# Demystifying patient satisfaction

John Yaphe, MD MClSc*

Patient satisfaction is another sacred myth that requires a critical re-evaluation on these pages. In previous editorials, we have looked at debatable issues like teamwork, continuity of care, and family-oriented approaches that have achieved almost untouchable status in family medicine. However, on closer examination, it appears that the emperor has no clothes or is only lightly dressed. We might ask if the belief in patient satisfaction as a desired outcome stands up to the scrutiny of research.

High scores on the EUROPEP patient satisfaction questionnaire have been valued in the current packet of performance indicators in Portugal. Evidence suggests that satisfaction with primary care in Portugal is elevated, around 73%.[1] The five areas tested by EUROPEP, relationships and communication (76%), medical care (74%), information and support (73%), continuity and cooperation (72%), and organization of services (69%), have all received scores close to the mean.

A recent unpublished internal report on patient satisfaction from ACES Porto Ocidental, confirms that patient satisfaction with family doctors (81%) and health units (74%) remains high. This study, conducted in November and December of 2014, looked at the satisfaction of over 2,000 clinic visitors using the EUROPEP instrument. Older, widowed patients were more satisfied with care than younger unemployed patients or students. Scores were higher in the newer Family Health Units (USF) compared to the older style health centres (UCSP). The effect of this positive report was an increase in professional satisfaction. This was followed by further reflection on ways to improve service, with attention to the negative points raised by patients regarding issues like telephone service and waiting times for appointments. This experience suggests that EUROPEP still has a role to play.

While it appears to be a valid and reliable research instrument for measuring patient satisfaction with primary health care services, including the work of doctors, nurses and secretaries, one wonders if it should be tied to pay for performance. What are the unwanted effects of the use of this tool?

Medical humourists have seized this topic and declared that uncritical attention to patient satisfaction can increase mortality rates.[2] In a mock medical report they show how giving patients antibiotics on demand leads to the rise of bacterial resistance and how failing to give an obese patient their cheeseburger in a hospital results in patient complaints and reduced income for the doctor. The court jester often draws the attention of the king to areas worthy of serious reflection when others are too subservient to mention them.

It is helpful to look at three distinct areas in patient satisfaction: the quality of medical care, access to care, and interpersonal issues.[3] Some may argue that assessment of medical quality is beyond the capacity of patients but this is not so. Patients can report their satisfaction with symptom relief and management of their chronic conditions. They can also report effectively on empowerment or enablement as a result of the care they receive. Access and interpersonal issues are often the areas that generate the greatest dissatisfaction, complaints and lawsuits. This is where we can put most of our efforts in improving satisfaction, if we believe this is important. Staying out of court is a reasonable goal and high patient satisfaction can help with this.

It all starts with access. Patients want to be able to reach their clinic by phone, to get a timely appointment, to be able to park their car or arrive by public transportation, and to be seen within a reasonable amount of time after arriving. Adequate telephone triage systems can help this process. Making provision for direct telephone contact with the nurse and doctor can also be a big advantage. E-mail has the potential for improving access and satisfaction as we have seen in a number of recent studies we published.

Interpersonal issues and communication can be

*Associate Professor, Community Health, University of Minho.

causes for complaint as well as sources of satisfaction. There is always room for improvement and there are proven strategies that can help. Medical students are trained in the art of good clinical communication from the first year in most medical schools. The patient centered care model of Stewart and others has been a useful to in teaching, research, and improving outcomes in clinical practice.[4] This not only increases diagnostic accuracy but it is therapeutic and also increases satisfaction with care. Rudeness by staff, neglect of patient suffering and other strong feelings, the use of technical jargon, and confusion with instructions are invitations for complaints. These can all be remedied with proper training and changes in attitude.

Complaints are a good way to study patient satisfaction. A recent review of 59 studies about patient complaints developed a useful taxonomy of complaints that can be helpful in planning programs to improve patient satisfaction. The broad areas most frequently mentioned in studies were satisfaction with quality of care, concerns about organization of services, and issues with relationships with staff.[5]

Every complaint is an opportunity to learn, if the principles of significant event analysis are employed. Our medical students are trained in classroom exercises in Braga by managing actual, anonymous patient complaints. They develop skills in recognizing the issues that led to the complaint and by devising corrective strategies.

We need to develop valid and reliable tools that are sensitive to change for the measurement of patient satisfaction in Portugal. We need more empiric research on the relationship between patient satisfaction and other health outcomes. We need studies that show us how improving satisfaction can also improve health. We would be happy to publish research of this type in this journal.

## REFERENCES


1. Ferreira PL, Antunes P, Portugal S. O valor dos cuidados primários: perspectiva dos utilizadores das USF, 2009. Lisboa: Ministério da Saúde, Missão para os Cuidados de Saúde Primários; 2010.
2. Schnabel D. Patient satisfaction survey study halted: mortality increased 238% with patient satisfaction. Gomer Blog; 2014 Aug 2 [cited 2015 May 5]. Available from: http://www.gomerblog.com/2014/08/patient-satisfaction-2/
3. White B. Measuring patient satisfaction: how to do it and why to bother. Fam Pract Manag. 1999;6(1):40-4.
4. Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, et al. The impact of patient-centered care on outcomes. J Fam Pract. 2000;49(9):796-804.
5. Reader TW, Gillespie A, Roberts J. Patient complaints in healthcare systems: a systematic review and coding taxonomy. BMJ Qual Saf. 2014;23(8):678-89. doi: 10.1136/bmjqs-2013-002437


## CONFLICT OF INTEREST

None reported


## ENDEREÇO PARA CORRESPONDÊNCIA

yonahyaphe@hotmail.com