

Measuring patient satisfaction in children

ELIZABETH WALTERS, Consultant Child and Adolescent Psychiatrist, The Park Hospital for Children, Headington, Oxford OX3 7HQ

The report of the Standing Medical Advisory Committee to the Department of Health, *The Quality of Medical Care* (1990), states that outcome is the most relevant indicator of quality of medical care. In addition to providing information about the appropriateness of treatments, there are important ethical and resource implications if activities are found to be unjustified. However, measuring outcome is difficult if there is no quantifiable change in symptoms or function following treatment. In child psychiatry this is a relatively common dilemma and outcome studies, while agreed to be essential, are frequently abandoned at an early stage or fail to get off the ground because of the complexity of the problems they generate. In a review of the ways in which child mental health services attempt to measure outcome (Pound & Cottrell, 1989) the authors acknowledge these difficulties and conclude that a start should be made by "Asking the customer's opinion" about the treatment they have received. In other words, "Are they satisfied?"

Whatever the age of the patients concerned there are three variables to such measurements:

(a) *When to ask?* How long an interval should elapse between the treatment and the enquiry to avoid "honeymoon" effects and the "It must get worse before it gets better" idea?

(b) *Who should do the asking?* It should not be the person who carried out the treatment or who ordered it in the first place, nor should it be a clinician to whom the patient may need to return in the future for further treatment in case the need for this affects the patient's honesty.

(c) *How should the enquiry be carried out?* In adults it is a straightforward matter to send questionnaires by post with direct questions such as: Are they pleased with the results of treatment? Do they feel they have benefited from it? Would they recommend the treatment to others suffering in a similar way? Given the same situation would they make the same decision to proceed?

When the patients are children there is an additional element:

(d) *Who is the customer?* Is the customer the parent who has sought help and given consent to the treatment for the child? It is difficult for parents not to feel that there has been some benefit when they have taken the decision to subject the child to a major procedure. There is also evidence which shows that

parents tend to underestimate distress in their children, particularly intrapsychic components. It would seem then that there will be a bias towards parents reporting treatments as beneficial. So should the children themselves be asked? This is in keeping with current thinking such as the Children Act where an emphasis is placed on listening to the child's opinion.

These problems were the challenges faced in dealing with a specific task for measuring patient satisfaction in children. It necessitated the development of novel tools in an attempt to overcome the problems and make a start with tackling such important issues.

The task

The request came from a surgical colleague and concerned young children who were having major surgery to correct a congenital craniofacial deformity in which the orbits were displaced either horizontally (hypertelorism) or vertically. Such surgery has an incidence of serious complications of around 10%, including a risk of death. There was no functional benefit from the procedure which was being done purely for cosmetic reasons in the hope of improving psychosocial functioning much later in life.

A wide age range was represented in the 32 patients and the shortest interval between surgery and enquiry was six months. For older children and adults a postal questionnaire along the lines described above was found useful but that left a group of ten children under the age of 12 years and a 16-year-old girl with learning disabilities who were thought to be unable to complete the questionnaire independently. It was important to find ways of eliciting the same information from these children but using techniques appropriate to their level of understanding. Even within this range, 4–12 years, no single method was going to be appropriate.

The tools used with young children

All the children were interviewed along with their parents. This was a semi-structured general child psychiatric interview. Towards the end of this interview two different approaches were used depending on the child's capabilities.

(a) Those children who were able to do so (in practice all those aged 7 years and over) were given specific

questions to answer using a point scale. There were initial practice questions to make sure that they fully understood the technique. These were followed by 11 questions relating to their surgery such as "I liked my old face . . ." (10 point scale from "not at all" through to "very much indeed"). The children all found the experience very acceptable they gave clear and thoughtful responses, often with verbal elaborations confirming their written answers.

(b) Those children who were under 7 years old were unable to use the point scale but it was still very important to try to elicit their feelings of satisfaction in a comparable form to the questions. After discussion about being in hospital and having an operation they were invited to draw pictures of their "old face" and "new face". Young children when drawing people often draw representations of themselves anyway but they were clearly asked to draw before and after pictures of themselves. This was not in an attempt to measure the anatomical differences between pictures but to facilitate a discussion about the impact of surgery on them as a person. This was done by gentle but direct questioning such as "which face do you like best? Which one does Mummy like most? Is there a sad/happy/lonely/worried/angry face? Which person has most friends to play with?"

After the picture session the children were shown a photograph of a child with the same condition and asked if they thought this child should have the same operation and if they would like to tell them anything about it.

The older group of children had also been asked to draw and discuss their pictures of themselves in an attempt to see if the information given was comparable to that provided by the point scales and in each case it was virtually identical. Supporting evidence also came from parental questionnaires which demonstrated good agreement.

Findings

The children were all very satisfied indeed with their operations and demonstrated clear benefit in emotional terms. Their perception of this improvement was slightly greater than that of their parents. Both patient and parent satisfaction were markedly greater than any benefit attributed by surgeons or lay people when rating the children's changes in appearance from photographs. In this way a major procedure which surgeons were questioning as beneficial was shown to be highly valued by children and their parents.

Conclusion

Measuring patient satisfaction in children is possible when using methods appropriate to their developmental stage. Such measurements provide useful information about the value of treatments. Child psychiatry can contribute to outcome measurement in other medical specialities but there are also possible applications within our own field. In-patient treatment and long-term play therapy are examples of often lengthy and expensive treatments with considerable disruption to schooling and family life where patient satisfaction may be a suitable starting point for measuring outcome.

References

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