Theories of patient satisfaction

Patients satisfaction

Formulation of Patient satisfaction

Pascoe (1983) defined patient satisfaction as "… *the health care recipient's reaction to salient aspects of the context, process, and result of their service experiences… (pp. 189)"* . It consists of a "… *cognitively based evaluation or grading of directly-received services including structure, process, and outcome of services… and an affectively based response to the structure, process, and outcome of services* … *(pp. 189)"*. In terms of the formulation of patient satisfaction, Pascoe described the Discrepancy Theory and Fulfillment Theory.

The two theories were originated from job satisfaction research, the Fulfillment Theory assumed the magnitude of the outcomes received under particular circumstance determine satisfaction and neglected any psychological evaluation of the outcomes. Discrepancy Theory has taken psychological evaluation of outcomes into consideration in satisfaction formulation and claimed that dissatisfaction results if the actual outcomes were deviated from the subject's initial expectation. It was understood that the Discrepancy approaches that view patients prior expectations as determinants of satisfaction have be frequently applied in many patient satisfaction researches, but what determines patient expectations at the first place?

Fox and Storms (1981) present two sets of intervening variables in satisfaction formulation, including Orientations Towards Care and Conditions of Care, mediated by patients' social and cultural characteristics.

Orientations Towards Care refer to patients' difference in their wants and expectation in a medical encounter, as people would have different beliefs in the causes of illness and in the socially-patterned responses to illness. Conditions of Care refer to the different Theoretical approaches to care, Situation of care and Outcomes of care delivered by the care providers. Patient satisfaction results if the Orientations Towards Care was congruent with the Conditions of Care. If the individual's Orientations Towards Care, including the perception and interpretation of care, can be affected by their broader social and cultural contexts, peoples with shared characteristics may presented a socially-patterned responses in their satisfaction formulation accordingly. *Suchman Edward Allen* proposed that " *… certain socio-cultural background factors will predispose the individual toward accepting or rejecting the approach of professional medicine and, hence, increase or decrease the possibility of conflict between patient and physician…(pp. 558)* [19]" which basically correlated patient's socio-demographic factors with satisfaction.

Patient satisfaction and Social identity theory

Linder-Pelz (1982) assumed a value-expectancy model in satisfaction formulation and defined *" patient satisfaction as a positive attitude… a positive evaluations of distinct dimension of health care, such as a single clinical visit, the whole treatment process, particular health care setting or plan or the health care system in general (pp. 578)".* Attitude was defined by *Fishbein and Azjen (1975)* as the " *general evaluation or feeling of favorableness toward the object in question* ". Built on the view of the Social identity theory that " *attitudes are moderated by environmental,*

individual, physical, psychological or sociological variables (pp. 72) ", *Jessie L. Tucker (2000)* claimed that patient satisfaction shall be " *moderated by socio-demographic attributes such as environmental, individual, physical, psychological and sociological characteristics (pp. 72) "*. In her later study, *Jessie L . Tucker (2002)* provided empirical support to patient satisfaction and social identity theory. Patient satisfaction theory considered patient satisfaction as an attitude, and her results confirmed that patient's evaluation of access, communication, outcomes and quality were significant predictors of satisfaction. Social identity theory argued that attitudes were altered and affected by demographic, situational, environmental, and psychological factors, and her research findings indicated that patient's specific characteristics significantly explain their satisfaction.

Haslam et al. (1993) study of in-group favoritism and social identity models of stereotype formation suggested that " *manifestations of favoritism are sensitive to comparative and normative features of social context (pp. 97)"* . The result revealed that a person's judgments will be impinged by his/her boarder macro-social context and background knowledge, and the stereotype formulation were not automatics but instead accustomed by the social context where meaning and attitudes towards different aspects were constructed.

Social identity theory was outlined by Sociologists *Henri Tajfel and John Turner* (1979) and was defined as " *the individual's knowledge that he/she belongs to certain social groups together with some emotional and value significance to him/her of the group membership (pp. 2)* [17]". The theory

believed that individual's process a repertoire of self identities with individuating characteristic at the personal extreme and social categorical characteristics at the social extreme. Depending on the social context, the personal identity may prominent and individuals would perceive themselves as members of a social group and adopt shared attitudes towards a particular aspect, and possibly satisfaction towards care, or vice versa. To construct a social identity, the theory proposed that individuals will " *firstly categorize and define themselves as members of a social category or assign themselves a social identity; second, they form or learn the stereotypic norms of they category; and third, they assign these norms to themselves and thus their behavior becomes more normative as their category membership (pp. 15)* [42]". The categories under which individuals assign themselves at the first place will depends on a person's social contexts such as life experience, backgrounds, culture and situation etc.

Social identity theory was closely related to the " Self-categorization theory", which was defined by *Hogg and McGarty* as the theoretical concept of Social Identify itself and " *concerns the ways collection of individuals comes to define and feel themselves to be a social group and how does shared group membership influence their behavior* ". *Lorenzi-Cioldi and Doise* claimed that Self-categorization theory led to accentuation of between-group differences and within-group similarities by the fact that " *different levels of categorization are simultaneously used by group members to encode information pertaining to their own group and to the other group (pp. 74)* [20] ", and the role constraints of members of inter-group give rise to a consistent mode of responding. Based on the theoretical framework, it

was assumed that patients with shared socio-demographic characteristics would categorize information they perceived (including experiences from a medical encounter) for subsequent satisfaction rating in a particular level and therefore presented a more or less homogenous rating with the care received.