SATISFACTION WORK: THE JOINT PRODUCTION OF PATIENT SATISFACTION BY HEALTH CARE PROVIDERS AND PATIENTS

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ABSTRACT

The disconfirmation model holds that consumer satisfaction results when product performance equals or exceeds expectations while performance short of expectations yields dissatisfaction. The argument of this essay is that in a hospital setting both patient expectations and standards for performance are negotiated as health care providers attempt to change unrealistic patient expectations/performance standards. As a result, satisfaction is a joint product of work done by both providers and patients. Satisfaction is a social process.

Those themes are illustrated by data from focused group interviews with patients, physicians and nurses analyzed using qualitative research concepts (symbolic interaction) and methods.

INTRODUCTION

Very strong evidence has been presented that customer satisfaction/dissatisfaction with services is contingent upon how service workers respond to consumer complaints (Bitner, Booms and Tetreault 1990). However, except for studies of organizational response to complaints (Yi 1990), the role of marketers in the satisfaction/ dissatisfaction process has been largely ignored. In particular, both the Bitner et al. (1990) study as well as the response to complaints literature focused on reactive efforts by marketers to handle customer complaints. The main thesis of this paper is that service workers are quite aware of the importance of consumer satisfaction and undertake proactive as well as reactive steps to help produce satisfaction. In fact, an important dimension of the work of service providers is the provision of customer satisfaction. The main contribution of this paper to the satisfaction literature is to suggest how two broad streams of sociological thought and research, the sociology of work and symbolic interactionism, can provide a framework for understanding why and how the behavior of service workers contributes to customer satisfaction/dissatisfaction. The arguments that are advanced in this paper are illustrated by data from focused group interviews with hospital patients, physicians and nurses. While the empirical setting is limited to the provision of health care services in a hospital setting, the main concepts advanced here of satisfaction work may have implications for the provision of service in other settings, (Bitner et al. 1990; Parasuraman, Zeithmal and Berry 1985).

BACKGROUND: THE NEGLECTED HALF- THE SERVICE WORKER

The Dominance of Disconfirmation

The dominant paradigm in research on consumer satisfaction, dissatisfaction and complaining behavior is the familiar "disconfirmation" approach. According to the disconfirmation model, the degree of post consumption satisfaction is the result of a three step process. First, consumers bring expectations, which are predictions of product (service) performance to the consumption experience. Second, the product/service is used and perceptions of performance are formed. Third, perceived performance is compared to expectations and as perceived performance increases relative to expectations (positive disconfirmation) satisfaction increases. Dissatisfaction results when performance falls short of expectations (negative disconfirmation). Finally, increasing dissatisfaction is likely to increase the probability of complaining. I will use: disconfirmation to refer to the disconfirmation paradigm. The dominance of disconfirmation is supported by Yi's (1990) recent essay in which he covered much of the extant consumer satisfaction literature as disconfirmation.

The Neglected Half-The Service Worker

It is important to stress that this paper is not a critique of the disconfirmation paradigm per se. Rather, a major argument advanced here is that two actors, the patient (consumer) and the health care provider (service worker), jointly act and react to produce patient satisfaction. With it's single minded focus on the consumer, the disconfirmation paradigm has simply neglected the other half of the service satisfaction process, the service provider. In an ironic twist, I will show that the disconfirmation paradigm is not just a theoretical model used by academic marketing researchers, rather it is a cultural resource used by health care providers to try and produce patient satisfaction. Including the provider goes beyond just achieving a more complete picture of the total satisfaction process. Essentially, providers believe in disconfirmation and act to shape the patient's expectations, perceptions of performance, and what level of performance should be considered good for a particular situation. However, patients may resist the provider's vision of the way things are or should be.

In summary, the process of service satisfaction is not just a cognitive comparison of performance to expectations by a lone consumer. Rather, the disconfirmation components arise out of a joint, processual and negotiable interaction between consumer and provider. As just one example of joint activities, I will describe how expectations are processual and negotiable between patient and provider. The thesis of this paper speaks directly to the concept in the services marketing literature of the inseparability of production and consumption (Parasuraman, et. al. 1985). However, the literature has not provided much in the way of detail on the processes involved in the production and consumption of services.

Qualitative Research and This Project

The data that were used to illustrate the points raised in this essay were drawn from the author's familiarity with fourteen focused group interviews gained as a result of preparing executive summaries from transcriptions of the interviews. The interviews were conducted by a professional marketing research firm as part of an effort to refine the measurement of patient satisfaction for an academic medical center. The academic medical center included affiliated hospitals providing patient care as well as medical education and research. The sampling plan was to cover a set of medical services (Obstetrics and Gynecology, Hematology/Oncology, Cardiology, Orthopaedics, Rehabilitation, Gastroenterology) and have three separate focus group interviews with patients, physicians and nurses for each service. This report is based on fourteen interviews that the author had an opportunity to analyze.

Morgan (1988) has argued that focus groups can serve as suitable data for qualitative research. Hypotheses testing vs generation of hypotheses is one of the major points of contrast between qualitative research and the frequently employed logical empiricist/realist stance of much current research in marketing (Hunt 1991, 394-398). Realism can be depicted as a theory, hypotheses, research sequence where hypothesis testing is a major activity. Qualitative research typically employees analytical induction where the data are used to both derive and test hypotheses. In this paper, the author has examined the data in order to derive hypotheses. The preliminary nature of the work was such that hypotheses testing cannot be claimed.

This paper followed the qualitative paradigm where the usual research procedure is to approach the data from a general perspective that includes some basic premises about social life. Specific concepts that help illuminate the data are used to provide the explicit theoretical framework for a particular article or paper. The general perspective was symbolic interactionism and the specific concepts used are presented throughout the paper.

Recently some marketing scholars have explored the prospects and potential of qualitative, interpretive or hermeneutic research philosophies (Anderson, 1983; Hudson and Ozanne, 1988; and Lutz, 1989). A qualitative literature on consumer behavior has emerged, (as examples see: Belk et al., 1988, 1989; Sherry, 1990; Prus 1989a; Prus 1989b), but not for consumer or patient satisfaction. A body of qualitative work has analyzed patient-physician behavior and some studies have included patient satisfaction, Semmes

(1991), Muzzin (1988).

Symbolic Interactionism

The basic thrust of symbolic interactionism is that individuals acquire the capacity to use symbols to assign meaning to objects in their environment and act towards objects depending upon the meaning assigned (Mead 1934; Blumer 1969). The individual has the ability, reflectivity, to view himself as an object as others would see him (her) and adjusts his/her acts in anticipation of the response of others. The acts of self and the other give rise to joint lines of action that emerge over time. Thus human group life is negotiable, relational and processual. This paper has drawn from insights concerning physician-patient/family negotiation and the idea of health care as a joint production of the patient and provider (Corbin and Strauss 1988).

The following major topics are discussed in the remainder of this paper: patient satisfaction as a socially constructed reality, the processual and negotiable quality of expectations, patient judgment of provider competence and reality definition contests.

PATIENT SATISFACTION: A SOCIALLY CONSTRUCTED REALITY

The Social Construction of Reality

Physicians and nurses reported undertaking work activities that they anticipated would improve patient satisfaction guided by their definition of reality. A major concept in the symbolic interactionist tradition is the social construction of reality which refers to two important ideas: 1) the nature of reality and, 2) the social construction of reality, an account of how reality as perceived is produced.

The social construction of reality argument holds that while the individual perceives reality as objective and external, reality is constructed and multiple realities exist (Berger and Luckmann 1967). As an example, I could argue from Aires (1962) that no children existed in Europe before the 17th Century. Of course, humans of the ages that we now consider as constituting childhood existed. The point is that childhood as a social category had not emerged. We experience childhood as objective and undeniable because the social category exists and the behavior of adults and young people creates and sustains the very reality of childhood.

The idea of patient satisfaction is part of the taken-for-granted reality of health care providers and patients. When the focus group moderator asked physicians or nurses or patients questions using the phrase "patient satisfaction," no one ever asked for any clarification or voiced any question about what might be meant by patient satisfaction. The creation of patient satisfaction as a reality is largely beyond the scope of this paper. However from the provider perspective, patient satisfaction was an administrative goal of the hospital (a patient satisfaction survey had been in use for a few years) and the topic of patient satisfaction appears in the professional literature.

Returning to provider work, it was clear that patient satisfaction was one of the outcomes that providers felt was desirable as they undertook (as will be described below) specific work activities that they felt would help facilitate satisfaction.

Patient Satisfaction As Contingent On The Fulfillment of Expectations

The reality of patient satisfaction as perceived by nurses and physicians was that patients had or formed expectations concerning procedures and treatment outcomes and, if expectations were fulfilled, the patient would be satisfied, while unrealized expectations would result in dissatisfaction:

> I was just going to say that you can't promise anything unless you're capable of delivering it. Again, because disappointment would be worse than . . . I mean, unrealized expectation would be the worse outcome (Physician - Gastroenterology).

Another dimension of the health care providers reality was that some patients had unrealistic expectations:

> I think, too, a lot of that (satisfaction) has to do with they come in to the hospital to get . . . . . fixed and it's a chronic problem then

their perception is that they're going to come in and get a pill and that's going to take it away. It might take a whole lot of education to convey that this is a chronic problem that occurred over a long period of time and it's going to take a period of time of several series of treatments to get rid of it, . . . (Physician - Gastroenterology).

Remember that to the individual reality is unalterable, so from the providers perspective, the cure for the unrealistic patient is to change the patient. As a result, patient expectations and concepts of good health care performance are processual and negotiable as health care providers do satisfaction work. In the next two major sections of this paper I will first cover expectations and then cover performance standards as joint productions of providers and patients.

EXPECTATIONS ARE PROCESSUAL AND NEGOTIABLE

Treatment Outcome Expectations

One category of patient expectations that health care providers would attempt to change was unrealistic treatment outcome expectations.

An important concept in the interactionist tradition is that social life consists of an ongoing series of negotiations as people attempt to coordinate their lines of action by persuading/ compelling the other party to change as well as altering their own views, demands, and behavior in response to the other party. The "negotiated order" as this framework has come to be labeled states that macro level structural elements of society, such as the provider-patient role structure, "reach" the micro level of interacting individuals as behavior shaped by the negotiations that people engage in, while at the same time behavior and negotiations define the social structure. The social order is a negotiated order (Maines 1982).

Negotiation over what outcomes and levels of performance on those outcomes the patient should expect can be seen in rehabilitation medicine. In brief, the general public seems to believe that competent medicine can restore most patients to a normal or near normal life after an event, such as an automobile collision, that seriously impaired the patient. The goal for patient and families is complete rehabilitation. In contrast, providers held that for some patients complete rehabilitation was technically impossible and the goal was to help the patient do the best that his/her post rehabilitation condition would allow. Providers reported such negotiations and patients claimed to have revised their expectations and outcome goals (e.g. performance in the disconfirmation paradigm):

And I think it's (unrealistic expectation of a miracle) so critical, and I've seen the times when I feel like we've really made mistakes, or there's been problems with families is definitely related to the differences in expectations or in the goals set in what's realistic. And I just think it can't be done too much for the physician and the staff to communicate, not just with the patient. Because a lot of times, the patient, especially if they have stroke or head injuries, they obviously are not going to comprehend. But for the family to understand on a week to week basis, what are the goals, remind them of what we started with, and remind them of what we haven't been able to accomplish, we need to refine this goal, and let them know on a very regular progressive scale where we are, what we hope to get, . . . (Physician-Rehabilitation Medicine)

Jack, a patient, talked about the difficult acceptance of his conditions as defined by providers (the names of individuals and local health care institutions are pseudonyms):

Moderator:
Were you able to get the emotional support you needed from "X" Hospital when you were going through that depression?

Jack:
I was getting support but I was rejecting it myself. I used to look real happy and everything but when you can't walk on concrete without your legs giving out, that used to bother me. I was an independent person. I had my own little job on the side. I was a diesel mechanic, and auto mechanic,

painted cars. I was into ceramics. At my church, I was the superintendent there and I am the teacher there at the mission.

Moderator:
Would you say that your condition is improving?

Jack:
I still have a chronic pain all the time every day. I learned to live with it. Two weeks ago I thought I was going to go out and find me a job. I went over to the occupational rehab across from the "Y" Hospital and I was so geared up that I was going to find something that I had made up my mind that there was a job out there that I could do. I got in there and I didn't have no support. I was sitting on that stool and I had a spasm and I had to stop. The doctors came in and said that they can't recommend that I continue to take this course right now because you just haven't healed yet.

Patient Expectations of Treatment Procedures and Outcomes Are Processual

In addition to treatment outcomes, from the providers' perspective patients can also be unrealistic concerning treatment procedures and become dissatisfied because procedures were not what the patient anticipated. Providers negotiated treatment procedures with patients.

In rehabilitation medicine, the providers reality was that the patient must learn to do simple tasks, such as feeding oneself, in order to progress towards some level of independence. However, the patient/family often resists rehab efforts to have the patient act for her/himself:

Helen:
I'm talking about the nurses side of it so that they would know what they are expected to do when they are able to do it. If they learn to do things for themselves, they are expected to do those things. This is for their independence, this is working towards their goals. On day shift I'll come up here and have seen patients sitting up and doing things that I thought they couldn't do because at night they'll lay in the hospital bed. When I find out that they can, I'll bring them a pill and I'll make them pick up their water and I want you to take your pill. Because they will lay there in the bed and do nothing. They need to know that they are expected to do as much as they can because that is the purpose of being at (Rehab Hospital) and some patients don't seem to know that they are supposed to do these things around the clock if they can.

The rehab patient-provider conflict in expectations flows from the patient's experience and definition of reality that his/her every need should be met by a nurse or other health care worker. The patient's definition of reality is understandable as processual and emergent from the patient's short term biography. The biography of many rehab patients is as follows. First, the patient experiences a serious, life threatening, medical emergency such as an accident or stroke. Secondly, the patient receives intensive care where the immediate medical goal is to prevent death. While under intensive care, the patient's needs are taken care of by hospital staff. The patient is not asked to do things for her/himself. Third, the intensive care physician announces that the patient will recover and can be sent to rehabilitation. What is meant by recovery is that the patient is no longer in a life threatening situation. Fourth, the patient arrives at rehab with two sets of expectations concerning outcomes and treatment that, to the rehabilitation staff, are unrealistic.

The first set of unrealistic expectations concerned the treatment outcome and emerged from the critical care physician's pronouncement that the patient would recover. To the patient and family, recovery has often been interpreted to mean that the ultimate outcome, following rehab, is that the patient would be restored to his/her pre-emergency health status. Note that by recovery the critical care physician meant that the threat of death had been removed. As discussed above in the proceeding section, physicians and nurses would negotiate patient outcomes expectations downward.

The second set of unrealistic patients that arose in intensive care and were brought by the patient into rehabilitation were expectations of treatment procedures and the division of labor between the patient and health care providers. Essentially, the

health care providers reality was that the patient must progress from extreme dependence to self sufficiency. The patients or their family were accustomed to having their "every need" met by nurses, physicians and others and reported that initially that were not ready to fend for themselves and had to make a difficult transition towards independence. A mother, Martha, the care giver for her son, accepted the providers' view that her son needed to act for himself as part of the regimen:

> Moderator:
> At (Rehab Hospital) they have a regimen of exercise and therapy, etc.?
>
> Martha:
> Every day. Even when he had not woke up, it was eight to four every day and off on weekends. They worked him hard and explained everything to me. Mom we don't want you there. They asked "if he drops a cup what are you going to do?" I said "I'm going to pick it up." That is why they didn't want me there. I would get to come in on Wednesdays . . .

However, some family members would have unrealistic expectations and interpret efforts to push patients towards independence as neglect on the part of hospital staff.

PROVIDER COMPETENCE JUDGED BY COMMON SENSE UNDERSTANDING

Four main themes are developed in this section. First, the process whereby product performance is perceived is an critical underdeveloped issue in the disconfirmation model. Secondly, a major theoretical school in the qualitative tradition, ethnomethodology, may hold promise as a framework for the analysis of expectations and product performance perceptions. The third theme consists of an account of how some patients judged competence by consistency of provider behavior using "the first way is the right way" test and implications of that test for judgments of performance and also expectations. Finally, nurses and physicians were aware of the patients' common sense tests of competence and as part of their work acted to appear competent and negotiated competence with patients.

Product Performance In The Disconfirmation Model

Briefly, disconfirmation studies concerned with product evaluation have either used physical products (Yi 1990, Table 4, p. 83) or services such as restaurants (Swan & Trawick 1981), in which it is reasonable to assume that consumers feel that they can make a rather "direct" judgment of relatively obvious performance attributes. As an example, Cardozo (1965) gave subjects a catalogue description of ballpoint pens to create expectations, then exposed subjects to pens that were of higher or low quality than those in the catalogue. Subjects reported product performance in terms of ratings. Two limitations in the scope of such studies are evident. First, the process whereby product ratings were generated by consumers was not investigated. Secondly, for "professional" services in general and for health care practitioners in particular, performance is in terms of role performances in which consumers undoubtedly realize that they can't judge a physician as another physician would. However, it is clear that patients do judge physician and nurse competency, so a theoretical framework for investigating how such judgments are made would be useful. I believe that ethnomethodology is a promising approach.

Ethnomethodology: How Common Sense Judgments Are Made

Ethnomethodology has been concerned with the common sense methods people use to obtain a sense of order and understanding of the situations in which they interact with others in their social worlds (Turner 1986, 389-404, Garfinkel 1967). Ethnomethodology is not concerned with the scientific validity of human judgments, but rather the "study of" (ology); "methods" used by "folk or people" (ethno). The interest has been on explaining how a person's sense of reality is constructed, maintained and altered. An essential argument is that to the individual the social order and society is perceived as an external objective, reality and others share a common vision about

what is real. Some judgments of physician/nurse performance by patients may well be understood as instances of ethnomethodological techniques.

Judging Provider Competence

Patients saw one of their task as judging the competence of health care providers. In the interviews, "competence" was mentioned by patients as one of the reasons for satisfaction and incompetence for dissatisfaction:

> Another thing, the nurse was trying to take my blood, and I don't think she knew what she was doing at all. She stuck me three times in my arm and pushing the needle around in my arm, it was very painful. She just says, well, I just can't do it, let me get another nurse. I was like, another nurse. Finally, she went and got another nurse, and she came and did the same thing. If someone has a needle in your arm and just moving it around, but this lady, I really don't think she knew what she was doing. Finally she said, let me go get someone else to do it. So, I didn't feel she knew what she was doing. (Patient-OB-GYN).

A concern for competence was also linked to the biography of some patients and can be seen very clearly in the reports from patients who told of "I could have died due to their mistakes" experiences. A women blamed a clinic for failing to notify her promptly of a cancer sign and ten months passed before she was recontacted by the clinic, retested and sent to a specialist:

> But by the time I found out that I had cancer. If I had known a year ago when the clinic was supposed to be in touch with me in the first place my options would have been different but by the time after the biopsy, I had no options. I had to have it. Although it hadn't invaded my body, it was sitting on the surface. If they hadn't gotten in touch, well they didn't get in touch with me. I had to go back to the clinic for another problem and that is when I found out. I was thankful that I had good doctors and they dealt with it. (Patient-Oncology)

Providers also attributed patient satisfaction to competence which can be understood in terms of a process identified by ethnomethodologists, the reciprocity of perspective, in which actor A assumes that were he/she to switch places with a role partner actor B, they would both perceive the same reality. Competence perceptions were linked to the joint activities of patients and providers as explained below.

Patients had a vision of reality in which competent people know what to do and did it. In contrast, a less competent person that does not quite know what to do, is inconsistent. Inconsistent (from the patient's perspective) health care providers were a source of dissatisfaction. The patient quoted above who experienced an inconsistent/incompetent blood test would illustrate this point.

Consistency testing by patients may have wide implications for satisfaction as it relates to expectations, judgments of performance and provider attempts to shape both patient expectations and performance judgments. An illustration of those processes is provided by "the first way is the right way" phenomena.

Both physicians and nurses recounted experiences in which during the first application of a procedure, a particular technique would be used. Patients would become upset and dissatisfied when later a second provider would use a different technique that was technically sound as it was just another alternative to achieve the same end:

> Rehab Nurse:
> Well, you may do it right when they want it now, but you may not do it how they want it done.
>
> Moderator:
> There are different ways to do it?
>
> Nurse:
> It depends on what they want, but our patients seem to be very particular about how they want certain things done.
>
> Moderator:
> Would one nurse or LPN maybe do it one way and it would be right and another nurse or LPN do it another way, and it would still be

right?

Nurse:
Exactly, but it's wrong to them.

Moderator:
Does that happen often?

Nurse:
Yes, All the time.

My interpretation of the above is admittedly speculative but here is what may explain "the first way is the right way" phenomena. A common element of the taken-for-granted reality is that there is one right way to do things. If the first time that the patient was exposed to a procedure, nurse Smith used a particular technique and the outcome was favorable, then for that patient the nurse Smith method becomes the right way. When nurse Jones on the next shift starts to use a different technique, the patient becomes fearful that Jones is not competent. Due to patient apprehension the outcome is not as favorable which further confirms to the patient that nurse Jones is less than competent.

Nurses were aware of the "first way is the right way" judgment by patients and made it a practice to negotiate a new reality for patients that different procedures are correct:

Nurse:
Sometimes I will talk with Betty (second nurse) if I do it one way and she does it one way, and then we'll get together and collaborate on a plan and we would take it to the patient. For instance, nurses have personalities too and they finished different nursing school so there is more than one way to do anything, but we would show genuine care and understanding we get on the same track, and we think we give him just about the same.

Another common sense judgment of competence reported by gastroenterology nurses was where patients with long illness biographies had acquired knowledge of their condition and asked questions that the patient knew the answers to, in order to test the knowledge of the nurse:

Ann:
I found that the GI patients, depending on the diagnosis, are more knowledgeable about their disease. They have done extensive reading so they are very knowledgeable about their disease. They probably have been in the hospital several times. Patients with ulcers and GI patients know what is going on.

Sue:
You see them asking you questions, and then about their medicines, or to see . . . like, you . . . some people you might take a cup of medicine and just get their medicine taken. "But what is this one for? What is this one for," to see if you know. They may very well know it all, but it's to see if you know, or to watch how you do IV's, as you say. I might, you know, watch your technique, or wipe it off and stuff . . . and they'll tell you about it.

So far, the emphasis has been on provider negotiations to change patient expectations and judgments. However, providers were not always successful in doing so, which is the theme of the next section of this paper on "reality definition contests."

REALITY DEFINITION CONTESTS BETWEEN PATIENTS AND PROVIDERS

Multiple Realities of Expectations and Performance

The negotiations over expectations and performance have a quality that goes beyond a basic premise of the logical empiricist/realist foundations of the disconfirmation paradigm. In brief, disconfirmation assumes that a single, fixed external reality exists that is independent of any consumer of provider. This premise is captured in the assurance that a true level of product/service performance exists, while recognizing that perceptions may depart from true performance and it may be difficult or impossible for consumers or providers to perceive true performance free of any error. The interactionist paradigm has rejected the premise of a single reality and has argued that different people do not necessarily share the same reality, multiple realities exist.

Interactionist theory and research has been concerned with how reality is generated, maintained and may thus have implications for disconfirmation. Specifically, interactionists have investigated "reality definition contests" in which one group of people attempts to have it's version of reality accepted by a second group (Loseke 1987). Health care provider attempts to get patients to hold "realistic" expectations and performance standards can be analyzed as reality definition contests.

Since reality is just that to people, the way the world is, resistance to attempts to impose a new reality can occur. In fact, provider attempts to change expectations can result in arousing suspicion on the part of patients or their family. That process can be found in instances where the patient's reality is that a cure for me is possible while the provider holds that the patient's goal is impossible and the patient receives confirmation of his reality:

> I've had this problem for about twelve years now. I was never sick a day in my life until twelve years ago. I had a tumor of the pancreas which is pretty serious. I had surgery over at St. Jame's. They did exploratory surgery twelve years ago and couldn't find out what was wrong. Two weeks after surgery they dismissed me and told me I had sixty days to live and that was it. In that sixty day period, I could have done a lot . . . I went out and got on the phone and found a surgeon at the Mayo Clinic and got on a plane and went to Rochester, Minnesota and had everything taken care of. (Gastroenterology Patient).

Persuasion and Power: Tools of Reality Re-Definition and Patient Control

While reality definition contests were not always won by physicians and nurses, providers played the game with a strong hand using power and persuasion as their tools. I use the term persuasion to refer to verbal attempts by providers to change the patients definition of reality by convincing the patient of the validity of the providers perspective. Persuasion and power are difficult to separate both conceptually and empirically as the effectiveness of persuasion rests, in part, on power. In this paper power has been defined as the actual or threatened: 1) withholding or granting of rewards and 2) the use or avoidance of punishment. Power was also based on the imposition of institutional rules.

Provider attempts to redefine the patients definition of reality were motivated attempts to increase patient satisfaction as explained above, however a need for patient control was a more basic reason for providers to shape patient expectations and beliefs. The imposition of patient control presented a dilemma for providers as control may have been gained, in some instances, at a cost in terms of patient satisfaction. An elaboration of my arguments concerning persuasion, power and control follows.

In dealing with many patients, providers, especially physicians, probably had little difficulty in persuading patients to accept providers definitions of reality for two reasons. Patients wanted to receive explanations from physicians and nurses concerning their prognosis. Indeed, a source of patient satisfaction was a provider that gave explanations to the patient:

> The doctors were very nice, the one that took forever to get there to check on me was very apologetic, he said he was somewhere doing something. I don't know, he was real friendly, and he told me everything he was doing, and that was real important to me, and said this is your so and so and so, and I said OK, and he wanted to show me that it was not damaged, and everything is going to be alright. (Emergency Room Patient).

Another reason for patient acceptance of provider supplied information was that physicians and probably nurses to some extent were initially presumed by patients to be professional and competent. An ethnomethodological concept, the "et cetera " principle of a taken for granted reality is useful at this point. In an ongoing interaction much is left unsaid as actors "fill in information to make sense of the other person''s words/gestures. People usually do not define their terms, explain what they mean as a taken-for-granted, unexamined reality is assumed until it is disrupted. Patients were satisfied with providers who were

professional and physicians/nurses attributed satisfaction to professional care.

What is striking about the remarks concerning "professional" is the taken-for-granted quality of that word. In many instances neither patients nor health care workers felt that it was necessary to explain or elaborate to any extent on what they meant by "professional". Just the word or phrase was given, the "et cetera" principle was at work, indicating a taken-for-granted reality that supported the credibility of information from providers to patients.

Power also supported the providers reality. One source of dissatisfaction were discharges that were premature to the patient. Providers would invoke "hospital rules" in support of the early discharge and used rules as a source of power:

> Moderator:
> How long were you hospitalized?
>
> Helen:
> Two days. I wanted to be there another day. I had major surgery and they kicked me out. I had insurance. This was a lymph node dissection which is no small operation and I was there over the weekend. I did not get into surgery until late Friday and by Sunday morning I was out. I felt this was one of my bones of contention. I tried to talk to the interns and say I'm not ready. I have a two story house and a husband that is going to work. The interns understood it but they could not convey that to Dr. Head (attending physician). I was insulated by those residents at all times. (Hematology-Oncology Patient).

Some patients reported being rewarded by hospital staff:

> Susan:
> Because I've been in the hospital so much, I know more of the levels. The nurses, the RN's. The majority of them was good. The RN's are the ones who saw that I was in pain and they hounded my doctors to try to get them to give me more medicine. Some of them, when I was hurting in the middle of the night, the RN's would come in and sit by my bed and try to take my mind off of the pain to see what they could do. They were the ones when it was time to get what little medicine that they were going to give me they'd say "we are going to give it to you in fifteen minutes." They knew that I was in pain . . . (Hematology-Oncology Patient).

Other patients suspected that they had been punished by staff who were seeking control:

> Dan:
> I think most of the nurses we see, . . . , are the people that come in at four or eight in the morning with that little sabre in their hand and they are going to take your blood. Some of them are in a good mood and some of them aren't. Nobody likes to get stuck at six in the morning so I try to kid around with them a little and some of them just really clam up and don't want to talk to you. I had one that really did a number on my arm and I was unable to use that arm for a couple of days. I swear to god, I think she did it intentionally because she wasn't in a joking mood that morning. (Gastroenterology Patient).

A source of patient dissatisfaction arose when patients did not accept provider definitions of reality, resisted control and were suspicious of physicians or nurses.

Staff Failure To Redefine Reality: Patient Biography and Discrepant Event

Biography or Life History (Schwartz and Jacobs, 1979, 61-74) is the sum of a person's experiences up to a point in time. Some patients with long illness histories had been treated by different practitioners in different health care institutions and had time and motivation to seek information about their condition. As a result, those patients felt that could judge health care services independently of what providers may have claimed. Another factor which undermined provider claims were discrepant events, instances of provider actions that, to the patient, were clearly mistakes or lapses in skills or judgment. Discrepant events could be a part of a patient's biography or a current event.

A female patient who was suspicious of

physicians and nurses had a biography that included a long illness, wide experience with different providers and had experienced discrepant events:

> Helen:
> I did a lot of research on breast cancer. I had a very small tumor that had been looked at and watched by a surgeon in another part of town. He said, in no way was it cancerous. A lot of time went by when they were looking and seeing and by the time I got the diagnosis that it was a small invasive tumor. I knew I needed to do research. I decided that I needed the best in this part of the world. I consulted with Dr. "Z" at "A Hospital". After Dr. "Z" sent me to Dr. "W" for a consultation on radiology, I started putting two and two together and thinking Dr. "D" is the best. I still think he is a fine technician. He is my technician and that is all he is to me because I'm a light breast to him and I never will be anything else. I understood that because I'm going to this person who is good, and I wanted the best.

In this section, I have discussed how patients and staff jointly negotiate realities of health care. The next topic is a summary of this paper.

SUMMARY

Patient satisfaction with hospital care depends upon how patient's define their expectations and judge the performance of health care providers. However, both expectations and performance standards are negotiated between patients and health care personnel. Physicians and nurses believe that patients become dissatisfied if their expectations are not met, but expectations are often "unrealistic". As a result physicians/nurses attempt to negotiate realistic expectations and performance standards.

Patients may resist a redefinition of their reality. Thus patient satisfaction is product of work done by health care providers and patients. The lone consumer of the standard disconfirmation model of consumer satisfaction is an incomplete view of patient satisfaction. Satisfaction is fundamentally a social process. The degree to which the observations made in this paper would hold for services in general (e.g. automobile repair, plumbing, laundromats, etc.) would be an interesting topic for future research. Negotiation of expectations and outcomes may occur in services where consumer involvement is high and providers and consumers have divergent initial views of the likely outcomes of the service encounters.

The main implications of my argument is that future research on satisfaction with services can be enriched by considering how consumers and service workers act and react to produce satisfaction. The analysis of satisfaction as a social process may be facilitated by the use of qualitative methods and theory, an emerging approach to research in marketing.

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