

WHEN SHOULD YOU MEASURE AND WHAT SHOULD YOU ASK?**THOMAS HEIDEGGER**Department of Anaesthesiology
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WHAT IS PATIENT SATISFACTION (WITH ANAESTHESIA CARE)?

Before asking about patient satisfaction with anaesthetic care we have to define the concept of *satisfaction*, which is rather abstract and far from clear [1]. From the patient's point of view, outcome quality is of major importance. – and satisfaction is a part of it. Hence, the evaluation of patient satisfaction based on their subjective perception of the care they received, should be an integral part of the measurement. A traditional definition of satisfaction is the degree of congruence between expectation and accomplishment [2]. Therefore, we have to know what patients expect before we ask about their satisfaction. Logically, the involvement of patients in the development of a questionnaire on patients' satisfaction is very important [3,4]. Unfortunately, many instruments do not consider this aspect [5,6]. Second, many lack psychometric development characteristics. A psychometric development is a step by step approach and should include elements of content validity (e.g. focus groups) and construct validity and reliability (internal consistency). [3,4]. When considering validity, there are two aspects which should always be addressed [7,8]. First, does the instrument really measure what it purports to measure, e.g. patient satisfaction? Second, is there a relationship between the observation and what it reflects or are there other confounding factors which may influence the result but were not directly involved in the causal pathway [9, 10]. Reliability, on the other hand, is a way to reflect the variance in scores which are caused by true differences and not due to inaccurate measurement [3,7,8]. The traditional understanding of reliability (test-retest-reliability) is only a part of reproducibility, among inter-observer and intra-observer reliability.

Most surveys about patient satisfaction only focus on single item ratings as '*Are you satisfied with your anaesthetic?*' [4,11]. This yields, not unsurprisingly, a '*yes*' in most cases. Does this reflect the true indication of care or only an over-optimistic picture and should it therefore give rise to concern? [12,13]. A survey from the Picker Institute (UK), for example, showed that 55% of the respondents who rated their in-patient episode as 'excellent' indicated problems in 10% of the issues measured on their specified questionnaire [12]. A study by Whitty et al. [14] on patient satisfaction with anaesthesia demonstrated a high overall satisfaction rate with 95% being very satisfied or quite satisfied. But the authors stressed '*If a satisfaction questionnaire is to be useful practically it must ask detailed questions about all aspects of a patient's care experience*'.

Data from our studies show a great difference between overall ratings and the graded response to specified questions about different dimensions of satisfaction with anaesthesia care [15-17]. The overall satisfaction scores were more than 98% whereas the total problem score - as an indicator of dissatisfaction – were between 17% and 19% in all surveys we conducted.

WHAT SHOULD YOU ASK THE PATIENT?

As mentioned above, one definition of patient satisfaction is the congruence of accomplishment and expectation [2]. Therefore, the logical consequence is that we have to know what patients really do expect. At the ESA meeting at Lisboa 2004, Roger Goss, a patient advocate from London, clearly stated that the patient wants to be informed in order to be satisfied. This raises two important questions: First, is this a personal statement or is it true in general? And second, is this applicable to anaesthesia, too.

From a survey of the 'Picker-Commonwealth Program' in the United States that consciously adopted the patient's perspective and included more than 6000 patients, we know that patient satisfaction is primarily determined by aspects like '*respect for patients values*', '*information*', '*coordination and continuity of care*', '*physical comfort*', '*emotional support*', and '*involvement of family*' [18,19]. Of course, patients also evaluate hospital services and medical care. And, of course, they expect technically sophisticated care which is up to date. But, these qualities often are difficult for the patient to judge [18].

Before answering whether these results are transferable to anaesthesia care the following points need to be considered. In preparation for this article I searched MEDLINE for '(patient) satisfaction' AND 'anaesthesia'. 778 out of 1874 articles (=41.5%) cover prevention/therapy for postoperative pain and/or nausea and vomiting. Does that mean that these topics are true indicators of patient satisfaction? In other words: is a patient, for example, who does not vomit postoperatively, by definition, more satisfied than one who does?

Are there other aspects determining patient satisfaction? In two editorials in *Anesthesiology*, Dennis Fisher emphasized the problems with surrogate outcomes and asked the question; are they at all meaningful [20,21]? But regarding nausea and vomiting or pain therapy we must keep in mind that drugs should also be judged by their adverse events and not only by their effects [22]. Is a patient with headache after treatment with ondansetron happier than the one who vomits and is otherwise adequately cared for? And, last but not least, how many patients actually do consider this as a major problem at all, and what is the impact on global patient satisfaction?

A large survey on patient satisfaction with anaesthesia care showed that a questionnaire should cover areas such as ‘patient information and involvement in decision making’, ‘continuity of care by the anaesthetist’, ‘respect and confidence’, ‘delay management’, ‘nursing care in the recovery room’, and ‘pain management’ [15]. Most problems were mentioned in the dimensions concerned with information and continuity of care (> 30% in each dimension). In comparison only 9% of patients were dissatisfied with pain management. Because all dimensions were developed with the involvement of patients they must be regarded as important in principle, although ‘information’ had by far the greatest influence. The underlying questions of the dimension ‘information and involvement in decision making’ are presented in the table below.

TABLE 1: UNDERLYING QUESTIONS OF THE DIMENSION ‘INFORMATION / INVOLVEMENT IN DECISION MAKING’

Information / Involvement in decision making
All in all, did you feel that you received enough information concerning your anaesthesia before you went into hospital?
Were you able to talk to the anaesthetist about the anxiety/doubts you felt concerning your forthcoming anaesthesia?
If you asked the anaesthetist questions during this discussion, did you fully understand the replies you got?
Did you feel you had a choice in the method of anaesthesia ?
Did the anaesthetist tell you how you would feel after the anaesthesia?
Did you feel that the anaesthetist gave you enough of his time?
Did you have enough privacy during your meeting with your anaesthetist?
At the start of anaesthesia, did the anaesthesia team keep you fully informed about what was happening to you?
For regional anaesthesia: did the anaesthesia team (anaesthetist and anaesthesia nurse) keep you fully informed about what was happening during the operation?

A study about patient satisfaction with a preoperative assessment clinic also demonstrated that information, both from clinical and non-clinical service providers, was highly correlated with overall satisfaction [23].

Information is also a crucial aspect in pain therapy. In a study on patient-controlled analgesia, Chumbley et al. [24] showed that involvement of patients in the development of an information leaflet proved to be more satisfying for the patients.

To answer the question, of whether the findings in social science are transferable to anaesthesia we can say that ‘information’ has a major impact on patient satisfaction. Further, many studies probably focus on fields that from the patients point of view are not regarded as important as others. But, of course, the latter must be tested with reliable and (re)validated instruments [8].

HOW MUCH INFORMATION SHOULD WE GIVE?

Although information is very important, we all know that there are large differences between patients concerning the type of information required, especially regarding information on risks and complications. In a study on elective urological procedures, 14% of all patients rated complete information about risk and complication as not necessary, because they were frightened [25]. This might result in a dilemma, because in case of a claim, a lawyer will look at all of the information that was given to the patient.

As mentioned earlier, information is strongly associated with involvement in decision making. And here as well, the extent of desire for participation among patients is very different. A study about information and participation preferences among outpatients undergoing post-surgical treatment for cancer showed that almost two thirds said the doctor should take the primary responsibility in decision making, whereas barely one third felt it should be an equally shared process [26].

WHEN SHOULD YOU MEASURE?

What timing should we choose to correctly assess patient's satisfaction with anaesthesia care? When do we achieve the most critical attitude and the highest response rate - possibly at the same time?

We normally assume that respondents to questionnaires answer honestly. However, there are some factors which may influence the patient's response. The type of assessment is one of them. In-hospital surveys of patient satisfaction, for example, have a tendency to answer questions as expected or what society regards as positive. This phenomenon, which is called social desirability, is intensified by in-hospital assessments and by face-to-face interviews [7]. On the other hand, personal communication in itself may contribute to patient satisfaction, [27].

Little knowledge exists about the impact of different follow-up times with questionnaires after hospital discharge in general, and in particular anaesthesia [28,29]. Available studies in social sciences show very different results [29,30]. Ware et al. [31], for example, found less critical appraisal with time, whereas Ley et al. [32] showed a curvilinear relationship with higher satisfaction rates 1 and 8 weeks after discharge and a lower degree in the intervening period. A recent study from Saal et al. [17] investigated the effect of timing on the response to postal questionnaires concerning satisfaction with anaesthesia care. They found a decreasing response after 9 weeks compared to 1 and 5 weeks after hospital discharge (67%, 65%, and 59%, respectively). A lower response rate over time has also been described by others [23,29]. The most reasonable explanation for these results was a gradual loss of critical attitude and diminishing emotional importance after hospital discharge. Overall satisfaction was not influenced by time, though.

In summary, patient satisfaction (with anaesthesia care) is predominately determined by the patient's perspective, in particular the provision of information. Therefore, the patient Roger Goss was right when he pointed out: *'To be satisfied I want to be informed'*. The extent of desire for information and participation in involvement and decision making is varying. The timing of questionnaires should be within a period of about one month after hospital discharge to maximize participation.

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