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Abstract

From an institutional perspective patient surveys is an idea given from outside to support changes in individual departments. It has been argued that related managerial initiatives only serve as legitimizing behavior because norms originating from the medical communities constrain micro-level change. From a rational perspective of planned change and organizational development, patient surveys are seen as an incentive for improvement.

The aim of this paper is to trace how wards react on actual feedback from their patients in a longitudinal perspective. Do wards get the intended ownership of patient survey results and are improvements achieved? This is analyzed at a detailed organizational level based on quantitative and qualitative data. Data on patient satisfaction were collected from 100,000 patients at 90 different public hospital wards from 1999 to 2006 in a Danish county. The disaggregated data make it possible to trace the specific barriers to change and specific explanations of actual change.

Patient satisfaction varies considerably between units both in a cross-sectional and a longitudinal perspective. Reactions from the departments can typically be characterized as legitimizing behavior unless the following conditions are fulfilled. First, a significantly lower score than comparable units is needed before change is initiated. Second, patient surveys need to have a perceived technical quality in order to be accepted by key professionals. Third, there must be obvious actions to cope with the mentioned problems and written qualitative comments from patients can be an impulse to change as important as quantitative results.

1. Introduction

Surveys on patient satisfaction seem to fit perfectly with an organizational development perspective. The patient satisfaction data are diagnostic data on the organizational outcome and may be an incentive to techno-structural, human process or human resource management interventions. However, several barriers may hinder rational planned change. In general, the role of patient surveys in change processes seems much more complex. Analysis from an institutional perspective indicates that patient surveys are given from outside to support changes in individual departments, but norms originating from the medical communities constrain such micro-level change initiatives. Furthermore, changes in health care are influenced by competing logics (professional, state, and managerial) as stressed by Scott (2003).

In this paper it is analyzed how patient surveys may become an accepted incentive for change and improvement. The aim is to trace the specific barriers to change and explanations of actual change drawing on the rational perspective of planned change and organizational development, but the paper explicitly takes into account that planned change is encapsulated by other motors of change. Thus, patient surveys are seen as possible impulses for change in complex organizations that are strongly influenced by regulated, normative and cultural-cognitive elements in the environment. In accordance with recent institutional approaches, however, the reactions at a specific level are important as there may be room for human agency.

Empirically, the paper is based on Danish data from 100,000 patients served by 90 different hospital departments/wards between 1999 and 2006 and on the department heads' reports on change initiatives. A mapping of patient satisfaction scores is the point of departure and the main research questions are: How do the wards react on actual feedback from their patients?

Are patient surveys accepted as relevant incentives for change? How do the roles of the surveys develop when repeated?

2. Theories of Organizational Change in Hospitals

Room for Patient-centered Change?

Hospitals are difficult to manage; they are also difficult to change. Danish as well as international research emphasizes that the particular conditions in the sector create organizational divisions and a relatively weak administrative management that rarely ensures adequate integration (Mintzberg, 1979; Glouberman & Mintzberg, 2001). The prerequisite of a strong management that organizes the work rationally and under a common goal is rarely met. Restructuring activities in hospitals often fail and may produce more problems than they solve (Walston, et al., 2004). It thus becomes difficult to live up to otherwise obviously important requirements about continuity in patient care or other patient-related considerations that go beyond a narrow medical procedure (Vinge, 2004). The consequences may be poor capacity utilization, waiting time, uncoordinated treatments – and frustrated patients. The media is full of stories about absurdities seen from both the patients' and the staff's perspective.

The general institutional perspective indicates that the competing logics of doctors, nurses, administrative management and political leadership also appear as problems at the organizational level. It is impossible to react with system interventions to errors and problems (second order learning). The individual employee typically has to handle urgent problems with first order learning, i.e. here-and-now solutions (Tucker & Edmondson, 2003). A number of initia-

tives in recent years focus on the patients, but it remains unclear whether patient surveys result in improvements (Barr et al., 2006).

Many forces of change affect the development in the individual organizational unit in the sector – there is influence from the outside and initiatives from within. All the change perspectives described by Poole and Van de Ven (1995) in their general typology of change processes thus contribute to an understanding of the actual dynamic (see Figure 1). The notion of changes as rational reactions to perceived problems only covers a small part of the explanation of change processes. That perspective is shown in Figure 1's lower right corner (cell 4): the purposeful or planned change (teleological model). In this model the processes are guided by goals and driven by a unified organization. The diagnosis of problems and opportunities is central. Data are collected, analyzed, and fed back to the organizations as inputs to a planned intervention.

Insert Figure 1 about here

However, changes are often so bound by guidelines and inherent outside forces that the goals of an individual person lose significance. This is illustrated in the regulated model or the life cycle model as shown in the lower left corner of Figure 1 (cell 3). The previous institutional theory can also be placed under this perspective. Organization is characterized by subordination to guidelines and frequently imitation of others' solutions. It is a way to legitimize oneself to the environment rather than pursuing own goals (DiMaggio & Powell, 1983).

There are many examples in the health care sector of this type of external influence, even if we focus only on notions about greater patient focus. These ideas are launched without any

major mutual coherence via different central projects, conferences, debating points from stakeholders and directions from central government. Among the most visible patient-focused ideas in the Danish hospital sector are; greater continuity in patient care (Jensen, 2005); continuous monitoring and publication of the professional quality based on the idea of evidence (Mainz, 2001); measuring patient-perceived quality (Enheden for Brugerundersøgelser, 2007); clear-cut waiting time guarantees; assigning a contact person to each patient; the transparent health care system where the patient will receive full information as a basis for her free choice (The Ministry of Welfare home-site); and a model for a patient-focused health care system.

The ideas come from different worlds or areas: cure (doctors), care (nurses), control (managers), and community (trustees) (Glouberman & Mintzberg, 2001). Each area has its own mindset with an inner logic and associated recommendations, but the ideas from the different areas may very well be contradictory.

Unless we are dealing with legal requirements, it is rarely the case that these ideas can be converted into practice at the individual hospital. This is a consequence of the divided nature of the sector. The multiple entity change models in Figure 1's upper cells (1 and 2) may characterize the change processes.

Change initiatives can turn into "political" processes that are affected by the stakeholders' varying interests and resistance to change. This perspective is found in the dialectic models (cell 2). It is particularly obvious in a sector where many different and competing logics are all brought into play (Scott et al., 2000; Scott, 2004). The fact that the management logic is

now frequently mentioned as dominant does not mean that the logic of doctors and bureaucrats/politicians are not active.

"Survival of the fittest" (cell 1) does not only mean that hospitals may compete with each other and that the hospitals that cannot handle this competition close down. This perspective has influenced the notion of free hospital choice and other free choices for informed patients. However, "survival of the fittest" also means that some wards and some ideas on work organization are more viable than others, for instance specialization.

The fact that all perspectives in Van de Ven and Poole's (1995) typology can contribute to an understanding of organizational change processes in hospitals also means that simple prescriptions regarding planned change may be of limited use. It is thus indicative that important analyses of conditions in the health care sector are based on institutional theory, which is not conducive to clear normative consequences. According to the early institutionalization theory, initiatives from the outside will push towards isomorphism (Røvik, 1998). It is thus to be expected that hospitals and wards are basically organized identically and that from this perspective hospital wards in Denmark are not left much room for individual influence on local organization. However, also recent institutional theory puts more emphasis on analyzing the active role of the actors. Institutional influence is not seen as completely determining, but rather as shaping the context in which rational, targeted activities can take place at the micro level (Oliver, 1991; Scott, 2007).

According to recent institutional theory it is to be expected that implementation of ideas about patient focus will only be partial and differ widely, since directions regarding increased user focus has had to compete against more clearly stated institutional norms about economic

incentives and professionalism. The directions regarding increased patient focus are somewhat ambiguous, even though they to some extent are supported by certain general evidence (Lewin, 2001). Imitation is thus simply one of several possible responses to institutional pressure. The organizational response may just as well be compromise, evasion, challenge or direct manipulation (Oliver, 1991). There is room for rational strategies.

However, rational planned change requires a certain degree of agreement on and clarity of objectives. In a professional organization like a hospital neither agreement nor clarity is given, not even in the early stages of data collection and data analysis. To organizations with such complex tasks, the idea about measuring performance, where "the immeasurable had to be made measurable", still has a large impact. Management was forced to create clarity, transparency and learning opportunities. As a management tool it could in principle lead to predictability and simultaneously respect the autonomy of the professional (De Bruijn, 2007).

Measuring patient satisfaction is thus a part of the management system. It is emphasized by the fact that the measurements can be repeated and institutionalized. As a subsystem of the organizational structure, the measuring systems must fit the tasks of the organization (Cummings & Worley, 2005). This requirement is complicated by the fact that measuring patient satisfaction is particularly linked with "care", whereas a hospital is also measured on the "cure" part in a national Danish registration system.

Satisfaction surveys as ritual or impulse for change

The normative literature on planned change emphasizes data collection and organizational diagnosis in the early stages of change. It is recommended that data is collected in compli-

ance with social science ideas based on shared diagnostic models. This implies a certain level of agreement as far as which dimensions describe important organizational conditions. Data collected in accordance with these principles is accepted as key information, especially if the staff in organizations has been incorporated in the collection and interpretation of the data. This can potentially create "ownership" of the change activities (Cummings & Worley, 2005). A recent study of restructuring in American hospitals shows that these considerations may be neglected, and this neglect may be an important cause for failures (Walston et al., 2004).

Patient surveys could provide key information about performance in the organizational units. But are they accepted as significant and valid, and are they disseminated in an interesting way? All this seems highly uncertain. The international literature thus indicates a number of problems with using patient surveys (Carr-Hill, 1992; Crow et al, 2002; Sofaer & Firminger, 2005).

First, patient satisfaction is not a concept that can unambiguously be related to the quality of the services from an organizational unit. Satisfaction can be seen as a product of fulfilled expectations from patients, but other factors affect satisfaction as well. The uncertainty also leads to question whether it is the patient's ideal expectations that are expressed in satisfaction surveys or rather moderated, "realistic" expectations (Avis et al., 1995; Thompson & Suñol, 1995).

Second, patient satisfaction surveys have for many years been known for high levels of satisfaction. Almost all patient satisfaction surveys end up at over 80% satisfaction (Hall & Dornan, 1988). This is problematic because it does not leave much room for measured improve-

ments, and because it makes the surveys lose credibility. Quantitative measures may be less critical and sometimes different from results of patient interviews (Williams et al., 1998). Even after very negative stories, a patient might check “satisfied” or “very satisfied”, since patients may not have “translated” what had occurred into dissatisfaction. The patients avoid making an evaluation with remarks like, “they are doing their best” or “it is not their job to …” Thus, tools that do not capture the patients’ actual experiences are misleading.

Third, satisfaction surveys are often driven by an unrealistically rational view of measuring and quality development. Recent institutional organization theory sees measuring patient satisfaction as an idea that is supported primarily due to its legitimizing character. No organization wanting acceptance dares refuse a patient satisfaction survey. In that way, measuring takes on a ritualistic nature (Dahler-Larsen, 2000; Scott, 2007). The official rational arguments cover up the fact that in reality the outcomes of the surveys are taken very seriously. At the same time, these theorists emphasize that the measuring may still affect an organization’s behavior, however in completely unintended ways.

Fourth, patient satisfaction surveys are criticized for lacking validity and reliability. Many studies ignore these problems completely (Sitzia, 1999).

Research questions

Theories about possibilities for change and the role of satisfaction surveys lead to three overall research questions for our project:

> How do the wards react on actual feedback from their patients?
> Are patient surveys accepted as relevant incentives for change?
> How do the roles of patient satisfaction surveys develop when surveys are repeated?

These questions encourage both comparisons between organizational units and analyses of a development.

3. Methods

The study is mainly comparative, but it connects quantitative and qualitative elements and has a longitudinal perspective. The point of departure is detailed patient surveys from all public hospitals in a Danish region (Aarhus Amt). These surveys have included 100,000 patients in 4 rounds from 1999 to 2006. Besides a general measure of satisfaction, patients have provided data on specific issues such as waiting time, information quality, continuity in care, and personal background. These data have been gathered through a mailed questionnaire sent to the patients from the departments after their treatment. The consultants in the region's quality office analyse the data and give standardized feedback presented in a comparative format to the hospitals after each survey. The process starts with a meeting between the consultants and the top management at the hospital. Before measuring, there is also a meeting between consultants and representatives from the department. The aim of this meeting is to customize the survey to some degree and to enhance ownership of data.

The patients are hospitalized or from outpatient departments, and the average response rate is 57 per cent. This study focus on 90 wards covering approximately 32,000 answers from the 4 rounds from 1999 to 2005.

The questionnaires are not totally structured since they are designed in a way that incites respondents to connect qualitative comments to the score of each item. In average each respondent comments on approximately two items. In order to enhance ownership to the data in the

wards, it was possible to adjust the semi-standardized questionnaire to the needs of the wards in some degree. Thus, there are elements of action-research in the method, since one of the authors acted as senior consultant during the development of the survey.

It should be stressed that the surveys are used to give the wards specific feedback on the specific ward. Thus, data can be connected to relevant small units. Each head of department has received an easy-read report with the quantitative score and the qualitative comments. The heads of departments/wards are then asked to make a minute to the hospital management as a respond to the consultants' reports in order to start a dialogue with top management on follow-up activities. Additionally, the head of departments fill in a questionnaire from the consultants on their experience with data collection, feedback, and follow-up initiatives. Thus, the article draws on 173 questionnaires with 640 qualitative comments from the head of departments.

4. Findings

At an overall level our study shows that several motors of change are operating and that all perspectives in the Van de Ven & Poole (1995) typology contribute to an understanding of the role of patient surveys in the change processes. The planned change perspective is only one part of an explanation. Planned change is constrained by other motors of change.

Apparently, a *life cycle and regulating motor* is operative. At least to some degree there are institutional rules or programs that determine a prescribed sequence of activities. This is not only indicated by the norm that all public hospitals should survey patient satisfaction and

publish the results on a regular basis. This is a central part of new public management. The hospitals do in fact follow the standardized guidelines and institutionalize procedures that make it difficult to neglect poor scores.

There is also an *evolutionary motor* operative. It is reflected in the closing down of small hospitals and mergers among others. In the struggle for survival or autonomy patient satisfaction score may be one of the market signal surrogates that could be important to hospitals and departments. However, cost efficiency and a general argument on function-bearing size of units are most important (Borum, 2004). In fact, two small hospitals in the region have been closed down despite very fine scores on patient satisfaction, emphasizing that patient satisfaction is a less important performance indicator in political decisions.

Constructive modes of change with *teleological and dialectic motors* are the most visible when internal change processes are considered. At a specific level our study indicates how several barriers should be overcome if patient surveys should act as incentives for organizational change. In our study we focus on three steps: Getting attention to problems, getting accept and ownership of data, and finding possibilities of action. This sequencing of organizational diagnosing and action planning relates to a rational planned change process, but it appears that in all stages there are strong institutional forces operating and the process may become more dialectic as the work progresses.

Step 1: Getting attention

Even where there is some accept of the procedure, the diagnosis is not always completed in the sense that problems are clearly recognized. First of all, their satisfaction score has to be

significantly different from others'. Employees in the ward normally pay attention to the patient survey if they have got a score below the score of comparable units on an important item.

The overall satisfaction is of interest when it is measured at the specific ward level. Then there are notable deviations as shown in Figure 2. The histograms give an overview over the number of wards with a "good" and "excellent" score on satisfaction among the 90 wards. All together there is no significant change in patient satisfaction from first to second survey. But there are systematic changes at the ward level. The dark part of the bars shows the fifth of the wards with the poorest scores in the first survey, and it appears that they generally improve their scores in the second survey. Together these eighteen wards increased their score about 10 percentage points and six of them in a statistically significant degree and they were able to sustain the level of satisfaction in the third and fourth round. Conversely, the eighteen best wards have experienced a reduction of 4 percentage points, one of them had significant reduction. Seventy six of the wards are not able to show a significant change in overall satisfaction; on average they show a non significant reduction of 1 percentage point.

Insert Figure 2 about here

These results have several explanations as indicated in the closer analysis below (Overview in Table 1). The general pattern shows that institutional pressure to consider patient satisfaction is notable, but so are competing pressures from institutions in the field. Small improve-

ments may reflect that the pressure towards patient-centering is sometimes met with legitimizing behaviour, decoupling, and avoidance (Oliver, 1991; Scott, 2007).

Insert Table 1 about here

Differences between wards have to be visible to get serious attention from the employees and the managers. Small differences in a general measure of satisfaction are normally considered to be random and are easily explained away. Similarly, when comparing measures of satisfaction in one period with the next, it is mainly significant improvements that get the attention. Especially, when there is a decline the managers refuse to take it seriously by referring to statistical problems. Furthermore, the repeated measuring implies decreasing attention. These reservations are indicated by the following, typical quotations from department heads: *"Since the sample is quite small (low response rate), the variations can be ascribed to randomness", and "Everything is random".*

It has to be stressed, however, that some of those who head a ward with a declining score accept the feedback and refer to barriers in their own organization. It could be resource scarcity formulated as *"time pressure"* or *"the bustle of the ward"*. Often there is referred to the necessity of being involved in other restructuring activities. *"Our results are unchanged. It is ok because we have had a merger and cuts on the budget".*

All wards together as well as individual wards have significant increases in several single items.

The general results on the specific issues are that patients' most important and most pronounced criticism is related to the organizing of the work. These issues include information to the patient during the removal to the hospital, the arrangement of the progress of patient care, and the consistency in what patients are told from different employees. According to traditional importance/performance analysis (Martilla & James, 1977) this is where improvement efforts should be concentrated.

Whereas the quantitative part of the satisfaction reports may be met with skepticism and defensive reactions, there is a positive attention towards the qualitative comments from the questionnaires. In general, 80 per cent of the head of departments find the comments "very useful" or "useful". This is at same level as a question evaluating the usefulness of the quantitative answers. The explanation seems obvious. A general satisfaction measure is less motivating than concrete formulations on specific problems.

Occasionally, the qualitative comments are also met with scepticism. They can be considered as expressions of isolated and maybe unfair perceptions. This is seldom formulated by the head of departments. One of them, however, calls the comments *"entertaining"* to signal that he considered them unimportant.

In accordance with the consultants' intentions, another head of department expresses the usefulness of combining the quantitative and qualitative elements: *"The chosen quotations from patients can be used in considering how satisfaction may be improved"*.

Step 2: Getting accept

In order to get accept of the data, it may be necessary to get accept of the survey instrument. The entire data collection procedure should be arranged in a way that makes users participate according to prescription from the organizational development literature (Cummings and Worley, 2005). Our study indicates that this is not always sufficient.

The questionnaire is not only designed to be customized to the hospitals, it is also adjusted to individual wards. Most of the questionnaire remains standardized because comparison is an important part of the feedback, but the wards were able to supplement with different parts according to their own needs. Almost all wards used this option or the option of customizing the feedback, for instance by specifying the results on different groups of patients. As expected, the head of departments were normally satisfied with the procedure and in general 82 per cent of the head of departments found the work of the consultants "good" or "excellent". The top management was significantly more satisfied with the evaluation than the department heads. These evaluations concern the entire process from data collection to the presentation of the final report. Nevertheless, the surveys may be met with skeptical attitudes from the professionals because they do not find that the surveys are in accordance with natural science norms. One physician expressed such a view sharply:

"If you … should take a study seriously, then there should be respect on methods, data collection, data quality, analysis and conclusions. As a professional you should expect a certain substance, when non-professionals are going to evaluate you… As a professional I cannot tacitly accept to be evaluated on the basis of such an inadequate analysis and look forward to

management's planning in the future of more ambitious analyses that can expose the real problems and bottlenecks in health care"

According to social science norms the quality of the surveys seems acceptable. Data collection is validated in pilot studies among 64 patients and by feedback from participants in the early studies. Questionnaires were developed in a group of representatives from doctors, nurses, management and consultants. A less thorough procedure would probably have given much more skepticism.

The questionnaire is mailed to all patients after the treatment. The response rate (average 57 per cent) for an anonymous survey is better than most other surveys.

Among the rather positive head of departments the complaints on the procedure were mainly related to time pressure or to the fact that the surveys did not include professional quality. Professional cure and care in the narrow sense is still considered to be the dominating core activities. Furthermore, it is worth noticing that time pressure is reinforced by the restructuring in the Danish public health care in these years. This reform shapes a competing pressure for changes that may be understood by the evolutionary model because some wards have to struggle for survival or autonomy.

Step 3: Finding action possibilities

Even in departments where the report in general is seen as useful by management, skepticism and disagreement become manifest when possible action is considered. This is reflected in the following quotation: *"The accomplished work [by the consultants] is evaluated very dif-*

ferently by the professions. From the nurses' view, the report can be used constructively whereas the enthusiasm is far less among the doctors" (Head of department). In this way there are predictable and competing institutional pressures that appear at the micro-level as disagreement. Thus, the change process may become dialectical and sometimes the changes initiated by the patient survey may be very difficult unless they are supported by powerful agents in the hospitals.

Nevertheless, 83 per cent of the department heads answered unconditionally "yes" to the question "Did the survey cause concrete follow-up initiatives" after the first survey. This percentage fell to 71 after the fourth survey. The mentioned initiatives are interesting. Typically it is enthusiastic nurses that take specific action such as preparing better information for the patients or guidelines for the communication that takes place between departments. Most often such initiatives are ad hoc solutions that can be done by individual employees. In this sense our results seem in line with the study by Tucker and Edmondson (2003).

In other cases more demanding solutions are initiated. For instance when more continuity in the treatment of patients and a reduction in the time for waiting are considered. It concerns solutions such as *"changed booking procedures between radiotherapy and out-patient treatment"* or "*we have changed our work schedule for the doctors" or "the organizing in teams might be the reason for our better score*". Such initiatives involve more employees, more professions, and more units.

From an organization development perspective this step often demands human process interventions (Cummings and Worley, 2005). This is also reflected in several comments from the head of departments. Although they do not use words like confrontation meeting or large

group meeting, they mention *"theme day on waiting time problems", "employee meeting on priorities of action", "focus on patient transfers … tools of communication, cross-disciplinary theme days"*. In some hospitals they seem able to get to a common understanding or to cope with the latent conflicts through these interventions. In a successful hospital a head nurse mentions that they deliberately included influential individuals in the action planning, not necessarily the most change oriented.

It is a general trait in the comments from department heads that they are reluctant to initiate large projects solely based on the surveys, although several ambitious projects are found and seem to have some impact on measures of patient satisfaction. Neither do our data give strong support for the fulfilment of the prescription that repeated measurement may provide motivating feedback during implementation (cf. Cummings and Worley, 2005). Even among the wards that have to improve their score in the second survey, the respondents are *"humble…because the survey is subject for unreliability"*. However, several respondents perceive an unconditioned relationship between change initiatives and improvements in patient satisfaction on specific areas. Sometimes they also indicate that it contributes to the motivation to continue the work with the improvement of quality in patient care.

Among the wards that have been unable to improve a poor score, some do accept the survey as a diagnosis of problems. They stress that the management of projects for improvement is dynamic, complex, and demanding. Often they are influenced by factors outside their control*: "because of the continuing increase in patients with suspected lung cancer in the day care ward, it has been necessary to reorganize other patient groups in the department"*.

Other comments mention other barriers such as the educational obligations of public hospitals. It implies that employees often change departmental affiliation. For example, a head of department mentions that the flow of younger doctors through the department made their cross-disciplinary training in communication with patients difficult.

A general comment is lack of resources to implement change. This result is in line with other Danish studies that indicate shortage of managerial power and administrative assistance to implement changes (FLOS, 2004) as well as American studies (Walston et al., 2004). Our quantitative analyses also indicate the importance of general understaffing as there is a significant correlation between bed occupancy rates and patient satisfaction. *"The period for the survey was characterized by an extreme bed occupancy rate. …There were more complaints and newspaper writings in this period"*.

Our results on implementation can be summarized by referring to an exemplary case of a hospital that has been able to improve its score significantly.

Example: The X-county Hospital

This hospital has visible improvements in almost all areas from the first to the second survey. The improvement involves different groups of patients, the different issues, and the overall score in different wards (The overall score in 13 wards is shown in the Appendix). Neither management nor employees were satisfied with the results of the hospital *in the first round* and although some skepticism was articulated on the survey, there was a general agreement among the head of departments that the feedback was good. The management found that the consultants were *"… responsive to us. From the planning to the release of the final reports…[shed light on satisfaction] down to individual groups of patients/wards, so you can take action where needed."*

The results were *"read and discussed with great interest in all departments, joint consultative committees etc .. .implied several initiatives for improvement*". In one de-

partment specific actions are discussed in six team seminars in the next months; in another department they claim to have initiated *"cross-functional reflection on own practice. Common attitude towards patient procedures in the department"*. Some departments make their own follow-up studies, for instance with *"dialogue fora" (focus group activities)* with patients and employees. The specific initiatives in the departments cover a broad range: *"new central reception with expertise", " new written information for patients", "work with the waiting time", "contact persons", etc.*

After the second survey the department heads are asked to mention causes to immediate positive and negative changes in scores and they point to: "dialogue fora" (found to make a stronger impression on employees than a survey), "external and internal projects to improve our patient relations", "quality of work life", and "physical facilities". In this period there has also been some redistribution of resources that favour some of the wards, but to others a*n " increase in activity level"* relates to a negative impact.

After the third survey there are still small improvements. Department heads refer to the earlier initiatives as *"large changes with positive impact"* on quality together with new action plans and focus on new patient groups. Even after the fourth survey a head of department mentions that a new initiative *"comes to fruition"*. In general, the hospital is able to sustain the improvements from the first to the second survey.

To the description above it should be added that the hospital also had to struggle with poor physical facilities and a merger with a larger hospital in this period. Still, there has been a strong top management support to the changes. This case - picked from the group of units with measurable improvements – indicates that patient surveys can be a valuable diagnostic input to changes over a longer period.

5. Discussion and practical implications

Whereas the results of our study support previous research on satisfaction surveys, the specific contribution of this article primarily consists of an analysis of the connection between satisfaction surveys and initiatives towards organizational development in the area.

The planning of the satisfaction surveys in the hospitals to some extent fits into a rational change perspective: The wards obtain data to identify problems and possibilities, including data to assess the performance of the organizational unit. Under some circumstances, these data will be accepted as data for which the employees feel "ownership", and in that way they may constitute a strong impulse for change. They may be repeated and may in some cases even be a motivating impulse for preservation of improvements and efforts towards further development. The study shows a high stability in the measurements for the individual units indicating that the measurements are not used actively, but rather as a confirmation of the state of affairs. The wards that can demonstrate statistically significant changes are found especially in the group of sections that make results that put the ward's legitimacy at risk.

However, the analysis also shows that the change processes must be seen in a greater context. Patient satisfaction surveys are to a large extent initiated from the outside by strong, regulatory forces and institutional bindings that affect both implementation and process. They can also be linked with the general trend towards market control, i.e. that satisfaction surveys combined with goals for professional quality are seen as markers that help the consumers navigate. If demand and costs are not satisfactory, the hospital or the ward must close. Although perfect market regulation does not exist in practice and only few citizens look for the published results at the Internet, the struggle for survival is very real.

We have focused specifically on the reaction that is triggered when the individual unit receives the external evaluation. It is documented that a survey methodology that complies with the guidelines of organizational development for adapting data collection to needs in the organization leads to dialogue. Likewise, the qualitative comments from the questionnaires

have a clearly motivating effect. Several department managers have developed the qualitative information by adding the department's own focus groups. This may be a stepping stone for future change efforts on theme days and at large group meetings.

However, further research is needed, because it is not obvious that the techniques for organizational development for conflict resolution and participation are adequate in this environment. It is fair to say that change processes in the health care sector must focus on developing cultures that emphasize learning and trust. Otherwise initiatives can be limited to minor changes and "feel good" courses (Cummings and Worley, 2005). However, involving representatives from competing activities can intensify the conflicts and the resistance to change that normally appear in connection with organizational changes (Flohr Nielsen, 2006). On this topic, the literature has little to offer.

Analyses of the institutional framework of the hospitals would be appropriate. From a broadly comparative point of departure, interviews could be carried out in different hospital wards regarding organization and various conditions. Focus would thus be moved to the planning of change, implementation and incorporation techniques in the later stages of organizational change.

In this perspective, our research project is only a point of departure, but it already points to practical implications. First, the surveys must have a technical quality that ensures "ownership" in the organizational units, if the patient treatment in these units is to change. This also implies that data can be related to smaller organizational units. Data must be so standardized that they enable valid comparisons, and they must be combined with specific qualitative and thus illustrative feedback from the patients. Second, suitable management reactions are

needed. It is not enough to rely on individual ad hoc solutions. Management must encourage and be responsive to the frontline staff's indication of problems and possible improvements in connection with patient feedback. Due to the mutual dependencies of the units and the complexity of the tasks, it will be necessary to take measures that go beyond for instance the individual solutions of a particular nurse or doctor.

There is also reason to consider the extensive performance measurement in the sector. It is our claim that the patient satisfaction measurements referred to in this article are based on a sober foundation and on incorporation of the affected parties on the individual wards. This may make the measurements useful. However, all measurements have an element of external comparison and a claim of fair comparison that encourages imitation rather than independent initiatives, which could get their strength from being adapted to particular conditions.

Our results also indicate a tendency that repeated measurements are institutionalized to the point that they lose their effect over time. Once an acceptable score is achieved, it becomes difficult to come up with significant measurable improvements. It is then time to look for other approaches with greater potential for improvements so that the progress becomes more visible. At this point it is perhaps even more relevant to incorporate the working conditions of the frontline staff, which is an area that often leaves much room for improvement – closely related to the quality of care.

All in all, it seems inconceivable to implement noticeable changes without incorporating the nurses' and doctors' wishes to fulfill their professional ambitions. Their identification of relevant problems must be given priority. Also top management at the hospital seems to play

an important role - putting the right questions to the departments and by commitment to projects for improvement.

6. Conclusion

The road from knowledge to action can be quite unsafe when it comes to converting results from patient satisfaction surveys into organizational changes. The first hurdle is often the involved parties' failure to accept the "diagnostic" data. It requires both fulfillment of the technical statistical requirements and adaptation to wishes in the organization. The first item is discussed in the technical literature on the topic. Organizational adaptation is still unheeded, although it may be just as important as the technical quality in terms of accepting data as "diagnostic data". However, not even acceptance guarantees that data is converted to action. Each organization unit is entangled in external institutional requirements that may lead to either ritual legitimacy or rational change activities. Competing considerations from other "institutions" and change forces in the field is a key premise for the change process.

The literature on organizational change suggests incorporation as a means to create the necessary agreement and progress. But it is dangerous to rely on strong preconditions of rationality. Without sufficient resources, including manageable bed occupancy rates and resources for change activities, many are forced to give up or limit their initiatives. However, it is worth noticing that the exploitation of the possibilities that do exist varies to a great extent.

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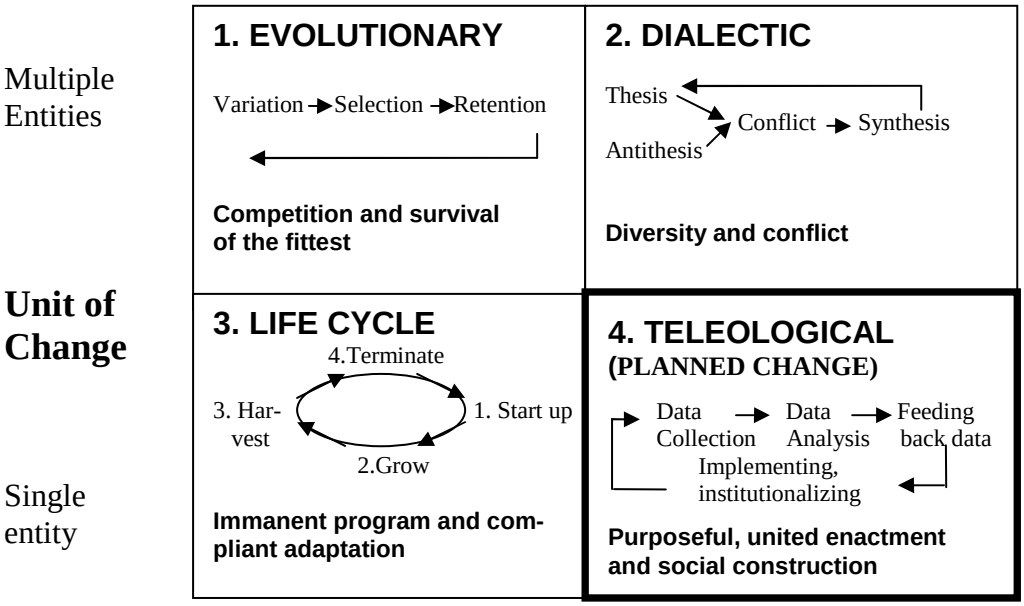
Figure 1

Process Theories and Planned Change



Mode of Change

Prescribed …….....Constructive

Adapted from Van de Ven & Poole (1995)

Figure 2
Overall patient satisfaction for 90 wards.
Percentage of responses with “Excellent” or “Good” score in 2000 and 2002.

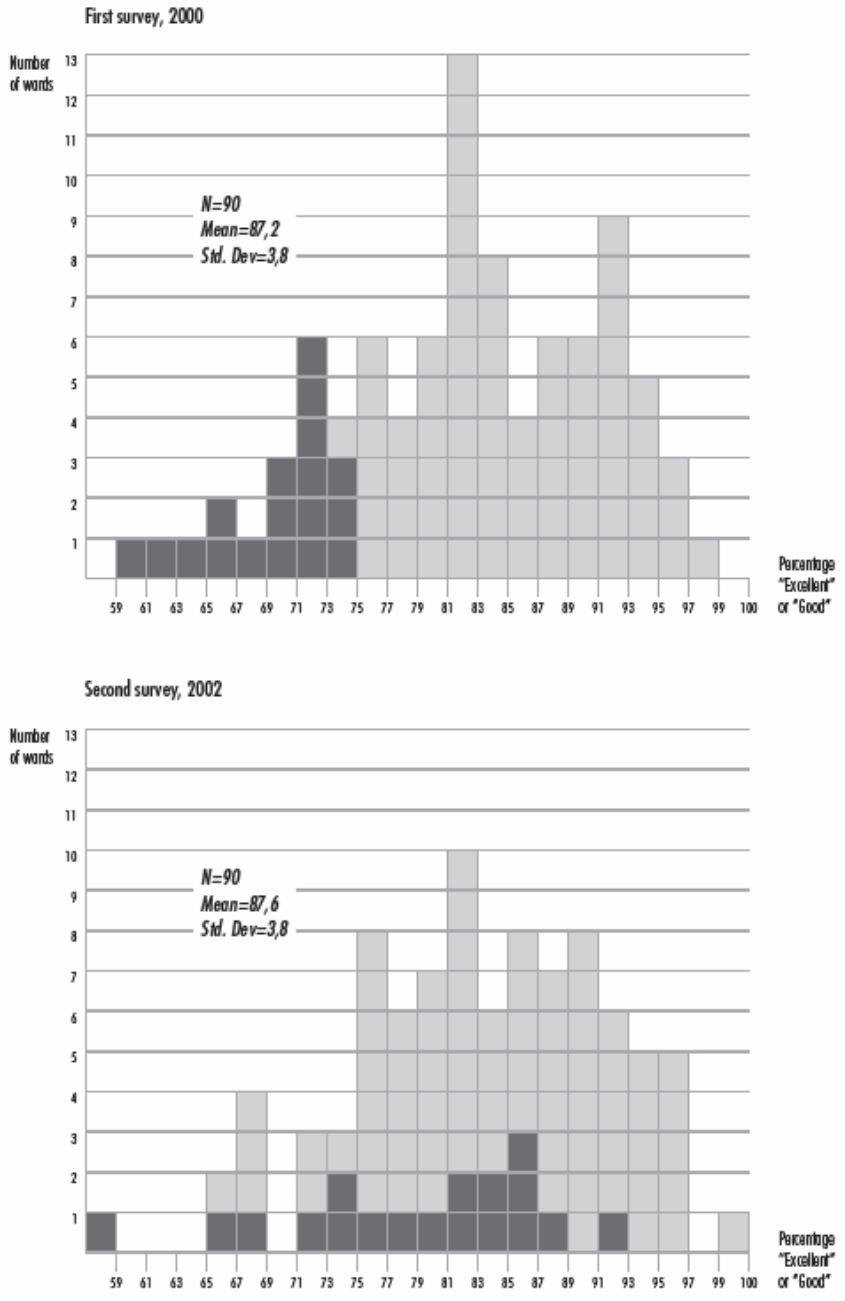


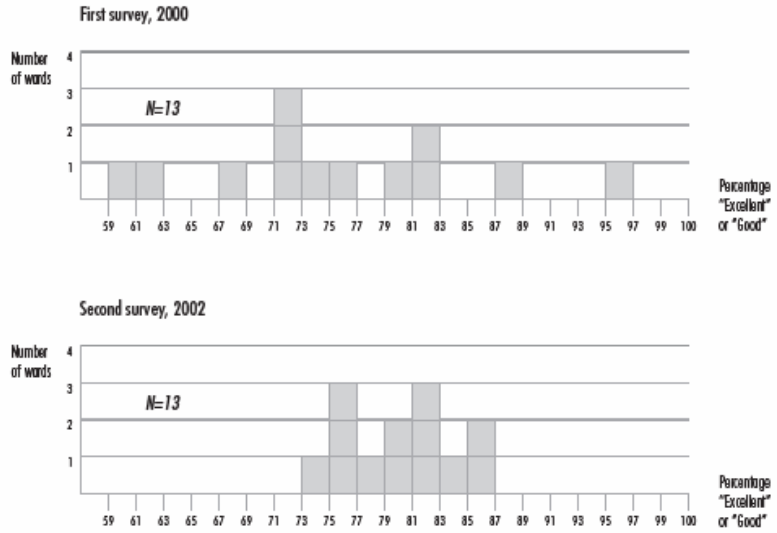
Table 1.
Indicators of Drivers and Barriers in the Change Process

(Based on department heads' comments)

	Drivers	**Barriers**
Attention (In data collection, data analysis, and data feedback stages)	***United focus*** - top management engagement - face-to-face meetings with department - selected questions with high importance - use of specific open ended questions - customizing surveys - intelligible reports and comparable format - significant deviations in results	***Multiple competing change motors*** - competition with other ideas in the field (decoupling mechanisms) - mergers and restructuring
Accept (In data collection, data analysis, and data feedback stages)	***Common values / compromising*** - professional participation in planning the survey - validation of surveys - sufficient sample size - relevant benchmarking - accepted methods of analyzing - building and sustaining support for evaluation	***Competing logics*** - disagreement on the usefulness of the results between professions - perceived by professionals as initiatives for standardizing and control - unclear theoretical foundation of concepts
Action (Intervention, implementation and institutionalizing)	***United action and actions to unite*** - top management support - participation of employees - engaged individuals - human process interventions - qualitative, local follow-up - experienced relationship between change initiatives and specific improvements - communicating progress and findings	***Competing forces*** - lack of resources - doctors' turnover - cross-functional cooperation problems - unclear action-effect relationships - lack of autonomy - unstable environment

Appendix A
X-County Hospital.

Overall patient satisfaction score at first and second survey (13 Wards).



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