Does Physician Uncertainty Affect Patient Satisfaction?

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Physicians may choose one of several strategies when initially uncertain about making a specific therapeutic recommendation. The authors investigated how patients' satisfaction is affected by disclosure of uncertainty and its attempted resolution during a clinical encounter. Three hundred and four patients awaiting appointments at a university hospital's ambulatory medical clinic were randomized to view one of five videotapes (VTs) of a patient seeking advice about antimicrobial prophylaxis for a heart murmur. In VT-1 and VT-2, the physician disclosed no uncertainty and prescribed therapy. In VT-3, VT-4, and VT-5, the physician openly conveyed uncertainty but then: (VT-3) prescribed antibiotics without resolving his uncertainty; (VT-4) consulted a reference book with the patient present, then prescribed; or (VT-5) checked a computer with the patient present, then prescribed. Patients rated their satisfaction with the physician on a standardized questionnaire. Differences in satisfaction between the five VTs were significant ($p = 0.001$), with the highest ratings found for VT-1 and VT-2, where no uncertainty was disclosed. The lowest ratings in satisfaction were found when the physician expressed but then ignored uncertainty (VT-3) or examined a textbook (VT-4). Global satisfaction was inversely and significantly correlated ($r = -0.47$) with the patients' perception of uncertainty in the physician. The manner in which clinical uncertainty is disclosed to patients and then resolved by the physician appears to affect patients' satisfaction. Key words: patient satisfaction; patient–physician interaction; physician uncertainty. J GEN INTERN MED 1988;3:144–149.

AN IMPORTANT OBJECTIVE during any clinical encounter is to maximize the patient's satisfaction, which has been associated with increased compliance,[1,2] increased continuity of care,[3] and decreased malpractice claims.[4] Patients' satisfaction, a desirable goal in itself, seems to be influenced by a variety of factors, including a physician's technical and/or communicative skill,[5] the concern for psychosocial issues,[5] the type of information exchanged during the clinical encounter,[6,7] and the physician's courtesy.[7] Because of the complexity of the patient–physician interaction, no single factor accounts for the variability seen in patient satisfaction. One particularly important dimension may involve the manner in which physician uncertainty is conveyed.

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Physicians' uncertainty is a ubiquitous aspect of medical care. It may arise from incomplete mastery of available knowledge or from the limitations in current medical knowledge itself.[8] Physicians may choose one of several communication strategies when uncertain about making a diagnostic or therapeutic recommendation. Uncertainty may be disclosed to, or concealed from, the patient. If revealed, it may or may not be resolved prior to the conclusion of the patient–physician encounter. It has been argued that doctors should share this uncertainty with their patients,[9] to foster mutual participation in the decision-making process.

Using a clinical analog setting, we investigated how patients' satisfaction is affected by the disclosure of uncertainty and its attempted resolution during a clinical encounter. Five options were assessed, representing some of the common responses available to physicians when faced with uncertainty. In the present study, patients were randomized to view one of five videotapes, each portraying a different physician response to uncertainty. They then evaluated the physician using a standardized questionnaire.

METHODS

The study was performed during a three-month period beginning in April 1986. All patients awaiting appointments in the Strong Memorial Hospital Ambulatory Medical Clinic were asked to participate during the 20 half-days chosen in this period. Each participant viewed one of five videotapes selected randomly and then completed a questionnaire.

Physician Uncertainty

The five videotapes each depicted a different physician response to uncertainty. All five tapes were approximately seven minutes in duration and were identical except for a one-minute variable segment. The videotapes portrayed an office visit in which the patient, who has a heart murmur, had been referred to the physician by her dentist for advice concerning antibiotic prophylaxis prior to dental repair. All five videotapes had the same first five minutes of history taking, simulated physical examination, and discussion of the patient's murmur. The conclusion of all five videotapes, during which the physician prescribed an antibiotic, was also the same. Embedded between these two constant segments was a one-minute segment that distinguished each of the videotapes (Table 1).

In Videotape 1 (control), the physician recommends antibiotic prophylaxis without acknowledging any uncertainty. He diagnoses a ventricular septal defect and simply states that the patient needs to take antibiotics. In Videotape 2 (leaves room), the physician again provides the diagnosis, but leaves the room for one minute prior to prescribing an antibiotic (as would occur when consulting a book or colleague outside the exam room). The patient is not told why the physician is leaving the room, nor does the viewer know, and when the physician returns he simply prescribes an antibiotic, as in Videotape 1. Videotapes 1 and 2 can be regarded as controls, in that no physician uncertainty is shown. In Videotape 3 (uncertainty not resolved), the physician provides the diagnosis but states his uncertainty regarding the need for antibiotics, then decides to prescribe medication, telling the patient, "You have nothing to lose." In Videotape 4 (book), the physician again provides the diagnosis, acknowledges uncertainty concerning the need for antibiotics, and then prescribes antibiotics with certainty after examining in the presence of the patient a textbook in which the need for medication is confirmed. Videotape 5 (computer) is identical to Videotape 4 except that the physician consults a computer console instead of a textbook in the presence of the patient.

TABLE 1
Videotape Scenarios

All videotapes	Identical history taking, brief physical examination, and discussion of murmur
• Videotape 1 (Control)	Antibiotics recommended without acknowledging any uncertainty
• Videotape 2 (Leaves Room)	Physician leaves room, then same as Videotape 1
• Videotape 3 (Uncertainty Not Resolved)	Physician acknowledges uncertainty, and prescribes antibiotics without resolving his uncertainty
• Videotape 4 (Book)	Physician acknowledges uncertainty, then resolves his uncertainty by consulting a textbook
• Videotape 5 (Computer)	Physician acknowledges uncertainty, then resolves his uncertainty by consulting a computer
All videotapes	Physician prescribes antibiotics

Patient Satisfaction

Immediately after viewing the videotape, study participants completed a patient satisfaction questionnaire to evaluate the physician. This questionnaire consisted of 19 items requiring an agree–disagree response on a 7-point Likert scale. Previously published satisfaction scales were used to construct this 19-item measure. Eight items were obtained from the measure developed by Wolf et al.,[10] six items were obtained from DiMatteo and Hays' questionnaire,[5] and two items were taken from Roter et al.'s scale.[11] Each of these measures has been shown to be reliable and homogeneous, with coefficients of internal consistency (Cronbach alpha[12]) between 0.92 and 0.93. A Chronbach alpha equal to 1.0 occurs when the response to any single question completely determines the response to all other questions, i.e., all questions are measuring the identical concept. A Chronbach alpha equal to 0.0 indicates all responses are completely independent of one another. Three additional items were used to inquire about general satisfaction with the physician, intent to comply with his instructions, and intent to return to him for follow-up. Negatively phrased items were adjusted prior to data analysis so that higher scores indicated greater satisfaction. All questionnaire items asked the viewers to rate the physician in the videotape (see Appendix).

The items had been grouped into four conceptually linked dimensions: general satisfaction, communicative ability, affective ability, and technical ability. However, the alpha coefficient for the entire 19-item satisfaction questionnaire was 0.96, confirming that the scale was based on a very reliable and internally consistent set of items. Thus, the individual subscales were not analyzed separately and the 19-item questionnaire was used as a single measure to determine a mean satisfaction rating.

Demographics and Attitudes

Demographic information was also collected, as well as information regarding various general attitudes toward physicians. These attitudes were assessed by 11 items requiring a similar agree–disagree response, each of which had been developed previously by other investigators. Bargaining with physicians,[13] acceptance of physician authority,[14] intolerance of ambiguity,[15] and other attitudes that have been correlated with patient satisfaction[16] were assessed. Two items concerning physician omniscience were also used. It was felt that these attitudes may influence patients' satisfaction with physicians and affect the satisfaction ratings of all or some of the uncertainty scenarios.

Data Analysis

Sample size calculations were based on a previous satisfaction scale.[5] Sixty subjects viewing each videotape would allow us to detect a clinically significant difference of 0.2 to 0.3. Three sets of anal-

TABLE 2

Characteristics of the Study Population

Demographic	Percentage ($N = 304$)
Age (years)	
≤40	41
41 – 60	34
≥61	25
Gender	
Male	35
Female	65
Race	
White	75
Non-white	25
Family income	
<$10,000	28
$10,000 – $35,000	50
>$35,000	22
Education	
No college	49
Some college	51
Outpatient visits per year	
≤3	46
≥4	54
Hospitalized in past year?	
No	73
Yes	27
Years with the same physician	
No MD	13
≤3	40
≥4	47

yses were performed. First, mean satisfaction ratings for the videotapes were compared using analysis of variance followed by pairwise comparisons. Second, the demographic characteristics were assessed by chi-square, and the effects of these characteristics on the satisfaction rating were analyzed using a main effects model.[17] Finally, the attitude responses were assessed using analysis of variance, and their effect on the satisfaction ratings while controlling for the videotape viewed was analyzed by analysis of covariance. All data were analyzed using SAS-PC and SPSS on an IBM 4381.

RESULTS

Table 2 shows the study population's demographic characteristics. Two variables, "race" and "years with the same physician," were not evenly distributed among the videotape conditions ($\chi^2 = 12.4$, $p = 0.01$ and $\chi^2 = 21.7$, $p = 0.01$, respectively). However, none of the demographic variables had a statistically significant effect on the satisfaction rating ($p > 0.07$ for all demographic characteristics) when controlling for the videotape viewed.

The overall mean satisfaction rating for all videotapes was 5.0 (standard deviation = 0.9). Mean ratings for the individual videotapes appear in Table 3. A rating of 5.0 indicates an "agree" response to a positive statement about the physician in the videotape. Ratings of 1 or 7 indicate a "very strongly disagree" or "very strongly agree" response, respectively. The difference among these mean ratings is significant ($F[4,299] = 5.64$; $p < 0.001$). Patient satisfaction was highest when no uncertainty was shown by the physician (Videotapes 1 and 2), and lower when the patient saw the physician communicate therapeutic uncertainty (Videotapes 3, 4, and 5). In these lower-rated videotapes, patients' satisfaction was influenced by the physician's method of resolving his uncertainty before therapy was prescribed. Viewer satisfaction was relatively higher when the physician consulted a computer (Videotape 5) and lower when he consulted a textbook (Videotape 4). When he did not resolve his uncertainty (Videotape 3), viewer satisfaction was intermediate. Individual viewers rated their satisfaction with the physician very differently. Seven per cent of the variability was accounted for by the videotape that was viewed.

Attitudes toward bargaining with physicians, physician authority, physician omniscience, tolerance for ambiguity in medicine, and several other characteristics were determined (Table 4). Mean ratings did not differ significantly among the five conditions. Six items were significantly correlated with satisfaction rating. Viewers who thought bargaining was desirable or who had more respect for physicians as authority figures tended to have higher satisfaction ratings. Two omniscience measures (items 6 and 7, Table 4) interacted significantly with the videotape viewed to predict satisfaction. The stronger a viewer's belief that the doctor (item 6) or other expert (item 7) should know the answer to all

TABLE 3

Mean Satisfaction Ratings

	Condition	n	Mean ± SE	Pairwise Comparisons[a]			
Videotape 1	Control	60	5.2 ± 0.1	1-2	1-3**	1-4**	1-5
Videotape 2	Leaves room	60	5.2 ± 0.1		2-3**	2-4**	2-5
Videotape 3	Uncertainty not resolved	65	4.8 ± 0.1			3-4	3-5
Videotape 4	Book	59	4.6 ± 0.1				4-5*
Videotape 5	Computer	60	5.0 ± 0.1				

[a] Pairwise comparisons were tested by method of least significant difference, with * $p < 0.02$ and ** $p < 0.01$.

TABLE 4

Influence of Viewer Attitudes on Satisfaction Ratings

Item	Significance of Item	Significance of Interaction	R^2
Bargaining			
1. I find it easy to bargain with the doctor over things I want.	$p = 0.005$	NS	0.12
2. Patients who are given a say in medical decisions are better off than those who aren't.	$p = 0.05$	NS	0.09
Acceptance of physician authority			
3. Relying on your own judgment and making your own decisions about what doctors tell you is very important.	$p = 0.01$	$p = 0.01$	0.13
4. Obedience and respect for physicians is most important.	$p = 0.001$	NS	0.12
5. The doctor ought to have the main say-so in deciding what to do about a person's health problems.	$p = 0.0006$	NS	0.13
Physician and expert omniscience			
6. I expect my doctor to know the answers to all medical questions.	NS	$p = 0.02$	0.11
7. An expert who doesn't come up with a definitive answer probably doesn't know too much.	NS	$p = 0.003$	0.12
Intolerance to ambiguity			
8. Many of our most important medical decisions are based upon insufficient information.	NS	NS	0.08
Other			
9. If I am dissatisfied with something, I usually tell someone about it.	$p = 0.02$	NS	0.10
10. People who are sick would do best not to ask too much from others.	NS	$p = 0.03$	0.10
11. People often disappoint me.	NS	NS	0.10

questions, the greater the satisfaction if the physician consulted a computer ($r = 0.25$ and 0.28), and less if he either used a textbook ($r = -0.27$ and -0.23) or expressed uncertainty without resolution ($r = -0.16$ and -0.24).

To explore further the relationship between uncertainty and satisfaction, a separate analysis was performed on a single item (rated 1–7) that asked if the "physician was unsure whether or not to give an antibiotic to the patient." A higher score indicated more uncertainty was perceived by the viewer. The mean ratings were significantly different for the five scenarios ($F[4,252] = 16.98$, $p < 0.001$). As expected, Videotapes 1 and 2 had the lowest ratings of physician uncertainty (see Table 5). In general, the perceived uncertainty inversely parallelled the satisfaction ratings, as confirmed by a highly significant negative correlation ($r = -0.47$, $p < 0.001$). The uncertainty rating accounted for 22% of the variability in satisfaction. Thus, perceived uncertainty explained a significantly larger amount of the variability in rated satisfaction than did the videotape condition to which subjects were assigned. When perceived uncertainty was statistically controlled, only the difference in mean satisfaction ratings between videotapes 1 and 3 persisted. All other differences in Table 3 were eliminated. This suggests that most of the satisfaction differences among scenarios were due to differences in perceptions of uncertainty. It also suggests that patients are less satisfied when uncertainty is unresolved (Videotape 3), independent of perceived uncertainty. Finally, there was no correlation ($r = 0.0$) between the rated satisfaction and perceived seriousness of the patient's condition.

DISCUSSION

The present study represents an initial attempt to examine the influence of physicians' uncertainty on patient satisfaction. Uncertainty may occur at several levels; it may not be known whether a specific symptom is abnormal, the diagnosis may be obscure, and/or the optimal therapeutic intervention may be unknown. This study considered only therapeutic uncertainty.

We found the manner in which clinical uncertainty is disclosed to patients and then resolved by the physician appears to influence patient satisfaction. Patients appeared to be most satisfied when no uncertainty was disclosed, as in Videotapes 1 and 2, and least satisfied when the physician consulted a textbook (Videotape 4) or prescribed therapy with-

TABLE 5

Mean Ratings of Physician Uncertainty

	Condition	*n*	Mean ± SE	Pairwise Comparisons[a]
Videotape 1	Control	46	2.8 ± 0.2	1-2 1-3* 1-4* 1-5*
Videotape 2	Leaves room	53	2.7 ± 0.1	2-3* 2-4* 2-5*
Videotape 3	Uncertainty not resolved	54	3.6 ± 0.2	3-4* 3-5
Videotape 4	Book	54	4.4 ± 0.2	4-5
Videotape 5	Computer	50	4.1 ± 0.2	

[a] Pairwise comparisons were tested by method of least significant difference with *$p < 0.01$.

out a clear resolution of his uncertainty (Videotape 3). There was substantial variation in individual reactions to the scenarios. This highlights the complexities of patient satisfaction; two patients witnessing the same encounter may have vastly different reactions. Indeed, only 7% of the total variability was "explained" by the videotape condition. This implies that many attributes may affect satisfaction and that individual patients react differently to the same attributes in a physician.

On the other hand, a much greater portion of the variability (22%) was accounted for by the perceived uncertainty. Patients viewing the videotapes felt that there were significant differences in the uncertainty among the five different scenarios; this perceived uncertainty, rather than the actual physician behavior, was the stronger correlate of patient satisfaction. Thus, the different actions of the physician in sharing and resolving uncertainty seem to have influenced patients' satisfaction largely by affecting the amount of uncertainty the patients perceived. In Videotapes 3, 4, and 5, the physician admits to the patient that he does not know whether antibiotics are indicated. Consulting a textbook appears to emphasize the physician's uncertainty or ignorance (Videotape 4 has the highest uncertainty rating), and thus produced a low satisfaction rating. By consulting neither a book nor a computer, and simply prescribing antibiotics (Videotape 3), the physician lessens the patient's perception of uncertainty, and satisfaction is slightly greater.

When perceived uncertainty was statistically controlled, the only remaining significant difference in satisfaction was between Videotapes 1 and 3, in which the patients' response to no uncertainty differed from that to uncertainty that remained unresolved. Thus, resolving uncertainty was viewed relatively more favorably by the patients in this study.

The demographic characteristics did not influence patients' satisfaction ratings. This is consistent with previous studies which have shown that neither patient nor physician demographics affect patients' satisfaction, with the possible exception of age.[5, 18, 19] Information regarding several personality traits was obtained. Patients who believed bargaining with their physician was desirable were generally more satisfied with the physician. Patients who strongly believed physicians should know the answers to all medical questions looked favorably upon computer use to aid in the acquisition of knowledge, but were otherwise unsatisfied when the physician disclosed uncertainty.

Videotapes were used in this study so that one aspect of the patient – physician interaction could be isolated and manipulated, with the remainder of the encounter held constant over the five scenarios. The ratings of uncertainty confirmed the intended differences among experimental conditions. It is important to emphasize that the present study was not conducted during a genuine medical encounter. The subjects who indicated their satisfaction were not personally the patient with whom the physician interacted. Although this could limit the generalizability of the findings, several factors strengthen the validity of the satisfaction ratings. First, patients who provided ratings were approached in a medical setting at the time they were awaiting their own ambulatory clinic appointment. This probably sensitized them to the evaluative judgment needed for rating patient satisfaction. Second, the questions were worded in the first person to facilitate identification with the "patient" in the videotape, e.g., "If I were this patient, I would see this same doctor the next time I had a medical problem." Third, the satisfaction ratings among all subjects displayed a good range of variability, something that is often obscured by the "halo" effect where patients uniformly rate their own personal physicians highly.[20] Finally, since there was no correlation between the viewers' perceptions of the seriousness of the patient's illness and the satisfaction rating, the results should be valid in situations involving more or less serious medical conditions.

There are many attributes of the physician, the patient, and the interaction between them that may influence patient satisfaction. We have isolated perceived physician uncertainty and have shown that this alone accounts for 22% of the variability in patient satisfaction in this study. When uncertainty does occur during a clinical encounter, what is a physician to do? Acknowledging uncertainty will bring the patient into the decision making process and encourage more honest, open communication between physician and patient. But is this worth the price of decreased patient satisfaction, which may adversely affect the quality of health care by decreasing compliance and follow-up? We feel strongly that the choice is clear, that uncertainty must be acknowledged and openly discussed. Doing so may, in fact, enhance the physician's therapeutic effectiveness by demonstrating honesty and a willingness to be more engaged with patients than is possible when communications are not as open.[21] Failure to acknowledge uncertainty can create a sense of psychological abandonment in patients, for the withholding of crucial information compromises intimacy, and physicians and patients can only engage in a more distant relationship. A close relationship based upon openness, mutual trust, and respect may be therapeutic in itself.

Sharing uncertainty gives patients a greater role in the decision making process, so that decisions

can be made by consensus. It has been advocated that this mutual exchange of information leading to shared decision making be the model for patient–physician interactions.[22] The patient's right to be informed of uncertainties is ethically preferable to concealment, and is the basis of informed consent. This not only encourages the patient to be realistic, but also protects physicians legally if a choice is made in the face of uncertainty, and the outcome turns out less than optimal.

If physicians have an obligation to share uncertainty with their patients, yet this may decrease satisfaction, what is to be done? The answer may lie in the art of medicine, in the skill of doctor–patient communication. If the physician is calm, reassuring, empathic, and appears untroubled in the face of uncertainty, patient satisfaction may not be diminished. If the patient feels that the physician is in control, is concerned, and has the optimal care of the patient as the highest priority, dissatisfaction may not occur. Although there is much to learn concerning communicating with patients, much work has been done in this field to elucidate the structure and impact of differing communication styles.[23] Improving physicians' communication skills may be the way to acknowledge uncertainty without jeopardizing satisfaction.

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APPENDIX

The Satisfaction Questionnaire Items

1. This doctor made clear just how serious the patient's illness was.
2. I have some doubts about the ability of this doctor.
3. I felt that this doctor didn't take the patient's problems very seriously.
4. This doctor didn't give the patient a chance to say what was on her mind.
5. This doctor would be someone I would trust with my life.
6. If I were this patient, I would follow this doctor's instructions.
7. I don't think I would recommend this doctor to my friends.
8. I would feel free to talk to this doctor about private thoughts.
9. This doctor told the patient all she wanted to know about her illness.
10. If I were this patient, I would see this same doctor the next time I had a medical problem.
11. This doctor always treated the patient with a great deal of respect and never "talked down" to her.
12. This doctor made the patient feel important.
13. I was satisfied with this doctor's decision about what medications the patient needed to take.
14. The doctor told the patient what the medicines he prescribed would do for the patient.
15. I felt this doctor accepted the patient as a person.
16. This doctor always seemed to know what he was doing.
17. In general, I would be satisfied with this doctor.
18. This doctor told the patient exactly what he planned to do.
19. I wish I could go to this doctor.