

Original Article

Core Aspects of Satisfaction with Pain Management: Cancer Patients' Perspectives

Susan L. Beck, PhD, APRN, FAAN, Gail L. Towsley, PhD,
Patricia H. Berry, PhD, APRN, Karen Lindau, MS,
Rosemary B. Field, MS, APRN, ACONS, and Shantelle Jensen, BS, RN
University of Utah College of Nursing (S.L.B., G.L.T., P.H.B., K.L.), Salt Lake City, Utah; Nursing Department (R.B.F.), Marymount Hospital, Garfield Heights, Ohio; and Nursing Department (S.J.), Primary Children's Medical Center, Salt Lake City, Utah, USA

Abstract

Context. The coexistence of high levels of satisfaction and high levels of pain has been perplexing.

Objectives. The aims of this study were to 1) describe patient expectations related to the experience of cancer-related pain, 2) explore the cognitive processes and meaning that underlie patient judgments about satisfaction and dissatisfaction with pain management, and 3) explore the discrepancies between ratings of high satisfaction with pain management with high pain intensity.

Methods. The sample included 33 patients: 18 with advanced cancer and 15 experiencing pain after a surgery for a cancer diagnosis. All patients had experienced "worst pain" of at least moderate intensity and were interviewed using standard pain measures from the American Pain Society Patient Outcome Questionnaire and open-ended questions about the underlying meaning of their answers. We systematically analyzed the transcribed qualitative data using NVivo software.

Results. Fifty-five percent of patients were females and were aged 25–78 years. Most (75%) were satisfied or very satisfied with their overall pain management. Key findings indicate that for some, the worst pain rating was often brief, even momentary. Most patients expected pain relief. Four key themes were important to the quality of pain management: being treated right, having a safety net, being in a partnership with their health care team, and having pain treatment that was efficacious. Key aspects of the patient-provider relationship that mattered were how the nurses and doctors behaved toward them and how quickly they responded to reports of pain. For some, an important factor was whether they had control of the amount of pain they experienced.

Conclusion. The findings inform measurement of patient satisfaction with the quality of pain management. *J Pain Symptom Manage* 2010;39:100–115. © 2010 Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.

This study was funded by a grant from the Oncology Nursing Society Foundation.

Address correspondence to: Susan L. Beck, PhD, APRN, FAAN, University of Utah College of Nursing, 10

South 2000 East, Salt Lake City, UT 84112-5880, USA. E-mail: Susan.beck@nurs.utah.edu

Accepted for publication: June 17, 2009.

Key Words

Cancer pain prevention and control, patient satisfaction evaluation, neoplasms, qualitative research, quality

Introduction

Monitoring and improving outcomes of care are ever-increasing concerns for health care organizations. Growing organizational interest in how to effectively measure outcomes of care related to pain management took on a new dimension in the United States when the Joint Commission published pain assessment and management accreditation standards.¹ In effect since 2001, the standards strengthened organizational expectations related to pain assessment, management, and patient education. More specifically, the performance improvement standard addresses assessment of outcomes of care including “patient satisfaction” and “the effectiveness and appropriateness of pain management.” Thus, understanding patient satisfaction related to pain management is acknowledged as essential to providing effective pain management for patients.

The measurement of patient satisfaction, however, has been complicated by the creation of what is essentially a paradox: the coexistence of high levels of pain and high levels of patient satisfaction. This, in turn, leads to questions about the construct validity of the measures of patient satisfaction with pain management. Until better measures are developed, there is an unfortunate possibility of concluding that patient satisfaction with pain management is evidence of effective pain management. This possibility exists in some of the nursing report cards that only consider satisfaction.²

The purpose of this study was to explore the reasons for this high pain-high satisfaction paradox. The specific aims were to 1) describe patient expectations related to the experience of cancer-related pain, 2) explore the cognitive processes and meaning that underlie patient judgments about satisfaction and dissatisfaction with pain management, and 3) explore discrepancies between patient ratings of pain intensity and their satisfaction with pain management. The resulting core concepts can serve as a guide to future measurement of satisfaction with the quality of cancer pain management.

Cancer-Related Pain

Studies of cancer pain prevalence indicate that approximately 30%–50% of patients receiving cancer treatment experience pain; prevalence increases with advanced disease.³ Pain can be acute in nature, such as the pain experienced after surgery for cancer, or chronic and progressive as disease advances. The past several decades of research document persistent pain severity and inadequate treatment of cancer pain across settings and populations, including ambulatory patients, postsurgical patients with cancer, and inpatients.^{4–22}

Patient Satisfaction

Patient perceptions are increasingly being used to measure the quality of health care.²³ The American Academy of Nursing Panel on Quality Health Care proposed that patient satisfaction to be included in one of their five categories of nurse-sensitive outcomes: the perception of being well-cared for.²⁴ Patient satisfaction is the congruency between expectations of care and perceptions of the care received.²⁵ High satisfaction with care is considered a desired outcome and may influence decisions to seek care, change providers or medical plans, and adhere to prescribed treatment plans.²⁶

The concept of measuring patient satisfaction with pain management emerged in the 1990s. The Quality Assurance Committee of the American Pain Society (APS) proposed an approach to measure patient satisfaction as part of their first standards published in 1991. Several investigators tested this approach and suggested ways to improve the measurement.^{16,19,21} In 1995, the APS published revised standards that included a Patient Outcomes Questionnaire (POQ) with three items related to patient ratings of satisfaction. Several studies have been published using the POQ,^{8,10,14,27–31} it remains the recommended approach although some investigators have used open-ended questions or developed their own tools. Additionally, the patient satisfaction items in the POQ have been criticized because

of their global nature; they are not recommended as a sole measure of quality of care related to pain.³¹

The High Pain-High Satisfaction Paradox

Regardless of how patient satisfaction with pain management has been measured so far, researchers have been surprised to learn that patients with significant pain severity report high levels of satisfaction. For example, in a study of 72 medical-surgical patients in an urban hospital, the mean worst pain score in the past 24 hours was 7.56 (0–10 scale); more than 70% reported a worst pain score of 7 or greater. More than 70% reported that they were very satisfied (20%) or satisfied (51%) with their pain relief.¹⁹ This paradox has been documented in hospitalized patients, including postoperative patients, in the emergency room, in oncology settings, and in children as well as adults.^{9,10,14,16,21,30–38} McNeill et al.²⁷ specifically compared the pain severity between satisfied and dissatisfied patients with severe pain. There was no significant difference for worst pain or pain now, but the dissatisfied patients did have a significantly higher average pain level (mean = 9.20) as compared with the satisfied patients (mean = 8.1). The published correlations between pain severity and patient satisfaction are generally inconsistent, ranging from –0.18 to –0.57 and variably significant.^{9,10,14,16,21,30,32–38} The pain satisfaction ratings are consistent with other satisfaction studies in that the data are often skewed in a positive direction. Most of the aforementioned investigators have hypothesized about the reasons for the high pain-high satisfaction paradox. They suggested that current approaches may be measuring caring behaviors, expectations that pain cannot be relieved or that it will have peaks and troughs, responsiveness to requests for pain medication, not “wanting to get anyone in trouble,” and bedside manner among other factors.

Several studies have been conducted in the past decade to explore this interesting paradox in more detail. In a study by Idvall³⁹ in Sweden, 24 postsurgical inpatients, after completing a questionnaire regarding pain management and level of satisfaction, were specifically questioned why they stated they were satisfied with their care, even though they reported high levels of pain intensity. The findings indicated that patients expected

to have some unrelieved pain and that it was often associated with movement, that the staff did their best and were kind, and that the patients did not want to be troublesome to busy staff. Sherwood et al. questioned 241 in-hospital patients, including those with postoperative pain and some cancer patients. They identified four separate themes that affected patient satisfaction: “patient pain experience, patient views of providers, patient pain management experiences, and pain management outcomes.”²⁹(p. 489)

Research exclusively focused on individuals with cancer is limited. In a qualitative study of 19 cancer patients conducted in Finland, investigators found that postoperative patients believed pain after surgery was inevitable, the staff tried to do a good job and should not be blamed, and patients did not want to be a bother. Participants emphasized the importance of communication and kindness in addition to a proactive approach to pain assessment as important to pain-related care.⁴⁰ In another study by Dawson et al.¹⁰ in which 316 primary care cancer patients were interviewed, it was found that high patient satisfaction was directly linked to the ability of the doctor or the nurse to identify pain management as an important goal and experiencing a decrease in pain over the past year. Lower levels of satisfaction were associated with patients’ beliefs that the presence of pain meant a decrease in quality of life. Other factors identified that influenced patient satisfaction included perception of efforts by the primary care physician, willingness to take pills, not wanting to be a bother, a belief that pain is inevitable, and pain had changed with medication. A qualitative component reinforced the importance of the patient-provider relationship in satisfaction.

Although there is a growing body of evidence related to the high pain-high satisfaction paradox, only one has specifically addressed the issue in individuals with cancer in the United States and the focus was on primary care.¹⁰ Thus, a qualitative approach was selected to further understand the expectations that cancer patients have for the pain experience and pain relief and to explore the cognitive meanings that may be influencing their interpretation and responses to questions about their satisfaction. Such findings can lead to development of improved ways of measuring satisfaction.

Research shows that the paradox of patient satisfaction with unrelieved pain exists for multiple types of pain populations, yet the expectations may be very different. Patients undergoing surgery for cancer might expect to experience pain and know that it would gradually improve; patients with advanced cancer may be uncertain about what to expect, may not understand the cause of the pain, and may fear progressive unrelieved pain. Expectations related to pain management and pain relief are not known and would clearly influence satisfaction.

Theoretical Framework

The theoretical underpinnings that are guiding this study are based in disconfirmation theory, also referred to as expectations-performance theory.²⁵ The theory, which was developed within the field of social psychology, has been extensively applied to the study of consumer satisfaction.⁴¹ In disconfirmation theory, satisfaction is conceptualized as the difference between what a consumer expects to receive and his or her perception of what was actually received. Thus, if the consumers' expectations are confirmed, satisfaction results. Disconfirmation results when the product performance does not meet the expectations (negative disconfirmation) or when performance exceeds expectations (positive disconfirmation). The key concept from this theory, which guided this study, is that expectations and performance form the reference point from which to assess satisfaction.

Methods

This exploratory qualitative study combined a structured questionnaire to measure pain intensity and satisfaction with a follow-up face-to-face interview using naturalistic inquiry to gather more in-depth information to clarify perplexing quantitative data.

Sample and Setting

To allow for a greater understanding and comparison of the expectations related to two very different types of pain experiences in cancer patients—chronic progressive cancer-related pain and acute pain after surgery for cancer—we included 1) patients with

advanced cancer who experienced peak cancer pain (i.e., the pain at its worst in the last 48 hours) of at least a moderate intensity (≥ 4 on a 0–10 scale), or 2) patients who experienced peak postoperative pain (i.e., the pain at its worst in the past 48 hours) of at least a moderate intensity (≥ 4 on a 0–10 scale). In addition, all patients were English speaking and physically and mentally able to participate. Patients with primary chronic pain not related to cancer (e.g., chronic low back pain or arthritic pain) and without concurrent cancer pain were excluded.

The study was approved by the University of Utah Institutional Review Board. All patients signed a written informed consent before participation. Advanced cancer patients were recruited from the ambulatory care settings of the Huntsman Cancer Institute and the University of Utah Radiation Therapy Department. Postoperative patients were recruited from the inpatient settings of the University of Utah Hospitals and Clinics and included patients who underwent surgery for cancer that required general anesthesia. Interviews were conducted in a setting convenient for the patient and included a private setting in the clinic, their home, a long-term care or assisted living facility, or the patient's hospital room.

Survey and Interview Guide

Each patient completed survey items to measure aspects of their pain experience and satisfaction with pain management as provided by the nurses, doctors, and overall. All items were selected from the APS POQ.^{19,42} The items selected from the POQ included items from the Brief Pain Inventory (worst pain intensity, percent pain relief, and amount of time in severe pain),⁴³ as well as three items related to satisfaction. The satisfaction items are numeric scales with verbal descriptors from 1 (completely dissatisfied) to 6 (completely satisfied).

We developed a semi-structured interview guide based on disconfirmation theory. The guide included specific questions related to expectations about pain before diagnosis, at the time of diagnosis, and at the present time. The guide also probed the rationale for patient responses to the satisfaction items (Table 1). The interview guide was tailored to the sample (i.e., advanced cancer vs.

Table 1
Example From Interview Guide Related to Nursing Care

1. Select the phrase that indicates how satisfied or dissatisfied you are with the way your nurses responded to your reports of pain.	
___ (1) Very dissatisfied	___ (4) Slightly satisfied
___ (2) Dissatisfied	___ (5) Satisfied
___ (3) Slightly dissatisfied	___ (6) Very Satisfied
2. What were you thinking or feeling when you answered that question?	
3. What about your experience influenced how you answered that question?	
4. (Satisfied) You were (insert response to question re: satisfaction with nurses) with your nurses response to your pain even though you had (moderate or severe) pain. So I am confused about what you reported. (Note: <i>may need to say why you are satisfied with the nurses' response even though you had this level of pain</i>). Can you help me understand this?	
<u>Probes:</u>	
What specifically did the nurses do to respond to your pain that led you to feel satisfied?	
Was this the same or different than you expected?	

postoperative) and the responses to the satisfaction questions. As needed, interviewers probed areas that emerged from the interviews that were relevant to the study aims. The interview guide was reordered several times to best create a flow that would allow patients to reflect on their responses to questions about satisfaction. Interviews were recorded and transcribed verbatim. Interviewer notes were used to supplement inaudible portions of three tapes. One participant was unable to speak because of a tracheostomy and chose to write his responses on the interview guide.

Analysis

Quantitative items were summarized descriptively (range, mean, standard deviation [SD]). Qualitative analysis followed classic procedures outlined by Miles and Huberman⁴⁴ for data reduction, data display, and drawing conclusions. The unit of analysis included phrases or sentences that conveyed one specific idea. Complex data bits were double coded so as not to lose the entire context of the response. The initial coding approach was guided by the theoretical concepts of expectations and performance as reflected in the interview questions. The first two interviews were analyzed by two investigators to

generate an initial coding scheme. All interviews were then systematically coded by research team members using NVivo⁴⁵ software (QSR International Pty. Ltd., Doncaster, Victoria Australia) to manage the data analysis. The principal investigator reviewed the transcribed interviews and coding reports to identify themes, overarching constructs represented in the data. The results are presented in a narrative that explores each theme and its key features using patient quotations.

Results

Sample Characteristics

The sample included 33 interviews with advanced cancer patients ($n = 18$) and postsurgical cancer patients ($n = 15$). Patients were recruited until data saturation occurred. In this recommended approach to sampling in qualitative research, a relatively small sample is needed before it becomes apparent that further interviews are not adding to what was already found in the previous interviews. The demographic and clinical characteristics are summarized in Table 2. Patients were 54.4% female and had a mean age of 53.7 years (range 25–78 years). The advanced cancer group

Table 2
Demographic and Clinical Characteristics of the Two Groups in the Study Sample ($n = 33$)

Characteristic	Advanced Cancer ($n = 18$)		Postsurgical ($n = 15$)		Total ($n = 33$)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Gender						
Female	7	38.9	11	73.3	18	54.5
Male	11	61.1	4	26.7	15	45.5
Race/ethnicity						
Non-Hispanic white	16	88.9	14	93.3	30	90.9
Native American	1	5.6			1	3.0
Hispanic white			1	6.6	1	3.0
Multiple: African American/Native American	1	5.6			1	3.0
Primary site						
Breast	5	27.8	0	0.0	5	15.2
Cervical/uterine	0	0.0	5	33.3	5	15.2
Colorectal	1	5.6	4	26.7	5	15.2
Prostate	4	22.2	0	0.0	4	12.1
Ovarian	0	0.0	2	13.3	2	6.1
Sarcoma	2	11.1	0	0.0	2	6.1
Esophageal	1	5.6	1	6.7	2	6.1
Other ^a	5	27.8	3	20.0	8	24.2
Age (years)						
Mean	58.22		48.20		53.67	
SD	17.27		11.60		15.59	
Range	25–78		31–70		25–78	

^aIncludes one case each of multiple other primary sites.

(mean = 58.22) was on average 10 years older than the postoperative group (mean = 48.20). Main diagnoses included breast (15%), cervical/uterine (15%), and colorectal (15%) cancers. The postoperative group had more colorectal and gynecologic cancers than the advanced cancer group.

Pain and Satisfaction Ratings

The responses to the structured items related to pain and satisfaction are summarized in Tables 3 and 4. Worst pain intensity in the past 24 hours ranged from 2 to 10 (one patient felt his pain had exceeded the scale but was scored 10), with a mean of 6.91 (SD 2.42). The postoperative group reported significantly higher worst pain intensity than the advanced cancer group; they also reported higher pain relief. Pain was moderately to severely troubling for 63.7% of patients. Twenty-two percent of the advanced cancer group reported severe pain frequently or constantly as compared with 6.7% of the postoperative group. Eighty-three percent of the advanced cancer group reported being very satisfied or satisfied with their pain management, as compared with 66.7% in the postoperative group.

Satisfaction with pain management was reported higher in regard to nursing care than medical care. Notably, four patients, three of whom were from the postoperative group, declined to rate their physicians.

Expectations

Expectations are critical to judgments about satisfaction. The interviewers explored expectations related to pain before diagnosis, at the time of diagnosis, and at the present time. In reflecting on the time before diagnosis, responses ranged from no previous experience or expectation to a vivid recounting of a close other who had recently died in pain. Many participants related a story of a family member, friend, or neighbor with cancer who had died in pain. Terms used to describe these experiences reflected suffering and included pain that was “severe,” “miserable,” and “excruciating.”

Expectations at the time of diagnosis varied by whether or not pain was one of the presenting symptoms of the cancer. Those without pain denied that pain was a concern at the time of diagnosis. They expressed a focus on “fighting the disease and coping with

Table 3
Pain Characteristics of the Two Groups in the Study Sample ($n = 33$)

Variable	Advanced Cancer ($n = 18$)	Postsurgical ($n = 15$)	Total ($n = 33$)
Time in pain			
Not at all	1 (5.6)	0 (0.0)	1 (3.0)
Rarely	2 (11.1)	1 (6.7)	3 (9.1)
Occasionally	3 (16.7)	1 (6.7)	4 (12.1)
Intermittently	1 (5.6)	5 (33.3)	6 (18.2)
Frequently	6 (33.3)	5 (33.3)	11 (33.3)
Constantly	5 (27.8)	2 (13.3)	7 (21.2)
Not reported	0 (0.0)	1 (6.7)	1 (3.0)
Time in severe pain			
Not at all	4 (22.2)	2 (13.3)	6 (18.2)
Rarely	4 (22.2)	4 (26.7)	8 (24.2)
Occasionally	5 (27.8)	4 (26.7)	9 (27.3)
Intermittently	1 (5.5)	3 (20.0)	4 (12.1)
Frequently	3 (16.7)	0 (0.0)	3 (9.1)
Constantly	1 (5.6)	1 (6.7)	2 (6.1)
Not reported	0 (0.0)	1 (6.7)	1 (3.0)
How much pain troubled you			
Not at all	0 (0.0)	0 (0.0)	0 (0.0)
Minimal amount	7 (38.9)	5 (33.3)	12 (36.4)
Moderate amount	7 (38.9)	5 (33.3)	12 (36.4)
Great amount	4 (22.2)	5 (33.3)	9 (27.3)
Worst pain intensity, ^a mean (SD)	6.00 (2.57)	8.00 (1.73)	6.91 (2.42)
Percent pain relief, mean (SD)	68.06 (27.71)	75.27 (20.66)	71.33 (24.66)

Values are expressed as n (%) unless specified.

^aScale = 0 no pain to 10 worst pain imaginable; $t = -2.57$ ($P = 0.015$).

treatment.” Those who experienced pain as a presenting symptom framed their story in terms of how the pain was evaluated and whether it led to a cancer diagnosis. The

meaning of the pain was intertwined with the diagnostic process and was often associated with anger or regret. One patient explained a sequence of visits to the emergency room:

Table 4
Reports of Satisfaction with Pain Management ($n = 33$)

Variable	Advanced Cancer ($n = 18$)		Postsurgical ($n = 15$)		Total ($n = 33$)	
	n	%	n	%	n	%
Overall						
Very dissatisfied	0	0.0	1	6.7	1	3.0
Dissatisfied	1	5.5	1	6.7	2	6.1
Slightly dissatisfied	2	11.1	0	0.0	2	6.1
Slightly satisfied	0	0.0	3	20.0	3	9.1
Satisfied	7	38.8	6	40.0	13	39.4
Very satisfied	8	44.4	4	26.7	12	36.4
Not reported	0	0.0	0	0.0	0	0.0
Nurses						
Very dissatisfied	1	5.5	0	0.0	1	3.0
Dissatisfied	0	0.0	0	0.0	0	0.0
Slightly dissatisfied	0	0.0	0	0.0	0	0.0
Slightly satisfied	0	0.0	2	13.3	6	18.2
Satisfied	4	22.2	4	26.7	8	24.2
Very satisfied	13	72.2	9	60.0	21	66.7
Not reported	0	0.0	0	0.0	0	0.0
Physicians						
Very dissatisfied	0	0.0	0	0.0	0	0.0
Dissatisfied	1	5.5	1	6.7	2	6.1
Slightly dissatisfied	2	11.0	0	0.0	2	6.1
Slightly satisfied	0	0.0	0	0.0	0	0.0
Satisfied	4	22.2	4	26.7	8	24.2
Very satisfied	10	55.6	7	46.7	17	51.5
Not reported	1	5.5	3	20.0	4	12.1

"The doctor in charge told me not to ever come back because I was a pill junkie. And he didn't realize that I had cancer. If they had just caught it then." Another explained: "At the time of my diagnosis I was in horrible pain. It was consuming. The pain was consuming."

In the postoperative group, expectations were framed around the expected surgery. Several patients explained that the pain and its causes were quite a bit worse than expected. One patient explained, "I didn't realize all the stuff that comes with it ... the tube down my throat. I didn't realize I would have a hard time coughing. ... where the surgery was I thought I would be numb ... but the anesthetic only went up so far." Others felt that the pain was minimal in terms of what they expected.

Patients had variable types and patterns of pain, yet they overwhelmingly believed that their pain would be relieved. This was captured by the following quote: "I had high expectations. I was positive that it could be relieved." There was an understanding that the extent of the cancer or type of surgery might influence the degree of pain. One woman said, "I do not expect to have cancer in my liver without having some sort of pain." Yet for many, the pain they were experiencing was worse than they expected. These experiences were based on both the nature and temporality of the pain as exemplified in the following: "The worst part about it is that it's a constant pain," "It's so heavy" or "It's much deeper than I expected." For some, pain that is "severe" is often for brief periods, for example, when medications wear off or when moving around or repositioning. One woman explained, "When I sit down it's like a cup of tea. The pain seems to be gone and I relax. It's telling me stay put."

For some, pain was well managed. One participant explained, "I just thought that I would be in some type of pain all the time. It would always be some discomfort, and the pain medications they have me on have taken the pain away completely. At times there is no pain." For others, pain was significant and unrelieved, especially for those who were very dissatisfied. One young man described his experience: "I can't stand for more than 5 minutes without pain. I can't walk for more than a quarter of a mile. High exertion

activities are out of the question. They can't find anything that works."

Sources of Dissatisfaction

Five participants (15.2%) were dissatisfied with their pain management care. Those who indicated that they were "slightly satisfied" ($n=3$; 9.1%) usually reported sources of dissatisfaction as well. Table 5 provides exemplary quotes for the sources of dissatisfaction, which included poor communication, a lack of focus on the individual, amount of time spent with the patient, pain was not believed, not being treated right, no treatment or ineffective treatment, delay in finding source of pain, and waiting time. Poor communication included a lack of information about diagnoses, questions not being fully answered, and limited explanation about medications and health condition. One patient, who had to wait a long time for medication, acknowledged that she would have been more satisfied if the nurse had explained the reason for delay. No treatment or ineffective treatment referred to the pain medication not working (i.e., the pain was not relieved). For several postoperative patients, the transition from intravenous or epidural to oral medication was problematic, because of either poor communication or inadequate relief during the transition.

Sources of Satisfaction: Being Treated Right

Sources of satisfaction are exemplified in Table 6. The main theme from this analysis was that patients felt that being treated right was essential to their satisfaction. Caring and concern about pain were key factors in patients reporting that they were being treated right. Patients wanted to feel that their doctors and nurses were genuinely listening to their questions and that they were conscientiously trying to help manage their pain. This was best explained as follows: "They considered my questions seriously and responded in a like manner. That's always a very good feeling, they don't brush the questions aside, but did the opposite. I felt that they were actually listening to my questions. The good ones don't make you feel like you're putting them out. They offer you all the things. That's just the difference."

The most significant traits that patients identified as contributing to being treated right

Table 5
Exemplars of Sources of Dissatisfaction

Source of Dissatisfaction	Examples
Poor communication	Well, I guess the inconsistency of the physician to say look (patient), in making me believe that hey, you can take these Lortabs three or four times per day. Don't worry about it. Or you know, it was really never explained to me.
Not focused on me	To me it seems like they're too busy to be focused on just one person at a time. The nurses have to come in first and take care of me and then the doctor is just an afterthought while she's going to her next patient.
Amount of time spent with patient	I feel like the doctors were not available to me.
Pain not believed	Sometimes my doctors don't take me seriously so I've turned in the past to medicating myself.
Not treated right	Don't come in acting like they're super Gods and you will do as you're told. The thing that really got me, she (my doctor) flipped. She ... said "Well, you know Margaret, you do have bone cancer," and just turned around and walked away and flipped her stethoscope at me and it was like ... a glass of cold water just splashing on me.
No treatment or ineffective treatment	That would be the pain doctor. Just for the simple fact that they can't find anything that works.
Delay in finding source of pain	I need to find out for sure about my hip. What it is that's making it hurt. I'm kind of wondering what are they going to do to me This sort of thing is what really bothers me.
Waiting time	I'll go and get her and ask if she can get somebody else to give it (medication) to me and "Oh go to your room and I'll get it for you" and then a half hour later she makes it.

were caring, being looked after, trying to help, timely responses, individualized care, and being knowledgeable. A sense that staff was caring was of major importance to many patients in the study. Numerous people indicated that nursing staff who expressed a genuine interest in how the patient felt and wanted to do as much as possible for them were major factors in their being satisfied with their care. As one patient described the manner in which her nurse took care of her, "It was like, I care and I'm sorry." Another commented, "Some people are just genuinely more caring for other individuals and naturally those people give you the greatest comfort." Satisfied patients felt that their health care professionals both responded with concern and demonstrated a personal interest in them. A caring attitude was also conveyed when patients' questions were carefully attended to, when needs were quickly addressed, when care was coordinated with other team members, and when attention was given to what the patient felt was most helpful. One patient stressed that she was satisfied because nursing staff conveyed information about her pain to her doctors.

The perceptions that an individual was being looked after and that health professionals were trying to help were described as valuable traits. It was important to patients that their

physician took a personal interest in their care and that they followed up on issues. They liked having nurses frequently come in to their room to check on them. They took note when staff asked if they had pain and if they needed anything for it. One patient appreciated a pain management doctor's advice about coordinating use of pain medication with activity. Others felt that staff who were solicitous, who listened to and believed their reports of pain, and who responded promptly were diligently trying to help. Another patient felt that she could rest because she was confident that others were taking good care of her. These behaviors and responses contributed to the sense that they were being treated right.

Timely responses were also very important to patients. This included rapid responses to questions, offers of treatment for pain, and returned phone calls if a patient was at home. Postoperative patients noted that because nurses were frequently "in and out of their rooms," they could respond quickly to their needs. The nurses "get right on your problem immediately." Prompt efforts to help ameliorate pain and the sense that staff took their reports of pain seriously contributed to patients' feeling that they were being treated right.

Individualized care was an important contributor to patients' sense that they were being treated right. Individualization of care was

Table 6
Exemplars of the Concept of Being Treated Right

Examples	
Caring	... it's a caring look. It's just a sweet look, a smile. If they can just be gentle and sweet and loving in an official way. I know they have to be official but just, just genuinely kind. They might give you a sweet look like ... not a pity look ... it's like a hug look. She seemed like she was sincerely concerned about my pain. They are all caring people. You just feel like you are the only one.
Looking after me	... They've got a lot of, a busy schedule, a lot of things going on, but I've always felt like he took a real personal interest in me as a patient. They would follow up. The nurses were always in and out. I could have just said "I need something" and it was here. "I can rest because I know that somebody's looking after my interests."
Trying to help	Just the valued information that he gave me and the way he talked to me. And yes the different drugs. They considered my questions seriously and responded in like manner. I felt like they got back to me whenever I had a concern.
Sollicitous	They were always asking me how my pain was ... and if I needed anything.
Timely response	She responds quickly to my questions. Or if I have any pain she immediately says, "You know, what can I get for you? What would help to make it better?" Gives me several options. They responded very rapidly, very concernedly; that's very good. I could have just said "I need something" and it was here. Rapid relief is important.
Individualized	... it wasn't like you have to take this certain pill. It was, "Well, let's do what's best for you and what you feel is best." So it really was pain management not just "Here's your regular dose, you take this every four hours and you will be fine." It wasn't like that. She comes and talks to me in my language.
Stay with it	They've tried real hard to give the right combination—you know, a little more of this, a little less of that or whatever.
Knowledgeable	She answered questions I never even knew could be answered. Appreciated explanations of why something didn't work or what could be done to make it work.
Coordination	Were they aware of the pain, were the nurses relaying the information that I gave to them? And they were.

observed in the practices of both physicians and nurses. It was reflected when health care professionals talked to patients in language that they could understand, when they gave choices about medication use, and when they respected patients' preferences about their care. Patients appreciated that professionals recognized the range of people's preferences with regard to use of pain medication; some patients only wanted to take medication if they were experiencing severe pain, whereas others wanted to avoid all pain. Consistency of staff was noted to be an important factor in allowing nurses to know their patients well and thereby treat them as individuals. "She just knew how I worked." Efforts to "fine tune" use of pain medication were greatly appreciated and demonstrated that the doctor was listening to the patient's concerns, persevering in attempts to treat their pain, individualizing care, and that the patient was being well taken care of. For example, "They've tried real hard to give the right combination—you know, a little more of this, a little less of that or whatever They wanted to get it just right." These factors represented a sense of staying with it, not giving up on achieving pain relief.

Confidence that health care professionals were knowledgeable was an additional

contributor to patients' feeling that they were being treated right. One patient was happy when her doctor "answered questions I never even knew could be answered." She appreciated explanations of why an approach to control her pain did not work and what changes might help. This sort of discussion helped her understand that there were a variety of methods that could be used to manage her pain and to help her feel more comfortable.

Sources of Satisfaction: Safety Net

The second major theme was the existence of a safety net for pain management. This theme refers to patients' perception of safety because a plan for pain control existed, which was under their control, readily available, and effective. One patient illustrated this concept when she noted that despite increased pain, she felt satisfied with her care because she knew that pain medication was available to her and that it was her choice whether or not to use it, by stating "It was under my control." Patients felt reassured if they knew that effective pain medication was readily available to them and that there were multiple options if medications used initially were not adequate. The reassurance that such a backup plan provided was demonstrated by a patient who

said, "They could always try something else." Other people said, "I always used a little bit less ... because any time I asked for it I was able to get it" and "They were always asking me how my pain was, and ... if I needed anything." Confidence that pain medication was effective was demonstrated by an individual who stated, "I'm just thankful to have good medicine" It was also important to patients that they felt supported in their desire to use pain medication. "Both the medication was there, and the support was there to use it." Prompt response by health care staff was another important contributor to this sense of safety net. "Whenever I called them and told them how I felt, they (always) seemed to take care of the situation" and "I got it when I needed it" illustrate how important prompt responses were to patient satisfaction with their pain management. One outpatient described her feeling of the existence of a safety net by staff response to her request for additional pain medication. "We just call down there, I mean boom, there is a prescription there." Health care team members who acted proactively to anticipate and respond to their patients' pain both while in the hospital and at home created satisfaction and a feeling of safety for patients in this sample.

A critical aspect of having a safety net was that participants wanted to be in control of their pain management whenever possible. A variety of reasons were given for their desire to have some autonomy in this aspect of their care. The mere fact that they were in control was important to some people. As one patient stated, "Being able to control it was great. I have to commend the staff at the hospital because it puts the patient more in control and the patient has more free choices and determination of the amount of medication. I just think it's a good thing when medical personnel do put the patient more in charge."

Others wanted to be able to exercise choice in how much pain medication they took at any given time. "One thing, I'm in control of it. And I like that. You know. If I want to go ahead and have the pain, I can if I want. Or if I want to get rid of it, then I can take the pills. So it's up to me to manage it. I just had to ask them, but they'd say, "One tablet or two?" So I was still the one making the final decision on how much I was taking."

It was important to others to have periods of time in which they were not using any pain medication: "I wanted to have some periods where I didn't have any in my system." One patient felt that it is beneficial to feel pain. This individual said, "I mean when you quit feeling that pain, you're well." They felt that periods without pain control allowed them to monitor their progress most effectively.

Some people were concerned about "getting hooked" or about unpleasant side effects: "I don't want to become dependent, or I don't want to be mentally slow. That's why I'd rather have a little pain." "I could ... take more, but ... I don't want to get hooked on anything." Occasional total relief was a consideration for another participant. This individual did not object to experiencing pain at times, but it was important to her that when she desired it, she had sudden pain relief. "I really like feeling that sudden relief, because then I can feel the pain go away."

Prompt responses by staff to patients' requests for pain medication made it easier for individuals to exert personal choice and control; because patients were confident that they would have ready access to pain medications when they were ready to take them, they did not worry about availability. One patient felt that she used less medication because she did not have to worry about lengthy waits for medication.

Another patient felt that self-administration of pain medications while in the hospital (through use of a patient-controlled analgesia pump) facilitated decreased use of pain medication. She said if she had had to ask for medication to relieve pain, "I probably would've asked for more relief than was necessary just from fear of the pain." Another person stated, "I don't think I used as much as I would have if I had ... not been in control ... if I would've had to ask for relief." Another explained, "One thing I really thought was excellent about it was giving the patient control of the situation because, in my case, I felt having that control allowed me to make choices. I'm still doing it my way."

Sources of Satisfaction: Partnership

Partnership was the third main theme and refers to collaboration between the patient and their health care team or among health

care team members to develop an effective pain management plan for individual patients. One patient characterized the importance of this partnership by saying that “the communication, working together” with her doctors was an important part of achieving the goal of managing pain. Another person described the importance of communication in the partnership by saying, “Were they aware of the pain, were the nurses relaying the information [to the doctors] that I gave to them ... when they came in and checked on me, were they asking if I was comfortable or not, and they were.”

Trust between patient and staff was an integral part of the partnership, which satisfied patients described. They felt that trust was reflected in having their questions answered, responsiveness to their preferences, and respect for their desire to be in control. One patient conveyed, “I felt that they were actually listening to my questions. They considered my questions seriously and responded in like manner. That’s always a very good feeling; they don’t brush the questions aside, but did the opposite.” Another patient characterized the attitude of her health care providers as “Let’s do what’s best for you and what you feel is best.” Satisfied patients described their partnership as one that emphasized communication, which made them feel that they worked together with staff and in which staff responded quickly to their needs. Two satisfied patients commented, “She just knew how I worked; she’d been on my shift quite a few times; they are there for you,” and “I felt like everybody was willing to find any means to help me.”

Knowing their patients well also enabled health care professionals to develop a partnership in which “They do the best for my personality, for what I want.” The partnership approach reflects a belief in the patient, a commitment to involve the patient in their own pain management, and coordination among team members. As one patient described the approach to her care, “we worked together.” Communication with the health care team about their pain control and preferences regarding use of medication facilitated participation in decision making. Greater knowledge about what a patient was experiencing allowed doctors and nurses to offer more options from which a patient could choose.

Sources of Satisfaction: Efficacy of Pain Management

The final theme identified was the efficacy of the pain management. The efficacy of the drugs prescribed and how quickly they provided relief were both important. One participant explained: “... letting me have the morphine ... as opposed to other doctors in the past who just gave me pills which were less effective and they didn’t give you ... sudden relief.” Another explained the source of her satisfaction as follows: “Well, because they controlled my pain. I was not uncomfortable pain-wise. I mean that was managed.” Another patient with advanced cancer explained, “When I’ve got the patch on, I’m free from it night and day.”

Satisfaction: Exploring the High Pain-High Satisfaction Paradox

One component to this study was to examine the paradox of patient satisfaction despite patients reporting moderate to high levels of pain. Thus, in the qualitative interviews, we probed this matter to explore this discrepancy between health care satisfaction and unrelieved pain. Respondents did not give one consistent reason as to why they were satisfied with their care despite having unrelieved pain, but, in fact, respondents often provided several explanations. One reason for the discrepancy was that patients expected some pain or they believed that their pain could not be completely relieved. One patient conveyed, “I’ve basically come to accept that until the cancer is gone, there’s nothing out there that’s going to ease my pain in my specific situation.” Another explanation for this discrepancy was patients had some pain relief in different forms. For example, some patients had pain medications available that provided relief, or their pain was relieved most of the time or relieved promptly. One patient said, “Well, I had some breakthrough medicines ... so I would give them credit for planning ahead.” Another patient explained that he/she was primarily in pain when the medication wore off, “It’s not like I was in that pain all the time.” Another patient conveyed, “... looking back and ... thinking that I haven’t had times when I was in a lot of pain. That makes me satisfied.”

In addition, as previously described, patients felt that they controlled the amount of pain and it was their choice to have some pain. In

these cases, experiencing unrelieved pain was attributed to the patient choosing to have some pain or not take the pain medication more frequently.

Finally, an unwillingness to blame was another reason identified to explain the discrepancy between satisfaction and unrelieved pain. One patient expressed, "I realize that you are human too, and that if I still have pain, it may be that there's a point that we cannot get rid of all the pain. So I don't want to blame ... for the pain that I have."

Discussion

This qualitative study explored the patient experience and identified core aspects of satisfaction with pain management from the perspectives of two groups of patients with pain: patients with advanced cancer and patients experiencing postoperative pain. The sample represented the diversity in pain experience found both within and between these two populations. The sample included the types of cancers that are likely to be associated with either advancing cancer or a surgical treatment option. The sample was diverse in age, yet homogeneous in race/ethnicity, thus limiting the generalizability of the findings. The sample was similar to many others reported in the literature in that participants were predominantly (75%) satisfied or very satisfied and yet experienced unrelieved pain (mean = 6.91).⁴⁻²¹ The significantly higher worse pain intensity in the postoperative group may have been because of peaks in acute pain typical in the postoperative period as the amount of time in severe pain was not different between the groups. In previous research,

others have suggested that the peaks and troughs associated with a period of pain experience may partially explain the paradox of patient satisfaction, although the pain appears to be unrelieved.^{10,21} This notion was supported by the experience of some patients in this study who indicated that their worst pain score was for brief periods, was often associated with activity or movement, and was relieved by taking prescribed medication.

The use of qualitative methods provided an excellent approach to systematically examine key aspects of dissatisfaction and satisfaction. Four key themes emerged and are summarized with definitions in Table 7. The differences between the advanced cancer and postoperative groups were mostly reflected in their expectations about pain; the aspects of satisfaction and dissatisfaction were consistent across participants from each group.

Many of the factors influencing satisfaction in this sample are consistent with hypotheses or findings by other investigators in multiple populations: caring behaviors, expectations that pain cannot be relieved or that it will have peaks and troughs, responsiveness to requests for pain medication, and not wanting to get anyone in trouble.^{9,10,14,16,21,27,30,32-38,46} We did not find agreement with the suggestion by Bostrom et al. that patients did not know what type of relief was available, although our findings support their suggestion that kindness is an important factor in patient judgments of satisfaction.⁸

The findings from this U.S. sample of cancer patients parallel many of the results reported by Simonsen-Rehn et al. in a similar qualitative study of 19 cancer inpatients in Finland.⁴⁰ Their findings indicated that it was the

Table 7
Definitions of Four Core Aspects Influencing Satisfaction with the Quality of Pain Management

Concept	Definition
Being treated right	The caring and concern of knowledgeable health professionals who listen, respond promptly, try to help, and believe the individual's reports of pain.
Safety net	Sense of safety knowing that there is a plan and medications in place. Health care team members act proactively to anticipate problems. Patient has control to take medication when needed.
Efficacy of pain management	The pain management plan is efficacious and not too complicated. Medications work quickly and side effects are managed. Health care professionals have expertise when designing and implementing the plan.
Partnership	Collaboration that occurs between the patient and the health care team or between health care team members to discuss, strategize, and plan for the patient's individual pain management plan.

combination of kindness and communication along with receiving pain-relieving medication when needed that constituted what they termed the “caring pole” of the continuum of pain management. Their informants also believed that staff tried to do a good job and should not be blamed if pain was unrelieved.⁴⁰

The importance of the patient-provider relationship has been identified as essential to satisfaction in other research with cancer patients.¹⁰ This concept was supported in our findings, particularly by the themes of being treated right and of a partnership between patients and providers in developing and implementing a pain management plan. This concept as well as many aspects of being treated right, including caring, respect, and individualized and coordinated care, are consistent with concepts of patient-centered care, as operationalized in the past 20 years and prioritized as essential to quality care by the U.S. Institute of Medicine.^{23,47}

One theme identified in this study provides a new insight to the knowledge related to satisfaction with the quality of pain management—the concept of a safety net. Important to this concept was a perceived sense that a plan for pain control was readily available and effective. The safety net was associated with a sense of security that there is help available and that the team will mobilize quickly if pain is out of control. Key to the concept of a safety net was that many patients believed that the implementation of the plan was under their control, that is, they could regulate the amount of pain and or side effects of medications that they were willing to tolerate. This control was important to their sense of satisfaction. This perception may be similar or related to the concept of self-efficacy for pain management and further concept clarification is warranted. This qualitative finding supports the results of a quantitative study of postoperative orthopedic patients in which perceived control partially mediated the relationship between pain severity and satisfaction.^{46,48}

Finally, it is notable that there was little evidence in the patient interviews of the use of nonpharmacologic therapies. Only position and activity were mentioned as alleviating or exacerbating factors to pain. Patients may not expect that nurses and doctors would use complementary and alternative therapies as part of their pain management plan.

Limitations

In addition to the lack of racial/ethnic diversity, this study was limited in that the sample was small and specific to the oncology setting; these issues are important in multiple settings and patient populations. We also did not know much about patients’ previous experiences with other pains and pain-related encounters in their lifetime, nor did we explore their previous experiences with hospitalization and pain management. We also had multiple interviewers, which may have influenced patient responses.

Implications

The findings from this study are being used to develop a tool to measure the quality of care related to pain management from the patient perspective. The findings provide both a conceptual model of important latent variables (Table 7) and specific factors that are important to include in such a tool such as timeliness of response or that providers believe reports of pain. Important lessons from this study include the notion that patients often cannot separate the pain management experience from their entire patient care experience. Designing a tool that includes more global aspects of patient-centered care such as being treated right in consort with specific pain management behaviors is needed. It also is clear that variability among professionals in the quality of care provided exists. Measuring perceptions proximal to the delivery of care, for example, at the end of a shift or clinic visit, is recommended to allow evaluation of specific episodes of care.

The findings also suggest implications for practice. Assessment of pain may be more precise by using a series of measures indicating “pain now” or an indicator of amount of time that pain was severe or intolerable vs. worst pain intensity over the past 24 hours. Patients expect that their reports of pain will be believed. They expect care that is caring, individualized, and responsive to their needs. They expect that health professionals will partner with them to develop a plan for pain management that is effective, works promptly, and allows them to balance pain relief with side effects of medications. And finally, they expect to have a safety net that will allow for a change in plans if the treatment does not work. These expectations can inform education of health professionals and quality improvement efforts

of organizations that care for cancer patients. Such efforts are gaining importance as nationally mandated indicators of quality, such as the Health Consumer Assessment of Performance Survey,⁴⁹ provide benchmarking data on patient reports of pain relief and responsiveness to reports of pain. Poor performance on these screening indicators will drive more detailed performance measures of the quality of care related to pain management.

Acknowledgments

The authors gratefully acknowledge the patients in pain who agreed to share their experiences and expectations with them.

References

1. Joint Commission. Pain assessment and management: An organizational approach. Oakbrook Terrace, IL: JCAHO, 2000.
2. Alexander GR. Nursing sensitive databases: their existence, challenges, and importance. *Med Care Res Rev* 2007;64:44S–63S.
3. McGuire DB. Occurrence of cancer pain. *J Natl Cancer Inst Monogr* 2004;32:51–55.
4. Bressler LR, Hange PA, McGuire DB. Characterization of the pain experience in a sample of cancer outpatients. *Oncol Nurs Forum* 1986;13:51–55.
5. Greenwald HP, Bonica JJ, Bergner M. The prevalence of pain in four cancers. *Cancer* 1987;60:2563–2569.
6. Peteet J, Tay V, Cohen G, MacIntyre J. Pain characteristics and treatment in an outpatient cancer population. *Cancer* 1986;57:1259–1265.
7. Portenoy RK, Miransky J, Thaler HT, et al. Pain in ambulatory patients with lung or colon cancer. Prevalence, characteristics, and effect. *Cancer* 1992;70:1616–1624.
8. Bostrom BM, Ramberg T, Davis BD, Fridlund B. Survey of post-operative patients' pain management. *J Nurs Manag* 1997;5:341–349.
9. Pignon T, Fernandez L, Ayasso S, et al. Impact of radiation oncology practice on pain: a cross-sectional survey. *Int J Radiat Oncol Biol Phys* 2004;60:1204–1210.
10. Dawson R, Spross JA, Jablonski ES, et al. Probing the paradox of patients' satisfaction with inadequate pain management. *J Pain Symptom Manage* 2002;23:211–220.
11. Paice JA, Mahon SM, Faut-Callahan M. Factors associated with adequate pain control in hospitalized postsurgical patients diagnosed with cancer. *Cancer Nurs* 1991;14:298–305.
12. Brescia FJ, Adler D, Gray G, et al. Hospitalized advanced cancer patients: a profile. *J Pain Symptom Manage* 1990;5:221–227.
13. Donovan M, Dillon P, McGuire L. Incidence and characteristics of pain in a sample of medical-surgical inpatients. *Pain* 1987;30:69–78.
14. Corizzo CC, Baker MC, Henkelmann GC. Assessment of patient satisfaction with pain management in small community inpatient and outpatient settings. *Oncol Nurs Forum* 2000;27:1279–1286.
15. Wells N. Pain intensity and pain interference in hospitalized patients with cancer. *Oncol Nurs Forum* 2000;27:985–991.
16. Bookbinder M, Coyle N, Kiss M, et al. Implementing national standards for cancer pain management: program model and evaluation. *J Pain Symptom Manage* 1996;12:334–347.
17. Cleeland CS, Gonin R, Hatfield AK, et al. Pain and its treatment in outpatients with metastatic cancer. *N Engl J Med* 1994;330:592–596.
18. Glajchen M, Fitzmartin RD, Blum D, Swanton R. Psychosocial barriers to cancer pain relief. *Cancer Pract* 1995;3:76–82.
19. Miasowski C, Nichols R, Brody R, Synold T. Assessment of patient satisfaction utilizing the American Pain Society's Quality Assurance Standards on acute and cancer-related pain. *J Pain Symptom Manage* 1994;9:5–11.
20. Thomason TE, McCune JS, Bernard SA, et al. Cancer pain survey: patient-centered issues in control. *J Pain Symptom Manage* 1998;15:275–284.
21. Ward SE, Gordon DB. Patient satisfaction and pain severity as outcomes in pain management: a longitudinal view of one setting's experience. *J Pain Symptom Manage* 1996;11:245–251.
22. Beck SL, Falkson G. Prevalence and management of cancer in pain in South Africa. *Pain* 2001;94:75–84.
23. Institute of Medicine, Committee on Health Care in America. Crossing the quality chasm: A new health system for the 21st century. Washington, DC: National Academy Press, 2001.
24. Mitchell PH, Ferketich S, Jennings BM. Quality health outcomes model. American Academy of Nursing Expert Panel on Quality Health Care. *Image J Nurs Sch* 1998;30:43–46.
25. Oliver RL. A cognitive model of the antecedents and consequences of satisfaction decisions. *J Mark Res* 1980;17:460–469.
26. Rosenthal GE, Shannon SE. The use of patient perceptions in the evaluation of health-care delivery systems. *Med Care* 1997;35:NS58–NS68.
27. McNeill JA, Sherwood GD, Starck PL, Thompson CJ. Assessing clinical outcomes: patient

satisfaction with pain management. *J Pain Symptom Manage* 1998;16:29–40.

28. Calvin A, Becker H, Biering P, Grobe S. Measuring patient opinion of pain management. *J Pain Symptom Manage* 1999;18:17–26.

29. Sherwood GD, Adams-McNeil J, Starck PL, Nieto B, Thompson CJ. Qualitative assessment of hospitalized patients' satisfaction with pain management. *Res Nurs Health* 2000;23:486–495.

30. Innis J, Bikaunieks N, Petryshen P, Zellermeier V, Ciccarelli L. Patient satisfaction and pain management: an educational approach. *J Nurs Care Qual* 2004;19:322–327.

31. Gordon DB, Pellino TA, Miaskowski C, et al. A 10-year review of quality improvement monitoring in pain management: recommendations for standardized outcome measures. *Pain Manag Nurs* 2002;3:116–130.

32. Devine EC, Bevsek SA, Brubakken K, et al. AHCPR clinical practice guideline on surgical pain management: adoption and outcomes. *Res Nurs Health* 1999;22:119–130.

33. Jamison RN, Ross MJ, Hoopman P, et al. Assessment of postoperative pain management: patient satisfaction and perceived helpfulness. *Clin J Pain* 1997;13:229–236.

34. Meehan DA, McRae ME, Rourke DA, Eisenring C, Imperial FA. Analgesic administration, pain intensity, and patient satisfaction in cardiac surgical patients. *Am J Crit Care* 1995;4:435–442.

35. Stahmer SA, Shofer FS, Marino A, Shepherd S, Abbuhl S. Do quantitative changes in pain intensity correlate with pain relief and satisfaction? *Acad Emerg Med* 1998;5:851–857.

36. Sennsson I, Sjöström B, Haljamae H. Influence of expectations and actual pain experiences on satisfaction with postoperative pain management. *Eur J Pain* 2001;5:125–133.

37. Apfelbaum JL, Chen C, Mehta SS, Gan TJ. Postoperative pain experience: results from a national survey suggest postoperative pain continues to be undermanaged. *Anesth Analg* 2003;97:534–540.

38. Sauaia A, Min SJ, Leber C, Erbacher K. Postoperative pain management in elderly patients: correlation between adherence to treatment guidelines and patient satisfaction. *J Am Geriatr Soc* 2005;53:274–282.

39. Idvall E. Post-operative patients in severe pain but satisfied with pain relief. *J Clin Nurs* 2002;11:841–842.

40. Simonsen-Rehn N, Sarvimäki A, Benkö SS. Cancer patients' experiences of care related to pain. *Nord J Nurs Res Clin Stud* 2000;20:4–9.

41. Kotler P, Clark RN. Marketing for health care organizations. Englewood Cliffs, NJ: Prentice-Hall, 1995.

42. Quality improvement guidelines for the treatment of acute pain and cancer pain. American Pain Society Quality of Care Committee. *JAMA* 1995;274:1874–1880.

43. Cleeland CS. Measurement of pain by subjective report. In: Chapman CR, Loeser JD, eds. Issues in pain measurement. New York: Raven Press, 1989:391–403.

44. Miles MB, Huberman M. Qualitative data analysis: An expanded sourcebook, 2nd ed. Thousand Oaks, CA: Sage, 1994.

45. QSR International. NVivo software. Doncaster, Victoria, Australia: QSR International Pty. Ltd., 2001.

46. McCracken LM, Klock PA, Mingay DJ, Asbury JK, Sinclair DM. Assessment of satisfaction with treatment for chronic pain. *J Pain Symptom Manage* 1997;14:292–299.

47. Institute of Medicine. Ensuring quality cancer care. Washington, DC: National Academy Press, 1999.

48. Pellino TA, Ward SE. Perceived control mediates the relationship between pain severity and patient satisfaction. *J Pain Symptom Manage* 1998;15:110–116.

49. Centers for Medicare and Medicaid Services (CMS). HCAHPS survey. Available from: www.hcahpsonline.org. Accessed April 20, 2009.