

Does age, gender or educational background effect patient satisfaction with short stay surgery?

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Abstract

Patient satisfaction is an area of special interest to health care workers. The aim was to investigate if a patient's age, gender or educational background effected their satisfaction with short stay surgery. The results showed that the 275 patients were quite satisfied with the care. The findings did not indicate a correlation between age or gender and patient satisfaction. There is however some agreement implying that patients with a higher educational level have a different view of the care given than patients with lower educational background. A standardization of design and questionnaire is necessary to be able to correlate patient satisfaction related patient characteristics. © 2000 Elsevier Science B.V. All rights reserved.

Keywords: Satisfaction; Short-stay surgery; Age; Gender; Educational background

1. Introduction

Patient satisfaction has been an area of special interest to health care workers at different levels for many years [1–5]. Globally, researchers have studied patient satisfaction both in general as well as specifically in surgical care [6–18]. During the last 15 years several review articles have been published, in which the authors have attempted to achieve consensus concerning a definition for patient satisfaction, thus far without success [1–5,8,19–23].

For the measurement of patient satisfaction several different methods have been suggested [3,5,19,23,24]. In Sweden, patient satisfaction studies have been based upon different questionnaires and interviews [9–13,18]. Regardless of which method is used, the researcher must be clear about what is to be investigated, and must be aware of the chosen method's particular weakness [4,23].

Patient satisfaction is a term that can be interpreted differently by patients. Its meaning can also differ for one patient at different times [4,17]. Various studies have presented diverging results concerning possible relationships between patient characteristics and patient

satisfaction with care and treatment [3,7,8,25]. Younger patients have been reported to be less satisfied with given care compared to older patients [7,18].

Research has shown certain important areas considered to be significant for patient satisfaction [2,3,11,14,16]. In a review study by Hall and Dornan humanness, competence, outcome, facilities, continuity of care, access, information, cost, bureaucracy, and attention to psycho-social problems were suggested to be of importance for patient satisfaction [2]. A review by Cleary and McNeil found good communication skills, empathy and caring to be the strongest predictors of how a patient evaluated the care received [3]. Bostrom et al. found a correlation between patient satisfaction and nursing staff continuity, particularly in young and acute patients [14]. Björkman et al. report staff empathetic qualities i.e. being interested, understanding, listening, and respectful to be of importance for patient satisfaction [11].

With the increasing demands from politicians and management, health care workers have attempted to make health care more cost efficient without a reduction of quality [4,19]. Health care workers can no longer disregard the financial aspects of their organization [19]. Patient care can become more effective by employing new strategies [26]. One method to increase

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efficiency and decrease cost is to shorten the duration of hospitalization [27]. In order to reduce cost, our surgical department changed certain routines. Patients with multiple diseases and who were in need of minor surgery or diagnostic treatment were selected to be treated in a special short stay surgery unit (*idem*). Short stay surgery is here defined as minor surgery with a post-operative inpatient time between 12 h and 4 days.

After 4 years of successfully developing and confirming the organization and the philosophy of care, the staff requested an investigation into patient satisfaction. Questions were also raised as to the importance of age, gender and educational background in relation to patients' satisfaction with care. These patient characteristics were chosen because the nurses experience was that younger patients and patients with higher education did not want to spend as much time on the unit as older and less educated patients.

The aim of this study was to investigate if patients' age, gender or educational background effected their satisfaction with short-stay surgery. In particular patient characteristics were related to perceptions of doctor and nurse continuity, information requirements, interpersonal care, emotional support, pain treatment, and need for assistance after discharge.

2. Method and patients

The study was prospective and the nurses of the unit asked all patients, who could read and understand Swedish, if they wished to be included. In connection

with discharge the patients received a questionnaire together with a stamped addressed envelope with which to return their responses. All patients were informed that the questionnaire would be handled anonymously. The patients' identities were not available to the authors, as the questionnaires were sent to a secretary at the department who removed identifying data. A reminder was sent out to patients who did not respond.

The questionnaire was distributed to 340 patients. Two hundred and twenty four patients answered directly and after reminders a total of 275 responses were received. This corresponds to a response rate of 66% and 81% with the reminder. Of those who took part in the study, 141 patients were females (mean age 54, range 24–88 years) and 134 were males (mean age 57, range 26–87 years). The demographic profile of the respondents can be seen in Table 1. The most common procedures were angiography, cholecystectomy (mean postop stay 1,3) and hernia operation (mean postop stay 1,1) (Table 1). The patients were divided into two age groups, one younger (24–65 years) and one older (≥ 66 years) according to the Swedish age of retirement. The younger age group was almost twice as large as the older age group (Table 1). Eight female and four male patients did not divulge their age.

The material has been divided according to the three levels of education in Sweden. Compulsory education involving nine years of schooling resulting in a basic level of education, upper secondary school, a further 3–4 years of education and university. University studies imply anything from one year of further education up to a completed degree. Of the patients studied, 142

Table 1
Diagnoses, gender, and mean age of patients participating in the study

Operation/examination	Number of patients <i>n</i> = 275	Gender		Mean age (years)	
		Female <i>n</i> = 141	Male <i>n</i> = 134	Female <i>n</i> = 133	Male <i>n</i> = 130
Hernia repair	74	10	64	69 ^a	60 ^a
Cholesystectomi, open	47	37	10	55	58
Angiography	33	21	12	58 ^c	63
Cholesystecomi, laporoscopic	29	16	13	41 ^b	56
Other operation	21	12		49 ^a	48 ^a
Vertical banded gastroplasty (VGB)	14	9	5	43	42
Endoscopic retrograde cholangiopancreatography (ERCP)	12	9	3	48 ^a	35 ^a
Other examination/do not know	9	3	4	72	64
Varicose veins	7	7	0	66	0
Hemorrhoids	7	2	5	65	59
Abdominal wall plastic surgery	7	5	2	32	71
Ärrbräck	6	3	3	56	39 ^a
Navel hernia	5	1	4	70	58
Breast reduction	4	4	0	65	0

^a One patient, age not given.

^b Two patients, age not given.

^c Three patients, age not given.

Table 2
Percentage of patients answering 'yes' to questions related to doctors and nurses continuity in short-stay surgical care

Questions to the patients (in short)	Age, <i>N</i> = 263 ^a		Gender, <i>N</i> = 275		Educational background, <i>N</i> = 273 ^a		
	24–65 years	66+ years	Female	Male	Compulsory education	Upper secondary education	University education
	<i>n</i> = 168 (%)	<i>n</i> = 95 (%)	<i>n</i> = 141 (%)	<i>n</i> = 134 (%)	<i>n</i> = 142 (%)	<i>n</i> = 70 (%)	<i>n</i> = 61 (%)
Importance of meeting the same doctor on each hospital visit	79	69	80	69	76	79	69
Knew doctor's name	92	76	84	87	85	87	87
Importance of meeting the same nurse on each hospital visit	51	52	56	46	54	54	39
Knew nurse's name	85	78	81	84	87	86	72

^a In total 275 patients answered, but 12 gave no age and two patients gave no educational background.

Table 3
Percentage of patients answering 'yes' to questions related to patients need for information in short-stay surgical care

	Age, <i>N</i> = 263 ^a		Gender, <i>N</i> = 275		Educational background, <i>N</i> = 273 ^a		
	24–65 years <i>n</i> = 168 (%)	66+ years <i>n</i> = 95 (%)	Female <i>n</i> = 141 (%)	Male <i>n</i> = 134 (%)	Compulsory education <i>n</i> = 142 (%)	Upper secondary education <i>n</i> = 70 (%)	University education <i>n</i> = 61 (%)
Questions to the patients in short							
Satisfied with information given prior to admittance	87	91	86	90	91	87	89
Staff explained functioning of unit	83	85	87	82	90	80	82
Patient knew whom to ask questions	85	79	79	87	81	81	90
Written information important	79	83	83	76	78	77	87

^a In total 275 patients answered, but 12 gave no age and two patients gave no educational background.

patients had completed compulsory education (mean age 62, range 27–88 years), as shown in Tables 2–4. Of the remainder, 70 patients had completed upper secondary school (mean age 52, range 24–83 years) and 61 patients had continued to university (mean age 48, range 26–86 years).

Of the 65 patients from whom responses were not received, three patients had died (two females and one male). One male claimed to have already responded, although the questionnaire could not be located, one female patient did not wish to respond and one female wished to wait until the next occasion of treatment. Of the remaining 59 patients, 32 were females and 27 males. The non-responders age and gender were thus similar to the responders. The 59 patients did not give reasons for non-participation.

According to the Ethical Committee of Lund University Hospital the research protocol was approved of by the chairman of the Department of Surgery at the University Hospital.

3. Description of the unit/setting

This study was conducted at the surgical department of a university hospital in southern Sweden, at a 12-beds unit [27]. Short stay surgery was introduced in 1990. The unit was staffed by doctors and registered nurses. Primary nursing as defined by Bond and Thomas was employed [21]. Thus, each patient was assigned one primary nurse responsible for his/her care on a 24-h basis [21]. Continuity of care was established by which the doctor and the primary nurse met the patient during outpatient visits and maintained contact during the hospital stay. The philosophy of the unit was that comprehensive information to patients about their condition and the perioperative period leads to a higher level of satisfaction with short-stay surgery and increases the chance of a successful outcome. The method

used was 'help to self help', in keeping with Hendersson thereby returning patients to normal daily life as quickly as possible [28].

Providing the patients with all necessary information was an important task for the nursing staff, particularly prior to the operation. The information given concerned the operative procedure, the patient's condition or disease and the normal post-operative course including pain, pain management, possible complications and sequel and how to act if they occur. Pamphlets for patients undergoing operations for hernias, varicose veins, hemorrhoids and morbid obesity were specially compiled as a complement to verbal information. The nurses' were also actively involved in planning the operation schedule. This enabled an efficient utilization of available resources. Our philosophy was that the more the patient knows about his/her condition and the perioperative period, the better the chances for a successful sojourn and a high level of patient satisfaction following short-stay surgery. The aim was efficient care with the highest degree of quality possible.

4. Data collection instrument

The data collection instrument used was based on a questionnaire used by Boman and Ramström-Lindgren in their study of a similar patient group [13]. Certain questions referring to age, gender and educational background were however added. The questionnaire was comprised of 43 questions. Nine questions concerning characteristics of the patient, type of surgery and length of hospital stay. Following these were 34 questions regarding the unit's care philosophy, eight questions regarding doctor and nurse continuity, eight questions regarding information requirements, three questions regarding interpersonal care, six questions regarding emotional support, six questions regarding pain relief requirements and three questions regarding the need for assistance following discharge. The re-

Table 4
Percentage of patients answering 'yes' to questions related to interpersonal care and emotional support in short-stay surgical care

	Age, <i>N</i> = 263 ^a		Gender, <i>N</i> = 275		Educational background, <i>N</i> = 273 ^a		
	24–65 years	66+ years	Female	Male	Compulsory education	Upper secondary education	University education
	<i>n</i> = 168 (%)	<i>n</i> = 95 (%)	<i>n</i> = 141 (%)	<i>n</i> = 134 (%)	<i>n</i> = 142 (%)	<i>n</i> = 70 (%)	<i>n</i> = 61 (%)
Questions to the patients (in short)							
Patient was well received	84	91	89	84	89	86	84
Did staff have the time to provide sufficient attention and care	70	75	71	72	76	71	62
Did staff pay consideration to your anxiety?	90	82	85	89	88	84	90
Do you feel it was correct to discharge you on the day on which this occurred?	83	80	82	83	83	79	87
Did you know whom to contact at the hospital?	70	67	67	72	70	74	66
Patient called someone	21	8	18	15	11	20	23

^a In total 275 patients answered, but 12 gave no age and two patients gave no educational background.

sponse alternatives were 'yes/no answers' or as three to seven choices corresponding to different degrees of agreement/disagreement with the care philosophy. Three experts in the field analyzed the questionnaire for content validity before its use. Reliability testing was not performed.

The questionnaire responses were analyzed with regard to age, gender and educational background to see if any correspondences could be identified. The statistical method employed to study correspondences was the Cramér Coefficient (C) [29]. Statistical significance levels of $P \leq 0.05$ were accepted.

5. Results

The patients were generally positive regarding the care they had received. The results showed no statistically significant differences between females and males in this respect. Positive responses from patients are presented in connection with the areas of special interest in Tables 2–4.

5.1. Doctor and nurse continuity

Patients of all categories felt that it was important to meet the same doctor on each hospital visit (see Table 2). Only eight of the investigated patients had had this opportunity. Most patients knew the name of the doctor who had the main responsibility for their treatment. There was a weak correlation ($C = 0.12$, $P = 0.05$) between gender and the degree of importance attached to meeting the same doctor on each visit. There was also a weak correlation ($C = 0.22$, $P = 0.01$) between age and familiarity with the name of the doctor. Half of the patients felt that it was important to meet the same nurse on each hospital visit. Only 25 patients met the doctors in charge of their treatment at admission, during their hospital stay and at discharge. Ninety-six patients met their primary nurse during all three occasions. Patients familiarity with the nurses names was generally less than their familiarity with the doctors names and was lowest for those patients with a university education. With regard to knowing the nurses name, there was also a weak correlation ($C = 0.16$, $P = 0.05$) with education.

5.2. Patients need for information

Overall, the patients were satisfied with the information they had received (see Table 3). In the older age group, males and patients with a compulsory educational background were the most satisfied with the information given prior to admittance. Most satisfied with the fact that staff explained how the unit was organized were the older age group, the females and patients with a compulsory educational background.

The younger age group, the males and patients with a university education knew whom to contact to ask questions on the unit. The older age group, the females and patients with a university education felt that written information was important.

Of the males, 86% felt that they had been given information about their operation. Of those patients with a university education, only 52% felt that their questions had been answered. Forty-three (16%) patients stated that they had no questions regarding their operations.

When asked whether they had been given answers to their questions regarding their illness, 51 (18%) patients answered they had no questions. Of the remainder, 81% of the females and 82% of the males felt that their questions had been answered. Those who were least satisfied with responses to their questions regarding illness were those in the older age group (51%) and those with a university education (51%).

In this material it was not possible to establish a correlation between age, gender or educational background and opinions concerning information about the functioning of the unit, operations or illnesses. The only exception was a weak correlation ($C = 0.12$, $P = 0.05$) between age and the issue of whether the patients' questions concerning their illnesses had been answered.

5.3. Interpersonal care and emotional support

Two questions were put regarding the concept of interpersonal care (see Table 4). In the older age group, 91% felt that they had been well received. When asked whether staff had had the time to provide the patient sufficient attention and care, patients with a university education (62%) were least satisfied, while those patients with a compulsory education (76%) were most satisfied. No statistical correlation between age, gender, educational background and interpersonal care could be established.

Patients in the younger age group and patients with a university education were most satisfied with the staff's consideration regarding their anxiety, while the older patients were less satisfied.

Of the 91 patients who had felt worried, all patients felt that the staff had given them time. When asked whether they had been given the opportunity to talk about their feelings and experiences, 153 patients answered that they did not have this need. Of the remaining 122 patients, 111 patient was satisfied. Ten patients felt that they could not talk about their feelings, eight females and two males. Of these ten, four patients had a compulsory education, one a secondary education, four a university education, and one patient had not answered the question about education. There was a certain correlation ($C = 0.22$, $P = 0.001$) between age and whether or not a patient felt that the opportunity to talk about feelings had been given.

5.4. Pain relief

The patients were asked whether they felt they had been given pain relief within a reasonable amount of time. No correlation could be established regarding age, gender and educational background and this matter; 186 patients felt that they had been given pain relief within a reasonable amount of time and 46 patients did not answer the question.

The remaining 43 patients (18 females and 25 males) were not satisfied with their pain relief. Of the 43 patients 22 patients responded that they had received pain relief within 'a reasonable amount of time'. Twelve patients felt that they had 'occasionally received pain relief within a reasonable amount of time'. Nine patients had 'never received pain relief within a reasonable amount of time'. The age range was from 27 to 86 years. The educational levels were evenly represented in the group of patients not satisfied with the treatment of pain.

5.5. Need for assistance following discharge

Patients' perceptions varied regarding whether or not their discharge from hospital had occurred at the correct point in time (see Table 4). Patients in the older age group and patients with upper-secondary education agreed least with this statement. One patient felt that the discharge could have taken place sooner and 43 patients felt that they should have been kept in hospital longer.

Most patients seemed to know whom to contact at the hospital following their discharge. The older age group, females and patients with a university education were the least certain of who to call. Few patients called back to the unit to ask questions, but those who called most were patients in the younger age group and patients with an upper-secondary or a university education, (see Table 4). Those who called least were the older patients. Only a weak correlation ($C = 0.04$, $P = 0.05$) existed between whether the patient rang anyone at the hospital after discharge and their age.

6. Discussion

There are different views as to the value of studies such as this one in which patients express their opinions about care [4,7,21]. Should the patient or the profession decide the standards for care and treatment? Leino-Kilpi and Vuorenheimo states that whether the patient is right or wrong is really of no consequence; what matters is the patient's subjective experience [8]. Ford et al. write that the challenge for managers is to ask the right questions at the right time, of the right group of patients, to obtain the information they need and exceed patient expectations regarding service quality [23].

This study has shown that some of the patients' expectations have not been fulfilled. Does the health care system have the possibility to fulfill the patients expectations? Avis and Bond draw the conclusion that patient satisfaction has a role to play in service evaluation and consumerism [5]. Other studies have been conducted to evaluate an organization from the patient viewpoint [12,13,17], but no study describes a goal of a patient satisfaction rate of 100%.

Can patient satisfaction be equated with quality of care? There is no distinct answer to this question [9,10,20] Research thus far has targeted different areas of quality and satisfaction. Certain studies have observed the patients' view before and after changes in health care organizations [13,17]. Another type of study has measured patient satisfaction as an indicator of quality of care [8]. A third type of study has assessed patients' satisfaction and compared the results with answers from staff regarding patient satisfaction [18].

In this study, as in certain other studies, patient satisfaction has been investigated without defining satisfaction or standards for the care given [4,20]. If we had had a definition and/or standards we could have measured the outcome of the study against them. Hall and Dornan discuss the problem that different instruments include different aspects of satisfaction, and raise questions about the comparability of satisfaction from one study to the next [1,2]. We agree with Hall and Dorman that it is difficult to compare our results with other studies, since we do not use same instrument or have the same standard.

One of the study's weaknesses was that the questionnaire was only tested for content validity, but no reliability test was done. The response rate was good compared to other studies [7,10,12,13,17]. Boman and Ramström-Lindgren had a response rate the first year of 89% and the second year of 83% [13]. Their questionnaire was mailed to the patients one-week after discharge. Carr-Hill stresses that it is important that the period between the health care and the answering of the questionnaire should not be long, to reduce the chance of biasing [4]. Another Swedish study had a response rate of 50% when questionnaires were handed out to patients in the whole hospital [17]. No individual was made responsible for the questionnaires on each ward and the response rate varied from one department to another. Possibly actively involving nursing staff in research projects can lead to an increased level of motivation to deliver the questionnaire to the patient and also motivate the patient to answer it. Wilde et al. used nearly the same method as in this study [10]. The staff nurse gave the questionnaire to the patient at discharge, but the patient received no reminder. Wilde's response rate was 68%, and concluded that the response rate depended on the motivation of the staff administering the questionnaire [10]. Williams and Calnan

mailed a questionnaire to a random sample of people living in a particular health district and after a reminder their response rate was 62% [7]. Ehnfors and Söderström had a response rate of 54% and the questionnaire was mailed to all patients after discharge, a possible explanation for the low response [12]. A low response rate reduces the researchers ability to determine the views expressed by the non-responders and sheds doubt as to the value of the results obtained. In a study by Wenging two ways of distributing a questionnaire are compared: by hand-outs or by mail [24]. The result showed a higher response rate for the questionnaires that were handed out (72% compared with 63% for the mailed ones) [24]. The nurses in our study handed out the questionnaires themselves. This could be one reason for the high response rate. Hall and Dornan say that the researcher has to be aware that the patient is reluctant to criticize their care providers' [1]. Did patients answer the questionnaire because of dependence on the nurse? Possibly a reason for the high response rate. The major disadvantage in studies of patient satisfaction is the patient's dependency upon the caregiver. Because of this dependency it can be difficult for patients to criticize the caregivers and the treatment given [20,23]. Therefore, it is vital that patients partaking in patient satisfaction studies are aware that all data is treated with complete anonymity. The nurses informed the patients that their responses would be treated anonymously.

The results showed no major differences between answers when related to age, gender, or education and the statistical correlations are weak.

The population in this study was much older than in many other studies [1,7,15,18]. This could have effected the results. In previous studies older patient are more satisfied [4,7,17]. Lövgren and Williams and Calnan, has demonstrated satisfaction by younger and older patients, but the patients between 13 to 39 years of age expressed the lowest level of satisfaction in almost all respects [7,18]. Leino-Kilpi [8] could not show any relation between patient characteristics and satisfaction with care, while Williams and Calnan [7] found socio-demographic variables, such as age and gender, to be of importance when evaluating care. A review study by Hall and Dornan found a total inconsistency with how authors report patient variables [1].

It seems that gender in this study had a limited effect on the patients' responses. This is in accordance with findings by other authors [8,10,12]. In other studies females have been reported to be less satisfied than males [4,7,17,18].

In our material 61 (21%) of the respondents were university educated compared to Minnick et al. who had 11% [25]. As patients with a university education were less satisfied this could have influenced the results in general. The university group was younger and less

satisfied with the care than the other two groups. Minnick et al. found that units where the average patient had more education were less satisfied with the care [25]. Half of the patients had compulsory education. Are they more or less satisfied as a group? This question has not been answered by this or other articles. Different studies have achieved differing results. Minnick et al. suggests that hospitals in the USA tend to optimize care systems for a single type of consumer that have relatively simple needs. In their study, units where the average patient had a higher education, patients were found to have less favorable teaching scores [25].

The patients thought it was more important to meet the same doctor than to meet the same nurse on each hospital visit. The patients were also more familiar with the name of the doctor than that of the nurse, even though the patients met the nurses more frequently than they met the doctors. Boman and Ramström-Lindgren also found that nurse continuity was higher than doctor continuity in short stay surgery [13]. But the patients thought it more important to meet the doctors on each hospital visit. Bostrom studied the impact of nursing continuity and found nursing continuity to have a small but significant effect on patient satisfaction [14]. Continuity for the patient was important for the staff. But we did not manage to maintain it. In another organization the patient has to meet the same doctor and nurse during their hospital visits. One way of doing that is to have doctors who are stationed on the unit and just doing minor surgery for a period of time.

The results showed that the patients were satisfied with the information given. The group who tended to be less satisfied was the university educated group. Do we have capacity to take care of this group and give them sufficient information? This type of question has not been posed in previous studies and cannot be answered by this study, but should be of concern for others. Furthermore it is of importance to know what kind of information and help each patient needs to be secure in a health care environment. However, a study by Breemhaar has shown that the information patients received was not in proportion to their need [16].

The lowest scores were given for the question concerning whether or not doctors and nurses had time to provide sufficient attention and care. Only 62–76% of the patients were satisfied and least satisfied were the younger patient group and the patients with a university education. This field is important to the patient. Hall and Doorman ranks humanness, which includes interpersonal care, as the second aspect. In the area of need for emotional support the younger and the patients with a university education felt that the staff had been considerate regarding their anxiety. The correlation was weak between age and opportunity to talk about their feelings.

More than half of the patients stated that they had received pain relief within a reasonable time. Half of the remainder did not answer this question. The remaining 43 patients were not satisfied. That is 16% of the whole group. In this group the patient categories were equally represented. No explanation can be offered but clearly such results are not acceptable and the unit's treatment of pain must be improved. The results differ from those of two other Swedish studies. Boman and Ramström-Lindgren and Ehnfors and Söderström showed that only a few percent of the patients were dissatisfied with the pain treatment [12,13]. Donabedian states that in the future we have to determine clinically relevant behaviour in the health-care system [19].

The need for assistance following discharge varied in the different groups. Most of the patients knew whom to contact at the hospital after discharge. It was the groups of oldest patients, females and university educated patients who were the least certain of whom to call. Of the patients that made telephone contact with the unit most were from the younger and the university educated patient groups. Here the conclusion could be drawn that higher education leads to a better orientation in different organizations.

In our study 82% of the patients felt that it was correct to be discharged on the day on which it occurred equating to Boman and Ramström-Lindgren findings [13]. Kaag found that there was no difference in satisfaction between a group with a postoperative stay of 4–6 days and an experimental group, which had a post-operative stay of 2–3 days [26]. Our post-operative stay for similar groups was 1.5 days. Maybe the length of the post-operative duration is not important, providing that information and planning for discharge commences when the patient is admitted.

According to Lövgren et al. less than half of the patients said that they always or very often received information about access to help outside the health care organization [18]. Our study showed that 65% of the patients knew whom to contact after discharge. Ehnfors and Söderström, Lövgren et al. have show that younger patients were less satisfied with the discharge procedure than the older patients [12,18].

7. Conclusion

The unit's philosophy and methods of care embraced terms such as continuity, thorough information and active listening, pain relief and mobilization in order to return the patient to normal life as quickly as possible. In this study the patients were quite satisfied with the care given. The only area with a low rate was interpersonal care and emotional support (62–76%), the least satisfied being the younger patient group and the patients with a university education. No indication that

age or gender is significant for patient satisfaction has been found. This shows some agreement with the literature and of the opinion held by some nurses that patients with a higher education have a different view of the care given, than the view from the other patient groups. There was no statistically significant difference in satisfaction between patients of different age groups, gender and educational background. That could be due to the method, questionnaire and number of patients used in this study. A standardization of designs of studies and questionnaire is necessary for the future to be able to evaluate and compare patient satisfaction related to changes in the health care system.

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