

VIEWPOINT

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Patient Satisfaction and Its Discontents

High patient satisfaction scores are increasingly used as a metric for physician reimbursement. But are they effective for assessing the quality of care?

It was no surprise that my palliative care team was asked to see Mr S. He was 71 years old and had been hospitalized 16 times in 2 years. He had multiple serious problems, including obesity hypoventilation syndrome, systolic heart failure, and severe functional impairment. In his medical record, there was no indication that he had completed a physician orders for life-sustaining treatment (POLST) or an advance directive or had any prior discussion about prognosis with any health care professional.

When I saw Mr S, he was short of breath and only able to speak in short sentences. He had plans—to begin a new business, to build model railroads, and to pay back debts. I asked about his understanding of his medical conditions. Although he could give me snippets of his problems—pneumonia, breathing problems—there was no indication that he had any ideas about “the big picture.” As I often do, I began by saying that some people would like to know their prognosis and other people would prefer not to know. He said emphatically “I am a straight shooter and don’t like any BS.” I reflected back to him that 16 hospitalizations in 2 years was an indication that his health status was tenuous and that he was likely to be dealing with a limited life expectancy, possibly a few years or less.

Mr S became furious. “You pulled the rug out from under me.” For 40 minutes, he vented about how insensitive I had been. “How could you do this to me?” he implored. Backtracking, I explained that prognostication is an imperfect science and that he had told me that he wanted the truth. A realistic idea of his prognosis would help him make better decisions. I tried to suggest to him that there was hope that he could spend time doing the things that he loved doing, including building his model trains. I left, somewhat shaken and questioning whether I had been sensitive enough.

In 1 study of elderly people, 65% said that they would want their physician to tell them if they had less than 5 years left to live.¹ I have these discussions almost every day, and they usually go well. I can usually determine, with appropriate opening questions, who is ready to hear bad news and who is not. Usually, once a patient states that he or she wants to know the prognosis, a difficult and productive conversation ensues, often replete with tears, hugs, and gratitude. But not always, and certainly not this time.

For Mr S, I called the chaplain and the cardiologist to tell them what had happened and to urge them to offer him a little support. The chaplain reported that Mr S was tearful and expressed regret about having borrowed a great deal of money that he was scared that he would not be able to repay. Later, Mr S com-

pleted a POLST and said that given his prognosis, he did not think he should undergo cardiopulmonary resuscitation. A few days later, he was discharged. Within the day, he was readmitted with respiratory distress. He died 6 weeks later.

Despite how upset my patient was, I still think that I did the right thing. Mr S said that he wanted to know the truth. The information that I gave him allowed him to make more informed decisions. However, he told anyone who would listen how insensitive I was. I do not know whether Mr S filled out a patient satisfaction survey about me, but if he did, I would guess that my ratings were low. Does that mean that I provided him with poor care? Should I get a pay cut because I am the physician at my institution who is most likely to have these types of discussions with patients?

Until recently, the organization for which I work dictated that for palliative care satisfaction surveys, patients who are discharged to hospice or to nursing homes (approximately 70% of our patients) or family members of patients who die in the hospital (approximately 10% of our patients) could not be surveyed. Therefore, we survey the minority of patients who are left, and they are disproportionately likely to be the unhappy ones. The methodology is clearly flawed, but I suspect that similar practices are not uncommon.

Increasingly, physician reimbursement is linked to patient satisfaction scores. Many colleagues and I worry that this linkage has made the delivery of bad news to our patients even more difficult—and it was plenty difficult to begin with. Physicians who deal with patients who are demented but continue to drive, or those with substance abuse or life-threatening illness or who request advertised (but often ineffective) treatments, know that doing the right thing can take time and make people angry.² We rely on physicians’ professionalism to ensure that the right things are being done, but it does not take much of a disincentive to defer a difficult conversation. A physician recently told me “I have figured this out. I no longer confront patients on their drug abuse or give them bad news because it will lower my satisfaction scores.” Who *would* want to give bad news under such circumstances? It is stressful, it takes extra time, people will dislike you as a result, and it will lower your income.

A consistent connection between patient satisfaction scores and high-quality care has not been established.³⁻⁶ In fact, there is evidence that higher patient satisfaction scores are associated with higher hospital admission rates, higher expenditures for medical care and prescription drugs, and increased mortality.⁷ Oncologists who are more optimistic—even if they give patients unrealistic information—are rated more highly than their more realistic colleagues.⁸ Although these associations should be explored in more detail, the avail-

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able evidence suggests that overemphasis on patient satisfaction scores may have unintended adverse effects.

Absent convincing evidence to justify the practice, there should be a moratorium on the linking of physician reimbursement to patient satisfaction scores. If this practice is to be continued, sound methodology for each specialty should be used. When a physician's patient satisfaction scores are calculated, it may be reasonable to include only certain types of "low stakes" encounters and to exclude encounters that are likely to be difficult. There may be better ways of evaluating difficult encounters, such as structured peer reviews with a checklist of desirable behaviors. Finally, it might be possible that patient satisfaction scores that are too high might in-

dicate that physicians are shirking their responsibilities for delivering bad news or failing to set limits on care that they know to be inappropriate or ineffective. Desirable satisfaction scores for physicians may be neither too high nor too low but somewhere in the middle.

In palliative care and other specialties, the use of patient satisfaction scores may create perverse incentives and worsen clinical outcomes. Physicians should not receive disincentives to talk with patients about difficult but important issues. If the quest for satisfied patients merely contributes to higher medical costs and poorer care, the profession has lost its way. This problem does not need to exist. Some thoughtful modifications to current practices would solve it.

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