# CHAPTER II

## LITERATURE REVIEW

### 1. Introduction

In the last two decades alone, about 15, 000 studies were carried out related to patient satisfaction and its factors (Peterson R., 1992). Sociologists, psychologists, marketing and health managers gave much focus since the 1960s when satisfaction studies were first conducted (Cordosa R., 1965). During early days of studies, service users were either known as consumers, customers, clients or patients.

There are a number of important models of health seeking behavior explaining various attributes that influence patient satisfaction. Some important and relevant ones were reviewed and included as background material in the development of this thesis.

In the Bhutanese context and as per our own experiences as physicians, doctor-patient relationship is vital for patient satisfaction. This aspect was reviewed too. Literature review, therefore, mainly dealt around defining satisfaction, inclusion of some conventional health seeking models and theories related to patient satisfaction and doctor-patient relationship. Mentions are also made of some important findings on factors that influence patient satisfaction.

## 2. Literature Related to Patient Satisfaction

The oxford dictionary defines satisfaction as "gratification of desire, contentment in possession and enjoyment, repose of mind resulting from compliance with its desires or demands".

As per Ross et al (1987), patient satisfaction is defined as "A patient's affective (or emotional) response to his or her cognitive (or knowledge-based) evaluation of health care provider's performance (or perceived quality) during a health care consumption experience"

Patient satisfaction is, thus, a multidimensional concept and a subjective phenomenon that is linked to perceived needs, expectations and experience of care (Smith C., 1992).

As per Donabedien (1966), satisfaction is an outcome that reflects quality of health care and Vuori H. (1987) elaborated further by saying that patients are satisfied only if care is of high quality signifying yet again that satisfaction is closely related to quality of health care. However, Bitner M., Hubbert A. (1994) perceived quality as only one of a number of antecedent factors for patient satisfaction.

More recent definitions emphasize satisfaction as a complex evaluative process. As per Hunt H. (1977), satisfaction is an outcome of what was expected and what the patient received in the process of seeking health care.

Zeithaml and Bitner (1996) strongly emphasized a close relationship between satisfaction and expectation. They explained that there are three types of expectations. These are the "desired" or "wished for" services which patients hope to receive. Patients feel that this level of performance can be and should be available to them. However, they are also cognizant of the fact that these may not be feasible and hence are mentally prepared to accept a lower performance or service level. These are "adequate" services that are the "minimal tolerated" services that they are willing to accept. Lastly, the "predicted" services pertain to services patients are "likely to receive" and imply some objective calculation. Any changes in these expectations will determine satisfaction or dissatisfaction. Pascoe (1983) who evaluated many models of patient satisfaction put the role of expectation as a central component. Ruggeri (1994) too supports this by saying that expressions of satisfaction are derived from prior expectations. Westbrook (1980) had agreed that expectations have direct relationship with services and satisfaction.

However, some argue that this expectation theory contributes to only about 8% variance in patient satisfaction.

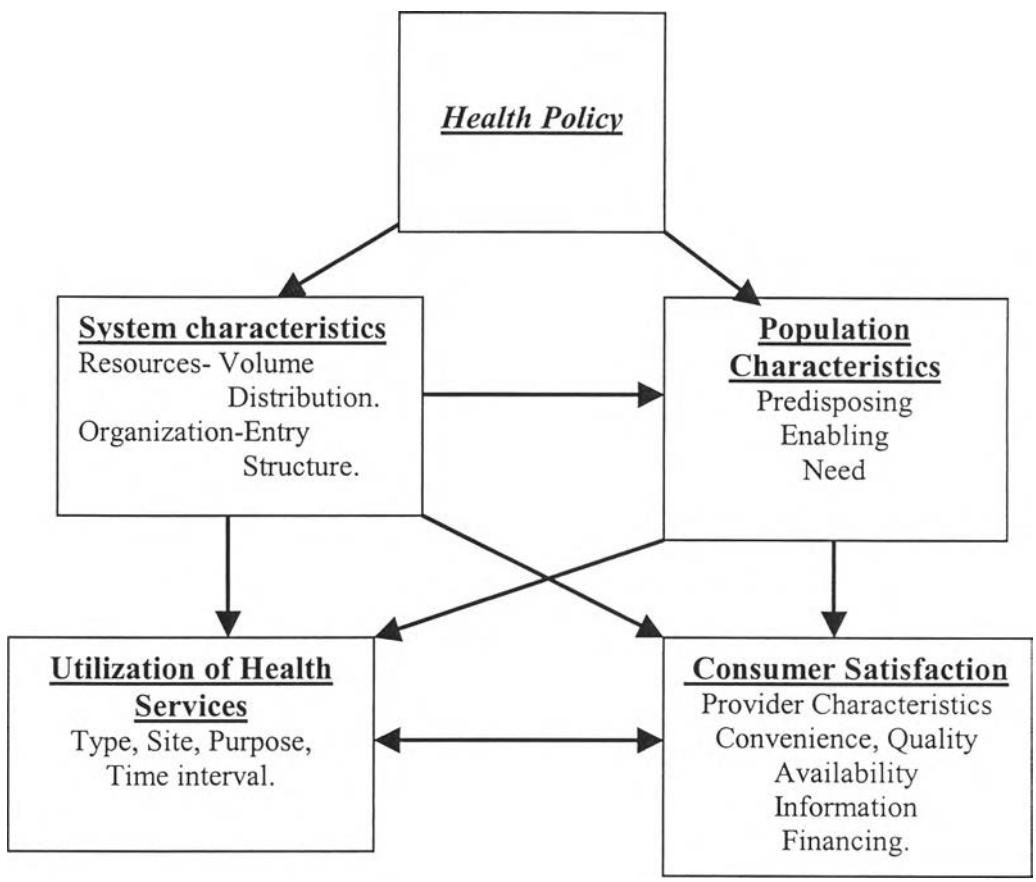
## 3. Some Models and Theories of Patient Satisfaction

Various theories and models related to patient satisfaction were reviewed and some important and relevant ones are included here. Some of them are as follows:

- Aday and Anderson Model (1974)
- Cognition-Affect Model of Satisfaction by Oliver R.(1993)
- Theory of Zone of Tolerance by Nelson E. and Larson C.(1993)

- Making Customer Satisfaction Happen Model of Roderick M.McNealy (1994).

### 3.1 A day and Anderson Model (1974)




Source: Aday and Anderson 1974.

**Figure 3: Aday and Anderson Model**

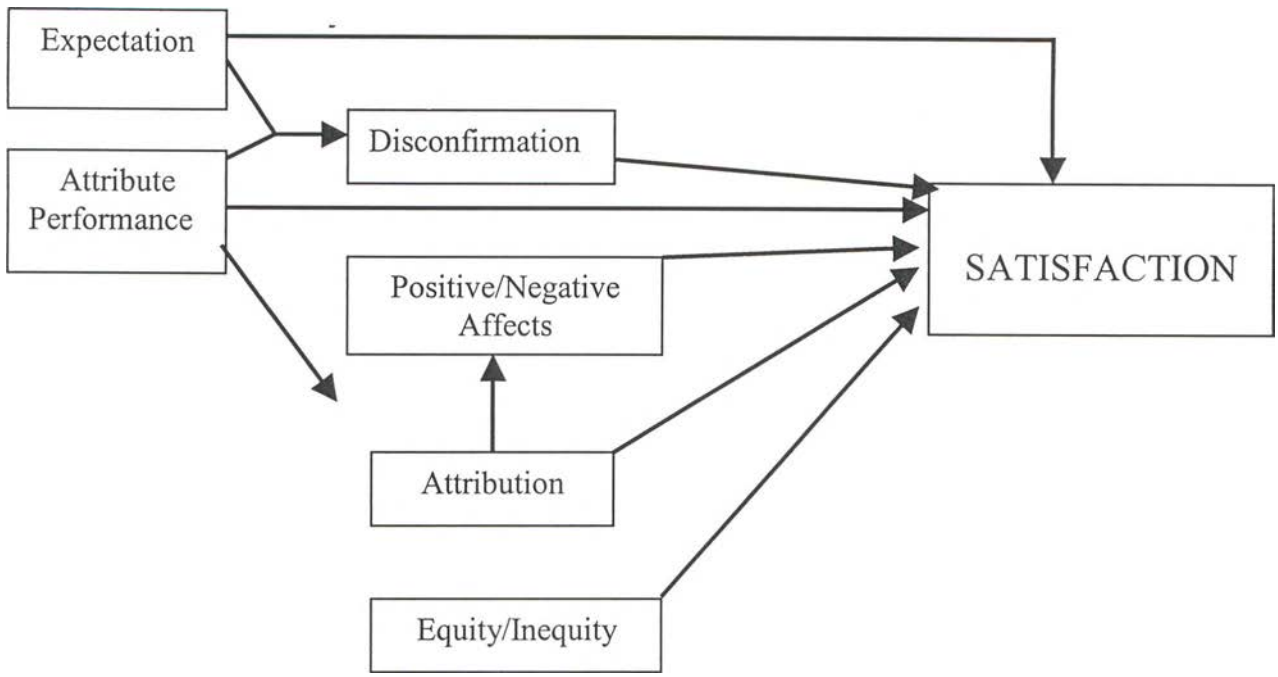
As per this model, national health policies and national health systems are the driving forces for optimal utilization of health services. These two factors with patient satisfaction are considered as inputs. Health service utilization is considered as the

outcome. Consumer or patient satisfaction and health service utilization are portrayed as having direct and complementary relationship.

### 3.2 Cognition -Affect model of Satisfaction by Oliver R. (1993)

This model explains the complex relationship between beliefs, perceptions and satisfaction. Here the main antecedents to health seeking behavior are considered as beliefs and perceptions of patients. Other important factors included in the model are attribution, equity/inequity of services, positive or negative attitudes of health care providers. Expectations of patients and performances of health care providers have direct effects on satisfaction. Effects may be mediated through a phenomenon of "disconfirmation". This is the difference between patients' expectations of care before treatment and level of services received in the process of seeking health care.

This model conceptualizes a variety of emotional responses including such affects as joy, excitement, pride, anger, sadness guilt etc for an outcome of satisfaction. As per this model satisfaction can be viewed as a positive or negative affective response.



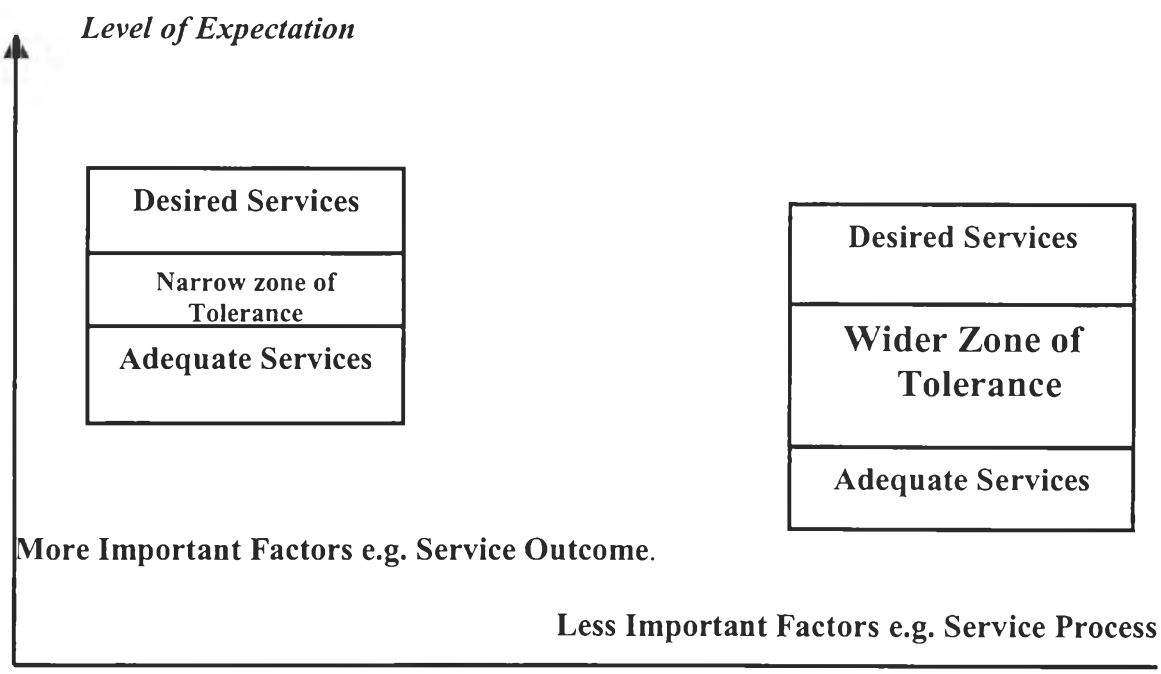

Source: Oliver R. 1993.

**Figure 4: Cognition-Affect Model of Satisfaction**

This theory also emphasizes that quality assessment comprises patient perceptions of a number of attributes related to care providers and service centers as follows:

- Reliability- ability to perform promised services dependably and accurately.
- Responsiveness- willingness to help customer and provide prompt services.
- Assurance- knowledge, courtesy and ability to inspire trust and confidence.
- Empathy- caring and individualized attention.
- Tangibles- quality of physical facilities, equipment, personnel and written materials.

### 3.3 Zone of tolerance for different dimensions by Nelson E., Larson C. (1993)




Source: Nelson E., Larson C., 1993.

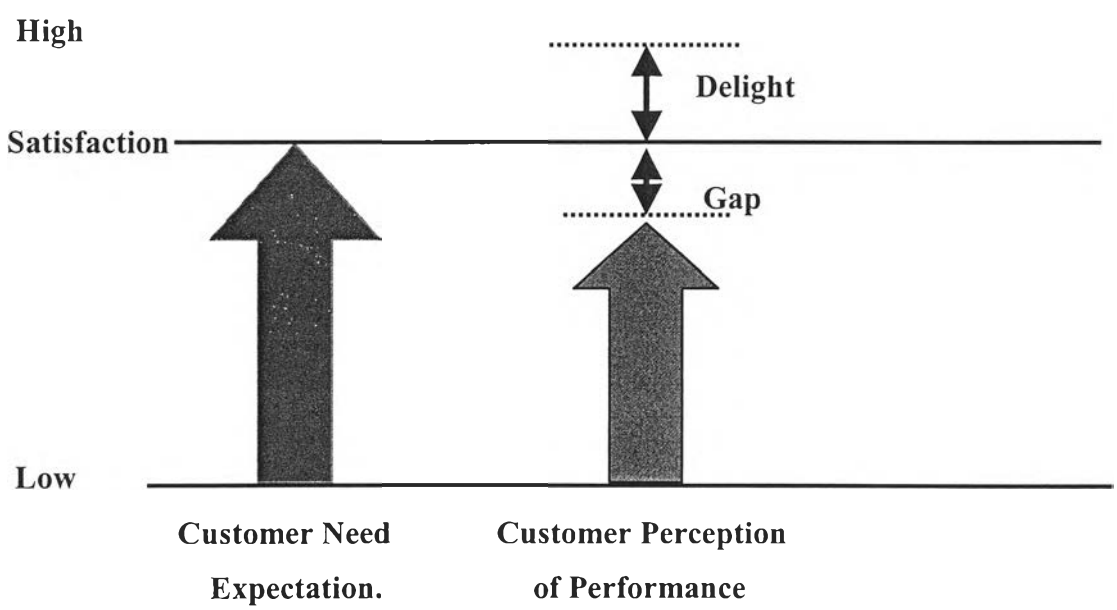
**Figure 5: Zone of Tolerance by Nelson E. and Larson C.**

Here Nelson E., Larson C. (1993) emphasizes importance of the so-called zone of tolerance. This theory explains that expected service could either equate with adequate or desired service but most likely may fall between the two i.e. within the zone of tolerance. The zone of tolerance is also considered like a range in which patients do not pay particular attention to service performance and do not normally complain. When performance falls above or below this range, patients express satisfaction or dissatisfaction respectively. Again if interest of patient is service outcome, an important factor, the zone of tolerance is narrow. In such cases the patients and/or party are sensitive and prone to express dissatisfaction. If interest is service processes, which are

considered less important factors, the zone of tolerance is wider and patients and/or party are less prone to complain or be dissatisfied.

The zone of tolerance also explains the effects of "good" and "bad" surprises and their culmination into expressions of satisfaction or dissatisfaction. Good surprises are when care received is above the desired level and bad surprises, conversely, pertain to care received being below adequate service level. The "no surprise" effect pertains to services falling within the zone of tolerance. Good and no surprises lead to patient satisfaction and bad surprises lead to dissatisfaction.

### 3.4 The Making Customer Satisfaction Happen Model by Roderick M. McNealy (1994).




Source: Making Customer Satisfaction Happen, Roderick M. Mc Nealy (1994)

**Figure 6: The Making of Patient Satisfaction Happen**

The author, Roderick M. McNealy, in his book Making Customer Satisfaction Happen emphasizes the importance of "perception gap" or the gap between patients' perceptions of care providers' performances and their needs and expectations. Determination of this gap is crucial and has strategic implications as a function of efforts towards patient satisfaction. If this gap is non-existent and performance level is already at satisfaction or at the "delight" levels, patients will be happy and satisfied.

The author also highlights that only 4% of dissatisfied patients complain. 96% move away to greener pastures but each of them at least tells 10-15 persons about their bad experiences. A radical group of 13% out of them, known as, the "lunatic fringe" tells about 23 persons each about their bad experiences. About 5% from both the informed groups get influenced. This theory also explains that out of the 4% who complain, 60% will maintain loyalty if issues related to their complaints are resolved and 95% will remain with the services if issues are resolved fast. Every delighted patient tells about their experiences to at least 5 other persons.

In our situation, however, patients keep on frequenting same hospitals or health centers despite their dissatisfaction as there are no other alternatives for care or private practices.

## 4. Literature Review Related to Doctor–Patient Relationship

Hypocrites, the great Greek philosopher said, "Treat the patient, not the disease" and the oath with the very name that all health personnel undertake has clear roles for both physicians and patients. But as time passed by, these sacred roles prescribed and followed for centuries have sadly deteriorated. The process of seeking professional help

and the doctor-patient relationship has changed over the years with significant transition occurring in the second half of the last century.

According to J. Hughes (1994), Talcot Parson was the first social scientist who theorized the doctor-patient relationship. He assumed that illness was a physical dysfunction that required medical attention. Illness could also be feigned and hence a legitimized sick role was advocated to maintain social order. He put forward four norms to define sick role mainly fitting the western society. These are described as follows:

- That individual is not responsible for an illness
- That sick may be exempted from normal duties till they are all right
- That illness is not a desired outcome
- That sick should seek professional help

Parson (1964) said that the initial western model of doctor- patient relationship was a harmonious one in which patients accepted physicians' superior status and medical skills without any questions and doubts. He also pointed out that the shift between doctors and patients over the years occurred as a result of emotional barrier between them. All these are relevant to the oriental as well as the Bhutanese context.

Even as late as the sixties, physical illness and their recoveries were considered as having close psychological relationship. A physician was considered like a drug. Vijay P.Sharma (1996) quotes a popular saying "Half the problem goes away when you see a doctor and the remaining half goes away when you take the medicine".

According to Scott T. Learner (1986) there were three factors responsible for the changes in the doctor-patient relationship. These were patients' loss of trust in their doctors, changes in financing systems of health care and lastly the changes in organization of health care as an offshoot of consumerism and commercialization of health care services. According to Dranove and White (1987) and Buchnan (1988) patients are interested in maximizing utility of health services and physicians are more inclined towards maximizing profits. This has been one of the features of consumerism coming in the way of doctor-patient relationship. This aspect is still an unknown phenomenon in Bhutan.

Barbara Seaman (1986) in Charting Doctor-Patient Relationship symbolizes this relationship as a tug of war in which physicians and patients are on opposite ends of a rope. To the doctor, illness is a disease process measurable by laboratory and clinical tests. To a patient, it is a disrupted life pattern. Updating advances in medical practices pre-occupies doctors while patients need to be heard and understood for which they are not given enough attention. This is further substantiated by a Journal of American Medical Association study (1999) which found out that 72% of doctors interrupted their patients' opening statements after an average of about 23 seconds. Patients who were allowed to continue further were interrupted in about another 6 seconds.

Information sharing seems to be an important aspect of relationship and for positive outcome of diseases. Crock R.D. et al (1999) explained that doctors feel frustrated when patients withhold relevant information regarding their health. However, patients are said to withhold information, as they are afraid of being ridiculed or reprimanded by

physicians. Patients feel devalued if doctors behave like mechanics who find and fix diseases in them like in a workshop.

Doctor- patient relationship also varies depending on the type and severity of diseases that they present with. Szasz, T.S. and Hollender, M.H. (1956) proposed that in case of acute illness the usual scenario is a passive patient and an assertive physician; in less acute condition it is a guiding physician and a cooperating patient. In the case of a chronic condition physicians participate in treatment plans and patients have the major responsibility of helping themselves with treatment.

The whole concept of disease process seems to have changed over the years in the perception of physicians and other health care providers. This has reached to such an extent that physicians and even public some times perceive certain diseases like lung cancer, obesity and AIDS as the responsibilities of the ill. Kelly (1987) emphasized this point further by saying that physicians and other care providers even react less favorably to such kind of disorders. According to Hafferty (1988) it is said that physicians often react negatively to dying patients, patients they do not like and those who complain too much.

Reeder (1973) and Haug and Lavin (1983) have demonstrated in their studies that an increasing proportion of educated population has begun to challenge the traditional sacred relationship between patients and doctors. The relationship now has changed more towards a provider-consumer relationship from the traditional one of respect and trust between them.

There are also researches pointing out that educated patients often take more assertive roles in the relationship downsizing the conventional role of passivity. They are more in favor of participating in self-diagnosis and negotiated management of their health conditions. Davis Roberts C. and Kutumbuwa Ogonjuwa (1981) reported on similar line and highlighted that patients in Africa are entitled to argue with doctors over diagnosis and management of their diseases. This scenario apparently seems to be on the rise even in Bhutan and does not include only educated but also the rich.

The concept of disease itself has taken a different form due to changing doctor-patient relationship. Anspack (1998) described that physicians separate diseases from the patients as biological processes, treat medical technology as agents and consider patients' accounts of their illnesses as subjective. Physicians have used their medical knowledge as an advantage to gain an upper hand over patients in all these processes and negotiations.

As per Hayes-Bautista (1976) cited in Approaches to Doctor-patient relationship by J. Hughes (1994), there are varying tactics that are being used by both patients and physicians in mutually managing the formers' health. Patients usually start by being submissive and try to convince for changes in their treatment. Patients argue saying that treatment is inadequate, too weak or too powerful in more assertive ways if the initial move fails. Physicians defend the treatment they prescribe using their medical knowledge as tools and threatening of consequences about non-compliance and ignoring advices. Ultimately, if this fails they change their tone and even plead the patients. In the process of this bargain, end results are compromise and continuation of

relationship, patient termination of relationship, physician termination or a mutual termination.

Kaplan et al (1989) concludes that physician-patient relationship is a prerequisite for a social support, which will influence patients' health status.

Kasteler et al (1976) pointed out that patients tend to change doctors or "doctor shop" as per the services they deliver. Suchman (1964-66), in similar line, explains that a social environment of health conscious and scientific colleagues, neighbors and friends have a role in molding health-seeking behavior and a word-of–mouth referral to doctors who deliver well usually by acquaintances is a pre-requisite to a lasting doctor-patient relationship.

In summary the attributes that hold stead for a good doctor-patient relationship are sympathy and kindness, good communication between patients and doctors, patience and shared responsibility in managing the latters'illness. Listening to patients' version of illnesses is equally important and finally the human bond between them is crucial.

## 5. Literature Review of Factors in Relation to Patient Satisfaction

There are innumerable factors that influence patient satisfaction with perhaps regional, ethnic, economic, social and cultural variations. These factors are classified as distal and proximal ones. Distal ones are mainly those related to national health system, health sector and economic policies that countries pursue. Insurance system, health care financing, patient referral, communication and transport system etc. are other important

factors. Only proximal and relevant factors that influence inpatient satisfaction are dealt with as reflected in the conceptual framework.

### 5.1 Socio-demographic factors

As per A.G. Zwier and D. Clark (2001) who carried out a survey in New Zealand, age, gender, ethnicity, occupation, education and socio-economic status are some of the important variables that predict patient satisfaction. Older patients were found to be more satisfied than younger ones. Di Matteo and Hayes (1980) reported similar finding. As far as gender is concerned, satisfaction depends on what aspect of care is in question. Female patients are more prone to be dissatisfied with nursing care. More Asian patients expressed dissatisfaction as compared to others showing ethnicity as being a predictor too. Patients who were socio-economically well off rated satisfaction about 5% higher than those with lower socio-economic status. Sitzia and Wood (1997) have reported similar findings. Patients hailing from rural background expressed satisfaction at about 20% higher than those coming from urban background.

In the research proposal patient education, occupation, referral status, type of disease, duration of treatment and admission history will be other relevant variables in the Bhutanese context.

### 5.2 Hospital milieu

Jun Gao et al (2002) says that accessibility to services and the availability of required services at affordable prices are important determinants for patient satisfaction and service utilization in a health care center.

A study in Hadassah hospital in Jerusalem by Shiloh (1965) found out that patients with egalitarian characteristics were satisfied with technical aspects of services but complained about hospital environment, noise in the ward and cleanliness and wanted to leave hospital early.

Under this domain, waiting time, attitude of support staff, hospital diet, comfort and social support will be included as other relevant and important variables in the context of present study.

### 5.3 Provider factors

Some of the main attributes that are essential in care providers for patient satisfaction are the following as per literature review.

Many researches by Di Matteo (1980), Hall, Roter and Katz showed that patients want physicians to have a holistic approach towards their disease. They expect physicians to talk to them, listen carefully to their problems, ask and answer questions in simple terms and ultimately help them make decisions about their care. William and Calnan (1991) said that inter-personal relationship between a doctor and a patient is one of the most important determinants for patient satisfaction. A doctor who listens and sympathizes well with patients will go a long way in satisfying them.

Suchman A. et al (1997) pointed out that health care providers underestimate the amount of information that patients want and over-estimate the ones that they impart to patients. In one study it was found that doctors felt that they had spent about 9 minutes

with their patients when in fact that they spent only about 1 minute per patient visit. Same researcher found out that doctors ignore patients' emotional health and seldom appreciated their emotional feelings even when patients brought them out. Instead of sympathizing, physicians always diverted the topic back to technical discussions.

Apart from the variables mentioned above, competence of health providers (both doctors and nurses) and comprehensiveness of care provided will be included and assessed. Service with Humane Face is a typical Bhutanese motto, which implies that care is provided with kindness, compassion and understanding and will be one of the variables.