

Patient Satisfaction with Family Physician Consultation at Primary Health Care Centers in Baghdad/ 2023

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Abstract

Background: Assessments of patient satisfaction regarding family healthcare Center physicians are important, not only as a measure of the quality-of-care Patients receives, but also in identifying potential areas for improving the content of Care provided by family physicians, since the core activity in family healthcare Centers is the "consultation".

Objectives: Assess the level of patient satisfaction with family physician Consultation at Primary health care centers in Baghdad and find out any relation between socio-demographic and socio-economic factors with patient satisfaction.

Patients and methods: A cross-sectional study with analytic elements was conducted at ten primary health care centers selected with multistage sampling in Al-Karkh district/Baghdad/Iraq. 350 patients were included in the study; analysis of Data was carried out using the available statistical package of IBM SPSS-29.

Result: More than half of patients were satisfied; there was a significant association between age, employment, number of visits, purpose of visit, time spent with the doctor, and Patient satisfaction level.

Conclusion: The overall satisfaction of the participants was acceptable.

Key words; patient satisfaction, family healthcare center, family physicians.

INTRODUCTION

Assessments of patient satisfaction regarding family healthcare center physicians is important, not only as a measure of the quality of care patients receive, but also in identifying potential areas for improving the content of care provided by family physicians since the core activity in family healthcare centers is the "consultation" Irrespective of whether patients consult for cure, services, counseling, prevention, or care, there is an increasing interest in the study of the consultation process and Patients satisfaction with it.⁽¹⁾ In addition to having effective communication, it is important that medical decisions stem from a collaborative process between physicians and patients, decision making is a process in which patients should be involved from the very beginning, and the result is a decision that reflects the Physician's medical knowledge as well as the patient's values and beliefs, patient feeling of confidence and ability to cope with his health problems after a medical visit (through the global concept of enablement) is, among many dimensions used to assess patient experience, considered as an interesting patient-reported outcome measure (PROM)⁽²⁾.

During a new patient consultation, the clinician is first trying to work out whether the patient is ill. Then the clinician tries to answer, 'What is the diagnosis?' so that the appropriate investigations, treatment, and review can be Plan. Expert clinicians know that most of the information directed towards the correct diagnosis comes from attentive listening to the patient's history of the presenting complaint, set in the context of the patient's life and known medical conditions. Physical examination adds some further useful information and tests used to confirm or refute possibilities⁽³⁾.

According to the World Health Organization (WHO), "quality of care is the degree to which health services for individuals and populations increase the Likelihood of desired health outcomes", care quality is linked to evidence-based professional knowledge, humane care, and avoiding harm⁽⁴⁾. In this way, patient care is guided by a people-centered approach that responds to individual Preferences, needs, and values. Furthermore, the quality of care is related to the quality of a healthcare system. This can be expanded to include the provision of timely, equitable, integrated, and efficient services regardless of gender, ethnicity, Geographic location, and socio-economic status, the importance of patients' reported experiences of outcomes in enhancing patient-centeredness has been acknowledged, and it reflects all healthcare decision-making, processes, and care.⁽⁵⁾

This study aims to assess the level of patient satisfaction with family physicians consultation at primary health care centers (PHCCs) in Baghdad.

PATIENTS AND METHODS

Cross-sectional study with analytic element was conducted at ten PHCCs selected with multistage sampling in Al-Karkh district/Baghdad/Iraq. Three centers were located in Al-Karkh health Sector (Shuhdaa Al-Atefea, Al-Yarmook and Al-Salam), three centers were located in Al-Dura health sector (Al-Dura, Belat-Al-Shuhdaa and Al-Hather), two centers were located at Al-Adel health sector (Al-Aameria and Al-Jameaa) and two centers were located at Al-Amel health sector (Al-Shuhdaa and Al-Jehad) .Data was collected during four months from 1st of May to the end of August 2023.

The study sample was the patient who was attending PHCCs after exiting from family physician appointment. The study participants were restricted to those who were ≥ 18 -year-old while Patients who were tired and refused to participate were excluded.

Data collection:

The data was collected by the researcher through a direct interview with the patients. Each interview lasted from 10 to 15 minutes, each visit was from 9 a.m. to 2 p.m., using a pre-designed and validated consultation satisfaction questionnaire (CSQ) ^(6,7).

Target population and sampling technique:

A convenient sample of 350 patients who agreed to participate and met the Inclusion criteria, the interview was conducted in a comfortable place at PHCC, none of the participant were interviewed in front of a family physician who was consulted to ensure confidentiality, the participants were informed that all the collected information will used for research purpose only without an identity.

Data analysis:

Analysis of data was carried out using the available statistical package of IBM SPSS-29 (IBM Statistical Packages for Social Sciences- version 29, Chicago, IL, USA). Data were presented in simple measures of frequency, percentage, mean, Standard deviation, and range (minimum-maximum values). The significance of difference of different percentages (qualitative data) was tested using Pearson Chi-square test with application of Yate's correction or Fisher Exact test whenever applicable. Statistical significance was considered whenever the P value was equal or less than 0.05. Socioeconomic status calculated according to this equation:

(SES = Education + Occupation + House ownership * 0.5 + (age-20)/100 – Retired/unemployed/ deceased) in a research (Developing a Socioeconomic index for health research in Iraq). The scale of the three levels was rated on the 5 points (Likert respondent scale) it was scored as a scoring of strongly agreed about by assigning a score of (5) for “Strongly agree”, (1) for “Strongly disagree” and score of (3) for “Neutral”. The questions regarding satisfaction with customers were ten questions so the Minimum Score= 10, Maximum Score= 50, and the Median Score = 30. A score of more than 75% was considered good (≥ 41 score), 51-75% moderate (31-40 score), and equal or less than 50% was taken as poor (≤ 30 score).

Ethical considerations:

Verbal consent was taken from each participant after full explanation of aim of the study and the collected data wouldn't be used for any purpose other than current study and would be anonymous.

RESULTS

The study included 350 participants with a mean age of (30.1±10.2), fifty percent of them aged between 20-29 year. Most of them were female (68.9%) while (31.1%) were male in Table (1).

Table (1): The Distribution of The Studied Sample according to Socio-demographic.

		No.(350)	%
Age (years)	<20years	24	6.9
	20---29	177	50.6
	30---39	86	24.6
	40---49	37	10.6
	50---59	19	5.4
	=>60years	7	2.0
	Mean \pm SD (Range)	30.1 \pm 10.2 (18-65)	
Gender	Male	109	31.1
	Female	241	68.9
Marital Status	Single (F=23)(M=18)	41	11.7
	Married	294	84.0
	Divorced(F=12)(M=2)	14	4.0
	Widowed	1	0.3
Female educational level (n=330)	Illiterate	-	-
	Read & Write	17	5.2
	Primary	55	16.7
	Secondary	87	26.4
	College	162	49.1
	Higher education	9	2.7
Male educational level (n=314)	Illiterate	2	0.6
	Read & Write	11	3.5
	Primary	46	14.6
	Secondary	55	17.5
	College	190	60.5
	Higher education	10	3.2
Employment	Governmental employee	130	37.1
	Non-governmental employee	74	21.1
	Not employed	3	0.9
	Housewife	101	28.9
	Students	42	12.0
Monthly income (MID)	<0.5MID	183	52.3
	0.5---1 MID	133	38.0
	\geq 1MID	34	9.7
Owning house	Yes	154	44.0
	No	196	56.0

47.4% of the participants were low socioeconomic status, followed by 43.7% and 8.9% of studied participants were located within middle, high socioeconomic Status respectively as shown in Figure (1).

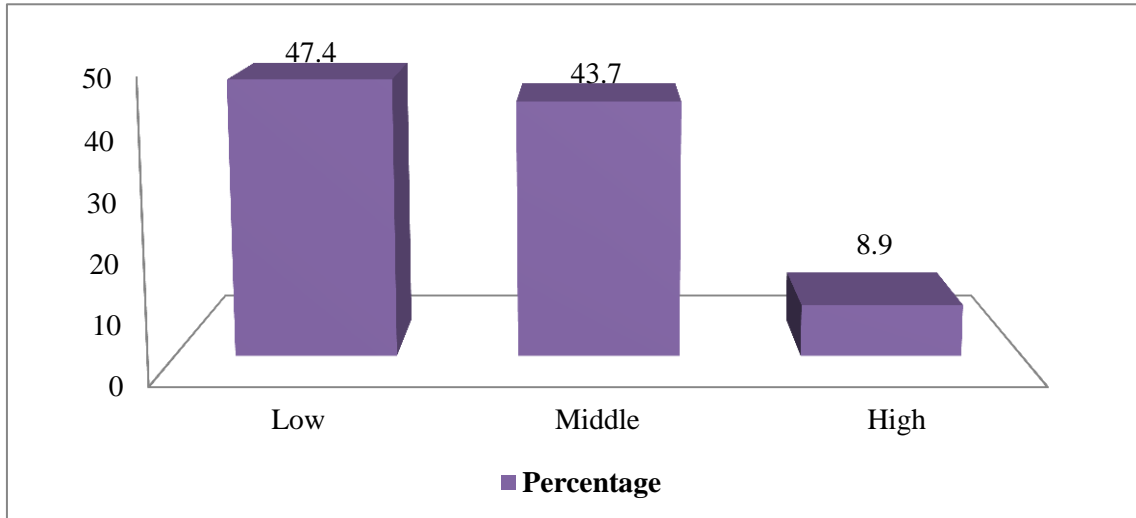


Figure (1): The Distribution of Studied Sample according to socioeconomic status.

About (28.6%) of the patients visited ANC followed by immunization (22.3%) and thereafter childcare (15.1%), NCD (13.7%), general check-up (12.9%), school health (4%) and infectious disease (3.4%) as seen in Figure (2).

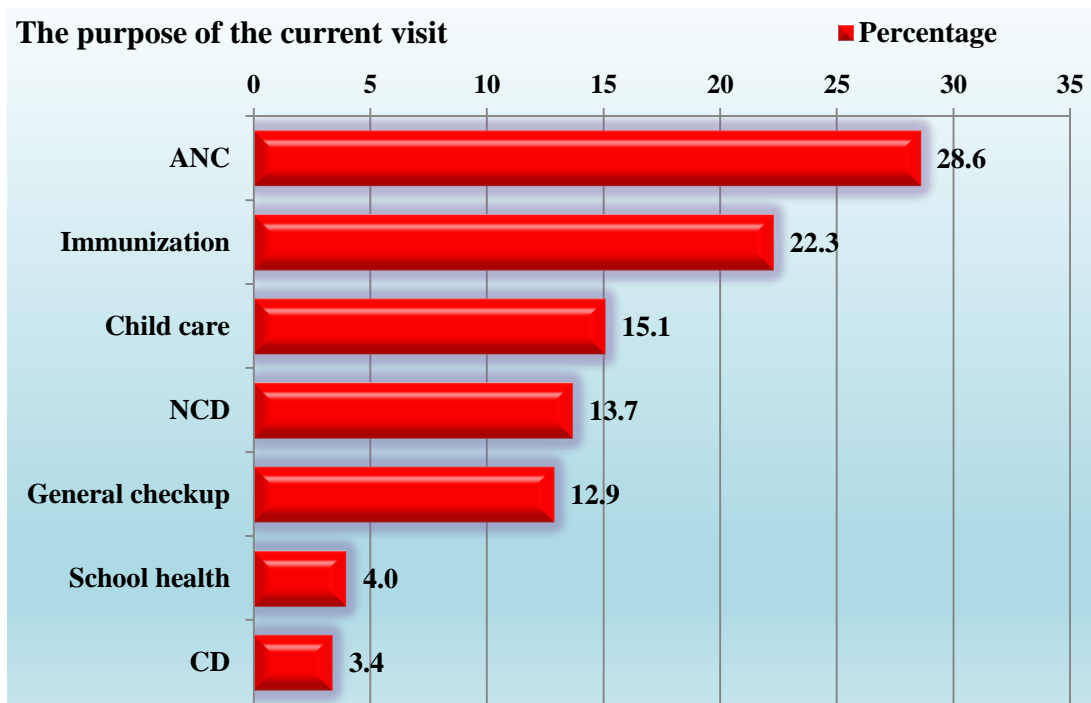


Figure (2): The Distribution of Studied Sample according to purpose of visit.

Most of the participants (76.3%) had (1-2) visits per year, more than half of the Visitors (56.3%) spent five to nine minutes on average time with doctors as seen in Table (2).

Table (2): The Distribution of Studied Sample according to number and time spent with the family physician.

		No.	%
Number of PHCC visits per year	1---2	267	76.3
	3---4	83	23.7
Time spent with doctor	<5minutes	132	37.7
	5---9	197	56.3
	≥10minutes	21	6.0

Patient Satisfaction regarding consultation with the family physician is shown in table 3, where 20.3% have good satisfaction score.

Table (3): The Distribution of participant's overall satisfaction

Satisfaction Score	No	%
Poor (<=30)	88	25.1
Acceptable (31-40)	191	54.6
Good (>40)	71	20.3

Regarding the association between the participant's overall satisfaction and their socio-demographic and socioeconomic characteristics, the participant within the age group (20_29) were statistically significant with good satisfaction(36.6%) among other age group, the government employees were more statistically significant satisfied (60.6%), with no significant difference in participant's overall satisfaction and their socioeconomic status as shown in table (4).

Table (4): The distribution of study group according to level of satisfaction

		Satisfaction Score						P value
		Poor (≤30)		Acceptable (31-40)		Good (>40)		
		No	%	No	%	No	%	
Age (years)	<20years	10	11.4	11	5.8	3	4.2	0.033*
	20---29	45	51.1	106	55.5	26	36.6	
	30---39	23	26.1	47	24.6	16	22.5	
	40---49	7	8.0	15	7.9	15	21.1	
	50---59	1	1.1	10	5.2	8	11.3	
	⇒>60years	2	2.3	2	1.0	3	4.2	
Gender	Male	33	37.5	56	29.3	20	28.2	0.325
	Female	55	62.5	135	70.7	51	71.8	
Marital status	Single	12	13.6	24	12.6	5	7.0	0.672
	Married	72	81.8	160	83.8	62	87.3	
	Divorced/ Widowed	4	4.5	7	3.7	4	5.6	
Female educational level	Illiterate/ Read & Write	7	8.9	5	2.7	5	7.2	0.329
	Primary	17	21.5	26	14.3	12	17.4	
	Secondary	20	25.3	50	27.5	17	24.6	
	College	34	43.0	96	52.7	32	46.4	
Male educational level	Higher education	1	1.3	5	2.7	3	4.3	0.065
	Illiterate/ Read & Write	5	6.1	2	1.2	6	9.4	
	Primary	16	19.8	22	13.0	8	12.5	
	Secondary	14	17.3	34	20.1	7	10.9	
Employment	College	45	55.6	105	62.1	40	62.5	0.0001*
	Higher education	1	1.2	6	3.6	3	4.7	
	Governmental employee	25	28.4	62	32.5	43	60.6	
	Non-governmental employee	18	20.5	50	26.2	6	8.5	
	Not employed	2	2.3	-	-	1	1.4	
Monthly income (MID)	Housewife	31	35.2	53	27.7	17	23.9	0.441
	Students	12	13.6	26	13.6	4	5.6	
	<0.5MID	51	58.0	100	52.4	32	45.1	
	0.5---	31	35.2	73	38.2	29	40.8	
Owning house	⇒>1MID	6	6.8	18	9.4	10	14.1	0.068
	Yes	31	35.2	85	44.5	38	53.5	
Socio-economic status	No	57	64.8	106	55.5	33	46.5	0.073
	Low	53	60.2	84	44.0	29	40.8	
	Middle	28	31.8	91	47.6	34	47.9	
	High	7	8.0	16	8.4	8	11.3	

*Significant difference between percentages using Pearson Chi-square test (χ^2 -test) at 0.05 level.

Table (5) showed the participants who visited the PHCCs (1_2) times per year had the most satisfaction (85.9%). The purpose of the visit had an association with the overall satisfaction of the participants with the ANC visit and had significantly good satisfaction (32.4%) while the immunization visit having significantly poor satisfaction (45.5%). The time spent with the doctor had a significant association with participant`s satisfaction with a time less than five minutes had the most dissatisfaction (83%).

Table (5): The distribution of participants according to level of satisfaction with number, purpose of visit and time spent with family physician.

		Satisfaction Score						P value
		Poor (≤30)		Acceptable (31-40)		Good (>40)		
		No	%	No	%	No	%	
Number of PHCC visits per year	1---2	57	64.8	149	78.0	61	85.9	0.006*
	3---4	31	35.2	42	22.0	10	14.1	
The purpose of the current visit	ANC	14	15.9	63	33.0	23	32.4	0.0001*
	Child care	12	13.6	32	16.8	9	12.7	
	Immunization	40	45.5	35	18.3	3	4.2	
	CD	4	4.5	7	3.7	1	1.4	
	NCD	11	12.5	22	11.5	15	21.1	
	General checkup	5	5.7	23	12.0	17	23.9	
	School health	2	2.3	9	4.7	3	4.2	
	Time spent with doctor	<5minutes	73	83.0	56	29.3	3	4.2
	5---9	14	15.9	125	65.4	58	81.7	
	≥10minutes	1	1.1	10	5.2	10	14.1	

***Significant difference between percentages using Pearson Chi-square test (χ^2 -test) at 0.05 level.**

DISCUSSION

Patient satisfaction is a critical indicator of care quality, health outcomes, and public trust in the health system⁽⁹⁾. In this study, several determinants of satisfaction were identified: 74.9% of participants were satisfied with their consultations, which is slightly lower than reported in a Baghdad survey (79.18%) but higher than in Saudi Arabia (60%)^(8,10). This relatively favorable outcome may be attributed to the fact that all consulting physicians were family medicine specialists, potentially facilitating more holistic and patient-centered care.

A strong patient-physician trust was evident, as most patients felt comfortable discussing personal health issues, aligning with findings from Taiwan⁽¹¹⁾. Such trust is fundamental in healthcare relationships and is widely recognized as essential for patient engagement and positive health outcomes⁽¹²⁾.

Remarkably, 77.7% of respondents agreed that physicians explained treatments thoroughly, enhanced their understanding of illness, and wished to revisit the same physician. These outcomes signal effective clinical relationships, robust communication skills, and meaningful cooperation. Similar findings were observed in a study from Pakistan, which demonstrated a positive association between healthcare service quality and patient satisfaction⁽¹³⁾. Over half of participants agreed that doctors explored their ideas and concerns, indicating that family physicians devoted time to soliciting patient input, thus strengthening satisfaction and therapeutic relationships, even in the presence of widespread barriers such as low health literacy and inadequate patient education. Satisfaction rates were highest for consultations lasting 5–9 minutes, supporting previous findings from Peru and Erbil that longer visits are linked to improved outcomes^(14,15).

Longer sessions facilitate comprehensive dialogue and the addressing of multiple health concerns, while shorter consultations—often result of physician shortages and heavy workloads—are associated with dissatisfaction. A study from China highlighted that communication quality is a more potent determinant of satisfaction than consultation duration⁽¹⁶⁾. Persistent barriers to extended consultations include high patient loads, heavy documentation requirements, and physician burnout.

Satisfaction varied by age group: individuals aged 20–29 was most satisfied, likely due to more effective communication and greater health awareness, whereas those aged 30–39 reported less satisfaction, potentially owing to heightened stressors during their life stage. In contrast with other research, elderly participants exhibited lower satisfaction, possibly due to their small representation in the sample⁽¹⁷⁾. Educational status, previously found to influence satisfaction in studies from Nepal and Australia^(18,19), was not associated with satisfaction in this study, suggesting that perceived quality of care took precedence over educational level. Employment status did have an effect: government employees reported greater appreciation for physicians and a deeper insight into healthcare challenges. A lower number of annual PHCC visits correlated with higher satisfaction, possibly reflecting better general health or more effective care that reduced follow-up needs. Satisfaction also varied according to visit purpose: antenatal care produced the highest satisfaction, likely due to specialized and personal services, while immunization resulted in the lowest satisfaction because of brief, routine encounters and limited communication.

Interestingly, socioeconomic factors did not affect satisfaction, diverging from studies conducted in Portugal, Iraq, and Saudi Arabia^(20,21,10). This discrepancy may be attributed to minimal socioeconomic disparities within the study population.

Limitation of the study:

When selected the sample the tired patients excluded from the study because they Are refusing respondent to the answers.

In addition, some answers might be affected by social and psychological factors during the interview. The data was collected during the time of work, which resulted in time limitation and use convenient sample size which might restrict the ability to generalize the results.

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