



# Patient Satisfaction as a Metric for Quality

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As orthopedic surgeons, we typically equate a quality outcome with the patient's end result—resolved or diminished functional disability, fracture union, and/or pain relief, to name a few metrics. Although research has not identified a clear link between quality outcomes and patient satisfaction scores, patient satisfaction is increasingly used as a proxy for quality of care. It's speculated that more personal care may result in better communication, more reasonable expectations, and more patient involvement, all of which may result in better quality of care. Regardless, it's unclear whether satisfaction is an attribute of quality care or an indicator.

In a recent article in *Modern Healthcare*, Irwin Press,<sup>1</sup> cofounder of Press Ganey, challenges any campaign to cast doubt on satisfaction as a relevant indicator of quality care: "It can be argued that diagnostic procedures, surgeries and therapies constitute treatment, but not care. Treatment alone isn't care.... One is objective, involving highly standardized technical, mechanical or chemical interventions. The other is subjective, composed of behaviors, decisions and interactions of humans with idiosyncratic personalities, stresses, agendas and sensitivities."

As surgeons, we understandably focus on objective treatment and outcome and may underappreciate the importance of the process—the experience of care. Wellness probably requires mastery of both. Indeed, just as a patient's poor coping skills, depression, anxiety, and proclivity to catastrophize may compromise their recovery and self-reported assessments of outcome,<sup>2-5</sup> so too do the qualitative components of our interaction with patients undoubtedly impact, not only their experience, but also their recovery. Patient self-efficacy (the feeling that they can do it), engagement ("activation"), compliance, and expectations all derive in part from the "Art" of our practice. Our "Heart" is as important to that Art, if not more so, than our "Head" (our intellect and knowledge). Whether we buy

into this or not is a matter of personal opinion and experience, I suppose, but the reality is that the important singular metric of patient satisfaction is here to stay—patient satisfaction has become an important component of pay-for-performance metrics which expressly intend to reward quality over volume.

What does this mean for us? First, we need to adapt to the reality that the patient's perception of their interaction with us impacts their experience and their level of satisfaction, and accept our role in their overall perception of quality. Being rewarded with a high satisfaction score is within our sphere of influence and requires more than just providing a good objective outcome. We might not revisit a restaurant with great food but lousy service and an underwhelming environment. We might also never eat at a place that was really nice inside

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and had great service, but which provided horrible food. So we must aspire to provide both objective quality outcomes and stellar patient care. As third-party payers increasingly follow the lead of the Centers for Medicare and Medicaid Services (CMS), the patient will not be at our table unless we both ask for feedback and respond to it. We all aspire to be great technicians and have a command of the knowledge base in our respective areas of practice. Some of us are privileged to have earned regional, national, or international reputations among our peers, but we all will be increasingly judged based on patient satisfaction with our care. This means that we must care about their experience and how they perceive our care: Do we spend enough time, listen attentively, answer questions, and explain the diagnosis and plan?

Just as we may hold our breath unknowingly during stressful situations when we are not mindful, so too might our "Heart" not be clearly evident in the complex health care environment today—too little time, too much paperwork, increasing patient demands. But practicing with heightened self-awareness,

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empathy, and unambiguous intention, and modeling our values during our interaction with our patients—“mindful practice”—is increasingly advocated as a necessary component to “best practice.” For truly rewarding practice, during which we can attain not only great results but also satisfied patients, we need to revisit why we do what we do, and rebalance our emphasis on what we do and how we do it. Mindful practice is both an objective and a strategy. It may require making structural adjustments to our practice, such as seeing fewer patients per hour, for, perhaps, an hour or two more in a day, completing some of our electronic medical record notes at day’s end, and maybe adding an extra clinic day every other week. We must also deliberately solicit feedback from our patients so that we can respond to any perceived room for improvement.

Thirteen years ago when I received my Master of Business Administration (MBA) degree, I felt that improving operational efficiency would enable me to do more in a day—and it did. But when patient satisfaction becomes the proxy for quality, sound business practice may not translate into sound

clinical practice. After 21 years of practice, and deliberate attentiveness to patient feedback, I am increasingly aware that the Art of practice is as important as the Science—our Heart is as important as our Head. In this light, patient satisfaction is a very sound metric for quality.

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