set out in the charter or the adapted American questionnaire they used cover the concerns of British patients.

It would be surprising if the satisfaction and views of diverse types of patients could be covered adequately by a general questionnaire. Bruster and colleagues' conclusion that many of the problems related to communication is not surprising since at least 21 of the 35 direct questions listed in table II are about communication, although they purport to be about other aspects of care. Among the questions on satisfaction, the patients were asked about the helpfulness and courtesy of staff, but we should expect more than this from health professionals. No questions were asked about practical aspects of care (for example, help with going to the toilet) or more intangible but equally important aspects of care, such as reassurance. Surprisingly, patients were not asked their views on the outcome of their treatment, a long recognised flaw in research into satisfaction among patients' and a major omission if the investigators really do regard patients as "expert witnesses in the care process."

Ensuring the validity of a questionnaire seeking to establish patients' satisfaction is vital if some of the problems the investigators refer to (for example, focus on easily measured items, hotel aspects of care) are not to be repeated, in this case on a grand scale. Methods of finding out what concerns patients are well developed and include the use of in depth interviewing and content analysis' as a prelude to designing questionnaires for larger scale use. In stroke care we have developed questionnaires to establish patients' and carers' satisfaction that cover concerns identified only from careful, in depth interviewing.^{4,5} Despite the large scale of Bruster and colleagues' survey we urge against its findings or methods being used as a gold standard.

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- 1 Bruster S, Jarman B, Bosanquet N, Weston D, Erens R, Delbanco TL. National survey of hospital patients. *BMJ* 1994;309:1542-6. (10 December.)
- 2 Cleary PD, McNeil BJ. Patient satisfaction as an indicator of quality care. *Inquiry* 1988;25:25-36.
- 3 Fitzpatrick R, Boulton M. Qualitative methods for assessing health care. *Quality in Health Care* 1994;3:107-13.
- 4 Pound P, Gompertz P, Ebrahim S. Patients' satisfaction with stroke services. *Clinical Rehabilitation* 1994;8:7-17.
- 5 Pound P, Gompertz P, Ebrahim S. Development and results of a questionnaire to measure carer satisfaction after stroke. *J Epidemiol Community Health* 1993;47:500-5.

Authors' reply

EDITOR,—Pandora Pound and Shah Ebrahim suggest that patients are asked about their satisfaction in order to achieve greater responsiveness to their needs. One of the outcomes of our survey was that asking about satisfaction produces little useful information. Asking about patients' experiences, however, can help to improve standards of care. In our paper the results of the questions concerning satisfaction were shown simply to illustrate that answers to these types of questions are positive despite the obvious problems reported in questions related to patients' actual experiences.

Pound and Ebrahim's interpretation that we took a limited view of patients' satisfaction is, we think, due to a misunderstanding. The paper certainly focused on the standards set out in the patient's charter and national charter. We chose to highlight these as we thought that they would be of interest to a general readership, particularly as no national data had been published on them since the patient's charter was first published. The survey, however, had a much broader scope than was

reported in the paper. With a limit of 2000 words it is impossible to cover all aspects of the survey. In the paper we described 75 of the 221 questions that were asked, so about two thirds of the results were not reported. We hope to publish more specific results in the future on the management of pain, planning of discharges, communication, and nursing implications of the survey—and these will illustrate the practical aspects of the survey, which included questions on help with using the toilet, bathing, and eating and questions relating to the reassurance of patients.

A considerable amount of qualitative work, including focus groups with patients, was used in designing the questionnaire. The number of problems reported by patients in this survey suggests that most of the questions we asked concerned topics of real concern to them. In addition, answers to open ended questions in the survey did not highlight any major concerns that were not addressed directly in the questionnaire.

Regarding the gold standard, we indicated that the survey was a national one, with over 5000 randomly selected patients interviewed face to face and with an 86% response rate, which could be used as a national reference dataset.

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Non-immunisation of children

Statistics on vaccination coverage may be a poor measure of practice performance

EDITOR,—Neil Simpson and colleagues cite homoeopathic and religious reasons for the non-immunisation of children.¹ My experience of inner city practice, however, is that repeated failure to respond to requests for vaccination, without active refusal, is also an important reason for "negative consent." The fact that in 40% of cases in Simpson and colleagues' study the parents did not respond or gave no clear reason for non-vaccination or the children were having delayed vaccinations is consistent with this.

I compared the experience of an inner city practice in giving the preschool booster to its target cohort with that of a suburban practice in Leicester for the quarter ending September 1994. I did this by examining the medical records and vaccination returns to the health authority. These cohorts were typical of the respective practices. The two practices are similar in their accessibility, the

vaccination clinics offered, the method of calling children, and the enthusiasm for vaccination, but their experience differs considerably. When the cumulative percentage vaccination coverage after successive call ups is compared the inner city practice is at a disadvantage because its population is less compliant (table). Not only does a lower proportion respond but those who do respond require more call ups, showing resistance to vaccination rather than refusal.

Among the children who remained unvaccinated active refusal was not a major problem (one child from the inner city practice) but poor compliance was. This manifested as persistent failure to attend (five children) or having had late primary courses (eight children), which delayed call up until after the cohort had been assessed for target payment. Unlike the suburban practice, the inner city practice found it essential to do home visits to achieve the top target. Four of the cohort were vaccinated in this way, but seven visits were necessary as patients were frequently out. In our experience most of the parents who regularly fail to bring children for vaccination are compliant with "on the spot" vaccination; this is consistent with findings elsewhere.²

The reasons for a poor response are complex but are probably partly related to increased mobility (3.5% of the suburban cohort compared with 13.5% of the inner city cohort joined the practices after the age of 3½). Employment status, receipt of social security benefits, single parenthood, immigration, and poor English have been identified as factors.^{2,3}

There is a role for health visitors in performing on the spot vaccination. Consideration should be given to including children in whom primary courses have been late in later cohorts to increase their chance of vaccination. Poor compliance greatly increases the effort required to reach top targets. It is clear that the value of statistics on vaccination coverage alone as a measure of practices' performance is doubtful.

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- 1 Simpson N, Lenton S, Randall R. Parental refusal to have children immunised: extent and reasons. *BMJ* 1995;310:227. (28 January.)
- 2 Jones K, Fasher B, Hanson R, Burgess M, Isaacs D, Joshi P, et al. Immunisation status of casualty attenders: risk factors for non-compliance and attitudes to "on the spot" immunisation. *J Paediatr Child Health* 1992;28:451-4.
- 3 Whiting CM, Schabas RF, Ashley MJ. Hib vaccine coverage in children attending day-care/nursery school in East York. *Can J Public Health* 1990;81:152-5.

The Society of Homoeopaths has no official policy on vaccination

EDITOR,—I wish to correct misleading information concerning the Society of Homoeopaths given in Neil Simpson and colleagues' paper on parental refusal to have children immunised.¹ The society

Vaccination coverage after successive call ups in suburban and inner city practices

	Suburban practice (n=142)		Inner city practice (n=168)	
	No vaccinated	Cumulative response (%)	No vaccinated	Cumulative response (%)
Attendance data available:				
1st Call	106	77.4	84	61.3
2nd Call	25	95.6	24	78.8
3rd Call	3	97.8	13	88.3
4th Call	2	99.3	6	92.7
7th Call	0	99.3	1	93.4
No response	1		9	
Attendance data unavailable:				
Joined practice after first call for preschool booster*	5		23	
Vaccinated urgently as was near end of quarter	0		5	
Not called because of late primary course	0		3	
No unvaccinated	1		17	

*The vaccination coverage of these children is worse than that for each cohort overall, implying that these children do not bias the attendance data that are available.