me really to solve the problem. There’s no medication they can give me” (p. 1356). Williams et al. suggest that the generally high ratings of services found on satisfaction surveys relate to the lack of congruence between ratings of the experience and ratings of the service itself.
Edwards and colleagues (2004) recently conducted a follow-up study to the Williams et al. (1998) exploration. They conducted repeated in-depth interviews with 19 elective orthopaedic patients, and found that only 1 of the 19 did not reflect on their treatment in a way that shifted their assessment of their care to a positive view. They assessed the patients’ processes of reflection that influence the transformation of negative opinions of experiences to positive evaluations of services, and identified three psychosocial pressures that influence patients’ interpretations (or at least expressions of interpretation) of events: the relative dependency of patients within the health care system, social etiquette and their need to maintain constructive working relationships with those providing care, and their general preference for holding a positive outlook. These processes allowed patients to hold seemingly contradictory views. For example, one participant who had a long wait for surgery said she did not mind “waiting her turn,” but in the next breath modified this to, “I do mind waiting my turn! … but I understand where he [the GP] was coming from” (Edwards et al., 2004, p. 172). Edwards and colleagues conclude that some degree of cognitive-dissonance (Festinger, 1957) helps patients cope with the health issue in a positive way, and suggest that if a “zone of tolerance” exists as suggested by the assimilation-contrast model from the consumer satisfaction literature, it is influenced to a large degree by the amount of choice a patient has, and further, that if a patient has little or limited choice in the care provided, the zone of tolerance will be very wide. In fact, the positive reinterpretations will become the default action. Similar results were found in a qualitative Canadian study (Sinding, 2003) conducted with those who had provided care to a relative or friend who had died of breast cancer. In this care context, participants muted their potential expressions of dissatisfaction, indicating there was no “point” in expressing negative opinions after the death of the cared-for person.

The results of these three studies suggest a further complexity in satisfaction theory and measurement. While not necessarily inconsistent with social psychological expectations theory, these results suggest that an individual’s social context and the interpersonal and power relationships between health care professionals and patients must be incorporated into modelling, and that broader determinants of satisfaction (beyond individual perceptions and attitudes) should be considered. As work in medical anthropology and sociology suggests, factors beyond individual perception influence the way in which people understand health care services, including the diverse symbolic
meanings society attaches to these services and the social control inherent in them (Annandale, 1998).

Expectations

As noted, in most models of satisfaction, expectations (whether operationalized as measures of values, entitlements, or probabilities) are included as the major determinant. The Avis et al. (1997) study suggests that the formation of these beliefs is complex and influenced by a variety of factors, both individual and social. There is little theory or research available that focuses on the determinants of patient expectations (Kravitz, 2001; Thompson & Sunol, 1995). Kravitz and colleagues (1996) investigated influences on the development and expression of expectations. Based upon transcript analysis for 88 individuals who identified their internists’ omissions of care, they proposed a preliminary model of patient expectations in the symptom-driven clinical context. Perceived vulnerability to particular health issues (e.g., due to age or family history), past experiences with similar symptoms (either personal or acquired while caring for others) and transmitted knowledge (e.g., from friends, via the media, or through health education) were found to influence expectations by affecting the interpretation of symptoms and by establishing an implicit standard of care. Kravitz (2001) posits that in the clinical context, the encounter therefore becomes a negotiation between patient and physician. However, given the sociological research on satisfaction, it is clear that this negotiation is situated within the context of professional-patient relationships, including the power and knowledge imbalance inherent between health care or social service professional and patient, and the resulting uncertainty or tentativeness of expectations.

Patient Characteristics

Patient characteristics comprise the other major category of determinants of satisfaction found in the literature (Hall & Dornan, 1988). However, these have been found to be a minor predictor of satisfaction (Sitzia & Wood, 1997), and results to date have been inconsistent, perhaps because the characteristics reflect complex social factors. The only generally consistent finding in the literature has been that age is positively related to satisfaction. In American studies, educational attainment has been found to be negatively related to satisfaction, but this variable may be confounded with income (which is a major factor in health care in the United States). The relationship of satis-
faction to other measures of socio-economic status, sex/gender, racial or ethnocultural group, and psychological state (distress/anxiety) have all been found to be situation and context dependent (Sofaer & Firminger, 2005).

EMERGING APPROACHES AND IMPLICATIONS FOR EVALUATION PRACTICE

Several weaknesses of satisfaction theory and research have been identified. In the majority of published studies, the components of care rated by patients using patient satisfaction instruments or surveys traditionally have been defined by health care professionals, leaving open the question of whether these dimensions are exhaustive, or are those of most importance to service users. In the relatively small number of studies that explicitly test psychosocial satisfaction theory, the generally accepted and adopted discrepancy theory has been shown to be inadequate. At the psychological level, consumer theory suggests factors such as affect and assimilation-contrast responses should be incorporated into models. More recent work from a sociological perspective suggests that the framing of the construct satisfaction may itself be simplistic, and that the link between ratings of the experience and ratings of the care is mediated by factors such as patient health system expectations and the power relationships inherent in the health care provider-patient interaction, as well as broader social factors such as the patient’s adoption of the role of “consumer” or more passive health care recipient, cultural factors, and so on. These factors also need to be taken into consideration in models of patient satisfaction. Current knowledge about expectations and expectations formation is even more rudimentary. Calnan (1988) suggests that a model of patient (“lay”) evaluation of health care must move away from simplistic satisfaction models toward an attempt to understand the logic, knowledge and beliefs of individuals, including purposes in seeking professional help, their level of previous experience with health services, cultural values placed on health care, and personal images of health.

Given the documented shortcomings of satisfaction theory, what is a program evaluator to do? Obviously, as an accepted (and expected) practice by both program managers and service users, satisfaction measures are not going to simply fade away. Newer research findings and approaches to capture users’ views of services provide some suggestions regarding appropriate methods.
There have been several calls for qualitative research into patient satisfaction (e.g., Aharony & Strasser, 1993, Sitzia & Wood, 1997), and indeed, over the past 10 years, there have been a growing number of published studies that use qualitative methods to document experiences with services rather than assess satisfaction directly. In areas as diverse as primary care (Anderson et al., 2001; Conacato & Feinstein, 1997), HIV testing in Canada (Worthington & Myers, 2002), nursing care (Larrabee & Bolden, 2001), and sexual health planning (Baraitser, Pearce, Blake, Collander-Brown, & Ridley, 2005), qualitative methods have been used to elicit descriptions and definitions of elements of care that demonstrate quality from the patient perspective. These studies show the same range and types of elements seen in more traditional patient satisfaction measures (see Table 1). Sofaer & Firminger (2005) summarize dimensions captured in 12 qualitative studies into seven categories: patient-centred care, access, communication and information, courtesy and emotional support, technical quality, efficiency of care/organization, and structure and facilities. The advantage of these descriptions is that they are service-specific, avoid some of the demonstrated difficulties with eliciting negative evaluations of services, and provide direct descriptions of service elements which service providers may examine for congruence with quality guidelines or best practices in a service area. However, qualitative approaches have their own challenges. While they have become widely accepted in evaluation and the social sciences generally over the past several decades (Patton, 2002), they are time-consuming, unstructured endeavours that rely heavily on the skills and integrity of the researcher-evaluator. If undertaken without adequate rigour and attention to both investigator preconceptions and relevant theory, qualitative research can lead to anecdotal, unreflective, and ultimately inadequate findings that are not useful for program improvement (Pope, Ziebland, & May, 2000).

Another approach that has been growing in popularity is the use of qualitative methods to assist in the development of satisfaction instruments that are specific to different care contexts. Canada has a strong cadre of qualitative health researchers, and many of these studies are Canadian (e.g., Boechler & Neufeld, 2002; Hilton, Budgen, Molzahn, & Attridge, 2001; Hudak, Hogg-Johnson, Bombardier, McKeever, & Wright, 2004; Hudak, McKeever, & Wright, 2004). With these instruments, qualitative methods (e.g., thematic analysis of individual interviews and/or focus group data) are used to identify elements of care that are incorporated into satisfaction instruments. Others have heeded the calls from sociological researchers to develop
measures that focus on service experiences rather than evaluations of service in order to avoid the power and social dynamics inherent in judging services (Webb, Clifford, & Graham, 1999). But early results from one such set of instruments, the Picker surveys in the United Kingdom (“National Patient Experience Survey,” developed based on qualitative studies with patients to focus directly on experiences) show the familiar pattern of positively rated experiences (Edwards et al., 2004). Another approach that has been suggested is to focus on dissatisfaction. Coyle and Williams (2001) constructed an instrument based on qualitative findings using a dissatisfaction approach, more particularly the theory of “personal identity threat” (previously described) that they hypothesize leads to dissatisfaction. Using this approach with a small (n = 97) clinical sample in a hospital, they measured dimensions of personalization, empowerment, information, approachability and availability of staff, and respectfulness, and found higher percentages of negative experiences reported with some care dimensions than would be found with a typical satisfaction survey. For example, 44% agreed or strongly agreed with the statement “I do not like to bother the nurses because they are so busy,” but for many other statements a high percentage reported positive experiences (e.g., 93% agreed or strongly agreed with the statement “I felt very reassured by the doctors”). Thus, unless we assume superlative service provision in these studies’ service contexts, these approaches to measure care experiences in a standard survey format need more developmental work before they are widely useful in capturing variation in experiences.

CONCLUSION

So where does that leave the program evaluator? At the least, those implementing patient or client satisfaction instruments should be aware of the difficulties and complexities inherent in their theoretical foundations, and exercise caution and thoughtfulness in their use in a specific context. Satisfaction levels of 80% and higher should be expected on surveys and not be considered clear evidence of high performing services or programs without substantial additional information (i.e., triangulation of results from other sources). If time and resources allow, qualitative methods should be considered as an alternative to surveys where possible, or as a complement to them. In addition, the social, interactional, and power dynamics of health and social services should be taken into consideration wherever possible, whether the evaluator chooses to frame this in their work as social desirability bias to be addressed in survey construction, or uses con-
cepts from emerging satisfaction research such as “zone of tolerance” or “identity threat” in the way research questions are framed and data collection is designed. In any case, the implication for evaluating quality service provision is clearly that attention needs to be paid to the context of patient-provider relationships and communication when conducting evaluations.

An emphasis on relationship factors in health is not new, and at present patient-centred care is a prominent model of service being promoted in many areas (Arbuckle & Herrick, 2006; Floyd & Seale, 2002; Gertais, Edgman-Levitan, Daly, & Delbanco, 1993; Stewart, 2003). Satisfaction measures have long included interpersonal manner or provider-client relations as the most extensive area of questioning, and evaluation research using a patient-centred perspective certainly shows that provider behaviours are linked to satisfaction. For example, Kim, Kaplowitz, and Johnston (2004) found that patient-perceived physician empathy significantly influenced patient satisfaction (and compliance) via the mediating factors of information exchange, perceived expertise, interpersonal trust, and partnership. Feddock et al. (2005) found that patient dissatisfaction with waiting time was associated with a shorter physician visit (i.e., patients did not mind a longer wait as long as they were able to spend more time with their physician). In their review of patient perceptions of quality using a patient-centred approach, Sofaer and Firminger (2005) have come to the conclusion that patients need to be educated about the pathways through which positive health outcomes are achieved so that they can take a more active role in assessing quality. If adopted within a comprehensive patient-centred approach (where the patient is a partner in planning and monitoring care and outcomes) this method makes sense. However, where there is a more traditional approach to care, less egalitarian power dynamics, and social etiquette that keeps patients from expressing contrary opinions, placing more responsibility on patients to be fully informed about their care and progress is simply placing additional burden on those the service is designed to assist. And given the sociological research findings from the last decade on the social contexts of care that influence expression of patient satisfaction, it appears that these social factors are important, and thus this approach does not appear widely applicable.

Finally, one Canadian researcher (Sinding, 2003) has pointed out that program evaluation generally (unless conducted from a critical or emancipatory perspective) ignores systemic and structural issues, and that these also deserve an evaluator’s attention. The health
care system has been of growing public concern in Canada. When patients excuse service performance on the basis of limited resources, staff pressures, or funding constraints, they are acknowledging and accepting a health care systems reality. However, this masks the need for evaluators and evaluation recommendations to consider “the big picture,” view services within their service system contexts, and include recommendations to promote services development as a component of their broader systems of health care.

ACKNOWLEDGEMENTS

The author would like to acknowledge support provided by the Canadian Institutes for Health Research (CIHR) (New Investigator award), and the Alberta Heritage Foundation for Medical Research (AHFMR) (Population Health Investigator award).

REFERENCES


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