medical literature into a form easily assimilable by busy practitioners is defining and producing practice guidelines. Many practice guideline programmes exist, both in the United States (for example the NIH Consensus Conference program which has been running since 1977) and in various European countries. But there is little evidence that the diffusion of such guidelines effectively modifies clinical practice.17 As sociologist Ann Greer explains, mere diffusion of written matter is not sufficient to modify practices ingrained in behavioural, social, and local factors.18 Some of the complexities of implementing guidelines in practice are described by Richard Grol in this issue (p 194).19

An approach to resolving uncertainty of medical practice would be to develop and integrate three disciplines – medical decision analysis, clinical epidemiology, and evaluation of the quality of health care – into medicine and thus put scientific principle into everyday clinical practice. Medical decision analysis can be described as “a systematic approach to medical decision making under conditions of uncertainty.”20 It is an aid to reasoning in that it separates the logical structure of a decision into its component parts and quantifies the probabilities of the different possible outcomes. The use of decision analysis forces the decision makers to consider explicitly the reasons and consequences of each choice. This allows each decision to be explained and justified to patients, to other health care workers and to the decision makers themselves.

Clinical epidemiology – the application of the principles and methods of epidemiology to clinical practice – promotes the practice of “a more systematic approach to gathering and interpreting clinical evidence”21 and provides a framework for answering, with scientifically based argument, questions such as, “How accurate are the diagnostic tests or strategies I've applied? What will the consequences be of having this disease? How will the treatment I’ve prescribed change its future course and affect the patient?”22 Clinical epidemiology thus drives medical practice away from empiricism and attempts to give it the characteristics of a science: it has been described as “the basic science of clinical practice.”21

Finally, through systematic evaluation of the quality of clinical care it is possible to assess the quality of the structure of care, the appropriateness and quality of medical procedures, and the desirability of outcomes for the individual patient.23 For this a methodical, rigorous, problem solving cycle which follows scientific principle is applied.24 By using an explicit and structured approach subjective influences are minimised and problems and their nature can be identified and prioritised; solutions and corrective measures may then be worked out and their implementation is verified to ensure their use and their effectiveness in producing the expected difference.25

Through acknowledging and understanding the presence of the variations and uncertainties in medical practice, practitioners may at least be able to give more open explanations of choices available to their patients. But application of the three disciplines could itself rationalise clinical practice and help diminish some of the uncertainty and variability in the practice of medicine – which must be in the best interest of individual patients. Integration of these disciplines into current clinical culture is likely to be slow. But many health professionals are now developing and using techniques for evaluating the quality of care. It is vital that all three disciplines should be integrated into medical and clinical studies so that clinical interventions can be used rationally and, when little evidence exists to support one approach or another, clinicians can inform patients to enable them to choose.

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Measuring patient satisfaction for audit in general practice

Patient satisfaction surveys are currently being conducted by many family health services authorities (FHSAEs) and medical audit advisory groups (MAAGs) in England and Wales. These are being used in an attempt to determine whether practices are providing a good standard of care as judged by their patients. Unfortunately, the results are likely to be of only limited value because the validity of many of these questionnaires has not been tested and their sensitivity is often so restricted that most patients seem to express high levels of overall satisfaction. General practitioners are also beginning to conduct
patient satisfaction surveys to help them to improve the
services they provide. Sometimes the surveys are
conducted within the practice and sometimes in
collaboration with neighbouring practices. The validity
of these questionnaires is also often not established, and
the design is undertaken by people with little experience
of the methods. Some guidance is becoming available1 2; the
most complete set of guidelines has been available for
several years, in the form of standards for psychological
tests agreed by the American Psychological Association.3
Two papers in this issue report the development and use of two questionnaires by a MAAG supported by an academic unit (p 153, 158).4 5 The
authors emphasise the advantage of general practitioners
and practice managers being involved in the
development of the questionnaires, but any MAAGs
which would like to follow this example and develop
their own questionnaires would be wise to remember the
commonly repeated advice to use already developed and
tested examples whenever possible. The Newcastle upon
Tyne questionnaires do show the value of some simple
evaluation techniques such as the assessment of non-
response to individual questions. Also a problem was
demonstrated with conditional questions to be answered
only by specific respondents, the other respondents
being asked to move on to later questions, and this
provides good evidence in support of the maxim to keep
questionnaires simple.

The use of patient satisfaction surveys in health
services research is well established. Such surveys are
now being introduced into medical audit and this raises
several new issues. Patients' views of their doctors
include delicate personal information, and feedback will
need to strike a balance between tact and providing clear
guidance on what needs to be changed. Research on the
most effective and useful forms of feedback is clearly
required. Establishing the role of patient satisfaction
surveys in encouraging change is also important, and
evidence is required of the effects of these changes on
subsequent patient satisfaction. The audit cycle must be
completed. Do patients report improved satisfaction
when appointment systems are revised to take their
concerns into account? MAAGs must take extra care to
ensure that the questionnaires they do use are adequately
developed and documented. Providing information to
practitioners which compares patients' opinions of their
practice with those of other practices does place special
demands on the questionnaires to be used. They must be
sufficiently robust for the recipients of feedback to have
confidence in the comparisons.

Encouraging change depends on the resolution of
these issues. Eccles et al highlight the likelihood of
involved practitioners instituting change6 whereas
passive participants will often find reasons for ignoring
the results of the survey. We do not know what happens
to practices that simply receive unsolicited information
about their performance, even if it is contrasted with the
performance of neighbouring practices, although some
evidence may become available from the experience of
regular and intensive feedback about prescribing costs
(PACT).

Improving the quality of care requires doctors and
other health care workers to be involved in all stages of
the audit cycle. Whether this should include the design,
of the audit tools themselves is presently unknown, but
when this is practicable it may increase the likelihood of
making appropriate changes within the practice when
problems have been identified.

Because patient satisfaction is now seen as an
important component of medical audit, many health
professionals who are unfamiliar with questionnaire
design will wish to undertake surveys. They should
firmly resist the temptation to devise their own
questionnaires. Those researchers who do have the
necessary skills should remember that robust tools are
now required for medical audit. They should ensure that
among those questionnaires that are developed are
versions that can be used by inexperienced health
professionals in a wide range of settings. Analysis must
be simple and the findings must be presented in an easily
understood format.

Patient opinion is far too important for it to be studied
with inadequate measures. Poor questionnaires act as
a form of censorship imposed on patients. They give
misleading results, limit the opportunity of patients
to express their concerns about different aspects of care,
and can encourage professionals to believe that patients
are satisfied when they are in reality highly discontented.
In our enthusiasm to ask patients for their views we must
avoid this disastrous trap. Through determined but
sceptical inquiry and attention to detail there is a great
deal that might be achieved. If reputable methods can be
used and we take serious note of the findings, the
therapeutic relationship between patients and their
doctors can only improve.

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Measuring patient satisfaction for audit in general practice.

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Qual Health Care 1992 1: 151-152
doi: 10.1136/qshc.1.3.151

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