The patient satisfaction chasm: the gap between hospital management and frontline clinicians

Ronen Rozenblum,1 Marianne Lisby,2 Peter M Hockey,3 Osnat Levitzion-Korach,4 Claudia A Salzberg,1 Nechama Efrati,4 Stuart Lipsitz,1 David W Bates1

ABSTRACT
Background Achieving high levels of patient satisfaction requires hospital management to be proactive in patient-centred care improvement initiatives and to engage frontline clinicians in this process. Method We developed a survey to assess the attitudes of clinicians towards hospital management activities with respect to improving patient satisfaction and surveyed clinicians in four academic hospitals located in Denmark, Israel, the UK and the USA. Results We collected 1004 questionnaires (79.9% response rate) from four hospitals in four countries on three continents. Overall, 90.4% of clinicians believed that improving patient satisfaction during hospitalisation was achievable, but only 9.2% of clinicians thought their department had a structured plan to do so, with significant differences between the countries (p<0.0001). Among responders, only 38% remembered targeted actions to improve patient satisfaction and just 34% stated having received feedback from hospital management regarding patient satisfaction status in their department during the past year. In multivariate analyses, clinicians who received feedback from hospital management and remembered targeted actions to improve patient satisfaction were more likely to state that their department had a structured plan to improve patient satisfaction. Conclusions This portrait of clinicians’ attitudes highlights a chasm between hospital management and frontline clinicians with respect to improving patient satisfaction. It appears that while hospital management asserts that patient-centred care is important and invests in patient satisfaction and patient experience surveys, our findings suggest that the majority do not have a structured plan for promoting improvement of patient satisfaction and engaging clinicians in the process.

INTRODUCTION
Patient-centred care has drawn increasing interest in recent years, highlighting the importance of incorporating patients’ needs and perspectives into care delivery.1–3 Consistent with this notion, implementation of patient-centred care and higher patient satisfaction has been shown to be associated with improved clinical outcomes, health service efficiency and also has a positive effect on business metrics.3–14

Triggered in part by the Institute of Medicine’s 2001 report Crossing the Quality Chasm, patient-centred care has become a high priority on the national agenda and has received increasing public attention.1,6 Motivated further by patient satisfaction and patient experience public reports, many healthcare organisations around the world have begun to strive to become more patient oriented, and use patient surveys to assess their progress.6 15–21 Yet, despite expanding initiatives, many healthcare organisations have faced barriers when attempting to transform their organisational culture from ‘provider focused’ to ‘patient focused’ and still fall short of achieving high scores on patient satisfaction.6 22–27 Concurrently, studies have shown that those healthcare organisations that succeeded in fostering patient-centred care into their organisations incorporated it as a strategic investment priority mainly by committed leadership, active measurement and feedback of patient satisfaction as well as engagement of patients and staff.22 28

A growing body of evidence supports a robust association between the quality of clinician care and outcome.5 29 30 In

addition, patient perception of the care received has been shown to be influenced mainly by their interaction with healthcare providers, particularly nurses and physicians. Furthermore, studies and reports suggest that the main determinants of patient satisfaction are associated with clinician behaviour, including communication with patients, attentiveness and responsiveness to patients’ concerns and needs, and involvement of patients in decision making. Thus, achieving high levels of patient satisfaction requires frontline clinicians to be engaged in this quality process.

Despite the desire of healthcare providers to improve patient experience and achieve higher patient satisfaction scores, relatively little attention is being paid to the activities of hospital management and the engagement of frontline clinicians in the patient satisfaction improvement process. Therefore, we undertook a study to examine clinician attitudes towards hospital management activities with respect to improving patient satisfaction and their engagement in this quality process, and did so in multiple countries to determine whether approaches differ across cultures.

**METHODS**

**Study design and survey instrument**

Between January and December 2009, we conducted a cross-sectional, multicentre study surveying physicians and nurses from four academic hospitals located in Denmark (Aarhus University Hospital), Israel (Assaf Harofeh Hospital, Zerifim), the UK (Oxford Radcliffe Hospital, Oxford), and the USA (Brigham and Women’s Hospital, Boston, Massachusetts).

A similar survey methodology was used previously in an international comparison study.

The methodology of our study has already been published in a previous article. While the previous article focused on clinicians’ attitudes, awareness, competence and performance related to patient expectations and satisfaction, the current article deals with the prevailing activities of hospital management, such as having a structured plan and targeted actions to promote improvement in patient satisfaction. The current article varies from the previous one by focusing on the role of management and its initiatives to promote improvement in patient satisfaction, and by examining organisational engagement of clinicians in this improvement process.

The survey instrument was developed based on a systematic literature review and in-depth interviews with physicians, nurses, researchers and senior administrators. Survey research experts further reviewed the draft survey to ensure comprehensibility and clarity. Subsequently, the survey instrument was pilot tested in a US population consisting of 20 physicians and 20 nurses. The questionnaire was modified and shortened accordingly. To check the internal validity of the survey several questions were reversed; the responses were symmetric, suggesting good internal validity. Moreover, some questions were specifically examined, for example, clinicians’ comprehension of the phrase ‘a structured plan for managing patient satisfaction’. In this case, we found that clinicians’ understanding was in line with our overall broad definition of the phrase, which was ‘any formal and designed intervention that was implemented in the clinicians’ department and aimed to improve patient satisfaction’. The questionnaire was forward translated into Hebrew and Danish by professional translators and backwards translated into English by another translator to confirm accuracy. Uncertainties or disagreements between the translators were resolved by consensus.

The questionnaire was found in all countries to be comprehensible and clear. To ensure that the survey content was consistently understood by respondents in each country, the researchers (who were native speakers in Danish and Hebrew) participated in the pilot study in all the countries. Consistency was checked by comparing the respondent’s feedback between the countries and similar understandings of the questions were found.

The final questionnaire included 32 questions (28 closed-ended questions and four open-ended questions) and consisted of three main sections related to patient expectations and satisfaction: clinicians’ experience (eg, ‘At or near discharge, do you routinely ask your patients about their satisfaction status during their hospitalisation?’); perceptions towards hospital management activities (eg, ‘In your opinion, should hospital management take a more active role in conducting patient satisfaction improvement programmes?’); and attitudes (eg, ‘In your opinion, is it important that clinicians talk with patients about satisfaction status?’). Furthermore, the survey included specific questions regarding awareness (eg, ‘In your opinion what is the level of awareness of clinicians towards patient satisfaction?’) and competence (eg, ‘In your opinion are clinicians trained to cope with different levels of patient satisfaction?’). Apart from the four open-ended questions, the majority could be answered on a three-point scale: ‘Yes’, ‘No’ and ‘Don’t know’. However, for the two questions related to ‘Awareness’, we used a four-point scale: ‘Low’, ‘Moderate’, ‘High’ and ‘Don’t know’. For the purpose of providing robust data analysis, these were subsequently dichotomised into the following categories: ‘Low/Moderate’, indicating modest awareness and ‘High’, indicating substantial awareness of patient expectations and patient satisfaction. The survey also asked about the characteristics of the responders, such as gender, years of hospital experience, seniority, administrative status and area of specialisation.
Study sample
Our sample size was calculated based on the results of the pilot study and revealed that approximately 80% of the clinicians (physicians and nurses) responded ‘No’ to the primary question ‘Do you routinely ask your patients about their expectations regarding the hospitalisation?’ The overall goal was to estimate the proportions of clinicians who respond ‘No’ to the above question. Based on these data, we estimated that 125 physicians and 125 nurses should be surveyed from each hospital to detect a statistical difference (80% power and 95% CI). Assuming a 20% non-response rate, a representative statistical sample of 157 physicians and 157 nurses was chosen from the Medicine and Surgery Departments at each participating hospital.

All physicians (residents and attending) and nurses (registered nurse with and without an academic degree) from the Medicine and Surgery Departments were eligible for participation; clinicians from other clinical settings were excluded. A de-identified, systematic random sample of clinicians was generated using random number blocks. Thus, the first clinician was chosen at random, and subsequently, every fifth clinician was selected.

Survey administration
The research team administered the survey in person and/or sent the questionnaire to the randomly selected clinicians through intra-hospital mail. Clinicians received an envelope including a cover letter, the survey and a return envelope. Non-respondents received reminders by intra-hospital mail. Participating physicians and nurses were assured confidentiality and anonymity of their responses and were asked to return the questionnaire in the attached envelope. The study protocol and survey instrument were approved by the Institutional Review Board or similar committees in the participating hospitals.

Statistical analysis
Surveys from all study sites were returned to Brigham and Women’s Hospital for data entry. Data were coded by country and entered into a computer database by research staff. STATA (V11.0) was used for data analysis, including $\chi^2$ tests and analysis of variance testing for univariate analyses. Multivariable analyses were conducted using logistic regression. All statistical tests were conducted at the 95% confidence level using Pearson’s $\chi^2$ test for independence on contingency tables.

RESULTS
Of 1256 providers surveyed, 1004 returned the questionnaire, achieving a response rate of 79.9% (table 1). Respondents were almost equally distributed between countries and between clinicians in Medicine and Surgery Departments. Almost half were physicians (46.6%), of which 61.5% were attendings. Administrative roles were held by a minority (18.3%) and women comprised 70.8% of the responders.

Structured plan for managing patient satisfaction
Less than 1 in 10 stated that their department had a structured plan for managing patient satisfaction and half of the respondents were certain that such a plan did not exist. The remaining 39% did not know or were not aware of any structured plan in their department (table 2). Nurses appeared to be more confident of the existence of a plan than physicians (11.9% vs 6.2%, respectively, $p<0.004$). There were considerable differences among countries, with departments in the USA being superior to departments in the UK, Denmark and especially Israel ($p<0.0001$). Finally, responders with administrative roles were far more likely to know if a structured plan were available in their department when considering the proportion of ‘Don’t know’ answers (17.9% vs 43.9%, table 2).

Feedback from hospital management
Overall, one-third of the clinicians stated that they had received feedback from hospital management regarding the level of patient satisfaction in their department during the last 12 months, and again differences between countries were highly significant ($p<0.0001$). Nurses more frequently stated that they had received feedback from management compared with physicians (39.6% vs 28.4%, $p<0.0001$). Likewise, a significantly larger proportion of responders with administrative roles answered that they had received feedback during the last 12 months (47.8% vs 31.3%, $p<0.0001$). Table 3 details these results.

### Table 1 Characteristics of respondents

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>No. of respondents (N=1004)</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>217</td>
<td>21.6</td>
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<tr>
<td>Israel</td>
<td>269</td>
<td>26.8</td>
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<tr>
<td>USA</td>
<td>257</td>
<td>25.6</td>
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<td>UK</td>
<td>261</td>
<td>26.0</td>
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<tr>
<td>Clinician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>536</td>
<td>53.4</td>
</tr>
<tr>
<td>Physician</td>
<td>468</td>
<td>46.6</td>
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<tr>
<td>Area of specialisation</td>
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<td></td>
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<tr>
<td>Medicine</td>
<td>548</td>
<td>54.6</td>
</tr>
<tr>
<td>Surgery</td>
<td>456</td>
<td>45.4</td>
</tr>
<tr>
<td>Administrative status</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>184</td>
<td>18.3</td>
</tr>
<tr>
<td>No</td>
<td>820</td>
<td>81.7</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>711</td>
<td>70.8</td>
</tr>
<tr>
<td>Men</td>
<td>293</td>
<td>29.2</td>
</tr>
</tbody>
</table>

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In multivariate analyses, respondents receiving feedback from hospital management were more than twice as likely to state that clinicians had high awareness of patient satisfaction (OR 2.45; 95% CI 1.59 to 3.78). Furthermore, they appeared to be almost three times as likely to ask the patients about their satisfaction compared with clinicians who did not ask (OR 2.69; 95% CI 1.73 to 4.19).

**Table 2** Characteristics of clinicians who reported that their department had a structured plan for managing patient satisfaction (N=1004)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Yes, N (%)</th>
<th>No, N (%)</th>
<th>Don’t know, N (%)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denmark, N=217</td>
<td>23 (10.6)</td>
<td>90 (41.5)</td>
<td>104 (47.9)</td>
<td>p&lt;0.0001</td>
</tr>
<tr>
<td>Israel, N=269</td>
<td>13 (4.8)</td>
<td>171 (63.6)</td>
<td>85 (31.6)</td>
<td></td>
</tr>
<tr>
<td>USA, N=257</td>
<td>31 (12.1)</td>
<td>112 (43.6)</td>
<td>114 (44.4)</td>
<td></td>
</tr>
<tr>
<td>UK, N=261</td>
<td>26 (10.0)</td>
<td>145 (55.6)</td>
<td>90 (34.5)</td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse, N=536</td>
<td>64 (11.9)</td>
<td>277 (51.7)</td>
<td>195 (36.4)</td>
<td>p=0.004</td>
</tr>
<tr>
<td>Physician, N=468</td>
<td>29 (6.2)</td>
<td>241 (51.5)</td>
<td>198 (42.3)</td>
<td></td>
</tr>
<tr>
<td>Area of specialisation</td>
<td></td>
<td></td>
<td></td>
<td>p=0.037</td>
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<tr>
<td>Medicine, N=548</td>
<td>57 (10.4)</td>
<td>263 (48.0)</td>
<td>228 (41.6)</td>
<td></td>
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<tr>
<td>Surgery, N=456</td>
<td>36 (7.9)</td>
<td>255 (55.9)</td>
<td>165 (36.2)</td>
<td></td>
</tr>
<tr>
<td>Administrative status</td>
<td></td>
<td></td>
<td></td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>Yes, N=184</td>
<td>26 (14.1)</td>
<td>125 (67.9)</td>
<td>33 (17.9)</td>
<td></td>
</tr>
<tr>
<td>No, N=820</td>
<td>67 (8.2)</td>
<td>393 (47.9)</td>
<td>360 (43.9)</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
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<td></td>
<td></td>
<td>p=0.597</td>
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<tr>
<td>Men, N=292</td>
<td>23 (7.85)</td>
<td>155 (52.90)</td>
<td>115 (39.25)</td>
<td></td>
</tr>
<tr>
<td>Women, N=711</td>
<td>70 (9.85)</td>
<td>363 (51.05)</td>
<td>363 (51.05)</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 provides an overview of the characteristics of the respondents who reported that their department had a structured plan for managing patient satisfaction versus those who reported that they did not have a structured plan or they did not know. p Value refers to the difference in distribution of Yes/No/Don’t know responses between the categories of each characteristic.

In multivariate analyses, respondents receiving feedback from hospital management were more than twice as likely to state that clinicians had high awareness of patient satisfaction (OR 2.45; 95% CI 1.59 to 3.78). Furthermore, they appeared to be almost three times as likely to ask the patients about their satisfaction compared with clinicians who did not ask (OR 2.69; 95% CI 1.73 to 4.19).

**Targeted actions to improve patient satisfaction**

Overall, 38.0% of clinicians remembered targeted actions that were conducted in their department to improve patient satisfaction, with statistically significant differences between all countries (p<0.0001). Likewise, clinicians with administrative roles were significantly more likely to remember targeted actions in their department (p<0.0001). Figure 1 details these results.

Multivariate analyses indicated that clinicians who remembered targeted actions in their department during the last 12 months were four times as likely to have received feedback about patient satisfaction (OR 4.10; 95% CI 3.04 to 5.54). Likewise, they were four times more likely to have reported a high awareness of patient satisfaction (OR 4.03; 95% CI 2.51 to 6.48).

**Factors associated with having a structured plan for improving patient satisfaction**

Multivariable analyses were conducted to examine possible factors for the main question in this article, ‘Does your department have a structured plan for managing patient satisfaction regarding their hospitalisation?’ The main factors associated with having a structured plan were feedback from hospital...
management, targeted actions to improve patient satisfaction and respondents who declared that clinicians had a high level of awareness with regard to patient satisfaction (figure 2). Furthermore, with regard to performance-related activities, clinicians who stated that their department had a structured plan for patient satisfaction improvement were almost twice as likely to ask the patients about their level of satisfaction and to document this in the medical record (OR 1.85; 95% CI 1.28 to 2.88; and OR 1.59; 95% CI 1.11 to 2.29).

Overall, 83.6% of the physicians and nurses stated that achieving high levels of patient satisfaction was important for the clinical success of healthcare organisations and 90.4% answered that improving patient satisfaction during hospitalisation was achievable. However, multivariable analysis did not reflect any association between having a structured plan for patient satisfaction and clinician belief in the importance of this for clinical success (OR 1.01; 95% CI 0.71 to 1.44) or clinicians who stated that improving patient satisfaction was achievable (OR 0.96; 95% CI 0.62 to 1.48). Finally, 85.5% of clinicians thought that hospital management should take a more active role in conducting patient satisfaction improvement programmes. When examined in adjusted multivariable analysis, clinicians who replied that their department had a structured plan were less likely to state that hospital management should take a more active role in conducting improvement programmes (OR 0.63; 95% CI 0.43 to 0.92).

DISCUSSION
The goal of this international study was to examine clinicians’ attitudes towards hospital management activities with respect to improving patient satisfaction and their engagement in this quality process. We found that only 1 in 10 clinicians stated that their department had a structured plan to promote improvement of patient satisfaction. In addition, only one-third recalled having received feedback from their hospital management regarding patient satisfaction status. We also discovered that while nearly all clinicians believed that improving patient satisfaction during hospitalisation was achievable, only 38% remembered targeted actions conducted to improve it. These findings highlight a chasm between hospital management and frontline clinicians with respect to improving patient satisfaction. It seems that, despite
the fact that hospital management espouses the importance of patient-centred care and invests in patient surveys, the majority of hospitals do not appear to have a structured plan to promote improvement of patient satisfaction nor engagement of clinicians in the process. Thus, 10 years after the *Quality Chasm* report that called for fundamental improvement and redesign in patient centred care,1,2 our findings raise concern as to whether today clinicians have an active role in enhancing patient satisfaction and are engaged in this dimension of healthcare quality by hospital management.

Consistent with our findings, previous studies and reports have shown that in spite of the emphasis on patient-centred care by policy makers and the various international approaches to promote this domain,3–21 the effectiveness of healthcare organisations’ efforts to improve patient satisfaction and patient experience has had mixed outcomes.6,22–27,40 Although patient satisfaction appears to have gradually improved in many organisations around the world, there is still considerable room for improvement.6,40 Nevertheless, it has been established that engaging frontline clinicians in the patient satisfaction process has a strong impact on its outcome.5,31–38 and studies have revealed that healthcare organisations should take a more active role in increasing clinician awareness and involvement in this process.17,38 We believe that the findings in the present article support and extend the findings in our previous article which focuses on clinicians’ attitudes and performance with respect to patient expectations.38 In the previous article, we revealed that the majority of clinicians do not routinely inquire about patient expectations, although addressing patient expectations is perceived as an important element of daily care delivery. We also found that the main determinants of clinicians’ lack of activity to address patients’ expectations were associated with insufficient awareness and inadequate training. This may be partly explained by our current findings that indicated limited institutional support for clinicians to manage and improve patient satisfaction.

Making patient-centred care a strategic investment priority in healthcare organisations seems to be successful when encompassing a variety of elements, such as use of systematic measurement and feedback, building staff capacity and a supportive environment, ensuring accountability at all levels, establishing an organisational culture that supports learning and improvement, and engaging patients and staff in the process.22,28 Thus, healthcare organisations are well advised to address these barriers, mainly through implementation of strong leadership and change management strategies.

Our study confirms and extends findings that have demonstrated barriers and gaps in the performance of healthcare organisations attempting to transform their culture from a provider to a patient focus, particularly by identifying the main factors associated with departments having a structured plan for improving patient satisfaction. After adjusting for other characteristics, we found that clinicians who received feedback from hospital management and remembered targeted actions to improve patient satisfaction were more likely to be employed in departments with a structured plan to improve patient satisfaction. Not surprisingly, these clinicians were also more likely to be aware of patient satisfaction, ask patients about it and document this information in the medical record. Nonetheless, it is important to note that there may well be other factors, such as availability of resources, managerial culture or local population attitudinal issues that might affect the likelihood of an organisation to have a structured plan to improve satisfaction. Finally, we also found that the majority of clinicians thought that hospital management should take a more active role in conducting patient satisfaction improvement programmes.

To gain deeper insight into the patient satisfaction improvement process, we further investigated the main factors associated with receiving feedback from hospital management. In multivariable analysis, we discovered that receiving feedback was the major determinant of clinician awareness of patient satisfaction and their performance. These findings reveal that clinicians receiving feedback from hospital management were more likely to have higher awareness of patient satisfaction and more likely to ask patients about their satisfaction. Consequently, we believe that the low number of clinicians having received feedback may affect their performance with respect to the patient satisfaction improvement process.

Consistent with our findings, previous literature has demonstrated that public reporting of patient satisfaction and experience surveys as well as enactment of pay-for-performance programmes focus attention on this quality process; unfortunately, quality improvement efforts typically focused mainly on improving satisfaction scores, rather than on improving the patient experience.24,25,41–43 Concurrently, studies reporting the use of comparative reports of hospital performance have shown that only about 30% of organisations reported using the data.44–47 There are a number of reasons why patient survey data are not systematically used in quality improvement efforts, such as manager perceptions of the usefulness of comparative reports of hospital performance, organisational barriers, professional barriers and data-related barriers, and the costs of collecting the data.17,27,43 We therefore concur with other researchers who have made the case that simply measuring satisfaction and patient experience will not be sufficient to result in substantial improvement.44,48,49 These findings have some policy implications. It appears that many healthcare organisations may be overinvesting in simply
performing surveys of patient satisfaction and patient experience rather than on improving it. There has been a general trend towards moving to more use of patient experience measurement rather than satisfaction, mainly because it may be a better target for specific quality improvements. Overall, though, there appears to be more emphasis on measurement than improvement. Thus, policy makers may want to consider new strategies that reward organisations for improving patient experience.

Finally, we found major differences between the countries with respect to having a structured plan, feedback from hospital management and targeted actions to improve patient satisfaction. Although the majority of clinicians in these four countries did not have a structured plan for improving patient satisfaction, the results from the USA, Denmark and the UK far exceeded those from Israel. Similarly, the three countries did much better than Israel with respect to clinicians receiving feedback from hospital management. In addition, Denmark was far superior with respect to implementing actions to improve satisfaction compared with the UK, the USA and Israel. This may in part be explained by the fact that patient satisfaction surveys have been conducted on a regular basis in Danish healthcare settings for more than a decade, and hospitals rated below acceptable standards are required to improve their performance and report how they expect to achieve these improvements. Although the differences between the countries may reflect general cultural differences, we believe that the health policy in Denmark played a key role in motivating hospital management to make patient-centred care a strategic investment priority in general and conduct patient satisfaction improvement programmes that reach frontline clinicians in particular.

This study has a number of limitations. Although recently there has been more focus on patient experience rather than on patient satisfaction, as it offers a wider range for specific quality improvement initiatives, in this study we chose to focus only on patient satisfaction. The concept of patient satisfaction has been widely used around the world for many years and was therefore expected to be more concrete for clinicians rather than patient experience, in the four countries examined. Moreover, although the literature differentiates between the two concepts, we believe that patient satisfaction is still perceived as strongly related to patient experience by many frontline clinicians. We are also convinced that both concepts highlight the importance of incorporating the patient’s perspectives into care delivery. Nonetheless, we are aware that by focusing only on patient satisfaction, we could have affected the results of the study. Therefore, in this study we turned our attention towards clinicians’ attitudes regarding patient satisfaction, we suggest that future studies examine clinicians’ attitudes and performance related to patient experience and compare these findings with those of the current study.

Due to the cross-sectional design, we have shown an association, but cannot confirm any causal relationships. Further investigation of how these findings change over time and factors that underlie their improvement would be helpful. Our survey was limited to clinicians in a few academic hospitals, and we included clinicians only from the Departments of Medicine and Surgery, which limits the generalisability of our results. Although we used similar instruments to obtain information from clinicians in all countries, language differences might have produced varying responses that could have affected our results. However, we used rigorous methods to verify the accuracy of translations and to confirm the applicability of concepts across cultures and languages. In addition, we did not examine inter-country differences in general and/or financial incentives related to improving patient satisfaction in particular, which could have affected the results of the study. The fact that the majority of hospitals do not have a structured intervention plan regardless of potential incentives diminishes the potential impact of this issue and suggests that these incentive measures, even if present, have not resulted in significant improvement at the level of frontline clinicians at this point in time.

The questionnaire was administered via two different modes: in person and/or through intra-hospital mail, which might have had some effect on the responses. Nevertheless, in three out of the four countries (Israel, the UK and the USA) the two modes were equally represented in all contexts. In Denmark the survey was administered only through intra-hospital mail. Furthermore, we found that the respondents’ results in the pilot study matched the main study findings. We therefore tend to believe that no significant biases were formed due to these different modes of questionnaire administration. We also recognise that the ‘yes–no’ response scale used partially in our survey may not indicate the degree of certainty of the respondent, nor does it enable the responders to elaborate on their answers which could have potentially affected our conclusions. However, the items using the ‘yes–no’ options in our questionnaire would not benefit much from a Likert scale. In addition, a ‘yes–no’ scale is commonly used in surveys. Finally, like all surveys, ours may have been subject to a potential response bias. Although we had a high response rate, it is possible that clinicians who responded had a greater interest in patient satisfaction than non-responders.

It appears that while hospital management asserts that patient-centred care is important and invests in patient satisfaction and patient experience surveys, the majority do not have a structured plan to promote improvement of patient satisfaction which reaches
frontline clinicians. Consistently, our findings indicate insufficient institutional support for clinicians to manage and improve this dimension of healthcare quality. Thus, hospital management may benefit from incorporating patient-centered care as a strategic investment priority as well as developing and implementing proactive structured plans that engage frontline clinicians in the patient satisfaction and experience improvement process. Moreover, hospital management should consider creating a patient feedback mechanism; ensuring frontline clinicians obtain routine feedback about patient satisfaction.

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Contributors All authors contributed to the study design drafted by RR and DWB. RR, ML, PMH, OLK, NE and CS contributed to the data collection. SL and CS designed and did the statistical analysis, and verified its accuracy. All authors helped draft this report or critically revise the draft. All authors reviewed and approved the final version of the report.

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