A New Paradigm to Improve Patient Outcomes:  
A Tongue-in-Cheek Look at the Cost of Patient Satisfaction

A landmark article entitled “The cost of satisfaction: a national study of patient satisfaction, health care utilization, expenditures, and mortality” was recently published in the Archives of Internal Medicine by Fenton et al. (1). The authors conducted a prospective cohort study of adult respondents (n=51,946) to the 2000 through 2007 national Medical Expenditure Panel Survey. The results showed **higher patient satisfaction was associated with higher admission rates to the hospital, higher overall health care expenditures, and increased mortality.**

The higher costs are probably not surprising to many health care administrators. Programs to improve patient satisfaction such as advertising, valet parking, gourmet meals for patients and visitors, massages, never-ending patient and family satisfaction surveys, etc. are expensive and would be expected to increase costs. Some would argue that these costs are simply the price of competing for patients in the present health care environment. Although the outcomes are poorer, substituting patient satisfaction as a surrogate marker for quality of care is probably still valid as a business goal (2). Furthermore, administrators and some healthcare providers are paid bonuses based on patient satisfaction. These bonuses are necessary to maintain salaries at a level to attract the best and brightest.

Although it seems logical that most ill patients wish to live and get well as quickly and cheaply as possible, the Archives article demonstrates that this is a fallacy. Otherwise, higher patient satisfaction would clearly correlate with lower mortality, admission rates and expenses. Since the hospitals and other health care organizations are here to serve the public, some would argue that giving the patients what they want is more important that boring outcomes such as hospital admission rates, costs and mortality.

The contention of this study – that dissatisfaction might improve patient survival – may have biological plausibility. Irritation with the healthcare process might induce adrenal activation, with resulting increases in beneficial endogenous catecholamines and cortisol. The resulting increase in global oxygen delivery might reduce organ failure. Furthermore, the irritated patient is less likely to consent to unnecessary medical procedures and is therefore protected from ensuing complications. An angry patient is likely to have less contact with healthcare providers who are colonized with potentially dangerous multi-drug resistant bacteria.

Specific bedside practices can be implemented in order to increase patient dissatisfaction, and thereby benefit mortality. Nurses can concentrate on techniques of sleep deprivation such as waking the patient to ask if they want a sleeping pill. Third year medical students can be employed to start all IVs and
perform all lumbar punctures. Attending physicians can do their part by being aloof and standoffish. For instance, a patient suffering an acute myocardial infarction might particularly benefit from hearing about the minor inconveniences the attending suffered aboard a recent south pacific cruise ship – “I ordered red caviar, and they brought black!” During the medical interview, non-pregnant women should always be asked “when is the baby due?” Repeatedly confusing the patient’s name, or calling them by multiple erroneous names on purpose, can heighten their sense of insecurity. Simply making quotation signs with your fingers whenever the physician refers to themselves as their “doctor” can be quite off-putting.

Simple props can be useful. Wads of high-denomination cash, conspicuously bulging from all pockets of the attending’s white coat, can promote a sense of moral outrage. Conspicuously placing a clothespin on your nose upon entering the patient’s room can be quite effective. Simply placing your stethoscope in ice water for a few minutes before applying it to the patient’s bare chest can make a difference.

Other more innovative techniques might arise. Charging the patient in cash for each individual medical intervention might be quite useful, emphasizing the magnitude of overcharging. This would be made apparent to the patient who for instance might be asked to pay $40 cash on the barrelhead for a single aspirin pill.

Often the little things make a big difference – dropping a pile of aluminum food trays on the floor at 4 AM, clamping the Foley tube, purposely ignoring requests for a bedpan, or making the patient NPO for extended periods for no apparent reason can be quite effective.

However, we fear that health care professionals may have difficulty overcoming their training to be responsive to patients. Therefore, we suggest a different strategy to National health care planners seeking to reduce costs and improve patient mortality, what we term the designated institutional offender (DIO). A DIO program where an employee is hired to offend patients would likely be quite cost effective. The DIO would not need expensive equipment or other resources. The DIO role is best suited for someone with minimal education and a provocative attitude. Only the most deficient and densest (as opposed to the best and brightest) should be hired.

Clearly, an authoritative group must be formed to establish guidelines and bundles for both the DIO and healthcare providers. We suggest formation of the Institute of Healthcare Irritation, or IHI. They could certify DIOs to insure that the 7 habits of highly offensive people are used (3). IHI can also establish clinical practice bundles like the rudeness bundle, the physical discomfort bundle, the moral outrage bundle, etc.
We suggest the following as an example to muster compliance with the physical discomfort bundle. The patient must be documented to be experiencing:

- Hunger
- Thirst
- Too cold (or too hot)
- Sleep deprivation
- Drug-related constipation
- And the inability to evacuate their bladder

Patient satisfaction with even a single component indicates failure of bundle compliance. Of course a cadre of personnel will need to be hired to ensure compliance with the bundles.

Based on the evidence from the Archives article, there was a 9.1% cost differential between the highest and the lowest satisfaction quartile. Shifting patients to lower satisfaction quartiles could result in huge cost savings. If the DIO and IHI the strategies to offend are particularly effective, many patients will not return for health care at all, resulting in further savings. Targeting those who are the largest consumers of care could result in even larger savings.

The DIO and IHI would also save lives. Those patients in the highest satisfaction quartile had a 26% higher mortality rate than the lowest quartile. If patients who have poor self-related health and ≥ 3 chronic diseases are excluded, the mortality rate is 44% higher in the highest satisfaction quartile.

Administrators could now be paid bonuses for not only compliance with the IHI bundles, but also lower patient satisfaction scores, since they can argue that lower satisfaction is actually good for patients. Furthermore, the administrators should receive higher compensation since the DIO and the personnel hired to ensure compliance with the IHI guidelines would be additional employees in their administrative chain of command and administrative salaries are often based on the number of employees they supervise.

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References