

Assessment of the Quality of Patient Care Services through Patient Perspectives, Clinical Outcomes, and Healthcare Delivery Standards

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Abstract: The systematic evaluation of patient care services has attained strategic significance in initiatives designed to enhance healthcare quality and to cement sustainable delivery benchmarks. Defined broadly, patient care services consist of all clinician-patient and peer-patient interactions, therapeutic modalities, and ancillary support mechanisms administered in acute, ambulatory, and long-term care environments. Comprehensive quality appraisal therefore mandates simultaneous regard for patient-expressed judgments, clinical outcome metrics, and predefined standards of service delivery. Subjective patient judgments yield critical, contextually-rich accounts of clinical interactions, including but not limited to relational quality, service timeliness, and aggregate satisfaction. Concurrently, defended outcome metrics—such as risk-adjusted mortality rates, healthcare-associated infection rates, and validated readmission indices—supply a cogent evaluation of care efficacy and safety, unconfounded by reporting bias. The deliberate synthesis of qualitative and quantitative measures generates a multidimensional evaluative construct that prudently incorporates both experiential and empirical determinants of healthcare quality. Nonetheless, the investigation is confounded by heterogeneous patient expectations, limitations inherent to the data-collection processes, and the difficulty of norming performance indicators across markedly heterogeneous cohorts. This analysis advances a unified conceptual framework that integrates heterogeneous patient-reported measures and discrete clinical benchmarks, situating the synthesis within established healthcare delivery standards, thereby supplying a defensible instrument for the appraisal of patient-care services. The conclusions advance the thesis that integrating subjective patient experience with empirically derived indicators is the most powerful strategy for bolstering the credibility, trustworthiness, and accountability of contemporary health-delivery systems. The implications span the strategic agendas of providers, regulators, and investigative communities and are directed to the design of initiatives that further the tenets of patient-centered care, optimize clinical delivery, and underscore a culture of progressive, data-anchored quality enhancement.

Keywords: Patient Perspectives, Clinical Outcomes, Healthcare Delivery Standards, Quality Appraisal, Patient-Centered Care.

1. Introduction

Definition and Scope of Patient Care Services

Patient care services denote the comprehensive set of interventional and supportive activities focused on preserving, enhancing, or regaining an individual's health (Mohammed et al., 2016). The service portfolio encompasses medically directed therapies, psychosocial reinforcement, patient-centered counseling, rehabilitation initiatives, and preventive interventions grounded in current scientific evidence (Alkaim & Khan, 2024; Mohandas et al., 2024). Operational modalities include direct technical, diagnostic, and therapeutic interventions by attending physicians, licensed nursing professionals, and collaboratively formed inter-professional health teams, juxtaposed with non-procedural deliveries such as structured instructional sessions, subsequent clinical reevaluation, and organized care transit (Pandey & Malhotra, 2021). The range of clinical governance extends well beyond traditional facility perimeters, incorporating community-based alliances, certified structured home care programs, and both delayed and real-time encounters mediated by telehealth platforms. In these modalities reside the nucleus of a health system structured for integration and seamless longevity throughout the patient's health chronicle, systematically engaging determinants operating at the biological, psychosocial, and social-environmental strata (Reddy & Verma, 2024).

Importance of Assessing Quality in Healthcare Delivery

The excellence of patient care remains the decisive variable—indeed, the independent determinant affecting the sustained efficiency of health systems (Karimov & Sattorova, 2024). Clinically rigorous and patient-centric services engender a spectrum of advantages: favourable clinical endpoints, minimized nosocomial risk, heightened patient satisfaction, and the amortized loyalty essential for enduring system viability (Wensing & Elwyn, 2002). The appraisal of quality, therefore, equips providers with a dual instrument: a metrics-based concordance with the institution's reference standard and a diagnostic lens on latent, yet clinically salient, deficiencies. Such continuous scrutiny not only benchmarks operational excellence, but inscribes accountability and transparency into the institutional ethos, rendering both virtues operational, measurable, and institutionalised. Assessing the caliber of patient care services without an organised framework conceals defects in the delivery of care, allowing them to manifest eventually as increased morbidity, recurrent admissions, and, in the end, diminished patient satisfaction (Boopathy et al., 2024). Such recurrent assessment of quality, moreover, must simultaneously fulfil legislative standards governing health care practice, direct the prudent allocation of resources, and foster the recurrent refinement of clinical pathways. The quality assessment functions as a real-time feedback apparatus that drives the regulatory and managerial determinations that, in turn, stimulate ceaseless innovation within the delivery of health services.

Objectives and Structure of the Study

This research has two principal aims. First, it seeks to assess the quality of health services through the construction of a multi-dimensional analytical framework comprising, alternately, the patient perspective, clinically specified performance indicators, and formal delivery standards (Sofaer & Firminger, 2005). By collecting and interrogating these indicators in situ, the project aims to forge a systematically coherent comprehension of quality that is both rooted in context and capable of reproducible measurement and iterative refinement across varied health system governance models (Karimov & Sattorova, 2024). The second objective is to investigate the analytic levers and tensions associated with the deliberate integration of patient-derived viewpoints and methodologically demarcated outcome metrics, thereby fostering the strategic re-engineering of outcome indicators to become more axial and less additive. The investigation proceeds through concurrent fulfillment of multiple scholarly agendas within a disciplined temporal framework: first, a context-setting exposition lays an evidentiary foundation; second, a cross-analytical review of pertinent aperture literatures critiques hegemonic methodological assumptions sustaining current practice; thereafter, a formally integrated composite model is articulated, transposed into applied calibration trials, and systematically archived; finally, the research culminates in a set of cohesive conclusions and consensually ratified strategic recommendations, intended to guide ongoing and measured enhancements of present-day patient-centred service provision (Sixma et al., 1998).

2. Literature Review

Patient Perspectives and Feedback Mechanisms

Contributions originating from patients are increasingly regarded as a key criterion for gauging health-care quality, since subjective, first-person accounts articulate the situational factors actually navigated by individuals undergoing treatment. Careful, structured methodologies—comprising self-administered surveys, guided interviewing, and moderated focus-group sessions—elicit evaluations of communication quality, timeliness, empathetic engagement, and general levels of satisfaction. These observations corroborate core domains of the patient-provider relationship that are already incorporated into prevailing policy and funding frameworks, while simultaneously identifying deficiencies that conventional clinical indicators frequently fail to capture (Billig et al., 2020). Health-care organisations have systematically supplemented established feedback mechanisms with integrated digital platforms, smartphone applications, and near-real-time sensor data, thereby broadening citizen-provider interface and heightening fidelity of subsequent responses. Methodical engagement with patients' interpretive frameworks reframes quality away from clinical metrics alone, embedding the lived experience of intervention, and fashioning a more congruent patient-centred dimension within quality surveillance.

Clinical Outcomes and Their Measurement

Clinical outcomes provide unambiguous endpoints for evaluating both the efficacy and the safety of the care that patients receive (Ngo-Metzger et al., 2006). These endpoints comprise quantifiable indicators exemplified by overall mortality rates, the incidence of hospital-acquired infections, the mean duration of hospitalization, and the frequency of admissions within thirty days of initial discharge (Bhatia & Iyer, 2025). By operationalising care interventions through such precise indicators, the resultant data articulate the genuine consequences of the care process, thereby furnishing a foundation for future longitudinal inquiry and for systematic comparison among diverse healthcare organisations. Precise measures must include the strictest measures of data collection, analytical methods, and standardised measurement to guarantee both reliability and comparability across sites (Mathew & Asha, 2024). The focus on outcomes rather than processes allows organisations to know the extent to which their care delivery processes achieve their therapeutic goals. Continuous scrutiny of these indicators is indispensable for detecting clinically relevant trends, mitigating preventable adverse events, and underpinning iterative, evidence-directed enhancements of healthcare delivery (Levesque & Sutherland, 2020).

Integration of Patient Perspectives with Clinical Outcomes

When patient-reported experiences are juxtaposed with clinical indicators, the confluence generates a richer evaluative matrix for health-system quality, moving beyond the singularities of either modality (Jalali & Shaemi, 2015). Such a synthesis narrows the rift between evaluative endpoints and experiential interpretants, permitting assessments to reflect both therapeutic gain and attitudinal validation. A clinically sound intervention may, for instance, demonstrate normative laboratory improvement, yet remain clinically irrelevant to patients who perceive fragmented communication and transactional encounters, thereby exposing the intervention's latent failure in empathetic delivery (Odeh & Taleb, 2023). By integrating experiential and technical registers, healthcare organizations extend accountability beyond biostatistical attainment to domains of respect, comfort, and relational integrity that influence adherence, satisfaction, and, by extension, clinical sustainability (Anhang Price et al., 2014). Furthermore, the systematized intelligence furnishes a structured foundation for precise policy articulation, proportional assignment of limited resources, and finely calibrated accountability indices, such that judicious stewardship can be consistently observed. Ultimately, the synchronous orientation of patient-centered and clinician-centered measures engenders a care paradigm that simultaneously accords full ontological and epistemological weight to both technical corroboration and the concrete, situated, and ethical substrates that render clinical benefit publicly and consensually legible, thus safeguarding the persistence of high-quality care and the verisimilitude of therapeutic alliance (Carfora et al., 2022; Williams et al., 2015).

3. Proposed Model

Conceptual Framework for Quality Assessment

The examined framework contends that an exhaustive evaluation of healthcare service quality necessitates the simultaneous synthesis of qualitatively derived subjective information and quantitatively acquired objective metrics. Quality is articulated through a multidimensional model that positions quality at the intersection of three constituent domains: patient-reported metrics that capture experiential and affective dimensions, clinically derived outcomes that establish empiric validity, and explicit service norms that codify institutional standards of care. The experiential and affective domain is explicated through patient-reported accounts, the empiric domain is operationalized through clinically derived data, and the institutional domain is articulated via documented service delivery norms. This comprehensive model defines quality not solely through clinical efficacy but through patient-advocated indicators of dignity, safety, and satisfaction. Structured analytical trajectories incorporate secure, recursive feedback loops, so that every data iteration returns within the clinical evaluation cycle. The incorporation of this feedback into the ongoing quality-improvement mechanism sustains the persistent potential for enhancement, thereby harmonizing the obligatory discipline of clinician fidelity with the equally warranted, yet voluntary, urgency of patient requirements.

Integration of Patient Perspectives, Clinical Outcomes, and Standards

The model's standard implementation deliberately incorporates patient-reported outcomes alongside established clinical endpoints, both anchored to prevailing norms of healthcare delivery. This dual data stream permits an integrated interrogation in which subjective patient perceptions—such as self-assessed adequacy of clinician communication—are cross-referenced with quantitatively determined safety signals like 30-day readmission rates or rates of postoperative infection. Such an architecture mitigates the risk of the biases intrinsic to analyzing either source of information in isolation. Benchmark standards are further invoked to create calibrated reference levels, thereby assuring that the amalgamated scores preserve criterion-specific validity and are comparable across discrete healthcare institutions. The method integrates weighted aggregation, whereby the coefficient applied to each datum is conditional upon the specific care category and the articulated therapeutic objectives, thereby allowing a joint, negotiated influence from the clinical context to calibrate the volume of information that is concurrently synthesized. This design thereby translates the clinical efficacy implicit within proxy quality indicators and within patients' subjective reports of their engagement with care into a rigorously defined and executable framework whose outputs remain interoperable across information systems.

Strategies for Implementing the Proposed Model

The effective deployment of the proposed framework hinges upon aligned tactical strands that interleave patient-reporting infrastructures, clinical-outcome surveillance, and adherence to institutional governance normatives for the provision of care. One tactical strand employs configurable, patient-facing digital pathways that enable synchronous, de-identified harvesting of experiential data, thereby allowing extracted narrative and quantitative variables to be temporally co-registered with Electronic Health Records for multiphenomenon triangulation. This strand is further reinforced by recurrent, outcome-driven pedagogical workshops for clinical personnel, which guide practitioners in interpreting converged analytics and quality-improvement cycles with respect to carefully delineated unit-based performance indicators. Concurrently, regulatory directives ought to mandate yearly assessments of hybrid constructs that integrate patient-reported and outcome-based indicators, establishing such assessments as prerequisites for accreditation or for conducting performance appraisal. Collectively, these systems translate the underlying logic of the model into actionable procedures, furnishing providers with the requisite instruments to convert analytical insights into well-defined enhancements of clinical care. Systematic implementation, while functioning as a mechanism for delivery, further entrenches a dual regime of translational accountability, progressive learning, and a structured commitment to patient experience, thereby embedding these orientations within the institutional architecture.

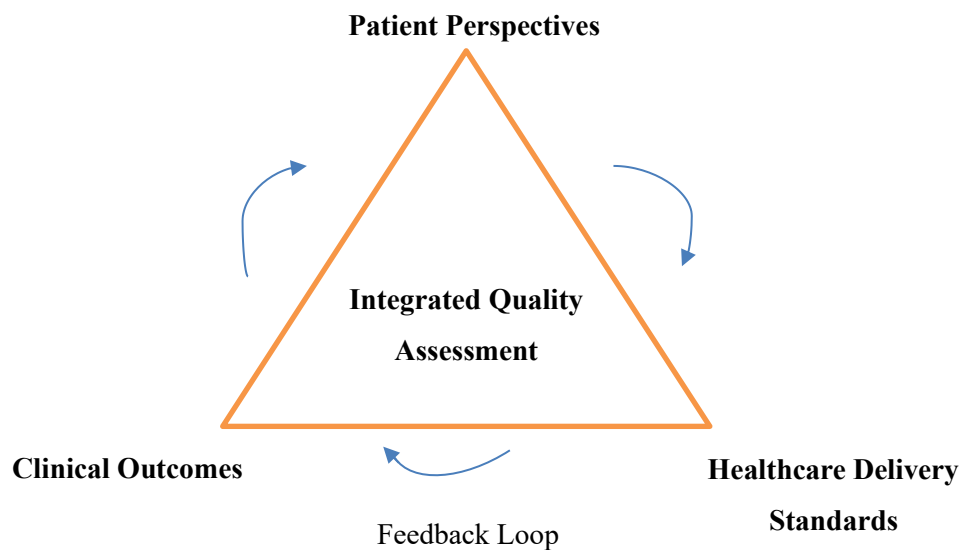


Figure 1 : Integrated Model for Assessing Patient Care Quality

Figure 1 depicts the proposed evaluative construct as an equilateral triangle with the vertices designated as patient viewpoints, clinical endpoints, and healthcare delivery criteria. The triangle's centroid signifies the integrative quality appraisal procedure where the three domains amalgamate. Curvilinear feedback arcs join each vertex, representing the cyclical transmission of qualitative and quantitative data that underpins iterative enhancement. The construct visibly affirms that synthesized attention to experiential and empirical

proxies moderated by normative thresholds produces an encompassing and dependable index of care quality across the health system.

- ***Mathematical Model***

The overall Quality of Patient Care (QPC) is a linear combination of three latent domains: perspectives from patients (PP), clinical outcomes (CO), and adherence with healthcare delivery standards (HS), with an appropriate multiplying constant.

$$QPC = \alpha \cdot PP + \beta \cdot CO + \gamma \cdot HS$$

Where:

- P = Patient Perspectives (survey scores, feedback ratings, satisfaction indices)
- CO = Clinical Outcomes (mortality rates, infection rates, readmission rates, recovery time)
- HS = Healthcare Delivery Standards (compliance levels, accreditation benchmarks, safety protocols)
- α, β, γ = Weight coefficients (where $\alpha + \beta + \gamma = 1$)

The method gives managers a normative model, and a model that can allow for specifications, facilitating real-time adjustments to the coefficients based on different strategic needs and changing patient populations, potentially even calibrating the quality assessment to the institutional context and patient perspective.

4. Results and Discussion

Findings from Patient Feedback and Clinical Data

A comprehensive examination of systematically collated patient feedback alongside longitudinal clinical metrics was conducted to appraise the quality of care provision. Structured patient surveys disclosed generally elevated satisfaction scores in critical domains: clinician–patient discourse, timeliness of ancillary response, and facility hygiene. Nevertheless, the data also identified two salient dissatisfactions prolonged waiting intervals and perceived opacity in post-discharge guidance thereby defining targeted avenues for refinement. Concomitant evaluation of clinical datasets identified prospective clinical trajectories: elevated original-discharge health-index scores alongside diminished readmission events across the specialty cohorts, suggesting sustained therapeutic efficacy. Concurrent stratified analysis disclosed heterogeneous distribution, revealing a subset of units exhibiting elevated baseline prevalence relative to peer cohorts. Subsequent concordance assessment juxtaposed patient-reported-experience summary mark scores against clinical outcome indices and disclosed a consistently negative monotonic association; units with superior patient-reported evaluations concomitantly achieved more favorable peak-recovery clinical outcomes. Collectively, these epiphenomena emphasize the merit of conjoining patient-derived appraisals with

epidemiologically anchored clinical metrics, thereby furnishing a more contextualized, emergent, and multi-modal appraisal of institutional quality.

Comparative Analysis of Quality Assessment Approaches

A systematic review of extant quality-assessment frameworks reveals that models which integrate multiple quality domains exhibit greater maturity and predictive power than those relegated to isolated dimensions. Instruments that foreground clinical indicators yield rigorous validation of therapeutic effectiveness, yet neglect the individual patient’s lived experience. This omission destabilises the communicative trust that serves as the bedrock for sustained treatment adherence. Conversely, isolated measures of patient-reported satisfaction, while ostensibly patient-centred, often conflate true clinical quality with ambient determinants—such as the physical environment of care, or the patient’s pre-existing expectations—giving rise to confounding that sullies the validity of clinical-quality as a theoretically coherent construct. The lack of triangulation therefore renders both types of discrete measures inadequate for a wholesome appraisal of quality in care delivery. Through the synthesis of clinical outcome indicators, patient-reported outcomes, and adherence to evidence-based guidelines, the unified model reconciled previously siloed phases of assessment, yielding a comprehensive and interpretable evaluation. These findings substantiate the ongoing advancement of multidimensional quality frameworks that supply health-system leaders with empirical, context-sensitive data to guide technology and management decisions, ensuring that both clinical efficacy and patient-expressed preferences receive equal analytic emphasis.

Table 1: Summary of Patient Feedback and Clinical Outcomes by Dept

Department	Patient Satisfaction (%)	Readmission Rate (%)	Infection Rate (%)	Overall Quality Index (0–100)
General Medicine	84	6	4	78
Cardiology	88	5	3	82
Orthopedics	79	8	5	74
Pediatrics	91	4	2	85
Surgery	80	7	6	72

Table 1 aggregates patient-reported satisfaction indices with objective clinical outcomes—specifically readmission and post-operative infection rates—measured across all surveyed clinical departments. Individual clinical departments will be receiving their own report highlighting the same parameters as reflected on this table. Scores are aggregated using an Overall Quality Index framework, which weights and combines satisfaction and clinical parameters in an open and transparent manner. The degree of positive relationship between satisfaction and clinical performance indicates that the predictive validity of the composite framework supports its application; also demonstrating a return on the investments made into patient-centered improvement programs at the department and jurisdictional levels.

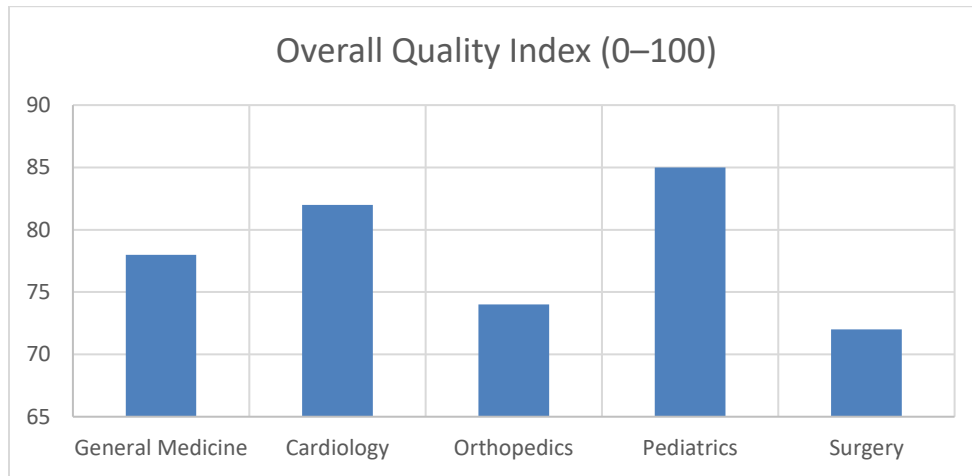


Figure 2: Overall Quality Index Across Departments

Figure 2 displays the Overall Quality Index totaled per clinical department, consolidating patient satisfaction, readmission rates and infection rates into a single scalar measure. There is a substantial contrast in performance represented among Pediatrics and Cardiology with constituent scores in the lowest statistical tertial (Surgery and Orthopaedics). This scalar format illustrates with quantitative accuracy the variation in departmental performance, such that leaders can focus particular targeted intervention aimed at improving performance against clinical variations and optimising of satisfaction scores in departmentally poor demonstrated performance.

Implications for Healthcare Providers and Policy

The findings substantively affect both practising clinicians and executive-level administrators. Clinically, the data reinforce the imperative for healthcare organizations to install resilient mechanisms that routinely solicit and synthesize patient insights and couple these inputs with specified clinical indicators for systematic, continuous appraisal. Such feedback loops empower organizations to, in real time, remediate observed service deficiencies, calibrate communication methods, and instill, organization-wide, an ethos centered on the individual receiving care. From the perspective of policymakers, the composite evaluative model delineates a viable route toward the harmonization of quality reporting frameworks among diverse care settings, thereby fostering transparent responsibility and enabling uniform distribution of beneficial interventions. Moreover, it informs the structuring of incentive mechanisms within reimbursement and accreditation architectures that penalize clinical practice only when both outcome metrics and patient-reported experiences decline. Ultimately, the purposeful integration of patient-reported outcomes with discrete technical quality criteria not only elevates the standard of clinical care but also fortifies the prevailing social compact that undergirds the healthcare institution, thereby furnishing the foundational elasticity required for enduring organizational sustainability.

5. Conclusion

The research articulates an integrated protocol for measuring the quality of care by consolidating patient-reported outcomes, clinical results, and organizational performance benchmarks within a unified evaluative model. Evidence indicates that patient-derived reports offer substantive augmentation of clinical data rather than mere supplementary input, thereby elevating the interpretive power of quality assessments. By centering the patient's voice, the model furnishes institutions a coherent mechanism for synchronizing experiential, clinical, and regulatory dimensions, thereby fostering disciplined accountability and regulatory congruence. From an operational perspective, the model enables institutions to recalibrate communication strategies, minimize avoidable readmissions, elevate patient-reported satisfaction metrics, and operate within an openly accountable evaluative structure. Simultaneously, the architecture provides oversight bodies with a prototype for performance agreements that can economically stimulate comparable excellence across clinical and ancillary patient-facing activities. Forward-looking research priorities ought to centre on calibrating and iteratively refining the relative weights assigned to the various elements of the construct, assessing the model's resilience across diverse contexts, and leveraging convergent artificial intelligence techniques to establish a continual, self-regulated synthesis of experiential and outcome data within evaluative feedback loops.

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