

# **Accounting and the sequestration of customer experience: The social life of a customer survey in healthcare**

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## **Abstract**

The customer survey has become increasingly central to accounting and accountability as pressures to make organizations and professionals more responsive to their customers has intensified over the past twenty years. Yet, the significance and effects of the addition of the survey technology and technique to practices of accounting has hitherto been overlooked. This paper begins to close this research gap by investigating what happens on and around the survey to remake it as central to accounting in healthcare. This paper shows the activities to account for the customer and to make organizations and professionals accountable to her through the survey to involve the ‘remanagerialization of the patient’—that is, the recreation of the patient as a customer with “experiences” uniquely capable of allowing healthcare providers to achieve distinctive managerial ends. This paper also shows these processes to involve the ‘sequestration of customer experience’. Accounting comes to express the customer’s view, and the customer’s view becomes an expression of accounting. This connectivity provides an ontological security and a moral vacuity: it at once establishes control over the experiences of customers and at the same time removes the full breadth of these experiences from organizational life. The intertwining of the survey with accounting, as such, is shown not to entail simply the adoption of a new technology, but rather the wholesale remaking of system to give a voice to the customer and allow her to be heard. Illumination of the processes by which such a system emerged provides insights into accounting change and means of accounting more successfully for customers.

## 1.0 Introduction

Surveys come in many forms and are called upon to do a wide variety of things (Halsey, 2004; Halfon, 2007; Marsh, 1982). They have, throughout time and place, variously involved observations, open ended interviewing, standardized phone and postal questionnaires, simple process protocols, and even activities that today would be described as investigatory journalism. This diversity in form has been accompanied by an equally diverse set of aims and ambitions: to record facts, promote political awareness and activity, establish a new basis for social science, manage more effectively, administer a population, access the workings of the inner mind, and much else besides. This paper investigates the process by which, in the midst of these diverse ends, the survey was made central to accounting and accountability in recent years, and illuminates its effects.

Surveys have come to be essential components of accounting and accountability over the past twenty years as pressures have intensified for companies to become ever more responsive and accountable to their ‘customers’ (Vaivio, 1999; Boyce, 2000; Johnson, 1994; Mouritsen, 1997; Rawson, Duncan and Jones, 2013; Meyer and Schwager, 2007). The imperative to know customers, suppliers, and others in the extended supply chain in more than financial terms has led to the development and extension of the customer survey (Stone and Banks, 1997). As a significant voice of the customer within the organization, it has been incorporated into systems of accounting, reporting, performance management and managerial control. Indicatively, Stone and Banks note that of The Times top 500 companies in 1997, 78 percent regularly used a survey as a customer-based measure of performance. The increasing use of surveys as measures of performance has likely continued as competition has centered more specifically on customization (Pine, 1999), servitization (Neely, 2007), and the specification of quality as understood through the customer’s eyes (Callon and Muniesa, 2005).

In the public sector too, the movement to make public organizations more responsive and accountable to their ‘customers’ has entailed the development of the survey into systems of accounting and accountability (c.f. Osborne, 1993; Fountain, 2001; Munro and Kernan, 1993; DuGay and Salaman, 1992; Wisniewski, 2001; Hood and Peters, 2004). In the absence of actual markets, the customer survey has become seen as a central proxy for the customer’s voice, and of organizational performance and service quality (Ogden, 1997; Pollitt and Boukaert, 1995, p.19). Efforts to improve quality and enhance public sector effectiveness have therefore entailed the incorporation of the survey returns into systems of external accountability (e.g. rankings, report cards, and regulations) and internal control (e.g. performance evaluation, and management accounting and control) (Kirkpatrick and Martinez-Lucio, 1995, p.1; Pfeffer and Coote, 1991; Fuller and Smith, 1991; Reichheld, 2003; Kelly, 2005).

Although surveys have been made central to accounting and accountability processes, there has been little concerted investigation into their role, significance, and effects. Within the accounting literature there is much (often critical and reflective) use of surveys as a research method (Luff and Shields, 2014; Van Der Stede, 2014). However, beyond the mention of a survey being used as part of a management accounting system (e.g. Brooks, 1980), there has been no consideration of the ways that the survey device, as employed within accounting practice, might have consequences and effects for social, organizational, and professional life—“an indication” Cäker and Strömsten (2010, p. 151) note, “of how management accounting as a subject is lagging behind marketing and management studies when it comes to the study of issues such as customer satisfaction.”

This is a notable omission given that researchers have found the surveys in other fields to be centrally implicated in the creation and manufacturing of new social phenomena such as, most notably, “public opinion” (Osborne and Rose, 1999; Habermas, 1970; Bourdieu, 1990). This omission is also notable given the important contributions that have been gained by investigating changes at the “margins of accounting” (Miller, 1998), where devices such as standard costing and budgeting (ibid), net present value calculations (Miller, 2001), and the Black-Sholes asset pricing model (Mackenzie and Millo, 2003) have been made part of the accounting craft, and transformed what accounting does as a result.

This gap in our understanding of accounting practice is not unexpected, for the survey has been shown to be a frustratingly elusive object of study (Marsh, 1982). It is an object that is shape-shifting, fluid, and occasionally what Singleton and Law (2005) describe as a “fire object”, jumping between discontinuous locations and transforming its characteristics along the way. Indeed, like other objects such as “audit” (Power, 1999), “alcoholic liver disease” (Law and Singleton, 2005), “risk management” (Power, 2008), or the “Zimbabwe bush pump” (de Laet and Mol, 2000), the survey is an object whose every dimension, and even its precise name, is rearranged and remade throughout place and time. These characteristics make it difficult, and more importantly unhelpful, to define in any functional way. To advance a common definition such as “an enquiry which involves the collection of systematic data across a sample of cases, and the statistical analysis of the results” (Marsh, 1982, p.9) not only overlooks a great many activities often described as “surveys” but also does little to clarify the object empirically because even within the boundaries of this definition there are a huge variety of ways that such enquiry can be undertaken and equally diverse meanings that can be attributed to the results.

These features that make the survey an elusive object of study, however, make it an ever more important thing to investigate. Its shape-shifting nature means that we must investigate rather than presume what the survey is, what it does, and what it means for organizations and society (c.f. Czarniawska-Joerges and Sevón, 2005). This paper advances a methodology for investigating the survey as it moves and transforms throughout place and time. Instead of observing directly the organizational adoption and use of the survey, this paper investigates the various transformations that take place on and around the survey to make it a part of accounting and accountability.

Specifically, this paper follows the survey activities beginning during World War Two that led ultimately to the emergence of a particular customer survey known as the Consumer Assessment of Health Providers and Services (CAHPS) survey, as central to systems of accounting and accountability in healthcare. The making of the survey in its various forms is shown to entail the crafting of momentarily stable relations between different aspirations, forms of expertise, survey technologies, and characteristics of patients. These relations are shown to constitute “regimes” of various dimensions and effects (Hood et al, 2001; Jones and Dugdale, 2001). Comparing these assemblages throughout time highlights a distinctive set of transformations that took place to make the survey central to accounting and accountability in healthcare.

Firstly, this paper shows the activities to account for and hold providers accountable to the customer through the survey to involve the remaking of the patient in a new managerial form (c.f. Power, 1997; 1999; Dahler-Larsen, 2012). The patient is made not just as a customer, but as a customer with experiences about what providers did or did not do. Like previous

representations of the patient in which the survey was involved, such as “satisfaction”, “stress”, and “lifestyle”, “experiences” circumscribe the possibilities for the patient as a customer to both speak and be heard. Secondly, and relatedly, this paper shows these activities to involve the construction of a new status of these ‘experiences’. Through the substitution of the traditional expertise of medicine and sociology with the self-effacing expertise of measurement scientists, quality improvement specialists, and survey methodologists, experiences are transformed from knowledge *about* customers, to knowledge ostensibly *of and from* them. This provides for a self-referential system with no external referent (c.f. MacIntosh et al, 2000). Through the survey, accounting comes to represent the customer and provide a means for her to be “empowered” to “participate” in her care, and at the same time, the customer is remolded to express herself a way that accounting requires.

The net effect of these transformations is argued to be *the sequestration of customer experience*. Like other dis-embedding mechanisms described by Giddens (1991), accounting and accountability are shown, through their embrace of the survey, to attend to, rationalize, and ultimately represent the voice of customers, and also to remove those experiences from both ethical considerations and the day to day lives of the organizations that attend to them. For Giddens, the cost of “ontological security” purchased through these internally referential systems relate primarily to individuals and new challenges of navigating self-identity (p. 156). This paper shows that ontological security also has organizational costs: by knowing themselves and their customers through these new systems of accounting and accountability, organizations become unable to know about and attend to the customer-patients as people and therefore become less, rather than more, capable of acting ethically.

This paper thus shows the making of the survey central to systems of accounting and accountability, at least in this particular case, to have potentially significant consequences for both customers and the organizations that seek to know them. It shows, consistent with other research, that attempts to know customers through accounting often involved activities to “marginalize” (Mouritsen, 1997), “alienate” and “exclude” (Boyce, 2000) them (Vaivio, 1999; Ogden, 1997). In contrast with this literature, however, this paper shows this outcome not to be the result of the complexity of the patient or incompleteness and failure of accounting, but the opposite—of measurement precision, accounting success, and the capture of the full breadth of the customer. Understood this way, accounting more successfully for customers involves a new set of challenges which are discussed in the conclusion at length.

This paper also illuminates distinctive dynamics of accounting change. By attending to accounting from the perspective of the device, this paper shows that accounting acts upon the world in part through the often-overlooked re-appropriation and transformation of devices. In this case, making the survey central to accounting involved the transformation of the possibilities of the device away from other representations of the customer, and toward distinctive managerial ends. This methodology also allows us to show that accounting aspirations are as much outputs as inputs of technological changes. In contrast with much research of accounting change, the device here is shown not just to be the recipient of accounting aspirations, but constitutive of them as well.

## **2.0 The nationally standardized patient experience survey in healthcare**

There are few customer surveys more central to widespread processes of accounting and accountability than *nationally standardized patient experience surveys* exemplified by the Consumer Assessment of Healthcare Provider and Services (CAHPS) survey in the USA. The nationally standardized patient experience survey, of which CAHPS was the first, has

emerged since the 1990s as a primary voice of the patient within healthcare, and as a primary measure of healthcare quality and performance. Seen to be as “robust” and “validated” as bio-medical measures such as mortality and morbidity (Chassin et al, 1998), it has allowed for the patient’s views to become part of systems of accounting, accountability, and regulation as never before.

Developed first in the USA, and then spreading internationally to hundreds of jurisdictions, the nationally standardized patient experience survey has been integrated into a variety of activities of external and internal accounting, reporting, regulation, evaluation and improvement. In the USA, it has quickly expanded from a voluntary reporting system for health plans in 1996 into a measure of quality for all kinds of providers, reported publicly, and linked to all kinds of regulation and rewards. Payers and regulators have made participation nearly mandatory by linking it to accreditation and payments. The survey returns have also been integrated into public reporting initiatives such as the Federal HospitalCompare.gov website and WhyNotTheBest.org. These websites provide for direct comparison between providers on the basis of the survey questions and composite scores (as shown in Figure 1) and illuminate geographical variations in quality as documented through the survey findings (as shown in Figure 2).

Figure 1: Comparative survey performance reported on HospitalCompare.gov

Figure 2: HCAHPS data reported on WhyNotTheBest.org

Constituted through accounting and reporting systems as a primary external measure of performance, healthcare organizations and professionals have responded by bringing these measures inside and integrating them in management accounting and control (c.f. Power, 1999). As one report on American hospitals explains:

The current requirements to publicly report scores on [HCAHPS...] ties the amount of reimbursement directly to levels of service performance. This reporting requirement has spurred a groundswell of activity around managing the perceptions of patients and ensuring a top service experience. (Beryl Institute, 2010, p.1)

This activity is evident in survey data showing patient experience emerging as a primary objective for healthcare providers. One 2011 survey shows 21 percent of respondents ranking “patient experience/satisfaction” as their organization’s number one priority for the next three years (falling between “quality/patient safety” with 31 percent and “cost reduction” with nine) (Beryl Institute, 2011, p.5). This objective has led to a variety of organizational changes including the installation of internal patient survey systems to monitor performance on the CAHPS questions at the ward level and in real time, the linking of these scores to internal performance evaluation and reporting systems, and the creation of high profile Chief Experience Officers (CXO) to improve upon the scores (see e.g. Wolf and Prince, 2014).

In summary, the nationally standardized patient experience survey has emerged in the USA and elsewhere as central to accounting and accountability. As a core representation of quality, the survey and its findings have been made central to public reporting, have been linked with commercial rewards, integrated into internal reporting and performance evaluation processes and practices, and have inspired far-reaching interventions in healthcare organizations and practice in order to improve upon its terms. To account for quality in healthcare, as such, now means to engage with the patient experience survey in a concerted way. It is precisely this

achievement—the intertwining of the survey and systems of accounting and accountability—that this paper aims to investigate and better understand. By illuminating this movement in the domain of healthcare studied here, it is hoped that we can begin to build a more comprehensive understanding of the significance of this movement more generally.

### **3.0 The survey and an approach to its study**

As noted above, functional definitions of surveys are difficult and often analytically unhelpful to provide. Instead of starting with such a definition, this paper advances a more structuralist one, indicated by the dictionary definition of the term. The term “survey” denotes both a process—“to look closely or examine (someone or something)”—and an outcome—“a general view, examination, or description of someone or something” (Dictionary.com). This double meaning is a defining feature of the survey. The survey, this paper argues, can be defined as an arrangement of things for constituting knowledge through its pursuit, or, to paraphrase Ian Hacking, for simultaneously ‘finding things out and making things up’ (c.f. Hacking, 1983; 1999; Miller and Rose, 1997). Surveys, to state it another way, are historically-specific ‘best practices’, called “surveys”, for constituting knowledge in a particular field and for particular ends (Osborne and Rose, 1999).

This definition of the survey allows us to appreciate and investigate its diversity throughout place and time. The survey becomes less a unified ‘thing’, than arrangements of things, which hold together, in different ways and in different locations and points in time, to constitute momentarily stable facts (c.f. Latour, 1988; 1996; Serres and Latour, 1995; Deleuze and Parnet, 2007). This definition, however, also allows us to appreciate that not anything can be a survey. Although there might be many different arrangements called ‘surveys’, this definition highlights that they only become survey phenomena to the extent that they affect and transform the world by making it up in new and consequential ways.

Understood this way, surveys represent outcomes or achievements and things to be explained rather than explanations of something else (c.f. Callon 1986). To understand the constitution of the survey as central to accounting, we therefore need to investigate the way in which particular things became entangled and mutually supportive of some legitimated practice for finding things out at a particular place and time. Methodologically, this requires that we investigate the various associations revolving around the survey and identify the associations that come to be repeated and stabilized, establishing the survey as a different sort of thing (Latour, 1988; Serres and Latour, 1995). Instead of identifying fixed ‘types’ of surveys, in other words, we seek to identify momentary survey “assemblages” (Mennicken and Miller, 2012), incarnations, or “regimes” (Hood et al, 2001; Jones and Dugdale, 2001). Such regimes represent the stabilization and repetition of different arrangements of things that make up the survey and establish its momentary significance (c.f. Burchell et al, 1985).

Such investigation could, in theory, be undertaken through quantitative analysis, by systematically collecting all of the associations between things and the term ‘survey’ throughout place and time, and then identifying patterns through factor analysis of some kind (c.f. Latour and Lepinay, 2008). In practice, however, these associations take many different forms and are catalogued in a variety of places, making the strictly quantitative identification impossible. Associations can be between elements of any kind—people, things, ideas, ideal, techniques, etc.—and this means that associations exist in many different places and forms. As such, the explication of associations requires concerted qualitative work, broad and far-reaching horizontal investigation.

Methodologically, this definition also requires that we investigate vertical relations and seek to understand the various threads that interact so as to establish conditions for stability and change. Consistent with “genealogical approaches to history”, this means attending to the wider connections and relays that form so as to establish a function and functionality for accounting (c.f. Miller and Napier, 1993, Miller et al., 1991). In contrast to most genealogical studies of accounting, however, this paper seeks to investigate change from the perspective of the accounting device itself. Drawing from research traditions in anthropology that seek to understand the “social life of things” (Appadurai, 1988; Miller, 2007; 2005; Marres, 2012; Marres and Lezaun, 2011), this paper investigates the accounting changes related to the survey as one chapter in the social biography of the survey itself. This approach involves asking biographical questions of the device as it moves throughout time:

What, sociologically, are the biographical possibilities inherent in its ‘status’ [...] and how are these possibilities realized? Where does the thing come from and who made it? What has been its career so far, and what do people consider to be an ideal career for such things? What are the recognized ‘ages’ or periods in the thing’s ‘life’ and what are the cultural markers for them? How does the thing’s use change with its age, and what happens to it when it reaches the end of its usefulness? (Kopytoff and Appadurai, 1986, p. 66-7)

Such an approach allows us to highlight not just that a new device is made a part of accounting, but the way that the device, in this context, is uniquely “culturally redefined and put to use” (ibid, p.67). Attention to this cultural redefinition allows us to better understand the consequences and effects of the survey as it is made part and product of accounting.

In order to undertake this sort of investigation in a systematic and empirically grounded manner, this paper draws loosely upon Latour’s (1987) theory of citations. Latour and his colleagues (Latour and Woolgar, 2013) argue that citations are not epiphenomena generated through the pursuit and advancement of science, but rather that they, along with the institutions, techniques, scientists and ideas that help to generate them, represent the front lines of scientific battle and facticity. As such, Latour (1987) argues, citations provide a sort of sedimentation of historical fact-making: a record of the various ways that citations were mobilized and remobilized throughout time to settle debates and constitute fact, which an archaeologist can illuminate and probe.

So too, this paper argues, the survey that has become central to accounting. The CAHPS survey was developed through a self-consciously scientific process, and, like all scientific facts, was justified through a bibliography that is still listed on the developer’s website. This 235-paper bibliography allows us to directly follow the patient survey ‘in the making’ as it was made and remade throughout time. In order to do this, the papers in the bibliography were traced backwards for three generations, and factor analysis was undertaken of each generation’s citations in order to identify the clusters of citations upon which debates about the survey were based. Represented schematically in Figure 3 below, this research process resulted in the identification of 7-8 clusters of citations in each period or generation, as the survey travelled throughout time.

Represented in Figure 3 by the citation most central to each of the clusters, these clusters constituted complex and changing debates about the nature, significance, appropriate form and function of the survey throughout time. In order to investigate these changing clusters, the papers in each cluster were read and analyzed for key authors, institutions, forms of expertise, preoccupations, ambitions, or any other such themes. These themes were then

investigated broadly, in order to illuminate relations between other fields and locations. Where, for example, cognitive psychology was identified, because the author was a cognitive psychologist or it was mentioned directly, an investigation of the development of cognitive psychology more generally was undertaken.

Figure 3: Bibliographic analysis of the CAHPS bibliography

In this way both the horizontal and vertical relationships around the survey were illuminated, providing a semi-linear timeline of associations among people, ideas, preoccupations, technologies, and ideals around the survey. Tracing these associations allow us to describe the particular processes, transformations, and movements that took place in order to establish the nationally standardized patient experience survey as central to processes of accounting and accountability in healthcare.

#### **4.0 The Patient Survey from War to Ward**

This paper presents a history of the emergence of the patient experience survey as central to accounting and accountability as revolving around the development, stabilization, and destabilization of three distinctive survey regimes. These regimes, corresponding loosely with three chronological periods of time, are represented schematically in Figure Four below. Although there are many diverse elements that compose each pattern, they are illustrated here on the basis of a number of characteristics that change throughout each instantiation: from the top clockwise, the central aspiration upon which they were based, the dominant form of expertise upon which they were designed, the name and form that they took, and the perception of the patient that they sought to reveal. These regimes, and the movements between them are illuminated in the sections that follow.

Figure 4: Three survey regimes

Section 4.1 documents the emergence and stabilization, between 1945 and 1980, of the morbidity and attitude surveys as central to the constitution of knowledge about a socio-psychological patient and her variously constituted view. These surveys are shown to help transform the status and significance of the patient, from the recipient of medical care, to a source of knowledge about health and illness in her own right.

Section 4.2 documents the way that this new knowledge about the patient was transformed in the early 1980s into a positive new role for the survey. The satisfaction survey was advanced as the voice of the patient and a means of holding providers accountable for the quality of care. This transformed the object of the survey from knowing about patients, to knowing about the providers of care.

Section 4.3 shows the way that, from the early 1990s, specific ideas and ideals related to evaluation and quality improvement transformed the survey once again. Redesigned to ask about experiences, the patient experience survey was constituted as seemingly capable of accounting for the customer and holding providers accountable for her care. The survey and accounting and accountability were thus extended in a mutually-reinforcing way, creating a new and distinctive way for patients to speak and to be heard.

#### **4.1 Morbidity and attitude surveys and the emergence of the patients' view, 1945-1980**

Prior to 1945, the use of surveys to undertake widespread investigations of health and illness had a long and significant history (Marsh, 1982). However, the activities of World War Two provided a variety of new and important conditions for the eventual intertwining of accounting and accountability and the survey. This section shows the way that the survey activities undertaken during the war led to the emergence and stabilization of surveys in the fields of psychology and sociology as a means of knowing about patients and constituting the existence of their views about health, illness, and care. These findings gave rise to a deep incongruence between the patient illuminated by traditional biomedical knowledge and the social and psychological patient illuminated by the survey.

The screening, selection, and rehabilitation activities undertaken by burgeoning psychiatric units in the military during the war transformed the development and use of the surveys in the post-war years (Carlson and Klerman, 1990; Pols and Oak, 2007). Technologically, these activities entailed advancements in sample selection techniques, which facilitated in-depth interviewing and surveying of much larger populations than before (Thunhurst and Macfarlane, 1992, p.317; Osborne and Rose, 1999). These activities also highlighted new possibilities for medicine about what illness was and where it was located. Surveys of soldiers and populations undertaken during the war illuminated not only a vast sea of undiagnosed ill-health, but also situational and environmental factors lying outside the existing bio-medical model that were potentially central to health and care (Carlson and Klerman, 1990, p.28; Pols and Oak, 2007; Jones et al, 2006).

This led to a far reaching “paradigm shift” (Carlson and Klerman, 1990, p.27) in psychology and epidemiology in the post-war years. Previous psychiatric etiology had been concerned with the individual factors that predisposed people to mental ill health and clinical epidemiology for the most part concerned itself with the somatic “degeneration” of individuals. The etiology of the post-war “golden era of social epidemiology” (Klerman, 1986, p.162), by contrast, focused increasingly on the “social institutions and historical forces” that might affect “the variations and prevalence of distress and disability” (Susser, 1985, p.150).

This paradigm shift went hand in hand with the extension and elaboration of the survey beyond its wartime ends. In the post-war period a variety of large-scale surveys were undertaken to find out about the “social and institutional” factors that were tentatively shown to affect health during the war (e.g. Srole et al, 1962; Hollingshead and Redlich, 1958; Gurin et al, 1960; Duncan-Jones and Henderson, 1978; Henderson et al, 1979). As the extract from the Midtown Manhattan survey in Figure 5 below illustrates, the surveys asked patients a bewildering array of questions, ranging from childhood fears to drinking patterns. However, coupled with diagnostic tools, they established a whole new methodology for knowing the patient. As Carlson and Klerman (1990) explain:

The new methodology emanating from this paradigm was the development of structured interviews to obtain standardized information about the patient's past history and current social functioning symptomatic status. In parallel, sets of operational criteria and diagnostic algorithms were codified and used in assigning an individual patient to one or another diagnostic category. (ibid, p.30)

Figure 5: Extract from Midtown Manhattan study interview schedule (from Srole et al, 1962, p.389)

This new methodology made the survey capable of constituting medical facts. It asked people about an array of psychological and environmental factors, and in doing so showed them to have all sorts of characteristics such as “dissatisfactions”, “lifestyles”, “stresses”, “behaviors”, and “social classes”, even if these remained differently defined terms (Armstrong, 1984, p.741; Collins and Klein, 1980; Freidson, 1961). This meant for medicine that illness could “escape the confines of medical diagnosis” (Susser, 1985, p.315); as Armstrong et al (2007) note, “patients who reported themselves as being highly anxious could be described as having anxiety disorder and those reporting depression could be labeled as having (clinical) depression” (p.572-3).

At the same time, the survey was coming to have a similarly constitutive role in medical sociology. During the war, academic sociologists based in the Department of Defense such as Stouffer, Merton, Lazarsfeld, and Likert, had undertaken hundreds of “attitude surveys” (Lazarsfeld, 1949, p.370) and conducted over half a million interviews with soldiers in order to access the social and subjective world on which attitudes and morale were tentatively thought to be dependent. These authors used this data immediately after the war to produce a series of volumes titled *The American Soldier* (Merton et al, 1946) that argued that attitude surveys could provide for the social world the sort of objective properties of objects that the natural sciences were able to rely upon.

The systematization of the social on the basis of the survey ushered in a movement similar to that seen in psychiatry and epidemiology. It provided a “new social science”, whose modern method would be “the rigorous testing of explicit hypotheses on largely quantified data accumulated by structured observation in empirical situations approximating (with specified deviations) the model of controlled experiments” (Lerner, 1950, p.222 in Platt, 1966, p.60). The volume, moreover, was greeted as “an exemplar of the ‘new social science’, ‘the modern method’” (Converse, 2009, p.222), and its enterprising authors established large and high-profile academic research centers with close ties to government and industry, thus “giving hegemony to the new model survey, and to the departments where its leaders were now located” (Platt, 1996, p.50).<sup>1</sup>

Throughout the 1960s and 1970s medical sociology extended and reified the survey and illuminated a new social world of patients to compliment the newly revealed psychological one. Koos’ (1954) survey of “what people think and why they behave as they do in regards to health” (p.38) marked the beginning of a proliferation of socio-medical surveys (Armstrong, 1984; e.g. Freidson, 1960; 1961; Zola, 1966; Hannay, 1979). Using a combination of structured surveys and open-ended discussions, these studies asked about, and constituted a whole host of new characteristics of the patient including “perceptions”, “hopes”, and “fears” (c.f. Armstrong, 2002; Miller and Rose, 1997).

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<sup>1</sup> These post-war American sociology movements were closely connected also with the rise of social indicator research, opinion polling (Lazarsfeld, 1957), consumer research (Wells, 1993), and other developments that had significance beyond the sociology departments of American universities (c.f. Rose, 1996; Osborne and Rose, 1999). These academics expanded this wartime work in order to advance the survey as a means of providing government, corporations, political strategists, and other authorities access to the inner minds, feelings, satisfactions, and other such constructs of the population they were helping to create.

These movements in medicine and sociology thus established a survey regime in the post-war period capable of standing up to the historically-constituted medical fact. The traditional bio-medical model upon which Western medicine had been based understood disease and patient to be wholly contained within the physical tissue (c.f. Armstrong, 1984; Porter, 1999). The survey findings, however, insisted that the patient expanded beyond the boundaries of tissue,<sup>2</sup> and that “the successful application of medical knowledge depends on what patients think and feel about doctors, nurses and hospitals” (Cartwright, 1964, p.3; Wadsworth et al, 1971).<sup>3</sup>

There was little clarity about what exactly patients thought and felt, especially since the surveys asked about a variety of different and overlapping constructs developed on the basis of different theoretical models and using different sample techniques, question wording, and scales (c.f. Carr-Hill, 1995). However, it was clear that the survey could provide a medical reality to rival the bio-medical one and as a result the possibilities for the identity of the patient were rapidly expanding. Indeed, up to the mid-1970s the divergence between ‘objective’ medical facts and ‘subjective’ survey responses was a “major area of difficulty” for the survey project (Wadsworth et al, 1971, p.93; Leblow, 1974). But by the early 1980s, it was stated that the assumption that patient opinion had to be validated with medical ‘fact’ was itself unfounded. Ware et al (1983), for example, stated:

Although satisfaction ratings are sometimes criticized for not corresponding perfectly with objective reality or with perceptions of providers or administrators of care, this is their unique strength. They bring new information to the satisfaction equation. (p.247)

By 1980, in other words, it was clear that whatever one thought of surveys, they were able to sustain something new and of medical concern: “*the patients’ view*” (Armstrong, 1984).

The provision of this new patient illuminated an often-incommensurable divide between the reality constituted within the traditional bio-medical model and that produced through survey activities (Porter, 1999). Indeed, paradigmatic of a “risk society” in which the limitations and risks produced by traditional knowledge undermine its social appeal, the survey activities took part in the movement from a “Golden Age of Medicine” in which medicine is singularly able to “define and interpret the nature of reality and human experience” (Starr, 1978, p.177), to an age in which the irrationalities of medicine “displace [...] scientific progress at the center of public attention” (Starr, 1982, p.37; Beck, 2006). They did this by highlighting perceptions of neglect, poor communication, helplessness and impersonality alongside the medical advancements that were being produced. Indeed, drawing on the survey findings, it was noted that different realities of healthcare existed, and that “patients and physicians see it differently” (Williams, 1971, cited in Scott et al, 2000, p. 259; see also Caper, 1974; McLachlan et al, 1976; Kennedy, 1971; Menninger, 1975). This culminated in the

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<sup>2</sup> As Armstrong explains: “A concomitant of the spread of morbidity surveys in the post-war years was the redefinition of the patient. Under the old regime the patient was no more and no less than the body which enclosed the lesion. The surveys on the other hand embraced everyone, and found that almost all experienced ‘physical’ symptoms or that most were mentally ill. [...] The conceptual and methodological correlation between the patient’s views and the lesion began to fragment as a new referent [sic], the social, made its appearance” (1984, p.740).

<sup>3</sup> One physician explained, “Diagnosis has been likened to peeling off successive layers of an onion. I insist that the opposite process is equally important: the layers have to be put back if we are to see what an onion really is. After a long preoccupation with tissues, organs and ‘disease’, the patient is being rediscovered and we are rediscovering too, his family, and rediscovering the community and environment of which they are part” (Wadsworth et al, 1971, p.91).

articulation of the “paradox of health”, which suggested that more medical intervention could produce patients that felt *less* well (McKoen, 1979).

#### **4.2 Patient satisfaction and the quality of care, 1980-1990**

In this gap between bio-medical knowledge and that emanating from survey activities, a new and positive role for the survey as measure of patient satisfaction and the quality of care was advanced. From 1980 reformers began to argue that quality was a matter not just of the application of medical science, but of patients being *satisfied* with their care. They argued, moreover, that the satisfaction survey could be developed as a measure of quality and a means of finding out just how well healthcare providers attained this goal. Redesigned to measure quality, the survey was transformed from a thing for knowing about *patients* to a thing for knowing about the *providers of care*.

The satisfaction survey came to be the major focus of attention from the 1980s for a variety of overlapping reasons, which the post-war survey activities had helped to produce. From a traditional bio-medical perspective, the patient or consumer’s “satisfaction” had been shown to be “a potentially important factor in health care in that it may influence whether or not a patient seeks medical help, whether the patient complies with a therapeutic regimen and whether the patient maintains a continuing relationship with a physician” (Larsen and Rootman, 1976, p.29; see Cartwright, 1983, p.87-92). This highlighted satisfaction’s medical importance even for those still skeptical of the patients’ view. As a result, clinicians wrote in 1981:

Patient satisfaction has long been of interest to health professionals, although the emphasis has changed somewhat. For example, 10 years ago the issue centred around whether to consider patient perceptions; today the discussion centres on how much weight to give the patients’ perceptions and how to measure those perceptions. (Stamp and Finkelstein, p.1108)

From the 1980s, the expression of patient satisfaction was also increasingly seen as a consumer right. Consistent with the wider consumer movement which posited the consumer as the ultimate judge and jury within the market (c.f. Schwarzkopf, 2009; 2011), satisfaction surveys was argued to be “a part of the democratic process” (Cartwright, 1983, p.198). Indeed, authors likened surveying patient satisfaction to an activity that “corresponds with casting a vote in the elections,” enabling, “patients to vent their feelings and gives them the sense that they participate in their care” (Vuori, 1991, p.x; Berliner and Salmon, 1980; Rubin, 1990). The satisfaction survey was thus advanced as a solution to the irrationalities and risk of medical expertise: it was hoped that it could be a radical means of reconstituting medical knowledge from below (Cartwright, 1981; Greenfield et al, 1988).

Patient satisfaction came also to be a significant topic in relation to growing worries and debates about the quality of care. Survey findings had, as early as 1966, showed that quality as the patient understood it was very different from the bio-medical point of view (e.g. Brook, 1977, Egdahl and Taft, 1976, Kennedy, 1971; Sidel, 1966; Menninger, 1975). These differences became centrally important when, throughout the 1980s and early 1990s, the system of quality assurance that had prevailed since the early twentieth century came under sustained critique (Scott et al, 2001; Scrivens, 1995). During this time, peer review requirements were standardized, allowing external scrutiny of the processes for the first time (Scrivens, 1995; Timmermans and Berg, 2003). This resulted in a variety of studies showing widespread and unexplained variations not just in care practices, but even in the specification

of clinical standards between regions (Timmermans and Berg, 2003). By the early 1990s, prominent research institutions, such as Harvard Medical School (1991), the Institute for Healthcare Improvement (IHI), and the Institute of Medicine (IOM) (1992, 1994,) were able to publish literature reviews showing clearly that the existing systems of quality control were inadequate, even in bio-medical terms (Scrivens, 1995; Chassin et al, 1998; Lohr, 1990). It was thus argued not just that patients and doctors understood quality differently, but that the medically-controlled oversight of quality through mechanisms of selection, education, accreditation and peer review were inadequate and needed to be replaced with a new arrangement altogether.

In place of the implicit system of assurance provided by the medical profession, measurement and formal evaluations were articulated and advanced (Enthoven, 1985; WHO, 1982). Authors such as Avedis Donabedian (1988), whose ideas would become “one of the very few points of consensus” in the following years (Leguido-Quigley et al, 2008, p. 10), argued confidently that public measures could replace professional judgments of quality. Against the claims that only the physician could ascertain quality, he stated, “I believe, on the contrary, that the concept of quality can be rather precisely defined, and that it is amenable to measurement accurate enough to be used as a basis for the effort to monitor or ‘assure’ it” (Donabedian 1992, p.xxxii). He outlined the simple Structure-Process-Outcome model to achieve this goal. The model posited that quality could be defined, evaluation, and assured by defining and attending to the relation between structures (such as facilities), processes (such as interventions) and outcomes (such as morbidity) of care. He suggested, in other words, that measurement science could make implicit notions of quality explicit for the first time.

These aspirations became serious objectives in the late-1980s with the launch of government efforts to attend to and improve the quality of care. Marking the beginning of intensive government intervention, Congress asked the Office of Technology Assessment (OTA) in 1988 to “assess whether valid information could be developed and disseminated to the public to assist their choices of physicians and hospitals” and in 1990 it charged the IOM with the task to “design a strategy for quality review and assurance in Medicare” (OBRA, 1996 in Lohr, 1990, p.R13). This federal effort paralleled the launch of the non-profit National Committee for Quality Assurance (NCQA), which sought to “build consensus around important health care quality issues by working with large employers, policymakers, doctors, patients and health plans to decide what’s important, how to measure it, and how to promote improvement” (NCQA, 2014).

Central to the precise definition and accurate measurement of quality that these agencies sought was the articulation of a significant role for the satisfaction survey. Donabedian and the agencies tasked with measuring quality argued that satisfaction was an essential outcome of care and that patient satisfaction surveys could be used to measure the attainment of this goal (Donabedian, 1980; 1988; Vuori, 1987). Indeed, throughout the 1980s, the satisfaction survey was advanced as a “central part” of the construction of a system of quality measurement and assurance (McMillan, 1989, p. x; Guzman et al, 1988). The OTA (1988) report, titled “*The Quality of Medical Care: Information for consumers*”, for instance, defined healthcare outcomes as changes in “patient satisfaction and health status” (p.8) and stated that, despite ongoing challenges, “satisfaction surveys” could measure them accurately (p.244).

The extension of the satisfaction survey was in many ways a continuation of the post-war survey activity, which had established satisfaction as a stable construct. In redirecting the

survey toward the ends of quality measurement, assurance and improvement, however, the object of the satisfaction survey was fundamentally transformed. Specifically, the survey was now being re-envisioned not to illuminate the characteristics of the *average patient* (as it had done in the past), but to evaluate the care of *individual providers* (OTA, 1998). For survey design, this meant the inversion of satisfaction from an independent to a dependent variable; surveys would not seek to document the existence of satisfaction, but would aim to show how well providers did in making patients satisfied.<sup>4</sup>

Measuring satisfaction in this new way was seen as a matter of drawing from the newly reinvigorated cognitive psychology expertise. Following a series of conferences in 1980 convened for the express purposes of developing survey activity on the basis of cognitive psychology (Tanur, 1992; Jobe and Mingay, 1991), authors note the emergence of a “paradigm shift” (Banaji and Heiphetz, 2010, p.360) in survey design beginning with the crime survey and then spreading to other fields. This entailed a move away from the psychological and sociological theories and ambitions as the foundation for survey development toward the development of survey constructs that corresponded with the mental categories themselves (Platt, 1992; Barnard 1991).

Although satisfaction surveys had been developed and undertaken by researchers in the 1960s and 1970s using cognitive psychology principles (e.g. Larson and Rootman, 1967; Hulka et al 1970), new challenges emerged for survey design when directed toward the express aim of quality measurement and assurance. Specifically, it raised the challenge of separating the patient from the provider of care. Indeed, it had been shown since 1983 that, “a patient satisfaction rating is both a measure of care and a measure of the patient who provides the rating” (Ware et al, 1983, p.248) and in fact, “the little information that exists regarding effect size actually suggests that satisfaction may be more affected by patient factors than by organizational characteristics” (Pascoe, 1983, p.200). This meant that, as Ware had noted years earlier:

Without a better understanding of what causes patients to be more or less satisfied with the care they receive, however, it is not clear whether the medical care system should be held accountable for all the variability in satisfaction scores. (Ware et al, 1977, p.24-5)

Enrolled toward the ends of quality measurement and assurance, it became centrally important to separate the satisfaction attributable to the patient (his or her socio-demographic characteristics, mood, form of payment, expectations, psychological state and much else) from the satisfaction attributable to the provider of care (what the provider did or did not do, and how they did it). The survey needed, in other words, to remove those characteristics of the patient that it had so carefully constructed in the previous years.

### **4.3 From patient satisfaction to patient experiences, 1990-2010**

The solution to this challenge was the substitution of “experiences” for “satisfaction” as the survey object. As this section will show, this substitution entailed the foregrounding of accounting, public reporting, and the other systems of accountability that specific models of

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<sup>4</sup> As one of the earliest proponents of this line of development, Ware et al (1977a), stated: “Regarding satisfaction as a dependent variable, Donabedian (1966) argued that patient satisfaction (along with health status) is an ultimate outcome in evaluating quality of medical care [...] His argument clearly implies that the patient satisfaction concept is an important dependent variable in health and medical care research” (ibid).

quality improvement and assurance were seen to require. As a result, the survey and accounting and accountability could and would be made increasingly synonymous with each other.

By the early 1990s, debates moved from questions of whether quality could be measured to propositions about how measures of quality could be best managed and improved (Brook et al, 1990; Shortell et al, 1998; Laffel and Blumenthal, 1989; Berwick et al, 1990). Central among these pronouncements was the argument that quality improvement was a matter of adopting and adapting industrial quality improvement techniques for healthcare. This argument was first advanced in Donald Berwick (who would later become the founder of the Institute for Healthcare Improvement and head of the Centers of Medicare and Medicaid Services). He called for “continuous quality improvement (CQI) as an ideal in healthcare”, in order to improve quality and reduce costs as had been done in other industries. This perspective on improvement quickly gained widespread support from accreditation agencies, regional purchasers, and leaders in the medical profession, and expanded into what was later called the “quality improvement movement in healthcare” (Øvretveit, 2000, p.74): an international movement to address quality through “modern industrial quality science” (Laffel and Blumenthal, 1993, p.285; Shortell et al, 1998; Blumenthal and Kilo, 1998).

It was also increasingly argued that quality improvement could best be achieved through public reporting, and empowering patients as discerning consumers of healthcare (Jordan et al, 1995; Hofer and Hayward, 1996). Beginning with the public reporting of standardized hospital mortality data by the Health Care Financing Administration from 1986 to 1993, there were a growing number of regional experiments with public reporting of standardized data, such as the Cleveland Health Quality Program and the California Cooperative Health Care Reporting Initiative (Sirio et al, 1994; Longo et al, 1997). By 1995, consumer focused websites such as healthgrades.com, healthcarechoices.org, and dartmothatlas.com had developed to the extent that patients in the USA could find, sort, rank, and compare the quality of their health plans, hospitals, or even physicians according to certain bio-medical metrics (Marshall et al, 2000). Even though these experiments were often heavily critiqued, they galvanized support for the possibilities of reporting and accounting for quality improvement.

These specific quality improvement objectives, which embraced processes of accounting and accountability, required further new things of the patient survey. Quality improvement was argued to require not just that patient’s views were sought but that the survey was used to gain specific and actionable feedback for healthcare providers. As Rubin explained in 1990:

During the last decade organization-wide quality improvement efforts in both service and manufacturing sectors in the United States have embraced customer evaluations of goods and services to monitor quality. American organizations are finally adopting the quality improvement theories of Deming and Juran responsible for post-war Japanese industrial success. *A key component of these theories is that suppliers of a good or service must receive feedback from customers in order to identify deficiencies and guide the design of improvements* [my italics]. Customer satisfaction surveys are evolving from marketing tools to product and service quality measures. (Rubin, 1990, S3)

Beyond feedback, it was also argued that public reporting for the purpose of customer choice required that surveys create knowledge about satisfaction that could differentiate between providers (Williams et al, 1998; Vuori, 1991).

On the basis of these evaluation objectives a significant transformation in the form of the satisfaction survey was advanced. A number of authors closely aligned with the cognitive psychologist John Ware and medical sociologist Paul Cleary argued for the satisfaction survey to be abandoned in favor of questions about specific and identifiable experiences with care (Cleary and McNeil, 1988). Instead of asking about satisfaction directly they advanced the “promising but rarely employed strategy” (Cleary and McNeil, 1988, p.26) of asking patients about “distinct quality-related attributes that can be measures and interpreted separately” (Ware/OTA, 1988, p.246). This entailed developing a construct of satisfaction by undertaking a literature review and content analysis of the things demonstrated to matter to patients. They had shown as early as 1983 how such a survey could be developed. Their Patient Satisfaction Questionnaire (PSQ) grouped satisfaction topics into cognitively distinct dimensions of satisfaction (such as access, finance, resources, and continuity of care), and then developed specific questions about experiences with care that might capture each dimension, as illustrated in Figures Six and Seven.

Figure 6: Satisfaction items (from Ware et al, 1983, p. 252)

Figure 7: Dimensions of satisfaction (from Ware et al, 1983, p. 256)

This process proved capable of separating the patient from the provider on the terms necessary for quality reporting and improvement. For this reason, it became the template for large-scale survey activities undertaken in the USA and elsewhere as the development of systems of quality evaluation became an ever more pressing concern (Gold and Woodridge, 1995). Large-scale patient experience surveys were developed by Ware and colleagues (Metereko et al) in 1990 and Cleary et al in 1991. They were argued to demonstrate the ability of the survey to “detect significant differences among [...] respondents receiving care at different places or times or under known different conditions,” (Metereko et al, 1990 p.S9), and were therefore argued to be “extremely useful for quality improvement and assessment efforts” (Cleary et al, 1991, p.261). High profile projects, such as the Commonwealth-Picker hospital survey—which was the forerunner to the CAHPS survey—(Gereteis et al, 1993; Zaslavsky et al, 2000), the Primary Care Assessment Survey (PCAS) in Massachusetts (Safran et al, 1998, p.728) and others (Rogers and Smith, 1999) all explicitly replicated this survey approach.

The identification of distinctive and largely verifiable experiences with care provided better conditions for the development of case-mix adjustment techniques. Survey developers could now overcome the central challenge of separating out differences in response patterns that reflected systematic biases rather than actual differences in the quality of care (AHCPR, 1997). By 2001 a near consensus had emerged about the sources of response bias and the means of controlling them (e.g. Zaslavsky 1998; Zaslavsky et al, 2001, Rosenheck et al, 1997; Elliott et al, 2001). This reinforced the seeming accuracy and validity of the survey as a means of measuring knowing customers and measuring provider performance (Zaslavsky, 1998).

The ability of the survey to validly measure experience meant that it could claim to speak for the patient, and to represent her view of quality, especially as it extended beyond bio-medical terms. With the development of the patient experience survey, it was argued following a two year national roundtable on quality undertaken by the IOM, that “the quality of health care can be precisely defined” and that “in many instances, quality measures have the same degree

of accuracy as the majority of measures used in clinical medicine to make vital decisions about patient care” (Chassin et al, 1998, p.11). With a measurable quality, and with “serious and extensive” problems in healthcare quality, “a major effort to rethink and reengineer how we deliver health care services and how we assess and try to improve the quality of care” was said to be required (ibid).

This rethinking and re-engineering called, as in other fields (c.f. Power, 1998) for the development of accounting and accountability—standardized reporting, explicit comparison, formal ranking, sorting, selecting, rewarding, and shaming—as never before. From the late 1990s, large-scale and often government-led activities were undertaken to systematically collect, formally standardize, and publicly report quality of healthcare providers and professions using the patient experience survey alongside bio-medical measures. The experience survey was first extended nationally for the purposes of performance management, benchmarking, and comparison in 1995, when the NCQA assessed the performance of health plans based on their HEDIS (Healthcare Effectiveness Data and Information Set), which included an “experience with care” domain based on experience survey returns (Thompson et al, 1998; Safran et al, 1998). The HEDIS measures, although “very controversial” (Epstein, 1995), were audited by a third party, and advanced as key measures of health plan performance. The findings were made available through the online reporting tool called Quality Compass, and the NCQA worked closely with the US News and World Report to rank health plans based on the data (Schneider and Leiberman, 2001).

By 1998, there were so many overlapping and sometimes contradicting measurement systems, “report cards” (Marshall et al, 2000), rankings and ratings that the Performance Measurement Coordination Council and the National Quality Forum were launched to standardize measures (Skolnick, 1998, p.1769-70). These initiatives highlighted the need for national and even international standardization of quality measurement, and by association of patient surveys (Safran et al, 1998). The Healthcare Research and Quality Act of 1999 responded to these calls by tasking the Agency for Healthcare Research and Quality (AHRQ) to “promote healthcare quality improvement by”, among other things, further developing “methods for measuring quality” (S.580, Part A, Sect 901). To do this, the AHRQ launched the CAHPS I research project to “develop and test questionnaires that collect information on consumers’ experiences and assess health plans and services” (CAHPS, 2014). The CAHPS team, led by those survey developers such as Paul Cleary and Susan Edgman-Levitan who had developed the Commonwealth-Picker survey previously, established the first nationally standardized patient experience survey (Darby et al, 2005).

The output of this first round of work was the CAHPS survey instrument (an extract of which is shown in Figure 8 below) and the public reporting of the returns for healthcare plans in 1998. Despite the fact that “most consumers [were] unaware of publicly available quality information” (Lake et al, 2005, p.xii), the survey was seen as a success (Scanlon et al, 2001; Crofton, Lubalin, and Darby, 1999). A review of the programme concluded that “the CAHPS project has become a leading mechanisms for generating scientifically sound measures of consumer perspectives on health care access and quality” (Lake et al, p. xi).

Figure 8: Extracts from the CAHPS survey instrument (from [www.cahps.arhq.gov](http://www.cahps.arhq.gov))

Although the benefits of the survey remained largely a potential, the survey was extended and solidified as a primary means of accounting for quality in the USA and internationally.<sup>5</sup> The CAHPS survey instrument was expanded to provide surveys of hospitals, and healthcare organizations, practices, and even individual professionals of various types throughout the 2000s. The survey was at the same time linked to ever more reporting, accreditation, and commercial mechanisms, such as the HospitalCompare.gov website, and various regional maps of healthcare performance. It was tied directly to reimbursement rates, and given an increasing reputational and commercial significance. As the 2005 review of CAHPS concluded:

Measurement and reporting efforts are now supported by diverse stakeholders for many different reasons, including marketing and planning, government regulation and private accreditation, enhanced purchaser decision-making, increased accountability of providers, and provider quality improvement activities (Marshall et al, 2000) (Lake et al, p.xi)

It was through this series of transformations that the patient or customer survey in healthcare came to have its specific form and function. In the next section, the nature and consequences of these transformations are highlighted and reflected upon.

## **5.0 The re-managerialisation of the patient and the sequestration of customer experience**

This paper has followed the development of the patient experience survey by tracking through its bibliographic history the multiple incarnations and transformations that took place for it to emerge. This has shown the survey to be constituted in different forms, for different purposes, and with different effects throughout time (see Figure Four above). Specifically, the survey was shown to be part and product of three different regimes, composed of differing aspirations, expertise, technological forms, and relevant characteristics of the patient. These elements of each regime emerged in tandem, and on the basis of each other. The aspirations and experts shaped the technological form of the survey—the kinds of questions, for example, and the way that they were asked. These aspirations and experts were also shaped by the technological form—the survey tentatively revealed things that provoked aspirations and ambitions that experts sought to achieve. Together these elements made up patients in different forms. By aligning distinctive ambitions, experts, and survey technologies, new knowledge about patients could be constituted—patients could be declared to have views, perceptions, satisfactions, and ultimately experiences with care.

Although the structural features of the survey regimes are largely the same, their dimensions and effects are not. Indeed, each survey regime made up part of the world in a new way and established a variety of new possibilities for patients, organizations, and much else besides. By comparing and contrasting these changing dimensions and effects, we can illuminate the distinctiveness of the current regime in which accounting and accountability have been made central. This analysis illuminates two distinctive and consequential central features of the constitution of the current regime, elaborated below: the re-managerialization of the patient and the sequestration of patient experience.

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<sup>5</sup> Schneider and Leiberan (2001, p.96) explain that following CAHPS, “The allure of a market based on ‘consumer choice’ is such that other nations are now trying to emulate its principles as they reform their own health systems” even though, “ironically, the USA has not itself realized this ideas ‘consumer choice’ market”.

The first distinguishing feature of the current regime is the type of patient or customer that it has helped to bring into the world. The extension of the survey toward purposes of accounting and accountability entailed the production of a patient-customer of an increasingly managerial form. Indeed, the immediately post-war regime helped to make a distinctively socio-psychological patient with a variety of views (about health, illness, family, worries, etc) to express. From the 1980s, however, the patient provoked by the survey was one increasingly capable of achieving distinctive managerial aims. Through the emphasis on “satisfaction”, the patient-customer was reimagined and remade as an informant of what providers did or did not do. Through the emphasis on “experiences” in the 1990s, moreover, she was remade as central to a system of accounting and accountability in which providers could be made comparable, their performance could be distinguished, and they could receive information about what they specifically could improve. The patient provoked by the survey, as such, was a customer increasingly created for the providers of care, able to tell providers about themselves in such a way that they could be managed and accounted for.

This process is argued to entail the *re-managerialization* of the patient because it is deeply connected with a critique of traditional forms of expertise, management and control. Indeed, the post-war survey activity undertaken by Cartwright (1964: 1983) and other reformers (Vuori, 1991; Bender and Salmon, 1980; Rubin, 1990) was positioned in opposition to the bio-medical model and the risks that medical knowledge manufactured. By illuminating patients outside of bio-medical terms for instance, the post-war survey showed the “paradox of health” in which patients received more care by felt less well (Barsky, 1988). The survey as such developed in opposition to traditional knowledge and expertise. It was advanced as a means of overcoming the sorts of risks produced by traditional expertise that authors such as Beck et al (1992) describe as pervasive of the contemporary risk society. Like other devices such as participatory budgeting, it was argued to be a means of participation and empowerment, and constituting knowledge ‘from below’ (c.f. Beck, 2008; Jasanoff, 2003). Yet, this paper shows the optimistic aspirations of participation and empowerment coming to be given an expression through another and more managerial form of expertise. In order to participate and to have an organizational voice, patients were re-envisioned and remade in a form necessary for a distinctive set of managerial ambitions: the improvement of quality, accounting for performance, and achievement of accountability through reporting. These ambitions shaped the survey and the terms by which measurement success was achieved. As a result they gave a new voice to the patient in the form of a nationally standardized report of their experiences with things that providers did or did not do.

The optimistic scenarios of the risk society were thus delayed or decayed into the more pessimistic scenarios of the “evaluation” (Dahler-Larsen, 2012) or “audit society” (Power, 1997; 1999; Power et al, 2009). Here the solution to the risks of traditional knowledge is not knowledge from below, but the extension of yet new forms of expertise extended in the patient or customer’s name. In this case, the expertise of measurement scientists, quality improvement specialists, and survey methodologists, while emerging in response to a critique of management, brought back “managerial ideals about rationality, procedures, oversight and predictability [...] with a new force” (Dahler-Larsen, 2012, p.174). The survey, like the audit, was thus shown to be both a tool for managing modern risks and, as Power notes, a “symptom of the limitation of those tools to engender control by other means” (p. 307).

The second and related distinguishing feature of the current regime is the new significance that it affords to the representation of the customer. The immediately post-war survey activity sought explicitly to find out about the patient from some specific point of view. Sociologists,

psychologists, and epidemiologists sought not to deny their theoretical perspective and its impact on the patients that they revealed, but to advance and prove their points of view. Indeed, the diagnoses that emerged from socio-psychological expertise were first and foremost argued to be about the pursuit and extension of medical knowledge (Cartwright, 1964), and *The American Soldier* (Lazarsfeld, 1949) was an explicit demonstration of what a quantitative sociology is able to do.

By the time that the survey emerged as central to accounting and accountability, however, the external referent had been almost entirely obscured. In contrast to the previous regimes, those experts designing and extending the patient survey altogether denied that they had a perspective or point of view. As the developers of the Commonwealth-Picker and later CAHPS surveys explain, their success has been a matter of merely doing away with prejudice, assumptions, and political aims:

Our conscious effort throughout this project [...] has been to set aside those *professional* frames of reference in order to cast a clearer light on the *patient's* perspective. Our aim is to find out what patients want, need and experience in healthcare, not what professionals (however well-motivated) believe they need or get. We invite the reader, at least for the time being, to do the same. (Gerteis et al 1993, p.xviii)

Such a narrative of careful and patient listening is common in survey literature (Marsh, 1984; Osborne and Rose, 1999), but it is extraordinarily advanced in the current regime. In this regime the survey is constituted as an expression emanating as if unaided from the patient and in opposition to traditional medical expertise. The survey methodologists explain that it is as if they are not there at all: “we stake no exclusive claim to the territory explored in these pages, nor do we pretend to be pioneers” (Gerteis et al, 2002, p.xxi).

This is a paradoxical outcome of a survey development process that has become increasingly elaborate, expert, and technical. However, it is not despite, but because of this increasingly technicality that it seems the survey has achieved the status of the voice of the customer. As issues such as sample selection, cognitive interviewing, factor analysis emerged as clusters of considerations around the development of the survey, other more political or critical considerations of the appropriate use, limitations, and implications for surveys were progressively pushed aside. In this process, the survey methodologists, measurement scientists, and quality improvement specialists were constituted as the technocrats of the customer and her voice. Although they embraced and advanced very specific managerial ambition and aspirations for accounting and accountability, they argued that they were simply providing the infrastructure for the customer to speak with the organization directly. Thus, although accounting and measurement knowledge was central to the remaking of the patient, in opposition to traditional expertise, it could remain “humble and mundane” (c.f. Miller and Rose, 1990, p. 183).

The process of making the survey central to accounting and accountability has entailed, in effect, the removal of the external referent from the survey regime. Through the patient experience survey, the customer and accounting have become inseparably intertwined as expressions of each other. “Experiences” emerge as both an accounting fabrication and the expression of the customer. These experiences may or may not correspond directly with the complex and messy reality of the patient’s experiences, views, and perceptions. However, the significant point is that, within the current regime, there is no longer any way to know. When the customer survey is made central to accounting and accountability, the possible other or external customer is a person is sequestered from organizational reality.

Giddens (1991) has articulated this process in relation to the individual and the creation of other internally-referential systems. He argues that while such systems purchase “ontological security”, they do so at the cost of engagement with ethics and the object of knowledge more generally (p. 156). Here too, at the organizational level, we might expect to witness the same inability to confront the external and ethical world. As accounting comes to express the patient’s view, and the patient’s view becomes an expression of accounting, a “hyper-reality” is created (c.f. MacIntosh et al, 2000) in which care can be delivered, quality can be improved, risks can be managed, and at the same time, the patient can, once again, feel less well—a second “paradox of health”, to use Barsky’s (1988) terms. Evidence of this possibility might be found in the continual accumulation of healthcare scandals that have emerged alongside the extension of the survey and as a means of accounting and achieving accountability (c.f. Walshe, 2001; Vogus et al, 2010; Keogh, 2013). Such unethical behavior continues to emerge both despite and sometimes *because* of the survey regime, as a recent investigation into unethical treatment of patients in a UK hospital between 2002 and 2006 explains (Francis, 2013, p. 48).

This paper shows, in summary, that increasing centrality of the survey for accounting and accountability has a potentially very significant effect. By accounting for customers through the survey, customers are not empowered, embraced, and illuminated, but remade on the basis of accounting knowledge. More significantly, by accounting for customers through the survey the patient as a person—as someone capable of expressing herself fully—is removed. This is not, moreover, because accounting has not fully or accurately achieved measurement precision, but because it has.

These findings highlight important limitations of the often-espoused ambitions of customer accounting and accountability. Consistent with other research, this paper shows attempts to know customers through accounting, and to reduce them to “the one number you need to grow” (Reichheld, 2003), to “marginalize” (Mouritsen, 1997), “alienate” and “exclude” (Boyce, 2000) them (Vaivio, 1999; Ogden, 1997). Existing literature suggests that the attempts to account for the customer are both unsuccessful and organizationally dysfunctional because customers are complex and cannot be reduced to just one number that everyone will agree upon (Mouritsen, 1997; Vaivio, 1999). As Vaivio explains:

Extending ever deeper into the organization’s operational dimension, the new non-financial measures will probably meet the limits of what can be expected from the increasing quantification of organizational life and prevailing management practices. Systematic quantification, even when focused on non-financial measures, tends to aggregate and standardize [...] but the resistance that surfaced [...] suggests that in the domain of operational management detail maintains critical significance (p.710)

It is the customer’s intimacy, and the multiplicity of perspectives on the customer, in other words, that are seen to prohibit accounting from embracing the customer fully. While this indeed might be the case within individual organizations, this paper showed that the opposite is the case when understood in terms of the accounting device. This paper showed that accounting failed to represent the customer not because she was too complex to be made account-able, but because accounting succeeded so completely in capturing the customer for itself. Indeed, the customer was sequestered from organizational reality here to the very extent that accounting was made to speak on the customer’s behalf.

This suggests that the ability to successfully account for the customer and hold individuals and organizations accountable to them is intimately interconnected with the failure to listen

and respond to customers themselves. Understood from the perspective of the survey device, the process of making the survey central to accounting and accountability, has entailed that the customer becomes less rather than more able to speak. This is, however, not an absolute necessary. Accounting is not more unable to grasp the intricacies of the patient than any other set of experts and concerns. However, accounting here sequesters the patient because it obscures and denies that it has an objective and a point of view. In order to account for the patient in a way that bring the patient back in, this paper suggests, accounting would need to be more explicit and confrontational about the objectives that it seeks and the types of patients that it demands.

## **6.0 Conclusion**

This paper has advanced an unconventional methodology for investigating and describing the effects of accounting change. Drawing loosely upon certain strands in anthropology (c.f. Appadurai, 1988), this paper investigated accounting change from the perspective of the device. This meant tracking back throughout time the social history of what was ultimately made into an accounting device and uncovering the various ways in which it was given an existence and had effects throughout time. This methodology is distinctive from other approaches to investigating accounting change in several significant ways, and this paper has illustrated some of the benefits and limitations of this approach.

Firstly, this methodology did not directly attend, as many other studies do (Mouritsen, 1997; Vaivio, 1999), to the organizational decisions to adopt or adapt the customer survey toward processes and ambitions of management accounting and internal and external accountability. Instead, this paper understood and investigated this organizational decision not as the emergence, but as one of the effects, of accounting change. It suggested, as authors such as Miller and Napier (1993; Napier, 2001) do, that the availability of a survey which contained the promise of accounting for the customer was itself an important part of the change process. As such, this methodology can be seen as a response to Burns and Vaivio's calls for "more light" to be "cast on how commercialized 'new' management accounting products are assembled, how they become transmitted and how they construct the problematic in organizations according with implicit societal ideals" (2001, p. 393-4).

Investigating these preconditions of organizational adoption allowed us to illustrate important dynamics of accounting change, and its effects. It provided a means of investigating and highlighting the series of transformation in the nature of intentions, the jurisdictions of expertise, technological possibilities, and in other fields which was both part and product of accounting change. Indeed, it showed the possibility of organizational adoption of a new accounting device to itself be a product of no less than the emergence of measurement and improvement science as a solution to the failures of traditional expertise, the redesign of the survey to ask about experiences with care, and the creation of a new kind of customer with distinctive kinds of managerial views to express. Investigations of accounting change at the organizational level would overlook these significant aspects of accounting (c.f. Burns and Vaivio, 2001).

This methodological choice, however, also came at the cost of not investigating the diversity of ways in which organizations might appropriate and perhaps transform the survey device in practice. This is indeed an important and significant aspect of accounting change, and it has been fruitfully pursued by a number of authors (e.g. Mouritsen, 1997; Vaivio, 1999). However, as a growing collection of studies show, an understanding of both the conditions of

adoption and the processes and adoption and transformation are required to fully account for accounting change (Quattrone and Hopper, 2001; Andon et al, 2007; Briers and Chua, 2001; Busco et al, 2000; Burns and Scapens, 2002). This paper has aimed to begin to fill the gap in our understanding of the current context in which the survey is seen to be central to accounting and accountability. Research that seeks to more closely investigate the relationships and relations between the preconditions of organizational adoption of accounting devices and processes and the actual processes and effects of adoption would be a natural and beneficial way of extending our analysis (c.f. Andon et al, 2007).

Secondly, by attending to the life of the survey device, this research methodology extended its analysis far beyond the specific event in which accounting and the survey converged. This is in contrast to investigations of accounting change that are “episode” focused (Burns and Vaivio, 2001, p. 393) and that investigate the particular set of elements that come together within some relatively bounded period of time to constitute the conditions of accounting change (e.g. Radcliffe, 1998; Briers and Chua, 2001). Indeed, this paper showed that the patient survey was not just one element in the emergence of an accounting constellation or regime, but a device that had been central to a number of other regimes in which calculations had been made. Expanding the historical horizon of analysis of accounting change via attention to devices allowed us to emphasize that the addition of a device of into the repertoire of accounting involves adding a new chapter to its social life, and transforming, in a zero-sum way, the possibilities for the device in the world. Accounting change was thus shown to have an effect on the world and on organizations and society specifically through what it made a particular device to do. Indeed, this paper showed the emergence of the regime in which accounting and the survey intertwined to involve the dissolution and replacement of the regimes that came before and the different types of patients that they sustained. This paper shows, in summary, that accounting change is not just additive but subtractive—it entails the appropriation of a device from other possible ends that might otherwise have been used to pursue.

This attention to the device also emphasized the significant role of technologies or devices in accounting change. Research characterized as “new accounting history” (Napier, 2001), which emerged on the basis of a critique of functionalist explanations of accounting change, has tended to downplay the significance of devices and their properties in explanations of change. Instead, it has drawn attention to “the different meanings that have been attached to practices at different movements in time” (Miller and Napier, 1993, p. 632). This has allowed researchers to avoid immediately functionalist explanations of accounting change, but it has also tended to produce explanations that deemphasize the agency of technology. By contrast, this paper shows that the technology of the survey did not just have meanings attached to it, but also created and provided new meanings. Indeed, by constituting knowledge, the survey regime produced new things in the world, such as patients whose views were of medical concern. In doing so, the survey regime helped to create the preoccupations and ambitions that would animate a new regime and accounting change. The very ambition for the survey to be developed into systems accounting and accountability, for instance, was itself shown to be a product of what the survey did before. The interconnection between regimes highlights, in contrast to existing genealogical accounts, that devices which come to be part of accounting change are central actors in producing the conditions and demands for change itself.

In summary, this paper shows that new methodologies for investigating accounting change that draw from the work of anthropology, or more specifically the ‘anthropology of things’ (Appadurai, 1988), can usefully complement existing approaches to investigate accounting

change. No doubt there will be quibbles and critiques of the methodological choices made in this paper. This paper, however, has been undertaken in the spirit of methodological experimentation and innovation. It is hoped that this experimentation will inspire the community to further pursue and explore some of the methodological innovations outlined here (c.f. Chapman, 2012).

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|  | <b>SADDLEBACK MEMORIAL MEDICAL CENTER</b><br>24451 HEALTH CENTER DRIVE<br>LAGUNA HILLS, CA 92653<br>(949) 837-4500 | <b>MISSION HOSPITAL REGIONAL MED CENTER</b><br>27700 MEDICAL CENTER RD<br>MISSION VIEJO, CA 92691<br>(949) 364-1400 | <b>ORANGE COAST MEMORIAL MEDICAL CENTER</b><br>9920 TALBERT AVENUE<br>FOUNTAIN VALLEY, CA 92708<br>(714) 378-7406 |
|--|--|---|---|
| Patients who reported that their nurses "Always" communicated well.  | 72%  | 76%   | 73%   |
| Patients who reported that their doctors "Always" communicated well.   | 76%  | 79%   | 77%   |
| Patients who reported that they "Always" received help as soon as they wanted.   | 56%  | 56%   | 61%   |
| Patients who reported that their pain was "Always" well controlled.  | 69%  | 72%   | 68%   |
| Patients who reported that staff "Always" explained about medicines before giving it to them.                                | 55%  | 59%   | 58%   |
| Patients who reported that their room and bathroom were "Always" clean.  | 69%  | 73%   | 71%   |
| Patients who reported that the area around their room was "Always" quiet at night.   | 42%  | 50%   | 49%   |
| Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home. | 81%  | 79%   | 79%   |
| Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).                             | 65%  | 75%   | 69%   |
| Patients who reported YES, they would definitely recommend the hospital.   | 70%  | 80%   | 74%   |

Figure 1: Comparative survey performance reported on HospitalCompare.gov

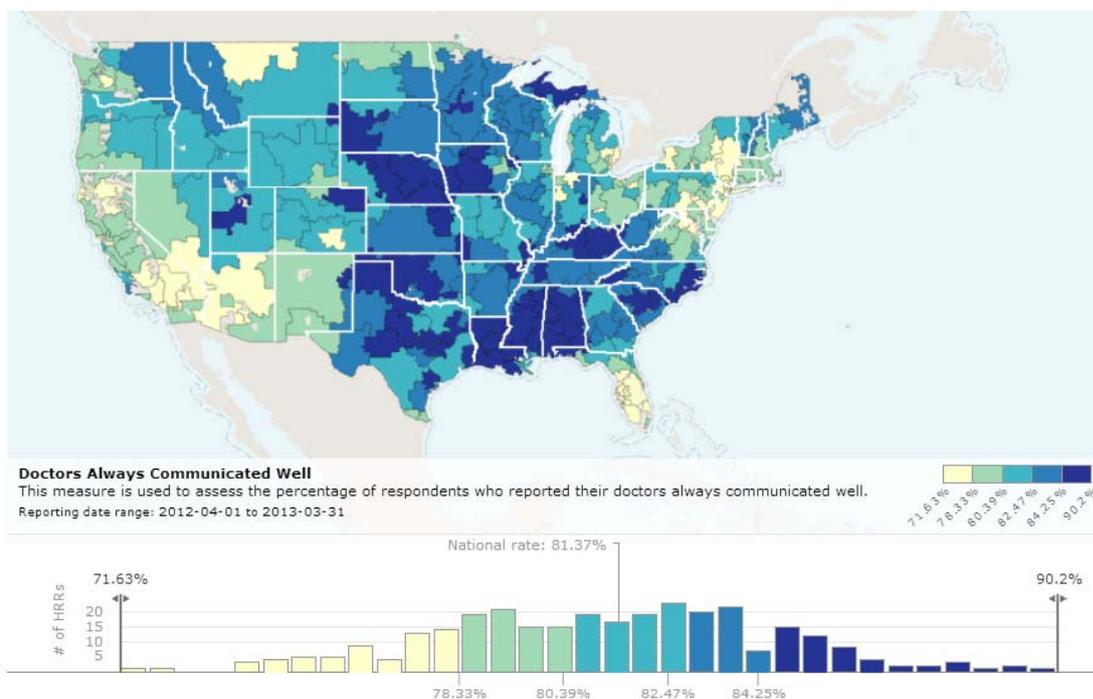


Figure 2: HCAHPS data reported on WhyNotTheBest.org

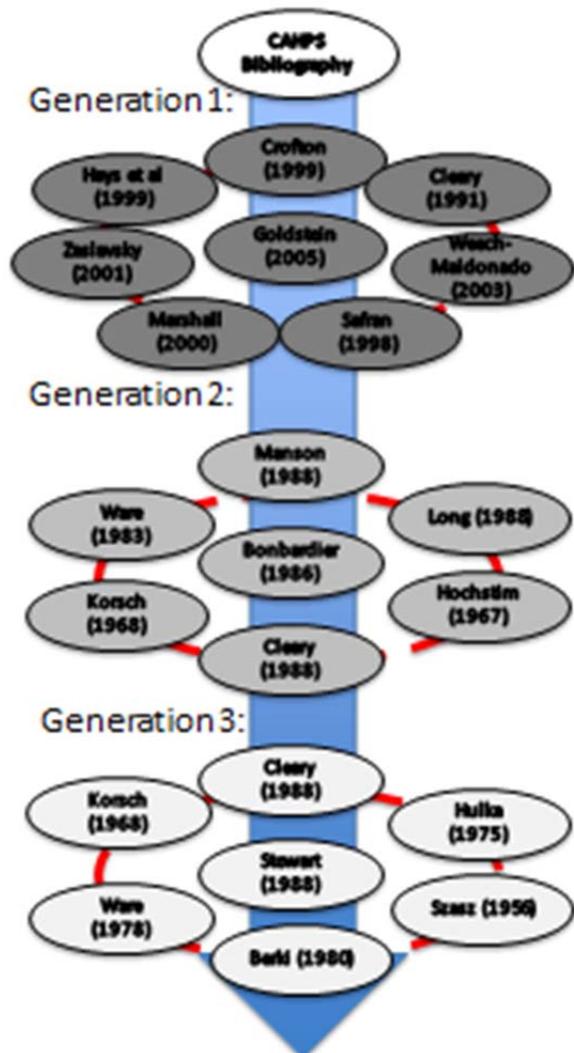


Figure 3: Bibliographic analysis of the CAHPS bibliography

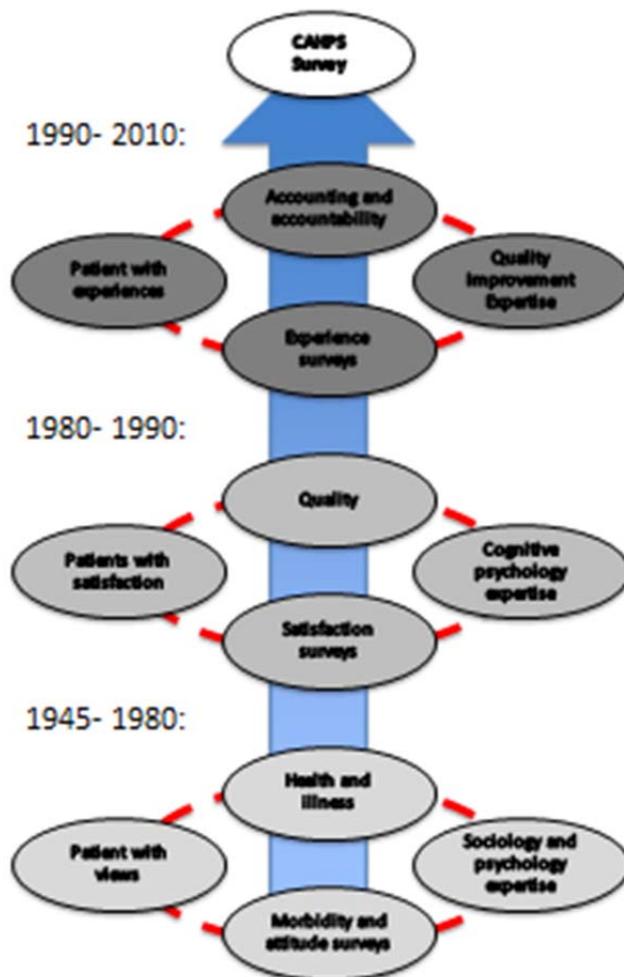


Figure 4: Three survey regimes

R25-3. Childhood health poor  
 R25-8. Birth defects  
 R26-5. Childhood trouble—sleep  
 R26-9. Childhood trouble—stammer or stutter  
 R27-1. Childhood trouble—upset stomach fairly often

Childhood Fears of

R27 Strangers 6. Little 7. Much  
 R28 Thunder 2. Little 3. Much  
 R28 Being left alone 8. Little 9. Much  
 R29 High Places 2. Little 3. Much  
 R29 Animals 8. Little 9. Much  
 R30 Being laughed at 2. Little 3. Much  
 R31 Being bawled out 2. Little 3. Much

R45-2. Is worrying type

B11-1. Dated opposite sex more often than others did 2. About same 3. Less often  
 B14-7. Liked school very much 8. All right 9. Disliked 0. Hated

G5-1. One should do everything perfectly  
 G5-5. One drink is one too many  
 G5-9. Never show feelings to others  
 G6-1. Never change mind  
 G6-5. Always be on guard with people  
 G7-1. Often, old ways are best ways  
 G7-5. Prefer to go out by myself  
 G7-9. Feel somewhat apart even among friends

Figure 5: Extract from Midtown Manhattan study interview schedule (from Srole et al, 1962, p.389)

TABLE 1  
ITEMS IN FORM II OF THE PSQ

| Item Number | Item Content  |
|-------------|---|
| 1*          | I'm very satisfied with the medical care I receive.   |
| 2           | Doctors let their patients tell them everything that the patient thinks is important              |
| 3*          | Doctors ask what foods patients eat and explain why certain foods are best.                       |
| 4*          | I think you can get medical care easily even if you don't have money with you.                    |
| 5*          | I hardly ever see the same doctor when I go for medical care.                                     |
| 6*          | Doctors are very careful to check everything when examining their patients.                       |
| 7           | We need more doctors in this area who specialize.   |
| 8*          | If more than one family member needs medical care, we have to go to different doctors.            |
| 9*          | Medical insurance coverage should pay for more expenses than it does.                             |
| 10*         | I think my doctor's office has everything needed to provide complete medical care.                |
| 11          | Doctors never keep their patients waiting, even for a minute.                                     |
| 12*         | Places where you can get medical care are very conveniently located.                              |
| 13          | Doctors act like they are doing their patients a favor by treating them.                          |
| 14*         | The amount charged for medical care services is reasonable.                                       |
| 15          | Doctors always tell their patients what to expect during treatment.                               |
| 16*         | Most people receive medical care that could be better.  |
| 17          | Most people are not encouraged to get a yearly exam when they go for medical care.                |
| 18*         | If I have a medical question, I can reach someone for help without any problem.                   |
| 19*         | In an emergency, it's very hard to get medical care quickly.                                      |
| 20          | I can arrange for payment of medical bills later if I'm short of money now.                       |
| 21*         | I am happy with the coverage provided by medical insurance plans.                                 |
| 22*         | Doctors always treat their patients with respect.   |
| 23*         | I see the same doctor just about every time I go for medical care.                                |
| 24          | The amount charged for lab tests and x-rays is extremely high.                                    |
| 25*         | Doctors don't advise patients about ways to avoid illness or injury.                              |
| 26*         | Doctors never recommend surgery (an operation) unless there is no other way to solve the problem. |
| 27          | Doctors hurt many more people than they help.   |
| 28*         | Doctors hardly ever explain the patient's medical problems to him.                                |
| 29*         | Doctors always do their best to keep the patient from worrying.                                   |
| 30*         | Doctors aren't as thorough as they should be.   |
| 31*         | It's hard to get an appointment for medical care right away.                                      |
| 32*         | There are enough doctors in this area who specialize.   |
| 33*         | Doctors always avoid unnecessary patient expenses.  |
| 34*         | Most people are encouraged to get a yearly exam when they go for medical care.                    |
| 35*         | Office hours when you can get medical care are good for most people.                              |
| 36*         | Without proof that you can pay, it's almost impossible to get admitted to the hospital.           |
| 37          | People have to wait too long for emergency care.  |

Figure 6: Satisfaction items (from Ware et al, 1983, p. 252)

VALIDATED ITEM GROUPINGS FOR PSQ SUBSCALES

| Dimension/Item Grouping              | Item Number                      |
|--------------------------------------|----------------------------------|
| <b>Access to care (nonfinancial)</b> |                                  |
| 1. Emergency care                    | 19, 37, 48                       |
| 2. Convenience of services           | 12, 43                           |
| 3. Access                            | 18, 31                           |
| <b>Financial aspects</b>             |                                  |
| 4. Cost of care                      | 14, 24, 49, 63                   |
| 5. Payment mechanisms                | 4, 20, 36, 56                    |
| 6. Insurance coverage                | 9, 21, 38                        |
| <b>Availability of resources</b>     |                                  |
| 7. Family doctors                    | 53, 67                           |
| 8. Specialists                       | 7, 32                            |
| 9. Hospitals                         | 42, 61                           |
| <b>Continuity of care</b>            |                                  |
| 10. Family                           | 8, 65                            |
| 11. Self                             | 5, 23                            |
| <b>Technical Quality</b>             |                                  |
| 12. Quality/competence               | 3, 6, 17, 25, 30, 34, 50, 51, 60 |
| 13. Prudence-Risks                   | 47, 54                           |
| 14. Doctor's facilities              | 10, 40                           |
| <b>Interpersonal manner</b>          |                                  |
| 15. Explanations                     | 28, 62, 66                       |
| 16. Consideration                    | 22, 26, 29, 39, 55               |
| 17. Prudence-Expenses                | 33, 68                           |
| <b>Overall satisfaction</b>          |                                  |
| 18. General satisfaction             | 1, 16, 45, 58                    |

Note. Source: Adapted from Figure 21 in Ware, Snyder, and Wright (1976a), p. 198.

Figure 7: Dimensions of satisfaction (from Ware et al, 1983, p. 256)

CAHPS Health Plan Surveys

8. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?

0 Worst health care possible

1

2

3

4

5

6

7

8

9

10 Best health care possible

9. In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?

Never

Sometimes

Usually

Always

Adult Commercial Survey 5.0

**Your Personal Doctor**

10. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

Yes

No → If No, go to #17

11. In the last 12 months, how many times did you visit your personal doctor to get care for yourself?

None → If None, go to #16

1 time

2

3

4

5 to 9

10 or more times

12. In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?

Never

Sometimes

Usually

Always

13. In the last 12 months, how often did your personal doctor listen carefully to you?

Never

Sometimes

Usually

Always

14. In the last 12 months, how often did your personal doctor show respect for what you had to say?

Never

Sometimes

Usually

Always

15. In the last 12 months, how often did your personal doctor spend enough time with you?

Never

Sometimes

Usually

Always

16. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

0 Worst personal doctor possible

1

2

3

4

5

6

7

8

9

10 Best personal doctor possible

**Getting Health Care From Specialists**

When you answer the next questions, do not include dental visits or care you got when you stayed overnight in a hospital.

17. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you make any appointments to see a specialist?

Yes

No → If No, go to #21

18. In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?

Never

Sometimes

Usually

Always

19. How many specialists have you seen in the last 12 months?

None → If None, go to #21

1 specialist

2

3

4

5 or more specialists

Figure 8: Extracts from the CAHPS survey instrument (from [www.cahps.arhq.gov](http://www.cahps.arhq.gov))