PATIENT SATISFACTION
A Case Study Of A South African Teaching Clinic

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**Abstract:** Patient satisfaction is a pre-requisite to successful clinical practice. While an efficacious treatment is an important consideration, other variables are recognized to contribute to clinical satisfaction. This case study of a South African teaching clinic identifies and compares variables perceived as essential, important and unnecessary by chiropractic students and their patients.

Method: A case study of the chiropractic student clinic at Technikon Natal was undertaken. A non-random sample of chiropractic patients and student clinicians were requested to respond to a questionnaire. Participants were requested to select 12 from a total of 27 closed questions and allocate 4 items to each of the three listed categories.

Results: Forty-three(43) patients and 17 student clinicians completed the questionnaire. Behaviours considered essential to chiropractic practice largely focused on listening carefully to the patient’s description of their problem and explaining how the problem could be avoided in the future. Patients and student clinicians were also agreed about the relative importance of the duration of the clinical consultation, the necessity for patients to choose how they wish to be treated and the desirability of a narrow/broad focus on the patient’s problem.

Conclusions: The importance of providing an understandable and comprehensive clinical discussion about the patient’s problem emerged in both this and a similar Australian Study. It is suggested that competence in communication skills be considered as an integral component of the undergraduate chiropractic curriculum.

**Key Indexing Terms:** Communication, chiropractic, clinical satisfaction.

A number of studies have found that chiropractic offers satisfactory and effective intervention for patients with low back pain, the outcomes were similar whether they received care from primary care practitioners, chiropractors, or orthopedic surgeons (1). Greatest satisfaction was however reported by the patients who went to the chiropractors. A study over 3 years comparing the outcomes of chiropractic and hospital therapist treatment of patients with low back pain found that patients treated by chiropractic derive more benefit and long term satisfaction than those treated in hospital (2). Another study comparing chiropractic management and medical management found that chiropractic are was at least as effective as medical care in reducing low back pain and functional disability due to low back pain of musculoskeletal etiology (3). The authors suggested that chiropractic patients were more likely to perceive their treatment to be successful in reducing low back pain compared to medical patients. Sawyer and Kassak found that, among a variety of factors which might influence patient satisfaction, the patient’s perception of treatment outcome was the most important predictive variable (4). The authors concluded that future research is needed to determine if the way in which chiropractic care is rendered affects patient satisfaction.

While manipulative technique and the skill with which the thrust is administered are likely to be important contributors to the healing process, a successful clinical consultation is not solely dependent on manual dexterity. The practitioners beliefs about patient expectations also determine the way chiropractic care is rendered. When practitioner beliefs are consistent with the patients’ perceptions of what constitutes a satisfactory clinical experience, it is hypothesized that an environment conducive to a healing clinical encounter is created. A Californian study of spiritual healing supported the notion that high expectancy in both practitioner and patient predict and facilitate the healing process. The degree of bonding or communication between the healer and patient was perceived as an important factor in this regard (5).

A case study of a chiropractic teaching clinic in South Africa was undertaken in order to clarify variables which are deemed conducive to patient satisfaction by patients and student clinicians. The psycho-social variables identified by South Africans as most and least important to a satisfactory clinical consultation were then compared to those selected by a culturally different population. By comparing the results of South African and Australian case studies of student clinics, this paper identifies variables contributing to a satisfactory clinical encounter which may transcend cultural idiosyncrasies.
METHOD

A case study of the variables perceived to influence a satisfactory clinical encounter was undertaken in the chiropractic teaching clinic of Technikon Natal in the latter half of 1995. A non-random sample of chiropractic patients on their second or subsequent clinic visit were invited to complete a questionnaire on patient satisfaction. Chiropractic students attending these patients were requested to complete a mirror image of the patient questionnaire.

From the Statements listed (see Table I and II), participants were requested to select 12 options: 4 which they regarded as essential, 4 which they regarded as important and 4 which they regarded as unnecessary to a satisfactory chiropractic clinical encounter. This forced choice format was selected in an endeavour to encourage each participant to actively discriminate and include or exclude options.

RESULTS

Forty-three (43) patients and 19 chiropractic student practitioners responded. Two student respondents did not limit their selection to four in each category. As these questionnaires failed to marginalise the options, they were excluded from the study. The student clinician participants were consequently reduced to 17.

Table I depicts the patients’ perceptions of which options are essential, important and unnecessary to a satisfactory chiropractic clinical encounter. Some internal consistency is demonstrated by the inverse relationship of responses to the questions pertaining to full physical (whole body) and regional (part with the problem) examination.

The options 30% or more of patient respondents perceived as essential to chiropractic practice are that the chiropractor:

- listen carefully to their description of the problem
- answer their questions
- tell them how to avoid the problem in the future

Other options regarded as of importance by almost half (49%) of the patient respondents are that the chiropractor:

| TABLE 1: Patient perceptions of a satisfactory chiropractic clinical encounter |
|---------------------------------------------------------------|
| % of respondents (N=43) selecting the variable as: | essential | important | unnecessary |
| It is important to me that my chiropractor: | | | |
| answers my questions. | 33 | 33 | 2 |
| is comfortable dealing with my problem/pain. | 29 | 21 | 2 |
| discusses any changes in my treatment with me. | 19 | 30 | 5 |
| listens carefully to my description of my problem. | 47 | 28 | 0 |
| accepts that my pain is real. | 19 | 13 | 4 |
| keeps the consultation short - max. 5 minutes. | 0 | 0 | 77 |
| makes me feel less worried about my problem. | 7 | 19 | 7 |
| lets me choose how I want to be treated. | 0 | 5 | 61 |
| only asks about my present problem. | 7 | 19 | 7 |
| tells me how to avoid this problem in the future. | 30 | 26 | 0 |
| offers a range of chiropractic/manual treatments. | 19 | 14 | 7 |
| checks my whole body when examining me. | 28 | 7 | 19 |
| only examines the body part with the problem. | 5 | 5 | 14 |
| takes/has me X-rayed. | 16 | 14 | 7 |
| explains my problem in a language I understand. | 26 | 23 | 7 |
| shows me what exercises to do. | 19 | 26 | 0 |
| gives me general health advice eg. diet. | 2 | 16 | 16 |
| requires maintenance care/regular adjustments. | 7 | 12 | 2 |
| tells me how many treatments I’m likely to need. | 7 | 12 | 2 |
| says how I’m likely to feel after each treatment. | 7 | 12 | 12 |
| is confident I can be helped. | 16 | 16 | 5 |
| sees me on time/keeps to schedule. | 5 | 7 | 9 |
| is easy to get an appointment with. | 14 | 2 | 2 |
| offers a range of payment options. | 2 | 7 | 14 |
| has a comfortable waiting room. | 2 | 7 | 33 |
| has pleasant and helpful staff. | 7 | 9 | 12 |
| ensures that the consultation is not interrupted. | 7 | 5 | 12 |
• is comfortable dealing with their problem
• discusses any change in treatment with them
• explain their problem in terms they can understand

Forty-five percent (45%) of patients also regarded it as important that their chiropractor show them what exercises to do.

Table II describes the options selected by the chiropractic student clinicians. Two options which more than 7 out of 10 chiropractic students selected as essential and no respondent considered unnecessary to chiropractic practice are that the chiropractor:

• explain how the patient may avoid this problem in the future
• listen carefully to the patient’s description of their problem

Overall behaviours identified as of importance to chiropractic practice by more than half of participating student clinicians include:

• demonstrating what exercising to do
• explaining patients’ problem in lay language
• providing general health advice
• answering patient questions

Given the forced choice format of the study, no patient or student clinician regards it as essential that:

• the consultation be kept short - 5 minutes or less
• the patient choose how they wanted to be treated
• the chiropractor only inquire about the presenting complaint

No patient or student clinician regards as unnecessary for the practitioner to:

• provide an explanation of how to avoid this problem in the future
• demonstrate what exercises the patient should perform

### TABLE II: Chiropractic students’ beliefs about patient clinical expectations

| I believe it is important to patients that their chiropractor: | essential (%) | important (%) | unnecessary (%) |
|-------------------------------------------------------------|---------------|---------------|-----------------|
| answers their questions.                                     | 29            | 35            | 0               |
| is comfortable dealing with their problem/pain.             | 38            | 12            | 0               |
| discusses any changes in treatment.                          | 6             | 6             | 18              |
| listens intently to the description of their problem.        | 71            | 0             | 0               |
| accepts that their pain is real.                             | 0             | 6             | 0               |
| keeps the consultation short - max. 5 minutes.              | 0             | 0             | 82              |
| make them feel less worried about their problem.            | 6             | 12            | 12              |
| lets them choose how they want to be treated.               | 0             | 6             | 59              |
| only asks about their present problem.                      | 0             | 0             | 29              |
| explains how to avoid this problem in the future.           | 71            | 29            | 0               |
| offers a range chiropractic/manual treatments.              | 29            | 29            | 0               |
| does a full physical/whole body examination.                | 18            | 29            | 0               |
| only examines the body part with the problem.               | 0             | 0             | 12              |
| takes/has the patient X-rayed.                              | 0             | 24            | 0               |
| explains their problem in lay language.                     | 41            | 29            | 0               |
| demonstrates what exercises to do.                          | 24            | 59            | 0               |
| provides general health advice eg. Diet.                    | 18            | 47            | 12              |
| requires maintenance care/regular adjustments.             | 24            | 0             | 29              |
| tells how many treatments are likely to be needed.          | 12            | 35            | 6               |
| says how the patient will feel after each treatment.        | 12            | 6             | 18              |
| is confident he/she can help.                               | 24            | 24            | 6               |
| sees the patient on a time/keeps to schedule.              | 6             | 6             | 12              |
| is easy to get an appointment with.                         | 0             | 0             | 24              |
| offers a range of payment options.                          | 0             | 0             | 24              |
| has a comfortable waiting room.                             | 0             | 0             | 12              |
| has pleasant and helpful staff.                             | 6             | 0             | 0               |
| ensures that the consultation is not interrupted.           | 0             | 0             | 12              |
DISCUSSION

Consultation characteristics which appear to be most valued by participants emphasize the desirability both of carefully listening to and achieving mutual understanding of the patient’s problem and of providing advice on how to prevent recurrences of the presenting complaint. Both the nature and content of clinical communication is an important aspect of health care.

The interpretative strategy used by the clinician is recognized as a critical determinant of the clinical outcome (6). It is recognized that “Explanation is one of the major functions of any system of ‘medical’ care” (7). It is necessary that this explanation be couched in terms which can be understood by the patient - both with respect to terminology and concept. The explanation needs to be culturally sensitive and reflect or, at least be consistent with, the patient’s belief. When an explanatory model is used in which there is consensus between practitioner and patient a satisfactory clinical outcome is more likely. When patient and practitioner agree on the nature of a problem they are more likely to achieve consensus on possible management solutions. Shared outcome expectancies can create a healing cognitive environment (8), and expectancies have been reported, in certain circumstances, to override pharmacological effects (9, 10).

It has been postulated that clinicians can promote shared practitioner-patient understanding by paying more attention to psychosocial factors and being more circumspect in drawing conclusions about patients’ problems.

Certainly, a serendipitous finding in a study of routine clinical encounters involving five experienced physicians and 189 patients found that, although patient characteristics contributed to specific forms of practitioner-patient disagreement about the clinical encounter, the overall discrepancy was greatest in cases in which the physician minimized the importance of psychosocial issues and/or felt relatively confident about understanding the patient’s problem (11). Agreement between patient and practitioner about the nature of the patient’s complaint may be best achieved by focusing on the practice behaviour variables identified as essential or important by participants in this study viz.: by listening carefully to the patient’s description of their problem, answering the patients questions and explaining the problem in understandable language.

In this case study, prevention of recurrences emerged as an important consideration in formulating the content of clinical communication. When coupled with the importance attributed to the clinician demonstrating which exercises the patient should do, this finding suggests the importance of adopting a relational practice model (12) in which the patient actively participates in restoring and maintaining a satisfactory health status. The notion of patient involvement in their own health care is further supported by the finding that patients appreciate the clinician discussing any change in treatment with them, yet regard it as unnecessary that they choose the particular intervention (‘how they want to be treated’). Whether patients favoured an informative, interpretative or deliberative model was not determined (13). Nonetheless, the importance attributed to patient-practitioner communication by participants is this study does support the suggestion that explanatory style is one of the fundamental concepts which appears to have promise as a predictor of physical health (14).

Unfortunately, extrapolation of any conclusions from this study are difficult in view of the small sample size and the non-random nature of sample selection. When the findings of the South African and Australian case studies (15) are compared, communication emerges as the primary consideration in both cases. While the South African participants appeared to rate prevention of recurrences and exercise more highly and Australian respondents appeared to attribute greater relevance to a complete physical examination, participant numbers do not warrant any conclusions about cultural differences. Certainly both studies do appear to support the hypothesis that ‘internal’ consultation variables such as focusing on an understanding of and explanation for the patient’s presenting complaint take precedence over ‘external’ variables such as consultation time, payment options or physically comfortable surroundings.

CONCLUSION

Patient-practitioner communication is recognized by patients and student clinicians as a fundamental consideration in achieving a satisfactory clinical outcome. While the content of such communication may vary depending on the presenting complaint and the cultural context of the clinical encounter, the process of skillful clinical dialogue would appear to be an essential aspect of successful clinical practice. It is suggested that the undergraduate chiropractic curriculum should diligently pursue the teaching/learning of competence in clinical communication skills.

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