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Editorial

Patient Satisfaction in Mental Health Care

Evaluating an Evaluative Method

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In May last year the *British Medical Journal* reported the results of a survey by MIND of users' views of psychiatric care (Kingman, 1994; Rogers *et al*, 1994), which revealed a level of dissatisfaction. In response, a letter appeared questioning the findings and pointing to higher levels of satisfaction in a patient sample (Crowe *et al*, 1994).

Contradictory conclusions are typical of research into patients' views. They are a cause for concern when we consider the growth of patient satisfaction surveys and the resources involved. Consequently, it is worth examining the extent to which patient satisfaction surveys, as evaluative tools, can fulfil the purpose for which they are intended. We should begin by clarifying the objectives of such surveys.

Reviews of the 'patient satisfaction literature' have tended to concentrate on methodological problems. We suggest that problematic and contradictory research findings may stem from unstable assumptions about the concept of satisfaction.

Ideology

In 1982 the best-seller *In Search of Excellence: Lessons from America's Best Run Companies* was published (Peters & Waterman, 1982), which embodied a belief that business excellence necessitated being 'close to the customer'. This ethos crossed the Atlantic and also the private/public sector divide (Barbour *et al*, 1984), and in the UK achieved formal official expression in *Getting Closer to the Public* (Local Government Training Board, 1987).

The ideology was developed within the National Health Service (NHS) in the NHS Management Inquiry, published under the chairmanship of Sir Roy Griffiths (Department of Health & Social Security, 1983). This introduced consumerism, accountability and democratisation, each contributing to the narrowing of the 'them and us' gap which had become obvious to, and less well-tolerated by, patients rejecting the passive role traditionally assigned to them.

This gap represents a division between the importance ascribed to patients' views and to those held by health professionals and managers. The divide is apparent in general health care, but appears most conspicuous, and politically most intricate, in the field of mental health care, as illustrated by relatively low compliance rates, and by the maturation of the mental health users movement (Rogers & Pilgrim, 1991).

"Getting closer to the public" incorporates two processes. Firstly, the views of service users are brought into decision-making procedures; and secondly, services are modified on the basis of such views. In the words of Sir Roy Griffiths:

> "The Management Board and Chairmen should ensure that it is central to the approach of management, in planning and delivering services for the population as a whole, to: ascertain how well the service is being delivered at local level by obtaining the experience and perceptions of patients and the community . . ." (Department of Health and Social Security, 1984, p. 9)

While such a principle has manifested itself in the statutory inclusion of members of the public in administrative processes, it has been most commonly experienced in the measurement of cognitive expressions of satisfaction through surveys. This was encouraged by the 1989 White Paper *Working for Patients* (Her Majesty's Stationery Office, 1989), a title reflecting a new accountability.

The relatively high public visibility of such surveys, advertising the new value attached to patients' opinions, is likely to contribute to the speed at which patients leave their traditional passive roles behind and become informed consumers. If this happens, the NHS might, paradoxically, find a widening of the gap between the public and itself.

Rationale

The rationale behind the choice of satisfaction surveys is fourfold: firstly, surveys in questionnaire form are considered relatively cheap and easy to conduct; secondly, there is a distrust of qualitative research and 'soft' data; thirdly, there is a desire for information in quantitative form in order to facilitate the Griffiths report's further recommendation that the service should '*monitor* performance' against such opinion; fourthly, and most importantly, patient

satisfaction surveys are highly visible and thus serve the purpose of demonstrating a concern for patient opinion, irrespective of whether the results are acted upon.

Patient satisfaction has become a legitimate and desired measure of outcome, an attribute of quality, and a legitimate health care goal (Shaw, 1986). As Vuori has concluded:

> "patient satisfaction could be included in Quality Assurance assessments as . . . an attribute of quality care; as a legitimate and desired outcome. *Put simply, care cannot be of high quality unless the patient is satisfied.*" (Vuori, 1987, p. 107; our italics)

This goes beyond treating patients' evaluations as an optional perspective on quality – satisfaction emerges as quality. It signifies a desired output of health care reflecting the value of consumer opinion.

Them and us

Denying that a gap between patients and health professionals should be closed may be regarded as politically incorrect – a debate beyond our scope, manifest in a conviction that the word 'patient' should be abandoned in favour of titles such as 'customer', 'consumer', 'client', 'user', or even 'survivor'.

Two points can be made:

(i) A shift from 'patient' to 'consumer' is not simply a question of modifying the doctor–patient relationship by giving the latter more rights. The consumer of health care is faced with added responsibilities: choice must be exercised, services need to be evaluated and complaints expressed, often at a time when an individual is physically or mentally ill. Increased rights carry added responsibilities for both patients and health professionals. While such a price is probably worth paying, it is seldom made explicit. Medical paternalism can remove concerns and anxieties but we are quick to forget these benefits and blame it when things go wrong.

(ii) The gap between patients and health professionals stems from the validity the latter ascribe to the formers' views (i.e. the degree to which such views are assessed to be genuine, true and accurate). This is a problem in general health care and it is an even greater obstacle in the field of mental health care, where there is concern about the ability of those with mental disorders to evaluate accurately the services they receive (Brandon, 1981). A solution might be the adoption of a pragmatic approach which entails assessing users' views for accuracy and thus validity. However, this would imply that the assessor is the arbiter of validity and that patients' opinions lack inherent validity – neglecting the principle that the customer/patient is always right.

Satisfaction and consumer opinion

If it is assumed that 'getting closer to the public' is both desirable and possible within the context of mental health care, the next question is, to what extent can patient satisfaction surveys contribute to this process? A critique can be divided into (a) the methodological aspect of whether such surveys accurately embody consumer opinion, and (b) the conceptual issue of whether the opinions of patients are of the same nature as those of consumers.

It is implicit in satisfaction surveys that patients are consumers, with expectations which need to be fulfilled for satisfaction to be attained. Consequently, dissatisfaction can be addressed by identifying patients' expectations and modifying service provision accordingly.

This model may be inappropriate for the majority of health service users. Patients do have informed expectations for certain aspects of health care provision (e.g. hotel facilities or amenities). However, knowledge of what to expect in other areas may prove more elusive. West (1976) has shown that if a service user is coming into contact with a health care speciality for the first time, then they may not have formed any expectations, although many other users have formed such expectations as a result of past experience.

Calnan (1988*a*) has pointed to the role of past experience in lay evaluations of care, and it is likely that this is mediated through the creation and continuing modification of expectations. The importance of past experience might help to account for the higher level of dissatisfaction among people with long-term mental disorders as opposed to those who have briefer contact (Williams, 1994*b*).

Another situation in which the nature and existence of expectations may be called into question is in relation to technical aspects of care. Patients are less likely to have enlightened expectations of what they perceive to be technical or esoteric issues. Where expectations do exist they are likely to be held with relatively little conviction, resulting in the patient modifying their expectations when they fail to be met, rather than blaming the quality of the service (Festinger, 1957; Carlsmith & Aronson, 1963). Such a phenomenon explains why, despite technical aspects of care being the main determinant of clinical outcome (Cleary & McNeil, 1988), some studies have found that patients' evaluations of technical matters explain little of the variance in overall satisfaction.

This issue becomes more elaborate when one considers the shifting boundaries of what is defined as 'technical'. Mass media coverage of mental health issues, such as the uses and adverse effects of medication, psychotherapy and ECT, partially remove these issues from the technical sphere and provide a basis upon which patients are able to hold discerning opinions.

Interpretation of the results of satisfaction surveys depends upon assumptions made about the way in which patients evaluate, whether they are thinking as consumers or as passive recipients of care. For those evaluating in a traditional role, an expression of satisfaction may not mean that an evaluation has taken place: such reports of satisfaction with technical aspects of care may be more accurately interpreted as expressions of confidence in the ability of health professionals.

This manner of evaluation may explain why overall satisfaction with health interventions tends to be high. A review by Lebow (1983) listed the results of over 50 surveys; the average percentage of satisfied patients was 77.5%. Furthermore, satisfaction has been shown to be positively related to age (Pascoe, 1983) a finding which would be expected if the traditionally passive role predominates among the elderly as opposed to the more consumer-oriented role among younger generations.

If the effect of the passive patient role is taken to a conclusion, one would expect satisfaction to be entirely the product of the individual and his or her perceived role; in other words, satisfaction would have nothing to do with care; and this is precisely what was found by Linder-Pelz (1982): expectations have an independent effect on satisfaction (i.e. irrespective of their fulfilment). She concluded that:

> ". . . beliefs about doctor conduct prior to an encounter play a significant role in determining subsequent evaluations of the doctor conduct, irrespective of what (s)he actually did or was perceived to have done. It suggests that patients are likely to express satisfaction no matter what care the doctor gives, at least in the setting of the present study." (Linder-Pelz, 1982, p. 588)

Expectation plays a part in patients' evaluations of care, but at best the relationship is complex, and at worst, fulfilment of expectations may have little to do with expressed satisfaction.

Embodiment of patient opinion

The concept of satisfaction is too general to provide a meaningful guide to the way in which patients think about health care. Fisher (1983) has argued that the concept provides only a "crude understanding of the reaction of clients".

When qualitative methodology is employed, little support is found for believing that evaluations can be located on a continuum of satisfaction (Fitzpatrick & Hopkins, 1983). Furthermore, studies by Calnan (1988*b*) and Locker & Dunt (1978) have noted that patients display critical attributes when they are encouraged to voice criticisms and concerns in their own terms.

Patients have a complex set of beliefs about satisfaction that are not easily embodied in descriptive statistics. Williams (1994*a*) has pointed out that the reductionism necessitated by a quantitative survey may result in:

> ". . . diverse opinions ranging from 'I've evaluated the service and I'm happy with it' through 'I don't really think I have the ability to evaluate, but I do have confidence in the staff' to 'the service was appalling but I don't like to critcise, after all they're doing their best' being collapsed into a single category of users all of whom expressed 'satisfaction'." (Williams, 1994*a*, p. 514)

At present, the benefits of an atheoretical quantitative methodology may be illusory since the quality of data on *why* (as opposed to whether) patients are dissatisfied is lacking. Implicit assumptions about the way in which patients evaluate are evident in both the design of surveys and the interpretation of results. However, little research exists to support these assumptions and the results from some satisfaction surveys point to the possibility that they may be wrong.

Conclusion

Sensky & Catalan have summed up the *status quo* well:

> ". . . the growing interest in patients' views should be welcomed, comments and questionnaire ratings may not necessarily be adequate end-points in themselves. In clinical audit doctors rightly insist that managers, politicians and others must understand how data are collected to judge their meaning accurately. This principle applies equally to data gathered from patients. The difficulties of interpreting information from patients should not detract from the aim of involving patients as fully as possible in their health care. Rather, this should act as an even greater incentive to research into communications between patients and health professionals." (Sensky & Catalan, 1992)

The success or failure of satisfaction surveys must be measured against their contribution to getting mental health services 'closer to the public'. As we have pointed out, satisfaction surveys are an

inefficient method by which to achieve this. If becoming closer to the public and being people-centred are to be integral objectives of mental health services, the patient's perspective must be understood in greater detail.

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