

The increasing importance of patient surveys

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Now that sound methods exist, patient surveys can facilitate improvement people often think of “exit” and “voice” as the main ways patients can influence healthcare quality¹—that is, patients can leave providers they are not happy with or they can voice their opinions in an attempt to change care. A common strategy for eliciting patients’ “voices” is to conduct surveys. Clinicians have long been sceptical about such surveys, partly because they communicate regularly with their patients and saw no need for another method of hearing their concerns and partly because satisfaction surveys used to be flawed measures of healthcare quality. Now, however, that is beginning to change as rigorous methods have been applied to developing and evaluating patient surveys.

Despite numerous studies of patient satisfaction,² they have not resulted in the quality improvement that many expected. Previous satisfaction surveys had little impact because they often did not meet minimal standards of conceptual or methodological rigour and were not designed to facilitate quality improvement efforts. Responses to such surveys are subjective and difficult to interpret since they are a complex function of expectations that may vary greatly among patients with comparable care. Moreover, the questionnaires assessed things, such as quality of the food, that have little bearing on the quality of clinical care, and thus the results provided little direction to those responsible for improving care processes.^{3 4}

It is now widely recognised that there is a need for rigorous methods, other than clinical conversations, to elicit patients’ views on such matters as treatment decisions and the quality of care received.^{5 6} Much effort has therefore been devoted to developing and evaluating survey measures that elicit reports about specific care experiences that reflect quality of care, not amenities.^{7 8} Such questions are less subjective and less influenced by patient characteristics, are more interpretable, and thus may be acted on for quality improvement purposes.⁹

The Picker Institute has developed and used such instruments to evaluate the quality of hospital care in the United States⁷ and more recently, in Europe. The Consumer Assessment of Health Plans (CAHPS) project has adopted a similar approach for ambulatory care in the United States.¹⁰ These newer instruments provide qualitatively better data than many earlier surveys, and the response of patients, clinicians, and others responsible for the quality of health care has been striking. One indication of the value of such surveys is the increasing public dissemination of the resulting data. CAHPS data were available to about 90 million Americans in 1999, including 39 million Medicare beneficiaries (<http://www.medicare.gov/comparison/default.asp>), 9 million federal employees, 40 million people covered by plans reporting to the National Committee for Quality Assurance, and people in plans surveyed by other sponsors.¹¹

Regional coalitions are also increasingly coordinating data collection and dissemination. A partnership of Massachusetts healthcare, business, and government leaders recognised the need for credible, publicly available data on the quality of hospital care in the state and launched a voluntary effort to collect information using the Picker survey from

24 200 patients discharged from over 50 Massachusetts hospitals.¹² Those data were used to create a report that was distributed to the hospitals and made publicly available after an initial cycle of internal reporting (<http://www.mhqp.org/statewidesurvey.html>). A testament to the quality and focus of the project is the fact that participants agreed at the outset to use the data not to judge “winners and losers” but to educate and inform hospitals and consumers and to focus and facilitate quality improvement efforts. The news media generally recognised that the important story was not that some hospitals were better than others, but that all hospitals were working collaboratively to respond to patients’ concerns. Clinicians and administrators embraced the new measures as valid and important and devoted new energy to making the care of patients better, rather than criticising the message. The report stimulated numerous quality improvement activities. A similar project is under way in California with a substantially larger group of hospitals.

What are the most important lessons for clinicians from these activities? Firstly, put aside preconceptions about the value of patient surveys: there now are valid and reliable instruments that ask patients objective questions about aspects of care that both clinicians and patients think represent quality. Secondly, newer surveys and reports can provide results that are interpretable and suggest specific areas for quality improvement efforts. Thirdly, we should not worry about whether or not to release information on quality to the public and whether that impedes quality improvement. Public reporting is an inexorable trend, so our efforts should be directed to making sure that these reports contain reliable and valid indicators of quality and that their focus is not on identifying “bad apples” but on stimulating and guiding quality improvement efforts. Patients would much rather their voices be heard than exit out of frustration. Now that we have the right tools we should all work together to hear patients’ voices clearly and meet their needs better.

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- 1 Hirshman A. *Exit, voice, and loyalty*. Cambridge: Harvard University Press, 1970.
- 2 Cleary PD, McNeil BJ. Patient satisfaction as an indicator of quality care. *Inquiry* 1988;25:25–36.
- 3 Williams B. Patient satisfaction: a valid concept? *Soc Sci Med* 1994;38:509–16.
- 4 Cleary PD. Satisfaction may not suffice: a commentary on “a patient’s perspective.” *Int J Technol Assess Health Care* 1998;14:35–7.
- 5 Fitzpatrick R. Surveys of patient satisfaction: I—Important general considerations. *BMJ* 1991;302:887–9.
- 6 Cleary PD, Edgman-Levitan S. Health care quality. Incorporating consumer perspectives. *JAMA* 1997;278:1608–12.
- 7 Cleary PD, Edgman-Levitan S, Roberts M, Moloney TW, McMullen W, Walker JD, et al. Patients evaluate their hospital care: a national survey. *Health Affairs* 1991;10:254–67.
- 8 Edgman-Levitan S, Cleary PD. What information do consumers want and need? *Health Affairs* 1996;15:42–56.
- 9 Cleary PD, Edgman-Levitan S, Walker JD, Gerteis M, Delbanco TL. Using patient reports to improve medical care: a preliminary report from 10 hospitals. *Quality Management in Health Care* 1993;2:31–8.
- 10 Hays RD, Shaul JA, Williams VSL, Lubalin JS, Harris-Kojetin LD, Sweeny SF, et al. Psychometric properties of the CAHPS 1.0 survey measures. *Med Care* 1999;37(suppl):MS22–31.
- 11 Veroff DR, Gallagher PM, Wilson V, Uyeda M, Merselis J, Guadagnoli E, et al. Effective reports for health care quality data: lessons from a CAHPS demonstration in Washington State. *Int J Qual Hlth Care* (in press).
- 12 Rogers G, Smith D. Reporting comparative results from hospital patient surveys. *Int J Qual Health Care* 1999;11:251–9.