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Doctor Satisfaction and the Effects on Quality — Discussion

Within this special issue, Casalino and Crosson (2015) ask should anyone care about doctors' satisfaction. This paper considers this question and the extent to which evidence exists, suggesting that we should indeed care about how satisfied they are.

Although Casalino and Crosson provide many examples of the ways that the psychological state of doctors—burnout, depression, and stress—might affect the care that they give, they do not consider the extent to which these states correlate with dissatisfaction. They point out that career satisfaction is actually high in this profession, perhaps because doctors can separate satisfaction for their professional role from satisfaction with the organization for which they work. They may enjoy the work they do daily, but dislike the way that work is organized, especially if they feel it impacts upon the quality they can give. However, dissatisfaction is clearly a part of one's emotional state, and we know that a doctor's emotional state does affect the quality of care (Firth-Cozens, 2001). Moreover, it is possible to study the relationship of job satisfaction to mental health indirectly. For example, a clinical study evaluating psychotherapy for depressed professional staff measured attitudes to work, including a job satisfaction scale, alongside psychological symptoms over the course of therapy. The study found that all aspects of satisfaction, even concerning the adequacy of their pay, rose significantly as clinical symptoms improved (Firth-Cozens & Hardy, 1992). This suggests that looking at the effects of psychological distress as a proxy for job satisfaction, as Casalino and Crosson do, is a reasonable method to consider its effects on quality.

Doctors do have higher psychological distress than most other working populations (Wall et al., 1997). Unlike findings in burnout studies, which have unhelpfully wide ranges for the proportion of high scorers, when a population measure like the General Health Questionnaire is used to assess their mental health, around 28% of doctors consistently score above the symptom threshold (Wall et al., 1997). It is possible that a proportion of those people are stressed, dissatisfied or unhappy over long periods of time (Firth-Cozens, Caceres-Lema, & Firth, 1999) which suggests that, for some doctors, this is perhaps dispositional.

The effects of doctors' mental health on patient care have been documented over decades (Firth-Cozens, 2001) but until recently have not included satisfaction or quality except indirectly; for example, as a predictor of early retirement (Newton, Luce, van Zwanenberg, & Firth-Cozens, 2004). However, there have been direct examples from other fields; for example, Schneider & Bowen (1985) showed that job satisfaction fed down through banks to customers: happy bank managers have happy staff and happy customers. Thanks to the annual National Health Service (NHS) survey of all English staff and patients, we do now have direct evidence for healthcare too. The NHS Staff Survey 2011 report, analyzing staff satisfaction and

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relating it to patient satisfaction in individual healthcare organizations, states:

> Staff satisfaction is directly related to subsequent patient satisfaction. For example, staff reports of the supportiveness of immediate managers and their perceptions of the extent of positive feeling (communication, staff involvement, innovation and patient care) in their trusts directly predicts patient satisfaction. Not surprisingly, staff intention to leave their jobs is also strongly related to lower levels of patient satisfaction (National Health Service, 2011, p. 9).

Further than patient satisfaction, the survey also found that "employee engagement" affected many aspects of patient care, including infection rates, mortality, staff absence and turnover. Engagement encompasses satisfaction but also includes a positive involvement in one's work and a commitment to one's organization (West & Dawson, 2012). Similarly, Prins et al. (2010) found that doctors who are more engaged in their work are significantly less likely to make mistakes, while another study (Leiter, Harvie, & Frizzell, 1998) suggested that nurses with higher work engagement have safer patient outcomes. "Engagement" therefore may be a more useful construct than job satisfaction since the latter somewhat confounds satisfaction with one's professional career choice and satisfaction with one's organization or the quality of care it permits (Casalino & Crosson, 2015).

Many of these measures of quality—mortality, infection, error—are included in the aspects of quality discussed by Nylenna, Bjertnaes, Saunes, Lindahl (2015) though it may be that a simple snapshot of staff health could provide us with considerable information about quality in itself. However, as Nylenna et al. (2015) point out, the patients' view of their experience needs to be included. Their expectations may have risen over the last few decades, but still the aspect of care they appear to focus upon when things go wrong is a lack of compassion and its related constructs of empathy and altruism (Francis, 2013). Generally, when doctors and nurses see poor care taking place they protect the patient, but fail to report the colleague (Firth-Cozens, Redfern, & Moss, 2004). However, the Francis report (Francis, 2013), and a string of other UK examples, make it clear that far from failing to report while still helping the patient, some doctors in these organizations allowed real harm to come to patients on a continual basis, by ignoring widespread poor care or, at least, by failing to report. It has been suggested that modern medicine has led to a decline in altruism (Jones, 2002) and certainly empathy reduces during medical training (Wear, Aultman, Varley, & Zarconi, 2006). However, there are organizational, technical and political factors which have been shown to contribute to a decrease in morale, or to an increase in burnout, and it may be this aspect of dissatisfaction, rather than any intrinsic lack of compassion, that leads to substandard care.

All NHS organizations (and most others that deliver health around the world) are under considerable financial pressure, but the NHS survey makes it clear that some of them, at least in 2011, had working for them engaged staff with low stress, high satisfaction and good quality outcomes, while others suffered the opposite. This suggests that many aspects of poor quality care, including organizational culture (Mannion et al., 2005), are likely to be the result of poor management feeding down through staff. In addition, there are other aspects of modern healthcare that have been shown to affect the morale of staff and thus quality, particularly in terms of patient experience, and these involve:

- increasing interactions with computers/form-filling, rather than with patients (Tipping et al., 2010)
- reductions in bed numbers and so higher bed turnover (Virtanen et al., 2008)
- more elderly or more seriously ill patients (Shaufeli, 1999),
- more specialization of doctors (Firth-Cozens & Cornwell, 2009)
- a focus upon targets to the detriment of other aspects of care (Mannion, 2014)

All these potentially take doctors and nurses away from any altruistic ideals they had when they chose to enter their profession; certainly they make the provision of compassionate care, which involves time and dialogue, more difficult (Firth-Cozens & Cornwell, 2009). Not feeling they are providing quality care is one reason Casalino & Casson give for any feelings of dissatisfaction in doctors, and there may then develop a vicious circle from this to the creation of poorer quality, more dissatisfaction, and so on. As one doctor from the Mid Staffordshire Inquiry said (Newdick & Danbury, 2013):

> “If you are in that environment for long enough, what happens is you become immune to the sound of pain… You cannot continue to want to do the best you possibly can when the system says no to you” (p. 5).

Having adequate time to spend with patients and to discuss with colleagues any difficulties within the role must affect every aspect of quality, from mistakes to compassion, and working on ways to allow this is a critical and continual task for modern healthcare.

There seems little doubt that both our evidence-based and our common sense responses to the question posed by Casalino and Crosson, of whether we should care about doctor’s satisfaction, is indeed a resounding “Yes!”

References

Casalino, L. P., & Crosson, F. J. (2015). Physician satisfaction and physician well-being: should anyone care? *Professions and Professionalism, 5*(1). http://dx.doi.org/10.7577/pp.954

Firth-Cozens, J. (2001). Interventions to improve physicians’ well-being and patient care. *Social Science & Medicine*, *52*(2), 215-222. http://dx.doi.org/10.1016/S0277-9536(00)00221-5

Firth-Cozens, J., & Cornwell, J. (2009). *Enabling compassionate care in acute hospital settings.* London: King’s Fund. Retrieved from: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/poc-enabling-compassionate-care-hospital-settings-apr09.pdf

Firth-Cozens, J., & Hardy, G. (1992). Occupational stress, clinical treatment and changes in job perceptions. *Journal of Occupational & Organizational Psychology*, *65*(2), 81-88. http://dx.doi.org/10.1111/j.2044-8325.1992.tb00486.x

Firth-Cozens, J., Caceres-Lema V., & Firth, R. A. (1999). Specialty choice, stress and personality: their relationship over time. *Hospital Medicine*, *60*(10), 751-755. http://dx.doi.org/10.12968/hosp.1999.60.10.1222

Firth-Cozens, J., Redfern, N., & Moss F. (2004). Confronting errors in patient care: the experiences of doctors and nurses. *AVMA Medical & Legal Journal, 10*(5), 184-190. http://dx.doi.org/10.1258/1356262041591195

Francis, R. (2013). *Report of the Mid Staffordshire Foundation NHS Trust Public Inquiry.* Volumes 1-3, HC-898-1-111. London: The Stationery Office.

Jones, R. (2002). Declining altruism in medicine: understanding medical altruism is important in workforce planning. *BMJ: British Medical Journal*, *324*(7338), 624. http://dx.doi.org/10.1136/bmj.324.7338.624

Leiter, M.P., Harvie, P., & Frizzell, C. (1998). The correspondence of patient satisfaction and nurse burnout. *Social Science & Medicine*, *47*(10), 1611–1617. http://dx.doi.org/10.1016/S0277-9536(98)00207-X

Mannion, R., Davies, H. T. O., & Marshall, M. N. (2005). Cultural characteristics of “high” and “low” performing hospitals. *Journal of Health Organization and Management*, *19*(6), 431-439. http://dx.doi.org/10.1108/14777260510629689

Mannion, R. (2014). Enabling compassionate healthcare: perils, prospects and perspectives. *International Journal of Health Policy and Management*, *2*(3), 115-117. http://dx.doi.org/10.15171/ijhpm.2014.34

National Health Service (2011). NHS Survey. NHS Staff Management and Health Service Quality. Retrieved from: www.gov.uk/government/publications/nhs-staff-management-and-health-service-quality

Newdick, C. & Danbury, C. (2013). Culture, compassion and clinical neglect: probity in the NHS after Mid Staffordshire. *Journal of Medical Ethics, 1*, 1-7. http://dx.doi.org/10.1136/medethics-2012-101048

Newton, J., Luce, A., van Zwanenberg, T., & Firth-Cozens, J. (2004). Job dissatisfaction and early retirement: a qualitative study of general practitioners in the Northern Deanery. *Primary Health Care Research & Development*, *5*(1), 68-76. http://dx.doi.org/10.1191/1463423604pc191oa

Nylenna, M., Bjertnaes, O., Saunes, I. S., & Lindahl, A. K. (2015). What is good quality of health care? *Professions and Professionalism, 5*(1). http://dx.doi.org/10.7577/pp.909

Prins, J. T., Hoekstra-Weebers, J. E., Gazendam-Donofrio, S. M., Dillingh, G. S., Bakker, A. B., Huisman, M., ... Van Der Heijden, F. M. (2010). Burnout and engagement among resident doctors in the Netherlands: a national study. *Medical Education*, *44*(3), 236-247. http://dx.doi.org/10.1111/j.1365-2923.2009.03590.x

Schaufeli, W. (1999). Burnout. In J. Firth-Cozens & R. L. Payne (Eds.), *Stress in Health Professionals* (pp. 17–32). Chichester: Wiley.

Schneider, B., & Bowen, D. E. (1985). Employee and customer perceptions of service in banks: Replication and extension. *Journal of Applied Psychology*, *70*(3), 423. http://dx.doi.org/10.1037/0021-9010.70.3.423

Tipping, M. D., Forth, V. E., O'Leary, K. J., Malkenson, D. M., Magill, D. B., Englert, K., & Williams, M. V. (2010). Where did the day go?—A time-motion study of hospitalists. *Journal of Hospital Medicine*, *5*(6), 323-328. http://dx.doi.org/10.1002/jhm.790

Virtanen, M., Pentti, J., Vahtera, J., Ferrie, J. E., Stansfeld, S. A., Helenius, H., ... Kivimäki, M. (2008). Overcrowding in hospital wards as a predictor of antidepressant treatment among hospital staff. *The American journal of psychiatry*, *165*(11), 1482-1486. http://dx.doi.org/10.1176/appi.ajp.2008.07121929

Wall, T. D., Bolden, R. I., Borrill, C. S., Carter, A. J., Golya, D. A., Hardy, G. E., ... West, M. A. (1997). Minor psychiatric disorder in NHS trust staff: occupational and gender differences. *The British Journal of Psychiatry*, *171*(6), 519-523. http://dx.doi.org/10.1192/bjp.171.6.519

Wear, D., Aultman, J. M., Varley, J. D., & Zarconi, J. (2006). Making fun of patients: medical students' perceptions and use of derogatory and cynical humor in clinical settings. *Academic Medicine*, *81*(5), 454-462. http://dx.doi.org/10.1097/01.ACM.0000222277.21200.a1

West, M. A., & Dawson, J. D. (2012). *Employee engagement and NHS performance*. London: King's Fund. Retrieved from: http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf