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PATIENT PERSPECTIVES ON DISSATISFACTION:
A QUALITATIVE ANALYSIS OF EXPECTATIONS FOR HOSPITAL CARE

A Thesis Submitted to the
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Degree of Doctor of Medicine

by

Alicia Veleen Lee

2009

PATIENT PERSPECTIVES ON DISSATISFACTION: A QUALITATIVE ANALYSIS OF
DISSATISFYING HOSPITAL CARE.

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The measurement of patient satisfaction has taken a prominent role in the assessment of healthcare quality. Patient dissatisfaction, however, is not well understood. While the concept of satisfaction often proves vague and difficult to accurately measure, experiences with dissatisfaction are more tangible. In order to more fully understand dissatisfaction and its relationship to patients' expectations, we conducted a qualitative analysis of patient suggestions for improvements in hospital care.

Data were obtained from telephone interview surveys of adult patients discharged from Yale-New Haven Hospital between July 1, 2007 and June 30, 2008. Patients were asked: "If there was one thing we could have done to improve your experience in the hospital what would it have been?" We randomly selected 10% of survey respondents and analyzed answers to this question using standard qualitative analytic techniques.

A total of 976 of 9764 surveys were randomly selected; 439 (45.0%) included at least one suggestion in response to the study question. We identified six major domains of dissatisfaction. These domains corresponded to six implicit expectations for quality hospital care: 1) safety, 2) treatment with respect and dignity, 3) minimized wait times, 4) effective communication, 5) control over the physical environment and 6) high quality amenities, and each expectation was associated with unique emotional responses. Respectively, patients felt: 1) unsafe (7.7%), 2) disrespected (6.0%), 3) anxious and/or abandoned (15.8%), 4) confused and mistrustful (7.4%), 5) confined and imposed upon (15.6%) and 6) disappointed (6.9%) when expectations were not met.

Dissatisfaction with hospital care was found to largely result from discrete episodes when expectations for care were not met. The expectations which emerged from our qualitative analysis represent patient-generated priorities for quality improvement in hospital care, which have previously not been adequately measured. Certain aspects of patient expectations were found to be in accordance with current quality improvement initiatives, while other aspects were found to be inadequately addressed.

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INTRODUCTION

The United States spends more money per capita on healthcare than any other industrialized nation (1), yet has the least satisfied patients (2). Consequently, interest in understanding patient satisfaction has exploded over the past two decades. Those interested in healthcare quality—hospital organizations, managers, insurance companies, government agencies, healthcare workers and patients—recognize that patient satisfaction provides valuable insight into the quality of care. The relationship between healthcare quality and patient satisfaction, and the varying components that contribute to each, have been extensively studied. Patient satisfaction proves to be an elusive concept, however, and its measurement challenging. Even the definition of satisfaction leaves room for confusion, for to satisfy can mean both “to make happy” and “to be adequate.” Because of this ambiguity, patient satisfaction does not necessarily equal the perception of high quality, but rather that care was adequate or acceptable (3). Patient satisfaction levels, however, are still widely used and interpreted as a measurement of patients’ perceptions of quality.

Healthcare professionals have used and interpreted patient satisfaction in three different ways: as one of several contributors to healthcare quality, as a patient-centered reflection of overall healthcare quality, and as a predictor of future health behaviors, such as compliance. The first interpretation views patient satisfaction as a desirable outcome in its own right and as one of the contributing factors that defines healthcare quality (4). The second uses patient satisfaction to assess the quality of health care from the patient’s perspective. In this argument, patient satisfaction reflects the achievement of other quality indicators, but is not an indicator itself. The third argument for assessing patient

satisfaction contends that there are health-related consequences when patients are dissatisfied, and that improving satisfaction could improve patient health outcomes (5). While most healthcare professionals agree that patient satisfaction is a desirable goal, if for different reasons, the measurement of patient satisfaction proves challenging.

Challenges to measuring patient satisfaction

There are several challenges to measuring satisfaction generally and patient satisfaction in particular. The first challenge is the fact that satisfaction is an inherently subjective evaluation and reliant on patient report (3). The personal judgment of satisfaction has been described as “cognitively based and emotionally affected”(6). The state of being satisfied is a uniquely personal experience that can be difficult to quantify and standardize. Just as there is no objective measurement for an individual’s level of pain, there is no objective measure for a patient’s level of satisfaction.

Another challenge to the measurement of patient satisfaction is the fact that satisfaction has been shown to be influenced by multiple dimensions, including characteristics of the patient, as well as characteristics of the actual service or care received. An identical care experience or encounter may lead to differing levels of satisfaction based on the personal characteristics of a patient. Whether satisfaction is a continuum, ranging from dissatisfied at one end to very satisfied at the other, has also been called into question. Qualitative studies have given little if any support that patients evaluate satisfaction on a continuum (7). Some suggest that satisfaction and dissatisfaction are different constructs, and that satisfaction and dissatisfaction may exist together (8, 9). Others propose that consumers will be generally satisfied unless

something unpleasant or improper happens, and that dissatisfaction is prompted by a “critical event” (3). Patients may also express overall satisfaction with a service or encounter, and yet also report specific criticisms about its shortcomings (10).

Predictors of satisfaction

Many patient-specific, as well as provider/facility-specific, factors have been identified as contributing to patient satisfaction. The influence of demographics on patient satisfaction levels has been widely studied. While some studies report a significant association between gender and satisfaction level, in a systematic review by Crow et al., no consistent relationship has been found between gender and satisfaction levels (3). Studies of the relationship between socio-economic status and level of satisfaction have also led to conflicting results, with the majority of investigators finding no association between satisfaction and level of income, education or job categories (3). Age and race/ethnicity, however, have consistently been shown to be associated with levels of satisfaction. Older patients were significantly more satisfied in over 70% of studies reviewed, and the majority of studies that looked at differences between racial or ethnic groups found minority groups to be significantly less satisfied (3).

The influence of health status on patient satisfaction has also been widely studied. Better self-perceived health status at admission has been shown to correlate with higher levels of satisfaction (11). However, discharge health status, regardless of whether this discharge health status represented stable, improved or declined health status, has been shown to better correlate with satisfaction than admission health status (12). Other predictors that have been shown to negatively influence satisfaction are non-emergency

admission, stay in a non-private room, longer length of stay, and perception of incorrect treatment (11, 13).

Methods of measuring patient satisfaction

The most common model for measuring patient satisfaction considers patient satisfaction to be a measure of overall quality, and it concentrates on defining and measuring health service attributes that contribute to patient satisfaction. The challenge however, comes in determining which healthcare attributes to measure. Satisfaction surveys, by nature, must choose which domains are relevant to patient satisfaction in the questions that they include. Health care attributes are often used as indirect indicators of patient satisfaction, and a degree of satisfaction is implied in the rating of specific aspects of care. Questions asking about a particular attribute of healthcare, for example how well a doctor listened to a patient's concerns, are used to imply a level of satisfaction or dissatisfaction with this behavior. This approach makes the assumption that these pre-selected attributes are desirable and lead to satisfaction, i.e. that patients are more satisfied when a doctor listened to their concerns. It has been shown that patients' overall satisfaction with care is disproportionately affected by low satisfaction with certain attributes, though, rather than an average among all attributes. This suggests that the experience of high dissatisfaction is more influential than high satisfaction (14), and/or that certain attributes are more important than others.

Hendriks et al. examined the link between health service attributes and willingness to recommend a hospital to family and friend. They found that, in decreasing order of significance, treatment with respect and dignity, confidence and trust in

providers, courtesy and availability of staff, continuity and transition, attention to physical comfort, coordination of care, and having enough involvement in decisions were all associated with willingness to recommend a hospital to family and friends (15). Other studies have found that environmental sources of satisfaction, including interior design, architecture, housekeeping, privacy and ambient environment also influence overall satisfaction with hospitalization, ranking just below perceived nursing and clinical care (16).

The number of patient survey instruments assessing these and other health service attributes increased rapidly during the 1990s. The literature review by Castle et al. (17) in 2005, found fifty-four different survey instruments addressing hospital care which varied considerably in terms of method of development, content, implementation and performance. They found that of these fifty-four surveys, only eleven used patient input or a combination of patient input and expert opinion in the development of these instruments. Two of the most widely used instruments at that time were the SERVQUAL (SERVice QUALity) and Picker questionnaires, whose dimensions of quality are outlined in Table 1. SERVQUAL was originally developed to measure service quality in the for-profit business sector. By contrast, the development of the Picker questionnaire included in-depth interviews with patient focus groups (18).

In an effort to standardize the evaluation of patient satisfaction with hospital care, the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey was developed in partnership between the Centers of Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), and came into use in 2005. HCAHPS was developed after an extensive literature review and a total

of 16 focus groups conducted in four cities to elicit the aspects of the hospital experience most important to patients, resulting in eight quality domains around which questions were designed (Table 1). These domains were also judged by the extent to which they reflected the Institute of Medicine’s previously endorsed domains of patient-centered care (19).

TABLE 1 Quality dimensions of healthcare as defined by various groups

SERVQUAL	Joint Commission	Picker Institute
1. Tangibles 2. Reliability 3. Responsiveness 4. Assurance 5. Empathy	1. Efficacy 2. Appropriateness 3. Efficiency 4. Respect & Caring 5. Safety 6. Continuity 7. Effectiveness 8. Timeliness 9. Availability	1. Regard of Patient 2. Coordination of Care 3. Information & Education 4. Physical Comfort 5. Emotional Support 6. Involvement of Family & Friends 7. Continuity and Transition
HCAHPS (CMS)	Institute of Medicine	Institute of Medicine endorsed Patient-Centered Care
1. Communication with Nurses 2. Communication with Doctors 3. Responsiveness of Hospital Staff 4. Pain Management 5. Communication about Medicines 6. Discharge Information 7. Cleanliness of Hospital Environment 8. Quietness of Hospital Environment	1. Safe 2. Effective 3. Patient-Centered 4. Timely 5. Efficient 6. Equitable	1. Respect for Patients’ Values, Preferences and Expressed Needs 2. Coordination & Integration of Care 4. Information, Communication & Education 5. Physical Comfort 6. Emotional Support 7. Involvement of Family and Friends

Qualitative insights

While the use of patient satisfaction surveys allows for the correlation of satisfaction with certain predetermined healthcare attributes, quantitative data fails to accommodate the full range of “feelings, values and experiences of patients”(8). Open-ended questions also tend to allow more room to generate more negative feedback and to

identify areas of dissatisfaction. Qualitative methods generally result in a fuller picture of patients' views about their healthcare service, but are usually more costly to conduct (3).

Qualitative studies have produced a number of theories related to satisfaction and dissatisfaction with health care that would not have otherwise been captured by quantitative surveying. Eriksson et al. identified a theme they called a "struggle for confirmation" in accounts of hospitalized patients who were not satisfied with their care. This "struggle for confirmation" was a feeling of distrust with providers due to a failure of providers to affirm, listen to and identify with patients and caregivers (20).

Another theory to explain patient dissatisfaction with hospitalization was that of a "personal identity threat" as described by Coyle. A personal identity threat was the experience of being dehumanized, objectified, stereotyped, disempowered and/or devalued, thus leading to dissatisfaction with a healthcare encounter (8). In another qualitative study by Attree, semi-structured interviews of acute care patients and relatives found that "good" quality of care was individualized, patient focused and related to need. Staff members who provided "good" care showed involvement, commitment and concern. "Not so good" care was described as routine and unrelated to need, and was provided by staff who were impersonal and distant (21).

A Norwegian study found that free-text comments from male in-patients most often expressed dissatisfaction with perceived mistakes in diagnosis or treatment, followed by unforeseen wait time. Female patients' comments were most often about being treated with a lack of respect and about poor communication (22).

In a post-bereavement study of family members of patient who had recently died following a hospitalization, 59% of those surveyed identified at least one negative aspect

of the hospital care received by the deceased. A qualitative analysis of written comments found themes of feeling “devalued,” “dehumanized” or “disempowered” which led to dissatisfaction with care. The theme of a deviation from the “rules” of expected healthcare encounters was also identified in negative comments (23). The qualitative comments in these studies suggest that the major driver of patient dissatisfaction is not the quality of specific health service attributes, but rather a violation of patients’ implicit expectations for care.

Role of expectations

An alternative to the health service attributes model in assessing patient satisfaction is an expectation/fulfillment model. Patient expectations are intrinsically related to satisfaction. Patients who have low or unclear expectations of service quality, or who are passive and uncritical by nature, may report a high satisfaction level even with a low standard of care (3). Conversely, patients with high expectations for their healthcare would be more likely to report dissatisfaction with an equivalent level of care. Some propose that patient satisfaction and dissatisfaction are governed primarily by expectations of what will *not* or should *not* happen, rather than clear expectations for what should happen (7).

Expectations are also shaped by previous health care encounters. Some theorize that patients who have had negative experiences in the past were actually more likely to be satisfied with a future care, suggesting a “failure to realize their worst fears” may be cause for satisfaction (24). Others have shown, however, that previous dissatisfaction

continues to hamper future medical interactions and prevents sharing of information and trust building (25).

Expectations have been shown to be linked to satisfaction levels. Patients who had their positive expectations fulfilled in areas such as “conduct and convenience,” “preparation and resources,” “waiting time,” and “cost and risk” were shown to be more likely to be satisfied with services (26). Expectations were elicited by ranking the importance of a predetermined list of possible expectations, however, which were developed by unclear methodologies.

The rigorous establishment of what patient expectations for health care truly are, especially when related to hospitalization, has been lacking. While qualitative studies have led to a more complete understanding of patient satisfaction and the experience of dissatisfaction with care, the role of patient expectations has not been well studied qualitatively. Although patients are often not fully cognizant of their expectations prior to an episode of hospitalization, dissatisfaction during the stay can bring to light previously subconscious expectations.

The factors that influence satisfaction with hospitalization are often distinct from factors that influence satisfaction with ambulatory or primary care. Overall satisfaction with hospitalization, as measured by a variety of patient satisfaction surveys, tends to be consistently high. Research has shown, however, that despite overall high satisfaction ratings, when patients are asked about specific aspects of their hospital experience, a majority will report experiencing specific problems (27).

A recent study of 228 inpatients in Boston showed that 38.6% of patients experienced a “service quality incident” during hospitalization. A service quality incident

was defined as a reported deficiency in service quality as separate from the technical quality of care, during hospitalization. Service problems were categorized using the Picker Institute's dimensions of quality (Table 1). Problems were most commonly related to waits and delays, problems with communication between staff and patients, environmental issues and amenities. Patients who reported service quality incidents were less likely to rate their hospitalization as "excellent" (28). Another large cross-sectional survey of patients recently discharged from the hospital showed that 10% of patients indicated that a problem occurred during hospitalization, most frequently related to not receiving information about the hospital routine, pain during hospitalization or lack of sufficient discharge information and guidance (29).

Statement of Purpose

This study aims to establish patient expectations for hospitalization by examining episodes of dissatisfaction with hospital care as reported by patients in post-discharge interviews. We particularly focused on identifying the underlying expectations implicit in patients' reports of problems, and on describing the feelings that arose when these expectations were violated.

METHODS

Study Design

We conducted a qualitative analysis of telephone survey data obtained from adults recently discharged from Yale-New Haven Hospital. Survey participants were asked a series of 5 questions, one of which was the open-ended question: If there was one thing we could have done to improve your experience in the hospital what would it have been? Answers to this question were included in this study.

Setting/Participants

Yale-New Haven Hospital is a 944-bed, urban academic medical center. Surveys were conducted by the Yale-New Haven Hospital's Discharge Call Center. Patients (or patient representatives) were routinely surveyed in a telephone interview conducted by trained staff 1-5 days after discharge from the hospital. Calls were attempted to 90% of adult discharged patients and approximately 50% of those were reached. A maximum of 2 calls to each patient were attempted. For this study, we included patients who were age 18 or older, spoke English, were discharged to home or with home care, and were discharged from a medical, surgical, gynecology-oncology, neurology/neurosurgery or intensive care unit. Of those patients, we (A.V.L.) randomly selected 10% of those surveyed between July 1, 2007 and June 30, 2008 for inclusion.

Primary Data Analysis

Qualitative data analysis was used to identify and classify patient suggestions. The study team included internal medicine physicians (J.P.M., L.I.H.), a medical student

(A.V.L.), and a recent college graduate (C.P.B.). Using a grounded theory approach (30), codes were generated in a mixed inductive and deductive approach to classify interview responses according to reading and rereading of the primary data. A set of 100 interview responses were first read individually by 3 investigators (J.P.M., A.V.L., C.P.B.), and investigators met to discuss common themes and ideas. A preliminary list of coding categories was then generated (A.V.L.). Each investigator then assigned these coding categories to additional survey responses in sets of 100. Subsequent meetings were held to generate, eliminate and refine the codes as needed with the constant comparative method (30). Disagreements were resolved by negotiated consensus. The full study group met periodically to review the code structure for logic and breadth. The coding list was modified after each meeting to reflect emerging themes (A.V.L.). Once thematic saturation was achieved, i.e., no new codes were being generated, the entire data set was coded/re-coded by at least 2 investigators using the final coding lists. The final coding structure had 42 unique codes, organized into 6 broader themes. We used descriptive statistics to characterize the coding category results (A.V.L.). Intercoder reliability among the 3 coders, was sampled with the κ statistic using PRAM software at 0.91 (A.V.L.).

This study was approved by the Yale Human Investigation Committee, which granted a waiver of informed consent (application by A.V.L.).

RESULTS

A total of 976 surveys were randomly selected from 9764 post-discharge phone interviews completed between July 1, 2007 and June 30, 2008. A total of 56.3% of patients were female. Patients discharged from medical units comprised 44.5% of the sample, 31% from a surgical unit, 10.6% from gynecology-oncology, 7.3% from ICU/CCU/Step-down and 6.6% from neurology/neurosurgery (Table 2). Of the 976 patients, 439 (45.0%) gave at least one suggestion for improvement, yielding a total of 579 suggestions in the dataset. Patients also offered specific comments about positive aspects of care, but these comments were not included in the analysis.

TABLE 2 Demographic information (n = 976)

	<i>n</i>	% of total surveyed
Total surveys	976	
Male	427	43.7
Female	549	56.3
Discharge Unit		
Medical	434	44.5
Surgical	303	31.0
Gynecology/Oncology	103	10.6
ICU/CCU/Step-down	71	7.3
Neurology/Neurosurgery	65	6.6
No suggestions for improvement	537	55.0
At least one suggestion for improvement	439	45.0

Through qualitative analysis, we assigned suggestions for improvement to six major categories of problems: 1) ineptitude, 2) disrespect, 3) waits, 4) ineffective communication, 5) lack of environmental control and 6) substandard amenities. We considered the inverse of these problems to represent 6 implicit expectations of good hospital care: 1) safety, 2) treatment with respect and dignity, 3) minimized wait times, 4) effective communication, 5) environmental control and 6) high quality amenities. Each expectation was associated with a unique emotional response when it was violated. When

expectations were not met in these domains patients felt, respectively: 1) unsafe, 2) disrespected, 3) anxious and abandoned, 4) confused and mistrustful, 5) confined and imposed upon, or 6) disappointed. The number of patient suggestions related to each domain is summarized in Table 3.

TABLE 3 Descriptive statistics of dissatisfaction domains (n = 976)

Domains of Dissatisfaction	<i>n</i>	% of total surveyed	% within domain
Perceived Ineptitude			
Adverse Events	18	1.8	24.0
Cleanliness	36	3.7	48.0
Perceived lack of knowledge/skill	12	1.2	16.0
Rushed Out	9	0.9	12.0
Total	75	7.7	100
Disrespect			
Unprofessional staff behavior	55	5.6	93.2
Lack of privacy/confidentiality	4	0.4	6.8
Total	59	6.0	100
Prolonged Waits			
Response to call bell			
Bathing/Toileting/Distress	24	2.5	15.6
General	41	4.2	26.6
Wait for physician	12	1.2	7.8
Wait for admission bed	29	3.0	18.8
Wait for transport	16	1.6	10.4
Wait for food	7	0.7	4.6
Wait for medication	11	1.1	7.1
Wait for diagnostic test/procedures	6	0.6	3.9
Wait for discharge	8	0.8	5.2
Total	154	15.8	100
Ineffective Communication			
Communication with patients	33	3.4	45.8
Communication with family	3	0.3	4.2
Translation	2	0.2	2.8
Communication between providers	13	1.3	18.1
Coordination of care (inpatient)	11	1.1	15.3
Medication reconciliation	5	0.5	6.9
Continuity inpatient to outpatient	5	0.5	6.9
Total	72	7.4	100

Lack of Environmental Control

Physical Environment			
Roommates	38	3.9	25.0
Noise	24	2.5	15.8
Temperature	12	1.2	7.9
Smell	1	0.1	0.7
Interruption by staff	15	1.5	9.9
Lighting	2	0.2	1.3
Chaos/hectic	4	0.4	2.6
Shorter Stay	8	0.8	5.3
General	3	0.3	2.0
Facilities			
Pain control	10	1.0	6.6
Painful procedures	17	1.7	11.2
Facilities			
Bathrooms	7	0.7	4.6
Maintenance response	5	0.5	3.3
Traffic/Parking	6	0.6	3.9
Total	152	15.6	100
Substandard Amenities			
Food Quality	26	2.7	38.8
Food Variety	5	0.5	7.5
Food Service	16	1.6	23.9
TV	8	0.8	11.9
Beds	8	0.8	11.9
Gowns	4	0.4	6.0
Total	67	6.9	100
Total Suggestions ^A	579		

^A Some respondents gave more than one suggestion resulting in a greater number of total suggestions than the number of respondents with at least one suggestion for improvement.

Implicit Expectation of Hospitalization:

1) The hospital will be safe and the medical staff will be knowledgeable and skillful.

The expectation for safety in the hospital was clear. Patients expected that they not be harmed while in the hospital, that the environment would be clean and safe and that staff would appear competent and skillful. Patients also expected that there would be no identifiable errors or adverse events.

Failure of expectation:

If the hospital facilities are not safe and medical staff is not knowledgeable and skillful, I feel unsafe.

A total of 7.7% of interviewed patients experienced a situation which made them feel unsafe during their hospitalizations. Patients cited several areas in which their expectation for safety was not met, including adverse events/near misses, uncleanliness and a perceived lack of knowledge or skill. While patients may lack specific expectations for the course of treatment, they were able to identify adverse events during hospitalization. Patients were most readily able to identify events that led to pain or injury. Errors in correct patient identification and medication administration were also noted. Patients who had managed chronic medical conditions themselves at home also recognized errors in the management of these conditions while in the hospital. Other areas which led patients to feel unsafe were a lack of cleanliness of the hospital, as well as being discharged before the patient thought he or she was ready.

Adverse Events

Adverse events or near misses were experienced in several areas. Errors related to diet orders, medication administration, patient identification and equipment malfunction were all cited as causing an adverse event or near miss, and accounted for 24.0% of suggestions related to ineptitude. Patients often explained that they or a family member were the ones who caught the mistake, and if it were not for their vigilance, the error would have occurred:

There was one male nurse in training, C*, who was about to give my mother an injection. I asked what he was doing because she was about to go into surgery. He said he thought she was going home. He looked at the chart again and it turns out he was holding her roommate's chart. I don't know what would have happened if I wasn't there.

The only thing was that when I was getting ready to get discharged, one of Dr. H*'s associates came in and said, "We have to readmit you for a further procedure." I said, "Well, that's strange because Dr. H* put in a stent yesterday, and I'm supposed to leave today." Well, he checked, and he had the wrong guy. I'm glad I said something or else they probably would have hauled me off.

I got a burn from the Bovie pad.

She's a diabetic. Her diet was listed as regular, and they gave her regular soda and french toast.

They were about to give my roommate more morphine and she had to tell them she already had it. They were going to double up on it.

Cleanliness

Patients considered the general cleanliness of the hospital a reflection of the priority the hospital placed on patient safety. Consequently, a lack of confidence in the hospital's ability to keep the facility clean led to a lack of confidence in the hospital's commitment to safety. Since patients were typically unaware of the hospital's infection control policies and procedures, their most tangible experience with cleanliness came in their

own bathrooms and room facilities. Dissatisfaction with the cleanliness of the hospital comprised 48.0% of safety concerns:

Yes, the rooms are dirty. When a patient checks out, the bathroom should be disinfected before another patient gets admitted because that's protocol. The floors are dirty. They don't sweep unless you ask them to. I got there Tuesday evening and they didn't clean the bathroom until Friday evening...It took three different people to come and clean the bathroom right. I have to come back for surgery and I'm scared to death with all that bacteria and uncleanliness.

You could clean that floor. My roommate used a bed pan the whole time and had a blood infection. We found drops of diarrhea with blood in it on the floor. I wouldn't let them take my blood in that room. With what I had, I shouldn't have been sharing a bathroom with him. The cleanliness was not what I expected from a hospital.

One thing I noticed about the hospital is that it's not as clean as a hospital should be. Even the windows are dirty.

The bathrooms aren't too clean and they need to be disinfected. It was not at all to my liking. It wasn't much cleaner even after they cleaned it. That's important in a hospital, I think. I was really disappointed. I didn't even want to use the bathroom.

Not one of the 20 plus medical people that came in my room turned me over to check my skin after sitting there for three days.

Practices for handling bodily fluids were also called into question:

I think it's a problem they don't change the plastic nostril things, for the oxygen. I had the same ones in my nose for four days. I think it collects germs and bacteria and I demanded that they change it and a nurse came in and wiped it off with a cloth.

When he threw up they threw it down the sink where people wash their face and brush their teeth.

Hand washing was also expected in order for patients to feel safe. While hand sanitizer is routinely available outside patients' rooms, some patients expected to see staff wash their hands for themselves:

Have more people come into your room and wash their hands.

Lack of knowledge/skill

When patients perceived a lack of knowledge or skill in nursing and physician staff, they question the expertise of their care:

The young nurses were inexperienced with trying to put in my IV. I had to get an older nurse to do it.

You have too many interns that are not too knowledgeable.

The level of competence goes down at the associate level. The PCAs [Patient Care Assistants] were below standard, even though there were some good ones. I have bruises on my hands because one or two of them were not good.

In my particular case, if we could've managed my blood sugar a little bit better, I probably would've felt better.

Patients with chronic illnesses were also in a position to have heightened expectations for the care which they should receive while in the hospital. The failure to appropriately manage blood sugar, for instance, caused the patient to question the expertise of the staff:

I feel like the diabetes issue was handled really wack. At home my units are between 20-25. At the hospital the max that was given to me was 6 units, so it was never under control.

Rushed out

Patients also felt unsafe when they were discharged before the patients believed they were ready. Unlike wanting to leave earlier than recommended, feeling rushed out produced a lack of confidence in doctors' judgment resulting in feeling unsafe.

I felt like I was rushed out. I should've stayed a little longer:

Not to rush me out the hospital. I was admitted at 10:00 Tuesday evening and discharged Wednesday morning and that was too quick.

I'm upset because every time I go in there I know there's something wrong with me and they never find out what's wrong with me and they send me home, instead of letting me stay until they figure it out.

Implicit Expectation of Hospitalization:

2) I will be treated professionally with respect and dignity.

To be treated with respect and dignity while in the hospital was of paramount importance to patients. While patients differed in expectations around the control of physical environment and even timeliness of care, disrespectful and unprofessional behavior was never rationalized or explained away. Slow or uncoordinated care was at times forgiven by patients, but rudeness and disrespectful treatment by staff members during these delays was not. Privacy and confidentiality were also expected as a part of respectful and professional treatment.

Failure of Expectations:

If I am not treated professionally with courtesy and dignity, I feel disrespected.

A breach in the expectation of courteous and professional treatment lead to patients feeling disrespected. A total of 6.0% of surveyed patients suggested improvements that reflected a failure to meet the expectation of respectful treatment. Disrespect came in several areas. A group of patients noted unprofessional behavior by staff, including poor work ethic and a perceived lack of warmth and caring. Patients also noted frank rudeness in comments and interactions with certain providers. A lack of attention to privacy and confidentiality was also seen as unprofessional and disrespectful and as a deviation from the protocol of care.

Unprofessional/rude behavior

Unprofessional and/or rude behavior by hospital staff accounted for 93.2% of suggestions related to disrespectful behavior. One aspect of professionalism that patients expected was warmth and caring by the staff. A lack of warmth, even in the absence of direct rudeness, was cited as an area that needed improvement with particular staff members. Warmth and caring was expected at all levels of hospital care, Patient Care Assistants (PCAs), nurses, physicians and administrative staff alike:

Yale has always been like [this] since I started going there in 1982. They're very good technically but their bedside manner kind of sucks. You survive but you don't walk away with a warm fuzzy feeling.

Hire people that care about patients, not people who do this just for a paycheck.

A few nurses were not as considerate as others. It's like they didn't really care so much about the patients, they were just there to do their job.

Patients' experiences with frank rudeness were often related to specific interactions in which a staff member said or did something offensive to the patient. This lack of respect was never excused or rationalized:

When I got there Tuesday night, the staff [was] rude and abrupt. It's a teaching hospital, and the ones in charge should be teaching how to deal with patients and families with more care. They acted like I was putting them out. One doctor, Dr. S* was very rude with my daughter when she tried to ask a simple question. Dr. S* said, "Let me see what's going on with her, then I'll talk to you." I wanted to get up and slap him for talking to my daughter that way.

Nurse G* in the recovery room was horrible. She was absolutely terrible. Her mouth is filthy. I spit up a little bit from the anesthesia and her response was, "What the f*, this is disgusting." Also, the elderly guy next to me was very sick and in pain and she said, "Oh please old man, give it a break." If I were her boss I would fire her immediately.

Transport was rude due to me being a heavy person. They were saying they didn't want to move me and snickering. Not really wanting to transport me due to my weight issue.

Floor supervisor was very snotty and not helpful at all.

Nurse M* stood there and said, "You're telling me you're on antidepressants and anxiety meds because of your husband's passing 3 years ago? That's not our problem." So I was on morphine for pain, and not getting my regular meds and it was a bad combination. I finally kind of let loose and M* was the one who was there. She was nice to me after that.

Staff members' condescension also showed a lack of respect and was upsetting to patients:

I stood in ER from 12:00 noon to 2:00am and they were very rude there. They talk to you like you're ignorant.

There was a nurse late at night who was a little upsetting... They couldn't find my veins and I was bruised, and she accused me of being afraid of needles and talked to me like I was a little child.

Several patients told stories that crossed multiple areas of concern, but ended with the patient feeling disrespected due to unwillingness by hospital staff to take responsibility for correcting the situation. Poor service quality, uncleanliness, confusion, feeling rushed out and disagreements with care plans were all inciting events for patients, but it was the unprofessional response which they received that left them feeling disrespected. The experience of disrespectful treatment often concerned patients more than the original complaint:

I got there Tuesday evening and they didn't clean the bathroom until Friday evening. A woman from that Patient Liaison department came up to see the bathroom after I called for a long time. When she finally came up, she looked at me with this look like, "You have the nerve to complain." I couldn't get her name because she kept mumbling it so I couldn't hear. I think it sounded like a man's name.

Nurse M* was kind of on a power trip with me. I stayed on my butt for 3 days because I'm paralyzed and they couldn't find me an XL wheelchair, and when they finally got me one I went outside like everyone else does and when I got back in she wanted to discharge me. Also the big chair in the small shower meant the shower wasn't accessible anymore. I could have used the larger shower down the hall, but no one told me. I've been in a wheelchair for a long time and I know about rights for handicapped people. Nobody wants to change your Johnny coat either. Five days at Yale were worse than 365 days in jail.

I ordered breakfast at 7am but it didn't arrive at all. Two hours later the breakfast still did not arrive. First, I received a call from Amy and then Barb saying the breakfast left the station at 7:20am. The food was really needed because I didn't eat the day before because of surgery. That was very disappointing. They should have just told me that they messed up and were going to send it again. Instead, they acted like they didn't know what happened.

I feel like the doctor that saw me that last night there was trying to get me out of there as fast as possible, saying not in so many words that it was because I don't have any insurance. He was a younger doctor. I just feel like they treated me like an animal. He was rushing me out of there at 10:00, 11:00 at night, "can you get a ride?" The transporter wheeled me downstairs and just left me alone at the entrance to wait for my ride.

I was taken down to MRI with the worst migraine of my life and pressure on my brain from the spinal fluid leaking. I was photosensitive and the lights were killing me. I couldn't eat, I couldn't see or read. My head was pounding harder from the bright lights and they put this helmet on me and put things in my ears and told me I had to go in the tunnel for 1 1/2 hours. It was inhumane. They told me to hit the little button if I had a problem. I started crying because I knew at that point it wasn't possible for me to get through it. I kept saying I wanted to go back to my room. They were indifferent to my headache and my crying. They just parked me under the bright lights in the hallway like a piece of meat, and I waited there at least 40 minutes for the transport. It was awful. Those two women were so insensitive to my pain.

The perceived unwillingness for medical staff to listen and respond to patients' concerns and preferences was also seen as disrespectful. These suggestions also crossed categories, including elements of ineffective communication, but the resulting dissatisfaction that patients expressed was of feeling disrespected and unvalued:

As far as the doctors are concerned, I wasn't [satisfied] because they don't listen.

When I spoke with the anesthesiologist before surgery, they asked if I had any questions or concerns. I told them that my fear was to wake up from surgery in pain and no one pay attention to me or won't be able to understand me. They said that if I was in pain, not to worry because a nurse will help me with pain meds. The day of my surgery came and after the surgery, I remember mumbling to my nurse that I was in pain but he said, "Oh, it's a part of surgery. You just got out of surgery so that's going to happen." He told me he wanted me to wake up a little more from the anesthesia before he gave me meds.

Mostly it was good, but there were a few people who weren't that great. Sometimes the meds don't work like they think and the only one who can really tell them that is the patient, but they don't want to stop to listen. They only want to dictate. That was my experience.

A lack of a strong work ethic was another area in which patients noticed a lack of professionalism. When staff members were perceived to not be working hard, this was taken by patients to be disrespectful and unprofessional:

The only thing was the aides. They didn't do anything nor did they even do their job.

Get rid of some of these lazy people.

One night a group of people including staff and doctors were talking and laughing outside my room like if it was the afternoon, and it was night time. I told them "I'm sorry but the party has to stop."

Sometimes I called because I needed to go to the bathroom, and the nurse would just stand there watching me and not offer to help.

Privacy and Confidentiality

Privacy and confidentiality have come to be expected as the standard of care. Failures to provide the courtesy of privacy, as well as perceived ambivalence towards confidentiality were interpreted as unprofessional and disrespectful:

In the E.R I didn't like that I had no privacy especially talking with the doctor because I was in the hallway. I didn't have any privacy therefore I wasn't completely truthful with the doctor because everyone could hear.

I think the doctors should conduct business in a private place not around patients. When I was there, there were two doctors in the hallway arguing about which one of them were going to perform a procedure. I thought that was very unprofessional and not very confidential.

There was no privacy in the room I was in. I had a roommate and no curtain in between our beds. When the doctor would come to examine me, we had no privacy.

Implicit Expectation of Hospitalization:

3) The hospital will function efficiently and wait times will be minimized.

In order for a hospital to function efficiently, multiple layers of patient care and ancillary services must come together seamlessly. An implicit expectation among patients was that the complexity of the operation would not result in exorbitant wait times, and that the visit would run smoothly. Patients also expected not to have to wait to access medical and personal care assistance from the medical staff.

Failure of Expectations:

If the hospital does not function efficiently so that wait times are minimized, I feel anxious and abandoned.

When patients experienced delays in the hospital, they expressed feelings of anxiety, frustration and even abandonment. The experience of waiting occurred in several primary areas. A total of 15.8% of all interviewed patients gave suggestions that involved dissatisfaction with wait times in the hospital. Waits for admission beds, typically occurring in the emergency department, waits during the discharge process, and waits for transport were the most frequently cited non-clinical waits. Waits for food and delays in diagnostic testing or imaging also generated similar expressions of frustration. Waits related to receiving patient care, for example the inability to access nurses or physicians, caused feelings of fear and abandonment.

Access to nursing

A total of 43.2% of suggestions involving prolonged wait time involved waits for nursing attention or response to patients' call bells. Of those, over one-third involved waits for toileting assistance, personal hygiene assistance and other urgent needs. Waits in these critical areas often produced feelings of abandonment:

I called for someone because I had to use the bathroom really bad, but I had those things stuck to my legs and needed help walking to the bathroom but no one came. Well, I had to go so bad that I had a panic attack. Then all these people came rushing in to help. I felt so embarrassed.

I sat in feces for an hour. I had to call my son so he could get someone to help me. I think you're short staffed.

Another distressing event was recounted by a family member about the experience of a delay in help with toileting:

I had a very bad experience with one of your PCAs named J*. As a result of all the meds [the patient] took, he was constipated. I asked a RN if she could please write her number on the board so that when he did go, I could call someone to help me. She said she will write the PCA's number so that we could call her first. Well, when he finally passed his bowels, the PCA came in and said she would be right back, but she never came back. After waiting a half hour, I cleaned him myself, cleaned the bed pan, and cleaned his bed. Come to find out, she left. I was very upset. I spoke with D* and I don't think she should lose her job, but she should be reprimanded for this.

Waits for assistance with bathing also caused dissatisfaction:

My face and body was never washed. I felt that if my husband was not there with me overnight, I would've been at a disadvantage. I don't know the protocol of care, but no one washed my face. My husband had to help me wash myself.

It took a long time for them to clean all my cuts and bruises--more than 24 hours.

Patients' experiences with delays in response to other urgent issues also produced feelings of abandonment:

One morning I was vomiting and no one appeared. I called and requested help because I had an emergency but I didn't get a response.

The nurses sucked. We called and called them to say his IV was bleeding but no one came for a 1/2 hour. I had to clamp it myself.

They ignored me when I called them because my blood sugar went down to 51. It was Tuesday, and I kept calling the front desk on the floor, but nobody would send someone to check it out. I was feeling it because I was getting sweats and everything. Finally, I had to yell at a nurse walking by to check my blood sugar and she said it was 51.

It was also distressing to patients to watch roommates experience a delay in help for urgent needs:

The lady next to me was an elderly woman with a brace on her neck, and she couldn't speak very well. She had diarrhea at night and she would ask for a bedpan. The nurses would take forever bringing it to her. When you've got to go, you've got to go. So now you have to clean up poop too. I just think when there are elderly people they should be more attentive to them because they tend to not be as vocal, you know?

During the day it took a long time for people to respond to my room. I had to get juice for my roommate twice and she is an 80 year old woman. My husband had to help her go to the bathroom. The response time was not good.

Patients also commented on a general lack of attentiveness, and the expectation to be checked on and watched over when they did not call:

Night nurses weren't very attentive, didn't really check in. [They were] more reactive than proactive.

It was hard to get the nurses to pay enough attention to you. In the middle of the day the nurse didn't check on me. In fact, I hardly saw anybody.

Suggestions related to call bells also encompassed the expectation that waits should be minimized even when the need was not necessarily urgent. These types of delays led to frustration and annoyance:

They need to acknowledge the patients a little more. If there's a patient with a problem and they're calling for some help, even if the staff can't get to them right away, they should at least acknowledge that the patient is calling. They could say, "Yes, I hear you and I'll be with you in one minute."

You call, you need something, they make you wait 10 years.

When I called for a nurse it took them a long time. Some were good and some couldn't be bothered.

Others noticed decreased attentiveness at night, on the weekend or during shift changes:

At night the responses were very slow. You would think in the middle of the night, with not much going on, that the responses to the call bell would be a little quicker.

At the 7am shift change, forget it. You couldn't get anything. There was no response to the call button.

Another sub-theme that emerged in patient suggestions regarding access to medical staff was the perception of the hospital being understaffed:

You guys are so short staffed. [The patient's] nurse J* couldn't even focus on giving him the proper care that he needed because she was so rushed.

It's hard to get people's attention because they're understaffed and overworked.

The perception of the hospital being short-staffed also resulted in patients requesting help less often than they may have needed it:

I knew they were so busy, and I could see that they did not have enough help, so I didn't ring as much for things because I could see they were frantic.

Access to physicians

Similar to the expectation of access to nursing and PCA care, there was an implicit expectation for prompt access to physicians, both for care and for consultation. A failure of this expectation also resulted in feelings of abandonment:

The first time I came in I was having a stroke and I waited in the E.R for about an hour because they kept telling me that I had to wait my turn. Finally one Dr heard me and then Melissa saw me and saw how bad I was and they brought me to the back immediately for attention. I know it's first come first served, but I feel I should have had to wait an hour having a stroke for some medical attention.

A delay to be seen in the emergency department (ED), as opposed to waiting in the ED for a room, was also echoed by this patient who was less than understanding about it:

I have to tell ya, this is the most paramount thing. The delay was just excessive in the ER. I came in at a quarter to eight because Dr. Monaco wanted me there at that certain time because we did call ahead. That really was the terrible part of the experience. Here's the thing, if you say you're understaffed there shouldn't be any staff members standing around talking by the water cooler about personal things. I was there at 8am and wasn't seen until 1am.”

Another frightening experience occurred on the floor to this patient who explained:

Every patient is different, I understand, but when you're there at night it can be a little scary. I was not only scared but in pain. The nurse on * tried to get a hold of the doctor that was on call, but the doctor took hours to respond. That was very scary.

Other patients described frustration over the lack of ability to talk with their doctors while in the hospital:

The only thing I didn't get to see was my doctor, Dr. R*. I would have liked to see him, but I know he's busy and I know he has a good team. Actually, they're top notch and I couldn't ask for better.

One of the problems that I see with the medical field...I guess everyone is working too hard, but the doctors come soaring through at 7 in the morning then they're gone all day. You hardly get to talk to anybody.

Wait for an admission bed

The experience of waiting in the emergency department for admission was a frequent source of frustration. 18.8% of suggestions involving prolonged waits related to waiting for an admission bed in the ED:

The worst part was the ED. He was there from 6:30 to 12 midnight before they got him into a room. It was dreadful, and very difficult.

The ER wait is too long. I was there from 8am to 2am the next day. I was there the whole day and night. When someone is in pain, they just want to be taken care of, not waiting around.

In the ER I was upset. I spent 23 hours in the ER. It's very depressing.

Some patients would have preferred a shorter wait, but did not necessarily expect improvement or assign blame:

I guess room availability. I had to wait in a room behind emergency until a room was open, but that can't be helped.

Others were less sympathetic, though:

In the ER the process was too long. They fool around too much down there.

Waits for test

Once patients were in their rooms, waits continued. During the hospitalization, patients continued to experience delays with diagnostic testing and procedures:

When I was admitted they were supposed to bump me up to get an MRI, but it was delayed because of the weekend. It's a shame because it's like you shut down on weekends except for the people who are dying.

Again some patients rationalized the wait:

There was kind of a screw up in tests in that they took a long time to do, but it was a holiday weekend and that's understandable.

Waits for food

Waiting for food, as separated from other expectations related to food service and quality, also caused frustration for patients during hospitalization:

The meals could have been a little better. The quality was good, but sometimes they came later than they said and sometimes they missed an item I ordered.

Waits for medications

Patients were also troubled by waiting for scheduled medications:

I had asked for my med at about 9pm and didn't get until 4am.

I had to wait a long time for meds and me and my dad saw a few nurses taking pictures of each other out in the hallway.

Waits at discharge

At the end of the hospitalization, patients again experienced waits related to the discharge process. Suggestions for improvement related to waits at the time of discharge, including the discharge process itself and transport after discharge, accounted for 15.6% of all waits:

Getting out was such an ordeal. They're so busy you're a low priority when you're getting ready to leave. And there's no continuity—people coming in and out.

The doctor discharged me around 3:00 but the actually papers weren't signed until around 5:00 and I still had to wait. The nurse was rude and told me I had no choice but to wait.

Complaints about waiting for transport, most often occurring at the end of hospitalization, again reflected frustration over being delayed:

A little quicker with the wheelchair when I was leaving. It was a half hour to 45 minute wait.

The transportation system needs improvement. They were supposed to wheel me down stairs and due to a long wait of 45 min we walked down instead.

Implicit Expectation for Hospitalization:

4) Information about my condition and plan of care will be communicated effectively to me and all my providers.

During hospitalization, a patient's clinical status and care plans can change rapidly. Patients expressed the expectation that information about their plan of care would be effectively communicated. In addition, there was an expectation that there would be effective communication between various care providers and departments in order to coordinate hospital services and to provide continuity between inpatient and outpatient care.

Failure of Expectations:

If information about my condition and plan of care are not communicated effectively, I feel confused and mistrustful.

A failure of effective communication during hospitalization caused confusion for patients and families. Confusion caused by ineffective communication was expressed by 7.4% of surveyed patients. Breakdowns in communication came in the form of poor communication directly with patients, poor communication with family members and inadequate translation services. The failure of care providers to effectively communicate with each other in order to coordinate care also caused confusion for patients and family members.

Communication with patients

Direct communication between medical staff and patients broke down in several areas.

The ineffective transfer of medical information to patients in a timely fashion produced confusion and dissatisfaction for patients. There was the implicit expectation the patients would be kept informed about their clinical status and outcomes of diagnostic testing:

I just didn't get all the information of what they did and what was the outcome.

I never got to see the results of my CT scan. Maybe a little more explanation of what tests were done and the results.

Explaining to me in a more timely manner the things that were wrong.

The only thing I was a little concerned with was that when I was leaving my nurse informed me that I had low sodium. I had low sodium once before and it was dangerous enough to go to the Emergency Room. Not once during my stay did anyone tell me I should restrict my water, but that last nurse did. Then when the visiting nurse checked my sodium she said it was fine. That's the only thing that troubled me because it was confusing.

There was also an expectation that patients would be kept updated about the plan of care and the schedule of procedures or surgery:

For days I thought I was having surgery on Friday. So all that day I ate and drank nothing and got prepped for surgery. Finally later that night I was told I was going to have it on Saturday. Saturday comes and still nothing. I never saw a surgeon or talked to anyone. I was told later on that night at about 9 pm that I was an add-on. I never quite understood what that meant. Then later after that I was told I'm not having the surgery. That was the most frustrating thing.

After surgery I was supposed to be discharged with a cast but I still ended up leaving with pins so I don't really understand what happened there. We are trying to get all that straightened out now.

There were a few days that [were] a little confusing to me. I didn't know if I was going to have surgery or go home. The communication wasn't that great.

Disagreement with the care plan

Ineffective communication between doctors and patients also led to a failure to involve the patient in treatment decisions and disagreements about the plan of care. This intersection between poor communication and a perceived lack of respect for the patient's wishes ultimately led to distrust in the physician's ability to provide proper treatment and a perceived lack of medical staff competence:

I asked for a port to be put in [be]cause I knew I would need one anyone for chemo but they didn't. They put a PICC line in. I was not happy with that. That was the worst experience I ever had at Yale New Haven Hospital.

I don't like being used as a guinea pig. They constantly try different medications on me. I come in and out of Yale all the time and this always happens. I'm never happy with Yale but I have to go.

Maybe if you guys had him walking around sooner. That would've been helpful.

The interns on the Atkins team need to improve. Everybody wants to be a leader. I was sent home on a Friday and was sent right back on Friday night because my blood count was low and I ended up needing a blood transfusion. I tried to tell them this but they didn't listen. They need to listen to the patients.

Translation

Translation services were available in the hospital through a translator phone line and in person for many languages, but patients still experienced inadequate translation services.

The ability to communicate effectively was obviously hampered when patients and doctors did not speak the same language. Patients expected to be able to communicate fully in their native languages, and that translator services would be utilized:

You should have some sort of phone communication for people who don't speak English. It would be nice if patients had phones in their rooms that have direct contact with someone who speaks Spanish for translation and any questions they may have.

I seen many people but none of them spoke Spanish. You need some people who speak Spanish so that we can communicate and understand.

Communication with family

Effective communication with patients' family members was also expected during hospitalization. Family members were often primary caretakers of elderly or chronically ill patients prior to hospitalization. Especially in this situation, family members expected to be kept informed about changes to the plan of care:

Explain to my child about changing my hour of medication. I always take my medication at 5 pm, but they didn't give it to me until 9 pm. It really upset my children.

I had to go back to the OR on the first day of being admitted and my husband was surprised because he wasn't informed.

Family members also expected to be kept informed about the patient's location, especially surrounding surgery:

The doctor told my husband that my surgery was over, but nobody told him when I had been moved back to my room. When I woke up I asked them where he was and the nurse said they must have forgotten to tell him, which turned out to be the case.

Communication between medical staff

While inadequate communication between doctors and patients often resulted in confusion, inadequate communication between various care providers also caused confusion for the patient. During hospitalization, patients are often seen by dozens of care providers, including attending physicians/hospitalists, specialists, residents, interns, medical students and nurses, many of whom were previously unknown to the patient. Patients expected effective communication between these care providers in order to coordinate a cohesive care plan:

The only problem I had was all the different doctors coming in and out. There's so many that it confuses the patient, and a lot of them would contradict each other. One doctor said I could go home and another doctor said, 'No, you need to stay.'

Internal communication needs to be improved. The staff members don't really know what's going on with the others. Not as soon as the patient would like anyway.

There is very poor communication, sometimes they asked me, "What did the doctor say to you?" because it wasn't in my chart.

Communication between attending physician and the med students was not good last time we were here. Some things get lost in translation because it is a teaching hospital

Patients also expected that information would be communicated between providers in their medical record so that they would not be asked the same questions multiple times, especially medication and allergy lists:

They always asked me, 'What meds are you taking?' instead of them just looking in the chart. Who asks patients that are on narcotics questions that you could find out yourself? I was groggy and just couldn't answer them.

The communication between departments is ridiculous. Four different times, different people asked me about my daily meds and the dosage and reason for each one.

The doctors didn't pay much attention to my allergies or medications either, I shouldn't have to repeat myself with every person, and I think it's just laziness that they don't check the chart before they come in the room.

Coordination of care

Confusion was also produced by a lack of coordination of care. Efficient scheduling and communication between departments was expected by patients in order to coordinate their care:

I came from Guilford by ambulance and when I got there and I was put in the room, I guess it was a shift change or something because I didn't see anyone for about an hour. So it was kind of a period of weirdness that I didn't know what was going on.

A little better coordination on getting me admitted and situated in a room and all. The pre-operation was a little uncoordinated and confusing for everybody.

Continuity- Inpatient to Outpatient

Attention to continuity between inpatient and outpatient care has become increasingly important as fewer primary care physicians admit their own patients to the hospital, relying on housestaff and/or hospitalists to care for their patients during hospitalization. With this model of care, patients expected that there would be effective communication between inpatient and outpatient providers. Other patients expressed the desire for a higher level of continuity and would have preferred to be followed by their hospital treatment team:

It was a little confusing because I went in there diagnosed with asthma but ended up with heart problems. I wish it could've been followed through with the hospital instead of my own primary doctor.

Other patients expected that service needs would be appropriately communicated and coordinated after discharge. A failure to arrange these services left patients confused:

They always sent her home in the past with materials for wrapping her leg. The visiting nurse has already ordered more, but they were shocked that she hadn't gotten some when she left.

They said the VNA is supposed to come. The nurse hasn't come to see me and she hasn't called...My daughter and I have been waiting.

Implicit Expectation of Hospitalization:

5) I will have control over my environment so that it is conducive to rest and healing.

A total of 15.4% of surveyed patients suggested improvements that expressed dissatisfaction with the inability to control their physical environments, reflecting the implicit expectation for control over the environment so that it was conducive to rest and healing.

Failure of Expectation:

If I do not have control over my environment so that it is conducive to rest and healing, I feel confined and imposed upon.

When patients are unable to control their physical environment, it results in feelings of being confined or trapped in uncomfortable, and at times intimidating, situations. All patients do not desire identical physical surrounds, but there is a shared desire to have some degree of control over the environment. The inability to control noise levels, roommate behavior, temperature, smells, lighting, staff interruptions, food service, smoking and even humidity levels were all anxiety producing for different patients. The feeling of being imposed upon by an uncomfortable physical environment also extended to hospital facilities. Poor maintenance responses, inaccessible bathrooms, traffic and parking were also areas where the lack of control over the environment was expressed as an area for improvement.

Roommate Behavior

Suggestions that reflected the expectation for control over rooming arrangements accounted for 25.2% of suggestions related to environmental control. Suggestions for improving rooming arrangements varied. Some patients expressed the willingness to pay for a private room, or had the expectation for a private room based on what they (or their insurance) were paying:

You should've kept me in my private room. I was in a private room at first but then they said, "We're going to have to put you in another room because there's a contagious patient that needs this private room." I was very disturbed by that. You know, my insurance would've paid.

My roommate was very sick and making a lot of noises. For the money that my insurance is paying, I didn't feel I should've been in that room.

Other patients suggested that patients should be asked their preference for rooming arrangement prior to admission:

You need to ask patients if they want to be in a three patient room before they just throw you in there....They did find me another room but they should've asked me if I wanted to room with two other patients.

Others suggested that rooms should be assigned based on patient characteristics:

I was put in a room with a man who had many issues. He was loud and yelling all night. It was a very disturbing experience; hard for me to sleep. Maybe those patients should be in a separate area where they can get special care.

Next time they shouldn't put an older person with a younger person. My roommate was swearing; he was something else. You should put elderly people with other elderly people.

Other patients described troubling experiences with roommates, and the expectation that the hospital should have prevented them:

They put me in a room with a mentally retarded person so I didn't sleep because he was watching *Leave it to Beaver* at 2:00 a.m., and let me add that the TV was blasted. I just thought it was so unusual.

I had a bad roommate. She had diarrhea and splattered the walls with it and had noisy visitors.

You could've told my roommate to not try to clean his throat in the middle of the night with such enthusiasm.

Another theme that emerged from patient suggestions for control over rooming arrangements was the perceived lack of enforcement of hospital policies and rules regarding roommate and visitor conduct:

My roommate had her boyfriend in the bed with her to stay overnight. The nurses said he had to go, but he didn't leave. Finally the nurse told him again to leave and [the roommate] got upset and said, "Now you have the room to yourself," and left with him. The nurse called her back so [the roommate] got upset and started being loud and obnoxious to annoy me. I don't think I should have to share a room with a girl and her boyfriend.

I was in a triple room and one of my roommates had at least six visitors in the room at a time everyday including two infant twins. Someone really should have said something about that. It became very disturbing, and I even left a day early because of that.

Another explicitly described the type of policy that s/he recommended should be in place:

I think the hospital has some policy issues to work on. The roommates have no rules. My first time there my roommate had a bad hygiene problem. This time my roommate played heavy metal music really loud and was banging on doors all night long. I think they need to have certain rules for patients to follow when they room with another patient to be able to keep a boundary of respect for roommates, and if not they should be dismissed.

While some patients expected nursing and hospital policy to resolve rooming problems, other who expressed dissatisfaction with rooming situations felt the staff were not to blame, but still mentioned the situation in the context of a suggestion for improvement:

One roommate came in at 6am and she was horrible and so was her family. They were so loud and I couldn't get any sleep. It wasn't the staffs fault because they actually came to apologize to me. I know they couldn't do anything about it.

The guy next to me screamed all night and cussed them out, but that's not their fault, not their doing. They did the best they could.

Noise

Dissatisfaction with noise, exclusive of noise related to roommate problems, accounted for 15.9% of environmental control suggestions. The expectation that the hospital should be quiet, especially during the night, was repeatedly expressed:

The night shift could have been more considerate of people trying to rest. There was a lot of noise and bangs. I know people have to laugh and have fun but it could have been a little more quiet.

It's so minor and I only have one comment. The last room I stayed in was located at the end of hall where the maintenance was. They would always slam the door when they were working and it was hard to rest.

Interruptions

Interruptions by staff members also accounted for a significant fraction of environmental control-related suggestions. 9.9% of environmental control suggestions focused on decreasing in the number of staff interruptions:

It's hard enough to get sleep, but then those blood suckers come in the middle of the night.

It always seemed like they did the vitals right after you just fell asleep.

The intern, I don't know his name, but after finally falling asleep at 3:30am he comes in at 5:30am and knocks on the door very loudly and turns on the overhead light.

Some patients were more accepting of interruptions than others:

They woke me up 5 times a night but its ok.

Not wake me up at 2:15am, but I know there's a reason for it.

Another theme that emerged at this teaching hospital was frustration over multiple exams:

In the ER, too many doctors had to poke me for the same diagnosis. One doctor came, then another and another. Can't they go by what the doctor before did. If one more doctor would've come, I think I would've bashed him.

Temperature/Smells/Lighting/Chaos

The expectation for control over the physical environment also included temperature control. Patients had differing temperature comfort levels, but shared dissatisfaction with the inability to personally control the temperature:

The air conditioner was on the other side where the other patient was and she kept turning it off, so I was sweating bullets.

Control of the physical environment also extended to the areas of smell, lighting, and overall chaos in the hospital:

Nurses should be aware of patients' sensitivity to smells. One nurse's cologne was so strong it almost made me vomit.

I hated the room and the environment. The room was very dim and dull. Everyone's TV was on blaring at the same time. That was depressing. I didn't like the ER, it's a little chaotic.

Facilities

The expectation for environmental control, in order to create restful and healing surroundings, also extended well-functioning and accessible facilities:

My one picky thing is the toilet height. I'm almost 6'2", and normal toilet height is normal for normal people but not for cardiac patients. I think it would be better for people to complain about the seat being 3 inches higher than having to call for a nurse to come pull you up."

Make sure everything is working. I had no control over the control on my TV and it wouldn't come on... They came and fixed it 2 times, but it still didn't work. So they said they would have to call an electrician, and somebody said, "Oh, it's been that way forever." I thought, "Well, you know, fix it."

Just to fix that shower. It flooded everything and was very embarrassing.

Traffic/parking

Traffic and parking concerns also reflected dissatisfaction with the physical environment, and the lack of patient control and accessibility:

The parking is too expensive, especially for families who come in and out.

The parking at the front entrance is horrendous, especially when you need to get into a wheelchair.

Pain

Controlling pain in the hospital relies on a partnership between patients and the medical staff. When patients felt that they were not in control of their pain management, dissatisfaction result. Patients expected the ability to control their pain medically, and to have painful procedures minimized. A total of 17.8% of responses related to environmental control involved pain:

The meds, it wasn't enough. I was in more pain than usual and I needed higher doses than they were giving me.

Probably to manage my pain a little better.

The expectation for complete pain management was not universal, though:

I wish you could've made my pain go away but I know it's in God's hands.

Only if they could alleviate pain, but I think they did the best they could.

Painful procedures, especially when seen as resulting from improper technique, also cause dissatisfaction:

The new needles they use for IVs are really painful especially after you take them out.

I came through the E.R. and they put an IV in my arm but it wasn't put in properly. When I finally went up to my floor they had to redo the IV again. I'm so bruised and marked...It's been a week and I still have pain and bruises.

Implicit Expectation:

6) My food and amenities will be of high quality.

While the expectation for an environment conducive to rest and healing was shared by many patients, there was also the additional expectation shared by some that the service level and amenities of the hospital should be of high quality. Food and personal amenities, such as gowns, bedding and TV, were expected to meet patients' standards of comfort, choice and quality. Moving beyond the expectation of having peaceful surroundings, this expectation was to be in a well-appointed environment.

Failure of Expectations:

If my food and amenities are not of high quality, I feel disappointed.

When patients did not receive the service level that was expected, suggestions were given that reflected a feeling of being slighted or snubbed by substandard quality. A total of 6.9% off all surveyed patients suggested improvements to amenity. The expectation for high quality food was most often expressed. Comfortable bedding, improved gowns and TV channel selections were also suggestions for improvement.

Food

The expectation for high quality food was expressed through suggestions for food improvement. A total of 70.1% of amenity suggestions involved suggestions related to food quality, options or service. Many suggestions expressed a general disapproval with food quality. Complaints were often very specific:

I thought the soups were very salty.

The quality of the food is not good, it's served very messy and the plate is too small. The carrots were undercooked.

The food, the food, the food! My eggs were uncooked and very runny and soaked up my toast.

The expectation for great-tasting food was not universal, however:

The food was not fair, but I can't expect it to be like home.

While patients were able to individually order food from a menu, some cited even broader food options as an area for improvement. There was an implicit expectation for multiple food options:

To have more choices for when you eat, especially breakfast. Have something other than eggs.

The level of food service, including ease in ordering, timing of meals and receiving the correct order was also an area of contention:

You never get what you order from the kitchen. Your tray either has something missing from it or it's the wrong tray or not the right diet.
It's very frustrating and hard to get the orders the way you want.

Specific suggestions to improve the level of food service were also offered:

The whole world there is awake at about 5-6 am. Breakfast doesn't come to the floor until 9am. If it's going to come so late then at least have some coffee, juice or tea for the wait meanwhile.

Amenities

The expectation for amenities such as TV, beds and gowns were areas in which patients also expressed room for improvement. Television was often a source of suggestions:

Better TV selections, [and] if they had some nice movies on.

I would've enjoyed a paper that could've told me what the TV channels were.

Another more novel suggestion came from an ICU patient:

In that ICU they should put a TV on the ceiling for when you're lying flat on your back looking at the ceiling tiles for 4 days. They probably won't do that, though.

Improvements to beds and gowns were also suggested:

The beds are not comfortable at all.

Maybe get rid of those gowns and get some fancy night clothes. You feel a draft with those gowns.

DISCUSSION

We analyzed 439 patients' suggestions for improving hospital care and found that dissatisfaction resulted from negative experiences involving 6 domains: 1) ineptitude, 2) disrespect, 3) lengthy wait times, 4) ineffective communication, 5) lack of environmental control and 6) substandard amenities. Analyzing reports of dissatisfaction led us to appreciate that these domains represent a corresponding set of implicit patient expectations for hospitalization, including the expectations for: 1) safety, 2) treatment with respect and dignity, 3) minimized wait time, 4) effective communication, 5) control over physical surroundings and 6) high quality amenities.

In-depth analysis of suggestions for improvement, as gathered by telephone surveys of recently discharged patients, was a particularly well suited approach to eliciting what patients truly value during a hospitalization. It became clear that when allowed to express dissatisfaction in terms of suggestions for improvement, patients talked freely about specific dissatisfying experiences. Using telephone interviews allowed a large volume of patient responses to be included, unlike focus groups which tend to be limited in size. Our study was also oral and did not rely on the literacy level of patients, as do written surveys. Additionally, the open-ended nature of questioning prevented some of the usual pitfalls of satisfaction surveys. We did not rely on predetermined satisfaction categories or presume the inherent value of particular attributes of care. This large scale qualitative analysis of patients' suggestions for improvement in hospital care furthers our understanding of what patients actually expect from their hospital care, the domains leading to dissatisfaction and the alignment of these patient priorities to current health care quality improvement initiatives.

Ineptitude

“Well, he checked and he had the wrong guy. I'm glad I said something or else they probably would have hauled me off.”

Patients clearly expressed dissatisfaction when ineptitude was perceived in care and/or safety standards. The dimension of ineptitude corresponded to an expectation for safe and appropriate care while in the hospital. Patients expected an appropriate course of treatment free from errors or adverse events, they expected cleanliness in order to prevent the spread of infection and they expected to be cared for in the hospital until they felt safe to go home. A failure to meet any of these expectations led to dissatisfaction because of perceived ineptitude and caused patients to feel unsafe and to question the competency of their care.

To patients, dissatisfaction with ineptitude encompassed concerns over the safety as well as the efficacy of care. While quality of care dimensions as developed by the Institute of Medicine and the Joint Commission have made a distinction between care that is safe (i.e., free from error) and care that is effective (i.e., complying with best evidence-based practices), patients do not appear to conceptualize this dichotomy. To patients, care that is either unsafe or ineffective results in harm or threat of harm, and it is this harm which patients expect to avoid. In a study designed to test the Joint Commission's quality dimensions, focus groups used in the development of the KQCAH (Key Quality Characteristics Assessment or Hospitals) scale also failed to generate the concept of efficacy as a characteristic of health care quality. As a result, the Joint Commission dimensions of efficacy, safety and continuity were combined into a single dimension of “effectiveness and continuity,” with the explanation that patients were likely unable to “meaningfully assess whether the outcomes were consistent with

professional expectations for the condition”(31). Our research has also shown that patients do not make a firm distinction between the safety and the efficacy of care. In expressing their recommendations to improve hospitalization, stories of adverse events emerged, but patients did not comment directly on the efficacy of the care they received, except in the context of managing a chronic disease such as diabetes, which the patient had experience with. The perception of a lack of knowledge or skill largely concerned technical nursing skills such as IV placement rather than doubts about the efficacy of treatment.

While elaborate methods have been devised to assess and compare the technical quality and outcomes of care in hospitals, the current version of the HCAHPS survey, a publicly-reported assessment of patient satisfaction with hospitalization, fails to directly ask patients about their direct experiences with safety while in the hospital, or the perception of ineptitude. While some would argue that patients cannot accurately assess the technical quality of care, it has been shown that patients are able to recognize adverse events during hospitalization and that adverse events are often underreported (32). Research has also shown that dissatisfaction with hospitalization was most strongly predicted by the number of reported problems (33) and the perception of receiving incorrect treatment (13). Our qualitative analysis of patient concerns regarding safety, adverse events and the perception of ineptitude in the hospital supports the idea that dissatisfaction is closely tied to the perceived technical quality and safety of hospital care.

While patients expected the highest standard of care while in the hospital, they also expected the hospital to be clean and to be able to stay in the hospital until they felt safe to leave. While individuals have varying standards for the cleanliness and tidiness of

their physical environments, a lack of highest standard of cleanliness in the hospital was perceived as shocking and even scandalous to some patients. The concern for the spread of infection was explicit, and the standard of cleanliness in patients' rooms was viewed as a reflection for the standard of cleanliness throughout the clinical areas of the hospital including the operating room. This was one of many examples in which patients generalized their immediate experience to represent a greater danger. While healthcare workers may argue that dust in corners of rooms on the floor in no way reflects the standards for maintaining sterility in the operating room, patients have no means of knowing this and generalized their immediate experiences to the hospital as a whole.

Respect and Dignity

“I just feel like they treated me like an animal.”

Dissatisfaction with disrespectful, rude and unprofessional treatment resulted from the implicit patient expectation to be treated with respect and dignity during hospitalization. A poor work ethic, the lack of a warm or caring disposition, rudeness, and breaches in confidentiality were all complaints that led patients to feel disrespected and dissatisfied with this aspect of their hospitalization. While others have identified warmth, caring, courtesy, concern, regard and respect (Table 1) as dimensions of quality and patient-centered care, the ability for quantitative satisfaction surveys to capture the experience of disrespectful treatment is limited, especially during hospitalization. The brief length of stay and interactions with numerous care providers makes rating respectful treatment on a numeric scale challenging. The experience of feeling profoundly disrespected during a single encounter could be masked by an otherwise satisfying experience.

Disrespectful treatment in the hospital was not only insulting, but also represented a degree of dehumanization and an abuse of power due to the inherent hierarchy of control in the hospital, with patients in the most vulnerable position. Patients are confined to the hospital for the length of their admissions, and are unable to escape rude or unprofessional behavior once it becomes evident. Patients are also dependent on the care that they receive and may fear reporting or addressing their dissatisfaction. Disrespectful treatment is also dehumanizing in that it represents the tendency of medical professionals to focus on clinical disease rather than the individual experience of illness, which is one of the tenets the patient-centered medicine movement (34). While medical professionals live daily with sickness and injury, the experience of hospitalization is a life altering event for most patients. Unprofessional and rude behavior by those who have been entrusted with the responsibility to care and heal represents for patient a disregard for the magnitude of the situation.

Privacy and confidentiality also play a pivotal role in respectful care. While patients may feel too vulnerable to speak up when they feel their privacy is not being respected, a failure to meet this expectation still takes its toll. Patients who have a secret to tell do not come with it broadcast on their sleeves, and as seen with the patient who admitted to not being completely honest with the doctors because “everyone could hear,” the perils of not respecting patient confidentiality are substantial. A lack of physical privacy during exams also represents a failure to respect the social norms for modesty that medical professionals have often become numb to while in the hospital.

Better outcomes have been reported when patients are treated with respect. Patients who reported being treated with respect, defined as “involvement in decisions”

and “treatment with dignity,” not only report higher satisfaction, but also increased adherence to treatment regimens (35). Treatment with respect and dignity was also strongly associated with willingness to recommend a hospital to family and friends (36). And disrespectful treatment, specifically when perceived to be racially motivated, has been shown to correlate with the likelihood to not follow a doctor’s advice or to put off care (37).

Waits

“You call, you need something, they make you wait ten years.”

While the Institute of Medicine identified timeliness as one of the 6 quality dimensions for care, the timeliness of medical care within the hospital takes on a different dimension. In the hospital timeliness is intertwined with efficiency, and minute-to-minute waits take on more significance than timeliness on the scale of days in accessing outpatient care. Dissatisfaction with waits during hospitalization reflected the expectation that wait times would be minimized and that the hospital would operate efficiently. The reduction of wait times has been under-emphasized in quality improvement initiatives, but has the potential to decrease dissatisfaction and anxiety during hospitalization.

With the uncertainty surrounding health and outcomes during hospitalization, having to wait for answers, for help or even for transport within the hospital heightens the anxiety of the unknown. While medical professionals are increasingly hurried and overburdened with the volume of clinical and administrative duties, the patient’s experience of hospitalization is often defined instead by inactivity, with long and lonely waits for staff attention. With increasing medical technology and treatments over the past century, care of the ill has moved away from a model of home care, primarily by family members and a visiting physician, to a hospital model, with care given by strangers in an

unfamiliar environment (38). While patients largely accept this model and trust in the advances of medical technology that require monitoring by trained professionals, they also expect that care in the hospital will be responsive to their needs. Waiting during hospitalization breaks this trust.

The importance of wait times in relation to expectations was particularly evident. It has been shown that patients with wait times that were “shorter than expected” in the emergency department were more satisfied than patients whose wait were “as expected” or “longer than expected,” but that actual wait time was not correlated to satisfaction level (39). Patients and physicians have also been shown to differ in the subjective experience of times and what constituted “fast,” “slow,” and “soon” (40). Some patients did seem to rationalize or forgive waiting, however, suggesting that the expectation for waits to be minimized is a fluid expectation and that each patient has a varying degree of wait time that is deemed acceptable. When waits were experienced and there was the perception that the staff was not otherwise busy or working hard, however, waits began to be perceived as disrespectful.

Waits for personal and medical assistance from doctors and nurses was particularly troubling to patients. In this context, the anxiety of waiting led patients to feel abandoned. Often physically incapacitated, patients rely on the medical staff to attend to all of their medical as well as everyday care needs. The range of needs is wide. Patients, often to their own frustration, must rely on others to receive food, medications and countless other personal care objects, like pillows, blankets and clothing and help with personal hygiene and toileting from the medical staff. They must ask for things that were previously taken for granted when not confined to a bed.

Lack of timely response to call bells was particularly frustrating. As chronicled by ethnographic research, the “dance of the call bells” proves to be a source of dissatisfaction for both patients and nursing staff, and brings to light issues of power and control between providers and patients (41). Patients also frequently commented on a perceived staff shortage, often absolving their personal nurses from blame, but identifying that higher staffing levels could potentially fix the problem. At other times, the attentiveness of the medical staff was interpreted as the failing of the individual staff members, including PCAs, nurses and doctors, who did not perform their jobs to the standard that was expected. In both cases, when call bells were not answered in a timely fashion for small needs, patients began to worry that this singular life-line would not bring someone to them promptly if they really needed help. This worst fear did come to fruition for some, causing emotional as well as physical damage when having to wait for bed pans, blood sugar checks and access to physicians. That patients assign broad meaning to experiences which healthcare workers may view as insignificant again illustrates the importance of eliciting specific patient expectations so as to better provide patient-centered care.

Communication

“One doctor said I could go home and another doctor said, ‘No, you need to stay.’”

The expectation for effective communication encompassed several previously-defined domains of quality. Grouping provider–patient communication, provider-provider communication, continuity and coordination of care together represented the common dissatisfaction that patients expressed with poor communication resulting in

confusion about their care. Similarly, focusing on ineffective communication across all of these areas more accurately reflects individual providers' communication skills, thus encouraging professional development and promoting personal accountability. While treatment with respect and dignity is often included in the domain of communication, patients conceptualized these concepts separately.

Optimal provider-patient communication has been described as a "balanced exchange of information, ideas, and preferences between the [provider] and patient, with each playing a complementary role during the interaction" (42). Dissatisfaction with provider-patient communication in the hospital primarily involved the failure to transfer information to the patient, or the patient feeling left out of care decisions. In the outpatient setting, patients are flooded with medical information from the television, print media and the internet and many have come to expect active involvement in their medical care. In hospital, however, there is typically an absence of information available to patients, where clinical status and care plans change frequently, and the patient is often the last to know. Once hospitalized, the focus of communication shifts towards the timely and effective transmission of information to patients, rather than gathering information from them. Effective communication also involves making sure patients agree with the plan of care through actively listening, explaining choices and accepting patient preferences when possible.

The influence of effective doctor-patient communication on patient satisfaction and outcome measures has been widely studied and reviewed in the outpatient setting, but less thoroughly studied in the setting of the hospital. Doctors' information giving, expressed affect, non-verbal behavior, medical language use, questioning style and

controlling behavior have been linked to patient satisfaction and outcomes such as compliance/adherence to treatment, recall and understanding of information and health status (43, 44) . Interventions involving specific teaching to improve communication techniques improve specific communication behaviors such as asking open-ended questions, expressing concern and empathy, providing information, and involving patients in decisions (42) . In the hospital setting, patient satisfaction has also been positively associated with specific physician behaviors such as encouraging questions, not interrupting, and discussing of options (45), while communication between doctors or nurses and patients more generally has also been associated with satisfaction level (15, 28, 29). When allowed to freely identify suggestions for improvement, we found that patients focused on information sharing as the most important aspect of provider-patient communication in the hospital.

Ineffective communication among providers and departments within the hospital also caused dissatisfaction for patients. When communication did not flow between providers, patients were left confused about the plan of care and dissatisfied with the need to repeat information multiple times. Communication problems between providers within hospitals has been chronicled as causing difficulties for nurses and physicians, as well as leading to adverse events or near misses (46-48), and its influence on patient satisfaction has not been widely assessed. The increasing use of hospitalist services has also added an additional level of crucial communication between inpatient and outpatient providers. The extent of dissatisfaction with continuity after discharge could not be adequately addressed in our study, since patients were called soon after discharge.

Environmental Control

“It's hard enough to get sleep, but then those blood suckers come in the middle of the night”

The loss of control over fundamental aspects of patients' lives, such as living environment, food, sleep, hygiene, and pain, led to dissatisfaction with the hospital experience. While satisfaction in the hospital has been linked to physical comfort, environment and pain, our qualitative analysis more accurately defines dissatisfaction in these areas from the patients' perspective. Patients' environmental and comfort concerns were found to stem from the expectation that patients' would have some degree of control over their physical environments. Lack of autonomy and the inability to control noise levels, rooming environment, food, sleep, personal hygiene and pain were the causes of dissatisfaction related to physical comfort and the environment.

When patients enter the hospital, they place trust in health care providers that they will be cared for and kept safe. Along with relinquishing the ability to control their physical health, patients have little control over their physical environments. Patients are also placed in the peculiar situation of living in very close proximity to people whom they have likely never met. In an era when a premium is placed on individuality, with widespread customization of consumer goods and experiences, the expectation that hospitals should also offer a personalized environment is quite strong. Patients share the desire to have some degree of control over the environment.

Difficulty with roommates was a frequent cause for dissatisfaction. On one level, the preference for a single room reflected patients' desire for privacy at a time of physical vulnerability, but also reflected the need for increased control over their immediate surroundings. In a review of the literature, single-occupancy hospital rooms were shown

to have lower nosocomial infection and patient stress rates, as well as increased privacy, opportunity to rest and involvement of family and friends. Additionally, upfront costs were found to be balanced by higher occupancy rates, reduced transfer costs (especially in acuity-adaptable rooms, as described later), shorter length of stay and fewer costly medication errors (49). Single rooms have also been shown to improve doctor-patient communication (50).

Noise and interruptions by staff members were also frequently cited frustrations related to a lack of autonomy while in the hospital. While noisy or inconsiderate roommates were often viewed to be out of the hospital's control, noisy staff or maintenance in the halls was not considered acceptable. Noise levels in the hospital have been shown to induce stress and negatively impact sleep (51, 52). Interruptions of sleep in order to draw blood or take vitals were also particularly bothersome. While in the hospital, patients expected to be able to rest and heal, which was hampered by being awoken at night and in the early morning in order to accommodate the schedules of the hospital medical staff. While some understood this practice, others felt that patients' sleep time should be respected.

Being subjected to painful procedures, as well as inadequate pain management during hospitalization also reflected the theme of a loss of control during hospitalization. Without direct access to medications, patients relinquish control of their pain to the medical staff, and rely on them to accurately assess and effectively treat their subjective experience. When pain was not successfully managed, or patients experienced pain during procedures like IVs and blood draws, the loss of autonomy in the hospital was acutely felt.

Amenities

“The food was absolutely atrocious and cold.”

Amenity levels during hospitalization, including food quality and choice, bedding, television and gowns were expected by some to be of a higher quality. While improved food and television options were often cited as areas that could be improved, patients did not express negative emotional consequences when this expectation was not fulfilled

Increased amenity levels, above that which patients traditionally expect from hospitals, however, has been shown to lead to increased satisfaction. Similarly, in competitive hospital markets, amenity levels have been shown to influence hospital selection to a great extent than mortality statistics (53). Rising levels of hospital amenities, however, lead to rising expectations, with unclear implications on satisfaction or dissatisfaction. Increased hospital amenities are often coupled with other structural and staffing improvements (54), making the influence of amenities difficult to separate from increased environmental control, better communication and reduced wait times.

Suggestions for Improvement**Reporting**

Improving the safety and efficacy of hospital care, and benchmarking the achievement of care standards for the treatment of common conditions has received broad attention in recent years. While patients have traditionally not had the tools to evaluate the standard of the medical care that they received, the internet has allowed them to expect certain specific care standards. Patients can now compare statistics about specific hospital compliance to certain treatment measures, for example receiving antibiotics

within the first 6 hours of arrival to the hospital for pneumonia, or a beta-blocker at discharge for an acute MI, as well as risk-adjusted mortality rates (55). With this increased knowledge, hospitals must theoretically improve compliance in order to draw patients and to reduce adverse events related to mismanagement of conditions.

The meaningfulness of outcomes-reporting to patients when selecting between hospitals or conceptualizing hospital quality, has been called into question (53). Asking patients directly and reporting on experiences when patients felt unsafe in the hospital, conversely, could prove more meaningful to other patients when attempting to judge hospital quality. Knowing that each patient could evaluate the safety of their care would also increase the accountability of individual hospital staff members.

Hospital Design & Policies

Targeting hospital design is another approach to improving the quality of hospital care. Improving hospital design by locating elevators and departments to facilitate transport and decrease wait times should be a priority for new hospital development. Utilizing electronic systems for coordinating activities and communicating within the hospital, and less emphasis on phone communication, could also speed the process of admission, obtaining studies, medication administration and discharge. Improved efficiency of the call bell system might entail distinguishing between emergent and routine care needs, and perhaps utilizing non-medically trained staff or volunteers to address certain needs.

Simple steps could be implemented to improve patient autonomy and the ability to control the physical environment. Short of giving all patients single rooms, individual

patient areas could allow for greater control. Thicker partitions and individual heating/cooling vents could improve noise, temperature and personality differences between roommates. A visible commitment to a quiet hospital environment by staff would also encourage visitors to respect these rules. Interruptions and disturbance of patient sleep time could be minimized by having protected patient sleep time during the night, outside of emergencies, in which routine vitals, blood work and exams would not be done. Having a specific policy related to interruptions would help patients know what to expect in this area.

Acuity-adaptable private hospital rooms have come to the forefront of innovative hospital design. The goal of the acuity adaptable room has been to maintain patients in the same private hospital room during an entire admission, regardless of changes to level of acuity. The required level of care is brought to patients, thus eliminating multiple transfers, and eliminating bottlenecks and delays due to the unavailability of beds with the correct level of care. In this model, critical care nursing would be combined with medical-surgical nursing teams in order to reduce hand-offs and provide smoother care transitions (56).

The Planetree model hospital unit has improved patient-oriented care in the hospital. First introduced in 1985 at the California Pacific Medical Center outside of San Francisco, the model is now in place at over 60 hospitals around the country. In keeping with our research, a part of Planetree's mission states that "physical environments can enhance healing, health and wellbeing." Patient-centered innovations include a hospital environment that is "home-like, comfortable, and soothing;" using primary nurses and health educators trained in providing personalized care; education and promoting patient

involvement. While in the hospital, patients are trained to be actively involved in self-care, and family and friends to encouraged to be involved in the care process (57).

Patients in a Planetree unit showed higher satisfaction with the stay and patient education than patients in a non-Planetree unit within the same hospital (54).

Personnel

Improving patient satisfaction should also focus on hospitals' medical and support personnel. Increased staffing levels could help to alleviate some of the waits associated with call bells and transfers, but must be coupled with better systems to manage responsibilities and flow of patients.

In order to ensure respectful treatment for patients, medical staff should be held to the highest standard of professionalism. While some elements of bedside manner are not easily taught, outright rudeness should never be tolerated. This commitment must come from the top down. In order to produce an environment in which patients are treated well, staff must be treated well. Hospitals must explicitly make a commitment to the highest standards of patient treatment, and create an environment in which medical staff at all levels are encouraged to participate and buy into this commitment.

In our study, patients were often more dissatisfied with the way complaints were handled than with the initial complaint. Training in how to appropriately address and anticipate patient dissatisfaction could prevent further insult. A renewed commitment to hospital cleanliness by all levels of staff, with incentives or contests, as well as better communication and patient involvement in determining when patients feel safe to go home, could also bolster patient confidence in the safety of their care.

Effective communication in the hospital involves a different set of skills than communication in an outpatient setting. Decisions often have to be made on a minute-by-minute basis, and the patient is often bewildered and overwhelmed. Physicians are often overwhelmed by administrative coordination and the acute management of unstable patients, often leaving little time for direct patient contact. Nursing staff are similarly barraged with care responsibilities. One model to improve communication with patients as well as the coordination of care could be to employ staff members who are solely responsible for coordinating these activities. Dedicating resources in this way, and having someone specifically trained and available to coordinate care between departments, at the time of discharge and to answer patient concerns, could also help to free other providers. Training in effective communication skills could also improve communication with patients and between departments.

Assessment

The assessment of patient satisfaction can be improved. Our research shows that allowing patients to give suggestions for improvement provides for candid descriptions of dissatisfying aspects of the hospital experience, and reveals inherent expectations. Surveys aimed at eliciting experiences of dissatisfaction in the domains of 1) perceived ineptitude, 2) disrespectful treatment, 3) lengthy wait times, 4) ineffective communication, 5) lack of environmental control and 6) substandard amenities, with space to describe specific events, may prove useful in understanding trends within and between hospitals, and identifying specific areas for improvement.

Conclusion

All hospitalized patients bring expectations for their hospital experience. While specific expectations vary between patients, expectations for: 1) safety, 2) treatment with respect and dignity, 3) minimized wait time, 4) effective communication, 5) environmental control 6) high quality amenities were found to encompass the core expectations for hospitalization. Attention to these expectations, and understanding the dissatisfaction that results from a failure to meet expectations, should improve the delivery and quality of hospital care.

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