Sapiens in Health Science

Sapiens in Health Sciences. 2026;4.1. 007
ISNN: 3072-7960
DOI: https://doi.org/10.71068/hs000107

Article: Research

Quality of outpatient care and its gaps in a public hospital in southeastern Mexico: an analysis using the servqual model

Calidad de la atención ambulatoria y sus brechas en un hospital público del sureste de México: un análisis mediante el modelo servqual

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Submitted: 09-08-2026 **Revised:** 29-08-2026 **Accepted:** 16-09-2026 **Published:** 17-10-2026

How to cite:

May Pérez, R. A., García Quinto, G., Durán Fajardo, M. N., Moreno Pacheco, E. de los Ángeles, & Villanueva Herrera, L. G. (2026). Quality of ambulatory care and its gaps in a public hospital in southeastern Mexico: an analysis using the servqual model. *Sapiens in Health Sciences*, *4*(1), 1-16. https://doi.org/10.71068/hs000107

ABSTRACT

The quality of outpatient care requires consideration of both service organization and the expectations of people using the services. This study examined gaps between expectations and perceptions in General Medicine at Dr. Agustín O'Horán General Hospital, Mérida, Yucatán. To assess perceived outpatient care quality using SERVQUAL and identify priority dimensions and attributes for improving patients' experiences. An observational, descriptive, cross-sectional study was conducted between September and October 2025. A total of 328 adults provided valid questionnaires. Twenty-two pairs of seven-point Likert items covered reliability, responsiveness, assurance, empathy, and tangibles. The gap was defined as expectations minus perceptions. Dimensional means and associations reported using chi-square tests were described. The mean of the five dimensional gaps was 0.7412. Empathy showed the largest difference (1.576), followed by reliability (1.120) and tangibles (1.010). The main concerns were delays relative to scheduled appointments (2.22), failure to respect arrival order (2.16), and interpersonal treatment (2.06). Assurance showed a negative gap (−0.310), whereas responsiveness reached 0.310. Associations of age and educational attainment with selected ratings of care were reported. The main opportunities for improvement concern punctuality, clinical communication, and physical conditions. The findings describe experiences reported by users of this outpatient service and can guide institutional actions whose effectiveness requires subsequent evaluation.

Keywords: quality of health care; outpatient care; patient experience; SERVQUAL; Mexico

RESUMEN

La calidad de la atención ambulatoria requiere considerar tanto la organización de los servicios como las expectativas de quienes los utilizan. El estudio examinó las brechas entre expectativas y percepciones en Medicina General del Hospital General Dr. Agustín O'Horán, en Mérida, Yucatán. Evaluar la calidad percibida de la atención ambulatoria mediante SERVQUAL e identificar dimensiones y atributos prioritarios para la

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mejora de la experiencia de los usuarios. Se realizó un estudio observacional, descriptivo y transversal entre septiembre y octubre de 2025. Participaron 328 personas adultas con encuestas válidas. Se aplicaron 22 pares de ítems de siete puntos distribuidos en fiabilidad, capacidad de respuesta, seguridad, empatía y aspectos tangibles. La brecha se definió como expectativa menos percepción; se describieron promedios y asociaciones mediante pruebas de chi cuadrado informadas por el estudio. El promedio de las cinco brechas dimensionales fue 0,7412. Empatía registró la mayor diferencia (1,576), seguida de fiabilidad (1,120) y aspectos tangibles (1,010). Destacaron los incumplimientos de horarios (2,22), el orden de llegada (2,16) y el trato interpersonal (2,06). Seguridad presentó una brecha negativa (−0,310), mientras capacidad de respuesta alcanzó 0,310. Se comunicaron asociaciones de edad y escolaridad con determinadas valoraciones de la atención. Las principales oportunidades de mejora identificadas se relacionan con puntualidad, comunicación clínica y condiciones físicas. Las cifras corresponden a experiencias comunicadas por usuarios de esta consulta externa y orientan acciones institucionales cuya efectividad deberá evaluarse posteriormente.

Palabras clave: calidad de la atención en salud; consulta externa; experiencia del paciente; SERVQUAL; México

INTRODUCTION

The quality of health care is recognized for its ability to respond to clinical needs and legitimate expectations of the population. This perspective incorporates dimensions such as timeliness, safety, effectiveness, and people-centered care. In public establishments, user experience allows us to identify organizational and communication problems that are not always reflected in productivity indicators. The World Health Organization highlights timeliness and people-orientation as necessary attributes of quality services (1). Experience indicators, therefore, should be used as a complement to clinical evaluation and not as a substitute for health outcomes.

In the outpatient clinic, the assessment of the service is built through multiple contacts, from the assignment of an appointment to the understanding of medical indications. The Organisation for Economic Co-operation and Development highlights that understandable communication, time spent in consultation and participation in decisions are fundamental components of the healthcare experience (2). These characteristics are especially relevant when there are crowds, various procedures or access difficulties. The perception of quality can deteriorate even if the medical procedure is correct, so institutions need to study both the organisational component and the interpersonal treatment.

Quality assessment requires distinguishing between structure, processes, and results. In his classic proposal, Donabedian explained that the resources and organization of the establishment influence care processes, while results depend on multiple clinical and contextual factors (3). Applied to the outpatient clinic, this framework allows for separate study of facilities, punctuality, and the development of clinical interaction. The fact that a person reports satisfactory treatment does not, in itself, demonstrate technical safety or therapeutic effectiveness. Therefore, measures of experience must be interpreted in a limited way and articulated with institutional performance evaluations.

The SERVQUAL model provides a specific approach to contrast expectations and perceptions of the service. Parasuraman, Zeithaml, and Berry developed a conceptual framework of differences between expected and perceived quality (4), which was later operationalized using a multidimensional instrument of 22 items (5). Its application in health requires explaining how the questions were

formulated and how the gap was calculated. In the present work, the difference between expectation and perception is adopted, so that positive values indicate higher expectations than valued care and negative values indicate a perception higher than expected. This convention should be maintained throughout the manuscript.

Empirical evidence indicates that the care experience is not evenly distributed among establishments and user groups. A Mexican study based on the People's Voice survey showed that perceptions of quality can be related to the choice between public and private services, although its cross-sectional design prevents individual causality from being deduced (6). In another public hospital in Guanajuato, de la Garza-Carranza et al. observed associations between SERVQUAL dimensions and satisfaction among hospitalized patients (7). These antecedents are relevant, but their results should not be directly transferred to the outpatient consultation of General Medicine, where the temporality of care and administrative interaction differ.

Research conducted outside Mexico also documents diverse results. A systematic review of Iranian university hospitals pointed to gaps between expectations and perceived services, with differences associated with context and measured dimensions (8). In primary care centers in Guayas, Ecuador, a study with SERVQUAL found difficulties in obtaining appointments and a different distribution of gaps than that observed in certain interpersonal dimensions (9). The diversity of results suggests that the application of the same instrument does not guarantee identical profiles of perceived quality. This heterogeneity requires examining each establishment in its own organizational, care, and sociodemographic environment.

In outpatient services in Ghana, Owusu et al. studied satisfaction and quality through a patient survey (10). In addition, research in rural South African hospitals documented experiences related to waiting times, cleanliness, accessibility, and professional treatment (11). International comparison helps to recognize common elements, although differences in sampling, instrument, and healthcare structure limit direct numerical equivalences. Consequently, it is pertinent to simultaneously analyze indicators of organization, clinical communication, and physical conditions within the same facility. For public management, this approach can guide prioritization based on the aspects that patients identify as most problematic.

The Dr. Agustín O'Horán General Hospital in Mérida constitutes the context of the study, focused on the outpatient clinic of General Medicine during September and October 2025. The research question was: what are the main gaps between users' expectations and perceptions and which dimensions of SERVQUAL concentrate the greatest differences? Its justification lies in obtaining specific evidence on punctuality, organization, treatment and material conditions. The general objective was to evaluate the perceived quality of outpatient care through SERVQUAL and to identify the priority dimensions and attributes for improvement. The contribution consists of presenting dimensional and reactive results in a clearly delimited institutional population, without equating perception with objective clinical quality.

LITERATURE REVIEW

Quality of care, patient experience and timely access

Contemporary research distinguishes between general satisfaction and specific care experiences. The former may represent an overall affective assessment, while the latter describes processes observable from the user's perspective, such as receiving understandable explanations or waiting less time. This distinction is relevant because a patient may positively assess the professional and, at the same time, report deficiencies in the organization of appointments. A systematic review on the duration of outpatient consultations examined how the time of the encounter is related to quality outcomes and showed the need to interpret the evidence according to its designs (12). Thus, a time gap does not identify the mechanism that produces it on its own.

Problems of opportunity have institutional components that transcend individual performance. McAvoy et al. studied waiting lists in specialized services from a systems perspective, showing the importance of understanding the flows of first consultations and reviews to propose organizational changes (13). Although this work was developed in another health system, its approach allows us to formulate pertinent questions about scheduling, sequence of care, and operational capacity. The difference between complying with the announced schedule and maintaining adequate clinical care should be analyzed as a tension of organization and resources. The user experience helps to identify it, but it is not enough to quantify real times or productivity.

Interpersonal communication, empathy and understanding of indications

Communication is an essential component of human-centered care. Herath et al., in a systematic review and meta-analysis of interventions directed to patients in surgical consultations, examined strategies to improve clinical interactions (14). The evidence supports the importance of studying the care encounter, but it does not allow attributing the problems of a specific institution to a single cause. Explanations about diagnosis, treatment, and procedures depend on language, time, expectations, and possibilities to ask questions. A difference between what is expected and what is perceived in these items should be interpreted as an opportunity to improve communication and confirm the patient's understanding.

A systematic review of diagnostic conversations showed that clinical interaction involves multiple ways of explaining problems and communicating medical information, with variations depending on the context (15). This background is useful for interpreting the empathy and safety dimensions of SERVQUAL as related, although not identical, perceptions. A person may be confident in professional ability and, at the same time, declare that he or she received insufficient explanations. Therefore, perceived safety measures should not be used as evidence of proven clinical competence. The joint interpretation of the dimensions provides a more careful perspective than that of a single overall average.

Asare et al. analyzed the information needs of people in the outpatient clinic in Ghana using an adaptation of SERVQUAL. Their research related care communication with the assessment of service quality (16). In primary care, Östensson et al. examined expectations and experiences of communication with nursing professionals, differentiating affective needs and practical orientations from the clinical encounter (17). Both studies show that the communicative experience requires

specific indicators and that global assessments can hide difficulties in understanding instructions, participating in decisions, or expressing concerns. For the present study, these antecedents offer a pertinent contrast with the gaps in medical treatment and understanding.

Ekberg, Beach, and Jones reviewed research on conversations in specialized outpatient clinics and distinguished activities such as gathering backgrounds, communicating diagnoses, making decisions, and addressing patient concerns (18). Their approach allows us to understand why attributes related to empathy and clarity of explanations should not be confused with a direct assessment of technical competence. In contrast to this approach focused on observed interactions, the present study uses questionnaires of expectations and perceptions. Both approaches are complementary, but their indicators are not interchangeable. This distinction provides a conceptual basis for interpreting communication results without assuming that a negative appraisal alone identifies the institutional cause.

Measuring SERVQUAL gaps and comparability across studies

The operationalization of SERVQUAL is supported by pairs of responses about what was expected and what was received. However, research may differ in the meaning attributed to the scores, the linguistic adaptation, the weight of each dimension, and the cut-off points used. The value of a positive gap indicates a distance in the direction adopted by the instrument, but does not automatically determine its clinical relevance. Comparison between studies requires knowledge of the number of items, the scale used, and the aggregation method. This article presents the means of five dimensions, whose sizes are different, and explains how the overall measure is summarized.

Recent literature provides background information on the diversity of profiles in public and private services (6-11). Some studies highlight difficulties in access or punctuality, while others identify differences in treatment, tangibility, or professional trust. These discrepancies may reflect real characteristics of the establishments, but also modifications in the instruments, differences in sample composition, and evaluation criteria. Consequently, the gap addressed by this study is mainly local and applied: there was a lack of an explicit dimensional diagnosis of the general medicine outpatient clinic of the hospital examined during the delimited period. The contribution consists of identifying descriptive priorities for management, without attributing causality or generalizing results to other services.

Qiu, Xiao, and Li applied a service quality model in public hospitals in China and contrasted expectations and perceptions related to digital health care; they observed different gaps according to patient attributes and characteristics (19). Their adapted instrument included dimensions different from the five used here, which limits direct numerical comparison. On the other hand, Aljohani analyzed satisfaction trends in primary care in Saudi Arabia between 2022 and 2024 through repeated surveys and found temporal and sociodemographic variations (20). Together, both studies reinforce the importance of specifying dimensions, denominators, and periods, and provide an international context to interpret the gaps in the Mérida hospital.

METHOD

Design, context and participants

An observational, descriptive, and cross-sectional study was developed, with prospective collection of questionnaires during September and October 2025. The setting was the General Medicine offices of the outpatient clinic of the Dr. Agustín O'Horán General Hospital, located in Mérida, Yucatán, Mexico. An approximate reference population of 2,240 user visits during the period was considered. The units of analysis were adults who provided valid questionnaires. As it is a measurement carried out in a single period, the information allows us to characterize the experience of those who participated, but not to identify longitudinal changes or establish causes of the observed gaps.

The sample size was estimated for a population of 2,240 attendees, with a confidence level of 95%, expected proportion of 0.5 and accuracy of 0.05. During the period, 360 people were approached, from which 328 valid questionnaires were obtained. The selection was organized through systematic sampling with random initiation and age and sex distribution controls, according to the procedure established for shifts and clinics. The study characterizes the experience of the included participants and analyzes the gaps in expectations and perceptions in this modality of outpatient consultation.

Users of both sexes aged 18 years or older who received care during the period and agreed to participate through informed consent were included. Medical emergency situations and exclusively administrative procedures were excluded, as well as circumstances that prevented answering the questionnaire. Incomplete forms were not included in the set of valid surveys. Age, sex, education, type of user, and shift of care were collected. These variables were used to explore differences in certain assessments, although the results of the study do not provide complete sociodemographic breakdowns. For this reason, this text does not incorporate population frequencies or additional distributions not recorded.

Instrument and operationalization

Perceived quality was assessed using a SERVQUAL-based questionnaire with 22 pairs of items: one for expectation and one for post-service perception. Each response used a Likert scale of one to seven points. The items were organized into reliability (1-5), responsiveness (6-9), safety (10-13), empathy (14-18), and tangible aspects (19-22). Table 1 presents the operational structure of the instrument and allows the identification of the contents measured by each dimension. The structure of 22 items and five dimensions of the applied instrument was respected, distinguishing the interpretation of the gaps from other psychometric properties.

For each item, GAP = expectation minus perception was defined. A positive gap indicates that the expectation exceeds the recorded perception, a gap equal to zero reflects coincidence, and a negative gap indicates a perception greater than the expectation. The dimensional mean summarizes the items assigned to each domain. The global mean of 0.7412 coincides with the simple arithmetic mean of the five published dimensional gaps; it should be distinguished from a mean weighted by the number of items in each dimension. The interpretation focuses on magnitudes and direction of the differences, without assuming that certain cut-off points are universally validated clinical standards.

Table 1

Dimensions and operationalization of the SERVQUAL questionnaire

Dimension	Evaluated content	Items
Reliability	Initial orientation, schedule, first come, first served, file and obtaining appointments	1-5
Responsiveness	Willingness and Opportunity to Respond to User Requests	6-9
Security	Trust and security that conveys attention	10-13
Empathy	Treatment, clinical interest and understanding of the problem, treatment and procedures	14-18
Tangible aspects	Signage, orientation, available equipment, cleanliness and comfort	19-22

Note. Structure of 22 items and five dimensions. Source: SERVQUAL questionnaire applied at the Dr. Agustín O'Horán Hospital, 2025.

Procedure and statistical analysis

The surveys were applied using digital devices by trained personnel. The procedure had institutional authorization and informed consent from the users. The data were processed with SPSS, version 22, and descriptive measures were obtained from the five dimensions and the items examined. Pearson's chi-square tests were used to evaluate the associations of age, education, and other characteristics with certain responses, with a significance threshold of 0.05. The results of these contrasts are presented using their p-values and are interpreted according to the cross-sectional design of the study, without attributing causal relationships.

The p-values were interpreted as evidence of association between categorical variables. Pearson's independence test does not establish direction, magnitude, or causality by itself; therefore, significant associations were differentiated from the descriptive comparisons. The values obtained in the statistical processing of the five dimensions and the items examined were maintained. For the interpretation of the means, the global average of the results was distinguished by dimension and by attribute, because each one describes a different level of care experience. The comparison of groups considered the variables age, education, sex, shift, and type of user.

RESULTS

Quality gaps by dimension

A total of 328 valid questionnaires of adults treated in the General Medicine outpatient clinic were analyzed. The results are organized by dimension and by specific attributes of the service. The aggregate gap was 0.7412 when averaging the five dimensions with the same weight. This measure summarizes distances between expectations and perceptions, but it is not equivalent to a percentage of satisfied users or a test of clinical efficacy. Table 2 allows us to recognize the relative differences of

each domain and places empathy, reliability, and tangible aspects as areas that deserve special attention in institutional evaluation.

Table 2

SERVQUAL Gaps by Dimension

Dimension	Medium gap	Descriptive reading
Reliability	1,120	Expectation higher than perception
Responsiveness	0,310	Smaller positive gap
Security	−0.310	Perception higher than expectation
Empathy	1,576	Largest Reported Gap
Tangible aspects	1,010	Expectation higher than perception

Note. GAP = expectation − perception; global mean = 0.7412. Source: SERVQUAL survey of 328 users, 2025.

Empathy presented the largest gap (1.576), followed by reliability (1.120) and tangible aspects (1.010). In contrast, responsiveness showed a smaller gap (0.310) and safety registered a negative value (−0.310). This last figure means that, on average, the reported assessment exceeded the expectation in the reagents of confidence and perceived safety; it does not demonstrate by itself the absence of incidents or proven technical competence. The differences between dimensions suggest that the user experience was heterogeneous and that the overall average hides particularly problematic attributes. Its interpretation should be related to the specific descriptions per item.

Attributes with the greatest differences between expectations and perceptions

The evaluation by items focused on 14 items of reliability, empathy, and tangible aspects. The values are individual gaps and not percentages. The three largest records were compliance with the scheduled schedule, respect for the order of arrival, and interpersonal treatment, all greater than or close to two points. The set also includes items with negative gaps, such as admission orientation and availability of medical records. Table 3 integrates the existing results in a single presentation, avoiding repeating three independent tables and without adding figures from the remaining eight items that were not provided.

Table 3

Reported gaps in the items of the priority dimensions

Dimension	Item	Attribute	GAP
Reliability	1	Intake Orientation	−0.64
Reliability	2	Consultation at scheduled times	2,22
Reliability	3	Respect for the order of arrival	2,16
Reliability	4	Availability of medical records	−0.34

Dimension	Item	Attribute	GAP
Reliability	5	Ease of Getting Appointments	1,88
Empathy	14	Friendly and respectful treatment	2,06
Empathy	15	Clinical interest in solving the problem	0,46
Empathy	16	Understanding disease or outcomes	1,92
Empathy	17	Understanding Treatment and Dosages	1,72
Empathy	18	Understanding procedures or analysis	1,72
Tangible aspects	19	Signage and Wayfinding	0,96
Tangible aspects	20	Staff available to guide	−0,06
Tangible aspects	21	Equipment and materials available	1,40
Tangible aspects	22	Cleanliness and comfort	1,74

Note. Positive gaps indicate expectation higher than perception. Source: SERVQUAL survey of 328 users, 2025.

The high differences in punctuality and order of care place the organization of appointments among the areas for improvement. In empathy, the gaps in treatment and understanding of explanations support the need to examine communication practices during the consultation. In tangible aspects, cleanliness and comfort registered the highest value of its dimension. These data do not allow attributing the gaps to a specific number of professionals, to the duration of consultations or to budgetary resources, because these variables were not directly evaluated. The priorities indicated come from the contrast of expectations and perceptions, not from an audit of care processes.

Associations with sociodemographic characteristics

Statistically significant associations were found between certain assessments and the variables age or educational level. The results are summarized in Table 4 as pairs of variable, item, and p-value, avoiding presenting the direction of the differences between subgroups as demonstrated. The interpretation focused on the significance of the contrasts and avoided equating it to the magnitude of an association. Similarly, the assertion of the absence of associations for sex, shift, or type of user is interpreted as a lack of significance in the reported contrasts, without turning it into a test of equality between groups. The analyses should be understood as exploratory within the cross-sectional scope.

Table 4

Associations of sociodemographic variables with quality items

Item	Variable	P value
2	Age	0,0004
2	Schooling	0,030
3	Age	0,002
5	Age	0,020
14	Age	0,001
16	Schooling	0,017
17	Schooling	0,024
18	Schooling	0,015
19	Age	0,018

Note. Pearson's chi-square p-values. Source: statistical analysis of the SERVQUAL survey, 2025.

The association between age and the perception of the scheduled schedule presented the lowest reported p-value. Associations were also observed between schooling and items related to clinical understanding. However, statistical significance alone does not determine the intensity or direction of a relationship and does not allow causality to be inferred. In addition, the number of reported contrasts requires caution against isolated associations. In summary, these results identify experience factors that deserve further exploration, but do not allow differentiated policies to be defined solely on the basis of p-values.

DISCUSSION

The findings allow us to respond to the general objective by identifying an uneven pattern of perceived quality in the outpatient clinic studied. The average of dimensional gaps communicates a positive difference between expectations and perceptions, but its added value does not sufficiently describe the domains of the service. The breadth of the empathy gap, together with those of reliability and tangible aspects, places interaction and daily organization as priority areas. This interpretation coincides with the multidimensional quality assessment approach proposed by Donabedian (3) and with the need to systematically incorporate user experiences into care management (1,2).

The greatest problem identified in empathy deserves a specific interpretation. Differences in friendly treatment and understanding of medical explanations do not necessarily mean that professionals lack clinical skills; they describe an interpersonal experience lower than stated expectations. A review of patient-centered interventions in surgical consultations highlighted the importance of supporting communication during the care encounter (14). Likewise, the analysis of diagnostic conversations documents that patient understanding depends on multiple elements of interaction (15). Thus, training in communication skills, understanding checking, and respect during the consultation are reasonable alternatives for institutional evaluation.

Recent precedents distinguish between valuing the professional relationship and measuring the information understood by each user. In the study by Asare et al., information needs were part of the outpatient quality assessment (16), while Östensson et al. examined different dimensions of communication in primary care (17). Ekberg et al. showed, from conversational analysis, that explaining diagnoses and sharing decisions constitute different clinical activities (18). These

contributions favor a specific interpretation of empathy in Mérida: treatment and understanding gaps represent different experiences, so they can be addressed with complementary institutional actions and evaluated separately.

Reliability mainly incorporates components of punctuality, order, and availability of appointments. These gaps deserve attention because the sequence of care is a specific part of the experience that can generate frustration even when the medical act is satisfactory. McAvoy et al. analyzed waiting lists using systems thinking and underscored the relevance of organizational dynamics (13). This research does not validate a particular intervention for the hospital in Mérida, but it allows the formulation of operational hypotheses about scheduling and patient flows. A review of actual times, frequency of delays, and administrative causes would be necessary before recommending specific changes in schedules or resources.

In an Ecuadorian primary care study, difficulties in obtaining appointments stood out among the service gaps (9), while other dimensions showed different profiles. The coincidence with the access problems identified in Mérida does not establish equivalence between populations, establishments, or tools used. Similarly, the evaluation of hospitalized patients in Guanajuato revealed associations between dimensions of SERVQUAL and general satisfaction (7), but its scope is different from that of ambulatory General Medicine. These comparisons support the relevance of assessing quality through differentiated components and warn against extrapolating results obtained in institutions with different care loads and forms of organization.

Tangible aspects represent an additional dimension of the experience. The gap in cleanliness and comfort suggests that users value the conditions of the physical environment along with treatment and the opportunity for care. Recent studies of outpatients in Ghana and South Africa included environmental attributes and organizational processes in their experience measurements (10,11). However, the results of SERVQUAL do not amount to an environmental inspection nor do they allow determining compliance with health standards. To decide on material improvements, it would be appropriate to complement the survey with structured observation of signage, accessibility, cleanliness, and condition of waiting rooms, without confusing perceptions with technical measurements.

The negative value in safety should be interpreted according to the expectation minus perception formula adopted in the study. It indicates that this dimension reached, on average, a perception higher than expected; it does not accredit the competence of the professionals nor does it demonstrate the absence of care errors. The finding contrasts with the high communication gaps and may coexist with them because the dimensions evaluate different attributes. The literature on quality emphasizes that the reported experience is a part of the evaluation, along with components of structure, clinical processes, and results (3). Consequently, scientific reading requires avoiding both excessively negative conclusions and claims of clinical excellence supported only by surveys.

The comparative literature also highlights the influence of context on quality measurements. Qiu et al. identified differences between expectations and perceptions in Chinese public hospitals using an instrument adapted to digital services (19). Aljohani documented variations in satisfaction between

periods and subgroups of users in Saudi primary care centers (20). Although neither of these results can be directly transferred to the population of Mérida, both support the need to distinguish organizational attributes, participant characteristics, and the instruments applied. In this study, the priority corresponds to the processes identified by General Medicine users during the evaluation period.

The associations between age, education, and attributes of care constitute a complementary result that can guide new questions about the experience of users. The chi-square contrasts presented allow the identification of statistical relationships between categories, but they do not establish causal effects or quantify the magnitude of the differences. The interpretation of these findings should consider patient characteristics, previous expectations, and organizational conditions of the consultation. Subsequent research could incorporate measures of association intensity and multivariate models to jointly examine the sociodemographic profile and the care processes involved in perceived quality.

The mode of aggregation of the scores is essential to interpret the gaps. The overall mean of 0.7412 is obtained by averaging the five dimensions with equal weight, although they comprise different amounts of items. In reliability, the arithmetic mean of the five individual GAPs reported is 1.056, while the dimensional mean presented is 1.120. This difference requires a review of the weighting and aggregation procedures before using both indicators as if they were equivalent. The main finding does not change: the greatest experience problems are concentrated in attributes related to communication, appointment organization and physical environment. A consistent description of the calculation will facilitate future quality comparisons.

Finally, the cross-sectional nature of the research and its performance in a single care modality delimit the scope of the conclusions. The surveys express the assessment of the participants during the period studied, so they do not replace direct measurements of clinical performance, observed times or physical conditions. Sociodemographic associations offer complementary information on the attributes examined, but do not justify causal interpretations. The work allows prioritizing relevant dimensions for continuous improvement, especially interpersonal communication, compliance with schedules and environmental conditions. A subsequent institutional evaluation could combine measurements of care processes with new experience surveys to estimate the effect of the improvements implemented.

CONCLUSIONS

The evaluation carried out in the General Medicine outpatient clinic of the Dr. Agustín O'Horán General Hospital allowed us to identify differences between the expectations of 328 users and the care perceived through SERVQUAL. The average of the five dimensions was positive, which indicates that, in aggregate terms, expectations exceeded perceptions. This result responds to the general objective of describing the perceived quality of the service examined, but it does not constitute a direct measure of clinical effectiveness nor does it authorize extrapolations to other hospital areas. The interpretation is limited to the period and population included in the research.

Empathy presented the widest gap and concentrated relevant differences in interpersonal treatment and understanding of clinical information. These assessments identify opportunities to review communication between staff and patients, especially the clarity of explanations about health problems, treatments, and procedures. Educational interventions, verification of understanding, and organized feedback from users are alternatives for strengthening these processes. Their convenience and effectiveness should be evaluated in the institutional context, without attributing to the descriptive results a proven effect on clinical outcomes.

Reliability also showed areas for improvement related to compliance with schedules, respect for the order of arrival, and ease of obtaining appointments. These differences indicate that the organization of the outpatient process is part of the experience valued by patients. Management decisions should also be supported by information on effective delays, availability of offices, and administrative circuits. The study does not determine by itself which factor causes each gap, so its contribution lies in guiding the operational diagnosis and not in establishing an institutional solution whose effectiveness has already been demonstrated.

The tangible aspects dimension showed an appreciable difference between expectations and perceptions, particularly with respect to cleanliness and comfort of the environment. At the same time, safety presented a negative gap, indicative of a higher than expected valuation in this dimension. The coexistence of these results shows that a favorable experience in perceived trust can be accompanied by dissatisfaction with facilities or organizational processes. It is not appropriate to infer technical quality or regulatory compliance only from this survey; it is necessary to complement the findings with maintenance records, environmental observations, and specific care evaluations.

The associations of age and education with certain items suggest differences in perception that deserve additional analysis, although they do not allow us to establish direction, magnitude or causality without complete tables and statistics. Likewise, the arithmetic divergence detected in reliability makes it advisable to review the aggregation procedure before using these figures as a definitive reference for external comparisons. Overall, the main contribution of the research is to locate priority attributes in a specific service and to support a process of continuous improvement with monitoring of indicators, periodic measurements and user participation.

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ETHICAL CONSIDERATIONS

The study was developed through a literature review based exclusively on previously published documentary sources. It did not involve the direct participation of human or animal beings, the performance of interventions, the use of biological samples, or access to personally identifiable data. Consequently, it did not require approval from an ethics committee or the obtaining of informed consent. During the research process, the principles of scientific integrity, adequate attribution of authorship, rigorous citation, and responsible use of the sources consulted were observed.

ARTIFICIAL INTELLIGENCE (AI) USAGE STATEMENT

The authors state that the AI tool was used exclusively to support the organization of the article and the translation of the text. Its use did not determine the scientific content, study design, selection of sources, data analysis, interpretation of results, or conclusions. Full responsibility for the content remains with the authors.

FUNDING

The authors state that this study did not receive any external funding from public, private, or non-profit organizations. All research, analysis, and development activities were carried out with their own resources.

CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest related to this study and that all the procedures followed comply with the ethical standards established by the journal. They also confirm that this work is unpublished and has not been published, either partially or totally, in any other publication.

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4. Acquisition of financing: not applicable
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8. Remedies: Not applicable
9. Software: Not applicable
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https://doi.org/10.71068/hs000107