I Can't Get No Patient or Practitioner Satisfaction

Is it purely an American conceit that we should get satisfaction from our giving or receiving health care rather than just good or cheap health? Market economists might argue so. Our patients may be saying so when they increasingly vote with their pocketbooks for non-allopathic, evidence-sparse, alternative care.¹ Is satisfaction a missing ingredient in our encounters that drives this trend? Satisfaction is an important variable to the extent that it is causally related or correlates with health or other outcomes important to patients, practitioners, or health systems. Patient and practitioner satisfaction can be with respect to individual encounters, the overall quality of care, the doctor-patient relationship, and the practice environment or system.

In the individual encounter, patient satisfaction relates to perceived practitioner competence, feeling heard, practitioner effects of interest and friendliness, whether or not the patient feels the practitioner likes him or her, and the practitioner's perception of the patient as physically or emotionally healthy. Patient dissatisfaction is associated with practitioner lack of punctuality, practitioner disinterest and unfriendliness or anger, the occurrence of shame and humiliation in the encounter and environmental variables such as staff rudeness, shabbiness, uncleanness and disorder. Patient satisfaction has also been linked to important outcomes such as show rate for follow-up visits, adherence to treatment regimens, litigiousness, consumer loyalty, and less robustly to clinical outcomes and healing.

Dissatisfied practitioners are more likely to report greater time pressure, a lack of autonomy and control over practice and administrative decision making, feeling not listened to by those in control, patient anger, and the perception that the patient is doing poorly, is self-abusing or has emotional problems.^{2,3} Dissatisfied practitioners have been shown to have lower patient adherence, sub-optimal prescribing behavior, and higher rates of divorce, illness, burnout, and job turnover.⁴ Inner city physicians are especially at risk of job dissatisfaction and turnover compared with their colleagues serving the urban middle class.⁵

Managed care organizations have found from myriad, proprietary studies that the two leading factors determining patient enrollment or disenrollment, where the rubber meets the road for health plans, are the perceived quality of the doctor-patient relationship and cost. It is less clear to what extent satisfaction is a primary variable related to quality of care or a consequence of other variables we associate with quality.

Haas et al.,⁶ in a large cross-sectional survey, report higher satisfaction among patients of more satisfied physicians. Patients were more likely to report high satisfaction if they were older, white, in better health, and had private, non-managed care insurance. Patients appeared more satisfied if their physician worked part-time. These findings must be viewed as primarily heuristic and preliminary for several reasons. It is among the first attempts to carefully study the link between patient and practitioner

satisfaction. While the statistical significances are high, they reflect small differences in satisfaction scores converted from five point scales to percentages. There is a single, psychometrically indeterminate, physician satisfaction question that is hard to interpret. Still, it seems common sense that less happy practitioners might communicate that to their patients, be less friendly or interested, and render patients less satisfied.

Major research questions remain to be answered. What are the most important variables determining patient and physician satisfaction? How can they be reliably and validly measured? A major problem with most such measures, as in the Haas et al. study, is that the scales used have high baseline scores, allowing little discrimination in post intervention results. This is because respondents routinely provide what they perceive to be the socially desirable response to survey questions. How can we retool these scales to improve their responsiveness? If a link between practitioner and patient satisfaction truly exists, what remediable factors influence such a relationship?

Given the early development of this research area, it is premature to draw strong implications for education or health systems management. Still, we know that many practitioners are unhappy, that they would not recommend medicine as a profession for their children, and that students and residents pick this up.^{7,8} We know that burnout is endemic and that both physician and patient turnover add personal and economic costs to systems. Efforts to improve communication and practice skills of students and residents to improve patient and physician satisfaction and lessen turnover seem reasonable goals. Curricula need to help our learners cope with the changing clinical realities. But what curricula, and do they work? A recent study by Brown et al. failed to show an effect of ten hours of communication skills training on a robust measure of patient satisfaction.⁹ This is not too discouraging because only two trainers, of undocumented skill, were involved; the pre-intervention scores were high; the experimental and control groups probably differed.¹⁰

Recruitment of students and residents to primary care internal medicine relates to their perception of how satisfying and viable the careers in it are. It seems appropriate to take all reasonable steps to ensure that those in the field are both satisfied and convey their satisfaction both to their learners and their patients.—**MACK LIPKIN, MD**, *New York University School of Medicine, New York, N.Y.*, and **MARK D. SCHWARTZ, MD**, *New York University School of Medicine and Gouverneur Diagnostic and Treatment Center, New York, N.Y.*

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