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Optimizing Quality Management in the Public Health Sector: Measuring Patient Satisfaction

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Abstract

Patient satisfaction is an essential indicator in assessing the quality of care, reflecting their expectations and perceptions. This article examines the most relevant tools and methods for measuring this satisfaction, with the aim of providing reliable and representative results for hospital services, thus helping to improve the performance of healthcare systems.

Keywords: *Hospital Management, Patient Satisfaction, Healthcare Performance.*

Introduction

The appearance and evolution of quality concepts in the field of medical care during the last half of the twentieth century was accompanied by significant changes in the politics and ethics of the health sector. Over time, the patient occupies more and more a primary place in the care system, and the interest of his perspective has developed. A consequence of this paradigm is an increase in work related to patients' points of view, their desires and expectations for medical care. The patient's opinion through satisfaction is an excellent way to make him actively participate in the evaluation of the care management process. This approach is important for politicians, managers, clinicians and researchers. Respecting patients' preferences is one of the aspects that makes it possible to improve the performance of a care system.

The measurement of patient satisfaction is considered as one of the tools of the evaluation of the quality of care. This article aims to clarify and specify the best tools and methods for measuring this satisfaction by opting for the best results reflecting the reality of hospital services

The measurement of patient satisfaction is considered as one of the tools of the evaluation of the quality of care. The evaluation of the quality of care is a frontier approach with epidemiology, a discipline with which it maintains close links. While epidemiology is devoted to population health problems, the evaluation of the quality of care favors:

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• A particular population group: patients, that is to say people who seek care from a professional or a health facility.

A particular determinant of the state of health: the care provided, in particular the means used, the organization implemented, and the practices of health professionals. This approach makes it possible to constantly compare the reality of the care provided, with references. Its development uses epidemiological methods. She uses a specific vocabulary.

o Satisfaction measurement perspectives

There are three aspects from the point of view of measurement that must be taken into consideration when measuring patient satisfaction:

From which concern is a measuring instrument built: patients, professionals or the administration? b.

With whom is the measurement carried out: patients, professionals or the administration?

Who are the results of the measurement intended for: professionals or administration? Regarding professionals; understanding and responding to the needs of patients is the priority of medicine.

It should be known that knowing the expectations of patients generates greater satisfaction at the level of care, which generates greater adherence to treatment. Analyzing the goals and expectations of patients allows clinical decisions to be made in which preferences are important, but because of patient expectations that can sometimes be unreasonable, practitioners must be prepared to educate their patients. Finally, giving importance to patients' expectations provides opportunities for clinical negotiations and makes the patient have an active role in medical relationships, which can themselves bring better results.

Concerning the administration; improving the quality of the services both of the care itself and of the care environment is a necessity. And respecting the preferences of patients is one of the dimensions that makes it possible to measure the performance of a care system. That said, unrealistic or erroneous expectations can increase the use and cost of health care when they produce only a small benefit. Understanding patient expectations can help educational efforts to reduce unreasonable demands (Kravitz, 1996).

The study of satisfaction is only significant if the position of the observer, on the one hand, and the objective pursued, on the other hand, are known. There is another point of view in the measurement of patient satisfaction, it is that of researchers who aim to identify the determinants, the consequences of satisfaction or the factors likely to improve it. Patient expectations can serve as independent variables in the study of patient satisfaction, practitioner behavior, consumer choice for the care provider and quality of care. Patient expectations can also serve as dependent variables in the study of how patients develop their expectations, the influence of the medical profession and the healthcare industry on their development and where education and other persuasion efforts can lead them.

Fields of Epidemiology

In 1968, the WHO defined epidemiology: "the study of the distribution of diseases and disabilities in human populations, as well as the influences that determine this distribution".

It is necessary to know that epidemiology is operational: it describes, explains, evaluates, in

order to act.

Thus, it is part of the public health approach, still according to the WHO, "epidemiological studies have three objectives:

Guide the development of health services by defining the extent and distribution of morbid phenomena in the community.

Identify the etiological factors in such a way as to make it possible to stop or modify the disease.

Provide a method for measuring the effectiveness of the services implemented to combat the disease, and improve the health status of the community".

So, there are three types of epidemiology: descriptive, explanatory and evaluative.

Fields of Satisfaction Studies

As we have already specified in the previous part "the points of view of the measurement of satisfaction", the measurement of satisfaction can be integrated into two main approaches for satisfaction studies: (1) the approach of professional evaluation of the quality of care with a descriptive approach, (2) the research approach: (the measurement of satisfaction) is, itself, object of research of explanatory type, or criterion of judgment in an evaluative approach.

Professional Assessment of the Quality of Care

Its purpose is to verify the effectiveness of the care provided to patients compared to a usual practice. It verifies the quality, the real effectiveness and the efficiency in a given application context. With this in mind, the objective is not to answer research questions, but to find out, for example, whether low molecular weight heparins are prescribed for at-risk subjects, and only for them, at the recommended dose, with the required supervision. It is then a question of comparing the practice carried out with external references defined beforehand and which, theoretically, are obtained from the results of the research evaluation. The different methods in professional evaluation are:

purely qualitative approach, descriptive approach, analytical approach, evaluative approach.

The purpose of measuring satisfaction with a descriptive objective is to describe the level of satisfaction without trying to find explanatory factors. This description can be a preliminary step to a program to improve the quality of care, as it can sometimes be the only objective. It results in the collection of information from patients (focus group, letter of complaints, exit questionnaires, specific surveys by satisfaction questionnaires) or information that may have an impact on the expectation or appreciation by patients (data on the hospital, on the healthcare team, on the patient...). Although the descriptive approach only provides so-called "elementary" information, its importance is paramount:

It makes it possible to understand the magnitude of health phenomena (by assessing their prevalence) and to have an epidemiological surveillance (ex: periodic survey) ;

It provides decision-making support in the areas of planning and management of health organizations or programs

It can be at the origin of hypotheses about the causes of the situation

The descriptive approach cannot establish a cause-and-effect link, it is not predictive.

The objectives of research on satisfaction

Its objective is to identify the factors influencing satisfaction, or expectations, the services provided, deviations. This approach helps to better interpret the results or makes it possible to make a comparison between care units taking into account these factors. The objectives of this approach are to answer the following questions

What are the determinants, the consequences of satisfaction?

What are the factors, the interventions likely to improve satisfaction?

Objectives of the Measure

The measurement of patient satisfaction makes it possible to select the malfunctions. Questionnaires and surveys specify the origin of dissatisfaction, this helps professionals to choose the necessary corrective measures to be put in place to improve the quality of care and services within the institution. These measures are to be "prioritized", and allow to respond in the most appropriate way possible to the expectations of patients. These surveys are also used to detect positive aspects, or even points of excellence, which must then be highlighted to staff and disseminated externally.

The use of satisfaction measures can be applied in different contexts :

A diagnosis of strengths and weaknesses: detection of malfunctions and application of the necessary corrective measures, as well as recognition and confirmation of positive points.

One of the indicators of a quality assurance program: criterion for judging quality approaches, indicator of an alert system in quality assurance programs.

One of the indicators for measuring the results (outcomes) of patient management: therapeutic trial judgment criterion, quality of care judgment criterion.

The Questionnaire As A Measurement Tool

In a satisfaction measurement survey, it is possible to choose between several data collection methods, each of which includes advantages and disadvantages. It should be noted that the evaluation of patient satisfaction is based on quantitative surveys (e.g. the exit questionnaire, the questionnaire in specific surveys), but also on in-depth qualitative surveys, it is important to integrate feedback from the field and the exploitation of customer complaints. These methods of evaluating patient satisfaction are classified between qualitative techniques and quantitative techniques, which represent two complementary approaches. The quantitative approach makes it possible to measure, and the qualitative approach makes it possible to provide elements of understanding and to go further in the exploration thanks to the free character of the answer.

Several authors, including Avis and Williams, recommend assembling qualitative and quantitative techniques for measuring patient satisfaction, to take advantage of the complementarity of the information they produce

The qualitative approach: allows patients to express their experiences in their own words. They bring rich details according to their point of view. However, it is not advantageous if the goal is to obtain generalizable data or to make comparisons between hospitals since the data obtained are not favorable for statistical analysis.

The quantitative approach: It is obvious that quantitative studies, carried out on representative

samples of the target population, often use closed questionnaires. These studies make it possible to easily calculate satisfaction indices (% and/or average). It is then easy to compare different populations with each other or the same population over time. However, for this type of study, it is important to know that it is not easy to give a correct interpretation of the figures obtained, apart from any suitable statistical test, because many factors can influence satisfaction rates or scores, which raises the question of the validation of the questionnaire.

The practice of the questionnaire is the most used method in this last approach. In the analysis of the literature, it is clear that this is the most answered method in satisfaction surveys. This probably comes from its apparent simplicity of use. The development of an adapted measurement system constitutes one of the essential axes of the policy of continuous improvement of the quality of care. For the establishments, it is a question of including this approach in their establishment project., there are several methods of collecting data when measuring patient satisfaction. The collection of data by a questionnaire can be done during hospitalization, consultation or remotely. Self-administered questionnaires can be used, filled out by patients. It is also possible to opt for questionnaires completed by a third party during a face-to-face interview (on site or remotely) or telephone.

Each of these methods includes advantages and disadvantages.

Definition

A questionnaire is a set of questions (or tems), each of which represents an elementary piece of data. A questionnaire can be used by direct contact with interviewees, or by the people themselves, but also to secondarily analyze the files established during patient care. Questionnaires are standardized data collection tools that have as their objective the reproducibility and validity of the information collected.

The development of a questionnaire is an essential and complex step, which requires the experience and point of view of different people. The choices are irreversible and determine the quality of the subsequent result. They are linked to the objectives and the different perspectives involved. A universal questionnaire does not exist and "no survey system is validated for it to be considered [...] as reliable, valid for the measurement of satisfaction". However, the development time of a new questionnaire is from 2 to 5 years.

The adoption of an existing tool therefore aims to save time and expenses. In addition, the adoption (integral or slightly modified) of questionnaires already used makes it possible to ensure the same properties as the original version, provided that the population studied is slightly different.

A satisfaction questionnaire usually has 4 parts :

A part dealing with additional information of a socio-demographic type and the identification of the patient.

A part dealing with general information concerning the previous experience and the organization of the patient's stay.

A part corresponding to the actual satisfaction.

A part containing validity indicator variables "validity indicator variables" used in the process of improving dimensions

Characteristics of the Instrument

The tools for measuring patient satisfaction are classified according to three main characteristics: the care structure concerned by the questionnaire, the level of specificity of the questionnaire and the typology of the items.

The Care Structure

It is essential to identify and differentiate between the types of care structure: short-stay, medium-stay or long-stay hospitalization, consultation, home care or care network. The same applies to the types of care: general care, specific care such as pediatrics, obstetrics, cancer and psychiatry. Because each of them has different characteristics concerning the context of the structure, the relationship between the nursing staff and the patient, and the mode of offering care.

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The Level of Specificity of the Questionnaire: Generic and Specific

A specific instrument is used to evaluate a particular event such as a hospitalization or a specific consultation (the last one, for example). A generic instrument is intended to measure patient satisfaction with the care offer in general.

The evaluation of a care structure (a hospital, for example) or a type of care (such as pediatrics) falls between these two poles, generic and specific, respectively.

A specific questionnaire includes items such as "did the doctor give you fairly clear explanations about your health problem?" (for example, during the last hospitalization), while a generic questionnaire has the following wording "does your doctor give you sufficiently clear explanations about your health problems? ».

It is clear that patient satisfaction is multidimensional, so the satisfaction questionnaire includes specific and centered questions and not ask for a global assessment of satisfaction. The more clearly specific and focused the question will be, the easier it will be to compare satisfaction between the different care structures. Hall and Dornan, state that questionnaires with more specific content tend to produce more favorable answers than those with generally formulated questions that produce a slightly more negative point of view. Other authors state that generic questionnaires generate higher satisfaction scores than specific questionnaires.

In recent years, a trend of individualization of patients' answers has been present, by adding the notion of "importance" for each question in the questionnaire. The level of importance is rated on a scale of 1 to 5 (not important at all ... very important).

The Typology of the Items and the Answers

The items represent the stimuli intended to obtain an answer and can be questions or affirmations. In the rest of the text, we will use the words item and question interchangeably according to their common use in French.

Formulation of Questions

In order for a study to have accurate and useful results, the questions must represent what patients consider important to them. Focus groups and patient complaints are a rich generator of topics for study questions. It is also essential, to establish questions with patients, to take into consideration the following elements:

The topic of the questions should be specific enough to be appropriate, but not too specific to the point that it becomes painful to answer them.

Please address only one idea per question.

To avoid politically sensitive topics or topics that could embarrass patients.

Express the questions in simple and direct language.

Please consider the purpose of the question by choosing the words and format.

Formulation - Open or Closed

Open-ended questions provide the respondent with a very wide freedom of response by freely

choosing his words and the length of the answer, which allows the subject to express himself freely, to provide qualitative information. They offer the student the ability to analyze in depth an attitude or an opinion; the topics are unlimited, but they are more difficult to analyze and summarize than closed questions. Example of an open-ended question : "What did you enjoy about the hospital ?».

Closed-ended questions are characterized by clear and precise possible answers. Example of a closed question: "Where did you go when you left the hospital ?». The answers "at home", "in another hospital", "in a rehabilitation center", "in a nursing home" are logical and increase the effectiveness of the interrogation.

The advantages of closed-ended questions: easy coding, simplified interpretation of the answers and easy and fast task of the respondent.

It is preferable to complete the closed questions with a few lines reserved for "remarks". Patients can then deepen or add explanations to their answers.

The Formulation - Direct or Indirect

According to Fitzpatrick and a meta-analysis of 221 studies carried out in 1988 (Hall, 1988), satisfaction questions can be classified according to their direct or indirect formulation.

The direct approach is characterized by questions addressed directly and related satisfaction levels "How were you satisfied... ?». For example, "Are you satisfied with the quality of the treatment administered?" or a positive response for "Is the treatment given suitable for you? which will be interpreted as an answer indicating satisfaction.

Whereas in the indirect approach, satisfaction is derived from the answers. Indirect items that represent a description of the management, for example: "Have you noticed an improvement in your health after the prescribed treatment?". The choice of the formulation of the questions is made on the basis of the objective pursued: do we rather seek to know the opinion of the patients or do we want, through the patient, to identify bad practices? For example, in the case of pain management, an indirect question helps to verify whether the modalities of pain management are in accordance with what they should be (standards, procedures, consensus). There are no established advantages of either approach. The distribution of this character over 200 studies is 43% direct, 37% indirect and 20% combining the two.

Formulation- Observation (report) or Evaluation/Judgment (Rating)

Questions of observation and experience are often formulated in the same way, for example: "Have they explained to you how the daily work in the service takes place?». This is a factual question, capable in principle of an objective verification (it happened or it didn't happen). But; what matters in this case is rather the question of whether the patients have experienced this fact enough to perceive it as such and remember it. Whatever the answer given to these questions, it does not directly translate whether the patient is satisfied with the act or not. To find out, it is necessary to opt for evaluation / judgment questions, so ask for example "How did you find the explanations received on how the daily work at the service takes place? ».

In order to be able to compare better, the evaluation / judgment questions are, as a rule, asked in a closed form, therefore accompanied by an answer scale ranging from a positive rating to a negative rating.

The Format of the Answers

During the development of the satisfaction questionnaire, the problem arises of defining the response scales for each item. In addition to analog visual scales, which are rather little applied in the context of satisfaction studies, the answers are most often established on response scales, akin to multiple choice questions, which are either binary (yes / no), or in several points. This choice is important as regards its repercussions on the psychometric properties of the calculated scores

answer "Yes/No"

It is considered the simplest format, it is binary, and despite the advantages of simplicity of this format, according to several analysts, it remains burdened by the fact that most of the answers of any item touching most of the respondents remain favorable answers for care. It does not make it possible to detect changes in satisfaction, and has significant floor and ceiling effects.

Multiple Choice

Currently, almost all questionnaires use more than two answers per question. This allows the respondents to express their point of view precisely. Especially since the reliability of the items increases when the number of possible answers increase. On the other hand, the reduction in the number of answers in the scale increases the reliability over time (it is more likely that the same individual will answer the same question identically asked twice a month apart if the answer scale has 3 points than if it has 6), but reduces its power of discrimination in a continuum of states of alteration of the quality. For example, a satisfaction scale comprising 20 questions whose answers are given in 3 points makes it possible to distinguish 60 (3x20) different states, while if the answers are given in 5 points, it makes it possible to distinguish 100 (5x20).

Nunally asserts that in practice, the gain in accuracy and reliability by increasing the possible answers is minimal when the number of answers exceeds 7, and in general, 5 answer categories are used. An odd number of answers allows the respondent to position himself as "neutral" or "without opinion" but may introduce a tendency to the systematic use of this category to avoid having to pronounce.

The main scales are :

Nominal scale: which lists a series of categories of a variable. Example: CSP

Ordinal Scales :

-Likert Scale: contains a number of declaratory statements accompanied by a graduated scale. It is one of the scales most often used in satisfaction surveys. Each of them has 5 typical answers, from "strongly/absolutely agree" (strongly agree) to "strongly/absolutely disagree" (strongly disagree).

- Semantic differential scale: instrument consisting of two contrary adjectives, arranged on a seven-point bipolar scale; the subject positions his answer on this scale that best describes his opinion.

Problems in the interpretation according to the answer format

Observation (report) vs Evaluation/Judgment (rating)

There are currently no clear results concerning the influence of the response format on the

evaluation of satisfaction by patients. No study to our knowledge compares the answer formats (observation vs evaluation/judgment) using the same questions. The results of Mathiew, cited by Rubin, show that there is more variation in the type of observation than that of evaluation. The type of observation is less influenced by the characteristics of the patients such as age, level of education, and being a civil servant. The evaluations/judgments, in the case of the satisfaction scale in particular (very satisfied - very not satisfied), are flattening in the distribution of scores (skewness) in almost all studies.

Scale "excellent/bad" vs "agree/disagree"

The "excellent/bad" scale has advantages in the variability and validity of the answers according to the intention. It helps to directly compare aspects of care, which is impossible for other scales such as "agree /disagree". Ware and Hays in a study of satisfaction among consultants, affirm that it is preferable to use an "excellent/bad" scale with a neutral item than a "very satisfactory/not at all satisfactory" scale. They show that the "excellent/bad" scale provides results with more variance, less flattening of the distribution (skewness) and better reflect the behaviors of patients vis-à-vis care.

Validation of A Measuring Instrument

The validation phase is based on a pilot survey, and allows to select the most appropriate tools for patient satisfaction.

This validation consists of implementing specific surveys and statistical analyses, in order to verify the suitability of the instrument used to actually measure what it is supposed to measure and in an optimal way.

Validation is also used to precisely identify the dimensions explored by the instrument.

Psychometric validation represents an essential step in the use of a satisfaction measurement tool. Its purpose is the selection of items, and the verification of the validity of the definitive instrument (validity) and its reliability (reliabiliy).

Validity

Validation is a process that aims to ensure that the measuring instrument is a clear representation of the study concept. For example, if we want to measure satisfaction with care-related information, we need to make sure that the items in the satisfaction measurement tool represent care-related information, not another concept.

The different points of validity are presented below:

The validity of appearance or apparent (Face validity): The validity of appearance is the judgment of the user. This validity is linked to a subjective judgment, taking into account the visible aspects of the scale: length, wording of the items, response methods, etc..... It helps to make the tool accessible and, the scope of the patients, in order to guarantee their involvement and their reactivity, therefore, the realization of a pilot survey is essential to allow to gather their remarks on the content of the questionnaire and on the formalization of the items.

Content validity: or external validity, makes it possible to judge whether the problem posed is answered correctly, that is to say the ability of the instrument to actually measure what it is supposed to measure and vary with what it measures. It assumes that the ~tems gathered explore in a complete way all the aspects of a given dimension, without redundancy between them. It

verifies how adequate the instrument is for the field of study, depending on the concepts, the scope of the field taken into account and the formulations

employees. This type of validation requires the preliminary definition of the concepts and the consensual agreement of the experts.

The validity of the structure or the validity of the construct (Construct validity): The study of the structure of the instrument, by various methods of multivariate analyses, helps to verify the validity of the structure or the construct. These criteria can be used when there is no reference (gold standard). It is one of the elements that helps to define the dimensions of the instrument. It is linked by internal coherence (validity of internal structure). This is the ability of the instrument to measure the different dimensions separately. Its verification requires the use of factor analysis and internal consistency.

Factor analysis: Based on the results of a pilot survey on a representative sample of the target population, we can, for example, research the factor structure of the instrument by a principal component analysis. The results help to optimize the number of tool items. Thus it is possible to eliminate the items correlated to several factors, to no factor, or even items that belong to a dimension explaining a small part of the total variance. However, it is not possible to calculate a score by summing items only if they belong to the same dimension; it is therefore not theoretically lawful to calculate an overall score in the case of a multidimensional instrument.

It should be known that internal consistency is based on the study of the average correlation between items. The measurement using the Cronbach's alpha coefficient is a popular approach. The internal coherence coefficient (Cronbach's alpha) is an estimate of the fact that the items of a questionnaire (or a subscale) measure the same concept. It varies from 0 to 1. The higher the coefficient, the more satisfactory the internal consistency of the questionnaire; in practice, a value of at least 0.8 is considered a good indicator of internal consistency. But this coefficient has the disadvantage of being dependent on the number of items.

Criterion-based validity (eriterion validity): In the event that the object evaluated by the instrument is completely and indisputably defined by another measurement method. This is the correlation of the new scale with other measures, ideally, a validated "gold standard" that is well accepted in the field.

It is obvious that with regard to patient satisfaction measures, there is no universally recognized standard or gold standard; that is why this type of validity cannot be measured.

Reliability

Reliability represents the total of the inherent errors in the measurements. Variability is fundamental in this concept. For example, a patient is asked to evaluate satisfaction using a visual analog scale of 100mm. The result obtained is 81. The patient is then asked again to repeat the evaluation four times, and we find that the results are 79, 78, 76 and 81. So what is the true level of satisfaction for this patient? If it is possible to make the assumption that the patient's satisfaction was stable during the period, it is obvious that the variation in the scores is random.

This is the measurement error in this case. If the experiment is repeated with 99 patients, we notice both variability between subjects - some people will be more satisfied than others - and this random error.

Reliability is generally linked to reproducibility (including stability over time and inter-observer

reproducibility), which represents the ability to have a stable result when the questionnaire is administered several times (or by several observers) to a stable population.

Terms of Delivery

The methods of administration

Maintenance or self-administration

The methods of data collection are determined from the type of population and the sample size, but also, these methods vary between the interview and the self-administered questionnaire.

Interview (individual or group)

Generally, it is recommended to give patients the time and freedom to respond. It is also essential to define their experiences, even for those with reduced or limited communication or autonomy (health). The most appropriate way to question these checkers is by personal or group interview (with or without the help of an interpreter, parents or relatives).

This modality is distinguished by the excellent quality of the data collected, when the investigators are trained: the missing data are exceptional, the refusals to answer are generally rare.

However, the presence of the investigator is likely to influence the answers :

by the Hawthorne effect, this expression is used to express the unreliability of an experiment in given situations, because the simple fact that it takes place influences the results obtained. This is explained by the fact that the staff and beneficiaries of the program sometimes adapt a behavior very different from their usual behavior if they know that they are being observed. This is the impact of being included in the study.

social desirability is, which leads to underreporting, illegal, illicit or socially devalued behaviors. It is a tendency to act in such a way as to perceive oneself and to be perceived by others in a positive way.

Self-administration

Self-administered questionnaires are sent by post or by hand on site; completed on site or at home; by the person himself or by a relative, with or without help.

This method helps to know the patients' point of view directly. It is true that the cost of this modality is lower, but the response rate is generally low, of the order of 10 to 50%, according to the authors (without stimulus). The respondents are often different from non-respondents so the results obtained involve a selection bias.

Face-to-face, phone or mail

We present the table by Delbancon (1996), cited by Pourin (Pourin, 1999) to present the advantages and disadvantages of the different methods of data collection.

The place of data collection: on-site or remotely

It is clear that the chosen place and time of transmission and completion of the questionnaire are likely to influence the way patients respond. Questionnaires can be distributed or filled out

on site (the hospital, the place of consultation, the maternity hospital). In this case, it is important to discuss the modalities such as the moment of attribution of the questionnaire - before, during or after the care meeting; the moment of request to fill out the questionnaire - during or after the care meeting. And the person who gives or asks to fill out the questionnaire to patients - the reception staff, the nursing staff or the staff outside the institution.

remotely (at home, nursing home ...): the time elapsed between discharge and the moment when the questionnaire is administered is important, several authors recommend a delay of 2 to 4 weeks. The organization and logistics to ensure the addresses or telephone numbers of patients. And the mode of monitoring non-responses if necessary (telephone reminder, mail...).

Interviewing patients at the point of care generally generates higher satisfaction scores than remote surveys. Some authors claim that the answers are more critical, others that the answers can be positively influenced by the fact that the patient is in a situation of dependence (inequity relationship).

At the level of questionnaires sent to homes, the problem of who really answers may arise.

If the answers are made with the help of younger people, they can be more critical. This can generally constitute a factor that can explain the similarity of the trends of the answers made between young and old subjects, namely more critical and not very positive. This interpretation may be consistent with that of Thorslund and Wameryd. Their work focuses on the existence of a difference between very elderly patients who had completed the questionnaires with help and without help. They thus specify that access to help to complete a questionnaire can probably influence the perception of this very elderly person on his own state of health in a positive way. Another possible interpretation, and perhaps more natural, is that very elderly patients have poorer health, with a greater need for care and therefore a greater risk of seeing this need unmet. The following table presents the advantages of 4 modalities. B. The moment of data collection

The moment of completion of the survey

In order to maintain a patient satisfaction survey, it is preferable to avoid as much as possible any work around holiday periods because of the lack of availability or the absence of patients. During the winter, the study may follow a flu epidemic.

The time elapsed between the exit and the moment of completion of the survey

With regard to hospitalization, only a measurement after hospitalization makes it possible to evaluate the discharge conditions and satisfaction with the follow-up. This measurement should be carried out just after hospitalization, and it is considered more reliable when it is close to discharge than when it is carried out several months after. And it is advisable to avoid the course of hospitalization, in particular to get the answers on the day of discharge. The ideal time to send a questionnaire to a patient is 2 to 4 weeks after discharge. A longer duration (6 months) is proposed in the case of a surgical intervention to allow the patient to integrate the results of the care.

The purpose of this deadline is to :

to provide the necessary time for patients to detach themselves from their hospital experiences, because if it is too close to discharge, we can risk the trauma-related bias of hospitalization and

to remember well what happened to them, because we can risk, with too long a delay, memory bias- In addition, a study has shown that patients who have been discharged for several months

are more satisfied than those who have only been discharged for a few weeks'6. It is advisable not to sample patients who have been discharged from the hospital for more than 3 months, since it is unlikely that the details of the patients' experiences will be exactly found.

Consent, Anonymity and Confidentiality

The consent and agreement of the patients or their entourage is very important in any investigation, regardless of the method of investigation used. Charles et al, quoted by Pourin, are testing two methods for collecting patient consent in Canada. A first technique is to have this consent collected from the patient while he is still hospitalized, by a member of the service. The other technique is based on sending a letter to his home after his discharge from the hospital. In both cases, the results of this study are translated with a response rate that does not differ significantly between these two techniques. However, the collection of consent in the hospital has several advantages: better involvement of the nursing staff, lower cost, better reliability of the address and the telephone.

It is essential to respect as much as possible two main principles: the anonymity or confidentiality of the answers and the neutrality of the person who collects data. Both of them help mainly to prioritize the sincerity of the expression of the point of view. The principle of anonymity is completely guaranteed if no method of identifying respondents is used, however, it is necessary to use certain techniques such as identification by coding numbers if the study requires the follow-up of non-respondents. Even if it prevents the possibility of recovery, the guarantee of anonymity or at least confidentiality is important in this type of investigation where there is a dependency relationship, the patient being likely to return to the hospital and / or the care services on which he expresses his opinion.

The privacy statement requires a simple explanation of how the information will be processed and analyzed. Several studies attempt to guarantee the neutrality of the person collecting data by involving research institutes or academic groups, which are less identified with health providers, during the collection and analysis of data, but this may not be feasible. It is therefore preferable to consider the hypothesis that the framework in which the respondents express their points of view influences the results, and that, for example, they are more frank in the privacy of their home. However, the systematic analysis of the effect of the framework has never been able to highlight such facts.

Studies show that the response rate is lower when the survey is anonymous, this is explained by the fact that some people may feel that their opinions are important only when they are identified.

Others choose to respond only if they feel a certain pressure, the possibility of anonymity reduces this pressure. Other studies claim that the guarantee of anonymity has little influence on the response rate.

To summarize, there is, to our knowledge, no direct comparison between the different methods of study in the literature. But the complete anonymity of the questionnaire leads to methodological problems that do not allow the results to be validated, such as the representativeness of the sample.

Investigative Bias

Biases are systematic and constant errors rather than random ones. This part deals with biases related to the collection of data.

Biases related to the information collected or the respondents

The information obtained must be "accurate". Or forgetfulness (old data, elderly people), fear (subject with a strong social impact: drugs ...), mistrust (negative perception of the investigation), the degree of involvement, represent as many elements likely to lead to an erroneous, "oriented" or incomplete collection of information.

Interviewer-related biases

The investigators must know their questionnaire well so as to reformulate the survey with each person identically (if it is an interview). The investigators must, as far as possible, maintain a "neutral" attitude. The biases linked to the investigators can concern the different types of investigation. However, retrospective surveys are more easily subject to these biases.

Acquiescence effect

The lack of knowledge of a Halo effect or an acquiescence effect is an extremely common source of bias in satisfaction surveys by questionnaire. The first designates the orientation of the response to an item by that provided to the previous one. Its occurrence is closely related to the order of the questions. It induces to ask the subject about his overall satisfaction only at the end of the questionnaire: a patient would feel incoherent if he criticized specific aspects of his experience after expressing a positive overall judgment. Acquiescence (or positivity bias) reflects the tendency of a subject to systematically use the positive response modality. It is more frequently encountered in elderly subjects, with a low income, a low level of education and revealing a poor perceptual health score". The acquiescence is however not independent of the content of the item. The alternation of favorable and unfavorable signification items controls the acquiescence bias. Other features of the questionnaire affect the results of the survey. Ross makes a comparison between seven instruments and asserts that the satisfaction rates generated by each of them are more correlated if they have the same response format.

The authors generally classify satisfaction questions into two opposite categories: stricto-sensu questions ("Are you satisfied with the doctor's information about your treatment?") and factual questions ("Has the doctor informed you of the side effects of the treatment?"). They affirm the discrepancy of the answers and reproach the former for providing an opinion without knowing the judging criteria of the respondents". This implies, in practice, the use of both types of formulation.

To what extent is the instrument applicable?

In order to ensure the obtaining of useful results, the instrument used must be relevant, efficient and also applicable, that is to say usable in practice. An instrument is applicable if it has the ability to meet at least 4 criteria, according to Rubin :

Reduce the cost of implementation

For ease of use

Improving acceptability for patients and administrators

The ease of interpretation of the results

Implementation costs

They depend on the method of investigation. In the field concerned, it is essentially a question

of passing questionnaires or grids, the cost varies according to the duration of the investigation but also according to the qualification of the investigator. It is also necessary to take into account the cost of their training and the verification of the answers. It is necessary to indicate that in a certain number of cases the indicator considered is included in a larger questionnaire (grid) covering multiple aspects. In certain circumstances, the indicator is constructed from a selection of items from the questionnaire; other times, items from an indicator constructed elsewhere are introduced into a questionnaire. This context can influence the acceptability for the investigator.

Ease of Use

Several studies opt for the choice of self-questionnaires, by mail, by phone, or live, and succeed in achieving the desired objective, it is true that a large number of commercial companies carry out these types of studies (especially in the United States). But most of them do not provide information about the cost of their methods, and do not provide data on reliability and validity, that said their presence on the market shows that these studies are easily

Acceptability

It is important that it is felt by investigators and patients.

For the investigators: whether it is a question of a grid or a questionnaire, the investigator must agree to the instrument used. And knowing the principles of construction, from the underlying philosophy to the intended objectives, this represents a necessary prerequisite for acceptability. For example, it is essential that the investigator be able to explain the meaning of the items and the principles of the rating.

For patients: the questions must be clear, unambiguous, unambiguous and written in such a way as to be understood by the population affected by the survey.

In summary, to ensure its accessibility, the instrument must be :

clear in its formulation which must be understandable for the patients and for the investigator. The choice of instruments of foreign origin provokes a translation associating experts from the country of origin and the country of use ;

clear in its presentation ;

the length must be appropriate, taking into account the context and the frequency of application.

It is important to adjust the need for precision and the risk of boring the respondent; to take into account the method of administration: by phone: short duration; at home: longer duration; it is also necessary to take into account the subject treated: if the subject really interests him, the respondent gives it more time, and finally take into account the cost of the study and the analysis time.

The name of the investigator (professional investigator, doctor, nurse, or social worker, etc.) can influence the responses of patients.

It is clear that it is necessary to take into account the fact that the answers are oriented by the qualification of the one who asks the questions. We will talk to a doctor less spontaneously about the problems of the material environment. The fear of losing a benefit is also likely to guide the answers.

We can evaluate the applicability of an instrument based on the percentage of subjects who

refuse to answer certain questions (acceptability for patients), the duration of the handover (not only of the items of the indicator itself but also of the entire instrument in which it is included) and the evaluation of an average cost per subject surveyed. According to a recent work that revolves around the development of standardized and efficient procedures for administering questionnaires, to judge the quality of the questionnaire, it is possible to be based on the following criteria :

Proportion of non-responses

Filling quality (proportion of missing data)

Discriminating content of the data (distribution of opinion modalities)

Handover time: the time required to complete the grid or the questionnaire is an important factor of acceptability and must therefore be known. It can influence the participation in the survey of the people solicited.

Interpretability

It is clear that the studies of measuring patient satisfaction qualify as useful by the administrators only if their results are understood and lead to clearly highlight the points of improvement. Nowadays, no one has yet made comparisons between the methods and instruments of study concerning this problem. This criterion may disagree with the other criteria that ensure the reliability of the measurements and their validity or validity. For example, the evaluation scales often used can be problematic because the interpretation by patients of the term "bad" or "excellent" can be clear. An administrator can ask to know with what regularity.

However, an evaluation scale is able to better succeed in revealing patients' points of view on the quality of care.

It should be known, that in most cases the evaluation of hospital care by patients is misinterpreted. The flattening of the distribution and the insensitivity of the satisfaction estimates can have the consequence of considering that 90 percent and 95 percent of the "satisfied" patients are close results while such variations can correspond to a big difference in the real conditions of care.

To ensure that the study best reflects reality, the interpretation of patients' judgments must be based on population standards or validated by others. These standards determine what the response levels mean. If the evaluations are recorded only with proportions of patients who are "satisfied" or who rate the care as "excellent", they will not be interpretable unless the sole purpose of the study is to determine which group among several is better care or in the case of a permanent survey, is to monitor changes in each level.

Testing A Questionnaire

It is essential to carry out a questionnaire test chosen on a sample of respondents before a complete study. This helps to predict several potential problems. This test makes it possible to examine the clarity and acceptability of the items of the questionnaire. Also, if respondents are provided with an open space for comments, additional items or issues that are not included in the first version of the questionnaire may appear. In addition, the variability of the answers can be checked.

The study will not be particularly informative if the final version includes too many items that

produce uniform answers.

Conclusion

In a hospital environment where the main concern is the quality of care delivered, and where patient satisfaction remains undisputed proof, patient satisfaction assessment is a sure-fire way of improving health services. In fact, it is one of the ways of circumventing care-related dysfunctions.

Measuring patient satisfaction is an essential lever for assessing and improving the quality of care in healthcare establishments. Measurement tools and methods must be rigorous and adapted to the specificities of each hospital context, in order to provide reliable and relevant data. Integrating quality assessment into healthcare management not only helps to improve patient care, but also to optimize organizational processes and increase the efficiency of healthcare systems. In this context, the active participation of patients and the consideration of their expectations are key to achieving high and sustainable quality standards.

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