

PROFESSION



Ensuring that patients have a positive experience is important, but it's time-consuming to refuse inappropriate requests, says Aleksandra Zgierska, MD, PhD. "Then all the other patients waiting are dissatisfied. It's a vicious cycle." [Photo by David Stiluka / AP Images for American Medical News]

Patient satisfaction: When a doctor's judgment risks a poor rating

Patients sometimes demand inappropriate care. Saying no could lead to unhappy patients, bad survey scores and even financial penalties. Some doctors see an ethical conundrum.

By **KEVIN B. O'REILLY**, amednews staff. *Posted Nov. 26, 2012.*

Family physician and addiction medicine specialist Aleksandra Zgierska, MD, PhD, often treats patients referred to her by primary care colleagues concerned about their patients' growing reliance on opioid analgesics. Caring for these patients raises clinical questions that even the most skilled physicians have trouble answering.

But recently, Dr. Zgierska has considered another question as she wonders how to proceed with treatment: Will using her best medical judgment harm her patient-satisfaction rating?

"If I feel the patient is not an appropriate candidate for opioids, I should say no," she says. "But in the back of my mind, the question can arise, 'What will the patient do with that?' Especially since the No. 1 question on our patient-satisfaction survey is, 'Are you happy with the way the physician treated your pain?'"

This is not just a matter of receiving a lousy review on one of the many consumer rating websites that have become popular in recent years. More physicians, no matter their specialty or practice setting, are finding their care graded on patient-satisfaction surveys that are used to determine pay.

A daily dilemma

Several surveys are in use, but they typically ask about areas such as nursing care, staff friendliness, test results follow-up and waiting times. They also ask patients about how well physicians communicated and whether doctors listened to their concerns, answered questions and explained things clearly.

Patients who do not get what they expect — even if it is medically inappropriate — can feel as though their doctors did not listen. The response: bad ratings.

"This is my day-to-day conundrum," says Dr. Zgierska, assistant professor in the Dept. of Family Medicine at the University of Wisconsin School of Medicine and Public Health in Madison. "The challenge is how do we discuss this with the patient so the patient doesn't leave unhappy. ... Saying yes is easy. I know from firsthand experience that it's very tempting."

Dr. Zgierska is designing a study to examine the relationship between opioid prescribing and patient-satisfaction ratings. The ethical tension created by the challenge of trying to satisfy patients while refusing inappropriate care requests goes beyond the controversy over proper use of opioids, she and other physicians say. Any time patients request care that will not help — common examples are antibiotics for a cold or imaging for uncomplicated low-back pain — doctors are placed in an unenviable position.

Many doctors already have trouble turning down patient requests. For example, 36% of physicians told researchers they would

yield to a patient who asks for a clinically unwarranted magnetic resonance imaging exam, according to a Dec. 4, 2007, *Annals of Internal Medicine* study.

“For all that doctors carry on about science and professionalism, the fact of the matter is that we want to please our patients,” says Howard A. Brody, MD, PhD, a retired family physician who is director of the Institute for Medical Humanities at the University of Texas Medical Branch in Galveston. “And patients are likelier to appear to be pleased when we do something, rather than nothing.”

Paying for satisfaction

For Dr. Zgierska and a growing number of physicians, saying no could carry a price tag. The University of Wisconsin Medical Foundation, the clinical practice organization for UW faculty physicians, recently created a new compensation plan for its primary care doctors. They can receive a 5% increase in their base pay if they meet benchmarks on certain performance measures, including patient-satisfaction metrics.

UW is far from alone. Nearly two-thirds of hospitals, health systems and large physician groups have annual incentive plans for doctors, said an October 2011 report from the Hay Group, a Philadelphia-based management consulting firm. Sixty-two percent of those use patient-satisfaction metrics as a factor, up from 43% in 2010, said the survey of 182 health care organizations covering physicians in 144 medical specialties. Many set base pay lower and require doctors to meet performance metrics to earn hefty incentive pay.

“Bonuses of less than 5% don’t get anybody’s attention. Make it 5% or 10% or 15%, and that’s a sufficient financial opportunity to get your attention,” says Ron Seifert, vice president of the Hay Group. “We’re going to see more of this.”

Medicare also is paying for and publicly reporting on patient satisfaction. Starting in October, the Centers for Medicare & Medicaid Services is withholding 1% in pay to hospitals and using the money to provide incentives to those with the highest performance-measure scores. Patient-satisfaction metrics account for 30% of the score. The percentage of pay withheld will rise to 2% in 2017.

In the proposed 2013 Medicare physician fee schedule, CMS outlined plans to include patient-satisfaction survey results for group practices participating in the Physician Quality Reporting System on the Physician Compare website “no sooner than 2014.” Starting in 2013, physicians who do not report enough quality metrics to CMS will see a 1.5% Medicare pay cut in 2015, which will rise to 2% in 2016 and beyond.

The impact of unhappy patients

With physicians’ reputations and pay riding on patient-satisfaction surveys, some doctors say a few angry patients can skew the ratings.

William P. Sullivan, DO, directed a hospital emergency department in suburban Chicago for several years. The department scored an overall 86.3 out of 100 on patient-satisfaction scores, as measured on surveys conducted by Press-Ganey Associates in 2010. Comparable small EDs averaged an 86.6 score.

Despite the tight bunching of scores, Sullivan’s department fared worse than 58% of other EDs. A handful of bad grades seemed to make the difference, Dr. Sullivan argues. Only 4.1% of the 90 patients surveyed in a three-month period marked their care as poor or very poor.

Patients unhappy about not getting the care they wanted may have been among those handing out bad grades, Dr. Sullivan says. There is no way to know definitively, as most surveys are completed anonymously. There was one patient, for example, who asked Dr. Sullivan to write a note to excuse her from work because of an unsightly pimple on her nose. He asked the woman why she couldn’t work.

“Maybe I can’t work because I’ve been up all night crying about it,” the patient said. Dr. Sullivan refused the request, but he wonders whether she was among those who gave his department a poor rating.

“People get mad and you think, ‘Great. There goes another bad score,’ ” he says.

Press-Ganey tells hospitals to use at least 50 patient surveys for a small ED before judging its patient satisfaction compared with other EDs. The company says its research shows that unhappy patients are not likelier to complete patient-satisfaction surveys.

Perfect ratings not the goal

While patient-satisfaction surveys are inherently subjective, some experts argue that a small number of demanding patients should not make much of a dent on overall scores of individual doctors, clinics or hospitals.

“Don’t worry too much about that,” says Mark Friedberg, MD, a researcher at the Boston office of the nonprofit RAND Corp. who has helped develop patient-satisfaction surveys. “This is not about getting a perfect rating with all patients. It’s to compare you to other physicians and to other practices. Everybody’s going to have some patients who, when you give them the best care, won’t be satisfied with it.”

Yet other experts see a troubling link on the push for patient satisfaction, an unwillingness to say no to patients and greater health care utilization. A March 12 *Archives of Internal Medicine* study of more than 50,000 U.S. adults found that those giving the highest patient-satisfaction scores also were likelier to land in the hospital and rack up more health care spending than the least-satisfied patients. The most satisfied patients also had a 44% higher mortality rate, even after adjusting for illness severity, researchers found. The study has its critics. They argue that its lack of illness severity measurement produced a spurious association among higher patient satisfaction, more spending and worse outcomes. But the study’s lead author, Joshua J. Fenton,

MD, MPH, says the research raises key questions about how the drive to satisfy patients is shaping medical care.

“Our study suggests that these patient-satisfaction measures have a pretty strong correlation with utilization overall,” says Dr. Fenton, associate professor of family and community medicine at the University of California, Davis, School of Medicine. “It seems like we need to understand that association, and the reasons for that association, a little bit better. ... I think there’s a great deal of uncertainty about the extent to which patient experience measures are related to care quality.”

In September 2010, the American College of Emergency Physicians adopted policy that methodologically and statistically sound patient-satisfaction surveys “can be a valid measure of the patient’s perception of health care value.” ACEP said such tools should be based on a statistically valid sample size free of selection bias, and transparently administered and analyzed, adding that unvalidated survey tools should not be used for financial incentive programs.

The American Medical Association has policy saying that as a counterbalance to financial incentive programs focused solely on cost reduction, physicians should advocate for incentives based on care quality and patient satisfaction. The AMA also favors improved measurement of patient satisfaction efforts to document the relationship between satisfaction and favorable health outcomes.

Customer service vs. medical care

Physicians still face the challenge of meeting patients’ expectations while providing optimal care. Experts agree that saying no does not have to mean an unhappy patient. They say that listening with empathy to a patient’s concerns, reviewing options in an evenhanded, nonjudgmental way, emphasizing the undue risks of nonbeneficial interventions, asking the patient to defer a decision, and even sitting down with the patient — instead of standing — can help.

Dr. Fenton, at UC Davis, recently secured federal funding for a study to test if certain patient-centered counseling techniques can aid physicians in reducing inappropriate or unnecessary tests. He believes that with the right training, physicians can steer patients clear of inappropriate care. But doing so requires a professional commitment, one that the patient-satisfaction push may undermine.

“If you make the incentive too strong to satisfy patients, it might really alter the way you view your job,” Dr. Fenton says. “You start thinking of yourself less as a physician whose job it is to really partner with patients and dispense medical advice — whether it’s easy to explain or something the patients want to hear or not — and you start thinking of yourself as a service provider. That’s a very different role.

“We have some things to learn from customer service, the retail industry and so on,” he adds. “But in medicine, we’re more than just service providers.”

ADDITIONAL INFORMATION:

The sickest patients give the highest ratings

A study of more than 50,000 U.S. adults found that patients who grade their care the highest are likelier to have worse health outcomes and rack up more medical expenses than the least-satisfied patients, even after adjusting for factors such as age, income, illness severity and insurance coverage.

Increase in percentages of highest raters over least-satisfied patients

Mortality risk: 44%

Any inpatient admission: 12%

Prescription drug spending: 9%

Health care spending: 8%

Source: “The Cost of Satisfaction: A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality,” *Archives of Internal Medicine*, March 12 (archinte.jamanetwork.com/article.aspx?doi=10.1001/archinternmed.2011.1662)

9 cases when primary care doctors should just say no

Refusing patient demands for nonbeneficial tests or treatments could result in low patient satisfaction scores. According to lists compiled by medical specialty societies as part of the American Board of Internal Medicine Foundation’s Choosing Wisely initiative, there are some common clinical circumstances when saying no is the right thing to do:

- Don’t do imaging for low back pain within the first six weeks, unless red flags such as severe or progressive neurological deficits are present.
- Don’t routinely prescribe antibiotics for acute, mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement.
- Don’t obtain brain imaging studies in the evaluation of simple syncope where the neurological examination findings are normal.
- Don’t do imaging for uncomplicated headache.
- Don’t use dual-energy x-ray absorptiometry screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors.
- Don’t order annual electrocardiograms or any other cardiac screening for low-risk patients without symptoms.
- Don’t perform Pap smears on women who are younger than 21 or who have had a hysterectomy for noncancer disease.
- Don’t obtain imaging studies as the initial diagnostic test in patients with low pretest probability of venous thromboembolism. Obtain a high-sensitive D-dimer measurement instead.

RECOMMENDATIONS FROM RESEARCHERS:

- Don't recommend follow-up imaging for clinically inconsequential adnexal cysts.

Source: American Board of Internal Medicine Foundation; items come from lists provided by the American Academy of Family Physicians, American College of Physicians and American College of Radiology (choosingwisely.org/?page_id=13)

6 reasons to refuse patient requests

Saying no to patients can upset them, threaten the physician-patient relationship and contribute to lower patient-satisfaction ratings. Experts say there are important reasons why doctors should hold fast when appropriate.

- Patient autonomy is essential, but that tenet does not oblige physicians to grant any specific patient demand for a test, medication, treatment or procedure.
- The treatment request may be scientifically invalid, have no medical indication or offer no possible benefit to the patient.
- Patients' subjective judgments of their medical needs may be incorrect, or the result of anxiety or some other personal concern.
- Allowing patients' demands for unnecessary interventions to trump careful clinical reasoning can undermine clinical excellence.
- Granting inappropriate care requests could lead to patient harm, such as a delay in beneficial testing or treatment, inconvenience or out-of-pocket expenses.
- Interventions that are ineffective can be costly, contribute to higher taxes and insurance premiums, and strain scarce medical resources.

Sources: "Addressing Requests by Patients for Nonbeneficial Interventions," *The Journal of the American Medical Association*, Jan. 11; "Opinion 8.20 — Invalid Medical Treatment," American Medical Association Code of Medical Ethics, June 1998

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"Patient Satisfaction and Patient-Centered Care: Necessary but Not Equal," *The Journal of the American Medical Association*, July 11 (jama.jamanetwork.com/article.aspx?doi=10.1001/jama.2012.7381)

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