Measuring patient satisfaction: Insights from social psychology

ABSTRACT

This article focuses on patient satisfaction, itself based on patient experience, as a means of tapping into patient quality of care. Current measures of patient satisfaction are inadequate. For instance, some do not acknowledge the role of cultural diversity, values, and identities in patient satisfaction. The main purpose of this article is to identify the aspects of an adequate measure of patient satisfaction. A brief review of existing scales is provided. More specifically, a small sample of scales in the following healthcare contexts is critically evaluated: primary care; out-of-hours primary care; outpatient care; nursing care; chronic illness care; integrated elderly care; mental health care; psychiatric care; and compassionate care. Various healthcare settings are explored in order to provide a more holistic overview of patient satisfaction. Drawing on a range of social psychological theories of identity, representation, and action, it is argued that an appropriate measure should be patient-focused and capture patients' perceptions and experiences of the care they receive; it should be culturally sensitive and consider cultural values; and it should encompass both the physical and psychological dimensions of healthcare. Conclusions provide general recommendations regarding the items that could form part of a new measure of patient satisfaction in healthcare, including a set of generic items that should constitute its backbone. This new universal measure could facilitate more systematic data collection surrounding patient satisfaction as well as the comparison of patient satisfaction in distinct healthcare contexts. A multi-faceted measure of patient satisfaction drawing on social psychological principles will be a pivotal tool for collecting data that are conducive to the improvement of patient quality of care.

INTRODUCTION

Patient quality of care can be defined in terms of the extent to which health services enable individuals to achieve desired health outcomes and the degree to which health services function in accordance with current professional knowledge (Institute of Medicine, 2001). Measuring patient quality of care adequately can facilitate the identification of aspects of healthcare that require improvement, thereby allowing for better healthcare delivery. The construct consists of three inter-related dimensions, namely clinical effectiveness, patient safety, and patient satisfaction. This article focuses on patient satisfaction, itself based on patient experience, as a means of tapping into patient quality of care. This is consistent with the patient-centered care approach that is advocated in the UK National Health Service (NHS). Patient-centered care is defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (Institute of Medicine, 2001, p. 6). It is noteworthy that patients and clinicians may construe "quality of care" differently – while patients attempt to improve their health in the context of their lives, clinicians may focus on solving the patient's specific health concerns in an event-based manner. In previous empirical research, patient satisfaction has been associated with several positive health outcomes, such as improved adherence to care and medication (Hall and Dornan, 1988), and better accommodation of medical advice (Moll van Charante et al., 2006).

The main purpose of this article is to identify aspects of an adequate measure of patient satisfaction. A brief review of scales of patient satisfaction is provided, which identifies their strengths and weaknesses. General recommendations are provided regarding the characteristics or items that could form part of a measure of patient satisfaction in healthcare, including generic items that should form the backbone of such a scale. This new universal measure could facilitate more systematic data collection surrounding patient satisfaction as well as the comparison of patient satisfaction in distinct healthcare contexts. A multi-faceted measure of patient satisfaction will be a pivotal tool for collecting data that are conducive to the improvement of patient quality of care.

Patient satisfaction itself is a complex construct. It consists of various dimensions including *inter alia* the patient's perception of physicians' clinical knowledge, accessibility of healthcare services, convenience of location, continuity of care, and other factors. Thus, operationalising this construct is similarly complex. For instance, satisfaction with healthcare services (Ware, Snyder, Wright, & Davies, 1983) and satisfaction with out-of-hours primary care (McKinley, Manku-Scott, Hastings, French, & Baker, 1997; Salisbury et al., 2005) are two instruments that have been used to measure patient satisfaction. However, there are many other instruments with distinct foci and used in specific contexts. The measurement of patient satisfaction can also be complex in social contexts characterised by diversity, as it can be challenging to measure the construct in a way that is meaningful to all groups in society. Different social and demographic groups may have distinct needs and expectations in relation to their healthcare, which current measurement instruments that have been developed in other empirical contexts simply fail to capture. For example, in some cultures it may be considered unacceptable to be treated by a doctor of the opposite sex, which could cause distress to the patient and, thus, adversely affect

their satisfaction (Ahmad, Kernohan, & Baker, 1989). Instruments that do not adequately acknowledge cultural diversity may fail to capture this expectation among some cultural minority patients. Additionally, patients who perceive their cultural values to be threatened in clinical contexts may also derive a negative patient experience (Matin and LeBaron, 2004). These issues highlight the important role of social psychology – both its empirical work and theoretical frameworks – in understanding the factors that are likely to shape and give rise to patient satisfaction in healthcare contexts. Aspects of social psychological theory and research are discussed in this article.

PATIENT SATISFACTION: A CRITICAL EVALUATION

In this section, we critically evaluate a small sample of scales of patient satisfaction in the following healthcare contexts: primary care; out-of-hours primary care; outpatient care; nursing care; chronic illness care; integrated elderly care; mental health care; psychiatric care; and compassionate care. We focus on a wide range of healthcare settings in order to provide a more holistic overview of patient satisfaction. Moreover, our critical review is guided by relevant theoretical tenets from social psychology.

Primary Care

Primary care is the essential frontline care (Starfield, 1992), and can be defined as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practising in the context of family and community." (Vanselow, Donaldson & Yordy, 1995, p. 192). Hojat et al. (2011) developed and examined the psychometrics of a brief instrument to measure patients' satisfaction with primary care physicians and patients' perceptions of physicians' empathy, the preventive tests recommended by the physicians (e.g. mammogram, colonoscopy), and patients' demographic details.

In this scale, one item measures the patient's level of understanding of the reasons why particular medical tests are undertaken ("My doctor explains the reason(s) for any medical test."). This is not necessarily an indicator of patient satisfaction because it has been demonstrated empirically that patients generally have confidence in their physician's knowledge and judgment (Mechanic and Schlesinger, 1996). Thus, some patients do not always have the desire to fully understand why they should take specific tests. Although some patients do not seek to understand the reasons underpinning medical tests, they often wish to discuss their health concerns with medical care providers. One item of this scale measures the extent to which patients feel able to discuss their health concerns with their physician ("My doctor encourages me to talk about all my health concerns."). Enabling patients to talk about *all* of their health concerns in a usually time restricted consultation is unrealistic and patients are encouraged to book separate consultations for them (Silverman and Kinnersley, 2012). Therefore, a more suitable item to measure patient satisfaction would capture the patient's ability to pose questions on their specific health issue during the consultation.

Conversely, one item in this scale taps into the extent to which patients understand their doctor's explanations ("My doctor explains things in a way that is easy for me to understand."). This is an important indicator of patient satisfaction because the patient's ability to understand their condition can have an empowering effect on them, thereby enhancing their sense of self-efficacy, that is, feelings of control and competence. Conversely, when patients do not understand their consultation with their doctor, their satisfaction may decrease. For example, in a Nigerian study conducted by Udonwa and Ogbonna (2012), patients' understanding of their illness following a consultation was a significant predictor of their satisfaction. Thus, the social representations (e.g. images, metaphors, comparisons) that clinicians draw upon in order to explain a medical diagnosis and its implications should be selected appropriately. For instance, pre-exposure prophylaxis for preventing HIV infection is often compared with the contraceptive pill, which has implications for how this is understood by patients (Jaspal and Nerlich, 2016). Patients' expectations may be unrealistic due to the use of inappropriate social representations in clinical explanations. To complement this overview of patient satisfaction in primary care, the next section considers out-of-hours primary care.

Out-of-hours primary care

Out-of-hours primary care is utilised when general practitioner surgeries are normally closed (Hallam, 1997). Salisbury et al. (2005) produced a brief measure in order to assess patient satisfaction of out-of-hours primary care, based on a previous scale by McKinley et al. (1997). This scale, however, suffers from a number of limitations. Several items are double-barrelled which means that participants' responses will be unclear (Fife-Shaw, 2000). For instance, one of the items measures patients' satisfaction with the doctor/ nurse's attitude towards them ("How satisfied are you with the manner of the doctor or nurse?") but in the responses it would not be clear which of the two practitioners' attitude is being referred to. During one's consultation, one may feel that the doctor's attitude was poor while the nurse's was excellent (Hughes, 1988). Therefore, this item does not differentiate patients' satisfaction vis-à-vis the two practitioners and, thus, does not measure the construct adequately. Additionally, in the same item, the term 'manner' is ambiguous, and could capture a wide range of factors such as support, attentiveness, acceptance, and empathy. Each of these factors might affect patients'

satisfaction differently. Thus, specifying the specific aspects of a desirable attitude would enable the analyst to identify those with which patients are satisfied/ dissatisfied.

However, there is an item in this scale that measures patients' satisfaction with the clinician's explanations about their problem ("How satisfied are you with the explanation the doctor or nurse gave you for your problem?"). This questionnaire item is suitably generic and can capture the diverse levels of explanation expected from healthcare professionals. For instance, some patients who have undergone liver function tests enquire about the levels of specific enzymes while others are concerned exclusively with the overall result (Kijakovic, 2012). Moreover, it is noteworthy that human beings seek to reduce uncertainty in their lives. While uncertainty reduction theory (Berger and Calabrese, 1975) describes the human motivation to avoid uncertainty in interpersonal relations, it is possible to extrapolate the theory to reducing uncertainty in relation to the self and indeed health-related problems that can threaten the self. Individuals may experience cognitive uncertainty in relation to their health, which can generate cognitive stress. Patients may seek more detailed information from practitioners or rely on other social cues (e.g. tone of voice, temperament, facial expressions) from practitioners for reducing uncertainty. A satisfactory explanation from a healthcare professional about their health condition could contribute to uncertainty reduction among patients. It is important that a scale should capture patients' satisfaction with the clinician's explanations as this, due to its relationship with uncertainty reduction, is likely to contribute to their overall satisfaction with their care.

Outpatient care

Outpatient care refers to medical services provided to patients that do not require a prolonged stay at a facility (Säilä, Mattila, Kaila, Aalto, & Kaunonen, 2008). Goel, Sharma, & Singh (2013) constructed the North India Outpatient Department Satisfaction Scale in order to assess patient satisfaction with outpatient department services. Positive aspects of this scale include three items that address the important issue of patient access to the health institution. One item addresses ease of access ("Health institution is easily accessible."), another convenience of location ("Health institution is conveniently located."), and the third perceived patient access in terms of space and physical comfort ("Adequate sitting space and chairs comfortable in waiting area."). Patients' engagement with care is predicted by perceived access (Mugavero, Norton, & Saag, 2011). However, another crucial factor that affects patients' satisfaction with outpatient department services is *psychological access*, which refers to the perception that one can access healthcare without any negative implications for one's physical and psychological wellbeing (Tobias, Cunningham, & Pounds, 2007). For example, HIV patients may experience stress at the prospect of attending HIV outpatient services for fear of stigma and involuntary disclosure of one's status, which in turn can decrease patient satisfaction (Sayles, Wong, Kinsler, Martins, & Cunningham, 2009). Patients with erectile dysfunction may not seek treatment for their stigmatised condition due to the need to disclose to a clinician information that can be damaging for self-esteem (Dunn, 2016). Thus, *psychologically* they may not have access to services. Psychological access refers to perception rather than practicality. In short, an adequate scale needs to capture both physical and psychological access.

Furthermore, patients may encounter issues concerning time-restricted consultations as they may feel that their problem is not heard. An item in this scale refers to satisfaction with the length of time dedicated to the patients during the consultation ("Doctor gave adequate time to explain the problem."). Although this item focuses on time for the doctor to provide explanations, the item should measure satisfaction with the amount of time provided for both the doctor's explanations and the patient's questions. General practitioners face considerable time constraints in consultations with patients (Silverman and Kinnersley, 2012). At the point of primary care, consultations are exploratory and require time and, thus, insufficient time within a consultation could adversely affect patient satisfaction. An item that captures patients' satisfaction with time is important. The issue of time is also relevant to nursing care, which is discussed next.

Nursing care

Nursing care can be defined as the incorporation of clinical judgement in healthcare provision as a means of enabling patients to enhance, maintain or regain good health outcomes, to manage emerging health problems, and to achieve the best possible quality of life until death (Royal College of Nursing, 2014). The Newcastle Satisfaction with Nursing Scale is an instrument for quality assessments of nursing care and consists of two subscales, namely the Patients' Experience of Nursing Care subscale and the Patients' Satisfaction with Nursing Care subscale (Thomas, McColl, Priest, Bond, & Boys, 1996).

In the Patients' Experience of Nursing Care subscale there are three items that tap into the important issue of patient-centred care. Specifically, one item ("Nurses took no interest in me as a person.") measures the extent to which the nurse's approach towards a patient is individualised. Another item ("No matter how busy nurses were, they made time for me.") measures nurses' provision of dedicated individual one-to-one time, despite the time constraints that medical staff usually face. The third item ("Nurses had time to sit and talk to me.") measures the nurse's response to patients' individual needs. There is evidence that patients wish to be treated by healthcare professionals as individuals (NICE, 2012) and, thus, a measure of patient satisfaction must capture this.

In addition to responsiveness, patients need to feel confident about the competence of their healthcare providers (Hall et al., 2002), and patients' perception of clinicians' level of competence is indeed captured in this scale. For example, one item ("Nurses knew what to do for the best.") measures patients' perception about nurses' ability to make the right decision regarding treatment. Thus, an item that taps into patients' perceptions of healthcare providers' level of competence should be included in the scale. There is also a question on the clinician's rapport with the patient as a marker of patient satisfaction. There are two items in this scale, which touch on the friendliness of the nurses towards patients, which appear to be less relevant to patient satisfaction. Particularly, one item ("It is easy to have a laugh with the nurses.") does not measure a phenomenon that would necessarily be reflective of satisfaction because the desire to "have a laugh with" the nurse is dependent on the patient's personality and cultural values. For instance, patients who value tradition and conformity and, thus, foreground socially imposed expectations vis-à-vis individual desires would not necessarily expect or wish "to have a laugh" with their clinician, while others who value stimulation and self-direction may well view this as a necessary component of high-quality care (Schwartz, 2012). Additionally, the other item ("I saw the nurses as friends.") is an inadequate indicator of satisfaction, as patients do not necessarily expect or desire to have a friendship with their medical professionals. Indeed, in most societies, medical professionals (especially doctors) maintain a level of interpersonal 'distance' from their patients, for example, by using the title 'doctor' rather than their first name (Norrby, Wibe, Lindstrom, & Nilsson, 2015). This would plausibly inhibit the expectation for a friendship with one's medical professional. In addition to values, social representations that are prevalent in a given culture will determine the extent to which patients expect particular styles of relationship with their healthcare practitioners (see Moscovici, 1988). Therefore, items like these should be reconsidered in terms of their validity or necessity in a scale that attempts to measure patient satisfaction .

With regards to the Patients' Satisfaction with Nursing Care subscale, one item in this scale ("Thinking about your stay on the ward, how did you feel about how nurses helped put your relatives' and friends' minds at rest.") is not an accurate indicator of patient satisfaction, as there exist cases in which healthcare practitioners simply cannot put the relative's and friends' minds at rest, such as end of life patients. Nevertheless, one item in this scale ("Thinking about your stay on the ward, how did you feel about nurses' awareness of your needs.") explores the extent to which the healthcare practitioner is sensitive to patients' individual requirements. This can include physical needs, such as regular provision of painkillers; psychological needs such as empathy; and cultural needs such as provision of space for prayer. Intrapsychic needs, such as the desire for self-esteem, self-efficacy, distinctiveness and continuity, may also be predictive of satisfaction (Jaspal & Breakwell, 2014). These intrapsychic needs may be curtailed during the course of treatment. Given that individuals will have specific physical, psychological, and cultural needs, which may be associated with satisfaction (Tucker, Marsiske, Rice, Jones, & Herman, 2011), the inclusion of this item might enable researchers to ascertain patient satisfaction with their overall care.

An important aspect of patient-centred care includes clinicians' understanding of patients' worries and concerns. One item in this scale examines the degree to which *nurses* are attentive to the patient's worries and concerns ("Thinking about your stay on the ward, how did you feel about how nurses listened to your worries and concerns."). Earlier in this article, we outlined the importance of the physician's attentiveness to the patient but nurses also play a fundamental role in the delivery of healthcare. For instance, some patients can develop anxiety, stress, and depression due to their health condition and, thus, it is vital that they be able to discuss their worries, anxieties, and concerns with nurses whom patients may see more frequently than doctors (Johnston, 1982). For example, cancer patients may be concerned about the impact of treatment, such as chemotherapy or radiotherapy, and its side effects and impact on their daily life. As discussed earlier in this article, individuals are motivated to reduce uncertainty about the self, and interactions with practitioners should be geared towards this goal. However, due to time and resource constraints, healthcare practitioners may feel constrained and not treat patients' worries and concerns with the attention they deserve. It is important to include in the scale an item that captures patients' perceptions of the extent to which healthcare practitioners attend to the patient's worries and concerns. The next section explores care in the context of chronic illness, which is also associated with psychological distress.

Chronic illness care

A chronic illness refers to an illness that is either long-term or permanent (Bury, 1982). Glasgow et al. (2005) tested the measurement performance, construct, and concurrent validity of the Patient Assessment of Chronic Illness Care, which is aligned with the Chronic Care Model (Wagner, 1998). The scale includes an item that captures patients' perceived involvement in developing their treatment plan ("When I received care for my chronic illness over the past 6 months, I was asked for my ideas when we made a treatment plan."). There is evidence that patients who are given the choice to actively engage with decision-making processes regarding their treatment are more likely to adhere to regimen recommendations and therefore to experience better care (Coulter, 2007). Although this is inconsistent with the traditional paternalistic model of medicine in which doctors take decisions regarding treatment (Stevenson, Barry, Britten, Barber, & Bradley, 2000), perceived inclusion in one's treatment plan may restore a sense of self-efficacy and lead to improvements in quality of care (Kidd, 2007). The principle of self-efficacy constitutes a key variable in psychological models of health

behaviour, future health behaviour and health behaviour change, because it is important for an individual to feel *able* to enact particular behaviours (Holloway and Watson, 2002). The theory of planned behaviour (Ajzen, 1991) is one such model. Self-efficacy has also been identified in identity process theory as a key principle of identity construction (Jaspal and Breakwell, 2014). Furthermore, self-efficacy – the perceived ability to do – constitutes an important component of agency (Bandura, 2009). Thus, a scale that measures patient satisfaction should include items that tap into patients' perspectives about their involvement in the care they receive.

Another important aspect of this scale is its focus on identifying patients' perceptions about the level of support for healthy behaviour change. For instance, patients with respiratory problems are often aware of the benefits of smoking cessation, and most patients diagnosed with HIV acquire awareness of the benefits of modifying risky sexual behaviours. Both patient cohorts may require support with behaviour change, which can in turn contribute beneficially to quality of care. The theory of planned behaviour (Ajzen, 1991) can provide useful insights into the nature of support offered to patients. The theory specifies three factors that guide human behaviour, namely behavioural beliefs, normative beliefs and control beliefs. Patient support may include exposing them to accurate information concerning the likely consequences of healthy behaviour change (*behavioural beliefs*), and signposting them to support groups that are affirmative of the behaviour change (*normative beliefs*) and that empower patients to believe that they are able and socially supported to enact changes in their behaviour (*control beliefs*). An item ("Over the past 6 months, when I received care for my chronic conditions, I was referred to a dietician, health educator or counsellor.") measures the frequency with which patients are referred to a dietician or a health educator in order for them to improve their health behaviours. In some cases, a change in lifestyle might slow disease progression or reduce disease symptoms. For example, epidemiological studies have shown that dietary modifications could prevent type 2 diabetes (Frank, 2011). A scale that measures patient satisfaction should include an item that taps into the extent to which the patient believes they are supported for behaviour/ lifestyle change.

On the other hand, this scale partially fails to capture patients' perceptions of how the healthcare system is dealing with common complications and psychological issues that surround chronic illnesses. For example, depression is a common correlate of living with a serious medical condition and has been observed to accompany chronic pain (Banks and Kerns, 1996). An adequate scale should include an item that captures patients' perspectives of the extent to which they receive and benefit from psychological support in order to cope fruitfully with their chronic condition. The next section focuses on another healthcare area in which multidisciplinary care is necessary, namely integrated elderly care.

Integrated elderly care

As people age they may require a variety of distinct healthcare services. The provision of integrated healthcare services can promote better healthcare outcomes in older people. Uittenbroek et al. (2015) developed the Patient Assessment of Integrated Elderly Care scale to assess the quality of integrated care, from the perspectives of elderly people, and to evaluate its psychometric characteristics. This scale contains several important items. One item elicits the patient's feedback on the degree to which the physician expressed interest in the patient's ideas and expectations vis-à-vis their treatment plan ("Over the past six months, when I received care and support for health issues related to ageing or my chronic condition(s), I was asked for my ideas and expectations, when we made a care and support plan."). Social psychological research demonstrates that potentially harmful effects of negative age-related stereotypes for the physical and psychological wellbeing of older people (Ory, Hoffman, Hawkins, Sanner, & Mockenhaupt, 2003). Older people may themselves accept and internalise these stereotypes, which can in turn compromise their self-confidence, self-esteem and ability to engage productively with health conditions (Palmore, 1999). For instance, older people may be excluded from decision-making vis-à-vis their care due to the (erroneous) stereotype that they are no longer cognitively competent (Dionigi, 2015), which can undermine patient satisfaction. More generally, patient satisfaction may be compromised when the patient's individual expectations are not met. Patients must therefore be given the opportunity to share their expectations about their treatment with their healthcare providers.

Furthermore, the following item taps into the degree to which physicians expressed interest in ascertaining the patient's goals vis-à-vis treatment: "Over the past six months, when I received care and support for health issues related to ageing or my chronic condition(s), I was asked which goals I wished to achieve regarding my health". When patients are involved in their treatment and set specific short-term goals that are achievable, they are likely to enjoy better health outcomes (see Coulter, 2007). Another item in the scale ("Over the past six months, when I received care and support for health issues related to ageing or my chronic condition(s), I was sure that my healthcare professional had thought about my values, beliefs, and traditions, when they recommended care and support to me.") captures the extent to which the patients believe that their healthcare professionals acknowledge aspects of their identity. In culturally diverse societies this is likely to be particularly important because a patient's identity consists of various components, all of which may play an important role in determining their sense of self (Jaspal and Breakwell, 2014). Healthcare, which does not acknowledge a valued aspect of identity, may conversely be resisted by the patient (Coyle, 1999). Indeed, the social identity approach (Tajfel, 1978) postulates that individuals are motivated to maintain both distinctiveness and self-esteem on the basis of valued group memberships. The maintenance, acknowledgement and validation

of key norms, values and traditions associated with valued group memberships (e.g. one's ethnicity, culture, religion) may serve to protect the integrity of one's social identity, while exclusion of these norms, values and traditions by (outgroup) healthcare practitioners could result in social identity threat. The experience of social identity threat in the healthcare context is unlikely to be conducive to patient satisfaction. It may also compromise mental health in the long term (Haslam, Jetten, Postmes, & Haslam, 2009), which is the focus of the next section.

Mental health care

According to the World Health Organisation (2016), mental health refers to a state of wellbeing in which the individual understands their capabilities, can deal with stress of everyday life, is productive, and has the ability to contribute to their society. Crucially, many health issues also have a mental health dimension (Stanton, Revenson, & Tennen, 2007). For instance, people living with HIV suffer disproportionately high levels of mental health problems, such as depression (Bengtson et al., 2016). Oades, Law, & Marshall (2010) developed the Consumer Evaluation of Mental Health Services to assess patients' satisfaction with mental health service provision. The scale includes an item ("I experienced stigma, from mental/health professionals, associated with this service.") that captures perceived stigma. Unfortunately, some chronic illnesses, such as HIV infection, and indeed possible mental health problems that can coexist with them, are stigmatised by healthcare professionals (Nyblade, Stangl, Weiss & Ashburn, 2009). Crocker, Major, & Steele (1998, p. 505) argue that stigmatisation occurs when an individual possesses or is believed to possess "some attribute or characteristic that conveys a social identity that is devalued in a particular social context." This in turn can reduce an individual "from a whole and usual person, to a tainted, discounted one" (Goffman, 1963, p. 3). It is easy to see how stigma encountered within a healthcare context, in which the patient expects understanding and treatment, can result in threats to identity and self-image. The experience of stigma is negatively correlated with self-esteem (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001), itself a key component of mental health. Stigma in healthcare can have a negative impact on patient satisfaction and cause disengagement from healthcare services (Beer et al., 2009), poor adherence to medication (Martinez et al., 2012) and poor mental and physical health outcomes (Chaudoir, Earnshaw, & Andel, 2013). Psychiatric care is a component of mental health care and is discussed next.

Psychiatric care

Psychiatric care refers to the diagnosis, treatment, and prevention of mental health conditions (NHS, 2016). Gigantensco, Morosini and Bazzoni (2003) conducted a study in order to construct and validate the Rome Opinion Questionnaire for Psychiatric Wards, a brief questionnaire for evaluating patients' opinions of the quality of care in inpatient psychiatric wards in Rome. One item in this scale attempts to measure the patient's perception of the general layout, the furniture, and the environment of the psychiatric ward ("How much do you like the layout and the furniture of this ward?"). The physical environment of a hospital, a clinic, or a ward may be important to patients and can be indicative of patient satisfaction. For instance, patients may feel more relaxed in an environment that does not remind them of a typical hospital or clinic and this could increase their engagement with healthcare (Fulop, 1990). There is a tradition of work in environmental psychology which focuses on the individual's relationship with place and space – loosely termed 'sense of place' (Pretty, Chipuer, & Bramston, 2003). Individuals draw upon social representations, that is, images, metaphors and 'common-sense,' in order to develop a sense of place in that they associate that place with other social phenomena (*anchoring*) and tangible images (*objectification*) (see Moscovici, 1988). For instance, a clinical space associated with illness may be resisted by the patient while a space evocative of wellbeing may conversely be more attractive. In short, it is likely that patients will more readily engage with healthcare and experience greater satisfaction with it, when their social representations of healthcare spaces (in this context, the psychiatric ward) are positive.

Compassionate care

Empathy, respect, and dignity are important tenets of compassionate care, which must acknowledge patients' socio-emotional concerns and needs. Lown, Muncer and Chadwick (2015) evaluated the psychometric characteristics of the Schwartz Center Compassionate Care Scale to measure patients' ratings of clinicians' compassionate care. An item in the scale measures patients' perceptions of the extent to which medical professionals communicate test results in a timely and sensitive manner ("During your recent hospitalization, how successfully did your doctor communicate test results in a timely and sensitive manner?"). It is important that test results be delivered in a timely manner because delays in receiving test results can cause anxiety and compromise psychological wellbeing (Gray et al., 2006). Moreover, test results should be delivered in a sensitive manner as this may otherwise aggravate patients' anxiety and, in the case of chronic conditions, challenge their sense of continuity (Corwin and Bradley-Springer, 2013). Drawing on identity process theory (Jaspal and Breakwell, 2014), a social psychological theory of identity construction, threat and coping, it can be argued that the diagnosis of a chronic illness, such as HIV, would be threatening for one's identity due to the

disruption of one's sense of continuity between past, present and future (*continuity*) and to the damage that HIV stigma can do to one's self-esteem (Daramilas and Jaspal, 2016). Yet, a diagnosis that is delivered in a timely and sensitive manner may enable the patient to begin to accept their diagnosis and assimilate and accommodate it in their sense of identity in a way that minimises threats to continuity and self-esteem. In short, patient satisfaction may be derived from timeliness and sensitivity in the delivery of disease diagnosis and, thus, from the ability to accept one's diagnosis without experiencing long-term threats to self-esteem and continuity.

RECOMMENDATIONS

This article presents a brief review of a small sample of patient satisfaction scales. On the basis of the review, we make a series of recommendations concerning the adequate measurement of the construct. Moreover, we draw on theories from social psychology, including the social identity approach, social representations theory and identity process theory, in order to substantiate these recommendations. There is general consensus that healthcare needs to be patient-centred (Maizes, Rakel, & Niemiec, 2009). In addition to providing evidence-based care, practitioners should manifest a thorough understanding of patients' feelings, experiences, and stories. Patient-centred care can improve patients' experiences of, and satisfaction with, healthcare. Thus, it is essential to devise a scale that elicits *patients' perspectives* about different aspects of the care they receive.

Generic versus targeted items

Patients with particular health conditions have specific needs. For instance, many people diagnosed with HIV require on-going psychological support in order to cope with stigma or other psychological difficulties associated with their condition (McDowell and Serovich, 2007). Additionally, many require assistance with modifying on-going risk behaviours, such as condomless sex and drug use (Parsons et al., 2016). On the other hand, oncology patients may perceive uncertainty in relation to their diagnosis and prognosis and may also face psychological challenges linked to physical changes that cancer treatment can bring about (Gregurek, Bras, Dordević, Ratković, & Brajković, 2010). They too may require psychological support. Healthcare must be tailored to particular health conditions as patients may have differing expectations in relation to their specific condition.

Nonetheless, there are some general expectations that patients have regarding their healthcare which could be measured across healthcare contexts. Although a generic scale *alone* would not be adequate, there are some items that may be generalisable across all settings. These items should form the backbone of any measure of patient satisfaction that measures *patients' perceptions* of:
* the environment of the ward or the clinic which they are attending;
* the level of empathy, compassion, and sensitivity of clinicians towards them,
* medical professionals' understanding of their issues, worries, and concerns,
* the quality of the advice they are given in order to deal with their health condition.

However, the backbone of generalisable items needs to be supplemented by an additional set of items specific to the particular healthcare context. Patients with any given health condition will experience particular issues, problems and challenges and have specific worries, concerns, or needs. For instance, people with mental health problems may face stigma from medical professionals (Corrigan and Watson, 2002) and people living with cancer might be concerned about side effects of their treatment, especially when their physical appearance is affected or when these side effects can lead to decreased autonomy and disrupt one's everyday life (Luoma and Hakamies-Blomqvist, 2004). Hence, some questions must be tailored to the specific conditions under investigation.

Cultural sensitivity

A scale that measures patient satisfaction should be culturally sensitive, and capture patients' perspectives about the extent to which care providers understand their background, whatever this may be (e.g. social class, ethnicity, religion). Moreover, the scale must acknowledge aspects of their identity, such as social group memberships and the norms, values and traditions associated with them (Tajfel, 1978). The acknowledgement of these tenets of group identities is central to the maintenance of a positive social identity (Brown, 2000). It must also be acknowledged that individuals typically possess multiple group memberships and that an understanding of the intersections between these group memberships (e.g. sexuality and religion) would be beneficial and indeed conducive to increased patient satisfaction.

There are many distinct social psychological approaches to the study of culture (see Jaspal and Cinnirella, 2012), including the cultural dimensions theory (Hofstede, 1980), individualism vs collectivism (Hui, 1988) and the Schwartz Value Survey (Schwartz, 2012). Cultures are associated with different value systems which guide people's lives and, thus, the Schwartz Value Survey constitutes a useful approach to the study of culture in relation to measuring patient satisfaction. Schwartz (2012) has identified some of these values and categorised them in four main groups, namely self-transcendence, conservation, self-enhancement, and openness to change. For instance, patients who identify with a culture that values tradition (a conservation value) are more likely to value and thus expect a more traditional form of healthcare, in which there are clear

professional boundaries between patients and healthcare practitioners. Conversely, those who value stimulation (an openness to change value) may be in favor of innovation in the healthcare setting and, thus, have distinct expectations of healthcare practitioners. Similarly, a person with a cultural background that values self-transcendence is likely to attach greater importance to public health whereas a person who values self-enhancement may prioritise individual health. Hence, a scale that measures patient satisfaction must acknowledge the cultural aspects of patients' lives.

Additionally, in some cultures like so-called eastern collectivist societies (e.g. Islamic and Arabic societies) there may be a strict division of genders (Dion and Dion, 1993). Therefore, in these cultures, it might be considered unusual and uncomfortable for female patients to be examined by medical professionals of the opposite sex. This may also plausibly be the case for some minority ethnic patients. Moreover, health conditions may be interpreted in accordance with different norms and representations. There are cultural beliefs about the antecedents of particular health conditions. For instance, it has been found that in some conservative Muslim cultures mental illness may be attributed to demonic possession (Khalifa and Hardie, 2005). Similarly, in some conservative Christian cultures there is a belief that HIV infection is a divine punishment for sexual promiscuity (Smith, 2004). Breakwell's (1993) synthesis of social identity theory and social representations theory from social psychology sheds light on the potential antecedents of such beliefs regarding health. Individuals draw on the stock of images, explanations and norms that are prevalent in their social groups. A valued group membership (e.g. one's ethnic culture) is likely to be perceived as a reliable source of information regarding the external world (in this case, mental health). It is possible that some patients may feel that their cultural beliefs are not taken seriously by healthcare practitioners, which could lead to social identity threat and thus decreased patient satisfaction.

Towards a multifaceted and holistic scale

Given the complexity of healthcare, a scale that measures patient satisfaction must be multifaceted and holistic, and capture both physical and psychological healthcare. Many medical conditions and illnesses also possess a psychological dimension (see also Banks and Kerns, 1996). People are concerned not only about their physical health but also about their psychological wellbeing. As part of their healthcare, they may expect some degree of psychological support. For instance, this support may seek to reduce psychological tension and uncertainty that the new health condition creates in their lives. Evidence suggests that offering patients assistance to cope with the psychological complications that arise from their health condition can result in improved physical health outcomes (Rendina et al., 2016). Consequently, a measure should include an item that captures patients' perspectives of the extent to which they receive and benefit from psychological support in order to deal with their condition. Psychological support can be provided to patients not only through traditional counseling but also through engagement with primary healthcare practitioners. Examples of this include encouragement of patients to attend community support groups that could help them, enhance their self-efficacy, and boost their confidence so that they can manage their condition.

Following the review of this small sample of scales, we provide a set of suitable generic items, which should be included in an adequate scale that measures patient satisfaction. These items should measure:

- Patients' perspectives and satisfaction with clinicians' explanations about their health problem. E.g. "To what extent are you satisfied with how your doctor explains things in a way that is easy for you to understand?" (Hojat et al., 2011); "How satisfied are you with the explanation the doctor or nurse gave you for your problem?" (Salisbury et al., 2005).
- Patients' satisfaction with access to healthcare and with the location of the healthcare institution. E.g. "Please record your satisfaction with each of the items: Health institution is easily accessible; Health institution is conveniently located." (Goel et al., 2013).
- Patients' satisfaction with the extent to which the clinicians' approach towards them is individualised. E.g. "During your hospitalisation, how successfully did your doctor treat you as a person not just a disease?" (Lown et al., 2015).
- Patients' satisfaction with the extent to which the healthcare practitioner is sensitive to their individual requirements. E.g. "Thinking about your stay on the ward, how satisfied were you with nurses' awareness of your needs?" (Thomas et al., 1996).
- Patients' beliefs about the degree to which aspects of their identity are acknowledged by healthcare professionals. E.g. "Over the past six months, when I received care and support for health issues related to ageing or my chronic condition, I was sure and satisfied that my healthcare professional had thought about my values, beliefs, and traditions, when they recommended care and support to me." (Uittenbroek et al., 2015).
- Patients' perceptions of the clinician's level of competence and their confidence in the competence of their healthcare providers. E.g. "Thinking about your stay on the ward, how satisfied did you feel about how: Nurses knew what to do for the best; Doctors and nurses worked well together as a team." (Thomas et al., 1996).

- Patients' perceptions of the time given to them by their care providers to discuss their concerns. E.g. "To what extent are you satisfied with the following items: No matter how busy nurses were, they made time for me.; Nurses had time to sit and talk to me." (Thomas et al., 1996).
- Patients' satisfaction with given information from their clinicians about their health or how to improve their health. E.g. "Over the past six months, when I received care and support for health issues related to ageing or my chronic condition(s), I was satisfied with the given information from my healthcare providers on how to stay healthy or improve my health." (Uittenbroek et al., 2015); "To what extent are you satisfied with how clear and complete was the information that the doctors and nurses provided on your health conditions?" (Gigantesco et al., 2003).
- Patients' perceptions of the environment in which they receive care or patients' satisfaction with the facilities in it. E.g. "How satisfied were you with the layout and the furniture of this ward?" (Gigantesco et al., 2003).

These generic items are proposed as indicators of patient satisfaction and could potentially be applied to various healthcare contexts regardless of the specific health condition under investigation. For instance, they would be equally applicable to patients engaging with sexual health services as to those engaging with oncology care. Furthermore, the use of generic items enables the researcher to compare services across all different sectors of care which can facilitate the continual improvement of patient quality of care. These items may still be modified in order to suit particular contexts. For instance, an item referring to nurses' empathy could be modified in order to capture empathy among physicians if they are the primary caregivers in a particular context, e.g. HIV care.

CONCLUDING THOUGHTS

The present review demonstrates the important role of social psychology in the development of a measure of patient satisfaction. Social representations theory (Moscovici, 1988) can elucidate the social psychological processes that can govern patients' perceptions and evaluations of their healthcare experiences. Social identity theory (Tajfel, 1986) reiterates the importance of social group memberships which can guide cognition, emotion, and indeed behaviour in relation to healthcare. The Schwartz Value Survey (Schwartz, 2012) emphasises the personality and cultural traits that can produce distinct expectations of, and responses to, healthcare. Identity process theory (Jaspal and Breakwell, 2014) is key to understanding the inter-relations between identity construction, threat, and coping, which is particularly pertinent to the study of health and illness. Collectively, these and other theoretical frameworks from social psychology specify and elaborate the social and psychological factors associated with patient satisfaction, thereby enabling us to make theoretically grounded recommendations about appropriate aspects of a measure of patient satisfaction. On the basis of this review, it is argued that an appropriate measure of patient satisfaction should be patient-focused and capture patients' perceptions and experiences of the care they receive; it should be culturally sensitive and consider cultural values; it should encompass both the physical and psychological dimensions of healthcare; and it must be targeted to specific health conditions with a backbone of generic items that are applicable across different areas of healthcare. A multi-faceted measure of patient satisfaction that draws on social psychological principles will be a pivotal tool for collecting data that are conducive to the improvement of patient quality of care.

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