

Telling Time to Make Time - a Randomized Trial on the Satisfaction of Patients when Previously Informed about the Consultation Length

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Declaração de Honra

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Agradecimentos

Ao meu companheiro e à minha mãe pelo apoio emocional incondicional de que muito precisei.

À minha amiga Francisca, pela ajuda e paciência imprescindíveis, na elaboração deste trabalho.

Às minhas orientadoras, pelas palavras sábias, conselhos e ajuda que me providenciaram.

Declaração de Dissertação de Mestrado

Na presente dissertação é apresentado o trabalho de investigação realizado sob a forma de dois artigos científicos.

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Telling Time to Make Time - a Randomized Trial on the Satisfaction of Patients when Previously Informed about the Consultation Length

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Abstract

Background: Patients' satisfaction has long been connected to better health outcomes. It has been suggested that patients' expectations impinge on their satisfaction.

Objective: We aim to investigate if informing patients of the appointments expected duration prior to their appointment influences their satisfaction.

Patient Involvement: There was no patient involvement in the design of the study.

Methods: We performed a randomized trial where patients were assigned to the intervention group (informed of the appointments expected duration) and the control group (not informed). Patients' overall satisfaction with appointments (prior to this study) and with the last appointment (after the intervention) was collected.

Results: The perceived duration of the appointment was similar in both groups 22.8 ± 10.7 and 23.4 ± 8.2 . In total, of the 65 consults that were interrupted, patients reported 86 disruptions. In the intervention group, patients recalled being informed of their appointment's expected duration. Both groups presented similar satisfaction with their appointment.

Discussion: Even though patients recall being informed and recall the given duration with accuracy, this information had no influence on patients' satisfaction. Other factors may influence, with greater value, patients' satisfaction.

Practical Value: Being informed of the appointments expected duration by a secretary through phone call had no influence in patients' satisfaction.

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1. Introduction

In primary health care (PHC), the diversity of patients in different life stages and with different comorbidities results in a wide range of consult types. Patients tend to voice more than one concern per appointment, with a higher number of concerns being found with longer waiting times between scheduling and date of appointment and when in the presence of multiple comorbidities.[1] Additionally, the management of complex patients' appointment duration, inadequately shortening it or reducing the next patients' time, is a source of physician's dissatisfaction.[2]

Patients' satisfaction with health care has been studied for several years. The relationship between patients' satisfaction and better health outcomes and quality of care, has conveyed more attention to the patient's perspective, being nowadays a crucial component of quality of care assessment and improvement.[3] In 2003, the Primary Provider Theory was introduced, stating that the patient's satisfaction with health care (waiting times and consult with the physician and nurses) is proportionally related to their prior expectations.[4] Some studies have supported this theory, with others failing to report this relationship.[5]

The association between the duration of consult in PHC and patients' satisfaction is complex. A connection between time spent in the consult, patients' perception of the doctor-patient relationship and the doctor's communication skills has been reported. Communication skills are shaped by having enough time to answer patients' questions and promote healthy lifestyles.[6] Longer appointments have been associated with opportunity for counselling, better patient enablement and satisfaction and fewer and more adequate drug prescription.[7] Thus, time spent in appointment may act as a communication facilitator, indirectly improving doctor-patient relationship.[6] Some authors, however, did not find an association between the appointments' duration and patients' satisfaction, being that some appointments were appropriately short, depending on the physician and the patient's agenda.[8, 9] It was also established that patients with poorer self-reported health rated lower communication scores.[8] The analysis of the relationship between patients' satisfaction with the consult and the perceived time spent in the waiting and in the examination rooms revealed that longer perceived times in the examination room (with the physician) were a better predictor of satisfaction, opposed to waiting room time.[10]

Patients struggle to estimate the time spent in consult, one study revealed that only 17% could accurately estimate this duration, with more than half (51,7%) underestimating it.[11] Patients have also revealed difficulties predicting the required duration for their appointment; only one-third of patients could, with reasonable accuracy, estimate this time. Expected, perceived and actual duration of the appointment equally influence patient satisfaction, although only moderately.[12] Other studies linked perceived time spent in the patient-clinician interaction and satisfaction with it. One study stated there was a positive correlation between patients' satisfaction with the consult duration and their perception of achieving or even surpassing the expected needed time for their appointment.[13] Another study linked patients' satisfaction closer to perceived time spent in consult than the actual time. This suggests other factors beyond real-time spent influence patients' satisfaction.[14]

Some studies have assessed if previous information about the appointment's expected duration, as well as prior listing and organization of patients' concern list, correlates to their satisfaction with the consult and with its duration. Several strategies have been described to shorten waiting times and delays and optimize appointments.[15-17] One of these strategies is called "the 12-minute slip", a piece of paper informing patients of the expected duration of the appointment (12 minutes) and inviting them to prioritize their list of concerns and reschedule some to other appointments. With this strategy, a 50% decrease in doctors' tardiness was noted.[15] Lindfords studied if the previous knowledge of the consult's expected duration in PHC would affect its actual duration as well as patients' satisfaction. Patients informed of the appointments' duration had shorter appointments, though with no statistical significance. High satisfaction scores in all patients prevented finding differences between patients informed and those not informed.[16]

With our study we aim to investigate whereas previous information of the expected duration of the appointment influences patients' satisfaction with the consult, in a PHC setting.

2. Material and methods

2.1. Population and Procedures

We conducted an experimental study, collecting a convenience sample of patients attending consults during the data collection period. Inclusion criteria were: having a scheduled appointment in the day of the study, speaking Portuguese and being over 16 years old. In consults with patients under sixteen, the answers were provided by the accompanying caregiver.

Patients with appointments scheduled for the days in which this study took place were randomized to a control and an intervention group and invited by collaborators (PHC secretaries) through phone call to participate in the study and informed of the study aim and procedures. After agreeing to participate, all the participants were submitted to a short six-item questionnaire (questionnaire 1). Patients were then informed of the consult date and time in the control group and of the date, time and expected duration in the intervention group. Questionnaire 1 and the intervention were performed 2 weeks before the consultation.

On the day of the appointment, after signing the written consent, patients answered a second, in person, questionnaire (questionnaire 2) to assess more specific information about the appointment and patient.

The present study was conducted in a public PHC Clinic in the North of Portugal, in an urban setting, with eight family medicine specialists and eight family medicine residents[18, 19] Representing a ratio of physician per clinic slightly above the national mean value (6.63),[20] the Health Unit serves 16 523 individuals, of which 51,23% are female and 18,28% are over 65 years of age, a younger population than the average national percentage per clinic (27,52%).[19, 20]

2.2. Instruments

A questionnaire was built after a review of the existing literature. Sociodemographic characteristics collected included: age of the patient, marital status, completed education and work status. Perceived health status was collected through a four-question questionnaire ranging from 4 (worst health perception) to 20 (best health perception). Appointment characteristics' included: appointment type, perceived duration, waiting time for its scheduling, number of problems addressed, familiarity with the attending physician and interruptions during the consult – categorized by number and type. Satisfaction was assessed through a 5-point Likert scale ranging

from “not all satisfied” to “very satisfied”, duration appropriateness was assessed using a 3-point Likert scale ranging from “not enough” to “more than enough”, and perceived past appointments’ duration was also obtained in minutes. Patients’ previous information of the appointment’s duration was evaluated with a “yes” or “no” question and, if patients reported having been informed previously, they were asked the consultation’s expected duration (in minutes) that they had been informed of. Quality of the doctor-patient communication was assessed by an adapted and translated version of the Consultation and Relational Empathy (CARE) measure.[21, 22]

In the first moment, patients were asked to fill in questionnaire 1 which included the satisfaction assessment and the previous knowledge questions.

In the second moment, patients answered questionnaire 2 which included sociodemographic characteristics, perceived health status, appointment characteristics, satisfaction assessment, previous knowledge of the appointments’ duration and quality of the doctor-patient communication.

Real duration of the consult was collected through the physician’s notes.

Participation was voluntary. Each subject was assigned a code to maintain anonymity. Patients were informed of the purpose of the study and gave oral consent before answering questionnaire 1 and signed a written informed consent declaration prior to answering questionnaire 2. Data was collected using Excel ® and then exported to 3.8 version of R® for statistical analysis. T-test was used for parametric tests and chi-squared/df, Fisher’s exact and Mann-Whitney tests were used for non-parametric tests; $p < 0.05$ was set to assess statistical significance. The study was approved by the *Administração Regional de Saúde do Norte* Ethical Committee (reference CE/2021/97).

3. Results

3.1. Sample’s sociodemographic characterization

From the 257 subjects initially randomized to the control and intervention groups, 228 agreed to participate. They were allocated to the control group (n=106) and the intervention group (n=122) and answered questionnaire 1. On the day of their appointment, 88 of the control group subjects and 109 of the intervention group subjects answered the second questionnaire (n=197) (figure 1). Thirty-one subjects

missed their scheduled appointment or did not agree to participate on the second assessment. Forty participants from the control group and 20 in the intervention group did not complete the study.

In the case of patients younger than 16 years old, the sociodemographic data collected was provided by their caregiver. Sociodemographic characteristics of participants are detailed on table 1.

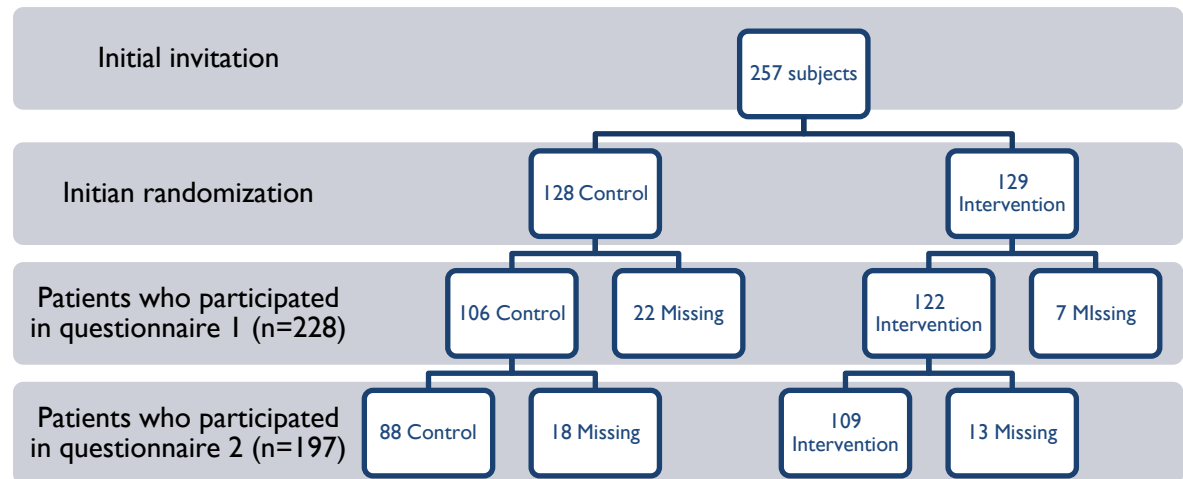


Fig. 1 Sample collection

Table 1
Sociodemographic characterization

	Total sample (n=197)	Control group (n = 88)	Intervention group (n = 109)	p value
Age				
Mean	53.15	56.75	49.13	TT:0.0380
Std Dev	25.71	24.41	26.28	
Minimum	0	0	0	
Maximum	94	92	94	
Sex				
Male	79 (40.1%)	39 (44.3%)	40 (36.7%)	CS: 0.2779
Female	118 (59.9%)	49 (55.7%)	69 (63.3%)	
Marital status				
Single	45 (22.8%)	15 (17.0%)	30 (27.5%)	CS: 0.0772
Married/ cohabiting partner	119 (60.4%)	53 (60.2%)	66 (60.6%)	
Divorced/Separated	14 (7.1%)	7 (8.0%)	7 (6.4%)	
Widowed	19 (9.6%)	13 (14.8%)	6 (5.5%)	
Completed education				
< Primary school	49 (24.9%)	23 (26.1%)	26 (23.9%)	FS: 0.2431
Primary school	75 (38.1%)	38 (43.2%)	37 (33.9%)	
Middle school	27 (13.7%)	13 (14.8%)	14 (12.8%)	
High school	33 (16.8%)	11 (12.5%)	22 (20.2%)	
University	13 (6.6%)	3 (3.4%)	10 (9.2%)	
Working status				
Active	61 (31.0%)	22 (25.0%)	39 (35.8%)	FS: 0.1379
Not active	136 (69.0%)	66 (75.0%)	70 (64.2%)	

Acronyms: < = less than; CS = Chi-Square test; FS = Fisher test; TT = T-test

3.2. Appointment characterization

Appointments' characteristics were similar in both groups. These results are demonstrated in table 2.

In both groups patients intended to address a mean of 2.6 subjects. Eight patients reported having no issues to address. These patients were in scheduled follow-up appointments, therefore they were solely scheduled to address the physician's agenda. Perceived time spent in the appointment was also not different in both control and intervention group ($p=0.6718$).

There was a total of 86 interruptions reported in 65 consults, with a maximum of four interruptions in one consult. There was no statistical difference between both groups regarding the number of interruptions. In the category "other interruptions", patients reported: one interruption by a patient's family member, one interruption by a phone call to the patient's phone and one interruption for the patient to be submitted to a treatment.

Patients self-reported health status was evaluated through a four-question questionnaire ranging from 4, worst health status, to 20, best health status. The self-reported health status was similar in both groups ($p=0.5686$).

Physicians' empathy score was evaluated using the CARE measure. Both the intervention and control group scored high in this scale. There was no statistical difference found between both groups.

Table 2
Appointment and patient's characteristics

	Control (n = 88)	Intervention (n = 109)	P-value
Type of Appointment, n (%)			
Diabetes follow-up	12 (13.6%)	11 (10.1%)	CS:0.2368
Hypertension follow-up	44 (50.0%)	39 (35.8%)	
Planned Parenthood	7 (8.0%)	15 (13.8%)	
Routine check-up	13 (14.8%)	21 (19.3%)	
Child or Adolescent follow-up	10 (11.4%)	17 (15.6%)	
Maternal follow-up	2 (2.3%)	6 (5.5%)	
Missing	0	0	
Waiting time for the appointment scheduling (days)			
Mean	152.38	142.27	TT:0.6918
Std Dev	173.01	174.69	
Minimum	0	0	
Maximum	1095.00	730.00	
Missing	2	7	
Amount of problems wanted addressed in consult			
Mean	2.57	2.57	TT:0.9982
Std Dev	1.88	1.92	
Minimum	0.00	0.00	
Maximum	10.00	15.00	
Missing	0	0	
Appointment with the regular family physician			
No	25 (28.4%)	37 (33.9%)	CS:0.4055

Yes	63 (71.6%)	72 (66.1%)	
Missing	0	0	
Familiarity with the attending physician			
No	21 (23.9%)	30 (27.5%)	
Yes	67 (76.1%)	79 (72.5%)	CS:0.5599
Missing	0	0	
Perceived duration of the appointment (minutes)			
Mean	22.80	23.37	
Std Dev	10.65	8.25	
Minimum	5.00	10.00	TT:0.6718
Maximum	60.00	45.00	
Missing	0	0	
Interruptions in consult			
Someone physically interrupted the consult	14 (15.9%)	20 (18.3%)	CS: 0.6524
The physician answered the phone	10 (11.4%)	6 (5.6%)	CS:0.1396
Hardware or missing material problems	8 (9.1%)	10 (9.2%)	CS: 0.9839
Software problems	2 (2.3%)	4 (3.7%)	FS: 0.6936
Other	1 (1.1%)	2 (1.8%)	FS:1.0000
Patients self-reported health status			
Mean	13.93	14.12	
Std Dev	2.23	2.34	TT:0.5686
Minimum	8.00	8.00	
Maximum	16.00	18.00	
CARE measure score			
Mean	45.55	46.02	
Std Dev	7.15	6.64	
Minimum	26.00	25.00	TT:0.6383
Maximum	50.00	50.00	
Missing	2	2	

Acronyms: CARE - Consultation and Relational Empathy measure; CS – Chi-Square test; FS – Fisher exact test; Std Dev – Standard deviation; TT – t-test

3.3. Information of the appointment duration and satisfaction

Most patients had never been informed of the consultation's expected duration prior to this study (n=190; 96.4%). Regarding questionnaire 2, in the intervention group, where all subjects had been informed of the appointment's duration, 69.7% participants recalled being informed. In the control group, 12.5% subjects reported having previously been informed of the appointments' duration these patients reported being informed by their physicians during their consult, by other staff members of the clinic before or after the phone call and by other means. There was a statistically significant difference between the control and intervention group regarding previous knowledge of the appointment duration ($p=0.00$). The duration that subjects recalled being informed of was also significantly different [mean of 24 minutes in the control (11 subjects) versus 29 minutes in the intervention group (76 subjects); $p=0.034$].

There was no statistical difference found between both groups regarding subjects' perception of the appointment duration ($p=0.6718$), nor with their satisfaction with ($p=0.1308$) it or with the appointment itself ($p=0.5808$).

Table 3 depicts the results of questionnaire 1 and 2 regarding patients' perception of appointment duration and their satisfaction with it and with the overall appointment. Questionnaire 1 addresses overall appointments whereas questionnaire 2 addresses the last appointment (which took place right before the questionnaire was taken). As its illustrated, there was no statistical difference found in any of the displayed questions between both groups in both moments of interview.

Table 3
Appointment duration assessment in both questionnaires

	Questionnaire 1			Questionnaire 2		
	Control (n=88)	Intervention (n=109)	P value Q1	Control (n=88)	Intervention (n=109)	P value Q2
Usual duration (Q1)/perceived duration (Q2) of the appointment (mins)						
Mean	20.85	20.05	TT:	22.80	23.37	TT:
Std Dev	9.04	6.68	0.4742	10.65	8.25	0.6718
Minimum	5.00	5.00		5.00	10.00	
Maximum	60.00	40.00		60.00	45.00	
Missing	0	1		0	0	
Categorization of appointment duration, n (%)						
Insufficient	2 (2.3%)	1 (0.9%)	FS:	0	0	CS:
Sufficient	77 (87.5%)	95 (87.2%)	0.8031	58 (65.9%)	76 (69.7%)	0.5681
More than sufficient	6 (6.8%)	10 (9.2%)		30 (34.1%)	33 (30.3%)	
I don't know	3 (3.4%)	3 (2.8%)		0	0	
Satisfaction with the appointment duration, n (%)						
Very satisfied	15 (17.0%)	24 (22.0%)	FS:	56 (63.6%)	74 (67.9%)	FS:
Reasonably satisfied	1 (1.1%)	8 (7.3%)	0.1121	0 (0.0%)	4 (3.7%)	0.1308
Satisfied	69 (78.4%)	75 (68.8%)		32 (36.4%)	31 (28.4%)	
Somewhat satisfied	3 (3.4%)	2 (1.8%)		0	0	
Not at all satisfied	0	0		0	0	
Satisfaction with the overall consult, n (%)						
Very satisfied	13 (14.8%)	30 (27.5%)	FS:	56 (63.6%)	74 (67.9%)	FS:
Reasonably satisfied	4 (4.5%)	6 (5.5%)	0.0885	1 (1.1%)	2 (1.8%)	0.5808
Satisfied	71 (80.7%)	72 (66.1%)		31 (35.2%)	31 (28.4%)	
Somewhat satisfied	0	1 (0.9%)		0	2 (1.8%)	
Not at all satisfied	0	0		0	0	

Acronyms: Std Dev – Standard deviation; Q1 – Questionnaire 1; Q2 – Questionnaire 2

4. Discussion and Conclusion

4.1. Discussion

High degrees of satisfaction with the appointments and their duration were reported by both groups. This could reflect an appropriate duration of the appointment or, as prior literature has shown, efficient communication and good doctor-patient relationship, may play a role in patients satisfaction.[3, 23-25] This factors have shown to mitigate other dissatisfactions with the health care system, suggesting a preference of time quality over quantity by patients.[11, 26, 27]

Patients reported an average of 5 months waiting for their appointment. This reflects the routine feature of the appointments studied, usually 6 months apart. Most of our appointments were performed by the family physician in both groups and, even when patients reported to have a different attending physician on the appointment (a resident), most patients reported knowing the attending physician from previous appointments. Patients considered their attending physicians as good communicators and empaths, as shown by high CARE measure ratings, higher than what was found in literature.[28, 29] The high empathy skills reported in both groups might be responsible for the high degrees of satisfaction in both groups, as supported by previous literature.[3, 23, 24] Our patients also reported average degrees of self-health evaluation and literature has shown that patients with lower self-health perception are less satisfied with their appointments[5], but due to similar levels in both groups this phenomenon was not observed, nor did it influence our satisfaction results.

Patients recall being informed of the appointment's expected duration, as confirmed by the previous knowledge of the intervention vs control group. Patients reported an average of 2.57 problems addressed per appointment. This finding was similar to what was found in literature. [30, 31] It was hypothesized that previous knowledge of the appointments duration could prompt patients to reduce the number of problems they wanted to address in the intervention group, as suggested by Knight [15], but there was no difference in the amount of problems they wanted to address. This might reflect an appropriate duration of consult, inflexibility of patients or their optimism in considering they have enough time to address all the problems they wanted. Furthermore, more direct approaches, as the one described by Knight, might be more fruitful in empowering patients to prioritize their lists of concerns.[15]

When analysing possible effects of informing the patient of the consult's expected duration, being informed had no influence on patients' perception of its duration, nor in their perception of the duration appropriateness.

According to prior studies, extending the duration of the consult beyond patients expectations , increases patients' satisfaction[10, 32]. However, this phenomenon was not observed in our study. Patients reported an average duration of previous appointments of 20 minutes. Even though the intervention group was informed that

the appointment's expected duration would be 30 minutes, and despite patients recalling this information with accuracy (mean 29 minutes) and in the control group some patients stating they had been informed of a mean expected duration of 24 minutes, these allotted times were not perceptibly surpassed in neither groups (the perceived duration in both groups was roughly 23 minutes). Nonetheless, both groups show high levels of satisfaction in questionnaire 2.

At the time the study took place, appointments on the PHC Unit were booked with a 30-minute intervals. The lower mean of estimated duration of consultation reported in the control group (not informed in the present study) might be influenced by shorter duration of consultations that was usual in years previous to this study or misinformation, although these results are limited by the low number of answers in the control group.

We noticed higher satisfaction rates in questionnaire 2: this might be due to questionnaire 1 being related to past appointments and negative memory bias from patients, who tend to more easily recall negative experiences. [33] Questionnaire 2, addressing only the last consultation experience, tends to better focus patients' attention.

4.2. Strengths and Limitations

A shortcoming we found in our study was the disparity in the size of both groups. In the initial randomization both groups were similar, yet the absenteeism of patients on the day of the appointment contributed to some discrepancies between both groups. Both the control and intervention group were similar in most aspects. The main difference was the age, mostly due to age differences in the youngest subjects. Their answers were provided by their caregivers, whose information was not collected. This is considered a limitation in our study, and further studies should also include the information of the caregivers. Another possible limitation was the study being performed in only one health unit. Other studies should be performed in larger settings, with multi-unit for better extrapolation of results. Additionally, having the information of the appointment's duration being carried out only by the secretary approximately 2 weeks prior to the appointment is limiting to extrapolation to informing on the appointment's duration. Other studies with

different timings of information and different messengers should be conducted to assess the best way to inform the patients and its repercussions on their satisfaction. Strengths found in this study were the plethora of variables studied and its originality.

4.3. Conclusion

We found that informing patients of the appointment expected duration by secretary staff prior to the consult did not prove to have any influence in patient's satisfaction with the consult itself. In our study we also found that, when informed, patients recall the appointments duration with accuracy. Patients stated that they are pleased with their appointments and their duration. On average, patients want to address 2,57 problems per consult.

4.4. Practice Implications

Patients recall being informed of the appointment's expected duration and recall the duration informed with accuracy. This information, when provided by secretaries prior to the appointment has no influence in patients' satisfaction. Other means of presenting this information to the patient might be better at improving patient's satisfaction.

5. Highlights

- Patients recall with reasonable accuracy being informed of the appointment duration
- Patients are satisfied with their appointments and their duration
- Informing patients of the appointment's duration had no effect on their satisfaction

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Patients' satisfaction with their appointment in Primary Health Care – the role of physicians' empathy and appointment length

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Abstract

Objectives: To evaluate Primary Health Care (PHC) patients' satisfaction with their appointments.

Methods: An observational study was conducted on patients at a PHC unit after their appointments. Patient satisfaction was evaluated using a survey and correlated with demographic and appointment characteristics, self-perceived health, and physicians' empathy scores.

Results: A total of 197 patients were included in our study (59.9% female, mean age 53.1 years). The majority of patients reported to be satisfied or very satisfied with their consultation. Satisfaction score was associated with the physician's communication skills ($p < 0.0001$), the PHC team ($p = 0.0068$), and perceived appointment length ($p = 0.0048$). No significant correlations were found between interruptions during the appointment and satisfaction (p value ranging from 0.2423 to 0.7839), but they increased the perception of its' duration ($p = 0.0018$).

Conclusion: In the studied PHC unit patients are overall satisfied with their appointments. A good doctor-patient relationship seems to play a role in their satisfaction, with it being influenced by their satisfaction with their physicians' empathy scores, satisfaction with the care team and perceived time spent in the appointment.

Keywords

Physician-Patient Relations; Primary Health Care; Patient Satisfaction; Empathy; Health Communication

Type of article

Original research: Observational study

Teaser

Patients' satisfaction was closely related to satisfaction with their primary health care team, physicians' communication skills and perceived duration of the appointment.

Resumo

Objetivos: Avaliar a satisfação dos utentes dos Cuidados de Saúde Primários (CSP) com as suas consultas.

Métodos: Um estudo observacional foi levado a cabo em utentes de uma Unidade de Saúde Familiar após as suas consultas. A satisfação dos pacientes foi avaliada através de uma escala *Likert* e depois comparada com características demográficas e da consulta, perceção de saúde dos utentes e de empatia dos médicos.

Resultados: Foram incluídos no nosso estudo 197 utentes (59,9% do sexo feminino, média de idade de 53,1 anos). A maioria dos utentes reportaram estar satisfeitos ou muito satisfeitos com a sua consulta. Os fatores que influenciaram a satisfação dos utentes com a consulta foram a equipa de saúde ($p=0,0068$), as capacidade de comunicação dos médicos ($p<0,0001$) e a perceção de tempo na consulta (0,0048). Não foram encontradas correlações entre as interrupções durante a consulta e a satisfação (valor de p entre 0,2423 e 0,7839), mas aumentaram a perceção da sua duração ($p=0,0018$).

Conclusão: Na unidade estudada os utentes estão globalmente satisfeitos com as suas consultas. Uma boa relação médico-doente parece desempenhar um papel na satisfação dos utentes, sendo influenciada pela satisfação com a equipa de saúde, pela empatia do médico e pela perceção de tempo na consulta.

Introduction

Patients' satisfaction has been attaining increased attention since it has been linked to better health outcomes and quality of care. These findings have brought value to the patient's perspective, making, nowadays, patients satisfaction a fundamental aspect of quality of care evaluation and improvement.[1] Recent studies have researched possible factors which influence patients' satisfaction, such as sociodemographic characteristics, continuity/format of health care, and clinical communication.[2]

The most consensual factor influencing patients' satisfaction is interpersonal care, ergo, communication skills.[1-3] A study conducted in Portugal concluded that the most relevant factor in patients' satisfaction with primary health care (PHC) was their satisfaction with their general practitioner team[4], which might reflect a good doctor-patient relationship grounded in good physician's communication skills. Other factors in the health care quality characteristics studied include: technical care (perceived health professional competence, experience and ethics)[5], efficacy and outcome of care[3-5], organizational characteristics (reputation of health care facility, staff's job satisfaction and size of facility)[4, 5], which have also shown positive effects on patients' satisfaction. Larger waiting time or perceived waiting time for a consultation, in emergency departments and outpatient clinics, have shown detrimental effects on patient satisfaction.[6, 7] This effect has been shown to be mitigated by communication skills/empathy of the health care professionals.[8, 9] Moreover, the quality of time spent (emotional support provided and listening skills) with the physician, instead of actual or perceived time spent, has shown to be a better predictor of satisfaction with the appointment and its duration.[10] Perceived time spent on consult has also been addressed has an influence in patient satisfaction. Studies have shown that longer time spent with physicians, particularly surpassing patients' expected duration of consult increases patients' satisfaction.[11, 12] Thus, time spent in consult may act as a communication facilitator, improving, indirectly, the doctor-patient relationship.[13] Patients with perceived poorer health, who were more worried about their wellbeing, visiting their usual physician or having their first visit to the physician have been shown to anticipate longer consults.[11]

Patients' related factors such as age, gender, marital status, education, geographic characteristics, and health status have also been studied. Age is the most consistent factor found, with older patients being more pleased with their health care.

Nonetheless, satisfaction correlation with patients' age revealed a sudden decline after 80 years old.[4, 5] Gender has shown inconsistent results with females being overall happier with health services, but males more pleased with nursing care and facility amenities.[4, 5] Marital status has shown contradictory results.[5] Patients' reported satisfaction with care is influenced by education and socioeconomic status, with lower education and higher income being associated with higher satisfaction.[5] Overall rural populations were found to be more pleased with their health care, particularly in Portugal, where Northern and Central areas reported higher satisfaction rates than the rest of the country.[4, 5] Patients with poorer health reported lower satisfaction rates.[5]

In the present study we intend to explore associations between patient, Health Unit and consult characteristics with patients' satisfaction with the appointment in a PHC setting.

Methods

We conducted an observational study with patients attending the consults in a public PHC Clinic in the North of Portugal, in an urban setting, with eight family medicine specialists and eight family medicine interns.[14, 15] We collected a convenience sample of patients attending previously scheduled appointments during two weeks in May 2022. Inclusion criteria were: having a scheduled appointment, speaking Portuguese and being over 16 years old. In consults with patients under sixteen, sociodemographic data was collected through the accompanying caregiver. Patients not speaking Portuguese, unable to provide answers for any other reason or walk-ins (with no previously scheduled appointment) were excluded from this study.

A questionnaire was built to assess sociodemographic characteristics, characteristics of the appointment (type of the appointment, waiting time for its scheduling, number of problems addressed, the PHC team, the physician who consulted them and familiarity with the attending physician). The instrument also included the evaluation of the quality of the doctor-patient communication (from a translated version of the *Consultation and Relational Empathy (CARE)* measure)[16, 17], and the patients' self-health perception (through a four-question questionnaire ranging from 4 (worst health perception) to 20 (best health perception)). The interruptions during the consult (categorized by number and type), the satisfaction with the appointment and with its' duration (through a five item Likert scale ranging from not at all satisfied to very satisfied), duration appropriateness (through a 3 item Likert scale, ranging from not sufficient to more than sufficient) and appointments' perceived duration were also evaluated. To prevent bias, collaborators and authors never collected data from patients they previously knew. Real duration of the consult was collected through the physician's notes.

Participation was voluntary, and all the participants were informed about the study purpose and procedures and signing an informed consent. Patients were given a code for anonymity. Data was collected in excel and then exported to 3.8 version of R® for statistical analysis. T-test was used for parametric tests and χ^2/df , Fisher and Mann-Whitney test were used for non-parametric tests; $p < 0.05$ was set to assess statistical significance. The study was approved by the Administração Regional de Saúde do Norte Ethical Committee (reference CE/2021/97).

Results

A convenience sample of 197 subjects was gathered.

Table 4 Patients demographic characteristics

	Total sample (n=197)	Sociodemographic characteristics
Age		Sociodemographics were collected and are shown on table 1. The population was
Mean	53.15	
Std Dev	25.71	
Minimum	0	
Maximum	94	
Sex		
Male	79 (40.1%)	59.9% female, 60.4% married/de
Female	118 (59.9%)	facto or living with partner and
Marital status		69% were not working
Single	45 (22.8%)	individuals. Completed
Married/De facto or living with partner	119 (60.4%)	education ranged from less than
Divorced/Separated	14 (7.1%)	primary school to university
Widowed	19 (9.6%)	degree, with the majority of
Completed education		patients having primary school
< Primary school	49 (24.9%)	degree or less (124 – 62,9%).
Primary school	75 (38.1%)	
Middle school	27 (13.7%)	
High school	33 (16.8%)	
University	13 (6.6%)	
Working situation		
Working	61 (31.0%)	
Not working	136 (69.0%)	

Appointment characteristics

Appointment characteristics were also collected. Results are detailed in table 2. The type of the appointment included follow-up of chronic health problems (Diabetes, Hypertension) and preventive appointments, such as, maternal follow-up and child or adolescent appointments, planned parenthood and “routine check-up”. The average waiting time for the scheduling of the appointment was 146.9 days. Most patients had the appointment with their family physician (68.53%) and only 25.89% reported not knowing the attending physician previously. Patients reported having an average of 2.57 problems to discuss in the appointment, perceiving to have spent an average of 23.11 minutes in their consult. Sixty-five patients recounted having at least one interruption in their appointment, with 86 interruptions reported in total. Besides the previously catalogued types of interruptions, there were 3 other types not foreseen (Catalogued as “other interruptions”), those were an interruption by a patient’s family member, one phone call to a patient and one treatment mid-appointment.

Table 5 Appointment Characteristics

	Total
Type of Appointment, n (%)	
Diabetes follow-up	23 (11.68%)
Hypertension follow-up	83 (42.13%)
Planned Parenthood	22 (11.17%)
Routine check-up	34 (17.26%)
Child or Adolescent follow-up	27 (13.71%)
Maternal follow-up	8 (4.06%)
Missing	0
Amount of time waiting for scheduling (days)	
Mean	146.90
Std Dev	173.43
Minimum	0
Maximum	1095
Missing	9
Amount of problems wanted addressed in consult	
Mean	2.57
Std Dev	1.90
Minimum	0
Maximum	15
Missing	0
Appointment with the family physician	
No	62 (31.47%)
Yes	135 (68.53%)
Missing	0
Familiarity with the attending physician	
No	51 (25.89%)
Yes	146 (74.11%)
Missing	0
Perceived duration of the appointment (minutes)	
Mean	23.11
Std Dev	9.38
Minimum	5
Maximum	60
Missing	0
Interruptions in consult	
Someone physically interrupted the consult	34 (17.26%)
The physician answered the phone	16 (8.12%)
Hardware or missing material problems	18 (9.14%)
Software problems	6 (3.05%)
Other	3 (1.52%)
Self-health status	
Mean	14.04
Std Dev	2.36
Minimum	8
Maximum	18
Missing	0

Acronyms: Std Dev = standard deviation

Association analysis

An analysis of possible associations between different factors and subjects' satisfaction with the appointment and its duration was conducted, results are shown in table 3 and table 4.

The associations between participants' characteristics and satisfaction were analysed. No statistical difference was found regarding gender ($p=0.6272$), completed education ($p=0.0515$), age ($p=0.0670$) and self-reported health status ($p=0.4169$).

There was also no statistical correlation found for these variables and satisfaction with the appointment's duration ($p=0.7757$; $p=0.1775$; $p=0.6864$ and $p=0.1184$).

Appointments' characteristics were scrutinized, and satisfaction was statistically different when perceived duration was analysed ($p=0.0048$), with longer perceived appointments ranking higher levels of satisfaction, this trend was also found in satisfaction with the appointment duration ($p=0.0047$). However, no statistical difference found in satisfaction when analysed by waiting time for appointment scheduling for satisfaction with the overall appointment and for its duration). Satisfaction with the overall appointment was also not statistically different according to type of interruptions with p values ranging from 0.2423, for physician answering the phone, to 0.7839, for software malfunction. Similar results were found when analysing satisfaction with the duration of the appointment, with p values ranging from 0.2142, for hardware problems, to 0.6084, for software malfunctions.

When analysing the relationship between satisfaction and CARE scores, there was a statistical difference ($p<0.0001$ for overall appointment and for its duration), with higher CARE scores ranking higher degrees of satisfaction. Scores in CARE questionnaire were statistically different between PHC team ($p=0.0003$), with higher scores reported in physicians with higher satisfactions scores. Appointment's perceived duration was also longer in PHC teams with higher degrees of satisfaction, with statistical significance ($p<0.0001$). Perceived and real duration relationship was calculated through a quotient between both durations. There was a statistical difference in this quotient between different PHC teams, with three physicians' average ranking over 1, ergo overestimation of consult, two of these being the two physicians with higher degrees of satisfaction.

Satisfaction with the overall appointment was analysed by PHC team (either senior physician or intern) with no statistical difference found regarding being seen by family physician, $p=0.5538$, and familiarity with the physician, ergo having met that physician before, $p=0.7304$. Similar results were found for satisfaction with the appointment duration, $p=0.1526$ and 0.5387, respectively. Nevertheless, a difference in satisfaction was found both in satisfaction with overall appointment ($p=0.0004$) as well as its duration ($p=0.0068$) when subjects were divided by PHC team, with two physicians ranking higher than the remaining six. No statistical difference was found in appointment duration classification ($p=0.1131$).

Table 6 Variables analysed by degree of satisfaction with the overall appointment

	Satisfaction with the overall appointment					
	Ns (0)	Ls (2)	S (62)	Rs (3)	Vs (130)	P
Gender						
Male	0	0	27	1	51	0.6272
Female	0	2	35	2	79	
Completed education						
< Primary school	0	0	19	3	50	0.0515
Primary school	0	2	32	0	38	
Middle school	0	0	2	0	17	
High school	0	0	1	0	0	
University	0	0	2	0	9	
Age						
Mean	Na	44.00	59.37	38.00	49.74	0.0670
Std Dev	Na	45.25	23.14	21.17	26.16	
Minimum	Na	12	0	22.00	0	
Maximum	Na	76	91	62	93	
Days waiting for appointment scheduling						
Mean	Na	135.00	183.66	181.67	129.00	0.2591
Std Dev	Na	148.49	185.55	182.51	167.01	
Minimum	Na	30.00	0	0	0	
Maximum	Na	240	730	365	1095	
Appointment perceived duration (mins)						
Mean	Na	25.00	19.61	23.33	24.75	0.0048
Std Dev	Na	7.07	7.06	5.77	10.03	
Minimum	Na	20	5	20	5	
Maximum	Na	30	40	30	60	
Interruptions						
Someone physically interrupted	Na	0	7	0	27	0.2944
The physician answered the phone	Na	0	0	1	8	0.2423
Hardware or missing material problems	Na	0	3	0	15	0.4259
Software problems	Na	0	3	0	3	0.7839
Other	Na	0	0	0	3	0.6715
Appointment with the family physician						
Yes	0	1	43	1	90	0.5538
No	0	1	19	2	40	
Familiarity with the attending physician						
Yes	0	1	44	1	99	0.7304
No	0	1	18	2	31	
PHC Team						
Physician 1	0	0	17	1	13	0.0068
Physician 2	0	1	13	0	10	
Physician 3	0	0	7	0	31	
Physician 4	0	0	7	0	15	
Physician 5	0	0	5	0	28	
Physician 6	0	0	2	0	5	
Physician 7	0	0	6	2	16	
Physician 8	0	1	5	0	12	
CARE measure						
N	0	2	61	2	128	< 0.0001
Mean	Na	40.00	41.74	35.22	48.00	
Std Dev	Na	14.14	8.51	13.04	4.34	
Missing	0	0	1	1	2	
Minimum	Na	30	25	26	30	
Maximum	Na	50	50	44.44	50	
Self-health assessment						
Mean	Na	12.50	14.29	12.67	13.97	0.4169
Std Dev	Na	6.36	1.95	0.58	2.39	
Minimum	Na	8	9	12	8	
Maximum	Na	17	18	13	18	

Acronyms: CARE= Consultation and Relational Empathy; Ls= little satisfied; mins = minutes; Ns= not satisfied; Rs= Reasonably satisfied; PHC= Primary Health Care; Std Dev = standard deviation; Vs= Very satisfied

Table 7 Variables analysed by degree of satisfaction with the duration of the appointment

	Satisfaction with the duration of the appointment					P
	Ns (0)	Ls (0)	S (63)	Rs (4)	Vs (130)	
Gender						
Male	0	0	27	2	50	0.7757
Female	0	0	36	2	80	
Completed education						
< Primary school	0	0	22	1	49	0.1775
Primary school	0	0	29	1	29	
Middle school	0	0	3	0	16	
High school	0	0	1	0	0	
University	0	0	2	1	8	
Age						
Mean	Na	Na	54.03	60.25	51.57	0.6864
Std Dev	Na	Na	25.78	11.95	25.98	
Minimum	Na	Na	0	48	0	
Maximum	Na	Na	91	76	93	
Days waiting for appointment scheduling						
Mean	Na	Na	171.83	157.50	134.79	0.4004
Std Dev	Na	Na	180.04	89.58	172.07	
Minimum	Na	Na	0	30	0	
Maximum	Na	Na	730	240	1095	
Appointment perceived duration (mins)						
Mean	Na	Na	20.10	20.00	24.67	0.0047
Std Dev	Na	Na	8.18	7.07	9.65	
Minimum	Na	Na	5	15	10	
Maximum	Na	Na	50	30	60	
Interruptions						
Someone physically interrupted	Na	Na	9	0	25	0.4542
The physician answered the phone	Na	Na	7	0	9	0.5148
Hardware or missing material problems	Na	Na	3	1	14	0.2142
Software problems	Na	Na	3	0	3	0.6084
Other	Na	Na	0	0	3	0.4615
Appointment with the family physician						
Yes	0	0	45	1	89	0.1526
No	0	0	18	3	41	
Familiarity with the attending physician						
Yes	0	0	47	2	97	0.5387
No	0	0	16	2	33	
PHC Team						
Physician 1	0	0	19	0	12	0.0004
Physician 2	0	0	13	0	11	
Physician 3	0	0	7	0	31	
Physician 4	0	0	7	0	15	
Physician 5	0	0	3	1	29	
Physician 6	0	0	2	0	5	
Physician 7	0	0	5	2	17	
Physician 8	0	0	7	1	10	
CARE measure						
N	0	0	63	2	128	<0.0001
Mean	Na	Na	42.57	31.00	47.63	
Std Dev	Na	Na	8.16	1.41	5.15	
Missing	0	0	0	2	2	
Minimum	Na	Na	26	30	25	
Maximum	Na	Na	50	32	50	
Self-health assessment						
Mean	Na	Na	14.32	12.00	13.96	0.1184
Std Dev	Na	Na	2.01	2.71	2.38	
Minimum	Na	Na	9	8	9	
Maximum	Na	Na	18	14	18	

Acronyms: CARE= Consultation and Relational Empathy; Ls= little satisfied; mins = minutes; Ns= not satisfied; Rs= Reasonably satisfied; PHC= Primary Health Care; Std Dev = standard deviation; Vs= Very satisfied

CARE measure answers from participants who reported to be either very pleased with the appointment or with its duration are depicted in table 5. The item “fully understand your concerns” had the highest rankings; the second highest was “helping you take control”, for patients very satisfied with the overall appointment, and “explaining things clearly” for patients very satisfied with the appointments duration; the third item with higher score was “making a plan of action with you” for both groups. The item “making you feel at ease” had the lowest rankings in both groups and together with “showing care and compassion” for the satisfaction with the overall appointment group and “really listening” for the satisfaction with the duration of the appointment.

Table 8 CARE measure evaluation

CARE measure item	Very Satisfied with the appointment (n=130)					Very satisfied with the duration of appointment (n=130)				
	Fair	Good	Very good	Excellent	Does not apply	Fair	Good	Very good	Excellent	Does not apply
Making you feel at ease	0	7	15	108	0	1	7	16	107	0
Letting you tell your “story”	0	5	16	109	0	1	6	16	107	0
Really listening	0	6	13	111	0	1	8	14	107	0
Being interested in you a whole person	0	6	14	106	4	1	8	12	105	4
Fully understanding your concerns	0	4	12	112	2	1	5	13	109	2
Showing care and compassion	0	7	15	108	0	0	8	15	106	1
Being positive	0	5	16	108	1	0	8	14	107	1
Explaining things clearly	1	2	18	109	0	1	4	17	108	0
Helping you take control	0	3	17	104	6	0	6	17	102	5
Make a plan of action with you	0	4	14	100	12	0	6	14	97	13

Results of the analysis of variables when analysing by family physician vs. intern are displayed in table 6. There was no statistical difference found, in the CARE measure, between interns and senior physicians, though interns ranked slightly higher than seniors. There was no statistical difference found in the appointment perceived duration or quotient between the perceived and real durations, in the duration classification or in the interruption.

Table 9 Variables analysed by Attending physician on the appointment

	Appointment by the PHC physician (n = 135)	Appointment not by the PHC physician (n = 62)	P
Appointment perceived duration (mins)			
Mean	22.87	23.63	TT: 0.5631
Std Dev	10.09	7.65	
Minimum	5.00	10.00	
Maximum	60.00	10.00	
How do you rate the duration of your appointment, n (%)			
Not enough	0	0	CS: 0.4748
Enough	94 (69.6%)	40 (64.5%)	
More than enough	41 (30.4%)	22 (35.5%)	
CARE measure			
N	133	60	TT: 0.1229
Mean	45.46	46.58	
Std Dev	7.20	6.02	
Minimum	25.00	30.00	
Maximum	50.00	50.00	
Missing	2	2	
Was your appointment interrupted?			
Yes	45 (33.33%)	20 (32.26%)	CS: 0.8815
No	90 (66.67%)	42 (67.74%)	
Perceived time/real time quotient			
N	81.00	55.00	TT: 0.8810
Mean	1.05	1.04	
Std Dev	0.48	0.38	
Minimum	0.22	0.43	
Maximum	2.81	2.00	
Missing	54	7	

Acronyms: CARE= Consultation and Relational Empathy; CS = Chi-Square; mins = minutes; PHC= Primary Health Care; Std Dev = standard deviation; TT = t-test

When analysing subjects by reported interruptions there was a statistical difference found in perceived duration ($p=0.0018$), with perceived longer appointments when the subject reported being interrupted. This difference was not found when analysing the quotient between the perceived and the real duration ($p=0.2653$). The classification of the duration of the appointment was not statistically different in both groups ($p=0.7982$), nor was in between the different physicians ($p=0.2524$) or the CARE measure ($p=0.8563$). The results are demonstrated in table 7.

Table 10 Variables analysed by having presence of interruptions in the appointment

	Reported at least one interruption (n = 65)	Reported no interruption (n = 132)	P
Perceived duration (mins)			
Mean	26.42	21.48	TT: 0.0018
Std Dev	11.08	7.97	
Minimum	5.00	5.00	
Maximum	60.00	50.00	
How do you rate the duration of your appointment, n (%)			
Not enough	0	0	CS: 0.7982
Enough	45 (69.2%)	89 (67.4%)	
More than enough	20 (30.8%)	43 (32.6%)	
Family physician, n (%)			
Physician 1	9 (13.8%)	22 (16.7%)	CS: 0.2524
Physician 2	3 (4.6%)	21 (15.9%)	
Physician 3	13 (20.0%)	25 (18.9%)	
Physician 4	8 (12.3%)	14 (10.6%)	
Physician 5	16 (24.6%)	17 (12.9%)	
Physician 6	2 (3.1%)	5 (3.8%)	
Physician 7	9 (13.8%)	15 (11.4%)	
Physician 8	5 (7.7%)	13 (9.8%)	
CARE Score			
N	64	129	TT: 0.8563
Mean	46.10	45.66	
Std Dev	6.95	6.83	
Minimum	26.00	25.00	
Maximum	50.00	50.00	
Missing	1	3	
Perceived time/real time quotient			
N	48.00	88.00	TT: 0.2653
Mean	1.10	1.01	
Std Dev	0.47	0.43	
Minimum	0.26	0.22	
Maximum	2.81	2.50	
Missing	17	44	

Acronyms: CARE= Consultation and Relational Empathy; CS = Chi-Square; mins = minutes; PHC= Primary Health Care;

Std Dev = standard deviation; TT = t-test

Discussion

Our study aimed to clarify the relationship between patients satisfaction and interpersonal care through the CARE measure, and organizational characteristics, namely interruptions, waiting time for the appointment, appointment type, which were found to be the most relevant dimensions in patient evaluation of the PHC experience.[18]. Factors dependant on the PHC setting, have also been studied and divided into different dimensions of satisfaction: interpersonal care, technical care, efficacy and outcome of care and organizational characteristics.[1-5] The patient's sociodemographic characteristics, including age, gender, education level, and marital status, have produced conflicting findings in research studies [4, 5]. While some studies have suggested that age may affect patient satisfaction, the results for marital status and gender have been inconsistent [4, 5]. However, our study found no correlation between these characteristics and patients' satisfaction. Similarly, the patient's self-reported health status did not appear to be linked to patient satisfaction, contradicting previous literature.[5]

We hypothesized that patients with more rapid appointment scheduling were more satisfied. Unexpectedly, waiting time for the consult had no influence on patients' satisfaction with the appointment, with an average of 5 months showing very high degrees of satisfaction. These findings were not in line with the literature[19] possibly for cultural factors. A lot of the appointments studied were follow-ups, scheduled by the physician, so patients might feel the interval in between follow-ups to be appropriate. Also, a high consumerism and frequency of appointments, with need for lower waiting times for the scheduling, might be itself a symptom of low satisfaction with the health care provided, demanding recurrent come backs in search for a "better" outcome. On the other hand, less frequent consults, such as 3 years apart, as we found in this study, may prove to be detrimental to patients' satisfaction with feelings of abandonment.

Another factor found to influence patients' satisfaction was their PHC team. Longitudinal care, provided in PHC and a good PHC team-patients relationship might be the foundation for increased patient satisfaction. A previous study found that the more familiar the patient is with their physician the more comfortable he/she is to be more active in the appointment, thus interacting and demanding more from the attending physician, with reduced patients' satisfaction [20], but satisfaction with the

PHC team was also found to be beneficial for patient satisfaction in another study similar to ours.[4]

Physicians' communication skills, assessed by the CARE measure were found to be associated with patients satisfaction with the appointment and its duration, which was in line with the literature.[1-3] Further analysing of the CARE measure responses, in particular in the most satisfied patients, feeling their concerns were fully understood as the highest ranking item. It seems that, cognitive empathy skills play a major role in patients' satisfaction. "Helping you take control" for the patients satisfied with the overall appointment, together with the ability to explain things clearly, thus the informing segment of the consult, for patients satisfied with the appointment duration, came as the second highest ranking item. Both these items contribute to patient empowerment. In third came negotiation/plan making ("make a plan of action with you") for both groups. Thus, active listening skills and empowerment actions were ranked highest in the most satisfied patients, emphasizing the importance of these measures. Making the patient feel at ease, thus ice-breaking skills, asking open ended questions, performing no judging and holding comfortable silences, was the lowest ranking item, seeming that patients value these skills less than the previously mentioned.

Another factor found to influence patients' satisfaction was perceived consult duration, with longer appointments providing more satisfaction. Similar results were found in previous studies, with patients being more pleased when they feel they stay longer with their physicians, particularly exceeding the appointments' expected duration. [11, 12, 21, 22]

Our study has also found that patients ranked interns with slight better communication skills, though with no statistical difference. This finding is in line with a previous study, which found residents and senior doctors communication skills to be similar.[23] The slight higher communication skills found might be a reflection of a more recent communication skills training in interns, as well as less pressure from having to keep appointments' time. Furthermore, senior physicians, might seem more paternalist and dominant when it comes to shared decision-making. As stated before, the higher demand and comfort in patients more familiar with their physician, as opposed to a more passive posture when they don't know their physicians as well, might have also reduced their satisfaction.[20] A possible bias might have taken

place, as, even though patients were asked to evaluate their previous appointment, their evaluation might have been tainted by previous encounters (increasing or decreasing their satisfaction, whether they were satisfying or not). This phenomenon would have been more prominent with the senior physicians (with whom the patients have been more times).

Surprisingly, the main factor found to influence patients perceived duration was interruptions during the appointment. These interruptions, however, did not seem influence patients' satisfaction. It seems that patients are accepting interruptions, but they recognise that they lengthen their appointment, since there was no difference in their satisfaction rates. The neutral impact of interruptions in patients satisfaction has been reported in a previous study.[24]

Strengths found in this study were the sample dimension, the variability of variables studied and its pertinence. Possible limitations found were it been performed in a single unit; further studies should be performed in larger settings. The variability of possible factors influencing patients' satisfaction, limits quantitative studies only to predictable variables.

Further studies, possibly of quality nature, for broadening of investigation, aiming other dimensions of satisfaction should be conducted to further evaluate the role of each in the overall satisfaction.

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Anexo I

Autorização do trabalho pela Comissão de Ética da Administração Regional de Saúde do Norte



COMUNICAÇÃO



INFORMAÇÃO



PARECER

DATA: 2021-12-15

REFERÊNCIA: CE/2021/97

PARA: CONSELHO DIRETIVO

DE: COMISSÃO DE ÉTICA

ASSUNTO ...: PI 20210070 - Telling Time to Make Time - A Randomized
Controlled Trial on the Satisfaction of Patients When Previously
Informed About the Consultation Length

A - Apresentação do pedido de apreciação

A Comissão de Ética para a Saúde da Administração Regional de Saúde do Norte, I.P. recebeu, o pedido de parecer sobre o estudo **"Telling Time to Make Time - A Randomized Controlled Trial on the Satisfaction of Patients When Previously Informed About the Consultation Length"**, a realizar na USF Casa dos Pescadores do ACES Grande Porto IV- Póvoa do Varzim/Vila do Conde, no âmbito da tese de Mestrado em Comunicação Clínica da Faculdade de Medicina da Universidade do Porto da Dr^a Matilde Agostinho Neto, interna em Formação Específica em MGF, cuja orientação é da responsabilidade da Dr^a Joana Silva Monteiro. Orientadora de tese, Prof.^a Dra. Margarida Figueiredo Braga. O pedido de parecer foi instruído com os documentos obrigatórios para a sua submissão.

B - Identificação de questões com eventuais implicações éticas ou metodológicas

Trata-se de um estudo randomizado e controlado que apresenta como principais objetivos avaliar se a informação prévia ao utente acerca da duração estimada da consulta aumenta a sua satisfação com a duração da mesma, e explorar associações entre a satisfação com a duração da consulta e fatores de desagrado do utente, tais como interrupções na mesma, pretende ainda perceber se os diferentes perfis de utilizador (idade, género, tipo de consulta) dos utentes se relacionam com a satisfação da duração da consulta.

A população alvo do estudo são todos os utentes em consulta programada presencial na USF Casa dos Pescadores do ACeS Póvoa de Varzim/Vila do Conde, que voluntariamente aceitem participar e assinem previamente o Consentimento Informado. Os utentes que aceitarem participar serão aleatoriamente divididos por dois grupos - grupo de intervenção e grupo de controlo. Os doentes serão convidados a participar telefonicamente e responderão a um questionário sobre o seu grau de satisfação geral com as consultas médicas. Posteriormente serão aleatorizados e divididos por dois grupos: o grupo de intervenção será contactado pela secretaria a informar a data, hora e duração da consulta, e, no caso do grupo controlo, apenas da data e hora. No dia da consulta, após a mesma, todos serão convidados a responder a um breve questionário sobre a satisfação e modo como decorreu a consulta. Os resultados serão analisados com recurso ao SPSS - Statistical Package for the Social Sciences versão 26.

EXARADO NA ATA Nº 2021_48
REUNIÃO DE 2021-12-21

DELIBERADO AUTORIZAR
2021-12-21



Carlos Nunes
Presidente do CD

Maria Clara Castro

Maria Clara Castro
Vice Presidente do CD



Paula Duarte
Vogal do CD

C - Conclusão

Reconhecendo a relevância do estudo e considerando que o mesmo satisfaz os requisitos de confidencialidade dos direitos dos potenciais participantes, a Comissão de Ética para a Saúde da ARSN deliberou nesta data, dar Parecer Favorável à realização do estudo. Os investigadores devem comunicar os resultados, assim que o estudo esteja concluído.

Aprovado, por unanimidade

Porto, 14 de dezembro de 2021



Maria José Ferreira Santos
Presidente da Comissão de Ética