

The Construction of the Dissatisfied Patient

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Abstract

The logic of governing in New Public Management (NPM) relies in the possibilities of transforming internal and external boundaries by making the customer the primary point of departure for all planning and evaluation activities. But the patient has proved to be difficult to arrest in terms of a customer. A major difficulty with for instance surveys of satisfaction is that the patients tend to report a very high level of satisfaction. That becomes a major obstacle to the inherent logic of improvability inherent in both NPM and in TQM more specifically. In later years we have thus come to see a shift from a reliance on surveys as such to a system of external specialist organisations providing analysis of survey data. Our paper will focus on patient satisfaction questionnaires as an ethical technology – repertoires for the conduct of conduct in particular contexts and for particular purposes, of images, norms, evaluations and techniques of selfhood. In our concluding discussion we will judge the emerging reconstitution of the patient by reference to certain ideals, which are not true or beyond discussion elements of practising the game of the open society: collective self exploration (rather than fixation of self), deciding who and what is in a need (rather than making needs to something beyond discussion), balancing individual and collective action (rather than balancing claims of recompense).

Introduction

It is widely recognised that power relations in modern societies are complex – distributed, mediated, multifaceted, polyvocal and reflexive, to name but a few of the defining terms used in this area (cf. Giddens, 1991; Beck, 1992; Rhodes; 1997; Bourdieu, 1998). It is sometimes difficult to be sure whether the modes of control described are seen as different steps in a historical development, as additional to each other in different layers in various spheres of action and relations or as new interpretations of a pre-existing social reality, put into words by the use of new theoretical frameworks. One line of research has reformulated the questions in this area from the particularities of “who has got the upper hand right now?” (Burchell et al, 1991; Miller & Rose, 1990; Rose, 1999, 1999; Dean, 1999). Traditional questions in power analysis like the role of state power in modern society, or the degree of autonomy/domination in working life has been criticized and redirected to an analysis of what makes certain relations of power possible and power as something *in becoming*, from heterogeneous regimes of practices.

In this paper we attempt to raise some questions concerning the use of some central concepts in this tradition, especially governmentality, and propose a more consequent distinction between organization of subjectivity as a way of shaping power relations, the problematizations that make such an orientation seem necessary and the very techniques of government. There is a tendency to let the complexity of power relations in modern societies, that many agree on from various viewpoints, also enter the conceptual dimension in the “governmentality” type of analysis. For instance, it is often claimed that power relations in modern societies are complex due their distributed and mediated character. That is reasonable for many reasons to assume, but the full complexity of the object of analysis does not need to be reflected in the analytical language. To be somewhat provocative, we feel that it is more promising to address empirical tasks in order to actually make sense of the “what” and “how” of power relations

(cf. Dean, 1999). There is an abundance of instrumental projects in various shapes in modern society that would be suitable both to address as cases of distributed and composite power regimes, but also helpful in developing the analytical language of governmentality studies.

Governmentality – a mode of analysis or a form of power?

Foucault (1976) presented a new understanding of power relations in modern societies as being to a large extent constructed by the shaping and organizing of subjectivity. From the “The Foucault Effect” (1991) this rather general idea has been contextualized and situated in analysis of political thinking and government¹ in the western world from the mid 19th century. The rise of the liberal political tradition was predicated on a never ending problematization of the danger of power. The inherent capacities and rights of the subject was considered to be under constant threat of being limited and violated. Where ever possible, the traditional sovereign power of the state should be minimized and delimited. Foucault and the tradition mentioned above made the liberal problematization of sovereign power to a turning point in history. Power becomes from that period more often mediated through complex, and less reliable in some sense, conduits of behavioural and systemic conditioning. To use concepts from organizational sociology, a drift began from direct and structural control to control of premises of action (Perrow, 1986). The main concern of researchers in this line of thought, from Foucault and onwards, has been to develop such an analysis in relation to “advanced liberal government”, the particular constellation taking shape from the mid 19th century (Dean, 1999, p. 164-166).

A critical reflection on this in itself stimulating and novel re-conceptualisation could have several points of departure. One obvious is that there are few empirical studies so far which could add nuances and details to this form of analytics, giving more credence to the refusal of totalizing explanations (Dean, 1999, p. 34-38). Empirical studies from other, but somewhat related traditions (cf. Rhodes, 1997, Scott & Meyer, 1994) could also be analyzed in that purpose. Another issue relates to how the different aspects of power as *governmentality* should be understood. We will point to a need for further clarification that actually departs from what is held to be important in this tradition. Governmentality as a logic of governing meaning *the conduct of conduct*, should be kept apart from the techniques of governing and both of these from the historically contingent problematizations which gave rise to the particular mode of governmentality in the occident from the 19th century. These suggestions are also attuned to what Dean suggest, that the techniques and ways of thinking used to foster subjectivity in the governmental mode of power, developed within the techniques, rationalities and institutions of sovereignty and discipline (1999, p. 19-20).

Therefore we propose a distinction between three related but analytically different aspects of governmentality²: the project of recasting subjectivity to a primary circuit of power, the historically situated problematizations that gave rise to a *particular* form of governmentality from the mid 19th century – stemming from liberalism’s concern with abuses of power and lastly the technologies used to instrument the former.³ To analyze how these three aspects connect historically is how we understand Rose’s suggestion to use ‘governmentality’ to mark

¹ A wide definition used in this tradition to cover all systematic forms of “conduct of conduct” (Dean, 1999). It thus includes all sorts of instrumented efforts of shaping action in everyday life, working life and the public sphere.

² We invite to a clarification of this very term: it is necessary to decide if governmentality should refer to a particular historical mode of power (power mediated through various and heterogenous circuits) or, a mode of analysing power (cf Rose, 1999, p. 22)

³ See also Hasselbladh & Kallinikos, 2000, for a discussion on similar issues in relation to the neo-institutional school in organizational analysis.

out “the field upon which one might locate all investigations of the modern operations of power/knowledge” (Rose, 1999, p. 22).

Following this reasoning we would say that the systematic organization of individual and collective subjectivity is the core of advanced liberalism (Dean, 1999, p. 165). It has developed into a covering frame of public and private life in modern societies by being linked to dominant ideas about rights and capacities of the individual and appropriate forms of government, by the enormous development of forms of thought and knowledge related to a very distinctive combination of subjection and subjectification (the “psy” sciences, self improvement as individual and collective projects, management of performance according to different norms) and the standardization of techniques to make cybernetic self control possible from the individual to supra state level (IQ-tests, statistics for benchmarking, accounting, “rational” markets etc). But what is new here is the seemingly covering and dominant status of this entire constellation, not the organizing of subjectivity per se. There is a danger in being too narrow-sighted on the liberal discourse as the birth of acting through subjects, cropped by the very discourse that latter operates through them. “Subject politics” has been around before, for instance was the early reforms of Octavianus directed at making cities in the provinces and local guilds to self-controlling political and economic agents, within a frame of distant political rule (Wells, 1984/1992). What is important about this is that it demonstrates that “politics of the subject” can take shape within other frames of thinking than the (neo-) liberal. Any coherent mode of constituting relations between a centre and a periphery can be made into a programme of “politics of the subject. The Romans knew nothing about the liberal conception of the individual, but had a very developed notion of citizenship, spelling out an entire ethos of public life, which these reforms attempted to universalise and make dominant throughout the empire.

The roman “politics of the subject” was thus linked to the ideals of citizenship (the situated version of the early principate, not a free-floating non-historical constant). Citizenship in those days and freedom in the age of liberalism are something put to work in practices, but it is not reducible to these practices. Ideas intervene in social life, and in that sense transcends their “pure” ideational status, when they are formulated into coherent modes of “questioning and interrogating the past, present and potential alternatives” including ways of evaluating success or failure (Dean, 1999). But problematization will not be consistent over time unless there is some common theme in the way questioning and interrogation proceeds. That is to say, there is no necessity of coherence in the actual problematization of a domain, it can be done from various points of departure. But if we maintain that liberalism is recognisable over time and contexts as a mode of questioning, certain traits must be discernable. Foucault’s suggestion seems to capture that - liberalism as an ethos of government that seeks to avoid the twin dangers of governing too much and too little (Rose, 1999, p. 70). Such a constituting ideal makes it possible to decide on things, to make distinctions (is or is not, good or bad) that define and delimit a part of the social sphere into something at hand to act on (compare Hasselbladh & Kallinikos, 2000). Another way to put this is that it should be a part of an analysis of governmentality to capture the *utopian* element of government, but in a way that addresses how an ideal (“freedom”) is brought to bear on practices of government (Dean, 1999, p. 33).

The last part of our proposed triptych is the techniques of government. Are they mere ‘practical’ features of government as Dean suggest (1999, p. 212)? One could say that it is their very practical nature that makes them profound to any type of government. Forms of notation, systems of representation, techniques of calculation, means for arranging space,

bodies and time construct and solidify government to a state of stability necessary for reproduction across time (Kallinikos, 1996). They make up power/knowledge regimes that any type of problematizing is bound to address. Thus, when liberalism's notions of freedom was articulated during the 19th century it could not avoid facing an institutionalised order of government – the operating techniques of sovereignty and discipline. The established order was reformulated to encompass the ideals of freedom (in new national and later international constitutions fixating various rights of individual's and collectives) but freedom became enmeshed with the techniques, rationalities and institutions of sovereignty and discipline, resulting in liberalism's distinctive formula as a mode of government: subjection and subjectification are laid upon each other (Rose, 1999, p. 165). Freedom as a way of governing societies became by that a new impetus for rearranging and developing new disciplinary practices, also outside the realm of the state and corporations. For instance, the rise of various popular movements in Scandinavia, Germany and Austria a century ago was accompanied with projects of self-disciplining that transformed farmers, workers and consumers to articulate collective actors in the public sphere.

Our attempt to explicitly keeping three aspects of governmentality apart – the shaping of subjectivity, different ideals to problematize from and techniques of government serves an analytical purpose. How do we go about to disentangle contemporary, or historical, configurations of governmentality (designating a type of analysis, or 'analytics', Dean, 1999, p. 20)? We find it somewhat premature to decide on the nature of the distribution, coherence and stability of government in modern societies. As Brown (1995, p. 18) points out, governing by means of deregulation and privatization does not necessarily imply that state domination is ruled out. We would even maintain question marks around the often-delivered statements about power being "distributed, polyphonic" etc, at least everywhere and always. The organization of subjectivity can take various shapes, run from different directions and be stimulated by other ideals than freedom. Not only can pastoral power go mayhem, as in state induced bio-political programmes (Dean, 1999, p. 132). Performativity, or mans dominance and systematic capitalization of "resources", living and dead, are ideals which has cohabited with liberalism's notion of political freedom (compare Castoriadis, 1987; Meyer, 1994; Kallinikos, 1996). For instance, the systematic organization of subjectivity has been used in industry in order to exploit human resources in a "deeper" sense since before 1920 (Jacques, 1996). The Scylla and Charybdis of liberal freedom is thus but one point of departure for engineering subjectivity in modern societies. The institution and proliferation of self-reflecting and ingenuous selves does not necessarily mean that we are witnessing government induced by freedom (even if it is understood without everyday positive connotations). It could also be that a few of freedom's behavioural attributes are reformulated within a programme of performance. We do not suggest "a critical turn", manufacturing reflexive workers are not necessarily more conspicuous than manufacturing political subjects. Manufacturing subjectivity within different frames does however have different real effects, regardless of any romantic views of belying or confirming the true subject.

In existing domains of action in society we will however seldom find unitary logics of government, or unitary forms of questioning or unitary programmes of change (Friedland & Alford, 1991; Fairclough, 1992). We are inclined to se some promises in keeping certain aspects of governmentality apart on an analytical level, in order to shed some light on forms of government, problematizations and programmes in real life, which we expect often to be entangled in and feeding upon each other. In the following we will address the problematization and following programmes of change developed around the public sector in the western world the last 15 years. "New Public Management" will not in itself be our object

of analysis. Instead we will focus on a thinner slice of the health services – how a certain object, and subject in becoming, of a regime of practices has developed. The patient has been mobilised in different ways and on different levels in the questioning and the following reform efforts, summarized as New Public Management. Departing variously, and sometimes simultaneously, from notions of freedom and performativity the patient has been mobilised in various ways. We will analyze how systems of representation, policy making and interrogations of an existing order join in constructing the subjectivized patient.

NPM and the patient to satisfy

As Power (1997) succinctly puts it: “Taxpayers and citizens, rather like shareholders, are the mythical reference points which give the NPM its whole purpose.” (p. 44). The relation between the public sector and society is individualized, omitting or glossing over the public as an “agora”, in favour of the individual citizens role as *user* of particular services. The production in the public sector is not regarded a part of politics, but something that takes place in organisations. Organizations must comply to what *users* want. Internal and external relations should be designed by making the customer the primary point of departure for all planning and evaluation activities (ibid. p. 58, Tuckman, 1995, p. 58). In health care, this anathema of NPM has been spun around the notion of the patient. But it is awkward to shape a public discourse making the patient to a subject, in the same manner as with taxpayers and citizens. The collective of patients has no institutional lineage, with established ways of articulating themselves and executing influence resembling other modes of political and economical subjectivity. The identity of patients is also constituted by definitions of temporal or permanent impairment of physical and/or mental faculties, assuming that the graver impairment, the more patient-like you become. The medical professions and the organizational settings of health care are also oriented towards *the patient as deficient*. Skills and socially sanctioned tasks of doctors are intended to repair or easing the incapacitation of patients. The perhaps most important actor group in health care is thus constituted by institutionally validated measures of incapacitation of its counterpart.

NPM inspired problematizations of health care, departing from the ideal of customer customer responsiveness, has thus confronted a dilemma. How shall we make the sick speak? Can the sick become articulate enough of their needs, experiences and wants in order to make possible as inputs of government? While internal relations can be transformed to customer-supplier chains and previous local or central political and administrative bodies be made purchasers by means of various techniques and schemes (internal price systems, new organizational forms etc), the patient has proved to be more difficult to arrest in terms of a customer.

The NPM is hardly a coherent way of interrogating public services (Hood, 1995; Olson et al, 1998). There are several ideals mobilized in the problematization of for instance health care and these are neither logically or historically coherent. A central part, and some would say core, of the NPM is the market/customer ideal mentioned above. But another ideal integrated in the interrogation of public services called NPM is that of performativity – specified in terms of cost effectiveness, relative size of national GNPs and quality of services. The third paramount ideal is that of control, in terms of seeing the public sector as a set of organizations. Are they tools in the hands of their political and administrative masters or have been occupied by other forces?

But as health care has been a target of requests for accountability before the rise of NPM, patient satisfaction became an area of knowledge production already in the 1970s. This early attempts to measure and evaluate patient satisfaction on a regular and systematic basis created

systems of record keeping – a prerequisite for making something possible to audit (Power, 1997, p. 87). A major difficulty with surveys on satisfaction is that the patients tend to report a very high level of satisfaction. That becomes a major obstacle to the inherent logic of continuous improvement inherent both in NPM in general and in TQM more specifically. In later years we thus have come to see a shift from a reliance on surveys as such to a system of external, specialist organisations providing analysis of survey data. Experts must interpret information in order to detect reasons for dissatisfaction, impossible to articulate by the respondents themselves.

Knowing the patient

During the last decade surveys have become a big business in the US. The largest firm in the business administers 4 million surveys a year. Also in Sweden patient surveys has come to be used as a part of quality management in the regional councils. A new legislation from 1996, making systematic quality management mandatory, effaces a quick development in this area.

In 1985 the department of finance presented a report on the declining productivity in Swedish health care. This report attracted much attention and led to a raised interest in quality and efficiency in the health field. Here, an important actor was The National Institute of Rationalising Health Care, an organisation that became one of the main producers of reports on the topic of how quality can be measured and improved in health care. A research project analysing measures and improvement of quality in the public sector showed that almost all the 27 Swedish county councils had quality definitions, and that these definitions often were linked to the way quality was measured (Rombach 1990). Also, a majority of all projects on quality in the counties focused on patient's attitudes.

Our paper will focus on patient satisfaction questionnaires as an ethical technology - repertoires for the conduct of conduct in particular contexts and for particular purposes, of images, norms, evaluations and techniques of selfhood (Rose, 1999). The Swedish case emanates from a statement in 1996 by the general director of the Board of Health, who questioned the traditional construction of patient questionnaires. Soon, an international institute specialised on patient satisfaction made their entrance on the Swedish scene. Instead of measuring patient satisfaction the method focus on "percentage of improvement potential". Their survey "pinpoint areas for quality improvement", and provide the buyers "with actionable results" in areas such as information, access to care and respect for patients' values. In this model, the patients are not themselves asked to set a value, good or bad, on their experience. Instead, the experts who evaluate the aggregated answers, for instance the number of minutes in the waiting room, and judges the result in terms of deviations from norms, and thereby scientifically display the strength and weaknesses of the caregivers. This method ensures that the prospects for improvement will be infinite. Even though the institutional actors that represent the patient's interest in Sweden and US are different in origin, their arguments and proposed strategies are much the same. We have named their joint programme the construction of the dissatisfied patient.

Also, the development of products in this area is described. Here we find trends towards national standards, repeated surveys, special questionnaires for groups that tend not to mark areas for improvement, computer software for analysis of patient classified according to diagnoses, and techniques for the dissemination of good examples. There seem to be a link between the design of the questionnaire, the areas for improvement that is made visible, and other products of the institute – products that will help solve the shortcomings of the caregiver.

Strengthening the patients' position

The importance of strengthening the patients' position through increased information and participation is emphasised everywhere in the discourse about health policy in the late 90es. The WHO declaration of patients' rights, in governmental reports, in the statements of professional associations and in the great amount of managerial literature where this topic is discussed in terms of quality, consumerism and technology.

This is also the focus of the reshaping of the Swedish health care service supported by the new laws and regulations, made in 1996 and 1997 (SOU 1997). Earlier the Swedish law of health care service emphasised the *obligations* of the health care professions, but the new law concentrates more on what the patient should be able to *demand* from the health care services. The regulations state that it is important that the health care service is made more accessible for all patients, that the patient should be able to choose the physician, and should be given information to increase the possibility to participate in choices between different treatments. The regulations also stipulate that the caregiver must document in the patients' records all the information on alternative treatments, the preferences of the patient and the resultant agreements from this discussion. The regulations also strengthen the board, which will receive patient's complaints and report these back to the health care departments (Health and Medical Advisory Board). State legislation is by that constituting the patient as a subject, by stipulating rights of information, choice and involvement.

These changes are motivated by the presumption that most patients want to have an influence over treatment options. This is the area, which generates a considerable section of patients' complaints (SOU 1997, p. 21; Patientnämnden, 2000). According to the governmental report "The Patient is Right", patients' participation will be even more important in the near future, "It will be of crucial importance for the legitimacy of the health sector for a large proportion of the population, that it can meet the demands for influence and participation that the citizens of the modern information society will pose" (SOU 1997, p.11). There is a concern that the common financing of health care service may be at stake if this can not be achieved (ibid. p. 75). Further, the report states that neither the patients of today or tomorrow are interested in the classic patient physician-relationship where the physician makes the decisions in the best interests of the patients (ibid. p. 22). The change in legislation is also motivated by the intention to ensure that weaker patient groups will have an influence on their treatment, and that the information is adjusted to the individual needs and condition – mirroring the state's intention to increase *justice* in health care (ibid. p. 76). Even if this information and participation makes demands on the time and efforts of the staff in health care services, it should be considered as an *investment* in the future as, according to the report, well informed patients are a resource in health care, and may need less treatments, shorter treatment periods, and will respond better (ibid. p. 69). The programme for reconstituting the patient was already at this point mixing a liberal conception of undeniable rights of the patient with ambitions to economise health care, something which will be more evident further on. The responsibility of implementing the change and making it have a real impact in local practices is laid on the political authority of the county councils as well as on the administrators:

"The leadership must show their interest in concrete action by inducing demands and stimulating an active development work with the objective to strengthen the patients' position in a long-term perspective. This points to a broad definition of leadership, a leadership that will clear the way for a new way of working in the health care sector, and in which the patients are made to participate and is considered as a resource. This is also about taking initiatives and creating conditions to ensure that the values and attitudes about

strengthening the patients position will pervade the staffs' work and the organisation.” (ibid. p. 13-14).

But to ensure that the staff shall “... change the dependent patient to a critical consumer of health care who questions and demands the display of performance results as well as information about alternative care givers” (ibid. p. 76), the management will need both tools and techniques. We will describe the evolution of an entire system, feeding politicians, health care managers and doctors with new criteria of relevance and measures of performance – all relating to subject status of patients.

The total patient feed-back system

The legislative reform stipulates that the health care staff must change their behaviour. It is in the treatment room, in the interaction between the caregiver and the patient that a new behaviour is to be put into practice. According to an agreement between the state and the county councils the demands for a reinforced position of the patient implies a new *pedagogic* role for the health care staff. They have to meet up to an active patient who seeks knowledge and who is capable of taking greater responsibility for his or her own treatment. The agreement says this will call for a willingness to listen and adjust the dialogue to patients needs, a competence which should be given more attention in basic and further education of health professionals (Socialstyrelsen, 1999). Three organisations in the field, The Federation of County Councils, The Swedish Medical Association, and The Swedish Society of Medicine together launched a project where the prerequisite for a ‘good meeting’ is discussed. In further education for physicians’ there are courses in self-knowledge, methodology of dialogue, and discussions on ethics (SOU 1997 p. 78; Ottosson, 1997). This is apparently a new way of framing the professional role of doctors, towards a more “therapeutic” orientation.

However, the dialogue with patients in the treatment room is not defined as part of “the total patient feedback system”, as it has been described in the literature on quality systems (Tasa et al, 1996). These are defined as the techniques used by politicians, managers, researchers, chiefs of clinics and quality teams and with which patients’ opinions are aggregated through patient satisfaction surveys (questionnaires, telephone interviews etc.), internal and external complaint systems and focus groups (consisting of discharged patients or members in patient organisations). The Board of Health has developed two main types of feedback systems to follow up the new legislation. First, the law of systematic quality systems in health care services is designed to ensure the patients’ dignity, integrity, participation and security through a system of self-checking in the health care organisations. These procedures must be carried out at every level of health care organisations. Secondly, the legislation strengthens the organisation for patients’ complaints through initiating a system of patients’ ombudsmen at the hospitals and a Patient board in every County Council. (Local incidences should as before be reported to a separate governmental authority.) These contrivances are made widely known through brochures in the health care departments, through advertisements in the telephone directory, and in the County councils own journal that is distributed to customers in pharmacies.

At present the Board of Health is conducting intensive development work exploring new ways to strengthen the patients position (Socialstyrelsen, 2000a) Databases with information about the performance of caregivers and easily comprehensible State of the Art-texts are made accessible on Internet. Also, questionnaires, which capture the patients’ opinions on the care they receive, are developed. Thus the Board of Health is trying to develop a milieu for the

active patient – deliberation and choice requires an environment of information and alternatives in order to be possible to enact.

A new science

In 1996 in an editorial of The British Medical Journal a professor from Harvard medical school proclaimed satisfaction surveys as an emerging new science (Delbanco, 1996). The growing importance of the concept of patient satisfaction has attracted large numbers of researchers to this methodology. In order to study the number of publications using this approach in medical and health research, a search was conducted on the PubMed database, which is available on the Internet. The search was designed to capture all articles that included the words patient satisfaction *and* questionnaire or survey in the title or abstract. The search was made separately for every year in the period of 1985 to 2000. As shown in figure 1 the number of articles fitting the description has increased strongly, from 39 in 1985 to 602 in 2000. From 1995 until present the increase is more pronounced than in the preceding decade.

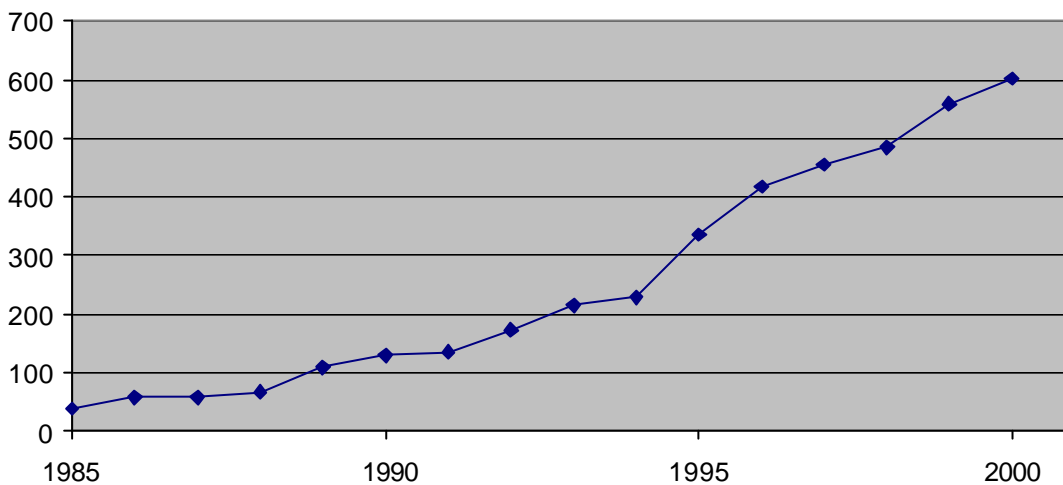


Figure 1. Number of articles in PubMed database with the words patient satisfaction and questionnaire/survey in title or abstract, during the period 1985 to 2000. (Search commando: patient* satisfaction AND (questionnaire* OR survey*)).

A number of academic journals specialising on this area of research have been introduced in the nineties, for instance the Health Expectations (started 1998), "aiming to promote critical thinking and informed debate about all aspects of public participation in health care and health policy". Another example is the quality journal launched by the British Medical Journal, the Quality Management in Health Care (started 1992). Other examples of journals in this research field are the International Journal for Quality in Health Care (started 1994), The Joint Commission Journal on Quality Improvement (started 1993), and Quality in Health Care (started 1992). There is also a vast landscape of university institutions and research institutes conducting education and research in this field.

Calnan (1988) has discussed the research on lay evaluation of health care. In a paper analysing the conceptual framework of this field of research it is argued that the importance of measuring patient's satisfaction is not considered interesting in its own right, but rather in the context of three separate, but interrelated reasons. One of these reasons is focused on the patients' satisfaction, as it is believed to be a part in the *process of health* through influencing compliance with medical advice and medical regimes. From this point of view the patient's

satisfaction is something to manage – a way of manufacturing subjection to traditional medical technologies. The second reason related to political beliefs. Here the emphasis is on the need to take account of the perspective of the patient as a way to *democratise* the health services, alternatively to strengthen the consumer sovereignty in relation to the supply of health care. The liberal conception of rights emerges here. The third reason has to do with professional *ethics and humanitarian* concerns. It is in this soil of different reasoning and beliefs that the technologies of patient satisfaction questionnaires prosper. But all these three are but ideals to problematize medical work from, until they have been instrumented to calculating and communicative practices.

The performance measurement industry

The quality programmes launched in the Swedish health services during the nineties have focused on improvements in the secondary service; i.e. the *manner* in which the basic, medical service is delivered. The most spread quality manual in the Swedish health service is “Quality – at your service” (Promentor Management & Brat International, 1995), which has been distributed in 140 000 copies in Sweden alone. Here the staff is instructed on how to create the company’s quality image, and become a “quality type” instead of a “couldn’t-care-less type”, and to set up “zero defect goals” and a “zero defect attitude”.

However, it has proved difficult to define lack of quality in the health sector. In patient questionnaires for instance, nine of ten patients consider that, on the whole, they are satisfied with their treatment in hospital. In Sweden, as in most other countries, patients express the same positive opinion when they have been asked to evaluate their treatment (Rombach, 1990; Spri 1999). The measuring of patients’ satisfaction, was discussed at a conference for caregivers in Stockholm in 1996. The general director of the Swedish Board of Health concluded that it was not possible to transfer instruments for customer estimations to patient estimations since:

“The patient is in a completely different position. He is suffering, frightened, and uneasy, has lost some of his integrity and independence, and is thus at a disadvantage. Also, he lacks the means of judging whether measures taken are motivated and correct. The majority accept and are grateful.” (Fakta, 1996 p .5)

This showed the need for expert knowledge and special methods which took the patients’ situation into account, and soon an international institute, the Picker Institute in Boston, USA, was invited to Sweden.

The international institute

The Picker Institute⁴ is a non-profit organisation and a main actor in the international health care performance measurement industry with offices in Boston, Oxford, Hamburg, Zug and Stockholm. The Picker Institute was founded in 1987 and its tools and methodology for patient satisfaction questionnaires has received numerous awards in the United States. The secret behind the ability of the Picker-surveys to detect *variations*, and thus differentiate

⁴In May 2001 the Picker Institute was transferred to the National Research Corporation (NRC) (www.nationalresearch.com). The material on the Picker Institute is collected mainly from their website (www.picker.org) which is now closed down. However, the European branch of the Picker Institute (www.pickereurope.com) prevail as an independent company with offices in Sweden, Germany, Switzerland, and UK. The NRC claims to be the 43rd largest and fastest growing research company in the United States. Other American companies in the patient evaluation business are the Foundation for Accountability (FACCT) (www.facct.org), Press Ganey Satisfaction Measurement (www.pressganey.com) (Press & Ganey, 1989); and the Hospital Corporation of America. (www.hcahealthcare.com) with the Patient Judgement System (Nelson et al, 1989).

between performance of hospitals, is that they ask patients to report in detail on “what happened” to them, rather than asking them to rate their satisfaction (Cleary & McNeil, 1988, Cleary et al 1993). For instance, instead of asking patients to rate general aspects of their care such as “the courtesy and helpfulness of your doctor”, the respondent is asked questions such as: “Were you told about the purpose of your medication in a way that you could understand?”, “Were you given enough privacy when being examined or treated?”, and “Did you receive information on what assistance you could obtain at home?” Another example of this type of questions is: “How many minutes did it usually take after ringing the bell before someone came?” The reply alternatives are given in minutes. The technique thus implies that it is the experts who decide what is a good quality of care by defining the content of the questions as well as the interpretation of the replies.

Considering the fact that a large proportion of sick people are very old, and the difficulties communication may involve for persons with reduced cognitive functions, the future possibilities for improvement in this area are endless. This is an important point in the construction of tools for continuous improvement. They must be designed in such a way that it will be impossible to reach a final goal. There must always be a reason for further improvement. As Picker Institute’s chief executive in Europe puts it:

“Across Europe health care providers, purchasers and policy makers are looking for ways to ensure that patients are centre stage in quality improvement. (...) People are realising that surveys such as ours ought to be the key component of any quality programme.”
(www. picker.org, 2000-10-12)

The performance measurement experts from Picker Institute will conduct the studies with a minimum of involvement from the clinical staff. The results are presented in tabular and graphical form and the presentation is designed to help purchasers determine *priorities for action*. The answers are presented in the phrasing of “potentials for improvement”, which is the euphemism for the percentage of patients that do not score the “best” reply alternative. Thus, the construction of the questionnaire displays the potential for improvement from those dissatisfied patients who can articulate a complaint, the dissatisfied patients that are unable to express their dissatisfaction (who are in a dependent and disadvantages position), and those who are satisfied but ought not to be (who accept and are grateful). However, we did not find any interest in identifying patients that should be satisfied, but none the less are dissatisfied.

The Picker Institute offers a variety of products to support their mission. Their Picker portfolio includes a dozen questionnaires for special patient groups, for example emergency services, cancer care, children inpatients, and hip replacement. Among their research projects are development of questionnaires for groups that have special difficulties in complaining, such as patients with early stages of dementia, culturally-sensitive measures for Asian Americans, and an end of life care survey for terminally ill patients. The Picker’s database provides comparisons with national and international benchmarks and targets for providers.

Picker also offers products for disseminating their theories. A monthly bulletin, a variety of seminars and courses as well as books and videotape series are the core of the staff educational program. To help staff prepare patients to leave the hospital, an educational video, can be ordered. Also, the Picker Institute offers an “action kit” for health planners and architects in planning the built environment of waiting rooms etc. These are some of the institute’s products that will help solve the shortcomings of the caregivers, in areas made visible through the questionnaires.

Two Swedish questionnaires

In the Swedish Health Service we also find some patient satisfaction questionnaires of Swedish origin. Together with the Picker tool they exemplify how the technology and expertise involvement vary in the field of measuring performance. We also find conspicuous differences according to theories, goals, and potential for inducing change.

The questionnaire "Quality of care from the patient's perspective" (QPP) was developed by medical scientists and psychologists using grounded theory to develop a theoretical framework from which a questionnaire was constructed (Wilde et al, 1993; Larsson et al, 1998). Another frequently used questionnaire, "Quality, satisfaction, performance" (QSP), was developed by health economists (Eckerlund et al, 1997) using a customer-satisfaction barometer as a model (Fornell, 1992). This model has been extended with parts that makes possible a cost-benefit valuation of the health care services (Eckerlund et al, 2000). The grounded theory-based QPP puts medical care and considerate staff in focus, while the health economists' model is "explicitly change-oriented" and focuses on accessibility, environment and participation. Also, in the latter model patient satisfaction is defined in relation to the goals of the organisation. Apart from the theoretical base, the models differ in the handling of the questionnaires. The nurses union markets QPP, and the material is delivered as a handbook and a CD which contains questionnaires and software for processing data. The whole process, from the handling of questionnaires to processing of data and presenting the report are made by the staff of the clinic. The QSO on the other hand, is marketed by a non-profit consortium including SIQ (The Swedish Institute for Quality Improvement), Stockholm Business School, and researchers from the Board of Health. Statistics Sweden carries out the studies all the way from developing a quality model for the purchaser until the presentation of graphics indicating where improvements are needed. Altogether we find that the Picker instruments and QSP have a clearer managerial/ideological agenda where the purchasers of care, and not third party payers, are viewed as main customers. The grounded theory-based QPP has a more medical/humanistic approach in assessing patient satisfaction.

In an overview of the development of patient-based quality measurement systems, a change was predicted (Nelson & Batalden, 1993). Tomorrows' systems would, according to these authors, measure areas beyond satisfaction, such as quality of care in relation to cost of care. They would produce trend data continually: present results in graphical feedback reports; use comparable data; have direct links to action; and users would be educated to interpret results and apply it for a multitude of purposes. Several of these characteristics are evident in the systems described above.

Effects of the new techniques

As described earlier, the law on health care services demands that health care organisations must use systematic quality systems, that patients should participate more and receive information about possibilities to choose care givers and alternative treatments, as well as where to make complaints if not satisfied. The law also stipulates that information given must be documented in detail in the patients' records. The importance of these measures is motivated with reference to improvements in health, democracy and ethics in care. The regulations in combination with the logic of the quality systems, with their focus on continuous improvements, measurement of results and documentation, have a potential to become a *perpetuum mobile*, profoundly changing the activities and behaviour of the health care staff. In this context, seemingly trivial techniques such as patient satisfaction questionnaires and the encouragement to patients to report complaints are important cogwheels.

An example of such a circle of displacement is as follows: Patient satisfaction questionnaires which comprise questions on information/advice and participation/involvement are often interpreted as indicating that too little has been done to inform and involve the patients in the process of health care. This finding will lead to management intervention, emphasising that this condition must be attended to. The management's statement will bring pressure on the caregivers to inform and involve their patients to a greater extent. In the treatment room the managerial instructions will be transformed to a focus on patients' choices and responsibilities, and the making of contracts and agreements, which is a late trend in the health policy of the nineties (Coulter, 1999). From here it is not far to a reconceptualisation of the suffering patient to a *responsible customer* - a customer who then is expected to have more requests for information and participation... This circle show how the demand for improved treatment in health care is accompanied by new demarcations and limits manifested as expectations for an increase in patients' own responsibility.

Another cycle is about the connection between formal complaints and the growing tendencies for extensive documentation of patients' records. (Physicians now use about a quarter of their working time for documentation and administrative work, Socialstyrelsen 2000b). According to the law patients must be informed on where they can make a complaint. Patient satisfaction questionnaires often comprise a question asking if the patient has received such information. The result on this item is, however, often disappointing, as a large percentage of patients have not received or apprehended this information. To manage this shortcoming many measures are taken, such as the production of brochures and advertisements. The formal complaints in health care have thus at least doubled during the nineties (Hälso- och sjukvårdens ansvarsnämnd 2001; Patientnämnden 2001). As a response to this "threat" the health care staff puts even more effort into the documentation of every measure taken, even if it is a matter of routine, and of every bit of information given about the complaint system, of possible side-effects, of the risks of treatment and possible choices, and so on. In this way documentation in patients' records will become less a system for communication over time and between caregivers, and more a way to "keep your back covered" in case of a formal complaint from the patient (Socialstyrelsen 2000b). This might lead to a poorer quality of health care and thus a source of increase in complaints. It resembles what Power refers to as the *eternal loop of auditing* - when evaluations are brought to bear on any existing state of art, it will raise more questions, motivating further evaluations (also including the technologies of auditing), which raise a new set of questions etc.

In our limited investigation of the rise of a new power/knowledge regime in health care, it is possible to see different departures for problematizing the traditional role of the patient in health care. Liberal conception's of inherent right's of the patient becomes entangled with ideals of economic rationalisation of health care. As we noted in the theoretical section, any type of problematization departing from the ideal of liberal freedom is bound to confront the techniques, rationalities and institutions of sovereignty and discipline. The strive to make a subject of the patient is late rejoinder to the NPM-programme, which we are inclined to see as a way of securing sovereignty (the rule of the principal) and discipline (controllable organizations) in the public sector.

But we can also discern a drift in what the state and its agencies, experts and private firms set out to produce, when they go about to reinvent the docile patient. In the primary stage of construction, something which could be summarised as the dissatisfied patient emerge - someone who is very actively constructed by seeking to catch every thinkable kind of

dissatisfaction – in communication, medical treatment, access etc. But appeals to involvement, responsibility and surpassing the limits of being a demanding and egocentric patient intervene. This could be seen as a triumph for the high ideals of citizenship. But notice that these appeals are directed towards the individual. He or she is supposed to become involved in issues of health politics and economics within the limited frames of a particular treatment. I.e., responsible action as a patient becomes a very extreme case of decentralisation. The patient, who at least in many cases is not feeling to well, is supposed to act as a pseudo-citizen, cut off from the communicative practices of the public sphere.

But how, then, does the reconstituted patient enter health care? We think that it possible to separate between two modes of entry. In the first case, we may find a patient induced by the individual doctor to engage in staged informal conversations about what they feel, think, know and value. That is a “real” patient but appealed by the doctor to articulate the self in the channels we know from the “psy”-sciences. The other mode is entry as selective measures of collectives, possible to split and divide in all possible forms – diagnosis, age, sex, social or ethnic status. Here we are more close to a management of patient satisfaction, which are derived from questionnaire responses from individual patients, but moulded and judged by expertise to reveal “truths” not discernible to non-expertise. Both these two modes point to something, which might be important. The therapeutic and the statistical modes both make interaction between patient and doctor to its object of analysis. The individual as cast in a mixture of therapeutic “learning-to-know-how-I-feel-about-this” and formal rights is recognisable from other areas in society (Rose, 1999). It might seem harmless, but in the following section we will argue that this combination can be a strong brew, manufacturing resentment.

Production of resentment

In our concluding discussion we will judge the emerging reconstitution of the patient by reference to certain ideals, which are not true or beyond discussion elements of practising the game of the open society: collective self exploration (rather than fixation of self), deciding who and what is in a need (rather than making needs to something beyond discussion), balancing individual and collective action (rather than balancing claims of recompense).

The development of this area of knowledge production is still in its infancy but we see some interesting questions here. What will the new expertise and the emerging practices of managing patient satisfaction lead to? They seem to advance a way of understanding the patient resembling what Nietzsche called *ressentiment* (Rose, 1999). The privatization of politics to individual suffering and minoritarianism is in our case mediated by a new expertise, located in large, international corporations – speaking for a suppressed patient. As a regime of power/knowledge this is likely to resemble other areas of contemporary victimisation (Brown, 1995). As in all these cases, manufacturing a subject constituted by a certain need and suffering, within a scientific displays of its causal mechanisms diminishes the possibilities of executing the practices of an open society. Therapeutization of patient-doctor encounters makes existential issues and communicative practices instrumental, as in similar situations in working life, schools and private life. Disciplinary management of aggregate patient satisfaction adds one more critical measure to evaluate, reflect and act upon to numerous others in health care (statistics concerning treatments, financial figures and mixtures of these such as DRG).

Neither the initial, somewhat unruly, dissatisfied patient nor the responsible version, involved by the doctor in making thoughtful decisions and priorities, seems to make room for the

practices of an open society. The dissatisfied patient, greedy in its complaints for recompense, makes an excellent point of passage for introducing disciplinary practices towards the profession. On the other hand, the responsible patient can turn out to be a frame for subjecting the patient to either duties for ones health (Greco, 1995) or for decentralising the balancing of costs in health care, or in the worst case, both of these.

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