

Patient satisfaction: the Australian patient perspective

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Abstract

The literature reveals little Australian academic study of the phenomenon of patient satisfaction and identifies several problems in current research practice. A theoretical discussion about the phenomenon of 'patient satisfaction' is for the most part absent, the rigour in the methods applied is often dubious, a definition of patient satisfaction is not agreed and the patient experience is often not the focus of research. To address some of these issues inductive research was conducted with Australian patients to explore what they considered important for patient satisfaction to exist. A series of 52 interviews were conducted with twenty elective surgery patients in an Australian teaching hospital. Patients were interviewed on admission to hospital, within one week of discharge from hospital and between six and eight weeks after discharge. Research with patients identified 16 themes that were important to make a patient's hospital stay satisfactory. Qualitative data have provided a foundation to better understand what 'patient satisfaction' means in its everyday use. Such an approach is faithful to the concerns and priorities of the patients who are the users of health care services.

Background

Despite the fact that patient satisfaction research has been conducted for decades, several issues still exist. Aharony and Strasser (1993) identify the following problems in patient satisfaction research: an absence of theoretical discussion about the phenomenon of 'patient satisfaction', no standardised approach, few comparative studies, and a lack of consensus by medical staff that satisfaction is an assessment of quality of care. Carr-Hill (1992) documents many of the methodological issues that have plagued patient satisfaction studies including: inadequate underlying patient satisfaction theory, who is interviewed—choice of population—timing of interviews, data collection methods, the evaluation and rating methods, characteristics of samples are rarely compared and the reliability of results. While many gaps are reported to exist in the methods used to research patient satisfaction there is also little known about what effect results have on organisations. After reviewing 221 patient satisfaction studies, Hall and Dornan (1988) concluded that little was known about how the data collected were actually used. In part it seems there is no direct correlation between patient satisfaction and improved outcomes (Aharony & Strasser, 1993). Following their extensive review of patient satisfaction literature, Draper and Hill (1995) conclude that there is a lack of expertise in design, execution and little evidence of action on results in current patient satisfaction research. They also report that while there has been considerable research on people's views of health services in the United Kingdom and the United States since the 1970s, there has been little comparable research completed in Australia (Draper & Hill, 1995).

Whose perspective is being measured in patient satisfaction research is rarely clarified. Carr-Hill (1992, p.245) observes that the questionnaire method, which is the most commonly used method to obtain information about patient satisfaction, '*...obtains replies to a series of pre-set questions, not the patients' considered (or spontaneous) views on the issues which concern them whether as current users or as members of the public.*' The patients' priorities are often omitted and questions are fashioned by the health practitioners' perceptions and definitions of good practice. One assumption has been that patients do not have either the knowledge or expertise to evaluate their care. Aharony and Strasser (1993) suggest that those who doubt the value of quality indicators, such as patient satisfaction, believe that patients lack expert knowledge to assess the technical competence of medical staff. However, patient satisfaction is one dimension used to measure the quality of health care delivery in Australian hospitals and, unlike measuring health outcomes, (which obviously benefit from some technical skill in their evaluation) patient satisfaction does not require previous expert knowledge or skills. NacRae concludes (2000, p.6):

Patients are often the only ones that can judge the kinds of quality we are taking about. The kinds of quality we are talking about relate to what it is like for them to experience illness – the subjective experience ... We really need to listen to what they have to say.

We've made the mistake of thinking we know what it is that patients need ...a lot of people learn by "trial and fire."

A phenomenological approach to patient satisfaction emphasises the social reality of patients' experiences. From this perspective, patient satisfaction can be treated as patients' reflections upon and satisfaction with their lived hospital experiences. A patient's experience results from a subjective process that is informed by their life experiences. The social reality of a patient's experience provides a basis to commence the study of patient satisfaction. The aim of this research was to acquire an understanding of patients' interpretations of 'satisfaction'.

Method

A qualitative design used patient interviews to collect data that would provide a better understanding of the social world of being a patient; in particular, what was important to make the patients' hospital stay satisfactory. The complexity of the hospital experience makes it impossible to understand or comment on all aspects of patient satisfaction. As such, emphasis was placed on describing the accessible and important components of patient satisfaction, as patients understand them. Data gained from interviewing patients were reflective of statements and actions in conversations related to a social context of being a patient.

The patient sample was selected from patients meeting the specified target population characteristics including:

- general surgery patients (patients diagnosed with carcinoma related disease were not included)
- patients should not have had surgery within the last five years
- 18 years or older
- male and female
- public patients
- English speaking (funding was not available for professional health interpreting services and telephone interviews could not be conducted with non-English speaking patients).

Patients from a teaching hospital in Australia were invited to take part in the research and participated in up to three interviews. The interview schedule for each consenting patient included: a face-to-face interview on admission to hospital (20 interviews), a telephone interview within one week of discharge from hospital (15 interviews) and a telephone interview between 8 and 10 weeks from the time of discharge from hospital (17 interviews). The final interview questions were:

- In your opinion what is important to make your hospital stay satisfactory?
- What should the hospital do to make your hospital stay satisfactory?

Actual satisfaction with the hospital stay was not measured in this research.

The same interviewer conducted all interviews. Data was scribed during each interview and extensive notes were written immediately following the interview. Data were coded and classified into themes. Continuous coding during the research program allowed data reduction and analytic categorisation of data, comparison of data, and recoding or regrouping of themes where necessary. In the final analysis, data themes were only counted once, irrespective of how many times mentioned, for each patient. Patients were not reminded about information they had provided in previous interviews. Individual variation in trends in thematic identification over the course of the interviews is not discussed; however thematic variation trends across the entire patient set are reviewed.

Results

Fifty-two interviews were conducted with twenty patients to explore patient perspectives of what was important to make their hospital stay satisfactory. All patients had elective procedures completed and no patient had any surgical complications related to the procedures undertaken. Sixteen themes, important to patients to make their hospital stay satisfactory, were identified across the data. The following results illustrate what patients thought about many different areas of their illness and hospital experience when considering 'patient satisfaction'.

Theme 1: Hotel services (n = 14 patients)

'Hotel services' was the most frequently discussed theme. Patients identified hotel elements of care to be: cleanliness; fresh air; food; bathroom facilities (including the toilets); bedding (including the mattress, sheets); heating; noise levels and parking facilities. While patients did not necessarily expect five star hotel facilities they did want to stay in a comfortable environment.

Theme 2: Medical outcomes (n = 13 patients)

The majority of patients were concerned about the outcomes of their surgery. When discussing outcomes patients focussed on the physiological aspects of their illness, wanted to get well and have successful surgery completed. They wanted to be free of complications identified as associated with surgical errors, or alternatively to being in hospital but not due to the surgical procedure. A comment by Patient 6, 'A lot of mistakes are made you know in operations and it's not publicised', illustrates the level of concern for some patients. Another comment made about medical outcomes was: '*If you have no problems you are grateful. You might not be if you had complications*' (Patient 1).

Theme 3: Provision of information (n = 13 patients)

Thirteen patients commented on the importance of being given information about their illness, treatment and medical outcomes. Importantly, patients wanted questions answered. Patients emphasised that provision of information needed to

- be disclosed willingly
- be accurate and relevant to a patient's point of view
- be presented in layman's terms
- include an explanation and not just be a string of facts
- be ongoing to keep the patient informed.

Theme 4: Clinical care (n = 12 patients)

The majority of patients stressed that the care they received was important to make their hospital stay satisfactory. Patients considered the theme of care differently. Key discussion areas were:

- Care needed to be compassionately delivered.
- Attention should be given when it was needed.
- Assistance with activities of daily living—mobility, going to the toilet, hygiene—was important in ensuring that patients were cared for properly.
- Care needed to be delivered competently, e.g. putting in an intravenous line.

Discussions about 'care' were more aligned to nursing care and the routine of how patients' basic care requirements were delivered.

Theme 5: Comfort, discomfort, pain (n = 10 patients)

Fifty per cent of patients talked about pain and or discomfort. Patients stressed that they relied on health practitioners to provide pain relief and make them comfortable.

Theme 6: Professionalism and competency of staff (n = 9 patients)

Nine patients asserted that professionalism and competency of staff were important to their perception of care. Patient 13, an 80-year-old gentleman, clearly stated that the doctor had a responsibility to do the operation successfully and he had a responsibility to follow the doctor's instructions. Many patients were very accepting of a medical system where the doctor gave orders for their care. In contrast many considered the role of the nurses to carry out the doctor's orders.

Theme 7: Time to wait for care (n = 9 patients)

In the analysis of these data time was interpreted as the time patients had to wait before receiving different aspects of their care while in hospital. Time was referred to in the contexts of time actually spent undergoing care and time waiting for care to be received. Patients regularly commented that 'time' was affected by the fact that staff were very busy. The theme of time was associated with words and phrases such as: priorities, giving patients equal time and waiting for discharge. Two particular comments summed up the sentiments about time generally: 'In hospitals time doesn't mean anything' (Patient 8), and 'minutes and hours are meaningless' (Patient 18).

Theme 8: Emotional support (n = 9 patients)

Nine patients said that emotional support was important in their care. Emotional support was seen to be concerned with helping patients to cope with their illness, understanding the patient's feelings and talking to the patient when they were feeling stressed, scared and nervous about the procedures and hospital experiences. The emotional needs expressed by patients were not concerned with dedicated psychological help. Rather, patients wanted health practitioners to be supportive and understanding of their concerns.

Theme 9: Access to care (n = 9 patients)

Nine patients identified access to hospital as an important area to consider in 'patient satisfaction'. Negative comments were dominant in this theme. Four major issues highlighted by patients were: waiting for long periods of time before being scheduled for surgery; not knowing when you would be contacted about the operation; having no guarantees that you would have the surgery done; and being cancelled. For example, patient 15 was placed on the waiting list in March 1998 and was not operated on until May 2000. During these two years he couldn't mobilise normally, wasn't confident to use public transport and had to rely on family members for transport. Two of the patients who discussed access issues had their operation cancelled and were then rescheduled on the current admission to hospital. A further two patients had previous experiences of being cancelled before being admitted to hospital. Five patients had never been cancelled. The five patients who had

never been cancelled only mentioned access in the first face-to-face interview. All patients who had experienced being cancelled discussed the access issues in the telephone interviews. The experience of actually being cancelled reinforced the importance of access.

Theme 10: Discharge from hospital (n = 7 patients)

Seven patients identified discharge planning as being important to achieve patient satisfaction. Specific areas of concern were:

- not being discharged before they were properly recovered
- nervous about being responsible for caring for themselves
- having a proposed discharge date
- the convenience of the discharge time—not having to sit in a chair for hours before they were discharged.

Patients wanted to be sure that all aspects of their discharge were well organised so they would feel confident about going home.

Theme 11: Friendliness of staff (n = 7 patients)

When discussing friendliness, patients often associated friendliness with the nursing staff. In this analysis ‘friendliness’ is identified as a separate theme because when patients spoke about ‘being given a smile’ they were passionate about the manner in which they were treated.

Theme 12: Medications (n = 6)

Patients in this research were concerned about different aspects of taking medications. Their concerns were that the right medication/s were given at the right time and that staff giving the medications were competent. Responses also raised concern about new bacteria that are antibiotic resistant and about appropriate pain relief medications being given.

Theme 13: Respect for the patient (n = 5)

Five patients directly discussed ‘respect’. Words used in association with the theme of respect included: respect, tolerance, patronised, judgements, attitudes, value judgements. The most chilling account about respect follows:

‘I lied about the fact I’m still on methadone because I didn’t want to be treated awfully again ...

... staff make value judgements ...

You don’t want to be treated like someone thinks you knocked off the video to pay for the drugs.’

Respect was strongly influenced by face-to-face encounters and the patient’s perceptions of how they were treated.

Theme 14: Social issues (n = 4 patients)

All of the four patients who commented on social issues were males, three lived alone and one lived with his wife. These men put forward a range of social concerns including: a pet being looked after; not having anybody at home to help with care on discharge; ability to return to normal social activities and the potential inequalities that exist for patients depending on whether they are public or private patients in the health system. While no conformity was identified in these data, it is still important to acknowledge such issues, not strictly the hospital’s concern, are issues that worried some patients during their stay.

Theme 15: Communication with staff (n = 4 patients)

Four patients identified 'communication' as being important to make their hospital stay satisfactory. These patients only mentioned communication in one of the three interviews they completed. One of these comments (Patient 2) was related to having telephone access while in hospital. The remaining comments related to communication with health practitioners. For example, patient 13 thought that he could talk freely with the doctor. Patient 16 took the opposite view and thought that medical staff were unable to relate to 'ordinary people'.

Theme 16: Patient participation in care (n = 2 patients)

Two patients, aged 24 and 52 years, discussed being able to participate in their care. The majority of the data suggested that patients were not partners in the care process—rather they were recipients of care.

Discussion

The method

The face-to-face and telephone interview methods were appropriate for this research. The face-to-face interviews explored the hospital experiences of patients; the focus was on what made the hospital experience satisfactory. Patients brought unique life experiences with them to hospital and these experiences influenced how they interpreted their present experience. The average time of the face-to-face interviews was 30 minutes. The longest interview, 75 minutes, was conducted with Patient 2 who discussed many aspects of his life in between answering the research questions. The face-to-face interaction with patients was critical in establishing a relationship with patients and encouraged patients to talk about their experiences and give opinions about what was important for them to be satisfied.

Both sets of telephone interviews typically took about 12 minutes. The telephone interviews were much less detailed than those conducted face-to-face. Patients didn't discuss life experiences in the same way and the focus of the interviews was more directed to the research questions. The telephone interviews were conducted after acute care had been completed. This may have impacted on patients' interest in participating in interviews. During the acute phase, patients may have been more focused on the actual experience and potentially had more time to participate in the interview. However, telephone interviews were an appropriate method to follow up on the information identified in the first face-to-face interview.

No new themes emerged in the data after the completion of 14 of the 52 interviews (eight of the hospital interviews had been completed at this juncture). Hence, no new themes emerged in the following 38 interviews. This suggests that it is reasonable to conclude that the data collected did represent the social world of being in hospital—the immediate experience of patients undergoing elective surgery—and what was important to make this experience satisfactory. The validity of the results is difficult to assess. Patients' interpretations of the research questions were potentially influenced by wide ranging factors. Each patient had different life experiences that contributed to both their understanding and responses to questions.

Demographic influences

Patient gender, living status, work status and age did exhibit some small degree of variation in thematic enunciation. Although, the size of the patient sample restricts any determinate analysis based on demographic data, the following discussion summarises demographic trends exhibited within the sample.

Gender: The patient sample was of 14 males and 6 females. Men rather than women dominated the following themes:

• Professional competence:	Male 8/14	Female 1/6
• Information:	Male 11/14	Female 2/6
• Social Issues:	Male 4/14	Female 0/6
• Communication:	Male 4/14	Female 0/6
• Respect:	Male 5/14	Female 0/6

Medical outcomes, clinical care, comfort/discomfort/pain, hotel services, and access to care were quite independent of gender.

Living status: Patients were coded as either living alone or living with some member of family. Five patients lived alone and fifteen with family. Patient satisfaction themes including: clinical care, comfort/discomfort/pain, hotel services, discharge, friendliness and access to care were independent of living status.

Work: Patients were coded as being employed (this included one student), unemployed or retired. That the employed patients were male might have generated some bias.

- Retired persons (9/10) identified nursing care more readily than either employed (1/7) or unemployed (2/3).
- Unemployed (2/3) identified social issues more often than either retired (2/10) or employed (0/7).
- Employed people were less likely (0/7) than either retired (5/10) or unemployed (2/3) to identify friendliness.
- Employed people were also less likely (0/7) to identify communication than either retired (4/10) or unemployed (1/3).
- Employed people were also more likely to identify patient participation in care, however only two patients identified this theme whereas no unemployed or retired did.
- The following themes—comfort/discomfort/pain, discharge, access to care and respect for the patient—were independent of work status.

Age: Coding the ages of patients was problematic. The areas that patients were recruited from tended to favour older patients. The coded ranges were selected to achieve a spread of patients in each category. No clear trends emerged that were associated with any division based on the age of respondents. Provision of information, comfort/discomfort/pain, social issues, emotional support, access to care and respect for the patient were strongly independent of age.

Themes

While sixteen patient satisfaction themes were identified across the data, no patient identified all themes. The greatest number of themes recognised by any one patient was eleven and the lowest was three. The importance ranking for each theme by individual patients cannot be concluded. The variation in what was important for patients to make their hospital stay satisfactory indicates that patients classify and attach meaning to being a patient in hospital based on their own system of relevancies.

When all the themes were analysed by interview sequence, the following patterns did emerge.

- The themes of ‘medical outcomes’, ‘clinical outcomes’, and ‘professionalism and competency of staff’ were the most consistently discussed themes across all three interviews by the individual patient. For example, ten patients discussed ‘medical outcomes’ in the face-to-face interview, nine further discussed the theme in the first telephone interview and eight of the ten patients discussed this theme in the last telephone interview. Patients were focused on what the health practitioner observed and how they then explained their observations: ‘What is wrong with me and what will happen now?’

- More patients discussed 'discharge from hospital' as their interviews progressed. Patient 1 and Patient 9 discussed discharge planning in all three interviews and both were concerned about being discharged too early. Both were male and lived alone. Patient 14 was only concerned about discharge in the first face-to-face interview and this concern was also related to a worry about being discharged too early. Four patients discussed discharge in the telephone interviews after they had been discharged. Two patients believed they had been discharged too early, and two were disappointed on how the discharge had been conducted. Discharge is an important aspect of the hospital experience for patients. The telephone interviews raised issues that would not have been discussed if the patients had not lived the experience.
- The remaining satisfaction themes were mentioned less frequently as the interviews progressed from the first face-to-face interview to the last telephone interview. For example, 'friendliness of staff' was only mentioned by one patient in the third interview and by seven patients while interviewed face-to-face in hospital. The fall off rate was dramatic when the patient was discharged from hospital.

Two themes that were notably not discussed in any great detail were 'communication with staff' and 'patient participation in care'. Only four patients discussed communication with staff as being important to make their hospital stay satisfactory. While communication was not a dominant theme in the data, provision of information was important to the majority of patients. How knowledge is imparted to the patient is linked to communication that occurs in the face-to-face relationships. Patient satisfaction is ultimately based on a totality of experiences based on a culmination of knowledge that is communicated in a variety of ways.

The lack of support for 'participation in care' may be seen to be quite contentious when viewed from a consumerist perspective in health care. Lack of comment suggested that the patients in this research did not actively or overtly consider their role as partners in their health care. Instead, they relied on health practitioners to deliver care that would make them better. The ages of the two patients who discussed 'participation in care' were 24 years and 52 years. The majority of patients were older than 40 years ($n=14$). The lack of support for 'participation in care' might be explained by the cohort effects relating to a traditional medical model of health where patients were not encouraged to actively participate in decisions about their care. Alternatively, Clark (2001, p.99) identified that 'patients prefer a model where the doctor keeps the patient informed and involves the patient in the decision-making process'. This study also found that participation in medical decision making was also influenced by demographic differences. Clarke (2001) concludes that females prefer an informed model of participation in health care decision making, and that younger people (<55) prefer to be more informed in their health care. Patient participation is influenced by a myriad of issues. It is something that continually changes and is influenced by the day-to-day care that is delivered to a patient. Patient participation cannot be simply explained or examined. Much still remains unexplained in understanding what patient participation means in practice.

A comparison of themes

The thematic groupings identified are not compared to any Australian patient satisfaction standard because no industry standard exists. The themes identified in this research are compared against work undertaken by the Picker Institute in the United States. Based on 10 years of research and more than 350,000 patient interviews, the Picker Institute identified and documented eight broad dimensions of care that most affect patients' experiences (Picker Institute, 2000). Table one compares these dimensions with those identified in this research. The dimensions in table one are not listed in any order of importance.

Table 1: A Comparison of Dimensions/Themes

Picker Institute (USA)	Research themes
Respecting patient's values, preferences and expressed needs	Respect for the patient
Information and education	Provision of information
	Communication with staff
Access to care	Access to care
Emotional support	Emotional support
Involvement of family and friends	
Continuity and transitions	Discharge from hospital
Physical comfort	Comfort, discomfort, pain
Co-ordination of care	
	Professionalism and competency of staff
	Medical outcomes
	Clinical care
	Time to wait for care
	Social issues
	Hotel services
	Friendliness of staff
	Medications
	Patient participation in care

When the themes identified in this research are compared against those of the Picker Institute similarities emerge. However, caution should be applied to this comparison as the Picker dimensions were established in a different health care system. The dimensions proposed by the Picker Institute are based on more extensive work than was possible in this research; however, seven of the research themes identified can be broadly related to the Picker dimensions. These themes are: respect for the patient; provision of information; communication with staff; access to care; emotional support; discharge from hospital; and comfort, discomfort, pain.

The two Picker dimensions not identified in this research were 'co-ordination of care' and 'involvement of family and friends'. The concept of co-ordination of care is indirectly associated with themes that were more explicitly discussed in this research such as 'time to wait for care', and the delivery of 'clinical care'. This difference could have been related to the way the themes were grouped in the analysis. The one dimension that did not come out in this research was 'involvement of family and friends'. Patients in this research did not discuss involvement of family in their care. Reasons for this cannot be stated because patients were not prompted in the research questions. An additional nine themes were identified in this research that were not included in the Picker dimensions. These themes represented very specific issues that patients considered to be important to make their hospital stay satisfactory.

It is useful to briefly consider themes established by previous patients' complaints research. Daniel et al, (1999) surveyed complaints' experience and the outcome of lodging a complaint about medical treatment. A random sample survey sent from the NSW Health Care Complaints Commission office to 500 complainants' addresses elicited 290 usable responses. Of these incidents, only 25 per cent occurred in hospitals. Complaints were categorised according to Health Care Commission guidelines. Overall, 64 per cent of respondents complained of clinical care, 22 per cent of rudeness or poor communication and 14 per cent of unethical or improper conduct. Complainants tended to be of high socio-economic status, 70 per cent were women and nearly half of all complaints were brought on behalf of someone else.

Although the categories used in Daniel et al (1999) can not be matched exactly with the themes in this research, some similarities can be drawn. The most significant complaint category—clinical care—shares similarities with our study's themes of medical outcomes, clinical care and professionalism and competency of staff. The majority

of patients in our study also discussed these comparative themes. Similarly, it is tempting to draw comparisons between other thematic areas. However, it may be misleading to attempt to correlate complaints data with our research. Our hospital sample was not of people registering a complaint and concerned their own personal experience of a hospital stay. Furthermore, our thematic areas were not ranked in terms of importance by the participants. No firm conclusions can be determined from any comparisons between complaint categories and satisfaction themes identified in this research.

Thematic Summary

Across the data the general context of the interviews was 'I just want to get fixed and go home'. The hospital was viewed as a place that generated assumptions about the role of patients and the role of the health practitioners. A consumerist perspective supports the view that patients should be partners in their care. This perspective advocates that patients should be included in dialogue and decisions about their illness and treatment options. To participate in their care patients have to be informed, aware of the potential outcomes of treatment, and be allowed to voice concerns and help plan and prioritise their care. In contrast, the medical model of health is more concerned with medical knowledge, treatment of biological abnormalities, and the science behind the preferred treatment. The social and cultural factors that make people respond to and evaluate the disease processes are of lesser importance. Patients generally accepted or alternatively were socialised to accept care that was consistent with a medical model of health.

Overall, the satisfaction themes reflected real life issues for patients. Patients wanted to be cared for by competent professionals in a friendly compassionate manner. They wanted to know what was wrong with them and what would happen to them during their hospital admission. Patients wanted to be comfortable and pain free, have their medications correctly given and be discharged from hospital with improved health. Satisfaction for patients was associated with attention to, and execution of, specific aspects of their care. Except for a minority of comments, patients discussed the construct of 'patient satisfaction' at a personal level and weren't concerned about organisational issues.

Limitations of research

Qualitative research results based on small numbers of interviews cannot be used to make any statistical projections to a given population. The results of this research cannot be generalised and relationships between themes cannot be concluded. A further limitation of the research was not being able to recruit non-English speaking patients.

Conclusion

A comment made by Patient 2 made a lasting impression about the construct of patient satisfaction: '*This is a hypothetical thing really.*' The construct of patient satisfaction is extremely complex, has little definition and cannot be the same for all patients. The difficulties in examining such a construct are that the construct is based on the reflection of real life experience and these experiences are all different. The data in this research have shown that patients emphasise different dimensions of what is needed to make their hospital stay satisfactory. But, while the priorities vary somewhat with individuals, core themes recur as each patient describes what is important for them. The practical development of patient satisfaction research rests on the assumption that typical patterns do emerge in the experience of many patients. Ultimately, these assumptions will be based on thematic information drawn from a number of patients' experiences. However, the identification of typical themes does not suggest that a typical patient exists. Each patient is an individual who lives a unique experience.

The experience of being a patient is tremendously different to the experience of delivering patient care. If patient satisfaction research is to be representative of what is important for patients then the research must first be concerned with a patient's experience. As Cleary and Edgman-Levitan (1997, p.1608) explain:

Even measures that seem, by their very nature, to incorporate the user's perspective may not adequately do so. For example, in spite of extensive research on the assessment of patient satisfaction, much of this work has not explicitly elicited information from users of health care to help define quality of care.

This research has drawn patients' observations and worries into categories and reflected the emphasis and generality of these in developing a fuller and more comprehensive understanding of patient satisfaction.

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