>> EDITORIAL | **Neal Flomenbaum, MD** EDITOR-IN-CHIEF

Patient Satisfaction

One way to engage an emergency physician from a busy ED in a heated discussion is to ask why patient satisfaction scores in the ED always seem to be several points lower than those from the hospital's inpatient services. To really anger the EP, mention that your family just returned from Disney World and, despite the fact that you were only able to go on three or four rides and spent most of the day standing in line, you left the park whistling a happy tune.

For many years, I could not get past the standard opening question on ED satisfaction surveys, which typically reads "Apart from the wait, how would you rate your overall experience in the emergency department?" To me, this sounded very much like "Apart from that, Mrs. Lincoln, how did you enjoy the play?" But I think that the real danger of overemphasizing patient satisfaction *scores* is the risk of neglecting some of the underlying causes that drive those scores. Some or most of those causes may relate to an inability of some ED staff to interact with patients in meaningful, compassionate, and caring ways. But other causes, such as insufficient inpatient beds, lack of space, and inadequate resources must also be addressed. Attempting to achieve higher satisfaction scores by focusing exclusively on one set of issues—typically, staff attitudes—may provide an inexpensive immediate "fix," but inevitably makes it almost impossible to sustain those achievements—not unlike the long-term results of most weight-reduction diets.

The best approach to patient satisfaction is to address both sets of issues, while never assuming that once a better score is attained, long-term success is guaranteed; then, to search for the ever-increasing, ever-changing conditions and patterns that drive down ED satisfaction scores. To do so effectively requires accurate and frequently collected data about all components of ED length of stay, including registration time, time to see a provider, time until laboratory and radiographic tests are available, time to completion of consultations, and arrangements for appropriate follow-up care.

No one ever likes to feel neglected, forgotten, or unimportant, least of all anyone who is ill and in need of help. For these reasons, no amount of resources to reduce LOS can replace a patient facilitator or "advocate," who will be at the patient's bedside frequently throughout the ED visit. Such a highly motivated person can answer questions, provide for patients' needs, reassure patients when appropriate, and alert care providers to possible problems. House officers (and attending physicians) in teaching hospitals should not need to be reminded that just seeing a patient at the beginning and end of an ED visit is insufficient "face time." But such frequent reminders apparently are necessary. Particularly relevant here is Woody Allen's expression that "80% of success is showing up," whereas not doing so always makes the situation worse. Routinely calling all discharged patients the day after their ED visits to inquire about their care and ongoing health issues also helps.

>> So what are the differences between happily waiting in line all day at Disney World and waiting in an ED? <<

So what are the differences between happily waiting in line all day at Disney World and waiting in an ED? There are many, beginning with good weather, being on vacation, and being offered interesting experiences during the wait. On the other hand, it helps if you're not there because you cut your finger open and bled all over the front of your tuxedo shirt or bridal gown a short time before your wedding, only to be told you'll have to wait a little longer; or because you are being successfully resuscitated from a cardiac arrest. Incidentally, the first of the two patients will receive an ED satisfaction survey; the second, an inpatient survey. □