A GROUNDED THEORY FOR PATIENTS' SATISFACTION WITH QUALITY OF HOSPITAL CARE

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Abstract:

Objective: Patient satisfaction with quality of care is a dominant concept in quality assurance and quality improvement programs. Elderly patients are the central users of health care services and therefore the development of a grounded theory that explains how they perceive quality of care is important for strategy planning and health services evaluation.

Sample and methods: The study was carried out at two hospitals, a capital hospital and an urban one in Greece. There were 24 elderly patients, with a mean age of 70±6.02 years old. The methodology for the data analysis was similar to the one described by Corbin and Strauss for grounded theory analysis. In order to assure the quality of our qualitative research we used triangulation (in-depth interviews, focus group and direct observation). Content analysis of the interviews was primarily based on conceptual analysis of the two main concepts: patients' perceived quality of care and patients' satisfaction with care.

Results: After open coding of the data obtained from the interviews, we identified five categories: *food, nursing care, medical care, room characteristics, and treatment/diagnosis.* These five categories are common whether we measure elderly perceived quality of hospital care or patient satisfaction. Second-level categorization (axial coding) included patients' feelings regarding each of the five care dimensions that are the subcategories of the previous categories. These feelings could be positive, negative, neutral or they may feel indifferent. The final stage of data analysis was selective coding categorization containing direct comments for each category. This third-level categorization contains specific dimensions of nursing and medical care such as: patients' respect as a human being, staff technical skills, staff effective communication, therapeutic touch and empathy.

Discussion: Our findings support the need to develop a conceptual framework for patients' satisfaction interpretation, based on their own quality of care assumptions. This is the first step for the development of a valid and reliable scale for measuring quality of care.

Key words: grounded theory, patient satisfaction, perceived quality care, hospital care, conceptual model, satisfaction anchors, elderly care.

INTRODUCTION

The importance of quality in the Health care sector has been recognized relatively recently, but it has been accelerated over the past years through the development of quality assurance, quality improvement programs and patients' agendas. Quality was very popular in the marketing literature where the notion of *«satisfying the customer»* was a dominant model of quality of service provided and consumer satisfaction. This movement initiated a global research with over 15,000 articles on assessing customer satisfaction in the past 20 years[1] and more than 18,000 articles on Medline measuring somewhat patient satisfaction with care. The vast majority of these articles developed and used a patient satisfaction scale. Only few researchers developed a conceptual framework for conceptualization of service quality and patient satisfaction, before validating their scale[2-4]. Measurement of patient satisfaction lacks a conceptual soundness as it reflects dimensions considered important by researchers and not by respondents. In fact, several times we measure what researchers think that quality of care consists of[5].

Perhaps the most consistent predictor of satisfaction is patient's age with older people being far more satisfied with health care than do younger people[6-10]. This could be attributed to a halo effect as elderly patients give socially favorable answers[10-12] and are not willing to challenge physician and nurse authority. Wirtz & Bateson argued that it is difficult to distinguish between true correlations and halo effects and that the density of the problem relates to the importance of service provided[13]. Hall and Dornan in their meta-analysis state that although patient satisfaction has been assessed across various patient groups and care settings, few studies have focused specifically on elderly patients[7]. This

could indicate a low priority to the investigation of elderly patients' view of their care. The aim of this article is to explore and generate a holistic view of elderly patient satisfaction and its determinants.

Towards the development of a conceptual model for perceived quality of care and patient satisfaction

Why is it important to conceptualize patients' perceived quality of care and their satisfaction with care provided? Because these two phenomena are complex. Locker and Dunt were among the first who pointed to a lack of any theoretical underpinning for the concepts of patient satisfaction and perceived quality of care provided[14]. Sitzia in his analysis of 195 studies of patient satisfaction found a very low proportion of studies adopting a primarily qualitative approach to develop a theory[15].

Quality of care form the patient's perspective and patient satisfaction are two major multidimensional concepts that are used several times interchangeably. Quality of care has a subjective profile as it involves a cognitive evaluation process and an objective determinant which is *«care»* as an outcome, a process or a structure measure. On the other hand patient satisfaction tends to have an objective profile and determinant which is patient's subjection. If we add the term *«perceived»* to both terms (quality and satisfaction) we conclude to an opposite meaning result: perceived quality of care and perceived satisfaction become a totally subjective concept as they are based on patients' own feelings. As a result, patient satisfaction represents the new phenomena or the new *«paradigm»* in the health care sector, after a long period of research experimentation. It could be necessary to use the term *«attributable»* satisfaction in order to describe the extent of this phenomenon, as patient satisfaction is attributed to patient's perceived value of several care dimensions.

The overall aim of a conceptual model is to make research findings meaningful and generalizable[16]. The general goal of a grounded theory research is to construct theories in order to understand complex phenomena[17,18]. The theory is considered grounded when it is validated against the data and mapped out narratively and when states of transition and intervening conditions are incorporated as well[19]. Strauss and Corbin[19] suggest that grounded theory analysts work to "uncover relationships among categories ...by answering the questions of who, when, why, how, and with what consequences ...to relate structure with process". The most frequently used theoretical model of consumer satisfaction is the one developed[20] by Parasuraman et al. SERVQUAL was designed to accommodate measurement of service quality across a wide spectrum of services including health care services. It was originally developed through involving a total of 12 focus group interviews three for each of the four selected services[20]. Wilde et al. used a grounded theory approach to develop a theoretical model of quality of care from elderly patients' perspective[2].

SAMPLE AND METHODS

Sample

The study was carried out at two hospitals, a capital hospital and an urban one. Potential subjects who met the following inclusion criteria were selected from the roster of each hospital unit with input from the nurse manager: (1) 65 years of age or older, (2) ability to speak Greek, (3) hospitalized for at least 3 days, (4) not to be suffering from severe mental or cognitive disorders, (5) willing to participate (6) communicable and (7) to be well enough to participate in the interview. In order to assess the cognitive function of elderly patients we used the Mini-Mental State examination[21]. Consecutive elderly patients who met the inclusion criteria were invited to participate in the study, after an informed consent had been obtained. The sample of patients was randomized in time and region, as random sampling gives an equal probability of the selection to each member of the population. They received a brief explanation of the purpose and the aim of the study and those who agreed to participate were asked to sign an informed consent form. There were 24 elderly patients, with a mean age of 70±6.02 years old (Table 1). In qualitative research, sample sizes are not determined by hard and fast rules[22] but by other factors, such as the depth and the duration required for each interview and how much it is feasible for a single interviewer to undertake it. Average length of hospital stay was 7.17±4.62 days.

Methods

The methodology for the data analysis was similar to the one described by Corbin and Strauss for grounded theory analysis[23]. In order to assure the quality of our qualitative research we used triangulation (in-depth interviews, focus group and direct observation). It is a validity method that compares the results from either two or more different methods of data collection, or more data sources. It may therefore be better to be seen as a way of ensuring comprehensiveness and encouraging a more reflexive analysis of the data than as only a pure test of validity. This is a genuine test of validity as any weakness in one method will be compensated by strengths in another[24].

Data collection

In-depth interviews

Interviewing in grounded theory intents to gain firsthand information from its source by exploring patients' experiences and placing them in context. Marshall & Roseman[25] described the fundamental assumption of in-depth interview technique, as *«the participants' perspectives on the social phenomenon of interest should unfold as the participant views it, not as the researcher views it»*. Husserl suggested that phenomena cannot be separated from the experience of them; therefore the way to assess the phenomenon is through pre-reflective descriptions of it, in the person's own words[26]. Thus he talks of *«lived experiences»* as the absolute determinants of the phenomenon. In order to explore the *«lived experiences»* of patient satisfaction phenomenon, patients were asked to describe it as fully and deeply as possible until they had nothing more to say. The interviews were audiotaped, the tapes were transcribed to best represent the dynamic nature of the living conversation, and the transcript was analyzed[27].

Table 1 Sample characteristics

	N	%
Gender		
Male	14	58.3
Female	10	41.7
Age group		
65-74	16	66.6
75-84	7	29.2
85+	1	4.2
Years of education		
0	1	4.2
2-7	16	66.6
8-13	7	29.2
Marital status		
Married	12	50
Widowed	12	50
Profession		
Blue collar	6	25
White collar	6	25
Agriculture	8	33.3
Housewife/househusband	4	16.7
Place of permanent residence		
Capital (Athens)	14	58.3
Urban	10	41.7
Length of hospital stay (days)		
3-8	19	79.2
9-15	3	12.5
>16	2	8.3
Clinic		
Surgical	15	62.5
Pathology	4	16.7
Orthopaedics	3	12.5
Urology	2	8.3

Initially we used in-depth interviews in combination with systematic observation in naturally occurring setting (patient's hospital room). Face to face conversation intended to explore issues and topics in detail and was kindly accepted by the elderly patients. Interviews were interactive and sensitive to the language and concepts used by the elderly patients. Questions were open-ended, neutral, sensitive and clear to them. In-patients were interviewed within the first three days of their stay in the hospital. They were interviewed in their rooms asking kindly from their caregivers to be removed for a time interval as long as required for the completion of the interview. Wherever this was difficult, we approached elderly patients who were alone in their room. It was the first time that patients saw and communicated with the researcher. These interviews were audio taped and transcribed verbatim. The average interview length was 45 minutes.

In-depth interviews are a powerful technique. Taking into consideration the need of guarantee of validity and reliability in the collection of qualitative data, they were analyzed in a continuous way, giving such feedback to the patients for additional comments that they reached at the point they did not have certain other thoughts to add. In two cases, elderly patients accepted to participate in the interview, but their caregiver prohibited them, by acting paternalistically as their *«guardian»*, alleging excuses as: "he is tired", "certain other moment", "you ask better me what you want". We were forced therefore not to include in the analysis these two cases.

Because phenomena as patient satisfaction and perceived quality of hospital care are multidimensional significances, we decided to ask for the collaboration of a researcher with specialised studies in counselling and interview taking. For five interviews, we remained as listeners and we were just keeping notes, as we believed in the importance of acquired experience as listeners. After each of these five interviews we had the time to exchange opinions and to cross our inquiring affairs. This method assures quality of classification and coding. The fundamental objective was not only the identification of several opinions, but also the creative blending and the further study of points in which we disagreed as for the interpretation. We focused our interest on content analysis of the interviews, mentioning the lists with the categories of codes as obtained through patients' proposals. Then we attempted to answer to the question: *«do elderly patients who make statement A, also tend to make statement B?»*. In that way, we intended to seek the linearity of terms: *achievement of expectations, gravity of concrete dimensions of care, perceived quality of care and elderly patient satisfaction.*

The questions placed were the followings:

1. Please describe to me what quality of hospital care means to you,
2. Please describe to me what you consider more important during your accommodation in the hospital,
3. Please describe to me what you would like to change in your care,
4. Please describe to me what you would like to improve in your care,
5. Please describe to me what you expect from the hospital and health care personnel as long you stay in the hospital,
6. Please describe to me how you feel during your hospital stay.

These days' trying to learn about social research is rather walking into a room of noisy people who use the same language but different words (terms) and display a distinctive jargon and cultural style. Some prefer to quantify reality, knowledge and truth and other choose to discover the concept of reality, knowledge and truth. This group uses qualitative research to investigate human phenomena that do not lend themselves by their very nature to quantitative methods or are prerequisites for quantitative research. The majority of researchers who use quantitative research methods show a tendency of reductionism. In the opposite, qualitative research allows each phenomenon -as care and satisfaction- to reveal itself in its fullness, as researchers *«look»* at it from every possible view, using all the senses. In fact, phenomena are apodictic, which means that they *«speak for themselves»*, but we must be prepared to listen to it!

Focus groups

Focus group was more preferable as it explicitly includes and uses the group interaction to generate data. For the majority of elderly patients, focus group was a unique chance to express their feelings, to provide distinctive types of data, and to clarify their view of care in a way that would be less easily accessible in a one-to-one interview, as they felt more comfortable. We asked patients to answer to two main questions: *«what does satisfaction mean for you?»* and *«what are the factors that cause you feelings of satisfaction or dissatisfaction?»*. Groups were *«naturally occurring»* as we selected patients from the same room of the same clinic.

We finally listed eight types of questions that can be asked in order to achieve the maximum information regarding how elderly patients perceive quality of care and satisfaction: *those based on experience*

from previous use of hospital services, on values, on feeling, on technical care knowledge, on sensory experience, on demographics or background details, on attitude and on intentional behavior. We tried to reduce the effects of personal characteristics such as social distance on the interview and the interviewer's relation to elderly care provided. At this point it is useful to note that the Hawthorne effect is not anathema to a qualitative research. This is because subjects will change their answer's direction in the presence of an observer or an interviewer, but will employ the same cultural frameworks to make such changes as they employ in everyday situations.

Direct field observation

One of the most useful methods for qualitative data collection is participant's observation as its purpose is to record social phenomena directly and prospectively. During five interviews we remained listeners and we kept watching rather than taking part in the interview. Direct observation tends to be more focused than participant observation as we were observing elderly patients rather than trying to become immersed in the entire context. It was a good way to gain a «rich picture» of a setting such as elderly patients' room.

Data analysis

Content analysis of the interviews

Qualitative methods use codes to categorize data rather than to quantify it. Content analysis is an effective research tool used to determine the presence of certain words or concepts within texts derived from the recorded interviews. Content analysis of the interviews was primarily based on conceptual analysis of the two main concepts: patients' perceived quality of care and patients' satisfaction with care. However, the focus of this study was to move beyond themes toward the development of a more cohesive theory through relational analysis of the concepts. According to Glaser & Strauss grounded theory is based on three types of coding procedures: open, axial and selective[28]. We used these three techniques by examining the transcripts by line as open coding is the part of the analysis concerned with identifying, naming, categorizing and describing phenomena found in the text produced through the interviews records. Every type is the end result of a grouping process as a core field was analysed in some groups or types. We analyzed field notes by identifying and grouping themes and coding, classifying, and developing categories. The researchers' categories were words elicited by the patients themselves, what Strauss and Corbin called "in vivo" language. Each category was searched for in the entire date set and all instances were compared until no new categories could be identified[19]. This analysis helped us to develop our "hypotheses", which were then tested in further data collection and analysis. To ensure agreement of categorization, coding was conducted independently by two research team members, with discrepancies reviewed and documented. The reliability of content analysis refers to its stability and reproducibility and validity refers to the correspondence of the categories to the conclusions, and the generalizability of results to a theory. Thus, as categories became saturated and the relationships among them became clear, the substantive *Grounded Theory of elderly patients' satisfaction with quality of hospital care* was developed.

RESULTS

The focus groups provided an insight on patients' perspective of quality of hospital care. After open coding of the data obtained from the interviews, we identified five categories: *food, nursing care, medical care, room characteristics, and treatment/diagnosis* (Figure 1). These five categories are common whether we measure elderly perceived quality of hospital care or patient satisfaction. An example of open coding is shown in table 2.

Table 2: open coding

Patient 3: 72 years old, interview transcript	**Code category**
All doctors are very kind with me. I do not want to know the truth about my health condition. Doctors know what is good for me.	Medical care

Second-level categorization (axial coding) included patients' feelings regarding each of the five care dimensions that are the subcategories of the previous categories. These feelings could be positive, negative, neutral or they may feel indifferent. For example, Greek elderly patients prefer to answer

that they feel *«good»* about nursing care. This is a positive valid judgment. However they may not be satisfied. Table 3, highlights three sub-codes which help to break down the volume of information initially obtained from the interview.

Table 3: axial coding

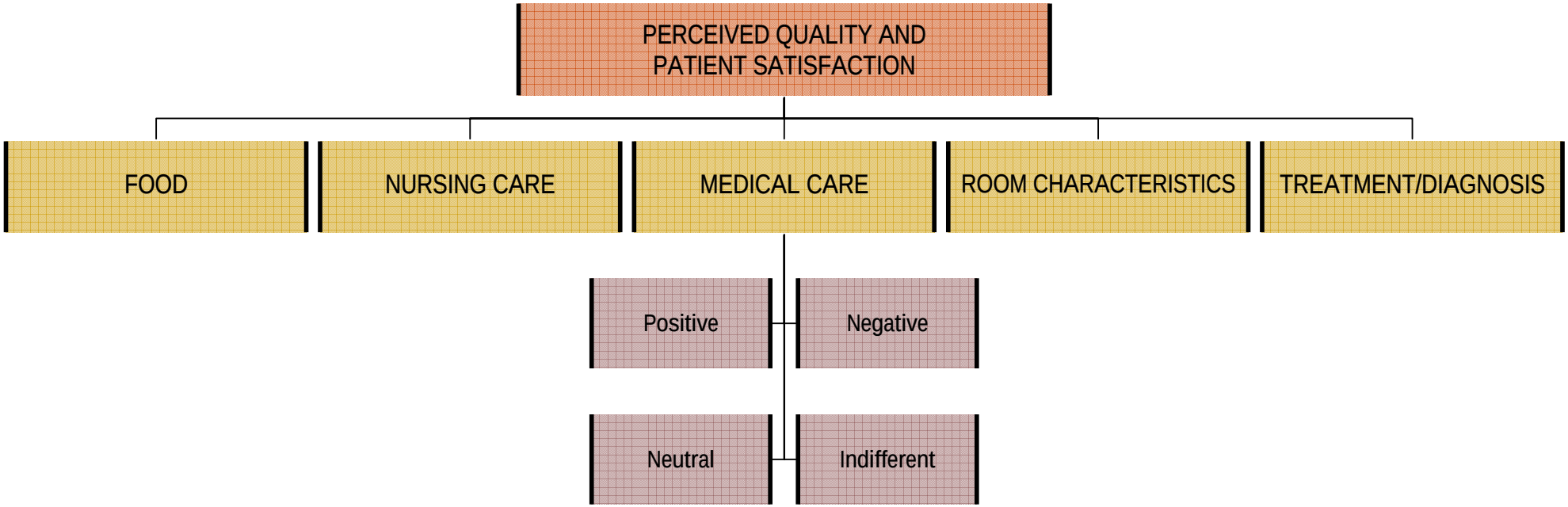
Nursing staff	**Sub-code category**
I feel indifferent with nursing care provided. I am afraid that something bad is going to happen to me. I feel empty of energy. I stand here and I look out the window, and I wish I were somebody out there. I do not want to live any more.	Indifferent
Nobody cares for me. In my times there was respect. Our world has become a jungle.	Negative
Listen to me my child. I am suffering from an infectious disease in my intestinal. Since now I have visited many hospitals. The staff in this hospital is the best I have ever seen. They gave me an intravenous therapy and now I feel very well. I do not feel pain. Patients need to care for them and not to face them as a number.	Positive

The final stage of data analysis was selective coding categorization containing direct comments for each category. This third-level categorization contains specific dimensions of nursing and medical care such as: patients' respect as a human being, staff technical skills, staff effective communication, therapeutic touch and empathy.

Development of a Grounded Theory for elderly patients' satisfaction with quality of hospital care

We concluded that elderly patients follow a *«career path»* during their hospitalization. This path is illness centered and all care episodes are the satellites of the career path. Care episodes are the basis for patients' evaluations of several quality of care dimensions, in case they perceive them. A career path is perceived successfully if patients approach the desired level of wellness. This does not necessary require total treatment of their illness. In Greek language career is referred as *stadiodromia* (σταδιοδρομία). It is a composite word: *stadio* that means stadium and *dromia* that means road. Metaphorically patients' career refers to all the stages that they pass from in order to become healthy, to return to their prior daily activities, or to learn to live with their illness. So, their career relates to the perceived outcome.

Figure 1: categorization of elderly patients' judgments



specific care dimensions

Accordingly to Table 2, if we try to typify *«attributable satisfaction»*, we must at first distinguish between different levels of expressed satisfaction (high, low, none) and patients' career path (successful or failed). Since all possible combinations rarely exist in reality, we can summarize single fields, a procedure called *«typological operation»* of reduction[29]. For example, in case that the level of satisfaction is low, elderly patients perceive a *«threshold satisfaction»* whether their career path is successful or failed. This is usually attributed to halo effect[30] given that elderly patients are not wiling to criticize their care as their *«core»* career (treatment) depends on their *«positive behavior»* during hospitalization (by expressing positive or neutral comments).

According to the Table 2, *Type I* is elderly patients who had a successful career path (became healthy, learned to live with their chronic disease etc) and feel satisfied with the majority of care dimensions. These patients perceive a reinforced satisfaction. *Type II* is elderly patients who failed to return to their prior health condition but remain happy with their disease management. These patients evaluate their care through specific care events that may fulfil their expectations or may correspond to what elderly patients think is essential for their care. As a result these elderly patients declare to be satisfied by considering these events as cut-off values for their satisfaction. The fact that they declare themselves to be satisfied does not necessarily mean that they are really satisfied. *Type III* is patients who despite their care career path (successful or failed) declare to be not very satisfied. The term threshold satisfaction reveals to elderly patients' attitude not to answer that they feel dissatisfied as they find it to be an offensive judgement. *Type IV* is patients who are not at all satisfied with the care provided but who avoid declaring their dissatisfaction as an evidence of their "compliance" with hospital care.

Some elderly patients tend to be neutral whenever we ask them to evaluate their care (Type V). These patients are neither satisfied nor dissatisfied or they are indifferent. For them satisfaction represents a perceived feeling which strongly correlates with their emotional status. This is a common finding in service quality literature and it is unexplained. A probable explanation could be that for a specific category of elderly patients with certain socioeconomic, cultural, and other characteristics there are certain care dimensions that do not add value to their welfare or to their career path. Depression and anxiety could explain this finding as elderly patients with a depressed mood tend to be more critique in their care evaluation[12].

Table 2: elderly patient's career path and satisfaction with quality of hospital care provided

Level of satisfaction	**Patient's career**	
	Successful	Failed
High	Type I «Double satisfaction»	Type II «Episode satisfaction»
Low	Type III «Threshold satisfaction»	
Non	Type IV «Limbic satisfaction»	
Neutral	Type V «Emotional satisfaction»	

To clarify patients' care career we introduced four factors that we label "satisfaction anchors" (Figure 2). These anchors are self-perceived attitudes and values that patients develop and which then guide their perceived satisfaction and perceived quality of care. All patients develop some kind of picture of their care life and their role in it. As we see in Figure 2, there four factors that contribute to patients' satisfaction are:

1. *Objectivity:* for example: *"the food served in the hospital is not tasty"*. According to the elderly patients it shouldn't be tasty because doctor said that it should be like this.
2. *Experiences:* for example: *"the doctor did not protect their body dignity causing them feelings of shame"*.
3. *Subjectivity:* for example: *"the nurse listens to my secrets. She is very kind"*.
4. *Truth:* for example: *"I see that there is a staff shortage so I try to be patient"*.

Discussion and conclusions

Since now most research efforts have concentrated on the measurement of patients' satisfaction and perceived quality of care provided without any theoretical underpinning for these two concepts. Concentrating on measurement alone, is rather like shutting the stable door after the horse has bolted. Our findings support the need to develop a conceptual framework for patients' satisfaction interpretation, based on their own assumptions regarding quality of care. Calnan[29], and Locker and Dunt[30] found that people are more critical of services when they are interviewed or respond to open-ended questions. This was also obvious in our study as patients' in-depth interviews gave them the chance to express their concerns about different aspects of care provided in a manner more confident and humanitarian. This is the first step for the development of a valid and reliable scale for measuring quality of care.

Greek patients look like the persons of the Cave in the eminent narration of Plato. Kalofissudis in his conceptual model for nursing science has successfully used Plato's allegory of the cave to describe the role of nursing in the Health care system as an empathetic science and an art[33]. Aristotle always said that the symbolism is the only *«example»* that approaches the truth. For this reason, we mention the following example: when the bee *«collects»* the pollen from the flowers (dimensions of care), it appears reasonable to say that the bee is moving and the pollen remains motionless in relation to the bee. Even when she places it in the beehive, it still remains motionless, but now it has found out its natural space. All this movement has a certain aim: *to obtain the natural mission of bee.* However, we say that the pollen *was shifted* and as a result it placed in operation another movement -the production of honey- that this time constitutes a dimension of pollen's *«natural mission»*. Through this example results the need to find the phases from which the patient passes, to evaluate the care that he receives before his admission (the pollen) to the hospital (the beehive) and after his discharge (production of honey) from the hospital.

Considering some elements from Plato's theory -that is in effect an *«affair»* that explains a lot of problems- we could lend to the term *satisfaction* a *«reasonable»* and a *«metaphysical»* meaning, or interpretation. The first dimension of theory is the *reasonable* etymology of the word. Thus, we say that this animal is a *cat*. The word *cat* is certainly something different from each *cat* separately. An animal is *cat*, provided that it belongs to a common group of cats with certain characteristics that last forever and are unique. This is the *«true»* dimension of the word that is confirmed by the infinity of reality. According to the metaphysic part of the theory, the word *cat* means an ideal and unique cat, the cat that was created by God. Thus the various approaches of satisfaction are not real copies of the *idea* that is the alone real satisfaction that the patient shapes by himself. If we tried to integrate the whole concept into the meaning of word satisfaction, we would accept that despite its multidimensionality the real information comes from a unique *«idea»* we have for patient satisfaction. It seems like we look at an object through the mirror; what we see is virtual and thus non-real. So, several theoretical or research-based approaches of *«patient satisfaction»* as a phenomenon are not real copies of the central *«idea»* that is unique real satisfaction grounded from the patient's viewpoint. This statement allows us to formulate a basic *«gnome»* (gnome=opinion) for the results of each research in order to explore patient satisfaction but we cannot reach the real *«gnosis»* (gnosis=knowledge) because we don't know the absolute interpretation of this term.

Firstly we have to decide whether we measure satisfaction as an *acceptable* or *expectable* quality of care indicator, or as a *perceived* patient judgment that is multidimensional and some times indescribable. Then we have to confirm the antecedents of patient satisfaction. In Greek language, satisfaction is a composite word and is derived from the verb «ικάνω» (ikano) that means: *«I arrive»*. Then patient satisfaction could be interpreted as *«I make a patient capable to evaluate his own care»,* based on his quality of care

perception. The word quality (in Greek language *ποιότητα*) is derived from the word *ποιός* (pios) that means *«what kind»* and relates to all these characteristics of a service that distinguish it from the other similar services. So, it is easier to describe quality dimensions than to define quality. For Greek elderly patients quality of care is whatever patients perceive and whenever they do it. It is also defined by all these care dimensions that assure a good health or a recovery from the illness. The absence of disease, disability as well as pain defines what Greek patients perceive as health and wellness. This was also stressed in a recent research among Greek gypsies[32].

We identified five factors that explain elderly patients' satisfaction and perceived quality of hospital care provided. These factors were the following: food, nursing care, medical care, room characteristics, and treatment / diagnosis. Wilde et al. by using a grounded theory approach they identified four factors that explain quality of care from the patient's perspective[2]. These factors are: the medical-technical competence, the physical technical conditions, the identity oriented approach and the socio-cultural atmosphere.

Patients' satisfaction as an attitude

By considering satisfaction as a phenomenon, we then accept that it is affected by multiple facts that are the perceived care incidents. These facts can never be isolated from the domain of *«values»* or removed from some form of ideological inscription. Values are clear statements about what is right, wrong, good, bad, quality component or not; thus, they are within the realm of moral claims. Human values are often referred to as relatively stable beliefs about the personal or social desirability of certain behaviours and modes of existence[335]. Some elderly patients attach a great value to the empathetic communication with hospital staff, while other people are more concerned with the technical competence of the staff. The values that govern patients' behaviour can be related to the profile of their satisfaction with care provided. Norms depend on values for their ultimate support. This explains what a person uses to justify either following or not following a norm. Through increased experience of using health care services, disputes over norms will soon move into value arguments. The value orientation is an antecedent of patient satisfaction as we ask the patient to evaluate (or criticize) his care considering what is important for him or what he expects from health care providers.

Linder-Pelz[36] supported the view of patient satisfaction as an attitude. She used the work on attitudes by Fishbein and Ajzen[37] as a basis for her framework. She found that expectations, values and perceived occurrences have independent effects on patient satisfaction with a clinic visit. It is essential to clarify in our mind that satisfaction is the *end-result* of several dynamic processes that affect patient's judgement. It may easily not represent a patient's judgment, but a *«perceived phenomenon»* that correlates with patient's culture, religion, and belief about disease and care, type of personality, previous experience and developmental stage. Terms such as *«perceived quality»* and *«satisfaction»* create an «*hermeneutic smog»* that is attributed to the researchers' effort to obtain a global agreement of its meaning. A statement like: *«patient satisfaction with quality of care»* is a *«performatif»* description of both terms, as it is not validated from the receptor - of this message- who is predisposed.

According to Ajzen attitudes are comprised of four components: cognitions, affect, behavioral intentions and evaluation[38]. Cognitions are patients' beliefs, theories, expectancies, and perceptions relative to the care provided. The affective component refers to patients' feelings with respect to the care provided such as liking, or anger. Behavioral intentions are patients' aspirations, and expected responses to the care provided. Evaluations are considered the central component of attitudes as consist of the imputation of some degree of goodness or badness to an attitude object such as care. Care evaluations are functions of cognitive, affect and behavioral intentions of the elderly patients. The assessment of patient satisfaction reveals to a dynamic process which leads to the exploration of the way that he thinks, he observes, he acts and pronounces. The study of patient satisfaction with the provided care constitutes, substantially, a study of patient's attitudes that is based on the analysis of the way they conceive the phenomena of care (care episodes).

Patients' satisfaction represents a global cognitive evaluation or judgment of their satisfaction with quality of care provided. According to this view, patients' satisfaction can be viewed as an attitude: "a summary evaluation of care episodes ranging from positive to negative". In other words, satisfaction is an evaluative summary of one's liking or disliking of one's care provided. We emphasize the role of broad individual differences in personality in satisfaction, and the role of certain situations, events, during hospitalization or during previous use of health care services in overall satisfaction with care provided. Several aspects of patients' personality affect the way they consider the certain or all stimuli of care environment. There is not necessarily a causal linear

link between patients' values, perceived quality of care and patients' satisfaction as even unpleasant events were shown to exert very little influence on patients' subjective assessments of quality of care. Findings indicate that patients facing problems with the communication with the staff or experiencing great recovery from their illness adapt quickly to these conditions. Taken together, these findings indicate that satisfaction is primarily a subjective phenomenon based on people's internal predispositions. That's why elderly patients formulate "ideal" expectations relating to care provided. It is notable that when we ask elderly patients whether they expect to be served a hot food during their hospitalization or not they usually respond: "shouldn't be served hot?" by outlining what was suggested below. Nevertheless, perceptions of care are substantially associated with objective situational characteristics.

It could be stressed that the satisfaction or dissatisfaction of patients' health care needs results in experiencing specific feelings or emotions. It is generally assumed that the discrepancy of a need yields positive feelings, whereas the dissatisfaction of needs will yield negative feelings. If a need is not satisfied then the related negative feeling will arouse a drive to satisfy this need. This depends on the temperamental dimension of patients' value system suggesting that specific personality traits such as emotional status are directly linked to satisfaction because they represent enduring affective dispositions. Pseudo-satisfiers may stimulate a false sensation of satisfying a certain care need, but they may in fact impair the fulfillment of that need. For example elderly patients from the urban regions were afraid that any negative comment could result to the closure of the hospital. By considering that in these areas there is only one hospital they could feel guilty for the closure of the hospital due to their negative comments. As a result they tried to be more "protective" in their judgment.

Finally does the Hospital constitute a parallel dimension of our society? Several studies have shown that the main source of patients' dissatisfaction is the bad communication with the health care personnel, by confirming that the Hospital constitutes the place of parallel monologues. We believe that the young patient who is admitted to the Hospital, is not still *«socialized»* according to the rules and norms behaviour required by the hospital society -as part of the Health Care System- in order to accept him as a new member. On the other side, the elderly patient is absolutely *«socialized»* and this characteristic is associated with his previous experience from the use of services and from the different degree of dependence upon the Health Care System. This may explain why elderly patients give socially desirable answers. It could be stressed that the elderly patient is more *«spacious»*, or we would agree with what Plato claimed, that: *«the eyes of the spirit see more clearly, when the sight of the body weakens»*.

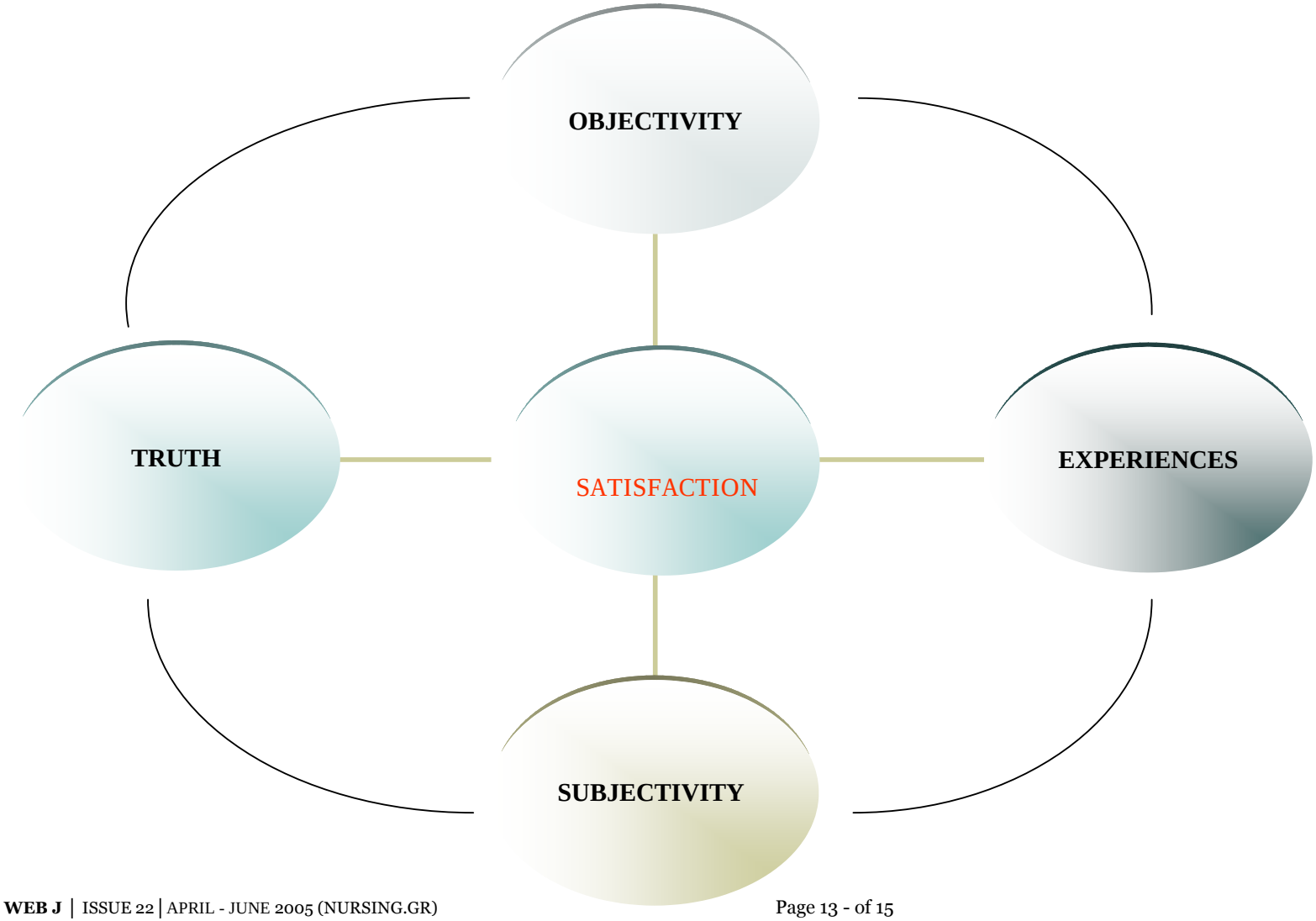
For the elderly patient the care constitutes a *«make»*. In his effort to profit 100% from this make, he functions *competitively*, via the *comparative exclusion*. This explains the use *of humour with the health care staff*, as a mechanism that guarantees care exclusivity, or a better care against the rest of the patients. Elderly patients, act with a norm -against which they evaluate the care provided- and they lend to each heath care professional *a «perceived role»*. Consequently, their expectations from each health care professional are the sum of role expectations and expectations from the past contact with the health care staff.

As previous researchers stated, participants need to have experienced the phenomena. This was also obvious in our research as patients evaluated only these dimensions of care they have experienced. The majority of patients were not able to evaluate the quality of care, as they believed that they were not *«experts»*. This explains why hospital patients took technical competence of the staff for granted and detected defects in the behavioural aspects of care, communication and empathy[39]. Passive acceptance of physician instructions is not necessarily a sign of commitment to them but it is a sign of adaptation to a social environment which they feel unable to judge and unwilling to resist. Besides elderly patients were not oriented toward active involvement in their health care as they were not wiling to participate with their physician in decision-making about managing their illness. They delegated their informal carer to take a more active role in managing their health problems. On the other side elderly patients believe that health care staff never tells them all the truth about the prognosis of their health problem. They always suspect that some important details are being held back. However they do not want to be involved in their care as they think that physicians do the best for them.

In conclusion patient satisfaction research has been criticized as having little theory to guide the hypothesis being tested. Few scales have been used to assess patient satisfaction based on a conceptual model. Since the new generation of research empowers the development of valid and reliable

scales there is a need to introduce these scales in nursing care modules within an electronic patient record[38] as patient satisfaction is a sensitive quality of hospital care indicator.

Figure 2: satisfaction anchors



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