The increase in consumerism in the Health Service has focused attention on patients' perceptions of, and satisfaction with, the service they receive. The implication that acknowledging patients' views is an innovation is deeply resented by those who have worked hard to respond to their patients' needs and desires for many years. However, there is an increased understanding that patient satisfaction is an integral part of quality care, and that some form of measurement can aid performance in this area. The problems are what to measure, how to measure and how valid are measurements.

WHAT MEASURES SHOULD BE USED

Donabedian's triad of structure, process and outcome [1] provides a useful starting point. Measurement of structure can usually be achieved by simple questionnaires or very simple observational surveys. For example, a simple questionnaire undertaken by the British League Against Rheumatism revealed that a significant number of patients with arthritis had difficulty gaining access to health care premises and moving about within them [2]. As a result of this, it was suggested that the 'arthritis friendliness' of general practitioner premises would be a good subject to audit [3]. Hospitals often reveal significant deficiencies in this area too, especially where general rather than specialist wards and out-patient facilities are used, and they would also benefit from similar appraisal. Observation from administrative systems can usually be used for assessment of waiting times for appointments, and simple direct measurement can evaluate waiting times within clinics. This can be a potent cause of patient dissatisfaction [4], but is an area where 'new' and 'old' consumerism can clash. For example, it has been suggested that timing of clinic patterns and consultation times might be an innovative approach to developing schedules to accommodate Patients' Charter standards, whereas some people have been using this technique since the 1960s and can demonstrate the efficacy of the method with regular data on waiting times recorded since then.

Some clinicians argue that these structural aspects are not an important part of the clinical care of patients. The results of many consumer surveys and patient interviews leading to the Patients' Charter suggest that they are essential parts of a quality service in the eyes of our patients. One valuable lesson we must learn is that medicine is not just a technical exercise, but is a consumer service, and as such needs to embrace the lessons of other service industries if patient satisfaction is to be maximized.

PROCESS OF CARE

Process measurements in rheumatology tend to revolve around the consultation and its consequences. It has been demonstrated that the communication aspects of a consultation are of major importance to British patients [5] and contributed more to patient satisfaction than relief of pain or disability. Spanish patients showed similar responses. There was an association between trust in the attending physician and the perceived effectiveness of communication. Lack of trust and poor communication were also associated with overall dissatisfaction with the quality of care [6]. It is possible to derive from questionnaire data information regarding the patient's perception of both technical skills and the quality of the consultation. A survey, using the Leeds Satisfaction Questionnaire [4], showed patients to have greatest satisfaction with the perceived technical competence of their attendants, less with interpersonal attributes such as empathy and attitude, and least with structural aspects of care such as waiting time and access. This illustrates the importance of encompassing all these attributes in any surveys in this area. The success of questionnaire studies such as this is important, as the alternative of in-depth face-to-face structured or semi-structured interviews is often advocated to this area. They have the disadvantage that their cost is high and this, combined with their time-consuming nature, means that numbers are often small with extrapolations being made from tiny, often unrepresentative, samples.

The medical contribution is only a small part of the total package of care offered by a rheumatology team [7]. Other team members' contributions and the organizational aspects of convenient—preferably 'one-stop-shop'—care delivery are relatively unvaluated but important areas. Patient education is assuming greater importance in the overall management of rheumatic diseases. There has been a progressive move from empirical interventions to more structured, behaviourally based programmes [8]. These can be shown to have beneficial effects on desirable attributes such as compliance and also on psychological perceptions such as control and helplessness. Improvements in this area are likely to produce more satisfied patients, but they will also be more knowledgeable and assertive, and will demand more from the medical consultation than the passive receivers of health care found in the past. This, in turn, requires
greater communication skills from doctors, otherwise dissatisfaction with the consultation is likely to increase.

The value of education programmes has been more widely evaluated than the educational value of one-to-one consultations, although the latter are cumulatively more important throughout the course of a chronic disease, hence our departmental slogan 'Every patient contact is an educational opportunity'. It has been shown that nurses may be more effective in this aspect of care [9], although the integration of individual approaches by a modern rheumatology team has yet to be evaluated. Some differences in response may be due to different patient perceptions of team members, with nurses scoring higher than doctors on approachability, and often being better communicators of information in non-technical, consumer-friendly language. Accessibility of specialist help always features as a major requirement of patients with arthritis, and its absence is a cause of dissatisfaction [4]. The use of open-access services and telephone helplines has developed to cover these needs, and is becoming more commonplace in well-organized departments [7]. Audit of them shows them to be perceived as both convenient and valuable by patients and professionals (J. Stamp, personal communication).

OUTCOME OF CARE

Outcome in chronic diseases is always less easily measured than in acute conditions with definitive interventions. Conventionally, outcome encompasses the seven Ds: death, disability, distress, disharmony, dissatisfaction, disadvantages, dollars. Satisfaction is assumed to be an integral part of good outcome by these criteria. An alternative approach is to divide outcome into disease outcome and patient outcome. Measures used in clinical trials, which form the biggest body of 'outcome' literature in rheumatology, conventionally focus on disease outcome. Some recent attempts to measure more patient-focused values, such as quality of life, reveal that this can be achieved but the process is costly and time consuming [10]. Some generic health status instruments, such as the SF36, contain data on quality of life and are more suited to routine use in everyday practice. Quality of care has not been evaluated in the context of clinical trials, mainly because the quality of care, epitomized by accessibility and attention, is often standardized, although sadly it is often superior to the care given to patients attending the same departments for routine appointments. Studies other than drug trials usually revolve around disability and health perception. It could be argued that these are characteristics likely to be influenced by quality of care, but this inter-relationship has yet to be fully explored.

STRATEGIES TO EVALUATE PATIENT SATISFACTION AND QUALITY OF CARE

The few examples given above show that quality of care and patient satisfaction can be successfully evaluated within the structure/process/outcome model, but there are some confounding factors. Patients with chronic diseases are very dependent on their carers, and are strongly motivated to assume that they are being treated in the best possible way. In addition, many patients have experience of only one rheumatology department, and as a result assume that the care given there is the norm. It is only those few patients whose care moves from one department to another who have a real basis for consumer comparison, and they are often the most enlightening group of people with whom to discuss departmental quality. For all these reasons, patients are likely to express considerable satisfaction with their care when asked about it and may lull professionals into a false sense of achievement when analysing results. When reviewing quality of care surveys encompassing, for example, all the departments in a hospital, it becomes obvious that the spread of results between excellent and poor services is very small, and self-satisfaction should not be allowed to diminish the impact of even the smallest of expressed deficiencies. The alternative of in-depth interviews has already been mentioned, but the 'representative' patients selected are often either the most disgruntled or the most vociferous. Unfortunately, organizations such as health care commissioners appear to ignore the non-representative nature of such samples and extrapolate wildly from them. They also appear to ignore the need for meticulous training and absolute objectivity in interviewers, as deliberate or accidental bias can be introduced during interviews. One half-way house is the use of an external observer of care. Use of this technique reveals the complete inadequacy of relying on professionals' own recording as a source of information [11]. Incorporation of the patient as a central team member in both planning and evaluating care is an important part of the philosophy contained in the Royal College of Nursing's Standards of Care in Rheumatic Disease Nursing [12]. This is another area of patient care where rheumatologists can learn profitably from their team colleagues.

PATIENT FACTORS INFLUENCE SATISFACTION

A further problem in assessing patient satisfaction is that of social, cultural and ethnic mix. In the context of clinical trials, it has been noted that there are differences in expressed side-effects between an urban and rural community, and such differences in the expression of symptoms appear commonplace to those of us who provide local services to small communities with differing social class structures, such as commuter villages versus mining communities. The middle class 'worried well' are often dissatisfied with conventional medicine which refuses to medicalize socialized anxiety. This group frequently turns to alternative medicine for advice with greater satisfaction.

Although this is often said to reflect the greater time of consultation and more empathetic approach of such practitioners, it would also appear that some people
accept their technical skill and knowledge as well. This casts doubt on the ability of patients to discriminate between doctors on a technical basis, which is a part of some satisfaction scales [4] and at the heart of much consumerism, and begs the question of the potential efficacy of the charming incompetent vis-à-vis the highly competent but charmless technocrat.

Even greater problems arise when there is an ethnic divide between the patient and the treatment team. This involves not only difficulties with communication, but the whole area of belief about illness and medicine, which is known to be important in any consultation [13].

Finally, treatment of rheumatic diseases is team based, not doctor based, although the style is often medically determined. Interactions within the team and between individual team members and patients are important parts of both patient satisfaction and overall quality of care. This is an area which might well be addressed through clinical audit, although that process is as yet insufficiently sophisticated to accommodate some of the potential hazards of such evaluations. Overall, however, the whole area of quality of care with its inter-linking to both patient satisfaction and outcome is an ideal subject for ongoing audit [14] and in a modern, consumer-oriented health service it is essential that it forms an important part of the clinical audit programme of every rheumatology department, and that customer satisfaction is firmly embedded in all our policies and actions.

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