

EDITORIAL

The anesthesiologist and the dissatisfied patient



Satisfaction is a sensitive measurement of a well-functioning service, and applicable to anesthesia. Dealing with dissatisfaction is a difficult task, but we must thank patients who, with their comments, somehow, contribute to improving our activity. After all, any complaint is a feedback. And in a competitive world, there is great value in always offering the best experiences.¹

Not perfection, but solving the problem when something goes wrong is what is expected. In fact, in an observational study, 35% of patients reported discomfort and complications related to postoperative side effects, such as thirst, pain, and drowsiness. However, only 5% of patients reported dissatisfaction with any aspect related to care provided by an anesthetist.² This could indicate that patient dissatisfaction is not directly associated with complications.³

In this issue of BJAN, Okuda et al assessed dissatisfaction with anesthetic care of patients submitted to general anesthesia in a Japanese hospital.⁴ They performed a retrospective study investigating the dissatisfaction rate for anesthesia and its contributing factors by using a questionnaire that included anesthesia-associated adverse events and a simplified patient satisfaction scale. Of the 9,429 patients analyzed, 549 assessed the anesthetic care as unsatisfactory (5.82%). The multivariate analysis identified the presence of a preoperative coexisting condition (OR, 1.29; 95%CI, 1.05–1.59), combination of regional anesthesia (OR, 1.44; 95%CI, 1.10–1.88), self-reported awareness (OR, 1.99; 95%CI, 1.29–3.06), postoperative nausea and vomiting (PONV) (OR, 1.54; 95%CI, 1.25–1.90), occurrence of nightmares (OR, 1.96; 95%CI, 1.52–2.53), and number of days required for the postanesthetic visit to be performed by the anesthetist (OR, 1.01; 95%CI, 1.00–1.02) as independent factors associated with dissatisfaction of the anesthesia service.

Even if the study was well conducted, it must be read within its limitations, and the major one is the retrospective design with data extracted from anesthesia records.

The records had incomplete information on each case, and consequently, many other non-registered variables may have affected patient satisfaction. Even if the exact reasons for the factors that contributed to dissatisfaction are unknown, the study suggests that there is room for improving our specialty.⁴

In our daily practice, we rarely find dissatisfied patients without active surveillance for extracting data on satisfaction. Although there is a growing number of publications addressing the issue, most of it is retrospective, uses non-validated inhouse questionnaires or data stored in databases, or face to face postoperative interviews with the investigator.⁵ This caveat must be highlighted, given that retrospective studies and interviews can contain confounding factors and biases in answers, because patients tend to show more satisfaction when seeking healthcare.⁶

Many factors contribute to patient satisfaction, including accessibility and convenience of services, which depend on institutional structures, interpersonal relations, competence of healthcare professionals, patient expectations and preferences, emotional status, severity of disease, previous experience with anesthesia, professionalism, cleanliness and quality of hospital facilities, waiting time, medical costs, and how easy it is to put in a complaint.^{7,8}

Determining surrogate results for anesthesia care-associated patient satisfaction is challenging, and not always appropriate. For example, could more empathy in postoperative care influence patient satisfaction more than the reduction in symptoms related to anesthesia complications.³ A study observed that the time spent in communicating with doctors, carefulness during clinical investigation, and the knowledge of physicians when providing an explanation on diseases were associated with outpatient satisfaction.⁹ Moreover, especially for elderly outpatients, a physician-patient relationship of trust, and assertive communication would be among the major factors associated with general satisfaction.^{10,11}

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By looking at the results of Okuda et al.,⁴ it seems reasonable to accept that PONV could be associated with dissatisfaction, given the observation that patients classify nausea and vomiting as an undesirable surgical result.¹²

Patients with memory of tracheal extubation have shown more dissatisfaction with the anesthesia received. This also seems logical, and that the variable should deserve attention in future studies.¹³ The satisfaction of patients has grown significantly with the introduction of one postoperative visit versus none.¹⁴ In a fast-tracking society, delay in time to post-procedure visits could be a reason for dissatisfaction.

But how can we explain the high rates of self-reported intraoperative awareness and postoperative nightmares based on a questionnaire? The results of this study provide important information on the understanding of the levels of patient dissatisfaction, but well-designed prospective studies are needed to define the incidence of intraoperative awareness and nightmares, and the impact on patient well-being and satisfaction.

When we analyze studies published, we can better understand how challenging surveying surgical patient satisfaction is. A systematic review studied the level of satisfaction of outpatient surgery patients and its influencing factors at tertiary Chinese hospitals. The domains studied more frequently included patient demographics, professional skills and attitudes of the medical and administrative teams, hospital cleanliness and aspects of the outpatient process. The analysis showed that satisfaction is associated with socio-demographic factors (age, sex, marital status, levels of income and schooling), professional skills, attitudes of the service and medical team, and waiting time. Patients generally are more satisfied with professional skills and attitudes of doctors and nurses, but less satisfied with hospital management and environmental aspects.⁵

In Ethiopia, a systematic review with meta-analysis studied satisfaction of pregnant women during the perinatal period and showed that women with informal education are 2.19 times more likely to be satisfied with existing perinatal care than women with formal education (Adjusted Odds Ratio (AOR) = 2.19; 95%CI, 1.47–3.25); that women seen by a health professional in 20 minutes were 2.97 times more likely to be satisfied with perinatal care than their counterparts (AOR = 2.97; 95%CI, 2.11–4.19); that women whose privacy was respected were 2.84 times more likely to be satisfied with care when compared to women whose privacy was not respected (AOR = 2.84; 95%CI, 1.46–5.55). The likelihood of satisfaction among women with existing perinatal services was 2.55 times higher among women in whom labor lasted less than 12 hours when compared to women whose labor was longer (AOR = 2.55; 95%CI, 1.70–3.81). This could be because being treated with dignity, respect, kindness, accessibility, and courtesy is an essential interpersonal behavior that increases satisfaction. Being able to respect privacy was an important factor associated with satisfaction with existing delivery services.¹⁵

An Australian study assessed patient satisfaction and other pre-determined outcomes, such as nausea, vomiting, pain and complication. The general level of satisfaction with anesthesia care was high (96.8%), 2.3% of patients were slightly dissatisfied, and 0.9% were dissatisfied.¹⁶

A Japanese study found 3.9% of dissatisfaction with anesthesia. Dissatisfaction rates were higher among women than among men, and for spinal in comparison to general anesthesia, and mainly for patients between 20 and 39 years of age.¹⁷

A Greek study showed that general patient satisfaction with the anesthesia service was high, in the range of 96.3–98.6%.¹⁸

A study performed in Brazil with patients submitted to orthopedic surgery showed that male gender, nausea, vomiting, pain during hospital stay in the ward, and deeper levels of sedation were possible predictive factors of lower scores for quality of recovery.¹⁹

To summarize, there is inconsistency regarding patient satisfaction studies, which can be explained by differences in institutional structures, interpersonal relations, competence of healthcare professionals, culture, education and economic status of different countries, patient expectations, and preferences and dissimilarities in tools used to collect data.

Conflicts of interest

The author declares no conflicts of interest.

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