Physician Empathy as a Driver of Hand Surgery Patient Satisfaction

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Purpose To examine the relationship between patient-rated physician empathy and patient satisfaction after a single new hand surgery office visit.

Methods Directly after the office visit, 112 consecutive new patients rated their overall satisfaction with the provider and completed the Consultation and Relational Empathy Measure, the Newest Vital Sign health literacy test, a sociodemographic survey, and 3 Patient-Reported Outcomes Measurement Information System-based questionnaires: Pain Interference, Upper-Extremity Function, and Depression. We also measured the waiting time in the office to see the physician, the duration of the visit, and the time from booking until appointment. Multivariable logistic and linear regression models were used to identify factors independently associated with patient satisfaction.

Results Patient-rated physician empathy correlated strongly with the degree of overall satisfaction with the provider. After controlling for confounding effects, greater empathy was independently associated with patient satisfaction, and it alone accounted for 65% of the variation in satisfaction scores. Older patient age was also associated with satisfaction. There were no differences between satisfied and dissatisfied patients with regard to waiting time in the office, duration of the appointment, time from booking until appointment, and health literacy.

Conclusions Physician empathy was the strongest driver of patient satisfaction in the hand surgery office setting. As patient satisfaction plays a growing role in reimbursement, targeted educational programs to enhance empathic communication skills in hand surgeons merit consideration. *(J Hand Surg Am. 2015;40(9):1860–1865. Copyright © 2015 by the American Society for Surgery of the Hand. All rights reserved.)*

Type of study/level of evidence Prognostic II.

Key words Empathy, communication, patient satisfaction, health literacy, reimbursement.

Additional material is available online.

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As health care in the United States transitions from a fee-for-service to an outcomes-based environment, enhancing the patient experience has become a priority for both policymakers and clinical leaders.[1] Patient satisfaction is a key dimension of patient-centered care and is increasingly incentivized and publicly reported.[2–5] Satisfied patients do not necessarily have better outcomes[6,7] but are more likely to comply with treatments, keep office appointments, and not file complaints or lawsuits.[1,8–11]

Despite growing interest, drivers of patient satisfaction remain incompletely understood in the hand surgery office setting.[12–17] Patient satisfaction has been inconsistently linked to emotional health,[13,15,17] educational attainment,[12] waiting time,[16] involvement in decision making,[13] and expectations of care;[14] yet, what is common to previous studies is the inability to explain most of the variation in patient satisfaction.[12–17] Empathy—the ability to understand and share the feelings, thoughts, or attitudes of another—is an essential component of the patient–physician relationship, but research on its influence on patient satisfaction is scarce and confined to the primary care setting.[18,19] In a highly specialized and technical field such as hand surgery—in which the usual model of clinical care is "find the problem and fix it"—identifying whether patients value affective concern is important for quality improvement purposes and may have economic and clinical implications.

We undertook this study to examine the relationship between physician empathy and patient satisfaction after a single hand surgery new office visit. We tested the primary null hypothesis that there was no association between patient-rated physician empathy and the degree of overall satisfaction with the provider. In addition, we sought to identify other correlates of patient satisfaction (eg, health literacy, psychological distress, waiting time, and duration of the appointment).

MATERIALS AND METHODS

Study design

After approval of our institutional review board, 115 patients visiting the office of 1 of 4 orthopedic hand surgeons for the first time were asked to enroll in this cross-sectional study. Patients were considered eligible for the study if they were at least 18 years old and spoke English fluently. Enrollment took place between December 2013 and March 2014. The patients were consecutively enrolled one clinic day a week. Three patients declined participation, leaving 112 patients in the cohort. Informed consent was obtained from each participant before enrollment.

Immediately after the visit, a research fellow not involved in patient care asked all consenting patients to rate their overall satisfaction with the provider and to complete a sociodemographic survey (eg, age, sex, race and/or ethnicity, education, insurance status, work status, and marital status), the Newest Vital Sign (NVS) health literacy test,[20] the Consultation and Relational Empathy (CARE) Measure,[21,22] and 3 Patient-Reported Outcomes Measurement Information System (PROMIS)-based computerized adaptive testing questionnaires: Pain Interference,[23] Upper-Extremity Function,[24] and Depression.[25] We also measured the waiting time in the office to see the physician (time elapsed from front office registration until the attending physician entered the room), the duration of the visit, and the time from consultation request to actual appointment. The management was classified as operative, nonsurgical (eg, orthosis, corticosteroid injection, and hand therapy), diagnostic testing (eg, CT, MRI, ultrasound, and electromyography), or counseling and/or observation. Although the physicians were aware of the existence of this study, they were unaware of which patients were being enrolled into it, and neither the patients nor providers knew they were being timed. With the exception of the NVS test, all questionnaires were completed using a laptop computer, and the answers were collected in a spreadsheet. The NVS was administered orally and the answers were collected in the same spreadsheet.

Outcome measures

The primary outcome of interest was patient satisfaction, measured directly after the office visit. Using an item derived from the Clinician and Group-Consumer Assessment of Healthcare Providers and Systems Adult Visit Survey,[26,27] we asked patients to rate their overall satisfaction with the provider on a scale from 0 (worst doctor possible) to 10 (best doctor possible). As described previously by Jha et al,[28] patients were considered satisfied if they rated this item with a 9 or 10. The Clinician and Group-Consumer Assessment of Healthcare Providers and Systems survey is a standardized survey instrument developed by the Agency for Healthcare Research and Quality to assess the patients' experience and perception of care in ambulatory office settings, including hand surgery.[16,27,29]

Our main explanatory variable was patient-rated physician empathy, assessed using the CARE Measure.[21,22] This validated questionnaire consists of 10 items that capture the patient's perception of the physician's empathic understanding and behavior during the appointment: "How was the doctor at… (1) Making you feel at ease?; (2) Letting you tell your 'story'?; (3) Really listening?; (4) Being interested in you as a whole person?; (5) Fully understanding your concerns?; (6) Showing care and compassion?; (7) Being positive?; (8) Explaining things clearly?; (9) Helping you take control?; (10) Making a plan of action with you?" Each item is answered on a 5-point Likert scale, with responses ranging from 1 (poor) to 5 (excellent). All responses are then added, giving a maximum possible score of 50 and a minimum of 10.

The NVS is a validated 6-item instrument to determine health literacy and numeracy.[20,30] It is based on a