Patient Evaluation of Physician Performance

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This study compares evaluations made by patients of family medicine residents' performances with evaluations made by experienced family physician teachers. No correlation was discovered in any of the assessment categories compared. The categories of physician-patient relationship and physical examination appear to be the major predictors of satisfactory performance from the patients' standpoint, while those of diagnosis and management are the major predictors from the point of view of the physician supervisors. The implications of these differences to family medicine teaching programs are discussed.

Traditionally, patients have been judged to be lacking the expertise necessary to assess whether or not they are receiving quality medical care. Nevertheless, patients do make judgments of their physicians, and these judgments are important to a physician's long-term success and satisfaction in practice. It would seem important, therefore, to attempt to ascertain the basis on which the patient assesses the physician, and in what manner this assessment may differ from that made by experienced physicians.

At the University of Western Ontario, in-center family medicine residents are formally evaluated by means of direct observation. These evaluations take the form of rotational teaching sessions whereby the resident is observed by a physician other than his regular supervisor, or by a social worker or clinical psychologist. This method allows exposure to a variety of teachers and alternate concepts. For each patient contact, the teacher completes an assessment form based on the "Mastery Evaluation Model" as delineated by Molineux et al.[1] The results of these assessments are tabulated to build a "Resident Performance Profile" which allows the resident to gauge his progress against the objectives established for the program and his resident peer group.

In the course of one such viewing session, one of the authors (J.T.B.) was critical of a resident's performance because he had performed an overly detailed physical examination in relation to a minor physical complaint. The laboratory technician who subsequently took blood from this patient revealed, however, that the patient was delighted with the resident's performance. The patient indicated that he had never had a more thorough assessment by a physician in his entire life, and was highly satisfied. This experience suggested that supervising faculty members may perhaps look at the resident-patient interaction from an entirely different perspective than the patient, and, as well, raised the question of which assessment was more useful to the resident.

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Date: _____ **Office No:** _____

Instructions to Patient

Please complete this form by circling the appropriate number in response to each question asked.

	Very Unsatisfactory		Satisfactory		Very Satisfactory
1. How comfortable were you with the doctor? Was he understanding?	1	2	3	4	5
2. Did you feel you were able to give the doctor all the important information about your problems?	1	2	3	4	5
3. Did you feel the physical examination, or absence of it, was appropriate?	1	2	3	4	5
4. Were you satisfied with the doctor's explanation of your problems?	1	2	3	4	5
5. Were you satisfied with the way the doctor treated your problem and/or what further steps should be taken?	1	2	3	4	5
6. Please indicate your overall satisfaction with this doctor on this office visit.	1	2	3	4	5
7. Please circle the number indicating the approximate number of times you have seen this doctor prior to today's visit.	0	1	2	3	4	5	6 or more

Figure 1. Facsimile of Office Visit Assessment Form Used for Evaluation by the Patient

With the above considerations in mind, a study was conducted to compare the evaluation of 70 resident-patient encounters by a physician supervisor with the evaluation of the encounters by the patients. For the study purposes, the supervisors for all encounters were experienced certified family physicians in the full or part-time faculty of the Department of Family Medicine.

Method

The study took place over a period of four months during the course of resident viewing sessions at St. Joseph's Hospital Family Medical Center, one of the teaching units associated with the Department of Family Medicine at the University of Western Ontario. The study involved residents on three of the five teaching teams.

For identification and matching purposes the name of the patient and the appointment time were printed on the physician evaluation form by the receptionist. At the conclusion of each viewing session, these forms were collected and given to a secretary who recorded the patients' names on a special sheet before forwarding to the evaluation coordinator.

Table 1. Physician and Patient Ratings of Resident Performance

	Physician-Patient Relationship	History	Physical Examination	Diagnosis	Management	Overall Satisfaction
Mean Physician Rating	4.3	4.2	4.5	4.3	4.2	4.2
Mean Patient Rating	4.6	4.4	4.5	4.5	4.4	4.6
Correlation Between Ratings	.20	–.06	–.21*	–.16	–.19	–.10

*P<.05

At the conclusion of the resident-patient encounter, the patient was given an envelope containing a modified, but similar evaluation form (Figure 1), together with a letter explaining the study signed by the appropriate team staff physician. The patient was requested to complete the evaluation form at the conclusion of the interview. The patient's chart number was recorded on the form, so that the completed forms could be matched for comparison purposes with those completed by the physician supervisor.

For ease of completion, the patients' evaluation form was constructed using a 5-point scale. For the comparison, the supervisors' evaluation form was converted from a 15-point scale to a similar 5-point scale.

On the presumption that the ratings for first and second year residents might differ, the sample for evaluation was balanced such that 35 evaluations pertained to first year residents and 35, to second year residents. The study involved 12 physician-supervisors.

Results

The study revealed two major findings, as seen in Table 1:

1. A higher mean rating in all categories by the patients with the exception of the physical examination, for which a significant difference was not obtained between groups; and

2. No correlation between the assessments of patients and supervisors in any of the performance categories, with negative correlations obtained in five of the six categories.

It is perhaps not surprising that the assessments by the patients and physicians do not correlate. The question which must be asked is, "Why does this occur?" Two hypotheses were investigated to explain this difference: (1) that the number of prior contacts with the residents may have influenced the patient's assessment; and (2) that the patient's assessment of overall satisfaction may have been influenced by performance skills which differ from those which influenced the physician's assessment of overall satisfaction (Table 2).

For the first year residents there was no correlation between patient satisfaction and the number of previous visits. However, with regard to the performance of second year residents, the average number of previous visits was higher for this group, and a significant correlation with the overall satisfaction rating was obtained in the patient's assessment. In terms of the number of previous visits, it is also seen that there is a difference in the performance skills which influence the satisfaction ratings by the physicians and by the patients.

The physicians seem to focus on diagnostic and management skills in assessing clinical performance, which focus agrees with the previous studies of Molineux and Hennen[1] in this area. It appears, however, that from the patient's standpoint the physical examination and physician-patient relationship play a more important role; moreover, there is a suggestion that the influence of the physician-patient relationship may relate to the number of prior contacts between patient and physician. To test whether assessment of the physician-patient relationship becomes more influential simply as a function of increased contact, the data were recast in terms of the number of prior visits, independent of the resident's level of training (Table 3).

Table 2. Predictors of Overall Satisfaction Ratings by Year of Residency

Residency Year	Rating	Overall Satisfaction Correlated with Number of Prior Visits	Highest Skill Correlated with Overall Satisfaction	Average Number Previous Visits
First Year Residents (N=35)	Physicians	−.17	Diagnosis (.76*)	1.7
	Patients	.16	Physical Examination (.77*)	
Second Year Residents (N=35)	Physicians	−.02	Management (.67*)	2.5
	Patients	.46*	Physician-Patient Relationship (.64*)	

*P<.001

The interesting result here is that the physical examination continues to be the major predictor of overall satisfaction. It is noted that for the physician-supervisor, management and diagnostic skills continue to be the most important correlation categories.

In reviewing the patient assessment form, it was appreciated that the resident could possibly be given a high rating when in fact a physical assessment had not been performed on the particular visit in question. It seemed that statement 3 (Figure 1) might be interpreted by the patient to refer to expectations rather than to whether or not a physical examination was actually performed.

To assess what actually happened, the 70 charts were reviewed and the physical examination classified into one of the three categories. The results were as follows: evidence of general examination, 43; evidence of specific examination, 15; no evidence of physical examination, 12.

The 12 charts showing no evidence of physical examination were reviewed in somewhat more detail. It was discovered that a physical examination relative to the problem had recently been performed on 7 of the 12 patients where no physical examination was recorded for the interview in question. Four of the remaining five patients clearly presented with problems of an emotional nature. Thus, in the opinion of the reviewer, a physical examination seemed to be indicated in only 1 of the 12 patient encounters in which no physical examination was performed.

The patient satisfaction rating in the case where a physical examination was not performed was 4.5 as compared with the overall average of 4.6. The physical examination rating was 4.4 as compared with the overall average of 4.5. It was interesting to note that the average overall satisfaction rating by the physician-supervisor for this group of physician-patient contacts was 3.8.

From these data, it was apparent that the patient's rating in the categories of physical examination and overall satisfaction was not, on average, adversely affected when no physical examination was performed during the office visit. The significance of this finding is not clear. It is speculated that the patient's expectations in regard to the physical examination were satisfied in these particular visits.

Discussion

This study has revealed interesting data. To the authors, the study indicates the importance of the physical examination to the patient, and that this influence should receive great emphasis in residency training. This has not been the case in this setting, in part because of logistics, but perhaps also because the teachers do not fully appreciate its importance to the patient. In debriefment sessions, the greater portion of time spent is often devoted to discussion of interviewing techniques and aspects of management. When a resident is experiencing difficulty in the management of a patient, it may rarely occur to the supervisor to consider whether or not the resident has recently examined or ever examined the patient, and

Table 3. Predictors of Overall Competency Ratings by Number of Prior Office Visits

Number of Prior Visits	Rating Group	Highest Skill Correlated with Overall Competency	
0-1 visits (N=34)	Physicians	Management	(.83*)
	Patients	Physical examination	(.55*)
2 or more visits (N=36)	Physicians	Diagnosis	(.62*)
	Patients	Physical examination	(.63*)

*P<.001

whether or not this might be an important thing to do. Yet it has been the experience of most family physicians that a patient's trust and confidence in the physician is often not significant until the physician has "doctored" the patient in the traditional sense. Examples of this might include suturing a laceration, applying a plaster cast, or making a home visit. It is likely that performing what is perceived by the patient to be an adequate physical examination at some time constitutes another example of doctoring which is more important to the patient than is emphasized in teaching.

It would be fair to state that family medicine residency programs have, in general, placed a major emphasis on establishing rapport with patients through effective interview techniques which facilitate better communication between physician and patient. The importance of this aspect of medical care is not in question, nor can it be minimized. However, from the patient's standpoint, the "laying on of hands" effectively may be of equal or even greater importance in producing satisfaction. It is undoubtedly a skill which must be maintained at a high level of expertise.

Conclusion

An attempt has been made to assess the factors which influence the patient's satisfaction with the physician's performance and to compare these results with the factors which influence the supervising physician's satisfaction. A review of the literature indicates no previous publications delineating the factors which influence the patient's satisfaction with physician performance. Corley indicated in a reply to a concern raised by Mishkin and Seifert that a satisfactory model to measure the patient's assessment has proved difficult to devise.[2] Heretofore, students and residents have been entirely dependent on their teachers to embody the view of the medical profession about what is important in the provision of medical care. Teachers often act as patient advocates, and students and residents must, for lack of objective studies, presume that their teachers appreciate what the patient considers to be important and worthy of emphasis.

As a result of this study, there is some objective evidence that teachers do not fully appreciate the factors which influence patient satisfaction. Because of their ultimate influence on the success and professional satisfaction of the practicing physician, the factors which influence patient satisfaction should be the subject of further research and should receive emphasis in family medicine residency programs.

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References

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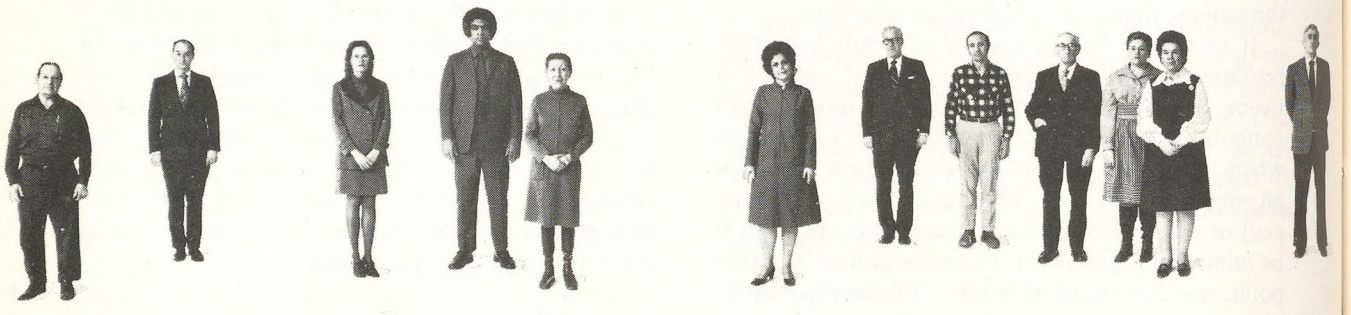

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