Efrén Garza has been a registered nurse for 23 years. He checks armbands, double-checks medication prescriptions and dosages, and constantly monitors his adult psychiatric patients for signs of psychosis, depression, or that they might hurt themselves or others. He spends time talking to them about their self-destructive urges and comes up with treatment plans that help them recover from trauma.

But if Garza were to follow the orders of his managers to the letter, he’d spend his shifts running from one room to the next, checking instead on whether his patients have water or need to go to the restroom, always ending his hourly rounds with, “Is there anything else you need? I have the time.”

“I feel like a butler or a concierge,” said Garza, who works at Alta Bates Summit Medical Center in Oakland, Calif. “It’s the same thing a waiter or someone in the service industry would do. It has nothing to do with my clinical skills.”

Garza’s story may sound all too familiar. In nursing stations from Massachusetts to California, nurses are facing two disturbing trends. First, the federal government is tying patient satisfaction scores to Medicare and Medicaid reimbursements,
essentially requiring hospitals to participate in programs which pur-

pose to measure patient satisfaction or risk losing funding. Second, 
hospital marketing departments are rolling out programs designed 
to elicit more positive responses on patient satisfaction surveys, 
whether it’s forcing RNs to make hourly check-ins with patients for 
appearance’s sake or literally putting words in nurses’ mouths with 
pat scripts crafted to promote their workplaces.

Nurses everywhere are protesting this hospitality and service 
model for their profession. They say it’s not only insulting and 
demoralizing to be told how to talk to their patients, but that these 
programs override their ability to plan and implement care based on 
their patients’ unique needs, that they interfere with their real work, 
threaten their autonomy and nursing judgment, and raise concerns 
about their job security. Most importantly, scripting and rounding 
programs are not an acceptable substitute for safe staffing levels.

As patient advocates, say nurse leaders, nurses should not just 
accept these changes. By banding together and with the help of their 
union, they can fight back to protect both their patients and their 
profession. “When people come into a hospital, they’re there because they 
need sophisticated nursing care – not because they need room serv-

ice,” said DeAnn McEwen, a critical care RN at Long Beach Memo-

rinal Medical Center in Southern California. McEwen is also a 
co-president of the California Nurses Association, chair of its Profes-
sional Practice Committee, and a nurse representative. “These prac-
tices deskill and dumb down nursing care and they’re an attempt to 
override the independent professional clinical judgment of the 
direct-care registered nurse.”

F O R E V E R, I T ’ S A L L A B O U T T H E M O N E Y. Fo r years, med-
ic centers have relied on patient perception and feedback 
to improve care and attract patients. But starting in 2006, 
caring about patient opinions became a near mandate 
when federal reimbursements became linked to participa-
tion in satisfaction surveys.

In that year, the Centers for Medicare and Medicaid Services 
(CMS) implemented a rigorous national feedback system for quality 
and perception of care at American hospitals called the Hospital 
Consumer Assessment of Healthcare Providers and Systems, or 
HCAHPS. Developed since 2002, the federal Office of Management 
and Budget approved the use of HCAHPS for public reporting pur-
poses in 2005, and CMS rolled it out the following year. The first 
statistics were available in 2008.

While participation is not mandatory, CMS began in 2007 dock-
ing annual payment increases by 2 percent from hospitals that don’t 
submit data. And starting in October 2012, HCAHPS scores will be 
among the measures used to calculate incentive payments to hospita-
tals under one of the new healthcare reform laws passed by Congress 
in March. HCAHPS scores are now available online at the CMS 
website and on websites like HospitalCompare.hhs.gov.

The HCAHPS survey contains 27 questions that judge a hospita-
l’s quality, including mortality, effectiveness of treatment, pain 
management, and discharge information. But it also contains sub-
jective questions: What did you think of the hospital’s cleanliness 
and quietness? What did you think of the responsiveness of hospi-
tal staff? Would you return to this hospital? Would you recommend it to others?

These questions reflect the healthcare industry’s treatment of 
patients as customers, as consumers of a product, and of beliefs 
in studies dating back to 1988 that claim to find a correlation 
between customer satisfaction and measurable quality of clinical 
care. A 1995 study found that health outcomes could be improved 
by so-called “psychosocial interventions” — such as politeness, 
friendliness, and gentleness on the parts of nurses and doctors.

In an influential 1999 study, Pensacola, Fla.-based Baptist Hospi-
tal saw both its clinical scores and its income increase when it 
instituted patient satisfaction techniques that included asking 
staff to be friendlier to patients. (Not coincidentally, the adminis-
trator for Baptist Hospital at the time, Quint Studer, went on to 
found the Studer Group, a consulting firm that is a leading seller 
of rounding and scripting programs.) And as recently as 2004, 
researcher Kelly Worthington announced that people who enter a 
hospital for medical care are part patient and part customer, 
adding, “acknowledgment that the person is also a customer 
affirms that person’s right to personalized service that meets all 
their expectations.”

But other studies are more skeptical about any direct link 
between patient satisfaction and clinical outcomes. In a 1991 paper 
by Hannu Vuori, chief of epidemiology statistics and research for the 
World Health Organization, Vuori says that there is no evidence in 
the literature that measurement of patient satisfaction has improved 
quality of care. Researchers can find little literature on the topic, and 
even physician administrators have commented that patient percep-
tion data are not objective measurement tools.

Despite the tenuous connection, hospitals are embracing the idea 
of catering to patients as if they were pampered guests. Hospitals are 
moving beyond marketing themselves based on medical excellence 
and compassion. Many are now following the hospitality model, 
reinventing themselves as upscale hotels, with marble lobbies and 
cascading waterfalls.

W H E T H E R O R N O T I T S H O U L D, t h e t r e n d i s s h i f t i n g 
toward basing more of a hospital’s Medicare and Medi-
caid compensation on patient satisfaction marks. To 
cater to hospitals’ pursuit of better scores, there’s now a 
booming business underway to develop and sell pro-
grams not only to increase patient satisfaction marks, but conduct 
the actual surveys.

For just $1,495, your hospital can buy a training DVD developed 
by the consulting firm Studer Group explaining the “recommended 
behaviors and actions” of hourly rounding, the program that Garza’s 
workplace instituted. Studer Group, based in Florida, also sells 
another popular program that hospitals adopt called AIDET, which 
is intended to reprogram how nurses talk to patients so that they 
have “a better patient experience.” AIDET stands for “acknowledge, 
introduce, duration, explanation, and thank you” — five things RNs 
are supposed to do every time they come into contact with a patient. 
The AIDET training DVD is yours for $2,150, according to Studer 
Group’s online store. An extra $60 gets you 25 participant guides 
and pocket cards for your nurses. In-person trainings by Studer 
Group “coaches” are more expensive, of course.

Press Ganey, based in Indiana, is another major healthcare con-
sulting firm that advises hospital clients how to implement rounding 
programs and other methods of improving patient satisfaction
scores. It is also a major vendor of patient satisfaction surveys; according to its website, more than 40 percent of the nation’s hospitals partner with Press Ganey for “service quality measurement and improvement.” And for $279, your hospital can buy a webinar titled “Rx for Patient Communication: Using scripts to provide consistent, effective communication with patients.”

Giving RNs scripts, lines, or keywords to say is not required by the HCAHPS. But just as preparatory programs and products for the Scholastic Aptitude Test proliferated when colleges started requiring prospective students to score well on these tests, so have programs, products, and consulting services geared toward raising patient satisfaction scores.

“I don’t want to use the phrase ‘teaching to the test,’” said Donna Hartman, vice president of clinical quality and patient safety at Long Beach Memorial. “But we do know that one of the measures on the HCAHPS is patient safety. Patients will be asked whether they felt their safety was important to the staff. So when a nurse checks the patient’s arm band, she makes sure to mention that she’s doing it to keep him safe. When the survey comes in the mail and it asks ‘Did you feel your safety was important?’ he’ll remember, ‘Gee, that nurse kept mentioning to me that they were doing all these things to keep me safe.’ It’s that kind of triggering.”

Many hospitals, however, have taken scripting to extremes. Almost every nurse interviewed for this article had been given a laminated card detailing exactly what she was supposed to say to a patient at the start of each shift, even if she had cared for the patient just the day before.

It goes something like this: “Hi Mrs. ________, my name is ______ and I’ll be your registered nurse today. I want to let you know you are in very good hands. I’ve been a nurse in this department for 20 years. Working with me is Betsy and she’s been a nurse for 30 years. Your physician is an expert in this procedure and has 15 years experience doing the kind of work you’re here for. The director of medicine has 30 years of clinical experience. Thank you so much for choosing our hospital for your care.”

“This is the same malarkey I’d expect from a waiter in a restaurant,” said Gail Jehl, an RN at Sparrow Hospital in Lansing, Mich. “You’re not allowed to greet the patient the way you want. You’re not allowed to use your own words. It’s nuts.”

In some hospitals, nurses are required to do follow-up phone calls with patients – not to find out how patients are healing or if they have any questions about disease management, but to ask if they received excellent care and would recommend the hospital to their friends. Those conversations are scripted, too, and nurses report that they are told not to deviate from their lines, even when patients want to start a real discussion about a problem they encountered at the hospital.

Besides being told how to talk to patients and sounding fake, RNs also object to scripts for other reasons. For instance, Sandy Reding not only feels uncomfortable “boasting” about herself, but she knew it would cause patients to unfairly compare nurses.

“Our patients are separated by a curtain,” said the operating room RN, who works at Bakersfield Memorial Hospital in California and is a CNA/NNU board member. “I did my spiel: ‘Hi, I’m Sandy Reding, I’ll be your OR nurse today. I want to let you know that you’re in really good hands. I have 20 years of experience. I’m certified in the operating room, certified in pediatrics.’ I did the whole thing and was disgusted. But then I heard the patient in the next bed say, ‘I want that nurse.’ The nurse he had had only one year experience. I find it really distasteful to have to do it.”

On a practical level, rounding and scripting adds more busy work onto nurses’ already hectic shifts, and makes nurses choose between following management directives or attending to the clinical needs of their patients. Ironically, nurses have been making rounds on their patients since time immemorial to conduct patient assessments and familiarize themselves with their assignments. But RNs say this new type of rounding that management wants them to do is more about creating the illusion for patients that they’re receiving a lot of attention by focusing on superficial comforts — such as whether the patient would like his pillow fluffed or her trash can moved closer to the bed — rather than letting RNs prioritize for themselves the care they know they must deliver to keep patients safe and to heal better.

Most nurses are asked to round every hour, always ending the conversation with the line, “Is there anything else I can do for you? I have the time.” Many RNs particularly bristle at this closing sentence, because it’s simply not true and makes it more difficult focusing on their real clinical nursing work.

Some nurses are finding that the scripting and rounding orders can actually worsen relationships with patients and their families. Some patients have complained that nurses sound fake. And on one nurse’s pediatric floor, she and her fellow RNs were instructed to hand off care at the end of their shifts in person — even waking patients if need be. At morning shift change, parents who had just gotten crying babies to sleep were furious when their newborns woke up and started screaming again after nurses entered the room and started reciting their scripts.

The way rounding and scripting interfere with the nursing process and supersede nursing judgment is probably the most frustrating and enraging consequence of these programs. “This is like Stepford nurses,” said Jehl. “It really takes away from the independent practice of the nurse. Patient care should be based on outcomes, period.”

Nurses are finding that if they don’t comply with these programs, regardless of staffing, they could be counseled, reprimanded, or even worse. At Jehl’s hospital, managers stand right next to the RN or outside the door to make sure that RNs are completing all five parts of the “AIDET” program. Recently, Garza learned that all the mental health RNs will receive only 2.5 out of a possible 4 points on the patient satisfaction component of their performance evaluations “until their Press Ganey scores are above 50 percent.” He was incredulous that the hospital would unilaterally judge him and his RN coworkers based on how patients felt about their stay at the hospital.

“We have schizophrenic and psychotic patients,” said Garza. “Some are involuntarily placed there and held against their will. And you’re asking them to score you? It’s just ridiculous.”
Besides just being insulting and a waste of nurses’ time, McEwen is afraid that rounding and scripting programs are providing a smokescreen for the real problem: that hospitals are often dangerously understaffed.

“It’s unethical and immoral to divert money away from providing the care patients need by making nurses attend these customer service trainings,” said McEwen. “This market-driven focus on enhancing patients’ perceptions is just being used to help the employers hide a really disgusting, grim reality.”

In an ideal world, hospitals would schedule enough registered nurses to provide the clinical care patients need and the small niceties they deserve. But they don’t. Or they would hire enough assistive staff to help take patients to the bathroom or make sure their water pitchers were filled. But instead, they have laid off LVNs and nurses’ aides left and right.

No matter how many scripts management comes up with, say RNs, they can’t substitute for putting money into staffing and lower nurse-to-patient ratios.

“If they followed the laws with no mandatory overtime, with appropriate staffing, breaks and lunch times offered to nurses, they’d end up with naturally high patient satisfaction rates instead of trying these tactics to force the issue,” said Reding. The research backs up Reding’s perspective. A study in a 2004 issue of the journal Medical Care found that improvements in nurse work environments could increase patient satisfaction all on its own. Articles in the New England Journal of Medicine have pointed out that patients are generally more satisfied with hospital stays at facilities with higher ratios of nurses to patients. Even in the 1999 Baptist Hospital study, part of the overall improvement in patient satisfaction was an improvement in nurse satisfaction and reduced turnover.

While RNs say they certainly do care about whether patients and their families feel they are getting the attention they deserve, patients often do not see the big, complex picture of what’s happening on their nurse’s shift or on the unit. For example, McEwen recalled a nurse who had been assigned a patient just in from surgery. But that RN was also around the corner, gowned and gloved, taking care of her other patient who was in isolation. The family came in and, ignorant of the staffing situation, became worried when alarms started going off in the patient’s room.

“The manager talked to this nurse, called her in a couple days later and said, ‘The patient’s family is upset and they’ve complained that no one was watching and paying attention. Where were you, what were you doing? What can you do to prevent this from happening next time?’” recalled McEwen. “As a nurse rep, I said, how we make it better is by assigning enough nurses to meet the needs of the patients. A fresh post-op should be assigned one-on-one with a nurse so the nurse can provide ongoing assessments to prevent complications. By putting that nurse in with another patient around the corner, that nurse can’t provide continuous and direct observation.” McEwen proposed to the nurse that she document the assignment as unsafe because the hospital refused to provide adequate secretarial, technical, and nursing assistant staff to help.

“In our experience as nurses, when patients and their families perceive that there has been inattention to their concerns in the hospital — delays in answering a call, put on hold too long, delay in being allowed to visit, delay or cancellation of awaited procedures, alarms and red lights flashing at the bedside without immediate response by a nurse — this perception is valid,” said McEwen. But it’s a mistake to believe that the reason is because nurses need to be better trained in customer service. “It is most often a result of short staffing, which is a systemic problem.”

When new clinical restructuring initiatives are introduced that interfere with the nursing process, RNs have a duty to protect their practice by fighting back as patient advocates.

When the hospital where Deirdre Tremblay works, Merrimack Valley Hospital in Haverhill, Mass., instituted “Studer rounds” and “Studer scripts” during patient handoffs, the medical-surgical RN and her coworkers protested en masse. At first, when the RNs questioned and challenged the programs, hospital management told them, “Listen, this is the way it’s going to be and if you don’t like it, you can find a job somewhere else,” remembered Tremblay, who is also her unit’s nurse rep.

With the help of the Massachusetts Nurses Association, the RNs filed a group grievance. While they were not able to eliminate the programs entirely, management did agree that the programs would not lead to any punitive actions, such as discipline, threats of termination, or negative performance evaluations. While the RNs do try to check hourly on their patients, all the RNs have basically boycotted the script. “The Studer program is designed as if you work at a hotel,” said Tremblay. “They are more concerned with the cosmetic things than why the patient is actually there, which is for medical treatment.”

At Mercy General Hospital in Sacramento, Calif., where float RN Kathy Dennis works, the nurses several years ago successfully refused to participate in rounding and scripting. “I wouldn’t do it,” said Dennis, who then started encouraging coworkers throughout the hospital to stop filling out the hourly rounding record sheets. When nurses learned that not everyone was participating, they naturally quit, too. The program fizzled away after six months.

“I told my managers that I check on my patients as appropriate according to my professional nursing judgment,” said Dennis. “Checking a box does not make my patient safe.”

Tremblay added that nurses at Merrimack felt it was important, like it is with the disease process, to “nip these programs in the bud” before they escalated or spread. It’s solid advice for nurses at hospitals across the country, too. “They want to restructure the way nurses act,” said Tremblay. “They want us to be more like puppets than nurses. If nurses do not stand up and squash this now, I think it’s going to get worse.”

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