

# Factors affecting patients' ratings of health-care satisfaction

Marianne K. Thygesen<sup>1,2</sup>, Marie Fuglsang<sup>2</sup> & Max Mølgaard Miiller<sup>3</sup>

## ABSTRACT

**INTRODUCTION:** Surveys that include rating scales are commonly used to collect data about patients' experiences. We studied how patients associated their ratings with their experiences of care.

**METHODS:** A survey and a qualitative study were conducted at a Danish hospital. Initially, 19 female patients completed a questionnaire using the response categories from very good to very bad; and subsequently they participated in a semi-structured interview held within two days of they completed the questionnaire. Additionally, 44 female patients participated in an interview within six weeks of completing a questionnaire. A phenomenological-hermeneutical approach was used in the analysis and interpretation.

**RESULTS:** Two major themes emerged: experienced versus expected clinical quality and health-care professional attitude. Patients responded to each question by combining their experiences of both themes, e.g. a "very good" experience required that clinical service was provided at the expected level, at the very least, and that it was provided with recognition and respect.

**CONCLUSIONS:** The female patients associated their experiences with their ratings, and two types of relation seemed to be at play: a care relation and a human relation. This finding can inform health-care practice, but department-specific examples may be needed to initiate improvements.

**FUNDING:** The study received funding from the Centre for Patient Experience and Evaluation, Copenhagen, Denmark. The Danish Scientific Ethical Committees deemed it unnecessary to be involved in this project.

**TRIAL REGISTRATION:** The Danish Data Protection Agency number of this study is 2008-58-0035.

Patient surveys are commonly used in Western countries to evaluate patients' experiences. However, to achieve the political goal of higher levels of patient satisfaction and greater patient influence on professional care, it is crucial to understand the motives involved in patients' ratings [1-4].

Surveys often include a Likert response scale. Response categories may, e.g., range from very good to very bad or from agree to disagree [3, 5]. Thus, a Likert scale presents a way to capture the relative intensity of the patients' emotions. When results of surveys with closed response categories were supplemented with

subsequent semi-structured interviews, it became clear that questionnaire responses were too positive relative to the interview results [6]. These studies, however, were conducted between ten and 20 years ago and only in England. Additional space for comments is now generally used [6]. In the present study, which is based on a Danish questionnaire, the aim was to find out how patients associated their experiences of care which was rated on a Likert scale with the categories very bad, bad, good and very good.

## METHODS

Patients' references for ratings in a Danish national questionnaire were explored employing a phenomenological-hermeneutical approach. Participants were adult outpatients who had recently been discharged from a department for women's conditions in a public Danish university hospital. Healthy women giving birth were excluded.

The aim of the questionnaire [5] was to measure patients' experiences of the health-care system and included space for comments. For our research purpose, questions about the patient's general practitioner and overall experiences were omitted from the national survey [5]. This article focuses on the ten questions that required responses on a scale ranging from very good to very bad, or from very well to very poorly. In Danish language, the latter scale also translates into the equivalent of very good to very bad; therefore, we will refer only to the very good to very bad scale in this article. These questions addressed issues relating to information, reception, staff preparedness, collaboration between care units, treatment process and management, and the handling of errors. Patients completed questionnaires during two randomly chosen weeks in 2011 and placed them in one of several mailboxes on the ward. In order to reduce recall bias and increase diversity in our subsequent sample, the mailboxes were emptied repeatedly, and patients who agreed to participate in an interview were divided into groups according to the care unit they visited. Patients were chosen randomly within these groups and many were interviewed [7] before they left the hospital. Additionally, in order to further verify our results in our own context, we continued to conduct as many interviews as possible for another six weeks.

## ORIGINAL ARTICLE

1) Institute of Clinical Research, Faculty of Health Sciences, University of Southern Denmark

2) Department of Gynaecology and Obstetrics, Odense University Hospital

3) Centre for Patient Experience and Evaluation, Centre for Health, The Capital Region of Denmark

Dan Med J  
2015;62(10):A5150

 FIGURE 1

Interview guide.

Would you elaborate on what made you choose the actual response categories in the questionnaire at the women's department?  
Please focus on the categories that have ratings from very good to very bad or from very well to very poor.

**[Possible additional questions.**

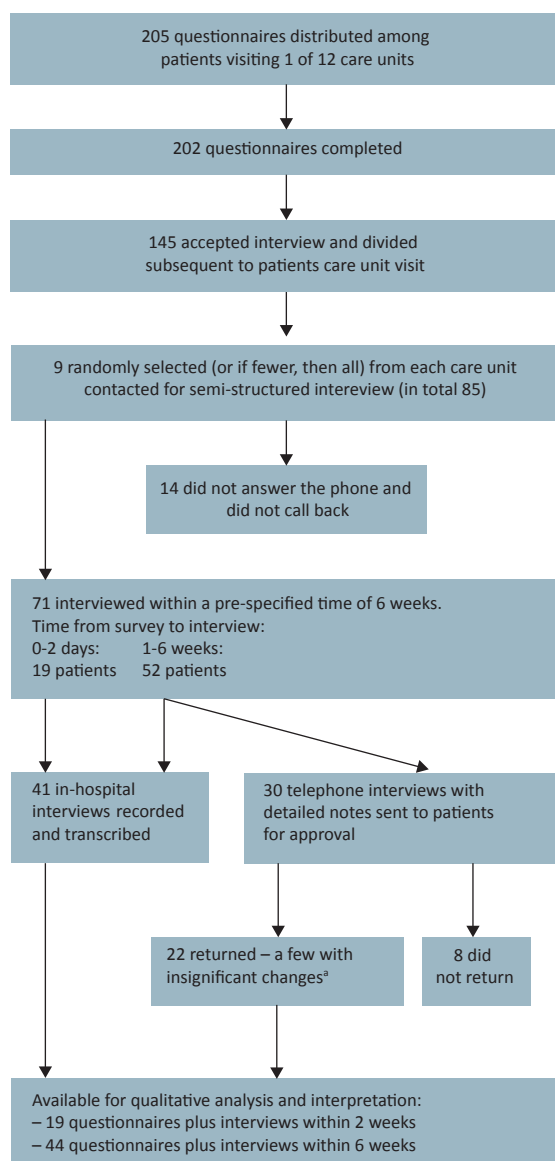
- What made you choose the response category you chose?
- What service would you have needed to receive in order to choose a different response category?]
- ... and clarifying questions.

If a) is not possible to answer, b) and c) is not addressed. Instead:

- What did you experience during your visit to the hospital unit?
- How did you feel about that?
- Why?
- ... and clarifying questions.

 FIGURE 2

Flow of data.



a) E.g. changed the order of the text or made limited supplementary comments.

We preferred face-to-face interviewing in a quiet setting, but telephone interviews were accepted on the patient's request. Moreover, we also accepted if patients preferred to be interviewed without being recorded, and their validation of the interview notes was subsequently obtained within ten days. The patient's completed questionnaire served as the starting point of the interview, followed by prompt questions (**Figure 1**). Fully recorded and transcribed interviews/patient-validated notes and the accompanying completed questionnaire were analysed and interpreted using an abductive process inspired by Paul Ricoeur [8, 9]. The process includes the following levels: 1) an overall, inductive interpretation in which all data were read as one whole text (a naïve reading). This led to 2) a structural analysis, which ran in a dialectical fashion between what was said (the actual words in the text) and what was talked about (a structure of units of significance) and included only the interviews from the first two weeks. This process allowed themes to be generated. Thereafter, 3) a deductive process was applied in which the convergence between the themes and the whole text was investigated. These three steps were repeated until the structural analysis validated a naïve reading without contradictions, and before the themes were discussed in relation to relevant literature.

### Ethics

Patients were informed verbally about the study, either by secretaries or by the first author. They were given a blank questionnaire, an information sheet and an invitation to participate in both the survey and in an interview about their experiences at the hospital. The study adheres to the Declaration of Helsinki [10]. The Danish Scientific Ethical Committees deemed it unnecessary to be involved in this project.

**Trial registration:** The study's Danish Data Protection Agency number is 2008-58-0035.

### RESULTS

Participants aged between 21 and 80 years completed the questionnaire. In total, 202 questionnaires were returned, and 19 patients were interviewed within the two survey weeks (duration 15-17 minutes). Additionally, we conducted 44 interviews within six weeks (average duration 16 minutes) (**Figure 2**). In the analysis and interpretation, two key themes were identified that relate to patients' rating of their health-care experience: 1) the quality of the clinical service, which comprised both timeliness, and expected and experienced professional service, but not the professionals' attitude and, 2) the health-care professionals' attitude where key factors were the patients' experience of recognition and re-

spect. Recognition and respect encompass feelings of being acknowledged, listened to, heard and accommodated, taken seriously, valued, and that nothing is done that would be upsetting. The themes are outlined in **Table 1** and will be elaborated upon in the following section.

### The quality of the clinical service

Exemplary clinical service was experienced when professional services were received in a timely fashion and at the expected level. This was experienced reported by those who rated the care as very good. The rating

“good” related to two different situations: either an exemplary clinical service or a dip in exemplary clinical service. An example of the former is the case in which a physician was not aware of being in earshot of the waiting patient at the outpatient clinic:

“The reception was good. The secretary was nice and quickly told me what I needed, and the physician smiled at me and shook hands with me. But I heard the physician I should have met say that he didn’t have the time for an examination and asked his colleague to do it. I felt like a number”.

An example of a dip in exemplary clinical service is



TABLE 1

Patients’ reference for rating – excerpt of the analysis and interpretation.

What was said, examples <sup>a</sup>	What was being talked about	Themes
<p><i>Patient marked: very good collaboration between care units</i></p> <p>“What they told me would happen at the new department actually did happen even on time, and the staff were very kind, accommodating, and in a good mood. Nothing was missed”</p>	<p>Very good service includes exemplary clinical service<sup>b</sup> and recognition<sup>c</sup> and respect<sup>d</sup></p>	<p><i>The quality of the clinical service, assessed in terms of Timeliness</i></p> <p>Expected and experienced professional service (within collaboration between hospital units, treatment process and management, information, staff reception, preparedness, and the handling of errors, but excluding act of attitude)</p>
<p><i>Patient marked: very good treatment process and management</i></p> <p>“I was taken seriously and that was a nice experience. I was quickly transported to the university hospital and when we arrived I went in ahead of all the others. The staff was so nice to me and my husband. They were genuinely interested in us. Indeed, they gave me excellent help like they should on a university hospital”</p>	<p>Good service includes exemplary clinical service<sup>b</sup> and poor recognition<sup>c</sup> and/or respect<sup>d</sup></p> <p>or</p> <p>Good service includes recognition<sup>c</sup> and respect<sup>d</sup> and has a dip from exemplary clinical service<sup>b</sup></p>	
<p><i>Patient marked: good reception</i></p> <p>“The secretary and the nurse were fantastic: nice, listened well and informative like they should. The nurse was fine too, but I told her things because I thought she was “my” nurse. I did not see her again. This was very awkward. She could have told me that she would be off duty. How many know my secrets?”</p>	<p>Bad service includes poor recognition<sup>c</sup> and respect<sup>d</sup> and has a dip from exemplary clinical service<sup>b</sup>, but this dip is corrected (or expected corrected)</p>	<p><i>Attitudes of health-care professionals, assessed in terms of Recognition<sup>c</sup> Respect<sup>d</sup></i></p>
<p><i>Patient marked: good written information</i></p> <p>“I did not receive written information about the treatment as I should have. I got it at discharge from the care unit. However, the staff informed me verbally and had huge human warmth and respect and I used what I knew from the other hospital and managed”</p>	<p>Very bad service includes poor recognition<sup>c</sup> and respect<sup>d</sup> and had a dip from exemplary clinical service<sup>b</sup>, but this dip was not corrected (or was not expected to be corrected)</p>	
<p><i>Patient marked: bad preparation</i></p> <p>“The physician asked me about times for investigations for which he had and ought to know the results. He then found the times himself. He was sort of absent-minded”</p>		
<p><i>Patient marked: bad verbal information</i></p> <p>“Physicians must be knowable. I got imprecise information from mine and I had to call the ward later to get answers. They are too busy for me. They don’t listen. You have to fight to be taken seriously”</p>		
<p><i>Patient marked: very bad preparation</i></p> <p>“Before removal of my epidural catheter, the nurses and physicians asked me if I had pain, but after the removal they never asked again. They didn’t even address possible pain at a planned conversation. I do not think this is all right. I think they didn’t care”</p>		

a) Examples are chosen from different questions in the questionnaire in order to show the common features in the underlying experiences.

b) Exemplary clinical service is achieved when the professional service is received timely and, as minimum, has the expected extent.

c) Recognition encompasses feelings of being acknowledged, listened to, heard and accommodated.

d) Respect encompasses feelings of being taken seriously, valued, and that nothing is done that would be upsetting.



Recognition and respect encompass the feelings of being acknowledged, listened to, heard and accommodated, taken seriously, valued, and that nothing is done that would be upsetting.

the case where a patient met an unprepared physician, but the patient valued his preparation effort as good:

“Physicians should be prepared, but mine did not know me or my condition. That is bad, but a nice nurse took the time to tell me beforehand that several physicians were on sick leave. I felt it was OK in that case that the physician simply asked me about my condition. That was the quick way to get prepared”.

Patients’ expectations of clinical service included, e.g., being registered and informed swiftly so that they could prepare themselves for the upcoming situations, and receiving information when they asked for it, at the latest. They expected professionals to read up on their case before a meeting and to manage the course of treatment and care without errors, delay or loss of information. In situations that were judged as bad, the clinical service was not offered in a timely fashion, but still it was offered; and in very bad situations, patients left the hospital without faith that they would receive the service in question. For further examples, see Table 1.

As shown in both Table 1 and in the above-mentioned examples, patients combined the experience of clinical service and health-care professional attitude in their ratings.

#### The attitude of health-care professionals

A very good experience required that exemplary clinical service was provided with an attitude of recognition and respect. Experiences rated as good could reflect that there was a partial lack of this attitude, and recognition and respect were always partly lacking in bad experiences. Examples include situations in which the staff member was not the first person to greet the patient, did not fulfil promises or used technical terms that were

hard to understand. Patients disliked when health-care professionals talked about them in the third person in their presence or verbally reduced them to a disease or an examination. In very bad experiences, patients felt that they were treated with indifference. For examples, see above and Table 1.

#### DISCUSSION

Our findings may be summarised as follows: when the patients rated the care they received, they evaluated experienced care against expected care. Therefore, their rating also reflected their relations with the health-care professionals. Our results identify two types of relation of significance for patients: The patient-professional relation (a care relation) in which clinical service was important, and a human relation in which attitude was important. It appeared that, for the patients in our study, an acknowledging and respecting professional (acting as co-creator of a human relation) had the power to improve patients’ experiences, a factor that was also reported by others, e.g. [11, 12], and found in relation to the Likert scale rating from good to very good [13]. This contradicts other research findings where the possibility of raising a rating from good to very good is questioned, e.g. [14]. However, our results also supplement that of others who succeeded in mapping only 17.5% explanatory factors for patient satisfaction and did not include health-care professionals’ attitudes [15]. Our results may suggest that excellent clinical quality could also improve patients’ rating at the middle of the Lickert scale. At the low end, it was the care relation that proved to be the more important, because the human relation could not compensate if patients were not allowed to have a patient role (i.e. left the hospital without faith in getting the care they needed). Clinical service and acknowledging and attentive health-care professionals have been found to be important for patients for many years, e.g. [16, 17], but the way in which patients may combine these two factors in relation to a Likert scale has not been investigated before. To put our findings into a wider context, we sought a theory of human relations that could explain our findings. Løgstrup states that, basically, we all seek to have good, trusting relations. This is achieved if the other party behaves as we expect. However, if the other person does not conform to our expectations, we need to take into account a greater or lesser degree of disappointment.

This could lead us to regard the other party in a negative way [18]. In other words, if health-care professionals deeply disappoint a patient, this patient may interpret signals from these professionals, or all, health-care professionals in a negative way; e.g., subsequent attention and smiling may be interpreted as “fake”. In relation to our results, patients rewarded the health-

care professionals who behaved as expected. Moreover, none of our patients gave information about helpful human relations in situations where they experienced a total lack of clinical quality; on the contrary, they felt that they were being treated with indifference. Løgstrup's theory deals with trust and distrust in human relations. He specifies that trust is an ethical requirement in all human interaction and considers the theory to be universal [18]. The fact that this theory fits well with our data may indicate that trust (or its lack) could be one of the factors underlying a choice of rating. In that sense, our findings support the idea that trust and patients' grading of experienced care are interrelated [19]. Such relations will need further investigation.

### Limitations

The strength of this study is its combination of qualitative interviews with a Likert scale survey which allowed for an investigation of how patients associated their experiences to the rating scale. The trustworthiness of our data could be questioned because the time from questionnaire completion to interview was up to six weeks and the length of the interviews was short in terms of qualitative methodology. Moreover, we used several data-generating methods of which telephone interviews lacked the visual element. However, for the initial 19 patients, all interviews were face-to-face, the time between events was a maximum of two days and our data collection was focused and included many parallels drawn between the individual answers. We gathered rich descriptions and considerations; albeit the final interview was not as detailed as the others. We included data from many patients which may induce cursory analysis and interpretation [7]. However, the second level of the analysis, which gave rise to themes, was based on the first 19 interviews, and this ensured overview and analytical depth. We experienced data saturation within the initial 19 interviews, but were able to provide further verification in the data from the rest of our participants. Furthermore, the deductive analysis did not reveal contradictions, and this strengthens the internal validity of our analyses. Our participants were adults (21-80 years of age) and they visited different wards and outpatient clinics; however, only women were included.

### CONCLUSIONS

Our female patients could associate their experiences with their ratings, and two types of relations seemed to be at play: a care relation and a human relation. Within these relations, the clinical service provided and the attitude of health-care professionals were important. Patients combined their experiences from these two factors when they evaluated the care they received.

Care rated as very good represented excellent clinical

service provided with recognition and respect, whereas a good care rating reflected a dip in either one of these factors. Our results may inform health-care practice, but department-specific examples may be needed to initiate improvements.

**CORRESPONDENCE:** Marianne K. Thygesen.

E-mail: marianne.thygesen@health.sdu.dk

**ACCEPTED:** 21 August 2015

**CONFLICTS OF INTEREST:** Disclosure forms provided by the authors are available with the full text of this article at [www.danmedj.dk](http://www.danmedj.dk)

### LITERATURE

1. OECD, Health Division. OECD reviews of health care quality: Denmark. Executive summary, assessment and recommendations. Copenhagen: OECD, 2013. [www.oecd.org/els/health-systems/ReviewofHealthCareQualityDENMARK\\_ExecutiveSummary.pdf](http://www.oecd.org/els/health-systems/ReviewofHealthCareQualityDENMARK_ExecutiveSummary.pdf) (Aug 2015).
2. Borgernes sundhedsvæsen. Danske Regioner, Danske Patienter, KL, Sundhedsstyrelsen, 2013. [www.regioner.dk/~media/Mediebibliotek\\_2011/SUNDHED/Akut%20og%20pr%C3%A6hospital/Borgernes%20sundhedsv%C3%A6sen%20-%20juni%202013.ashx](http://www.regioner.dk/~media/Mediebibliotek_2011/SUNDHED/Akut%20og%20pr%C3%A6hospital/Borgernes%20sundhedsv%C3%A6sen%20-%20juni%202013.ashx) (Aug 2015).
3. NHS Surveys. Focused on patients' experience. Secondary NHS Surveys. Focused on patients' experience. [www.nhssurveys.org/](http://www.nhssurveys.org/) (Aug 2015).
4. Groene O. Patient centredness and quality improvement efforts in hospitals: rationale, measurement, implementation. *Int J Qual Health Care* 2011;23:531-7.
5. The unit of patient-perceived quality: The National Danish Survey of Patient Experiences – in brief. Copenhagen: Unit of Patient-perceived Quality, 2010. [http://patientoplevelser.dk/files/dokumenter/artikel/lup\\_pixi\\_uk.pdf](http://patientoplevelser.dk/files/dokumenter/artikel/lup_pixi_uk.pdf) (Aug 2015).
6. Riiskjær E, Ammentorp J, Kofoed PE. Er otte ud af ti patienter tilfredse? Om forståelse af patientkritik og anvendelse af åbne spørgsmål. *Nordisk Sygeplejeforskning* 2011;13:93-110.
7. Kvale S, Brinkmann S. Interviews – learning the craft of qualitative research interviewing. 2. ed. London: SAGE Publications Inc., 2009.
8. Ricoeur P. Interpretation theory. Texas, USA: The Texas Christian University Press, 1979.
9. Pedersen BD. Sygeplejeforskning, sprog & erkendelse. Aarhus: Fællestrykkeriet for Sundhedsvidenskab og Humaniora, 1999.
10. World Medical Association Declaration of Helsinki. Ethical principles for medical research involving human subjects. *JAMA* 2013;310:2191-4.
11. Frederiksen HB, Kragstrup J, Dehlholm-Lambertsen G. It's all about recognition! Qualitative study of the value of interpersonal continuity in general practice. *BMC Fam Pract* 2009;10:47.
12. Johansson P, Oleni M, Fridlund B. Patient satisfaction with nursing care in the context of health care: a literature study. *Scand J Caring Sci* 2002;16:337-44.
13. Collins K, O'Cathain A. The continuum of patient satisfaction - from satisfied to very satisfied. *Soc Sci Med* 2003;57:2465-70.
14. Boelsen MW, Plum LM, Hillingsø JG. Improved questionnaire concerning the Danish National Survey of Patient Experiences. *Ugeskr Læger* 2013;175:1954-7.
15. Bleich SN, Ozaltin E, Murray CK. How does satisfaction with the health-care system relate to patient experience? *Bull World Health Organ* 2009;87:271-8.
16. Larson PJ. Important nurse caring behaviors perceived by patients with cancer. *Oncol Nurs Forum* 1995;22:481-7.
17. Shattell M. It's the people that make the environment good or bad: the patient's experience of the acute care hospital environment. *AACN Clinical Issues* 2005;16:10.
18. Løgstrup KE. Den kendsgerning hvorfra den tavse fordring undspringer Den etiske fordring. Copenhagen: Gyldendal, 2008:17-39.
19. Van Den Assem B, Dulewicz V. Patient satisfaction and GP trustworthiness, practice orientation and performance: implications for selection, training and revalidation. *J Health Organ Manag* 2014;28:532-47.