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Satisfaction of Patients in Health Care: Some Critical Issues with Research Projects that Measure Satisfaction

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ABSTRACT

This paper presents three critical issues that researchers need to consider when preparing a research project that measures the satisfaction of patients in health care. These issues are: the correct interpretation of the research objective and formulation of the research questions, selection the appropriate research design, and the credibility of the research project and its conclusions.

Keywords: satisfaction of patients, formulating research questions, appropriate research design, credibility of research projects



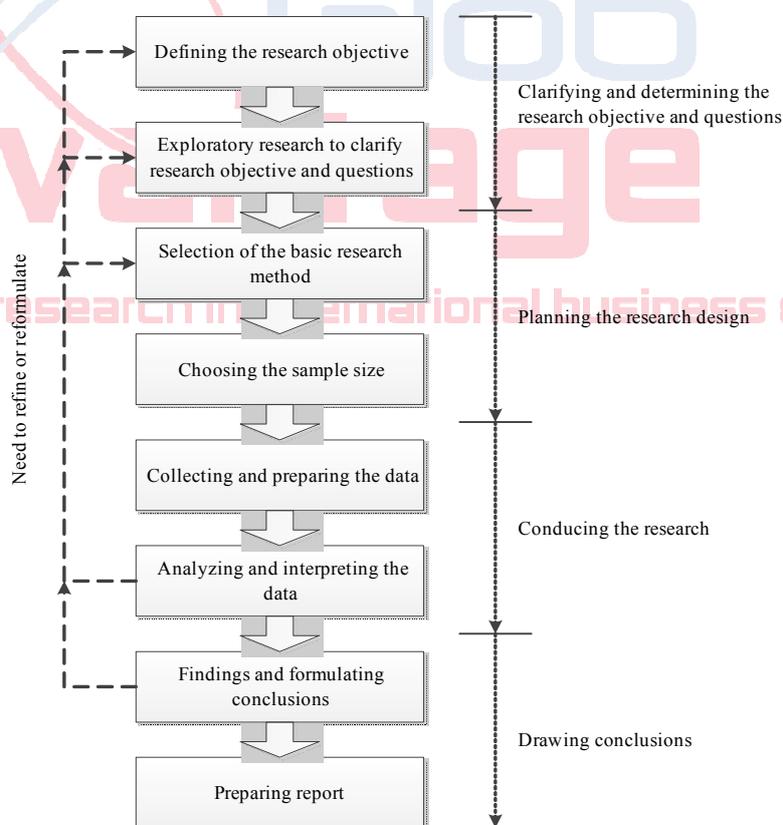
Satisfaction of Patients in Health Care: Some Critical Issues with Research Projects that Measure Satisfaction

Researchers have to consider three critical issues that when preparing a research project that measures the satisfaction of patients in health care. These are: the correct interpretation of the research objective and formulation of the research questions, selecting the appropriate research design, and the credibility of the research project and its conclusions. To situate these issues within a possible research project, the generic activities required to develop any research project should first be understood.

Research Project

A research project generally involves a sequence of highly interrelated activities. These activities constitute the ordered—but continuously overlapping—stages of the research process, as illustrated in Figure 1.

Figure 1. Research Process



Source: Adapted from Cooper and Schindler, 2011, p. 80, and Zikmund, Babin, Carr, and Griffin, 2013, p. 61.

The research process activities begin with the researcher clarifying and defining the research objective and questions, planning the research design, selecting the basic research method, choosing the sampling size, collecting and preparing the data, analyzing and interpreting the data and findings, and formulating conclusions. The process ends with the preparation of the report (Cooper and Schindler, 2011; Zikmund et al., 2013).

Research Objective and Questions

The objectives and questions of any research project that measures the satisfaction of patients in health care cannot be properly determined until there is a clear understanding of the possible managerial decisions that the particular health care provider can make. Any service provider (and, in particular, health care provider) will have constraints that are dictated by costs and feasibility.

There is no point in measuring the satisfaction of patients if their expectations are unrealistic and impossible to satisfy. If the expectations of patients are unrealistic, the research project has to uncover this, and the health care provider must develop an appropriate communication to educate patients with the limitations of the service.

The objective for the research is to measure satisfaction of patients with the quality of the service provided under the existing constraints. This means that the research project has to measure satisfaction within the possible characteristics of the service provided. These characteristics have to be recognized as changeable through managerial decisions. Additionally, the research objective should be oriented more toward the discovery of changes that may improve satisfaction, than simply toward confirmation or justification of the quality of existing services.

To meet the research objective, patients will need to evaluate their experiences with the health care service provided, using specific criteria. These criteria must be within the domain of possible characteristics for the service. This raises two fundamental issues that the researcher must address. First is the need to understand the expectation of patients within a health care service: particularly their expectations for the service and its

outcomes. Second is the need to understand the criteria that patients use to evaluate their satisfaction with the service experience: particularly if this satisfaction is related to the service provided or its outcome.

These two issues—expectations of and satisfaction with the experience—are strongly correlated. If patients' expectations are met they will probably be satisfied; if not, they will likely be unsatisfied. If the researcher is not careful, he or she may unwittingly measure conformity with the expectations of patients, instead of the possible quality of the service provided.

This does not mean that expectations are not important. On the contrary, expectations for a service are an important component of client satisfaction. Nevertheless, expectations are very difficult to manage in the context of health care. Expectations for a health care service can arise from comparison with other types of service that patients experience. One problem for the researcher (and for the service itself) is that clients' expectations for the outcome of health issues are unpredictable. When these expectations are not met, the provider is required to convince patients that they are getting the best possible service.

For the reasons just explained, the research objective—to measure the satisfaction of patients in health care—has to consider both expectations of the service and actual experiences with the service. The measure of satisfaction with the service experience focuses on aspects of the experience that determine (or could determine) satisfaction, and the feasibility of changing or introducing these aspects. These considerations will orient the formulation of the research questions.

The clarification and definition of the research objective and questions determines the research tasks. Hayek (1967) explained the importance of the research questions and their connection to the research tasks: "Until we have definite questions to ask we cannot employ our intellect; and questions presuppose that we have formed some provisional hypothesis or theory about events" (p. 22). Hayek termed the connection between research objectives, questions, and research tasks, as the *provisional hypothesis* or *provisional theory*. This connection enables analysis to be made and conclusions to be drawn about the data collected, in order to answer the research questions. The research objectives, questions, and provisional hypothesis or theory that

support them have to be clarified. If possible, these should also be validated by exploratory research prior to the planning of the research design.

Exploratory Research

A useful way to approach the formulation of the research questions is to start from basic questions and to then try to develop other questions by progressively breaking down the basic questions into more specific ones. These specific questions are used for exploratory research into alternative provisional hypothesis or theories. The results of this exploratory research should be a set of questions that are based on the provisional hypotheses and theories.

To illustrate the process, the following research objective and basic questions for the measurement of satisfaction of patients can be examined:

Objective: To measure the satisfaction of patients in health care, and to ameliorate the levels of satisfaction.

Basic questions: What are the expectations of patients for the service? What service aspects determine the level of satisfaction among patients? What changes to the service will increase the overall satisfaction of patients?

Note that the basic questions about expectations and aspects of the service provided will converge or diverge, and these will determine how patients assess their experiences. When the actual experience of the patients meets—to some degree—their expectation, a convergence occurs, and the degree to which this expectation is met will coincide with levels of satisfaction. On the other hand, if patients expect a specific aspect of service and this expectation is not met, divergence and dissatisfaction will result. In the case of convergence, clues on how to improve the satisfaction of clients can be researched. In the case of divergence, the researcher has an opportunity to introduce an aspect to the service to improve satisfaction or an unrealistic expectation by the patients.

According to Cooper and Schindler (2011), the first phase of the exploratory research should cover the following steps:

1. Research and analysis of secondary sources:
 - Published studies on satisfaction of patients in health care, service expectation, and customer satisfaction.
 - Retrieval of information about satisfaction of patients from their health care provider.
2. Expert interviews:
 - Interview with those knowledgeable about measuring the satisfaction of patients in health care and possible ways to ameliorate satisfaction.
 - Interview with experts in measuring customer expectation and satisfaction.
3. Individual in-depth interviews and focus group discussions:
 - Interviews with patients of health care to identify their expectations and experiences: particularly about aspects of the service.
 - Interviews with potential patients (those without experience with health care) to understand their expectations.
 - Focus group discussions with individuals involved with the provision of health care services to allow patients to understand the views of these providers on the aspects that cause satisfaction or dissatisfaction, along with the collection of suggestions as to how to ameliorate satisfaction.

The first phase of the exploratory research should expand the researcher's understanding of the research objective and questions so that this knowledge can be used to refine the research questions based on provisional hypothesis and thesis.

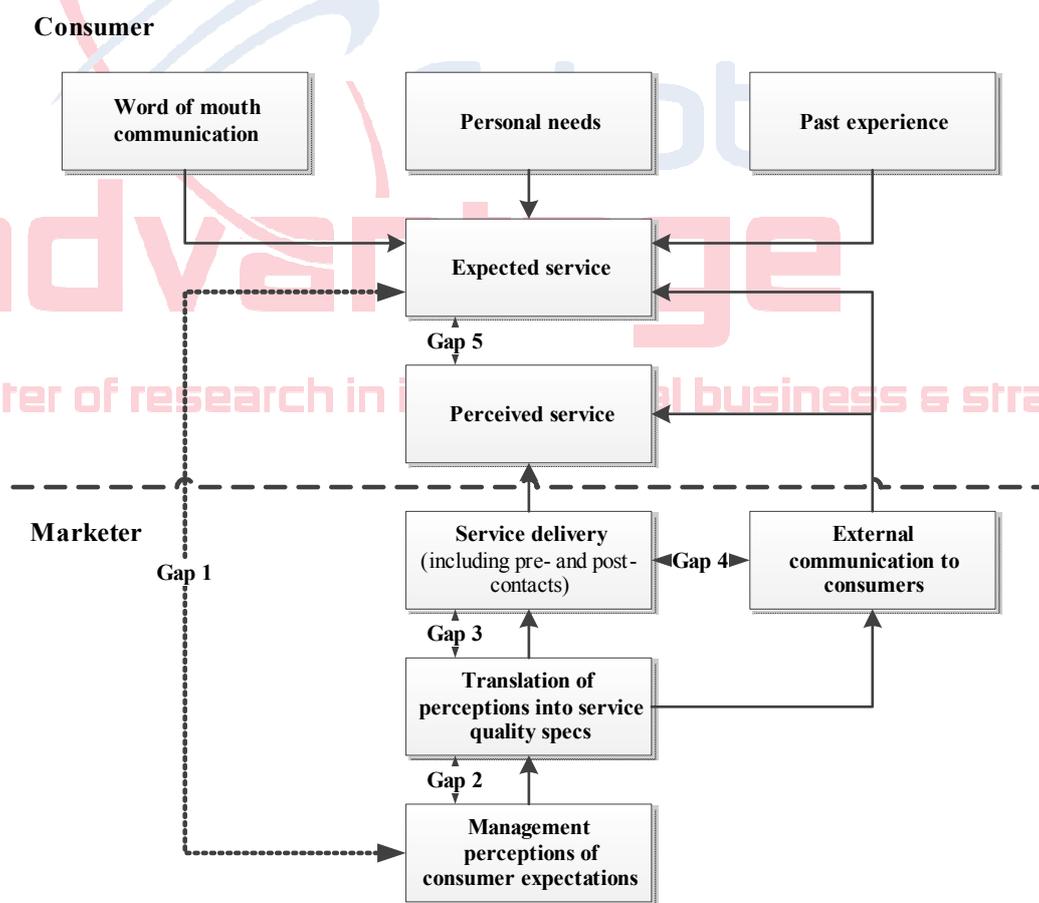
Research and Analysis of Secondary Sources

On reviewing the literature, the researcher will find some recent studies on the satisfaction of patients in health care. This may include the work of Kumaraswamy (2012), Ramez (2012), Soita (2012), and Altunta and Yener (2012). These authors use the service quality model SERVQUAL, which was

developed by Parasuraman et al. (1985) to measure the satisfaction of patients based on the gap between expected and perceived service.

The SERVQUAL model was developed using extensive executive, service categories, and focus group interviews. The key insight of Parasuraman et al. (1985) into the concepts of service quality was their identification of five gaps (these are highlighted in Figure 3): the consumer gap between expected and perceived service (Gap 5), the associated marketer gaps between expected service and management perception of consumer expectations (Gap 1), management perception and translation of perception into service quality specs (Gap 2), service quality specs, and service delivery (Gap 3), and the gap between service delivery and external communication to consumers (Gap 4).

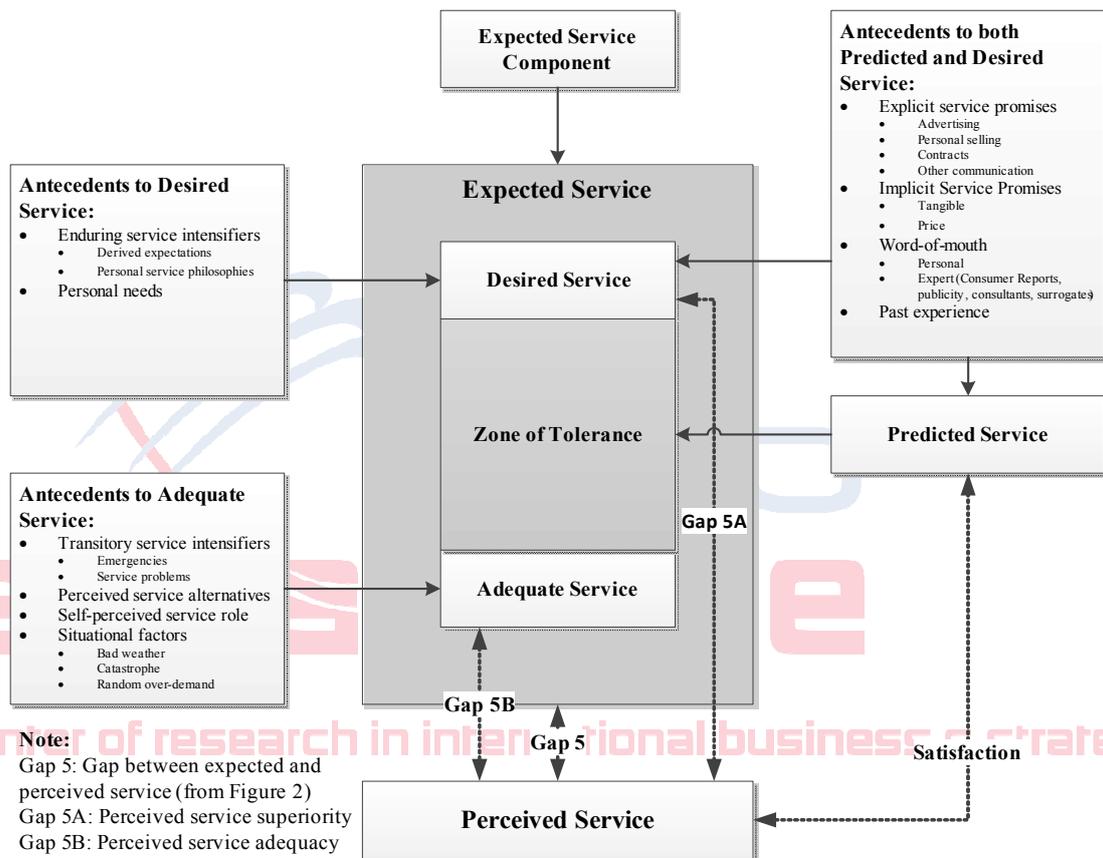
Figure 2. SERVQUAL model developed to measure satisfaction based on the gap between expectation and performance



Source: Adapted from Parasuraman, Zeithaml and Berry, 1985

The same authors that created SERVQUAL model (Parasuraman et al. 1985) developed a conceptual model of the nature and determinants of customer expectations of service (Zeithaml et al., 1993). The generic model of customer expectations developed by these authors (Figure 3) divides this into four main sections: (1) expected service component, (2) antecedents of desired service, (3) antecedents of adequate service, and (4) antecedents of both predicted and desired service.

Figure 3. Customer expectation of service and satisfaction



Source: Adapted from Zeithaml, Berry, and Parasuraman (1993)

Additionally, Parasuraman et al. (1985) developed propositions about the nature and relationships of the components of the model for each one of the four sections (Figure 4). Zeithaml et al. (2009) expanded on these propositions and gave additional insights into customer expectations.

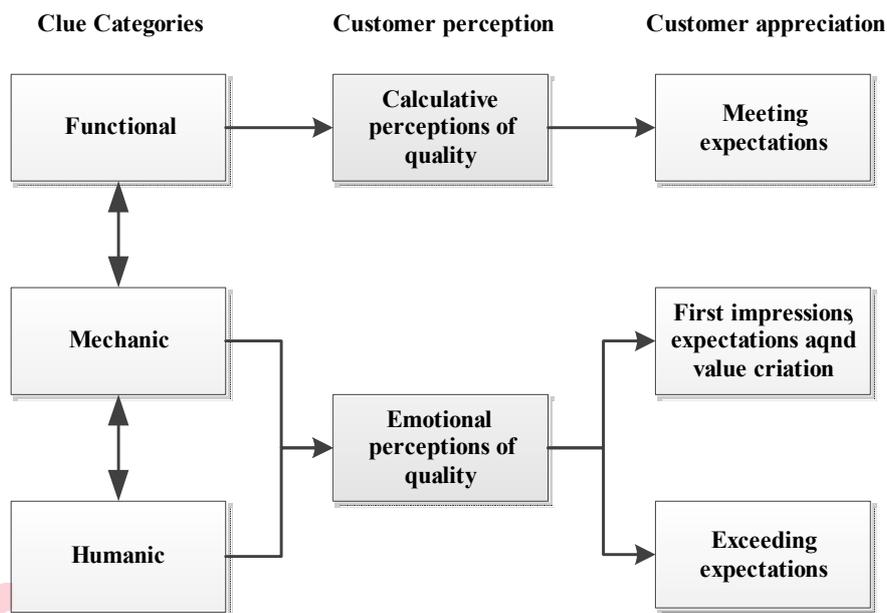
Figure 4. Propositions about the nature and determinants of customer satisfaction

Expected Service Component	Antecedents of Desired Service	Antecedents of Adequate Service	Antecedents of Both Predictable and Desired Service
<ul style="list-style-type: none"> Customer assesses service performance based on two standards: what they desire and what they deem acceptable A zone of tolerance separates desired service from adequate service The zone of tolerance varies across customers The zone of tolerance expands or contracts within the same customer The desired service level is less subject to changes than the adequate service level 	<ul style="list-style-type: none"> Enduring service intensifiers elevate the level of desired service A positive relationship exists between the level of personal needs and the level of desired service 	<ul style="list-style-type: none"> In the presence of transitory service intensifiers, the level of adequate service will increase and the zone of tolerance will narrow The customer's perception that service alternatives exists raises the level of adequate service and narrows the zone of tolerance The higher the level of a customer's self-perceived service role, the higher the level of adequate service. Situational factors temporary lower the level of adequate service, widening the zone of tolerance Two types of service quality assessments are made by consumers: perceived service superiority, which results from a comparison between desired service and perceived service; and perceived service adequacy, which results from a comparison between adequate service and perceived service The higher the level of perceived service, the higher the level of adequate service and the narrower the zone of tolerance 	<ul style="list-style-type: none"> The higher the level of explicit service promises, the higher the levels of desired service and predicted service Implicit service promises elevate the levels of desire and predicted service Positive word of mouth communication elevates the levels of desired and predicted service A positive relationship exists between levels of past experience with a service and the levels of desired and predicted service

Source: Adapted from Zeithaml, Berry, and Parasuraman (1993)

Berry et al. (2006) introduced the idea that in providing service the "little things" count: "While many managers focus on achieving fundamental goals in the in the delivery of services, it may be that greater attention to the details would result in greater customer satisfaction" (p. 43). Again, the researcher is required to use the interviews with patients and service providers to identify what Berry et al. called service clues, which affect the satisfaction of patients. Berry et al. classified these clues into categories of: functional clues, mechanic clues, and humanic clues (Figure 5). Functional clues primarily influence customer's cognitive or calculative perceptions of service quality that form their appreciation if the service meet expectations. Mechanic and humanic clues primarily influence customer's emotional or effective perceptions. Mechanic clues form customer's appreciation of the first impressions, expectations and value creation, and humanic clues influence the customer's experience of exceeding expectations.

Figure 5. Clue influence on customer perception and appreciations



Source: Adapted from Berry et al., 2006

Another important aspect in measuring satisfaction of patients in health care is a patient's emotional state when experiencing the service. Dubé et al. (1996) identified that health care interventions aimed at managing patient's emotions can influence health-related outcomes (such as satisfaction, compliance, and adjustment to therapeutic interventions). According to Dubé et al., health care providers can pick up cues on patient's emotional states and adapt their intervention accordingly. In doing so, they will increase patient satisfaction. The basic dimensions of patient emotions include: positive emotions, situation-attribute negative emotions, and other-attribute negative emotions. Dubé et al. concluded that only the latter proved to have a detrimental effect on patient satisfaction. Maute and Dubé (1999), Zeelenberg and Pieters (2004), and Tronvoll (2011) expanded this conclusion to include the effects of negative emotions on customer satisfaction.

The researcher has to consider that patients are complex human beings. Jansen and Meckling (1994) explained that an understanding of human behavior is fundamental for understanding how organizations function, whether these are profit-making firms in the private sector, non-profit enterprises, or government agencies that are intended to serve the "public

interest.” They also point out that the usefulness of any model of human nature will depend on its ability to explain a wide range of social phenomena. The test of such a model is the degree to which it is consistent with observed human behavior.

Jansen and Meckling (1994) investigated five alternative models of human behavior that are commonly used—albeit usually implicitly—in social science literature and in public discussion. For convenience, they labeled the models as follows: the *resourceful, evaluative, maximizing model* (REMM), the *economic model* (or money maximizing model), the *sociological model* (or *social victim model*), the *psychological model* (or *hierarchy of needs model*), and the *political model* (or *perfect agent model*). They concluded that the explanatory power of REMM (resourceful, evaluative, and maximizing model) for human behavior dominates that of all the other models. Specifically, they argued that each of the models captures an important aspect of behavior, while failing in other respects; whereas REMM, according to Jansen and Meckling, incorporates the best of each of these models:

- From the economic model, which is most commonly applied to evaluating satisfaction with services, REMM takes the assumption that people are resourceful, self-interested, and maximizers; but it rejects the notion that they are interested in only money income or wealth.
- From the psychological model, REMM takes the assumption that income elasticity of demand for various goods has certain regularities the world over. Nevertheless, in taking on this modified notion of a hierarchy of needs, REMM does not violate the principle of substitution by assuming that people have “needs.”
- From the sociological model, REMM takes on the assumption that “society” imposes costs on people for violating social norms, which in turn influences behavior; however, it also assumes that individuals will depart from such norms if the benefits are sufficiently great. Indeed, this is understood to be how social change takes place.

- From the political model, REMM takes on the assumption that people have the capacity for altruism: they care about others and consider their interests while maximizing their own welfare. REMM rejects, however, the notion that individuals are perfect agents.

According to Jensen and Meckling (1994), the researcher who uses REMM needs to add details in order to tailor the model to serve as a decision guide in specific circumstances. These details must specify people's tastes and preferences (for example, by making explicit assumptions that people have a positive attitude toward the future as opposed to the present) and that they value leisure, as well as intangibles such as honor, companionship, and self-realization. Jensen and Meckling explained that by combining these assumptions with knowledge of the opportunity set from which people are choosing in any situation (that is, the rates at which people can tradeoff or substitute among various "goods" and "bads"), leads to a powerfully predictive model.

The original SERVQUAL model and its refinements are very popular with researchers as a means to measure the satisfaction of patients in health care. However, many other models exist. Seth et al. (2005) demonstrated this by reviewing 19 alternate models. Exploratory research needs to determine whether one of these (or other) models can be used to measure the satisfaction of patients and—not forgetting that they are complex human beings—to model their behavior.

Expert and Individual In-Depth Interviews and Focus Group Discussions

The purpose of the expert and individual in-depth interviews and focus group discussion is to clarify and define the research questions. These start with basic questions using the insights gained by the research and analysis of secondary sources. This initial research includes the selection and adaptation of a model such as the SERVQUAL model, and the construction of a behavior model of patients (eventually adapting the REMM model) to serve as provisional hypothesis and theories for these questions.

For researchers who are not familiar with how to conduct the qualitative interviews and focus groups that are commonly used in exploratory research, a comprehensive introduction on how these research methods can be used in the context of health care can be found in Pope and Mays (Eds., 2006). Further references include Tracy (2013), who has described ways to plan and conduct interviews and has offered insights into qualitative research methods; Creswell (2009), Cooper, and Schindler (2011); and Zikmund et al. (2013) who describe the broad aspects of qualitative and quantitative research methods. The following considerations about qualitative in-depth and focus group interviews are drawn from the recommendations contained in Pope and Mays (Eds., 2006).

The qualitative in-depth interviews with experts and individuals that are conducted in the exploratory stage of the research project need to be unstructured, interactive, and sensitive to the language and concepts used by the interviewee. The agendas of researchers are required to be sufficiently flexible to cover, in depth, the issues related to three basic research questions, and to uncover and clarify details that will lead to the research questions. The aim is to go below the surface of the issues raised by exploring what the interviewee says in as much detail as possible, and to thereby uncover areas and ideas that were not anticipated at the outset of the research.

Focus group discussions during the exploratory stage of the research project help interviewees to explore and clarify their views about the basic research questions in ways that are less accessible in one-to-one interviews. The group discussion setting encourages interviewees to explore the issues that are important to them in their own vocabulary by generating their own questions and pursuing their own priorities. When group dynamics work well, the interviewees act as co-researchers: taking the basic research questions in new—and often unexpected—directions.

During the exploratory stage, researchers begin using the ideas and insights collected as the interviews progress to form and test the possible research in relation to the provisional hypothesis and theories identified from research and analysis of secondary sources (particularly the models to measure satisfaction of patients and their behavior). As a result, the

researchers are able to refine the research questions and connections in subsequent interviews to refine the planning of the research design.

Planning the Research Design

After the researchers have formulated the research questions, they must develop the research design stages (shown in Figure 1) by selecting the basic research method and choosing the sample size. Zikmund et al. (2013) described the research design as a master plan that specifies the methods and procedures for collecting and analyzing the information. The researcher must have identified the appropriate answers to the research questions to effectively measure satisfaction of patients in health care.

Creswell (2009) explained that each one of the three approaches to research design—qualitative, quantitative, and mixed approaches—has a specific use in research:

- Qualitative research is used for exploring and understanding the meanings that individuals or groups ascribe to social or human events.
- Quantitative research is used for testing objective theories by examining the relationship among variables.
- Mixed research is used for understanding the meanings that individuals or groups ascribe to events and the incidence of each particular meaning in events.

Creswell (2009) suggested that qualitative and quantitative approaches should be viewed as different ends of a continuum and that the mixed approach resides in the middle and takes elements from both ends.

Based on the knowledge acquired by the researcher during the exploratory research stage (particularly the need to explore and understand the meanings and emotions that influence the perception of the health care service by patients) the best approach to finding the answers to the basic research questions is the mixed approach. Qualitative approach is more effective for understanding how patients attribute meaning and perceive satisfaction with the health care service and to identify and understand the

meaning of clues to improve the service, and quantitative approach is more useful for evaluating the different meanings and perceptions of patients and the relative importance of the clues to improve the service.

The appropriate qualitative research approach, as recommended by Pope and Mays (Eds., 2006), is the use of structured interviews. The interviewers are trained ask questions based on a structured questionnaire (mostly with fixed choices as responses) in a standardized manner. The structured questionnaire will guarantee that the data gathered will be appropriate to answer the research questions. Note that these research questions and fixed choices as responses connect to the selected provisional hypothesis and theories (the selected or adapted service quality and patients behavior models established in the exploratory research stage). Note also that these structured interviews are of completely different nature than the in-depth unstructured interviews used in the exploratory research stage.

The selection of the interviewees and sampling size depends, in most cases, on the convenience and opportunity of the researchers. Ideally, the selection of interviewees is random. The sample is drawn from potential and current patients of the health care, and the required sample size will depend on the importance given by the researchers to the statistical significance of the different meanings and perceptions of patients and the relative importance of the clues to improve the service.

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Conducting the Research and Drawing Conclusions

The quality of the interviews, analysis of the data, and conclusions will depend directly on how well the researcher has planned and conduct the research projects. Most importantly, the quality of the conclusions depends on the selection, during the exploratory stage, of the research questions and on the use of fixed choices as responses in the structured interviews.

The researcher's selection of the research questions and fixed choices as responses builds on their personal interpretation of the provisional hypotheses and theories that substantiate the selection. These personal interpretations by the researcher guides their selection or adaptation of service quality models (such as the SERVQUAL model) and the adoption

behavior models for the patients (such as the REMM model). This means that the way researcher is positioned in relation to the research subject will influence their interpretations of the provisional hypotheses and theories, the formulation of the research questions and fixed choices as responses used in the research interviews, and consequently the conclusions of the research project.

An example of personal bias by researcher could be seen in the implicit adoption of the sociological model (SM), as described by Jensen and Meckling (1994), to evaluate behavior in health care of patients. The adoption of this model (very popular with governments for dictating policies to citizens) implies that researcher considers patients to be the product of their cultural environment. The patients would be seen as conventional and conformist in their behavior, reflecting the customs, mores, and traditions of the society into which they were born and raised. From this perspective, the researcher will view patients as social victims that need to be oriented by experts on what is best for them. Under this bias, the researcher postulates that they only can evaluate the health service, and have no enough knowledge of the service to suggest changes.

Other models, such as the RMM model (Jensen and Meckling, 1994), give more credit to capacity of patients to contribute to improve or even change the health care service. The adoption of the RMM implies that the researcher acknowledges a link between the behavior and personal beliefs of patients, insofar as RMM optimizes the underlying tangible and intangible costs and benefits of patients' actions. When patients perceive that the underlying costs and benefits that have influenced their behavior have changed, they face a conflict between the established behavior and the new optimal behavior. Usually, the patients will gradually change to accommodate the new behavior. This researcher perspective leads to a focus on understanding the underlying costs and benefits that determine the behavior of patients, the evolution of these, and how they affect the patients' expectations and evaluations of the health care service provided. The researcher will also search for clues that can change the patient's perception of the underlying costs and benefits of the health care service in order to improve their satisfaction with the service.

The Researcher's Stance

Savin-Baden and Major (2010) termed the way that researchers position themselves in relation to their research subject, the beliefs of the participants (particularly the interviewed), and their own beliefs the researcher's stance. The researcher's stance is a fundamental criterion for establishing the reliability and validity of the research projects and its conclusions. Migiro and Oseko (2010) used *reliability* to refer to the degree of consistency with which stances are assigned to the same category of interviews or by the same interviewer on different occasions, and *validity* to whether a test or measure of any kind or a data set used actually measured the thing it was intended to measure. They also pointed out that the validity of the procedure depends on the stance (calling this the *lens used*) taken by the researcher to establish validity in a research project and the paradigm assumptions underlying this stance. Hayek (1976) used the term *paradigm assumptions* to describe the provisional hypothesis and theories that researchers have to presuppose to establish the research questions.

To establish the validity (or credibility) of the conclusions of the research project, researchers have offer complete transparency in terms of the methods and analysis used (Bluhm et al., 2011; Bansal & Corley, 2012). Migiro and Oseko (2010) suggested that this may include: self-disclosure of the researcher's role in the research project; description of the research setting, the participants, and the themes of the study in detail (a *thick description*; see Tracy, 2013); providing clear documentation of all the research decisions and activities; peer-reviews; triangulation; and confirmation of the research information and narrative accounts from participants.

Bansal and Corley (2012) noted that for many researchers, communicating their journey (from initializing the research project to submitting the report) gives meaning to the accounts of the data and emergent conclusions, as well as signaling the quality of the research, and ultimately, the trustworthiness of the data and the emergent conclusions.

Conclusion

A successful research project to measure the satisfaction of patients in health care has to correctly consider the three issues discussed in this paper. The first—and most critical—issue that the researchers have to consider is the correct interpretation of the research objective and formulation of the research questions. Hayek (1967) explained that questions presuppose a provisional hypothesis or theory about the events that will be the focus of these questions. The objectivity and meaningfulness of the questions that are used to accomplish the research objective will depend on the quality of the exploratory research undertaken by the researcher: as these are used to choose or adapt a service quality model and a behavior model for patients. An effective model takes into consideration the emotions of patients and fosters patient cooperation by incorporating suggested changes.

The second issue is the selection of the appropriate research design. This is directly related to the formulation of the research questions, the service quality model, and the behavior model of patients. Special attention should be paid by the researchers to the careful preparation of the structured interviews to collect data on the research questions, the selection of the sampling size (so that the results are statistically significant), and the training of the interviewers to obtain the maximum reliability of the collected data. Arguably, the best advice is to closely follow the recommendations of Pope and Mays (Eds., 2006) on how to structure and conduct interviews in health care.

The third issue is the need for researchers to provide full and detailed disclosure of the whole research process, from the exploratory research to the analysis and findings with the collected data. This gives the necessary credibility to any research project to measure the satisfaction of patients in health care and its results. Toward this end, Migiro and Oseko (2010) and Bansal and Corley (2012) have provided some sound advice on why and how on the issue of full disclosure to guarantee the necessary credibility of the research project.

References

- Altuntas, S., & Yener, E. (2012). An approach based on TRIZ methodology and SERVQUAL scale to improve the quality of health-care service: A case study. *Ege Academic Review*, 12(1), 95–104.
- Anderson, E. W., & Sullivan, M. W. (1993). The antecedents and consequences of customer satisfaction for firms. *Marketing Science*, 12(2), 125–143.
- Bansal, P., & Corley, K. G. (2012). Publishing in AMJ - Part 7: What's different about qualitative research. *Academy of Management Journal*, 55(3), 509–513.
- Berry, L. L., Wall, E. A., & Carbone, L. P. (2006). Service clues and customer assessment of the service experience: Lessons from marketing. *Academy of Management Perspectives*, 20(2), 43–57.
- Bluhm, D. J., Harman, W., Lee, T. W., & Mitchell, T. R. (2011). Qualitative research in management: A decade of progress. *Journal of Management Studies*, 48(8), 1866–1891.
- Cooper, D. R., & Schindler, P. S. (2011). *Business research methods* (11th ed.). New York, NY: McGraw-Hill / Irwin.
- Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Los Angeles, CA: Sage.
- Dubé, L., Bélanger, M.-C., & Trudeau, E. (1996). The role of emotions in health care satisfaction. *Journal of Health Care Marketing*, 16(2), 45–51.
- Hayek, F. A. (1967). *Studies in philosophy, politics and economics*. Chicago, IL: University of Chicago Press.
- Jensen, M. C., & Meckling, W. H. (1994). The nature of man. *Journal of Applied Corporate Finance*, 7(2), 4–19.
- Kumaraswamy, S. (2012). Service quality in health care centres: An empirical study. *International Journal of Business and Social Science*, 3(16), 141–150.

Maute, M. F., & Dubés, L. (1999). Patterns of emotional responses and behavioural consequences of dissatisfaction. *Applied Psychology, 48*(3), 349–366.

Migiro, S., & Oseko, A. (2010). Qualitative research paradigms: What the novice researcher needs to know. In J. Esteves (Ed.), *Proceedings of the 9th European Conference on Research Methods in Business and Management* (pp. 334-341). Reading, UK: Academic.

Parasuraman, A., Berry, L. L., & Zeithaml, V. A. (1991). Refinement and reassessment of the SERVQUAL scale. *Journal of Retailing, 67*(4), 420–450.

Parasuraman, A., Zeithaml, V. A., & Berry, L. L. (1985). A conceptual model of service quality and its implications for future research. *Journal of Marketing, 49*, 41–50.

Pope, C., & Mays, N. (Eds.). (2006). *Qualitative research in health care* (3rd ed.). Malden, Mass.: Blackwell.

Ramez, W. S. (2012). Patients' perception of health care quality, satisfaction and behavioral intention: An empirical study in Bahrain. *International Journal of Business and Social Science, 3*(18), 131–141.

Savin-Baden, M., & Major, C. H. (2010). *New approaches to qualitative research: Wisdom and uncertainty*. London, UK: Routledge.

Seth, N., Deshmukh, S. G., & Vrat, P. (2005). Service quality models: A review. *International Journal of Quality & Reliability Management, 22*(9), 913–949.

Soita, P. W. (2012). Measuring perceived service quality using SERVQUAL: A case study of the Uganda health and fitness sector. *International Journal of Business & Social Science, 3*(5), 261-271.

Teas, R. K. (1993). Expectations, performance evaluation, and consumers' perceptions of quality. *Journal of Marketing, 57*, 18–34.

Tracy, S. J. (2013). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. Chichester, UK: Wiley-Blackwell.

Tronvoll, B. (2011). Patterns of emotional responses and behavioural consequences of dissatisfaction. *Journal of Service Management*, 2(1), 111–134.

Zeelenberg, M., & Pieters, R. (2004). Beyond valence in customer dissatisfaction: A review and new findings on behavioral responses to regret and disappointment in failed services. *Journal of Business Research*, 57, 445–455.

Zeithaml, V. A., Berry, L. L., & Parasuraman, A. (1993). The nature and determinants of customer expectations of service. *Journal of the Academy of Marketing Science*, 21(1), 1–12.

Zeithaml, V. A., Bitner, M. J., & Gremler, D. D. (2009). *Services marketing: Integrating customer focus across the firm* (5th ed.). Boston: McGraw-Hill Irwin.

Zikmund, W. G., Babin, B. J., Carr, J. C., & Griffin, M. (2013). *Business research methods* (9th ed.). Mason, OH: South-Western.



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