

The Hospital Experience Through the Patients' Eyes

Journal of Patient Experience
2020, Vol. 7(3) 408-417
© The Author(s) 2019
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/2374373519843056
journals.sagepub.com/home/jpx



Haverly J Snyder, BS¹, and Kathlyn E Fletcher, MD, MA²

Abstract

Background: Posthospital syndrome is associated with a decrease in physical and cognitive function and can contribute to overall patient decline. We can speculate on contributors to this decline (eg, poor sleep and nutrition), but other factors may also contribute. This study seeks to explain how patients experience hospitalization with particular attention on what makes the hospital stay difficult. **Design:** Qualitative interview study using grounded theory methodology. **Setting:** Single-site academic medical center. **Patients:** Hospitalized general medicine patients. **Measurements:** Interviews using a semi-structured interview guide. **Results:** We recruited 20 general medicine inpatients from an academic medical center. Of the participants, 12 were women and the mean age was 55 years (range = 22-82 years). We found 4 major themes contributing to the hospital experience: (1) hospital environment (eg, food quality and entertainment), (2) patient factors (eg, indifference and expectations), (3) hospital personnel (eg, care team size and level of helpfulness), and (4) patient feelings (eg, level of control and feeling like an object). We discovered that these emotions arising from hospital experiences, together with the other 3 major themes, led to the patients' perception of their hospital experience overall. We also explore the role that patient tolerance may play in the reporting of patient satisfaction. **Conclusions:** This article demonstrates the factors affecting how patients experience hospitalization. It provides insight into possible contributors to posthospital syndrome and offers a blueprint for specific quality improvement initiatives. Lastly, it briefly explores how patient tolerance may prove a challenge to the current system of quality reporting.

Keywords

patient expectations, patient feedback, patient perspectives/narratives, patient satisfaction, qualitative methods

Introduction

The experience of hospitalization is not easy (1–3). Patients often leave the hospital less able to care for themselves and in a state of health worse than their baseline (1,2,4). This period of potential decline, termed posthospital syndrome, places patients at a higher risk for a range of adverse events, including unsteadiness, readmission, and death (2,5,6). Some of these can be attributed to their illnesses, but that does not explain the entire functional and/or cognitive decline sometimes seen in hospitalized patients. We can make educated guesses based on literature clinical experience about factors that might contribute to this decline: Sleep, nutrition, hospital provider, depersonalization, and mood can all be negatively impacted by hospitalization (7,8). However, other factors may come into play. It has also been shown that health outcomes are positively correlated with metrics that can assess the patient experience, indicating that a crucial part in improving quality may lie in addressing the hospital experience (9–13).

Currently, the health-care experience is often assessed with surveys. Since their implementation, CAHPS Hospital Survey and Press-Ganey have worked to standardize data reported from hospitals about quality (14). This has allowed for meaningful comparisons across hospitals as well as incentivized accountability and quality improvement (14,15). For example, HCAHPS provides important data about hospital quality and patient satisfaction (14). However, these questions are closed-ended and responses are restricted to a 4-point Likert scale; they only skim the surface of the

¹ Medical College of Wisconsin, Milwaukee, WI, USA

² Department of Internal Medicine, Medical College of Wisconsin and the Clement J. Zablocki VA Medical Center, Milwaukee, WI, USA

Corresponding Author:

Kathlyn E. Fletcher, Department of Internal Medicine, Medical College of Wisconsin and the Clement J. Zablocki VA Medical Center, 8701 Watertown Plank Rd – A7743, Milwaukee, WI 53226, USA.
Email: kfletche@mcw.edu



patient experience. Instead of a question such as “what made it challenging to sleep?” patients are restricted to responding to a yes or no question about if the hospital was quiet (14,15).

As medical professionals, we can speculate on what patients may want improved about hospitalization. Some studies have been conducted about particular areas, such as service handovers and food quality (16–18). However, this focused approach does not allow for new themes to emerge and instead assumes that the focus area is one which patients would like improved. Others have gone one step further to discuss with patients what they would like to improve (19,20). A limitation of these studies was that participants were interviewed after discharge and thus may not remember everything that occurred during their hospitalization. Qualitative literature on patient-derived areas for improvement is lacking. We conducted this study to gain a better understanding of how patients view their hospitalization with particular focus on the factors that patients feel make their hospital stay difficult.

Methods

Study Design

This was a single-site qualitative interview study. We chose this technique with several thoughts in mind. Qualitative studies are ideal when the primary aim is to gain a deeper understanding of a scenario or phenomenon (21). We chose to implement interviews in order to glean patient-derived data to explain the processes and emotions associated with hospitalization, a technique well supported in qualitative research methodology (21). We anticipated this technique would provide us with the most robust data that we could then use to form a model of the hospital experience that accurately represented the data. We interviewed general medicine patients from June to August 2016 with particular interest in understanding the parts of hospitalization that were difficult for patients.

Participants

Our participants were recruited from an academic medical center located in a large, Midwestern city. The hospital has 585 beds and approximately 29 000 admissions per year. We included inpatients on general medicine teams, who were at least 18 and thought to be within 2 days of discharge. We excluded patients who were unable to speak English or were unable to give informed consent. We included patients from both housestaff and hospitalist Advanced Practice Provider (APP) teams.

Instrument

Based on a literature review, we designed a semistructured interview guide to explore the hospital experience. It contained a variety of open-ended and more direct questions with the goal of obtaining an in-depth view of what patients

perceived as important during their hospitalization. The interview process began with asking open-ended questions such as “walk me through your hospital stay. What were some of the major things that happened?” The interviewer made notes and went back to elements of the patient’s story to probe more deeply about crucial elements (as seen in the Supplementary Interview Guide). The interview guide was designed to allow patients to talk through their experience in its entirety and to also steer the conversation if they felt something was crucial to their hospital stay, a process that is well supported in the literature (21). Additional direct questions focused on specific topics such as comfort, meals, hospital workers, and what they felt should be improved were addressed depending on the amount of detail the original open-ended questions solicited. Patients were continuously probed further by questions such as “can you tell me more about that? What was that like? How did that make you feel?” This process was created to reveal patient-generated areas for improvement as well as to assess hypotheses about areas suspected to be difficult. We shared the guide with experts in doctor/patient communication, medical education, and hospital medicine and made adjustments based on their feedback. As the interviews progressed, we adapted the interview guide to explore emerging themes in subsequent interviews.

Data Collection

To perform the interviews, we obtained the team lists and went team by team in a random order to identify eligible patients. Each patient on the selected team list was assigned a number. We then spoke with either a resident or attending physician to identify eligible patients. If there were no eligible patients or the team could not be reached, we moved on to the next team. Using a random number generator, we randomly selected the order in which eligible patients were approached.

After completing 9 interviews, we switched to purposive sampling to ensure a broad age, gender, and racial representation of patients. Specifically, we switched techniques to account for racial diversity in our sample. This was achieved using the process described above, just substituting purposive sampling of eligible participants. We chose to begin with random sampling in order to achieve a diversity of participants and increase the generalizability of our results (22). We then used purposive sampling in order to ensure a diversity of our sample, anticipating that different participant demographics would lead to differences regarding hospital experience, thus providing more diverse, comprehensive data (22).

Patients completed a brief demographic survey. Interviews were audiotaped using a Zoom H4n Handy Recorder and then transcribed verbatim. We began data analysis while continuing to collect data to allow us the chance to explore new themes in subsequent interviews. We reached thematic saturation after completing 12 interviews and completed 8 more interviews before ending data collection (Table 1).

Table I. Saturation Grid.

Theme	Subtheme	Participants																			
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Environment	Cleanliness			X					X	X	X	X		X			X				
	Directions	X			X	X						X									
	Emergency department	X		X	X		X	X	X	X			X	X	X						X
Patient factors	Entertainment		X	X		X	X	X			X	X	X	X	X	X	X	X	X	X	X
	Food quality	X	X	X	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X
	Expectations	X	X	X	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X
	Family	X	X	X	X	X	X					X	X	X			X	X			X
	Indifference	X	X	X	X	X	X	X	X			X		X				X	X		X
	Life outside hospital				X					X				X	X		X	X			X
	Privacy									X	X										X
	Self-care				X						X	X			X				X		X
	Hospital personnel	Capacity	X				X				X		X	X	X					X	
Care team size		X		X	X	X		X	X	X	X	X	X	X			X	X	X	X	X
Level of helpfulness		X	X	X	X	X	X	X	X	X	X	X	X		X	X		X	X	X	X
Showing they care		X	X	X	X																X
Teamwork									X				X								
Feelings	Anxious	X	X		X	X			X	X	X		X	X				X	X	X	
	Appreciative	X	X		X	X		X		X	X	X	X	X	X		X		X	X	
	Boredom			X		X	X					X	X	X		X	X	X	X	X	X
	Feeling bothersome		X			X					X						X				X
	Feeling like an object								X								X				X
	Irritation	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X
	Level of control	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X
	Loneliness					X															
	Overwhelmed				X	X		X		X	X	X									X
	Trust	X	X									X	X								X
Areas of thematic overlap	Uninformed/confused	X	X																		X
	Advocacy								X		X		X						X		X
	Electronic Medical Record (EMR)												X						X		X
	Level of comfort	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X
	Mood influencers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Patient-provider relationship	X	X	X	X	X	X	X	X	X	X	X	X	X				X	X	X	X
	Patient strength	X	X									X	X				X	X	X	X	X
	Procedures	X			X		X		X	X			X	X	X		X	X			X
	Provider-provider communication	X	X		X	X	X		X				X	X			X	X			X
	Repetitive processes	X		X		X		X					X	X	X		X	X			X
	Sleep quality	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X
	Tolerance		X	X	X	X	X	X	X		X		X	X		X	X	X			X
	Wait time	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

We held a larger meeting with experts in physician/patient communication, medical education, and hospital medicine after half of the interviews were complete in order to gain outside opinions about how the analysis was progressing, and we made some adjustments to the interview guide as a result. This study was approved by this academic center’s institutional review board.

Analysis

We used a grounded theory approach to the data analysis and interviewed patients until we achieved thematic saturation (23). Grounded theory does not use a previous theory or model to analyze and interpret data. Rather, it uses the data

obtained to develop a model that accurately represents the findings (24). Transcripts were analyzed using NVivo qualitative data analysis software. The transcripts were first analyzed using open coding to identify distinct concepts that appeared in the transcripts. Open coding is a process in which there are no preformed ideas of exactly what the codes will be, they are derived from the transcripts themselves (24). Two of the study team members met on a weekly basis to discuss codes and themes as they were emerging during the interview process. We then developed a code book with codes and definitions and examined the breadth of experiences within each code (Table 2). After open coding was complete, we used axial coding to develop larger themes and concepts that allowed us to develop a framework. We began

Table 2. Coding Scheme for Transcript Analysis.

Code	Definition
Advocacy	Times when patients describe being advocated for or advocating for themselves
Anxious	Things that make patients feel anxious or stressed
Appreciative	Instances where patients communicate appreciation for someone or something
Boredom	Times patients were bored during their hospital stay
Cleanliness	cleanliness of something described by the patient
Concerns about family members	Things patients are worried about concerning their family
Capacity	Times when patients feel comforted or confident in their care provider's abilities
Control	Situations when patients describe directly or indirectly their level of control in the hospital
Maintaining control	Patients feeling like they have maintained control during their hospital stay
Not in control	Times that patients weren't in control of the situation; things done without consent and/or input
Directions	Directions to places (cafeteria, parking, rooms, information desks, etc)
Emergency Department (ED)	Issues from the ED
Electronic Medical Record (EMR)	Times patients discussed their experiences with the EMR
Entertainment	Descriptions about what patients and/or family members do or wish they could do for entertainment
Expectations	Expectations patients express about the hospital or hospital stay, what they thought should/would happen
Feeling bothersome	When patients describe feeling bad for doing certain things or feeling like a bother to their providers
Food quality	Describing the food quality during the stay
Getting to know providers	Times when patients describe getting to know their providers or wishing they got to know their providers better
Hospital Personnel	Descriptions of hospital personnel
Flustered	Times patients describe workers being flustered and how that impacts them
Helpful personnel	Times when patients perceived care providers being very helpful or doing something nice
Showing they care	Experiences which patients described unhelpful hospital staff
Unhelpful personnel	Times patients describe providers showing that they care about their patients and how that makes patients feel
Indifference	When patients do not care how something is done or how something is
Irritation	When patients feel frustrated or upset
Large care teams	Feelings about having a lot of providers in the same room at once
Level of comfort	Patients describing their comfort level during the hospital stay including physical environment
Comfort	Things that make hospitalization comfortable
Discomfort	Things that made patients physically uncomfortable
Life outside the hospital	Things patients discuss about their life outside the hospital including financial stressors
Loneliness	Patients describing times they were lonely in the hospital
Misleading information	Information that was either intentionally or unintentionally wrong
Mood influencers	
Mood enhancing	Things or people that improve the moods of patients
Mood nonenhancing	Things or people that did not improve the moods of patients or negatively affected the moods of patients
Overwhelmed	Times patients described being overwhelmed with a situation
Patient suggestions	Suggestions made by patients to improve hospitalization
Patient-provider communication	Communication between patients and their providers
Amount of information received	Times patients discuss how much information they receive from their providers and whether they want more or less
Feeling like an object	Times patients discuss feeling like they are on display or feeling like an object
Not feeling heard	Times when patients do not feel their provider is hearing or understanding what they are saying
Patient safety issue	Times when patients discuss things that could have or did result in an adverse event or a near miss
Privacy	Times patients describe privacy concerns or how they maintained privacy
Provider-provider communication	Communication between different providers
Repetitive process	Descriptions of processes that patients experience multiple times
Security	Patients discussing security personnel or situations in which they interfaced with hospital security
Self-care	Patients describe things that they do or need to do in order to feel better or feel like a human
Sleep quality	Discussion of factors affecting sleep in the hospital
Strength	Factors affecting patients' strength - things that make them stronger or weaker
Activity level	Times when patients mentioned or alluded to their physical or mental activity levels and how they feel it is affecting them
Importance of quality food	Times patients discuss the importance of having good food in the hospital and what it means to them as a patient
Teamwork	Times when patients describe team dynamics they witnessed during their hospital stay

(continued)

Table 2. (continued)

Code	Definition
Tolerance	When patients settle for something because they think that is how it is in the hospital, but they are not really happy with it
Trust	Trusting or developing trust with care providers
Wait time	Times when patients describe their wait times for certain aspects of their hospital stay
No waiting	Very short or no wait
Waiting	Text associated with patients having to wait for something

by organizing similar codes together to assess their relationships. Some were denoted as “daughter” codes within the NVivo software as they were better explained in their association with their “parent” code (Table 2). For example, the original codes “helpful personnel” and “unhelpful personnel” became daughter codes of hospital personnel. After parent and daughter codes were identified we began to look for relationships between codes, organizing codes into subthemes. The relationships, or lack thereof, between subthemes allowed for organization of major themes and areas of overlap between major themes. Our work in the form of major themes and subthemes are representative of substantive-level theory about the patient experience. Each theme and subtheme were derived from the data to represent specific areas of the patient experience (24). We presented preliminary findings to a group of experts (including clinicians and researchers) to further refine our axial coding. To assess for agreement, one investigator identified the chunks of text coded and marked these on an uncoded copy of 3 randomly selected transcripts. Overall agreement was calculated by the number of chunks that had any coding agreement (considered if the coders agreed on at least one code for the chunk) divided by the total number of chunks. Coding agreement was 89%.

Results

We interviewed 20 patients. The mean age was 55 (range = 22-82); 8 were men; 4 were African American, and there was a wide range of employment and education status (Table 3). Direct, comprehensive chart review was not performed as part of the original study protocol. However, several patients self-reported the reason for their admission during the interview. These reasons for admission reflected a wide range of internal medicine topics such as cystic fibrosis exacerbation, abdominal pain, bowel obstruction, and mechanical fall (Table 3).

A model representing the patient experience emerged from the analysis (Figure 1). The model consisted of 4 major themes (Table 4): environmental factors, patient factors, hospital personnel factors, and patient feelings. Each major theme was composed of several subthemes. There were also several subthemes that overlapped between major themes. The interaction between the environmental, patient, and hospital personnel themes and subthemes seemed to influence the feelings patients developed throughout their hospitalization and therefore contributed

to their perception of their hospital stay overall. In the following paragraphs, we highlight the main themes and selected subthemes.

Environment

The first major theme was the hospital environment, which focused on aspects of the hospitalization that were intrinsic to the hospital itself. When discussing the hospital environment with patients, 5 subthemes emerged: cleanliness, directions, emergency department, entertainment, and food quality.

Patient Factors

The second major theme was patient factors. This theme included factors brought to the hospitalization by patients themselves. The subthemes were patient expectations, family, indifference, life outside the hospital, privacy, and self-care.

A commonly discussed subtheme was the concept of indifference. We defined this as when patients did not have a preference about a situation or about how something was done. For example, when asked if they would like more information about their hospital providers, one patient replied, “I don’t have to know—as long as they’re doing their job. I mean, I don’t really care . . . they always introduce themselves when they come in and—and that’s all I need to know.”

Hospital Personnel

Hospital personnel reflected the attitudes and work of the hospital workers. Subthemes within this theme included capacity, care team size, level of helpfulness, showing they care, and teamwork.

Care team size referred to the number of people on the team taking care of the patient. This number was dependent on whether the team was resident or Physician Assistant/Nurse Practitioner based. Feelings toward the care team size varied widely. For example, several patients described large care teams as, “very overwhelming . . . when you have the one head doctor that always comes in in the morning . . . then you have the students . . . and you have 6 of ‘em pile in . . . it’s a lot.” However, it was also common for patients to enjoy or feel indifferent about having a large care team.

Table 3. Participant Demographics.^a

Gender n (%)	
Female	12 (60)
Male	8 (40)
Age	
Mean	55
Range	22-82
Race n (%)	
Caucasian	16 (80)
African American	4 (20)
Employment	
Currently employed	5
Unemployed and not seeking employment	1
Retired	9
Unable to work	2
Other (disability)	2
Prefer not to say	1
Education	
No school completed	1
Through 8th grade	1
Some high school	2
High school General Education Diploma (GED) or diploma	8
Some college credit	4
Associate degree	1
Master's degree	3
Reason for admission (self-reported)	
Mechanical fall	
Crohn flare with weight loss	
"Urological issue"	
Cystic fibrosis exacerbation	
Alcohol withdrawal	
Abdominal pain	
Headache	
Bowel obstruction	
Diverticulitis	

^an = 20.

Feelings

Feelings was the theme that included emotions that patients experienced throughout their hospitalization as a result of the interplay between the hospital environment, their personal patient factors, and the hospital personnel. Patients described a wide range of emotions including anxiety, appreciation, boredom, feeling bothersome, feeling like an object, irritation, level of control, loneliness, overwhelmed, trust, and uninformed/confused.

One subtheme frequently discussed was level of control. Patients described frustration due to the minimal control they have over their schedule. Others described their frustration from their lack of personal space stating, "these people just sort of walk in and they take over the room . . . I understand put the mute button on but, it's like, you're coming in to my space."

Overlapping Subthemes

Several aspects of hospitalization fit within more than one theme. Level of comfort, for example, was not only

dependent on the hospital environment but also on the hospital personnel. Another area of immense overlap existed between patients and personnel and included areas such as patient-provider communication.

Another area of overlap was between environment, patients, and hospital personnel. A topic within this area of overlap was patient strength. Some patients described how they felt that being able to move about the hospital, either for exercise or entertainment, played a pivotal role.

A final area of overlap was the concept of tolerance. This subtheme emerged as a combination of patient expectations, hospital environment, and personnel factors. This subtheme describes when patients settled for something because they believed that is the way it is in the hospital, even though they were dissatisfied. One of the earliest examples emerged when a patient remarked, "what do you do?" while describing that the patient in the neighboring room was loud and kept him awake for most of the night.

Discussion

This study aimed to understand the patient experience, paying special attention to aspects of hospitalization that are particularly difficult. We discovered that hospital factors, patient factors, and personnel factors played a role in determining the feelings that patients experienced during their hospitalization. The feelings ranged from anxious, to appreciative, to feeling out of control. The model emphasizes the importance of hospital personnel in setting the tone for patients' experiences. Patients wanted their care providers to be kind to them. This may seem obvious, yet it reinforces that patients want their providers to demonstrate they care and to know that they are working as hard as they can on their behalf (25).

In addition to explaining the hospital experience, this model provides insight into possible contributors to posthospital syndrome. Some factors such as lack of sleep or food quality have been studied or suggested as factors that contribute to posthospital syndrome (17,19). This study sheds light on other factors that may also contribute, such as the opportunity for self-care, mood influencers, patient strength, and advocacy. Since patients described self-care activities (eg, showers, essential oils) as calming or making them feel better, improving the ease with which patients can perform these activities may help patients feel better sooner. Patient strength also seems to play an important role. Current literature emphasizes the importance of early mobility in intensive care unit patients (26). Similarly, encouraging appropriate mobility and exercise may prove beneficial not only for physical health but also for patient morale and self-efficacy.

The concept of tolerance was intriguing. We identified tolerance when patients responded to questions with phrases such as "it's fine." We ultimately defined it as when patients settled for something because they believed that is the way it is in the hospital, even though they were dissatisfied. Upon

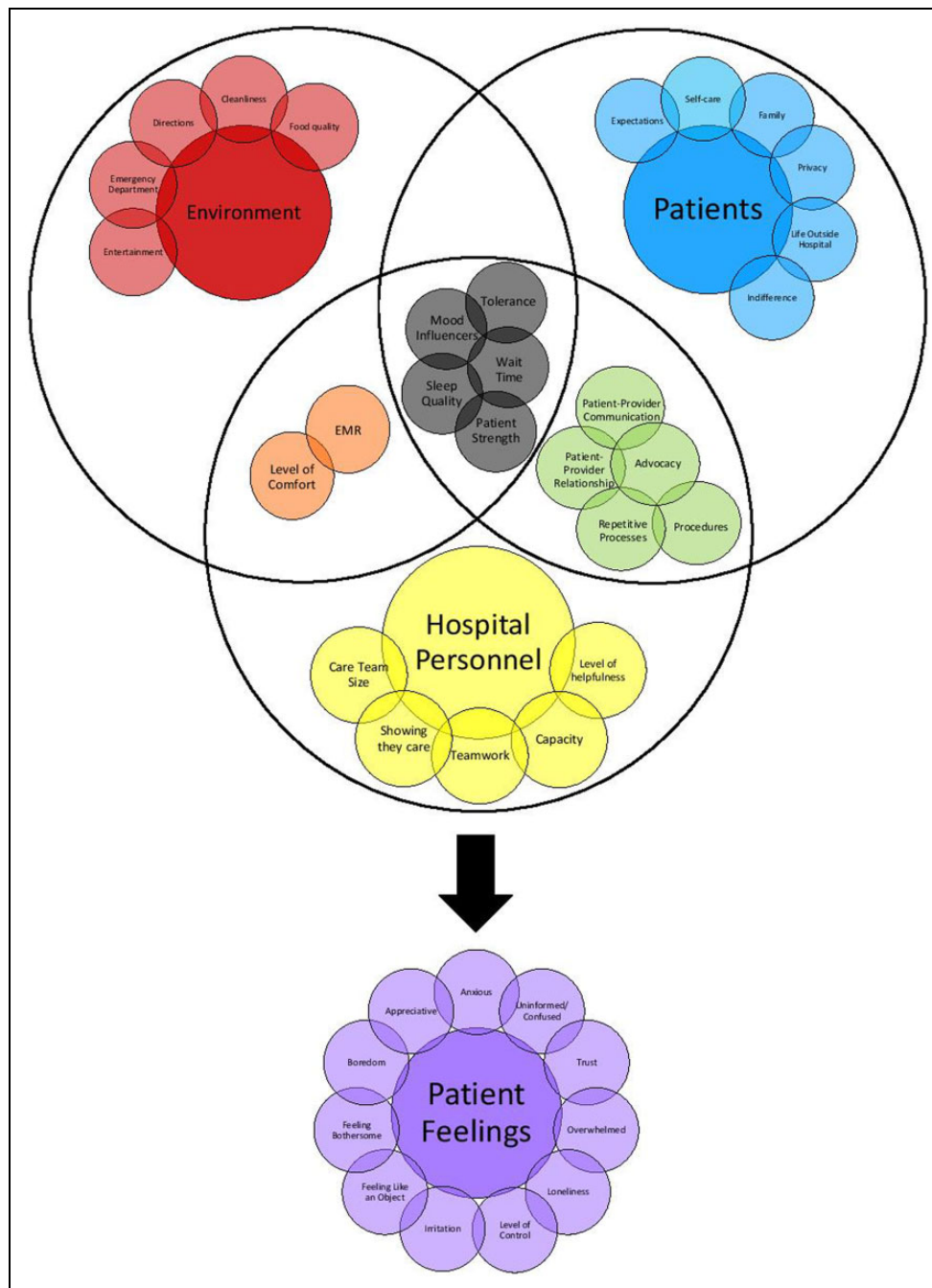


Figure 1. Patient perceived factors and the patient experience of hospitalization.

hearing these responses early in the interview process, we were uncertain how to characterize them. In order to further investigate, we added probes about what ideal might look like; this allowed patients to offer feedback or suggestions. As we continued to acquire and analyze data indicating that patients did not enjoy certain aspects but did have suggestions on how to improve them, the tolerance concept separated itself from indifference. Where indifference suggests that patients truly do not have a preference regarding a specific topic, tolerance emerged as a concept where patients accept the norm but do have an underlying belief regarding

the manner in which something should be done. For example, while discussing staff entering the room at night, one patient stated that “they gotta do that . . . but you know, that [gets] kinda annoying sometimes.” When probed further about what his ideal night would look like, he suggested that “twice a day” would help him to sleep better. Further probing with a subsequent patient produced this statement: “I haven’t complained, only because I figured there was nothing that could be done.” These responses indicate that patients may have more to say than they initially let on or even realize, and that with the appropriate conversation they

Table 4. Major Themes, Their Subthemes, and Representative Quotes.

Theme	Subtheme	Representative Quote
Environment	Cleanliness	"They have cleaned every day and it's absolutely spotless"
	Directions	"She's not from this area so . . . or she hasn't been for a very long time. So she had a problem figuring out where to park"
	Emergency department	"they had the waiting times for lab work posted on the wall, however, it ran far longer than they said"
	Entertainment	"art. Hmmm . . . Books and magazines . . . even if—a-a group movie. So a person can be in a wheelchair"
	Food quality	"the food is absolutely excellent . . . I had tenderloin tips . . . , grilled cheese and, cheeseburger—the cheeseburgers are absolutely excellent"
Patient factors	Expectations	"The ER wait was a little bit longer than I thought it would be or [was] in the past"
	Family	"She was very tired, um, because she came from work and she'd been up since, um, 5 o'clock"
	Indifference	"I don't have to know who it—or what—as long as they're doing their job. I mean, I don't really care. I mean it—they always introduce themselves when they come in and—and that's all I need to know"
	Life outside hospital	"I mean, I'm missing out on money"
	Privacy	"they're pretty good, too. You know, they knock"
	Self-care	"it made [her] feel so damn good . . . if they can't do a shower, a sponge bath would help"
Hospital personnel	Capacity	"this doctor explained that we could mix these two drugs together . . . he wanted to do this test this morning, it got done, they're rushing orders. And then the physician on the floor, he's here 2, 3 times a day . . . he stops in to make sure that I know that he's still watching the case"
	Care team size	"very overwhelming . . . like when you have the one head doctor that always comes in in the morning . . . then you have the students . . . and you have like 6 of 'em pile in and . . . it's a lot"
	Level of helpfulness	"they took a lotta time, were just very personable, very, informative . . . [I felt] very respected, very, just involved"
	Showing they care	"they always ask if they can help me with it or anything . . . they've been very, very considerate and polite"
	Teamwork	"when you have different teams of doctors to come see you for different things and they all ask you the same questions, in my mind I'm just like why don't you guys talk to each other?"
Feelings	Anxious	"they're—talking about me and my body and like . . . it was really struggling and that was just like bringing my anxiety up a lot"
	Appreciative	"They took time to listen to me, and that's what means a lot to me"
	Boredom	"Sometimes I'll go walk into the courtyard . . . just to be outside . . . just so I don't have to be in the room all the time"
	Feeling bothersome	"I felt so bad because, here I ordered this sandwich and I got maybe a quarter of it down . . . I ordered it special and I couldn't eat it"
	Feeling like an object	"I would've appreciated a little bit more checking in with me from the doc . . . okay, this is what we're doing, we're gonna talk about you—but, you know more acknowledgement of me"
	Irritation	"constantly getting poked . . . that's what frustrates me"
	Level of control	"these people just sort of walk in and they take over the room . . . I understand put the mute button on but, but, it's like, you're coming in to my space"
	Loneliness	"that always makes me feel a little better . . . just someone to talk to about their days"
	Overwhelmed	"I was really sick, they were giving me all this information, and it just got way too overwhelming, so I just asked everyone to leave, just to talk to the doctor on my own"
	Trust	"when you get a new doctor or a new nurse, they seem to know you and know your case . . . you feel more at ease"
	Uninformed/confused	"her contribution freaked me out . . . how does she expect me to live with that? . . . and then yesterday the ostomy nurse came in and she finally explained what it was"
Areas of thematic overlap	Advocacy	"the nurses are on my side . . . they're on my side and they're trying to help as much as possible"
	Electronic Medical Record (EMR)	"I guess they didn't know in their computer why I was here . . . I guess it wasn't on the computer"

(continued)

Table 4. (continued)

Theme	Subtheme	Representative Quote
	Level of comfort	“Very uncomfortable on the cart”
	Mood influencers	“the view. I thought, gee, I got a nice view here . . . It makes life a little better . . . there’s something about having the outside world coming in”
	Patient–provider relationship	“I had really good attention . . . the residents were just really great”
	Patient strength	“would’ve been nice to get more exercise”
	Procedures	“they told me I couldn’t eat . . . almost 12 to 15 hours before I was able to eat”
	Patient–provider communication	“it’s like you’re just not listening, at all . . . it’s in one ear and right out the other”
	Repetitive processes	“They come to get blood or to check my vitals or whatever. Ya know. Typical hospital stay. I’ve never been in a hospital yet where they let you sleep all night”
	Sleep quality	“I think I’d feel better if they let me sleep”
	Tolerance	“I haven’t complained, only because I figured there was nothing that could be done”
	Wait time	“And that was—that was the hardest thing, waiting, but, you have to—sometimes people are worse off than you”

may be able to provide suggestions for improvements that may otherwise be undiscovered.

Understanding that patients view hospitalization through a lens of tolerance led us to wonder how well satisfaction surveys truly discern quality. If patients are viewing and assessing their hospitalization through a lens of tolerance, are the data being reported on satisfaction surveys accurately reflecting the patients’ experiences? Our data suggest that sometimes patients are not considering the possibility that things could improve, which may also impact survey results. Moreover, this may suggest that our current method of assessing quality is not well rounded and may need improvements in order to ensure maximal patient-centered improvements.

This concept of tolerance also presents unique challenges when approaching hospital leadership to discuss change. If surveys do not accurately reflect how patients feel, it could prove challenging to convince leadership that change is needed. Additionally, if patients realize they can expect more from hospitalization, they may begin completing surveys based on what their ideal situation would be. This could lead to a decrease in satisfaction scores that would then require a response from hospital leadership. Leadership may be hesitant to explore what ideal would look like for patients. However, we believe that eliminating tolerance and striving for ideal deserve serious consideration and future study.

There are several limitations to this study. First, this was a single-site study with a sample size of 20, which limits the generalizability of our results. Although the sample size and obtained patient demographics make these findings somewhat preliminary, we did achieve thematic saturation and we used both random and purposive sampling to obtain a diversity of participants. Second, our results are qualitative and we are therefore unable to describe them in a quantitative manner. We can say, however, that these are issues present in the hospital and that we should address them. Third, the study was restricted to English-speaking participants only as we did not have the resources to provide translation services. Non-English-speaking patients

have their own unique challenges and may have unique stressors related to hospitalization. However, we used a combination of random and purposive sampling to ensure maximum diversity.

One area we did not address in this study is actual post-hospital recovery. In other words, we did not follow patients home and reinterview them to understand their recovery. If they experienced posthospital syndrome, how long did it take for them to recover? A future study could address how patients’ posthospital recoveries are impacted by factors such as those identified in this study.

Limitations notwithstanding, this study adds depth to our understanding of the patient experience and provides data that we can use to improve hospital care. Because this was a single-site study, further exploration at an additional site would be a reasonable next step. The implications of these results are numerous. Most markedly, the conceptual model provides a framework from which to draw areas for targeted quality improvement initiatives. For example, future initiatives encouraging the maintenance of a home routine (ie, bathing, brushing teeth) as well as timed coordination of nightly interruptions (eg, bloodwork, vitals, wound checks) could lead to drastic improvement in patient sleep quality, thus improving multiple aspects of hospitalization. This study also provides patient-derived data on important areas of hospitalization that could be used to develop a more patient-centric instrument to measure patient satisfaction. It also suggests that future instruments may need to include methods to address patient tolerance in order to gain a deeper and more comprehensive assessment of patient satisfaction. Whether through targeted quality improvement initiatives or larger policy changes, this study will serve as a framework to produce meaningful change for patients and improved quality for all.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Ms. Snyder received a Young Scholar in Hospital Medicine award from the Society of Hospital Medicine to fund her summer work on this project.

Supplemental Material

Supplemental material for this article is available online.

References

- Detsky AS, Krumholz HM. Reducing the trauma of hospitalization. *JAMA*. 2014;311:2169-170.
- Krumholz HM. Post-hospital syndrome—an acquired, transient condition of generalized risk. *N Engl J Med*. 2013;368:100-2.
- Schattner A. Hospitalization-associated disability in adults admitted to a safety-net hospital. *J Gen Intern Med*. 2016;31:460.
- Ehlenbach WJ, Hough CL, Crane PK, Haneuse SJ, Carson SS, Curtis JR, et al. Association between acute care and critical illness hospitalization and cognitive function in older adults. *JAMA*. 2010;303:763-70.
- Dharmarajan K, Hsieh AF, Kulkarni VT, Lin Z, Ross JS, Horwitz LI, et al. Trajectories of risk after hospitalization for heart failure, acute myocardial infarction, or pneumonia: retrospective cohort study. *BMJ*. 2015;350:h411.
- van Seben R, Reichardt LA, Essink DR, van Munster BC, Bosch JA, Buurman BM. “I Feel Worn Out, as if I Neglected Myself”: older patients’ perspectives on post-hospital symptoms after acute hospitalization. *Gerontologist*. 2019;59:315-26.
- Zisberg A, Shadmi E, Gur-Yaish N, Tonkikh O, Sinoff G. Hospital-associated functional decline: the role of hospitalization processes beyond individual risk factors. *J Am Geriatr Soc*. 2015;63:55-62.
- Palese A, Gonella S, Moreale R, Guarnier A, Barelli P, Zambiasi P, et al. Hospital-acquired functional decline in older patients cared for in acute medical wards and predictors: findings from a multicentre longitudinal study. *Geriatr Nurs*. 2016;37:192-9.
- Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*. 2013;3:pii: e001570.
- Agoritsas T, Bovier PA, Perneger TV. Patient reports of undesirable events during hospitalization. *J Gen Intern Med*. 2005;20:922-8.
- Fremont AM, Cleary PD, Hargraves JL, Rowe RM, Jacobson NB, Ayanian JZ. Patient-centered processes of care and long-term outcomes of myocardial infarction. *J Gen Intern Med*. 2001;16:800-8.
- Glickman SW, Boulding W, Manary M, Staelin R, Roe MT, Wolosin RJ, et al. Patient satisfaction and its relationship with clinical quality and inpatient mortality in acute myocardial infarction. *Circ Cardiovasc Qual Outcomes*. 2010;3:188-95.
- Jha AK, Orav EJ, Zheng J, Epstein AM. Patients’ perception of hospital care in the United States. *N Engl J Med*. 2008;359:1921-31.
- Centers for Medicare & Medicaid Services, Baltimore, MD. <http://www.hcahpsonline.org>. Retrieved November 18, 2018.
- LaVela SL, Gallan AS. Evaluation and measurement of patient experience. *Patient Exp J*. 2014;1:28-36.
- Wray CM, Farnan JM, Arora VM, Meltzer DO. A qualitative analysis of patients’ experience with hospitalist service handovers. *J Hosp Med*. 2016;11:675-81.
- Dall’Oglio I, Nicolo R, Di Ciommo V, Bianchi N, Ciliento G, Gawronski O. A systematic review of hospital foodservice patient satisfaction studies. *J Acad Nutr Diet*. 2015;115:567-84.
- Kebede S, Shihab HM, Berger ZD, Shah NG, Yeh HC, Brotman DJ. Patients’ understanding of their hospitalizations and association with satisfaction. *JAMA Intern Med*. 2014;174:1698-700.
- Neeman N, Quinn K, Shoeb M, Mourad M, Sehgal NL, Sliwka D. Postdischarge focus groups to improve the hospital experience. *Am J Med Qual*. 2013;28:536-8.
- Wong EL, Coulter A, Cheung AW, Yam CH, Yeoh EK, Griffiths S. Item generation in the development of an inpatient experience questionnaire: a qualitative study. *BMC Health Serv Res*. 2013;13:265.
- US Food and Drug Administration. Patient-focused drug development guidance public workshop: methods to identify what is important to patients & select, develop or modify fit-for-purpose clinical outcomes assessments. <https://www.fda.gov/downloads/Drugs/NewsEvents/UCM620707.pdf>. FDA (accessed April 8, 2019).
- Lincoln YS, Guba EG. *Naturalistic Inquiry*. London: Sage; 1985.
- Glaser BG, Strauss AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine; 1967: 101-15.
- Creswell JW. *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Thousand Oaks: Sage; 1998.
- Fletcher KE, Furney SL, Stern DT. Patients speak: what’s really important about bedside interactions with physician teams. *Teach Learn Med*. 2007;19:120-7.
- Hopkins RO, Mitchell L, Thomsen GE, Schafer M, Link M, Brown SM. Implementing a mobility program to minimize post-intensive care syndrome. *AACN Adv Crit Care*. 2016;27:187-203.

Author Biographies

Haverly J Snyder is a 4th year medical student at the Medical College of Wisconsin. She will graduate with her doctor of medicine degree in May 2019. She plans to pursue a residency in Obstetrics-Gynecology at the Ohio State University.

Kathlyn E Fletcher is a professor of Medicine at the Medical College of Wisconsin and the Clement J. Zablocki VAMC in Milwaukee, WI. She practices hospital medicine and is a patient safety researcher. She has served as the program director for the Internal Medicine Residency Program since 2017.