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Beyond Patient Satisfaction: Toward a Psychosocial Theory of Healthcare Experience, Emotional Meaning, and Perceived Care Quality

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Abstract

Patient satisfaction remains one of the most visible indicators of healthcare performance, yet satisfaction alone cannot explain what patients experienced, what those experiences meant to them, or why apparently similar encounters generate different judgments of care quality. This conceptual article develops a psychosocial account of perceived care quality that separates care events from their interpretation. It argues that satisfaction is best understood as a downstream evaluative judgment shaped by expectations and comparison standards, whereas healthcare experience encompasses reported events, interactions, relational conditions, continuity, material environments, and opportunities for participation. Emotional meaning is treated not as an accessory to experience but as part of the interpretive process through which events acquire significance. Recognition, dignity, trust, voice, information usability, and continuity can therefore alter perceived quality without being interchangeable with satisfaction. The article further emphasizes that evaluation is temporally cumulative: earlier encounters modify expectations, trust, vigilance, and interpretation of subsequent care. Cultural conditions, illness severity, organizational arrangements, digital modalities, resource inequalities, and power asymmetries constrain these processes. The resulting theory is explicitly proposed rather than empirically validated. Its purpose is to provide a bounded conceptual architecture for distinguishing what happened during care, how patients interpreted it, and how those interpretations contribute to perceived quality. This distinction has implications for measurement and quality improvement because global satisfaction scores may conceal clinically and organizationally important differences in patient experience.

Keywords: Patient experience, Patient satisfaction, Perceived care quality, Emotional meaning, Relational care, Continuity of care

Introduction

Patient satisfaction occupies an unusually powerful position in contemporary healthcare evaluation. It is easy to collect, readily summarized, and intuitively appealing as an indicator of whether care met patients' needs. Yet the construct does not simply record what happened during care. Conceptual analysis indicates that satisfaction is fundamentally evaluative: patients compare perceived care with expectations, standards, needs, or prior assumptions and then form a judgment about the adequacy of the encounter [1]. A favorable satisfaction rating therefore cannot by itself identify which events occurred, whether patients understood them, how those events were emotionally interpreted, or whether structural constraints narrowed the range of alternatives against which care was judged.

Patient-reported experience measures were partly developed to address this limitation by asking more directly about care processes and events. However, the

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existence of an experience measure does not eliminate conceptual ambiguity. A systematic review of patient-reported experience measures found substantial variation in their psychometric evaluation, with several measurement properties insufficiently assessed across instruments [2]. Experience is consequently not a self-validating category simply because a questionnaire uses that label.

A further difficulty is scale. Hospital experience is associated with influences operating at patient, interpersonal, organizational, environmental, and wider system levels [3]. A patient may receive technically appropriate treatment yet experience uncertainty because communication is fragmented; may report respectful communication while perceiving poor quality because coordination fails; or may express high satisfaction despite limited participation because expectations for involvement were low. Evidence distinguishing expectations, experienced care, perceived value, and satisfaction supports treating these as related rather than interchangeable constructs [4].

This article therefore develops a psychosocial theory of perceived care quality organized around a central distinction: care events are not equivalent to the meanings assigned to those events, and neither is equivalent to the final evaluation of care. The proposed theory treats patient experience as a temporally extended field in which clinical events, communication, emotional responses, recognition, participation, continuity, organizational conditions, and structural constraints are interpreted through changing expectations and comparison standards. Satisfaction becomes one possible evaluative output of this field rather than its comprehensive representation.

The argument is non-empirical. It does not claim that the proposed architecture has been prospectively validated or that its components form a universal causal sequence. Instead, existing empirical, qualitative, psychometric, and synthesis evidence is used to establish distinctions and boundary conditions from which a testable psychosocial model can be constructed.

Why satisfaction is an insufficient endpoint

The central limitation of satisfaction is not that it is meaningless. It is that a single evaluative judgment compresses multiple processes that may differ substantially between patients and encounters. Two patients can report equivalent satisfaction after experiencing different communication, participation, uncertainty, continuity, or recognition. Conversely, two patients exposed to similar care processes can evaluate them differently because expectations, prior experiences, illness severity, preferred roles, and perceived alternatives differ.

This problem is visible in research on shared decision-making and patient-centered communication. Patient satisfaction with decision-making does not establish that meaningful involvement occurred, and observational assessments show that shared decision-making and broader patient-centered communication can diverge even when both are associated with favorable evaluations [5, 6]. Satisfaction may therefore conceal process variation that matters theoretically and practically.

Trust illustrates another reason not to elevate satisfaction into a universal endpoint. A scoping review of interventions intended to increase shared decision-making found mixed effects on trust, with many included studies failing to demonstrate significant improvement [7]. This does not imply that shared decision-making is unimportant. It shows that relational constructs should not be treated as automatic consequences of apparently patient-centered processes. Baseline trust, preferred participation, clinician behavior, institutional history, and the meaning assigned to involvement may alter the relationship.

A satisfaction score also lacks diagnostic specificity. A low rating might reflect poor communication, unmanaged fear, unmet expectations, discontinuity, logistical burden, disrespect, perceived inequity, or dissatisfaction with an outcome that clinicians could not reasonably control. A high rating may coexist with informational deficits or low participation if the patient expected little, valued deference, perceived few alternatives, or prioritized another dimension of care.

The proposed interpretation is therefore that satisfaction functions as evaluative compression. It condenses a broader experience into a summary judgment after multiple psychological and contextual processes have already operated. This makes satisfaction useful but insufficient. Quality improvement based solely on raising a global satisfaction score risks intervening on the visible judgment while leaving the underlying experience architecture unidentified.

Distinguishing satisfaction, experience, and perceived quality

Conceptual precision requires separating three connected constructs. Patient experience concerns what patients

report encountering during care: communication, access, coordination, information, involvement, interpersonal treatment, environmental conditions, and related processes. Satisfaction concerns an evaluative response to those experiences in relation to expectations or standards. Perceived care quality, as used in this article, refers to the broader judgment patients form about the quality of care after interpreting experience through emotional, relational, temporal, and contextual meaning. The distinction is important because measures presented as experience measures vary considerably in development and psychometric completeness. A systematic review of adult inpatient patient-reported experience measures found uneven assessment of important measurement properties and identified major gaps such as responsiveness and measurement error [8]. Consequently, researchers cannot assume that every instrument cleanly distinguishes experienced events from evaluative appraisal.

Context complicates the issue further. Development of a recent inpatient experience measure in South Korea demonstrated that culturally and system-relevant domains may need to be incorporated rather than imported unchanged from other healthcare environments [9]. The implication is not that every health system requires an entirely unique theory of experience. Rather, constructs must be distinguished from their operationalization: a concept such as communication may recur across settings while the indicators through which patients recognize adequate communication can vary.

Care modality creates another boundary. Validation work on video encounters identified dimensions associated specifically with virtual care, including technical quality and appropriateness for the problem being addressed [10]. A patient can experience empathic communication yet still judge a virtual encounter poorly because technological instability prevents meaningful interaction. Conversely, convenience may improve evaluation even when the relational content of an encounter is relatively limited.

Experience information can also be used to identify improvement priorities, but the importance assigned to specific attributes depends on setting and population rather than following automatically from a global score [11]. This supports a layered interpretation. Patient experience records or reconstructs care processes; satisfaction evaluates those processes relative to standards; perceived quality integrates process information with emotional meaning, relational interpretation, continuity, and contextual judgment.

The boundaries are porous rather than absolute. Satisfaction itself is part of experience in ordinary language, and perceived quality may influence later recollection of an encounter. Nevertheless, collapsing the constructs removes explanatory leverage. The proposed theory therefore treats them as analytically distinct states capable of reciprocal influence rather than as alternative names for the same phenomenon.

The emotional content of healthcare encounters

Healthcare encounters are emotionally consequential because they occur under conditions of vulnerability, uncertainty, bodily threat, dependency, and unequal expertise. Yet emotion should not be represented as an internal patient reaction detached from the organization of care. Qualitative work in long-term cleft-care relationships shows that affective relationships can be actively cultivated through professional practice and organizational norms [12]. Emotional experience is therefore partly relational and institutionally conditioned. Respect and dignity illustrate this relational character. Qualitative evidence across intensive care and among multicultural women living with HIV identifies personhood, equality, nonjudgment, concern, autonomy, privacy, and the manner in which clinicians make themselves available as important dimensions of experienced dignity and respect [13, 14]. These findings should not be generalized mechanically across all patients, but they demonstrate that emotional meaning arises from how clinical actions position the patient within the relationship.

The care environment may also contribute. Research involving patients receiving cancer treatment found that material features of hospital environments could participate in affective experience rather than functioning merely as neutral background [15]. Noise, spatial organization, privacy, bodily exposure, waiting, and movement through institutional spaces may therefore alter how interactions are interpreted.

The proposed theory treats emotion as an interpretive weighting process rather than a detachable outcome. Fear can make unclear information more consequential. Relief can increase the salience of responsiveness. Shame may transform an otherwise routine question into evidence of judgment. Feeling recognized can give procedural actions interpersonal significance. None of these examples establishes a universal causal pathway; their

function is to clarify why the same observable clinical event can carry different meanings.

This framing also prevents a common error in patient-centered discourse: equating positive emotional experience with friendliness. Emotional quality may depend on difficult conversations, honest uncertainty, appropriate limit setting, or respectful disagreement. A patient may experience distress during high-quality care and comfort during care that later proves poorly coordinated. Emotional meaning therefore contributes to perceived quality but cannot independently establish technical or clinical quality.

Meaning formation during care

Experience becomes psychosocially consequential when events acquire meaning. Patients do not encounter communication, waiting, treatment decisions, clinician behavior, or organizational routines as isolated stimuli. They interpret them through prior experience, expectations, illness concerns, available knowledge, social position, perceived alternatives, and the unfolding trajectory of care.

Research comparing patient and provider perspectives demonstrates that broad values may be shared while expectations concerning how healthcare should be delivered remain different [16]. This distinction matters because an action intended as efficient or clinically routine can be interpreted as indifference, while an action intended as patient-centered may be experienced as burdensome when it conflicts with a patient's preferred role.

Structural conditions can enter meaning formation directly. Rural healthcare users in Peru described responsiveness through experiences involving respect, perceived abandonment, resource availability, and unequal distribution of services [17]. These accounts caution against treating expectations as purely psychological baselines located inside individuals. Expectations are also produced by histories of access, local service capacity, social comparison, and beliefs about what institutions are willing or able to provide.

Information is another example. Hospitalized patients' communication needs concern not only whether information is supplied but its timing, form, source, and usability during different stages of care [18]. Information that is technically accurate but delivered at an unusable moment may not reduce uncertainty. Repetition may be reassuring in one context but signal disorganization in another. Meaning therefore depends on the relationship between information and the patient's changing interpretive situation.

The proposed theory defines meaning formation as the process through which an experienced event is assigned significance for the patient's understanding of care, self, relationship, or future trajectory. This formulation does not assume that meaning is consciously articulated or stable. It identifies an analytical layer between occurrence and evaluation.

A missed explanation, for example, could mean simple oversight, organizational fragmentation, deliberate exclusion, or nothing important at all. Which interpretation becomes dominant may depend on prior encounters, trust, vulnerability, subsequent repair, and contextual expectations. The same event can thus support different perceived-quality judgments without requiring the assumption that one patient's evaluation is irrational.

Because the main analytical danger is treating one interpretation as inevitable, the principal exception and failure conditions developed in this section are summarized below before proceeding to expectations and comparison standards **(Table 1)**.

Table 1. When Similar Care Events Acquire Different Meanings: Exception States That Prevent a Simple Event-to-Evaluation Inference

Patient or care-context state	Meaning-forming process	Contextual modifier	Competing interpretation or uncertainty	Boundary or exception	Consequence for the proposed theory
Clinically accurate information is provided but remains difficult to use	Information is appraised through immediate uncertainty and comprehension demands	Timing, illness burden, language, unfamiliar terminology	Poor comprehension may reflect content complexity, distress, delivery, or all three	Information provision cannot be equated with experienced understanding	Separate documented communication from usable meaning

A routine interaction is perceived as dismissive	Behavior is interpreted against expectations of recognition	Prior experiences, perceived status, stigma, vulnerability	Clinician intention is not directly observable from patient report	Negative meaning does not itself establish deliberate disrespect	Preserve patient interpretation without converting it into an unsupported motive
Limited participation produces a favorable evaluation	Care is compared with the patient's preferred role and expected responsibility	Decision preference, urgency, familiarity with treatment	High evaluation may reflect desired delegation rather than strong participatory process	More participation is not inherently better for every patient	Evaluate concordance with legitimate participation preference
Resource limitations shape what care can offer	Institutional constraints become part of the interpretation of responsiveness	Rurality, affordability, service availability, staffing	Dissatisfaction may concern the health system rather than an individual clinician	Encounter and structural sources of meaning must remain distinguishable	Model perceived quality across rather than only within the dyad
A difficult encounter is later reinterpreted after repair	Later information modifies the meaning assigned to an earlier event	Continuity, explanation, apology, subsequent outcome	Recall may change without the original event changing	Experience is temporally revisable	Allow retrospective updating rather than fixed encounter meanings
An apparently positive encounter leaves unresolved uncertainty	Warmth and reassurance coexist with unclear next steps	Severity, diagnostic uncertainty, care transitions	Positive affect can coexist with informational or coordination deficits	Emotional positivity cannot substitute for process quality	Keep emotional meaning and care-process assessment analytically separate

Expectations, comparison standards, and evaluation

If meaning determines what an event signifies, comparison standards help determine how that meaning is evaluated. Satisfaction research has long implied some relationship between expectations and appraisal [1], while more recent modeling continues to distinguish expectations, experience, perceived value, and satisfaction rather than collapsing them [4]. The crucial theoretical question is therefore not whether expectations matter but what constitutes an expectation and how it changes.

Expectations can concern clinical outcomes, waiting, communication, interpersonal conduct, continuity, participation, convenience, or institutional responsiveness. They may arise from prior encounters, family narratives, public information, cultural norms, clinician promises, service reputation, or experience with other health systems. Evidence that patients and providers can share broad healthcare values while differing in delivery expectations supports this more plural account [16].

Structural experience also sets comparison standards. In resource-constrained environments, what patients believe is realistically obtainable can alter evaluation, while persistent scarcity or neglect can itself become part of the standard against which institutions are judged [17]. A favorable rating under constrained alternatives should therefore not automatically be interpreted as evidence that all relevant needs were met.

Information changes expectations during care. As patients receive explanations about diagnosis, uncertainty, waiting, procedures, or discharge, the standard against which later events are judged can be revised [18]. Expectations are therefore not fixed variables positioned only before the encounter. They can evolve within and across encounters.

The proposed theory consequently treats evaluation as reference-dependent and temporally updateable. Perceived quality emerges partly from the relationship

between experienced care and the comparison standards available at the time of interpretation. This also explains why uniformly attempting to "manage expectations" is conceptually problematic. Lowering expectations could increase satisfaction without improving experience. A patient-centered system should instead clarify realistic expectations while separately examining whether the care processes and structural conditions being evaluated are acceptable.

Relational experience and recognition

Healthcare experience is relational when patients interpret not only what clinicians do but what those actions communicate about their standing within the encounter. Recognition refers here to the patient's experience of being treated as an intelligible person whose concerns, preferences, knowledge, vulnerabilities, and capacity for participation are taken seriously. It is related to compassion, respect, participation, communication, and trust but is not identical to any of them.

Patients' descriptions of compassion emphasize observable practices such as listening, understanding, follow-up, continuity, and respect for preferences [19]. This is important because relational quality cannot be inferred solely from a clinician's intention to be caring. Recognition becomes experientially available through actions the patient can interpret.

Participation provides a more difficult case. In cancer care, patient-centered communication has been associated with trust partly through patient participation, while preferred decision role modifies that relationship [20]. Recognition therefore cannot be defined as maximizing participation regardless of preference. Inviting voice, explaining options, and allowing meaningful choice may be recognitional even when a patient ultimately prefers to delegate the decision.

Power conditions influence whether voice is usable. Adults with serious illness have reported poorer communication experiences that include greater uncertainty and concern about speaking up [21]. Under such conditions, the formal opportunity to ask questions does not necessarily mean that questioning feels safe or consequential. Recognition depends partly on whether participation is practically and relationally credible.

Trust further complicates the relationship. Qualitative work in therapeutic encounters in Maputo shows that trustworthiness is interpreted through verbal, nonverbal, and material features of care and can be reassessed through ongoing interaction [22]. Trust should thus be treated as revisable rather than as a stable patient attitude that simply precedes care.

The proposed theory uses recognition as a relational interpretation that can connect immediate interaction with broader perceptions of quality. When patients experience that their voice, dignity, uncertainty, or preferences have been treated as legitimate, routine care processes can acquire a different meaning. When recognition is absent, technically appropriate processes may be interpreted through exclusion, indifference, or hierarchy. These are possibilities to be tested, not universal causal claims.

The temporal distinctions matter sufficiently that the major relational transitions are displayed below **(Table 2)**.

Table 2. Relational Recognition Across Time: How Interaction States Can Be Reinforced, Revised, or Disrupted

Initial relational state	Interaction that becomes salient	Possible temporal transition	Condition that can alter the transition	Interpretive limit
Mechanism–context case — Patient seeks clarification during uncertainty				
Tentative reliance on clinician expertise	Question is invited, answered, or discouraged	Greater confidence, unchanged uncertainty, or reluctance to speak later	Serious illness, hierarchy, time pressure, prior dismissal	Asking fewer questions does not establish understanding or trust
Mechanism–context case — Patient is offered involvement in a decision				
Uncertain or established decision-role preference	Choice, explanation, and delegation options are negotiated	Participation becomes experienced as recognition or as unwanted burden	Preferred role, decisional complexity, urgency	Maximum participation is not the universal endpoint
Mechanism–context case — Patient perceives compassionate attention				

Vulnerability with uncertain interpersonal expectations	Listening, follow-up, acknowledgment, or preference-sensitive behavior	Relational confidence may accumulate across encounters	Continuity and consistency of subsequent behavior	A warm encounter alone does not prove durable trust
Mechanism–context case — Patient encounters perceived disrespect or nonrecognition				
Existing trust or cautious engagement	Dismissal, stigma, privacy failure, or inequitable treatment is perceived	Rupture, withdrawal, vigilance, complaint, or later repair	Explanation, apology, institutional response, prior relationship	Patient interpretation should not be converted into unsupported attribution of intent
Mechanism–context case — Care crosses clinicians, organizations, or modalities				
Reliance distributed across several relationships	Information and responsibility are transferred or fragmented	Recognition may become system-level continuity or system-level abandonment	Coordination, information transfer, digital access	Strong clinician relationship cannot by itself compensate for every organizational failure
Mechanism–context case — Earlier interaction is reinterpreted later				
Provisional meaning of prior care	New diagnosis, explanation, outcome, or relational repair changes context	Earlier event acquires more positive, negative, or ambiguous meaning	Time, memory, subsequent care, outcome knowledge	Patient experience should not be modeled as a fixed snapshot

Continuity and the temporal nature of patient experience

Patient experience is often measured after an encounter but is rarely produced by a single encounter alone. Continuity creates the temporal structure within which expectations are updated, trust is revised, meanings are stabilized or repaired, and separate events become a perceived care trajectory.

Patient-reported continuity is multidimensional, encompassing relational, informational, management, and knowledge-related aspects, while available instruments and outcome studies also show that perceived continuity cannot simply be reduced to administrative contact patterns [23-25]. The distinction is crucial. Seeing the same professional repeatedly may support continuity but does not guarantee that information is transferred, that the patient feels known, or that different parts of care are coordinated. Conversely, team-based care can sometimes produce experienced continuity despite multiple clinicians if responsibility and information remain coherent.

Fragmentation becomes especially visible where patients cross organizational boundaries. Veterans using more than one healthcare system reported more coordination and communication hassles than those relying on a single system [26]. Such findings support a temporal interpretation in which perceived quality is affected not only by the quality of individual encounters but by the work patients must perform to connect them.

Digital care adds another form of temporal reorganization. Experiences with telemedicine-based follow-up of chronic conditions show that acceptability and usefulness depend on implementation, workflow, user circumstances, and organizational fit rather than on technology alone [27]. Digital continuity may reduce burdens for some patients while generating new access, technical, or relational difficulties for others.

The proposed theory therefore treats experience as path dependent. Each encounter can modify the interpretive conditions of the next. A delayed result may be tolerated within a relationship characterized by reliable explanation but interpreted as abandonment after repeated communication failures. A prior episode of respectful care may create relational credit; repeated failures may produce vigilance even when a later encounter is technically adequate. Repair can also occur. Explanation, acknowledgment, restored coordination, or dependable follow-up may revise the meaning of an earlier rupture without erasing the original event.

This temporal framing establishes an important boundary for subsequent theory development: perceived care quality should not be modeled as the instantaneous sum of isolated encounters. It is better understood as a revisable judgment emerging from accumulated events, emotional meanings, expectations, relational recognition, and continuity under changing clinical and structural conditions.

A psychosocial model of perceived care quality

The preceding analysis supports a proposed model in which perceived care quality is neither a direct readout of care events nor a synonym for satisfaction. Instead, patients encounter clinical and organizational events, interpret their significance through emotional meaning and relational recognition, compare them with expectations and available standards, and carry prior experience forward into subsequent encounters. These processes occur within material, organizational, digital, cultural, and structural conditions that can enable or constrain interpretation and participation.

Evidence concerning women with migration experience illustrates why the model must extend beyond the immediate clinician–patient dyad. Patient-reported experience can reveal both individual agency and barriers located in access arrangements, institutions, and broader service structures [28]. Likewise, a synthesis focused on people experiencing homelessness indicates that conventional experience measures may incompletely represent priorities such as compassion, safety, equity, and accessibility [29]. The implication is not that particular populations possess uniform psychosocial responses. Rather, the conditions under which care is encountered differ, and those conditions affect what patients are able to experience, interpret, compare, and report.

The article therefore proposes five analytically separable but interacting states: experienced care events, emotional meaning, comparison standards, relational recognition, and temporally accumulated care experience. Perceived care quality is the revisable evaluative state emerging from their interaction. Satisfaction may express part of that evaluation but does not exhaust it.

The model is deliberately non-linear. Earlier perceived quality can modify later expectations; trust or vigilance can change interpretation of subsequent ambiguity; continuity can stabilize meaning; rupture can reorganize it; and later repair can retrospectively change how an earlier event is understood. Organizational fragmentation, unequal access, digital conditions, language, stigma, illness severity, and resource constraints operate as boundaries rather than as peripheral covariates.

Because these constraints act at different levels and cannot be represented adequately as one global adjustment factor, their distinct roles are summarized below **(Table 3)**.

Table 3. Constraints That Alter How Healthcare Experience Becomes a Judgment of Care Quality

Experience signal	Meaning-forming condition	Quality-judgment consequence	Alternative interpretation
Constraint level — Illness and vulnerability			
Psychosocial state most directly affected	Emotional meaning and voice	**How interpretation may be altered**	Uncertainty, dependency, or fear can increase the significance of communication and responsiveness
Critical boundary	Distress must not be equated with poor care	**Consequence for the proposed model**	Clinical state modifies interpretation without determining it
Constraint level — Relational conditions			
Psychosocial state most directly affected	Recognition and trust	**How interpretation may be altered**	Listening, dismissal, responsiveness, or repair changes how actions are understood
Critical boundary	Clinician intention is not identical to patient experience	**Consequence for the proposed model**	Relational meaning remains distinct from technical quality
Constraint level — Organizational coordination			
Psychosocial state most directly affected	Accumulated experience	**How interpretation may be altered**	Fragmented responsibility can convert individually acceptable encounters into a poor trajectory
Critical boundary	One clinician cannot represent the whole system	**Consequence for the proposed model**	Perceived quality may emerge across encounters and institutions
Constraint level — Cultural and social conditions			
Psychosocial state most directly affected	Expectations and comparison standards	**How interpretation may be altered**	Norms concerning authority, disclosure, participation, and acceptable care can alter evaluation

Critical boundary	Group membership cannot predict an individual preference	**Consequence for the proposed model**	Comparison standards require contextual rather than demographic inference
Constraint level — Digital care conditions			
Psychosocial state most directly affected	Experienced events and continuity	**How interpretation may be altered**	Access, technical reliability, suitability, and modality alter what participation is possible
Critical boundary	Convenience does not establish relational or clinical adequacy	**Consequence for the proposed model**	Digital experience requires modality-sensitive interpretation
Constraint level — Structural disadvantage			
Psychosocial state most directly affected	Access, voice, recognition, and standards	**How interpretation may be altered**	Scarcity, stigma, cost, or exclusion can narrow alternatives and change what is considered achievable
Critical boundary	High satisfaction under constrained choice does not demonstrate equitable care	**Consequence for the proposed model**	Structural conditions must remain visible when interpreting patient evaluations

The proposed architecture should therefore be read as a bounded explanatory system rather than a validated causal pathway. **Figure 1** makes the temporal updating, feedback, and multilevel constraints explicit.

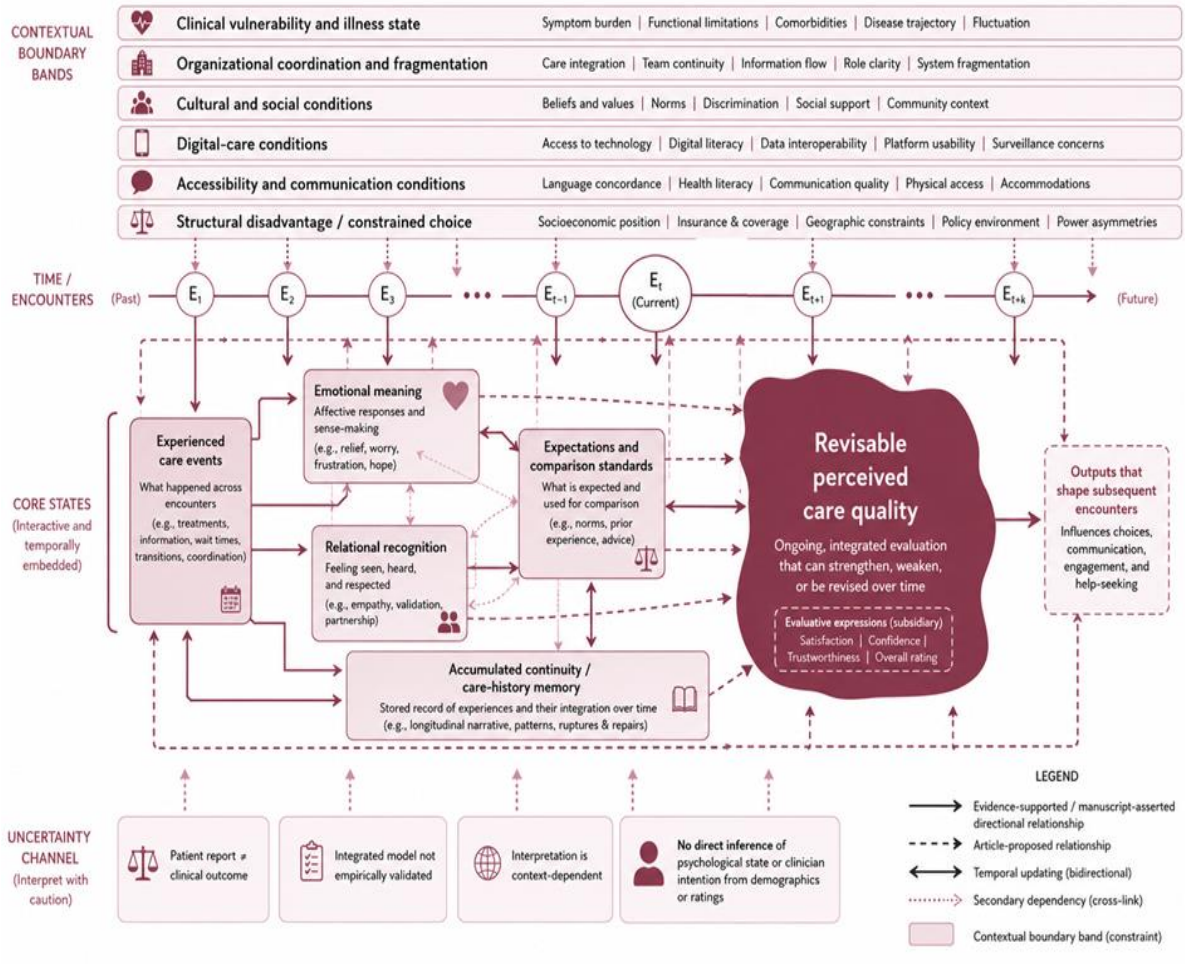

Figure 1. Temporal Updating of Perceived Care Quality Under Relational and Structural Constraints

Measurement implications

The theory requires measurement strategies that preserve the distinctions it proposes. Instruments should not combine reported events, emotional interpretation, satisfaction, continuity, and perceived quality into a single score without testing whether those dimensions remain empirically distinguishable. Existing PREM reviews already demonstrate substantial variation in measurement completeness [2], while inpatient instruments continue to show gaps in properties such as responsiveness and measurement error [8].

Measurement must also be sensitive to context. Culturally grounded instrument development [9] and modality-specific validation for video care [10] show why apparently equivalent questions cannot automatically be assumed to function identically across systems or modes of delivery. Continuity instruments similarly demonstrate that patient-perceived continuity contains several dimensions and that psychometric limitations remain even in carefully developed measures [23]. Instrument refinement therefore should preserve uncertainty rather than implying that a numerical score reveals an underlying psychosocial state without error [25].

The proposed model favors longitudinal and modular measurement: report what occurred; assess how it was interpreted; identify expectations and preferred participation; measure relational recognition and continuity; and then examine satisfaction and perceived quality. Structural accessibility and patient agency should also be represented when relevant [28]. Measurement systems developed without marginalized populations may otherwise omit dimensions that matter strongly in those contexts [29].

Implications for quality improvement

Quality improvement should consequently begin by diagnosing what a poor evaluation represents rather than treating the score itself as the problem. Experience data can support prioritization of specific service attributes [11], but a low global score cannot indicate whether the primary issue is communication, recognition, fragmented continuity, unrealistic expectations, structural access, digital fit, or another condition.

Implementation also matters. Telemedicine experience depends on how technology is integrated into care rather than on digital availability alone [27]. Likewise, formal patient participation in improvement initiatives does not guarantee meaningful influence; organizational strategy, hierarchy, representativeness, and feedback mechanisms can constrain participation [30].

The proposed practical rule is therefore: identify the experience process before selecting the improvement response. Raising satisfaction through reassurance, convenience, or expectation adjustment would not constitute adequate improvement if the underlying problem were exclusion, unsafe communication, fragmentation, or inequitable access.

Results and Discussion

This theory reframes patient evaluation as a psychosocial and temporal process. Satisfaction remains useful, but it is positioned downstream of more specific experiential and interpretive states. That interpretation helps reconcile evidence showing that apparently patient-centered processes do not uniformly produce trust [7] and that instruments labelled as experience measures vary substantially in what they capture [8].

The model also resists a universal patient pathway. Rural resource constraints can alter the meaning of responsiveness [17]; serious illness can change the practical conditions of voice [21]; migration-related access barriers can extend experience beyond the encounter [28]; and conventional measurement may inadequately represent priorities of people experiencing homelessness [29]. These conditions are not secondary caveats. They define where interpretations may differ and where transportability requires testing.

Several limitations follow. Much of the supporting evidence is observational, qualitative, psychometric, or review-based. The proposed integrated architecture itself has not been prospectively validated. Relationships shown as proposed should therefore be examined longitudinally, including whether emotional meaning and recognition mediate or modify later evaluation, whether rupture and repair alter subsequent interpretations, and whether identical reported events produce different perceived-quality trajectories under different comparison standards.

The strongest test of the theory would not be whether every component correlates with satisfaction. It would be whether separating events, meaning, recognition, continuity, expectations, and perceived quality explains clinically and organizationally important variation that global satisfaction measures conceal.

Conclusion

Patient satisfaction is informative but too compressed to serve as a complete theory of healthcare experience. A patient may be satisfied without having experienced strong participation, continuity, understanding, or recognition, and may be dissatisfied despite technically appropriate care. The proposed psychosocial theory therefore separates what happened during care from what those events meant and from how care was ultimately evaluated.

Perceived care quality is conceptualized as a revisable judgment shaped by emotional meaning, comparison standards, relational recognition, accumulated experience, and contextual constraints. These processes unfold over time and can be modified by rupture, repair, organizational coordination, digital conditions, inequality, accessibility, and changing expectations. The framework does not claim universal causal validity. Its contribution is to make these distinctions explicit and testable. Measurement and quality improvement can then move beyond asking only whether patients were satisfied toward understanding which experiences occurred, how they were interpreted, and why they became evidence of good or poor care.

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References

1. Ng JHY, Luk BHK. Patient satisfaction: Concept analysis in the healthcare context. Patient Educ Couns. 2019;102(4):790-6. doi:10.1016/j.pec.2018.11.013
2. Bull C, Byrnes J, Hettiarachchi R, Downes M. A systematic review of the validity and reliability of patient-reported experience measures. Health Serv Res. 2019;54(5):1023-35. doi:10.1111/1475-6773.13187
3. Guan T, Chen X, Li J, Zhang Y. Factors influencing patient experience in hospital wards: A systematic review. BMC Nurs. 2024;23(1):527. doi:10.1186/s12912-024-02054-0
4. Rao X, Luo L, Xiang J, Wang X. The impact of perceived value, customer expectations, and patient experience on the satisfaction of contracted patients in hospitals. BMC Health Serv Res. 2025;25(1):7. doi:10.1186/s12913-024-12118-1
5. Tian CY, Wong ELY, Qiu H, Zhao S, Wang K, Cheung AWL, et al. Patient experience and satisfaction with shared decision-making: A cross-sectional study among outpatients. Patient Educ Couns. 2024;129:108410. doi:10.1016/j.pec.2024.108410
6. Siebinga VY, Driever EM, Stiggelbout AM, Brand PLP. Shared decision making, patient-centered communication and patient satisfaction - A cross-sectional analysis. Patient Educ Couns. 2022;105(7):2145-50. doi:10.1016/j.pec.2022.03.012
7. Strokes N, Lloyd C, Girardin AL, Sánchez Santana C, Mangus CW, Mitchell KE, et al. Can shared decision-making interventions increase trust/trustworthiness in the physician-patient encounter? A scoping review. Patient Educ Couns. 2025;135:108705. doi:10.1016/j.pec.2025.108705
8. Kang Y, Guan T, Chen X, Zhang Y. Patient-reported experience measures in adult inpatient settings: A systematic review. J Nurs Manag. 2024;2024(1):5166392. doi:10.1155/jonm/5166392
9. Song Y, Kim JE, Koo BM, Choi YG, Kim UN, Lee JY, et al. Developing the Patient Experience Assessment Questionnaire for hospital inpatient care in South Korea. Health Expect. 2026;29(1). doi:10.1111/hex.70560
10. Slightam C, SooHoo S, Greene L, Zulman DM, Kimerling R. Development and validation of a measure to assess patient experiences with video care encounters. JAMA Netw Open. 2024;7(4). doi:10.1001/jamanetworkopen.2024.5277
11. Peruzzo E, Seghieri C, Vainieri M, De Rosis S. Improving the healthcare user experience: An optimization model grounded in patient-centredness. BMC Health Serv Res. 2025;25(1):132. doi:10.1186/s12913-024-11960-7
12. Liu D, Tian X. Repairing with a warm heart: How medical practitioners cultivate affective relationships with clients. Soc Sci Med. 2024;362:117449. doi:10.1016/j.socscimed.2024.117449
13. Sun X, Zhang G, Yu Z, Li K, Fan L. The meaning of respect and dignity for intensive care unit patients: A meta-synthesis of qualitative research. Nurs Ethics.

2024;31(4):652-69. doi:10.1177/09697330231222598
14. Fernandez SB, Ahmad A, Beach MC, Ward MK, Jean-Gilles M, Ibañez G, et al. How patients experience respect in healthcare: Findings from a qualitative study among multicultural women living with HIV. BMC Med Ethics. 2024;25(1):39. doi:10.1186/s12910-024-01015-1
15. Wiltshire G, Pullen E, Brown FF, Osborn M, Wexler S, Beresford M, et al. The experiences of cancer patients within the material hospital environment: Three ways that materiality is affective. Soc Sci Med. 2020;264:113402. doi:10.1016/j.socscimed.2020.113402
16. Natafgi N, Ladeji O, Blackwell S, Hong YD, Graham G, Cort M, et al. Similar values, different expectations: How do patients and providers view 'health' and perceive the healthcare experience? Health Expect. 2022;25(4):1517-28. doi:10.1111/hex.13493
17. Pesantes MA, Perez-León S, Lazo-Porras M, Cárdenas MK, Miranda JJ, Beran D. "We feel like orphans": Listening to users' expectations to ensure more responsive healthcare services in rural Peru. BMC Health Serv Res. 2025;25(1):1549. doi:10.1186/s12913-025-13535-6
18. Marca-Frances G, Frigola-Reig J, Menéndez-Signorini JA, Compte-Pujol M, Massana-Morera E. Defining patient communication needs during hospitalization to improve patient experience and health literacy. BMC Health Serv Res. 2020;20(1):131. doi:10.1186/s12913-020-4991-3
19. Baguley SI, Pavlova A, Consedine NS. More than a feeling? What does compassion in healthcare 'look like' to patients? Health Expect. 2022;25(4):1691-702. doi:10.1111/hex.13512
20. Jiang S, Wu Z, Zhang X, Ji Y, Xu J, Liu P, et al. How does patient-centered communication influence patient trust?: The roles of patient participation and patient preference. Patient Educ Couns. 2024;122:108161. doi:10.1016/j.pec.2024.108161
21. Davila C, Nouri S, Chan SH, Feltz B, Gosline A, Arenas Z, et al. Perceptions of patient-clinician communication among adults with and without serious illness. JAMA Netw Open. 2025;8(3). doi:10.1001/jamanetworkopen.2025.0365
22. Rodrigues CF. Communicative trust in therapeutic encounters: Users' experiences in public healthcare facilities and community pharmacies in Maputo, Mozambique. Soc Sci Med. 2021;291:114512. doi:10.1016/j.socscimed.2021.114512
23. Ljungholm L, Årestedt K, Fagerström C, Djukanovic I, Ekstedt M. Measuring patients' experiences of continuity of care in a primary care context-development and evaluation of a patient-reported experience measure. J Adv Nurs. 2024;80(1):387-98. doi:10.1111/jan.15792
24. Burch P, Walter A, Stewart S, Bower P. Patient reported measures of continuity of care and health outcomes: A systematic review. BMC Prim Care. 2024;25(1):309. doi:10.1186/s12875-024-02545-8
25. Safstrom E, Arestedt K, Hadjistavropoulos HD, Liljeroos M, Nordgren L, Jaarsma T, et al. Development and psychometric properties of a short version of the Patient Continuity of Care Questionnaire. Health Expect. 2023;26(3):1137-48. doi:10.1111/hex.13728
26. Noël PH, Barnard JM, Barry FM, Simon A, Lee ML, Olmos-Ochoa TT, et al. Patient experience of health care system hassles: Dual-system vs single-system users. Health Serv Res. 2020;55(4):548-55. doi:10.1111/1475-6773.13291
27. Sten-Gahmberg S, Pedersen K, Harsheim IG, Løyland HI, Abelsen B. Experiences with telemedicine-based follow-up of chronic conditions: The views of patients and health personnel enrolled in a pragmatic randomized controlled trial. BMC Health Serv Res. 2024;24(1):341. doi:10.1186/s12913-024-10732-7
28. Abel T, Tadesse L, Frahsa A, Sakarya S. Integrating patient-reported experience (PRE) in a multistage approach to study access to health services for women with chronic illness and migration experience. Health Expect. 2023;26(1):237-44. doi:10.1111/hex.13649
29. Miller JP, Hutton J, Doherty C, Vallesi S, Currie J, Rushworth K, et al. A scoping review examining patient experience and what matters to people experiencing homelessness when seeking healthcare. BMC Health Serv Res. 2024;24(1):492. doi:10.1186/s12913-024-10971-8
30. Westerink HJ, Garvelink MM, van Uden-Kraan CF, Zouitni O, Bart HAJ, van der Wees PJ, et al. Evaluating patient participation in value-based healthcare: Current state and lessons learned. Health Expect. 2024;27(1). doi:10.1111/hex.13945