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<th>Methods of surveying patients' satisfaction. Patients' satisfaction is based firmly on their expectations.</th>
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that passive immunisation within 96 hours of exposure has not been shown to prevent intrauterine transmission or to alleviate fetal infection. In a large prospective study of chickenpox in pregnancy, however, no cases of congenital varicella syndrome or chickenpox in infancy occurred among the 97 pregnancies in which maternal chickenpox occurred after post-exposure prophylaxis with varicella zoster immunoglobulin. Specific IgM antibody was found in one (1%) of 89 expectant mothers who were tested, compared with 76 (12%) of 615 samples from asymptomatic infants whose mothers did not receive prophylaxis (P = 0.005, χ² test with Yates's correction).

On the basis of this evidence, pregnant women who are exposed to varicella zoster virus should be encouraged to seek medical advice. Their immune status should then be ascertained and varicella zoster immunoglobulin given to those found not to be immune to the virus; this will attenuate the attack rate of maternal chickenpox and, for women in the first 20 weeks of pregnancy, decrease the risk of fetal infection.

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Methods of surveying patients' satisfaction

Patients should help decide the wording and design of questionnaires

Editor—Geoff Cohen and colleagues report their study of the consistency of methods of surveying patients' satisfaction that are used in the evaluation of services. The authors suggest that choice of wording was one possible reason for the underestimation of dissatisfaction with certain elements of the service. They suggest cross validation of satisfaction surveys as a method of improving the reliability of results.

We recommend that patients should help decide on the wording and design of the questionnaire itself. In a recent survey of patients' satisfaction in this hospital, after consultation with our patient advisory council, the proposed questionnaire was modified to make it more easily understandable. It is also important that patients, and not the research staff or those who provide services, should determine the dimensions used to assess quality of services.

One page questionnaires were circulated to the patient advisory council and a small cohort of patients on the wards; the recipients were asked to list the most important issues for them in the maternity service and their requirements for a good service. Feedback from this initial research allowed the final questionnaire circulated in the hospital to give priority to dimensions of the quality of the service determined by patients. In a similar fashion a focus group of staff and a small cohort of partners of patients at the hospital were consulted. The final questionnaires circulated to patients, partners, and staff were similar, although some minor modifications were necessary. Comparing dimensions defined by patients and patients' satisfaction scores with dimensions defined by staff and families and with staff and families' satisfaction scores may be useful for evaluating the quality of services and improvement.

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Patient satisfaction is based firmly on their expectations

Evans—Geoff Cohen and colleagues suggest that statements in surveys on patients' satisfaction yield different results if they are worded positively rather than negatively. This is entirely feasible. One way to avoid the distinctions between positive and negative statements and all the biases that these might pose, however, is to present them as a statement of the type: "The amount of information the doctor gave me was ..." The patient then selects one of a range of responses, such as "Very satisfactory" or "Very unsatisfactory." We have used this method to develop an instrument for measuring patients' satisfaction with specialist outpatient departments among Cantonese-speaking Chinese patients in Hong Kong. Using a bottom up approach of first identifying from patients their areas of concern and then carrying out factor and regression analyses, we derived a 20-item instrument and a shorter, nine-item version. We found that the domains identified as being most influential in overall satisfaction were the quality of relationship and communications, firstly with doctors and secondly with nurses. Key items in these domains address how the doctor gives information, the doctor's manner and the respect that he or she shows, the doctor's involvement, and the doctor's overall attitude. This finding concurs well with those of studies in Britain as far back as the 1970s in which communication and relationship domains were reported as most important. The fact that these same domains are found in an Asian culture with the use of a method known to minimise cultural bias emphasizes the universal role that good communications and a caring relationship have in achieving patient satisfaction. We also found that the demographic composition of the samples used to test the instrument had a disproportionate effect on the satisfaction reported; we needed to calculate a scaled score to take into account several factors, including first or subsequent visit, age, sex, type of specialist outpatient department clinic, and even time of visit.

One clear conclusion that emerges from this is that satisfaction is based firmly on expectations and that expectations differ. Hence the differences that Cohen and colleagues found according to whether positive or negative wording was used in the surveys may reflect different impacts of the two question forms on expectations.

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2 Evans M. Psychological studies of doctor-patient communication. In: Rachman S, ed. Contributions in medical psychol.


Deprivation payments to general practitioners

Scores are calculated relative to national average

Editor—I agree with F Azeem Majeed and colleagues that a shift to a system of payments based on enumeration districts targets deprivation payments more sensitively and, from the point of view of improving general practitioners' total practice payments. Changing the area unit on which the score is calculated (that is, enumeration district versus ward) does not, however, address the important underlying issue of change in social composition over time and its impact on general practitioners' workload and deprivation payments.

A fundamental reason for change in the underprivileged area score for a ward stems from the method of calculation, whereby the score is relative to the national average. Thus for a particular ward, even if the socio-demographic profile of its residents and its physical boundaries remain exactly the same from one census to the next, whether it qualifies for payment will depend on the position of that ward with respect to all other wards in Britain. Since the score is not linked to a baseline level of entitlement (such as the 1981 national means of the eight factors in the score), a practice that qualified for additional payments for its patients living in a deprived ward in 1981 might cease to qualify in 1991 not because the ward has, say, fewer lone parents or unemployed people but because a rise in the national percentages of these factors means...