Assessment of satisfaction with cancer care: development, cross-cultural psychometric analysis and application of a comprehensive instrument
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Chapter 1

Patient satisfaction assessment:
rationale, purposes, meaning and components
I Introduction

Patient satisfaction has attracted increasing attention during the past decades [1]. This issue has become particularly discussed in industrialised countries although several studies on patient satisfaction have been reported in developing nations [2]. Patient satisfaction instruments have been mostly developed and are now routinely utilised in Anglo-Saxon countries [3-5]. Initiatives to elaborate and validate patient satisfaction questionnaires across countries are more recent [6,7].

The present chapter will start with some preliminary considerations aimed at situating patient satisfaction assessment within the context of clinical research and health care quality evaluation. The following two sections of this chapter will address the rationale and purposes of patient satisfaction assessment. The fourth section will cover the theoretical models currently proposed to understand what patients mean in rating their satisfaction with the care provided. The fifth section will highlight the rationale for assessing multiple aspects of care and for involving patients in the elaboration of a patient satisfaction questionnaire. Finally, in the sixth section the motives for developing a new patient satisfaction questionnaire will be specified.

1.1 Preliminary considerations

The evaluation of patient satisfaction emerged in the context of health care quality evaluation. This evaluation has been more recently considered in clinical research. In this latter setting, this variable expands on quality of life assessment.

1.1.1 Patient satisfaction and health care quality evaluation

Traditionally health care quality evaluation was mainly based on objective criteria pertaining to the structure (material and human resources, organisation of care) and process of care (professional activities associated with providing care), and its resulting outcome (e.g.: treatment success rate or complication rate) [8]. More recently this evaluation has also included subjective criteria, such as quality of life or satisfaction with care.

The consideration of patient satisfaction refers to the notion of “social acceptability” as an additional parameter in the evaluation of health care quality [9]. This parameter pertains to the extent to which the health care services or therapies are provided to satisfy reasonable expectations of patients, clinicians and the public.

1.1.2 Patient satisfaction and quality of life evaluation

Patient satisfaction and quality of life are both patient-centred subjective endpoints. Quality of life depends on medical (type and stage of disease, type of treatment) and psychosocial factors (e.g.: coping mechanisms, family support, socio-economic status). Satisfaction with care relies on the different features of the healthcare received (i.e.: the structure of care, process of care, and its resulting outcome).
Whereas health care managers are accustomed to patient satisfaction assessment since a long time, clinicians in contrast are more familiar with the subjective measure of quality of life. The former are especially concerned with ensuring the competitiveness of the health care service, regarding patient satisfaction data as a marketing tool. The latter are rather interested in evaluating the effectiveness of therapies, supplying this assessment with quality of life data.

It is only recently that, in clinical research, clinicians have also found valuable information from patient satisfaction assessment. This variable may be viewed as a significant determinant of quality of life, providing evidence that aspects of treatment modalities constitute an increased burden on quality of life. It has been argued that, among cancer patients and those with other chronic disease, the perceived quality of medical care plays a central part in the patient’s overall evaluation of quality of life [10]. This has been supported in a recent study involving patients with angina pectoris [11]. However, exploring the associations between patient satisfaction and health-related quality of life is complex. There is not necessarily a unidirectional causal relationship between patient satisfaction and clinical outcome. Patient satisfaction may also be seen as a consequence of improved quality of life or health status. Whether greater patient satisfaction lead to better health status or vice versa, and whether these relations are mediated by factors relating to patient’s experience of medical care (e.g.: the provision of adequate information on treatment), are incompletely explored [12].

II Rationale for patient satisfaction assessment

A growing attention has been paid to patient satisfaction assessment over the past twenty years. Several reasons may explain this preoccupation. Firstly, the increasing costs of technologically advanced medicine and resulting concerns for the limitations in health care budget lead to focus on health care quality assessment. Appropriate choices between health care interventions had to be made considering cost and effectiveness. In this respect, patient satisfaction has been accepted as a valid and important endpoint of health care evaluation [13]. From an analytic perspective, it may be viewed both as an outcome measure and as a measure of the structure and process of care and its resulting outcomes (see figure 1). So it may be considered as an objective of care in itself [14] and as a predictor of effectiveness [15]. A patient satisfaction assessment indicates the success of a service in meeting patients’ needs and expectations (i.e.: satisfaction with the results of care). This assessment may also shed light on factors underlying the link between the structure and process of care, and its resulting outcome. For example, patient satisfaction with the interpersonal manner of the physician (e.g.: willingness to listen to the patient’s complaints and to impart information in an understandable way) may be found to relate significantly to the patient’s tolerance of, and compliance with treatment regimen [16]. In the literature, satisfied patients appeared more likely to comply and co-operate with medical treatment, thus favouring treatment effectiveness [17]. Moreover there is some evidence that satisfaction is related to improvement in health status [18].

Secondly, the need for assessing patient satisfaction has emerged in a changing socio-cultural context. Over the past years patients have acquired not only the necessary information but also the opportunities for selecting their health care providers or services. It became crucial for health care providers to evaluate their performance from patients’ viewpoint in order to ensure their competitiveness.
Higher education levels and increased medical information in the population overall have raised patients' needs and expectations of care. The divulgence of medical errors or deficiencies in the health care system also led patients to become more demanding: their expectations may be rising [19]. At the same time, the increasing number of health care providers and services, and treatment options have expanded patients' choices. A more "liberal access" to health care services has been evidenced, which may impact on the viability of a health care service. Satisfied patients tend to praise or recommend the service they attended. In contrast, dissatisfied patients tend to report the real or subjectively perceived deficiencies of the service, and so spread criticisms and bad reputation [20]. If the economic sustainability of health care services depends on patient attendance, and if patients may choose between health care services, then services not performing well on satisfaction aspects may become less competitive.

Thirdly, sociological movement are claiming for more humane care in the face of the increasing weight taken by bio-technological aspects. More humane care refers to patient-centred care, attention to overall physical, psychological and economic needs, completeness of information on illness and treatment options. It also includes properties like respect for individual preferences, promptness of reply, dignity, privacy, involvement of loved ones, attention to comfort. Patients' associations forcefully claim for overall quality of care and services. With regard to the humane aspects of care, an assessment of patients' opinion conveys a perspective that objective sources of information, such as hospital records, could not provide.

So, different reasons motivated the dissemination of patient satisfaction surveys. Among these, the need for identifying effective interventions accounting for patients' viewpoint, and the increasing role taken by health care users and patients' associations in claiming for overall health care quality, have been underlined.

### III Purposes of patient satisfaction assessment

In health care evaluation, Coulter (cited in Sitzia et al. [1]) argued for at least four fields of evaluation: 1) the evaluation of specific treatment (e.g.: drug therapies or surgical procedures); 2) the evaluation of patterns of care for particular patient groups (e.g.: the organisation of the care of patients with
chronic conditions); 3) the evaluation of organisation (e.g.: a hospital or a day centre); 4) the evaluation of health care systems (different models of health care delivery). Similarly, a patient satisfaction assessment may take place in clinical research, clinical practice, hospital management, and in the evaluation of health care service delivery or health care systems (see table 1). Expected results from these surveys consist in measuring treatment ‘acceptability’, identifying sources of dissatisfaction or motives for non-compliance to treatment, and generating databases for comparative assessment and benchmarking. Expected output of patient satisfaction assessment involves the selection of best treatment, prioritising of improvement initiatives, and the implementation and monitoring of enhanced or alternative interventions, pattern of care, services or care organisation.

Table 1. Purposes of patient satisfaction assessment

<table>
<thead>
<tr>
<th>Fields of patient satisfaction assessment</th>
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<tr>
<td>1. Clinical research</td>
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<tr>
<td>(treatment, medical test, pattern of care or psychosocial intervention)</td>
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<td>2. Clinical practice (including clinical encounter)</td>
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<td>3. Hospital management (within an institution)</td>
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<td>4. Evaluation of health care systems (modes of health care delivery across institutions)</td>
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Expected results

1. Establishing optimal treatment acceptability
2. Identifying sources of dissatisfaction
3. Identifying motives of non-acceptance, non-compliance to treatment regimen or drop-out from treatment protocol
4. Generating database for comparative assessment
5. Generating database for benchmarking

Expected output

1. Selecting treatment
2. Setting priorities for resource allocation
3. Implementing and monitoring enhanced or alternative care interventions, programs, services or organisation

3.1 Patient satisfaction in clinical research

In clinical research or trials, a patient satisfaction assessment may be part of the evaluation of: 1) a specific treatment or medical test (e.g.: drug therapies, vaccines, prosthesis, medical devices, surgical procedures), 2) psychosocial interventions, or 3) patterns of care for a specific health condition (e.g.: management of pain, psychiatric disorders, diabetes, rheumatoid arthritis).

In evaluating a treatment, medical test or psychosocial intervention, patient satisfaction may constitute a further endpoint for judging efficacy. This evaluation may provide information on the extent to which a specific outcome (e.g.: cure of illness or symptom relief) has been reached. Besides information on levels of patient satisfaction may convey useful information on the treatment or
intervention acceptability or on its burden on patient’s quality of life (e.g.: regarding the length, location or mode of delivery of treatment or intervention).

For example, the measure of patient satisfaction is increasingly used in the evaluation of pain treatment [21] or surgical interventions [22,23], as well as in the assessment of psycho-social interventions: specific programs aimed at enhancing providers’ communication skills [24], improving patients’ retention of medical information [25], participation in medical decision making [26] or rehabilitation [27].

In the comparison of patterns of care for patients with a specific health condition, patient satisfaction assessment has been applied for the evaluation of a pluri-disciplinary team taking care of oncology in-patients [28], or patterns of care for individuals at higher genetic risk of developing cancer [29,30].

3.2 Patient satisfaction in hospital management and clinical practice

Many patient satisfaction surveys are now performed in medical institutions, mainly in hospitals. Initially, collecting patients’ satisfaction data may frighten health care providers. It may point to differences in their level of performance. However, these surveys present strategic information for shaping the provision of health care and improving the attractiveness of the institution. As primary witness of care, patients may provide valuable perspective on the health care institution performance. The data they provide through surveys may elicit important suggestions, identify hidden problems and document the impact of efforts done to improve the quality of care [31]. For example, service quality in health care (level of waiting, inconvenience) and in particular, interpersonal aspects of the patient-clinician interactions (unanswered questions, unclear explanation) have been shown to deeply pervade patients’ experience of care [32]. Care outcomes are affected by aspects such as delays in diagnosis, limited consideration of patient’s all concerns. Organisation managers may focus on these aspects for care improvement and resources allocation.

In clinical practice, patient satisfaction assessment is increasingly used in assessing consultations and patterns of communications [18]. This evaluation may sensitise clinicians to patients’ concerns and allow them to better meet their needs. If shared in the consultation, these data facilitate more effective communication. They may lead to strategies for helping patients form more reasonable expectations of care and to promote adherence or co-operation to treatment by confronting motives of dissatisfaction.

3.3 Patient satisfaction in the evaluation of health care systems

In the evaluation of service delivery organisation, satisfaction with care may be considered in an analysis of the costs and benefits of different programmes. For instances, accelerated discharge after breast cancer surgery has economic advantages [33]. But short hospital stays may also induce feelings of abandonment or confusion affecting patients’ quality of life. The insufficient provision of information on self-care at home, the difficulty to contact specialised hospital doctors or nurses in case of need may have detrimental impact on patients’ satisfaction. Hence, the net result could be that the cost-benefit of accelerated discharge may not be so advantageous once patient satisfaction and its impact on quality of life has been taken into account. An evaluation of patients’ satisfaction with the various aspects of care may provide evidence of patients’ unmet care needs, and help to identify points
that could be eventually responsible for the failure of projects that at first sight, conveyed medical and economical advantages.

Further examples may be found in other health care settings, with regard to the assessment of the respective advantages of home care or hospital care for terminally ill patients [34]; of minimal versus intensive follow-up after cancer treatment [35,36].

Besides, initiatives have also been taken to evaluate patient satisfaction across health care systems (e.g.: managed care, primary care). In this context, the evaluation of patient satisfaction may provide overall information against which a particular health care system (e.g., a social security office) or component (e.g., a hospital, a large outpatient service) may assess its own performance by comparison to other systems or components. Large database of patient satisfaction ratings may be constituted for comparative assessment and benchmarking (e.g.: the determination of threshold satisfaction ratings that may prompt quality improvement initiatives or alternative health care system).

Third party payers such as private insurance organisms or social security may well become sensitive to these patient satisfaction data, particularly when patients may make a choice between health insurance companies or programmes, or between social security institutions.

It should be noted that efforts to evaluate patient satisfaction with health care systems across nations need standardised patient satisfaction instruments that take into account cultural peculiarities in terms of patients' expectations and values. For example, Calnan et al. [7] undertook a study aimed at elaborating a standardised patient satisfaction instrument for monitoring primary care in different countries. Initial steps for this enterprise consisted in selecting relevant aspects of care across countries to compose the patient satisfaction questionnaire, and in determining the relative weight of each aspect of care for patients' overall satisfaction.

To sum up, the different purposes of patient satisfaction assessment consist in: 1) assessing treatment acceptability, 2) identifying sources of patients' dissatisfaction, motives of non-compliance to treatment, 3) establishing databases for benchmarking and comparative assessment. Fields of application of this assessment include the evaluation of treatments, patterns of care, care service delivery or health care systems.

IV Meaning of patient satisfaction

Different conceptual models have been proposed to capture the meaning of patient satisfaction. However it is still difficult to understand this concept and to apprehend what patients mean when they say they are satisfied with a particular aspect of care. In fact, the assessment of satisfaction with care is more complex than the assessment of satisfaction with any other service. Firstly, patients' expectations and needs for health care are multiple. As stated by Leebov et al. [20], "whereas in hotels, the personnel only needs to be sympathetic and helpful, in health care services, providers need to be precise, skilful, safe, caring, responsive, gentle, quick, and a lot more...". Secondly, the interactions between patients, health professionals and services are complex. The dependency, uncertainty and anxiety involved in these interactions are likely to influence patients' judgement. It is thus difficult to propose a simple definition of this concept and straightforward criteria for its assessment.

According to Wilkin et al. [37], different conceptual questions may be raised: what does 'patient satisfaction' mean?; what is the relationship between patients' experience, expectations and satisfaction ratings?; what are the appropriate objects (components) for assessing satisfaction with care?

Common definitions of the word 'satisfaction' highlight the ambiguity of this term, not only speaking of the English meaning, but also of its meaning in other languages. Just contemplating the
English word, one definition consists of the ‘fulfilment of desire or need’ or the ‘ample provision for desire or need’. The patient is supposed to be satisfied if he feels that his or her desires or needs have been met. However, another usage of the word carries associations with the term ‘satisfactory’, meaning adequate or acceptable, where satisfaction implies only the achievement of a basic minimum standard.

Simply stated, patient satisfaction may be defined as a patient’s personal subjective evaluation of the care received, which is both a reflection of care realities and of patient characteristics.

Among most conceptual models suggested to grasp the notion of patient satisfaction, ‘expectations’ appear to play an essential role. Patient’s care expectations refer to his/her anticipation that a specific care event is appropriate. Based on attitude theory and job satisfaction research, Linder-Pelz [38] hypothesises five socio-psychological variables which affect satisfaction ratings: 1) the expectations which are beliefs about the probability of an attribute being associated with an event; anticipated occurrence; or perceived probable outcome; 2) the values which are evaluations in terms of good or bad, important or unimportant, of an attribute or an aspect of a health care encounter; 3) entitlement which is an individual belief that she or he has proper, accepted grounds for seeking or claiming a particular outcome; 4) occurrences which refer to events which actually take place or the individual perception of it; 5) interpersonal comparisons which pertain to the individual’s rating of what takes place in the health care encounter by comparing it with all other such encounters known or experienced by him/her.

Entitlement and interpersonal comparison are further considered as types of expectations. From an analysis of these variables, Linder-Pelz [38] proposed a ‘value-expectancy model’ where patient’s expression of satisfaction is defined as “the expression of an attitude, an affective response, which is related to both the belief that the care possesses certain attributes and the patient’s evaluation of those attributes”. Thus satisfaction is supposed to be based on beliefs (expectations) strength and evaluations of dimensions of care.

Oberst [39] expands and applies this framework in the oncology field. She suggests that patients determine their own needs of cancer care on the basis of a variety of personal characteristics, attitudes, and prior experiences, coupled with the knowledge and information they receive from healthcare professionals. From these factors, a set of expectations about care outcomes, caregivers behaviour, and the performance of the system is formed. These expectations form in turn the subjective standard against which care actually received is judged to be satisfactory or not satisfactory.

Similar conceptual frameworks involving the concept of expectations include a ‘fulfilment model’ and a ‘discrepancy model’ whereby satisfaction corresponds to the difference between what occurs and what should be/has expected/has desired [38].

A slightly different theoretical conception is suggested by Fitzpatrick [40]. Whereas Linder-Pelz [38] focuses on expectations and values as linked determinants of satisfaction, Fitzpatrick [40] suggests three independent determinants of satisfaction: 1) the socially created expectations; 2) the goal of help-seeking; 3) the importance of emotional needs. Firstly, socially created expectations would be the primary determinant of the degree of satisfaction, explaining cultural differences in the degree of satisfaction perceived toward a particular health care service. Secondly, the major concern of patients would not be ‘satisfaction’ but some resolution of their health problem. Satisfaction surveys should thus integrate an evaluation of patients’ perception of change in health status although this is rarely considered. Thirdly, the emotional component of health care provision is stressed. Many health care problems encompass feelings of uncertainty and anxiety in patients. This theoretical position argues that patients’ evaluation of care is significantly conditioned by their impression of the affective component of the medical encounter.

According to Pascoe [41], most satisfaction with care studies implicitly favour the ‘discrepancy model’ which is based on the difference between expectations and perception of care received, weighted by the importance of expectations. However the relationship between expectations and satisfaction is not straightforward. For example, testing the ‘value-expectancy model’, Linder-Pelz [42] found that expectations, values and perceived occurrences taken together only accounted for 10% of the explained variance in satisfaction, even if expectations appeared the strongest predictor.
More recently assumptions about the role of expectations and values in patients’ expressions of ‘satisfaction’ have been questioned [43]. While most satisfaction surveys report high satisfaction levels, patients’ unmet care needs are frequently observed. These discrepancies have elicited doubts on the validity of satisfaction survey results. For example, a study on patients’ satisfaction with pain treatment highlighted high levels of satisfaction whereas 28% of the patients still experienced intense pain after medication and more than 48% of these patients had to wait at least 15 minutes before receiving pain treatment [44].

The interpretation of satisfaction as an outcome of an active evaluation by patients based on expectations and values, had to be revised. Through in-depth interviews, Williams et al. [45] evidenced that health care users can provide detailed descriptions of their care experiences and attribute a value to it. However, he observed that experiences described by users in positive or negative terms did not necessarily correlate with the user’s evaluations of the services which produced those experiences. Negative evaluations of services could only be provided when users also perceived the notion of duty and culpability associated to their negative care experience. According to Williams et al. [46] expression of satisfaction may more often reflect attitudes such as “they are doing the best they can” or “well, it is not really their job to do...” Dissatisfaction would only be reported when the user believes that the service or provider has failed in its “duty” and that it or he/she has no excuse for that.

In attempting to explain what patients mean when they express a certain level of satisfaction, the above conceptual models mainly deal with socio-psychological determinants. However satisfaction ratings may also be affected by patients’ socio-demographic or health variables. Besides patients’ evaluations of care are expected to account for the quality of attributes of health care providers and services. This makes the relevance of patient satisfaction assessment for quality of care evaluation.

Considering both patients’ characteristics and attributes of health care providers and services, according to Ware et al. [3], differences in satisfaction would substantially account for the realities of care, although these differences might also represent patients’ preferences and expectations.

So far, the term ‘patient satisfaction’ is still poorly defined and the interpretation of satisfaction ratings remain confused. In an attempt to explain what patients mean when rating their satisfaction with the care received, different theoretical models have been proposed, involving expectations and values. However, considering the over-reported high satisfaction levels in most surveys, it was suggested that dissatisfaction be only expressed when an extremely negative event occurs.

V Components of patient satisfaction

5.1 Taxonomies of patient satisfaction

The following section addresses the components (or attributes) of care which are suggested, according to empirical studies, to play a significant role in patient satisfaction ratings. As highlighted above, there is a lack of theoretical underpinning for the concept of satisfaction; clear indications for interpreting satisfaction ratings are still needed. In contrast, much empirical work has been performed to determine the underlying components or, as in the Wilkin’s question mentioned above, the ‘objects’ of satisfaction with care assessment. The main objective in patient satisfaction research was in fact to design questionnaires or scales for providing information of practical use for administrators, practitioners or consumer groups.
Researchers have initially considered satisfaction as a global concept to be measured by a single item (e.g. 'How satisfied are you with the medical care you received?') [46]. In the eighties, there has been a growing consensus that satisfaction with care is a multidimensional construct necessitating the use of multi-item scales [3,47,48]. There has been some evidence that patients develop distinct attitudes towards the different characteristics of providers and health care services [3]. Moreover a single item raises questions about which facets of satisfaction respondents are rating. Finally, considering the over-reporting of high satisfaction levels in satisfaction surveys, it has been recommended to assess detailed and specific aspects of care rather than global questions in order to ensure greater response variability [1]. Thus it appeared more valid and relevant to consider the concept of satisfaction as multidimensional. But, which objects of care (dis)satisfaction it is appropriate to measure?

If the concern is to assure or improve the quality of care including the perspective of patients, theoretically patients' viewpoint might be searched for the same criteria as those utilised in quality of care evaluation: i.e., the different aspects of the structure and actual provision of care, and its resulting outcomes for the patient. Different classifications of care components have been proposed for the context of general practice or medical specialities; ambulatory or hospital care; out-of-hours or emergency services. These taxonomies have lead to various measures assessing specific dimensions of care.

For assessing characteristics of doctors and medical services, Ware et al. [3] developed a comprehensive taxonomy based on literature review and empirical studies. They identified eight major dimensions: 1) interpersonal manner (e.g.: concern, friendliness, courtesy, respect); 2) technical quality of care (e.g.: thoroughness, accuracy); 3) accessibility/convenience (e.g.: time and effort required to get an appointment, waiting time at office, ease of reaching care location); 4) finances (e.g.: reasonable costs, comprehensiveness of insurance coverage); 5) efficacy/outcomes of care (e.g.: helpfulness of care providers in improving or maintaining health); 6) continuity of care (e.g.: see same physician); 7) physical environment (e.g.: cleanliness, comfort, pleasantness of atmosphere); and 8) availability (e.g.: enough hospital facilities or providers in an area).

For evaluating patients' perception of hospital performance, Rubin [49] listed seven aspects as important components of patients' hospital experience: 1) admission; 2) nursing care; 3) medical care; 4) communication; 5) other staff, service and care; 6) living arrangements; 7) discharge procedure. In developing satisfaction scales for use in the context of home care for chronically ill, McCusker [50] proposed seven subscales: 1) general satisfaction, 2) availability of care, 3) continuity of care, 4) physician availability, 5) physician competence, 6) personal qualities of physician, and 7) communication with physician.

In the oncology field, Loblaw et al. [51] developed a patient satisfaction questionnaire for the oncology out-patient medical consultation and identified four domains of patients' perceptions toward the doctor's behaviour: 1) information exchange, 2) interpersonal skills, 3) empathy; 4) quality of time. Sitzia et al. [52] established six distinct components of care to assess patients’ satisfaction with nursing care in the context of ambulatory chemotherapy: 1) interpersonal aspects of care; 2) technical aspects of care; 3) patient education, 4) multidisciplinary teamwork; 5) treatment environment and 6) hospital accessibility.

5.2 Relation between patient satisfaction components

Although present consensus is on the use of multi-item scales for measuring patient satisfaction, patients' evaluations of the different aspects of care appear often strongly correlated [13]. More specifically, whether patients distinguish between the personal qualities and the technical aspects of care has been much debated. It has been suggested that patients' judgement of the technical skills is largely determined by patients' views of the extent to which the doctor was friendly and reassuring. In
their initial work, Ware et al. [48] considered that measures of attitude toward caring (humaneness) and curing (quality/competence) aspects of the doctors' conduct appeared to reflect the same underlying attitudinal dimension. Other researchers also included the art and technical aspects of care within one dimension [53] whereas Hulka et al. [54] made a clear distinction between the personal qualities and the professional competence of providers. In analysing her scales, McCusker [50] found that the three sub-scales measuring physician competence, personal qualities and communication, did not perform well in terms of discriminant validity (i.e.: the extent to which items expected to pertain to one care dimension more strongly relate to that dimension than to a dimension supposed to refer to another care dimension).

The influence of a strong 'halo effect' (i.e.: the tendency to allow an overall impression of a person's particular outstanding trait to influence the total rating of that person) has been raised to explain the high correlation obtained in the assessment of patient satisfaction with providers' interpersonal and technical skills [55], questioning the accuracy of measuring separately these care dimensions which are not clearly independent. Considering that more recent empirical work on patient satisfaction [51] identified clear factors for the technical, interpersonal and even empathy of providers, it may be that patients can make a distinction between dimensions when the item they are rating is clearly designed to reflect such a distinction.

A further issue concerns patients' ability to assess some dimensions of care. Whether patients are capable to assess the technical skills of providers has been questioned. Patients might be influenced by the quantity and complexity of the technical process for their assessment of the technical competence of providers. However there is some evidence that patients are generally good at assessing the technical aspects of care or have a reasonable level of medical knowledge. Reviewing the literature, Rubin [4] concluded that most studies have found that staff and patient evaluations concur with regard to quality of care.

5.3 Importance of patient satisfaction components

Apart from deciding that patient satisfaction encompasses multiple components, researchers have also underlined the importance of involving patients in selecting objects toward which (dis)satisfaction might be measured. It has been stressed that in the evaluation of care quality, patients can play an important role in defining what constitutes care quality [13]. However measures of patient satisfaction have rarely been constructed on the basis of patients' expressed priorities. They have been primarily elaborated according to clinicians' or health care managers' agenda. As a result, organisational aspects of the service and amenities (e.g.: food, parking, cleanliness) have often been the focus although these aspects might not be considered as so important by patients [56].

This is illustrated in the following research works. In an American study where outpatients at a urban hospital had to rank six components of care, the most important dimension of care was found to be the behaviour of doctors and nurses, followed by clinical outcome [41]. In an English study, the specific criteria which yielded the highest association with overall satisfaction scores had more to do with the nature and quality of the doctor-patient relationship than with availability and accessibility [57]. In an international study, patients in different cultures or health care systems were found to present a broad consensus on the importance of aspects concerning the doctor-patient relationship, information and support, availability and accessibility [58]. Different views according to cultural background appeared with regard to the priority of care aspects in relation to the provider's role, such as relieving symptoms or preventing disease. In the context of ambulatory cancer care, Wiggers et al. [59] highlighted the following aspects of care as being most important to patients : the technical quality of medical care, the interpersonal and communication skills of doctors, and the accessibility of care.
5.4 Selecting issues for assessing patient satisfaction

So far, a broad consensus has been established on the need to consider multiple aspects of care in measuring patient satisfaction. Patients appear capable of differentiating aspects of care although their evaluation of each of these may be highly correlated. The importance of involving patients in the selection of issues for the construction of a patient satisfaction questionnaire has been underlined. If this condition is not satisfied, the identification of important care deficiencies from patients' perspective may be compromised.

Thus, various taxonomies of patient satisfaction have been elaborated depending on the context and objective of assessment. There is a consensus that measures of patient satisfaction should consist of multiple items, since a multidimensional assessment provide greater score variability and clear indications for prioritising care improvement. These items should also be relevant to patients. Across cultures and health care settings, the importance of the care provider-patient interaction has been underscored.

VI Motives for the development of a patient satisfaction questionnaire for cancer patients

6.1 Why is satisfaction with care so important for cancer patients?

Cancer is a disease that is likely to considerably affect a patient's well-being. Even if the cancer is of good prognosis and exempt of aggressive therapy (e.g.: a small cutaneous melanoma, or an intra-epithelial lesion of the uterine cervix), this diagnosis entails psychological distress. It labels a subject as being a "cancerous patient", which may have a dramatic effect on his/her psychological and social well-being. When a cancer is of uncertain prognosis, it often necessitates therapies that encompass unpleasant and debilitating side-effects. The threat of death and the impact of treatment on overall patient's life is still more distressing. Different studies conducted these last decades revealed that pathological levels of distress were highly prevalent in oncology: figures range from 2% to 46% for anxiety, 6% to 42% for depressive and 32% to 52% for adjustment disorders [60-69].

The recognition of the considerable impact of cancer and its treatment on all facets of cancer patient's life has emphasised the need for improving their global care. Global care refers to the consideration of the multidimensional aspects of health, i.e.: the physical health, mental health, social and role functioning [70]. Human aspects of care are underscored in face of the increasing weight taken by bio-technological aspects of medicine. This approach is particularly relevant in the field of cancer. In a recent study, compared to other chronic illnesses, cancer and its associated conditions was found to significantly damage patients' quality of life [71].

However, cancer patients' global care has evidenced shortcomings. Unmet care needs have been highlighted in a significant number of them [72,73], not only with regard to their need for medical information [74,75] but also for psychological attention [76,77].
Additionally, various reports showed dissatisfaction with care in oncology [78-84]. Cancer patients appeared less satisfied with aspects of their interaction with providers (e.g. information provision, attention to psychosocial needs). Lower levels of satisfaction have also been noted concerning features of care organisation, in terms of continuity (e.g.: exchange of information between hospital specialists and general practitioner or home care nurses), or of waiting time for receiving medical tests results, or for obtaining medical appointments.

The development of a patient satisfaction questionnaire for cancer patients originates from the need to assess care improvement initiatives that are primarily intended to attenuate the burden of cancer and its treatment on patient’s well-being. For this purpose, a subjective measure of patient satisfaction was found to be particularly appropriate.

6.2 Why develop a new cancer patient satisfaction questionnaire?

In the literature we did not find a standardised comprehensive patient satisfaction measure that could be used for assessing cancer patients’ subjective perception of the quality of care provided in hospitals. In order to achieve its purposes (i.e. highlight care deficiencies, assess and monitor care improvement initiatives across oncology hospital settings), the questionnaire that was needed should contain sub-scales that: 1) represent major components of the care provided in oncology hospitals; 2) reflect issues perceived as relevant to cancer patients; 3) are applicable across settings; and 4) demonstrate evidence of reliability and validity.

However, as shown in table 2 existing cancer patient satisfaction instruments are generally designed for a specific care context. As a result, they usually contain a limited number of care aspects. Moreover their mode of construction (wording of questions and response scale) vary. This prevents comparison of their results, and their use in collaborative research so as to define actions that may be implemented across settings to improve cancer patients care.

A last issue motivated the elaboration of a new cancer patient satisfaction questionnaire. Patient satisfaction instruments generally result in highly skewed score distributions owing to over-reporting of elevated satisfaction levels. This lack of response variability impairs the identification of different levels of satisfaction and the monitoring of care improvement programs. Socio-psychological artefacts may explain the report of high satisfaction levels [1]. In cancer patients, for example, the reluctance to complain for fear of unfavourable treatment in the future might be of particular importance. Alternative methods for minimising these artefacts and eliciting more valid reports of satisfaction with care had thus to be tested.

Thus, the identification, in oncology, of unmet care needs and dissatisfaction emphasises the need to improve care in this setting, and so assess and monitor this endeavour. However we did not find a standardised comprehensive questionnaire that could be used for assessing patient satisfaction in the oncology hospital. This prompted the present work, the development and validation of such a questionnaire across different countries.
Table 2. Patient satisfaction questionnaires developed in the oncology field

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<th>Medical consultation</th>
<th>Health care service</th>
<th>Population survey</th>
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<td>Mammography clinic*</td>
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* Authors provided some evidence of reliability and validity

References


Patient satisfaction assessment: rationale, purposes, meaning and components


