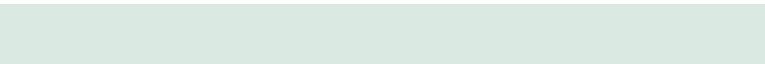




Patient-Satisfaction Surveys on a Scale of 0 to 10:

Improving Health Care, or Leading It Astray?



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Patient-satisfaction surveys can call attention to the importance of treating patients with dignity and respect, but good ratings depend more on manipulable patient perceptions than on good medicine. In fact, the pressure to get good ratings can lead to bad medicine.

While patient-satisfaction surveys have a valuable place in evaluating health care, “patient satisfaction” is a term that remains poorly defined. Moreover, the current institutional focus on patient satisfaction¹ could eventually compromise the quality of health care while simultaneously raising its cost. In this paper, we begin with an overview of the concept of patient satisfaction. Next, we trace the evolution of patient-satisfaction surveys, including both their useful and problematic aspects. We then describe the effects of patient-satisfaction surveys, the most troubling of which may be their influence on the behavior of health professionals. The pursuit of high patient-satisfaction scores may actually lead health professionals and institutions to practice bad medicine by honoring patient

requests for unnecessary and even harmful treatments. Patient satisfaction is important, especially when it is a response to being treated with dignity and respect. Nonetheless, some uses and consequences of patient-satisfaction surveys are problematic and may actively mislead health care.

Before we begin our discussion of patient-satisfaction surveys, we identify three different ways patients may be “satisfied.” First is the provision of medically necessary care that actually improves their outcomes. The second concerns interventions that patients or families want but that are medically unnecessary and may negatively affect health outcomes. The third category includes “humanistic” aspects of health care, such as good communication and treating patients with respect, as well as peripheral aspects of health care, such as convenient parking, designer hospital gowns, and architecturally impressive hospital lobbies. Aspects of health care that fall in this category are less likely to affect health outcomes but may certainly contribute to a sense of dignity and

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well-being. These distinctions will be important as we explore patient satisfaction and its implications.

What Exactly Is Patient Satisfaction, Anyway?

Patient satisfaction lacks a clear, agreed-upon definition. Although a number of theories about patient satisfaction have been proposed and tested, there is no established consensus.² For example, Susie Linder-Pelz defines patient satisfaction as “positive evaluations of distinct dimensions of health care,” such as “a single clinic visit, treatment throughout an illness episode, a particular health care setting or plan, or the health care system in general.”³ As reflections of this lack of consensus, patient-satisfaction questionnaires evaluate issues ranging from the communication skills of health care professionals to the cleanliness of hospitals, to the ease of parking or scheduling a clinic appointment.

As a term without an established definition, “patient satisfaction” is often confused or conflated with “patient-centered care” and “shared decision-making.” The Institute of Medicine defines patient-centered care as “care that is respectful of and representative to individual patient preferences, needs, and values ensuring that patient values guide all clinical decisions.”⁴ Shared decision-making is “an approach where clinicians and patients make decisions together using the best available evidence.”⁵ These terms are similar to patient satisfaction in that they each ascribe importance to patients’ views and opinions about their health care. Indeed, all three concepts may have originated from efforts to increase patient engagement in health care, thereby promoting patient compliance and positive health outcomes. However, patient-centered care and shared decision-making represent factors in the actual provision of health care, whereas patient satisfaction is an evaluation that follows the provision of health care. For example,

a physician practices patient-centered care when she considers the unique clinical needs and personal values of a patient in designing a treatment regimen for his hypertension. The physician and patient engage in shared decision-making when they collaborate to design his treatment regimen, together choosing an anti-hypertensive medication and deciding which lifestyle changes would be best for him. Patient-centered care and shared decision-making describe an interaction between a patient and a provider, while patient satisfaction describes the patient’s attitude after the interaction. The evolution of patient satisfaction into a consumer survey further distinguishes it from patient-centered care and shared decision-making. Unlike patient satisfaction, patient-centered care and shared decision-making have not yet been commercialized, marketed, and transformed into business concepts.

How patients evaluate their health care. It turns out that “patient satisfaction” means something different to everyone. Despite countless efforts to elucidate the manner in which patients assess their health care, the process remains poorly understood. As will be detailed later in this paper, patient satisfaction bears no clear relationship to the technical quality of health care—to “the extent to which the use of health care services meets predefined standards of acceptable or adequate care relative to need.”⁶ Rather, it relates to other, less objective qualities of health care. As Jessie L. Tucker and George M. Munchus conclude, “[P]atients define quality in terms of the non-technical, human dimensions of empathy, reliability, responsiveness, communication, and caring.”⁷ Tucker and Munchus found that these nontechnical factors accounted for 71 percent of the variation among patients’ evaluations, suggesting an “absence of any scientific basis of determination.”

Peter Johansson and colleagues demonstrated that patient satisfaction is influenced by patients’ expectations and sociodemographic

backgrounds as well as by providers’ communication, interpersonal skills, and medico-technical competence.⁸ Many authors have examined the role of patient expectations in patient satisfaction. David J. Owens and Claire Batchelor note that, “where levels of general satisfaction are high, patients’ expectations may be low or even non-existent.”⁹ Brian Williams, furthermore, suggests that patients are satisfied unless negative expectations are realized. He maintains, “[T]he expression of dis/satisfaction is governed primarily by (negative) expectations as to what will/should not happen.”¹⁰ Other evidence suggests that social aspects of the relationship between the patient and provider shape patient satisfaction. “[H]igh levels of satisfaction can be explained,” according to one study, “in part by the relationship of dependency and friendship between patient and nurse.”¹¹ Sara Bleich and colleagues found that patient satisfaction with health systems depends less on patients’ health care experiences than on other factors, such as expectations, health status, and personality. In their study, patient satisfaction varied widely across countries despite similarities among the health systems, suggesting the influence of “broader societal factors.”¹² Indeed, whether a patient is satisfied may depend as much on subjective factors unique to the individual patient as on his or her health care.

Where Did the Patient-Satisfaction Survey Come From?

A health care concept, commercialized. Patient satisfaction originated as a health care concept. Researchers hypothesized that more satisfied patients demonstrate better commitment to and compliance with recommended treatments.¹³ Patient satisfaction became associated with measures such as “appointment keeping,” “behavioral intentions to comply with recommended treatment,” and “medication use”—all worthy

objectives of health care.¹⁴ The relationship between patient satisfaction and compliance led providers to consider patient satisfaction instrumental in optimizing health care outcomes. As Williams explains, “[S]ince high quality health outcome is dependent on compliance which, in turn, is dependent on patient satisfaction, the latter has come to be seen as a prerequisite of quality care. Consequently, this helped legitimize the importance of the patient’s perspective among health care professionals who are primarily concerned with clinical outcome.”¹⁵ Yet consumerist influences and commercialization transformed patient satisfaction. The consumer movement, which declared the centrality of the consumer and consumer opinion, elevated patient satisfaction to, as Williams puts it, “a legitimate and desired outcome in itself, not solely a means of improving compliance.” However, making patient satisfaction an independent goal arguably made it ripe for commercialization. Companies founded on the mission to “improve the patient experience,” such as Press Ganey, developed patient-satisfaction surveys.¹⁶ As the number of patient-satisfaction surveys multiplied, companies began to track patient-satisfaction scores and advise hospitals on how to improve them.¹⁷ Thus, patient satisfaction and the creation of patient-satisfaction surveys entered the commercial marketplace and became a profit-making business.

Today’s patient-satisfaction surveys. The interest in measuring and tracking patient satisfaction born in the business world ultimately spread to the federal government. In 2002, the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) together developed the Hospital Consumer Assessment of Healthcare Providers and Systems survey, a twenty-seven-item questionnaire given to a group of randomly selected hospital patients after discharge.¹⁸ As a result of various legislative measures adopted since

its inception, the HCAHPS survey currently enjoys widespread use and carries substantial weight at most hospitals.¹⁹ For example, the Deficit Reduction Act of 2005 established “pay for reporting,” requiring hospitals to submit their HCAHPS data in order to receive their full reimbursements.²⁰ Moreover, CMS instituted public reporting of HCAHPS results in 2008, making HCAHPS scores available for all to view and compare.²¹ The Patient Protection and Affordable Care Act (PPACA) increases the weight placed on HCAHPS scores by using the results as a factor in its hospital value-based purchasing program.²² Thus, the results of patient-satisfaction surveys, such as HCAHPS, ultimately came to affect hospitals’ financial bottom lines. Assessing patient satisfaction thus evolved into a business

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practice constructed to please and attract consumers and reinforced by the federal government via financial carrots and sticks for hospitals.

Presently, a broad array of patient-satisfaction surveys exists. Companies focused on evaluating patient satisfaction, such as Press Ganey, continue to appeal to hospitals’ financial interests, promising increased profits through improved patient-satisfaction scores and the increased patient volume and federal rewards that might follow. For example, the Press Ganey website advertises the company as “the industry’s most recognized leader in improving the patient experience by delivering patient-centered care, and improving bottom-line results.”²³ Moreover, a variety of CAHPS surveys have developed based on the original HCAHPS survey. These include the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) survey, the Medicare

In-Center Hemodialysis survey, and the Home Health Care Survey, among others.

What’s Valuable about Patient-Satisfaction Surveys, and What’s Still Missing?

Despite the vagaries inherent in the concept of patient satisfaction and the manner in which patients evaluate their health care, patient satisfaction is not unimportant. Hannu Vuori cites philosophical, ideological, and ethical reasons for the importance of patient satisfaction. “[P]atients should have the right to influence the decisions and activities influencing them,” he argues, and “the measurement of patient satisfaction realizes the principle of community participation in health care.”²⁴

Moreover, patient-satisfaction surveys can address attributes of health care that promote, and are sometimes essential to, its quality. Valuable patient-satisfaction measures assess not only the humanism and communication skills of health professionals but also threats to patient safety and confidentiality.

Humanism. Patient-satisfaction surveys often address the humanism of health professionals, touching on qualities such as caring, compassion, and concern. Some survey items simply measure whether health professionals display basic human decency toward their patients. The HCAHPS survey asks, for example, “[H]ow often did doctors treat you with courtesy and respect?” and the CGCAHPS survey asks, “[H]ow often did this provider show respect for what you had to say?”²⁵ Furthermore, CGCAHPS supplemental items assess whether health professionals

“used a condescending, sarcastic, or rude tone with patient” and “showed interest in the patient’s questions or concerns.”²⁶ Other patient-satisfaction survey items assess whether health professionals treat patients in a gentle, caring manner. The Medicare In-Center Hemodialysis survey asks, “[H]ow often did dialysis center staff insert your needles with as little pain as possible?” and the Home Health Care CAHPS survey asks, “[H]ow often did home health providers from this agency treat you as gently as possible?”²⁷ Sometimes, patient-satisfaction survey items go beyond evaluating the behaviors of health professionals: they attempt to evaluate the level of concern and compassion that underlies these behaviors. The Medicare In-Center Hemodialysis survey contains the following questions: “[H]as anyone on the dialysis center staff asked you about how your kidney disease affects other parts of your life?” and “[H]ow often did you feel your kidney doctors really cared about you as a person?”²⁸

Communication. Good communication is important in two ways. First, it is a key element of humanism and respect for persons. Second, communication skills are critical to the success of care-planning and to decisions about most clinical interventions. For example, both shared decision-making and patient-centered care rely on a health professional’s ability to listen to and talk with patients in an effective manner. It is common for patient-satisfaction survey items to assess the manner in which health professionals listen and explain information to patients. For example, the HCAHPS survey asks, “[H]ow often did doctors listen carefully to you?” and, “[H]ow often did doctors explain things in a way you could understand?”²⁹ Sometimes, patient-satisfaction surveys address more specific aspects of communication skills. Supplemental items of the CGCAHPS survey examine whether health professionals “talked too fast” or “used medical words the patient did not understand.”³⁰ Other

patient-satisfaction survey items assess whether the health professional gave the patient the time and opportunity to speak via questions such as, “[H]ow often did this provider spend enough time with you?”³¹

Patient safety and confidentiality. Patient-satisfaction surveys also address patient safety and confidentiality—matters that can carry significant and possibly devastating consequences for patients. Needless to say, poor knowledge about medications can be dangerous. Patient-satisfaction survey items often assess whether health professionals communicate important information about the indications and side effects of new medications. The HCAHPS survey asks, “[H]ow often did hospital staff tell you what the medicine was for?” and, “[H]ow often did hospital staff describe possible side effects in a way you could understand?”³² Some patient-satisfaction surveys also assess whether health professionals tell patients what to do in case of an emergency. For example, the Medicare In-Center Hemodialysis survey asks, “[H]as dialysis center staff told you what to do if you experience a health problem at home?” and, “[H]as any dialysis center staff ever told you how to get off the machine if there is an emergency at the center?”³³ The HCAHPS survey is also intended to determine whether health professionals consider patients’ safety after discharge and inform patients about new symptoms that might require medical attention.³⁴ Finally, some patient-satisfaction survey items assess whether health professionals maintain the confidentiality of patient information. For example, the Medicare In-Center Hemodialysis Survey asks, “[D]id dialysis center staff keep information about you and your health as private as possible from other patients?”³⁵

What’s still missing from patient-satisfaction surveys. Despite some positive attributes, many critical aspects of health care are still missing from patient-satisfaction surveys. Patient-satisfaction surveys generally do not address hospital-acquired

infections, surgical complications, readmission rates, and death rates. Medicare tracks these outcome measures and even publishes the results for patients to view and compare hospitals.³⁶ Thus, one must wonder why patient-satisfaction surveys do not address them. Patients are certainly able to appreciate whether they acquire infections or experience complications during a hospital stay. Survey items that address these issues could certainly reflect patient satisfaction, especially if patients knew their hospital’s infection and complication rates.

Should Patient-Satisfaction Surveys Be Used to Measure Health Care Quality?

It is increasingly common for patient-satisfaction surveys to be used as an indicator of health care quality, and patient-satisfaction scores are also being used to determine individual provider pay. In a recent survey, 59 percent of physicians reported that their pay is linked to patient-satisfaction ratings.³⁷ Some patient-satisfaction survey items ask patients to evaluate the technical quality of their health care. A survey for primary care settings asks patients to assess whether the provider “gives you good advice and treatment.”³⁸ Moreover, patient-satisfaction surveys regularly ask patients to “rate” their health professionals and hospitals. The HCAHPS survey contains the following question: “Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?”³⁹ The CGCAHPS survey contains a similar version of this question that asks patients to rate doctors on a scale ranging from the “worst doctor possible” to the “best doctor possible.”⁴⁰ Such survey items not only presume that patients are able to assess the technical quality of health care; they also conflate health care quality with patient satisfaction.

Patient satisfaction and health care quality. The relationship between patient satisfaction and health care quality is unclear. Like patient satisfaction, health care “quality” is difficult to define. According to Avedis Donabedian, “[T]he definition of quality may be almost anything anyone wishes it to be, although it is, ordinarily, a reflection of values and goals current in the medical care system and in the larger society of which it is a part.”⁴¹ As such, quality may encompass many different aspects of health care, such as provider communication, facility cleanliness, and technical aspects of health care. Donabedian describes “the goodness of technical care” as “proportional to its expected ability to achieve those improvements in health status that the current science and technology of health care have made possible.”⁴² Technical quality of health care may be reflected in lower rates of infection and mortality, in surgical success, and in improved functionality. For decades, authors have asserted the importance of patient satisfaction to health care quality while acknowledging the ambiguity of this relationship. As Vuori holds, “[P]atient satisfaction is part and parcel of quality health care” and “should be taken seriously although we do not know whether its measurement improves the quality of care.”⁴³

Adding further to this unclear relationship between patient satisfaction and health care quality is a lack of evidence that the publication of patient-satisfaction data improves health care quality. Although studies have suggested that the publication of these data may prompt hospitals to engage in quality-improvement initiatives, such initiatives do not always yield quality improvements.⁴⁴ The failure of these initiatives to support a relationship between patient satisfaction and health care quality also calls into question one of the purported uses of patient-satisfaction data—the promotion of health care quality.

The relationship between patient satisfaction and the technical quality

of health care may be even less clear. Patients are able to appreciate some technical health care outcomes. Patients can recognize whether a broken leg heals, whether pain subsides, and whether a cancer does not recur. But most health care interventions address chronic illnesses and complex problems where success and failure are rarely so dramatic and obvious. Overall, patients demonstrate poor ability to evaluate the technical aspects of their health care. According to a recent study, the “technical quality of care was not significantly associated with global rating of care.”⁴⁵ To cite a common explanation for this finding, “[P]atients did not go to medical school.”⁴⁶ Because so much of the practice of medicine is still not evidence-based, even physicians may be poor judges of the technical qual-

Many hospitals “teach to the test” in an effort to manipulate patient responses. The standardized questions and measures allow hospitals to design interventions specifically to improve their scores by shaping patient perceptions.

ity of care they provide. Moreover, patients’ health status and patient-provider interactions may influence patients’ perceptions and assessments of the technical quality of their health care.⁴⁷

Sick patients versus “cool-headed consumers.” The nature of the patient-physician relationship adds another layer of complexity to assessing patient satisfaction. Talcott Parsons called attention to the asymmetry of the patient-physician relationship, given the physician’s expert health knowledge and fiduciary responsibility to care for the patient. Needless to say, the patient-physician relationship is not egalitarian. It is “comparable to the relation of teacher and student in higher education.”⁴⁸ The patient plays an institutionalized “sick role” comprised of three factors: patients are not responsible for their

condition, patients are exempt from usual social obligations, and patients are expected to seek and comply with the advice of physicians. Over the past few decades, the Parsonian model, which is basically paternalistic, has been modified by notions of patient autonomy and shared decision-making. More recently, a business model in which patients are regarded and spoken of as consumers has come to the forefront. Patient-satisfaction surveys very much approach the patient as a consumer.

The role of the consumer hinges on three very different notions: a consumer opinion exists, the consumer feels that his or her opinion is legitimate, and the consumer is willing to express an opinion.⁴⁹ Williams emphasizes the dichotomy between the “sick role” and the consumer

role, stating, “[C]onsumerism is dependent on a refusal to accept paternalism; it relies on the existence of consumers and not passive patients. Consequently, satisfaction data can only be useful if patients leave passivity and Parsonian roles behind and actively evaluate and criticize.”⁵⁰

Thus, for patient-satisfaction surveys to be valid and useful, eliciting meaningful patient-satisfaction data, a patient is required to step out of the “sick role” and assume the role of a “cool-headed consumer.” While the notion of a “cool-headed consumer” is appealing from a market-driven libertarian point of view, most patients are far from this ideal. Rather, they are vulnerable individuals seeking physician expertise and care. In this position, patients and families may trust that excellent technical care will be provided to them and be more

sensitive to other care factors such as institutional ambience, friendliness, and other more easily evaluated, humanistic factors. Feelings of helplessness may even cause patients to believe their technical care is better than it actually is, simply because someone they trust is trying to help them.

What Do Patient-Satisfaction Surveys Really Assess?

Patient perceptions. Many patient-satisfaction survey items focus on measures that bear little relationship to the health care provided, let alone indicate its quality. The HCAHPS survey asks, “[H]ow often were your room and bathroom kept clean?” and, “[H]ow often was the area around your room quiet at night?”⁵¹ The CGCAHPS Adult Primary Care Questionnaire asks, “[H]ow often were clerks and receptionists at this doctor’s office as helpful as you thought they should be?”⁵² When survey items pertain to the health care, they assess only the patient’s perception of it. The Home Health Care CAHPS survey asks, “[H]ow often did home health providers from this agency seem [emphasis added] informed and up-to-date about all the care or treatment you got at home?”⁵³ But how can patients possibly know how informed their health care providers are?

More troubling is the evidence that hospitals, motivated by financial concerns, engage in efforts to manipulate patient assessments in order to increase their patient-satisfaction scores. As stated earlier, hospitals have a definite financial interest in performing well on patient-satisfaction surveys such as HCAHPS. The value-based purchasing program directly ties a hospital’s HCAHPS scores to its Medicare reimbursements.⁵⁴ Additionally, however, HCAHPS data are made publically available for all established and potential patients to view. Such data, if positive, can attract new patients. An increase in patients translates into increased

revenues and profitability. James Merlino and Ananth Raman’s description of one hospital’s successful mission to “improve” patient satisfaction further suggests that a hospital’s desire to attract patients and thereby increase its revenues may be the motivating force behind its efforts to improve patient-satisfaction scores.⁵⁵ Despite its reputation for “medical excellence,” this hospital long suffered from poor HCAHPS patient-satisfaction scores. Yet the hospital did not decide to address these low scores until 2008, when HCAHPS data became available for all present and potential patients to view. The CEO “realized that he couldn’t count on medical excellence to continue attracting patients—for many people choosing a hospital, the anticipated patient experience trumped medical excellence.” Poor HCAHPS patient-satisfaction scores equate with a negative “anticipated patient experience.” That the hospital in question chose to address its low patient-satisfaction scores only when HCAHPS data became publically available may be coincidental but more likely speaks to the data’s importance to attracting patients and, ultimately, to helping the hospital’s financial bottom line.

Teaching to the test. To achieve high patient-satisfaction scores, however, many hospitals “teach to the test” in an effort to manipulate patient responses. The standardized HCAHPS questions and measures allow hospitals to design interventions specifically to improve their scores by shaping patient perceptions. For example, as one nurse describes, “[I]t’s no longer enough to turn out the lights and close the door so patients can have an environment conducive to a good night’s sleep. Now nurses must add the phrase, ‘I am closing the door and turning out the lights to keep the hospital quiet at night,’ so patients have a mental cue implanted when they encounter a related HCAHPS question.”⁵⁶ Indeed, studies support that communication and other interpersonal skills assessed by the HCAHPS survey can

be taught in a manner to increase patient-satisfaction survey scores.⁵⁷

“Teaching to the test” is arguably manipulative, but it is nevertheless effective in increasing these scores. After the hospital discussed earlier required all employees to undergo “caregiver” training, the institution’s scores increased by 26 percentiles, reaching the 92nd percentile by 2012.⁵⁸ However, such “teaching to the test” raises the question of whether higher HCAHPS scores truly represent higher patient satisfaction. A hospital that achieves higher “quiet at night” HCAHPS scores may not be more quiet at night, but instead better at implanting mental cues that create such a perception among patients. Alternatively, training may have led staff members to actually be more receptive and helpful to patients, for example, in finding their way if they are lost.

Patient-dependent standards. At times, patient-satisfaction survey results may say more about the patients than the providers. For example, supplemental items of the CGCAHPS survey assess whether the “patient could tell [the] provider anything,” the “patient always told the truth about health,” and the “patient could trust the provider with medical care.”⁵⁹ Clearly, it is important that patients feel that they can tell their health professionals “anything” and can trust their health providers. Yet given the wide variability of comfort levels, truthfulness, and trust among individuals, these measures may say more about the individual patients than their health care. For example, a patient with alcoholism may not feel that he can “tell the provider anything” about his drinking habits, and a patient who has been the victim of medical malpractice may not feel that he can “trust the provider with medical care.” These measures, though important, may be out of place in patient-satisfaction surveys.

Other patient-satisfaction survey items may hold health providers to impossible standards. For example, a CGCAHPS supplemental item

assesses whether the provider “cared as much as the patient” about the patient’s health.⁶⁰ Providers should care about the health of their patients. But asking providers to care as much as the patient may be unrealistic and even undesirable.

How Do Patient-Satisfaction Surveys Influence Health Care Professionals?

Providing unnecessary, inappropriate care. An emphasis on patient satisfaction as an indicator of health care quality may lead to an excessive emphasis on patients’ perspectives and wishes. For example, the CAHPS Survey for accountable care organizations asks, “[D]id this provider ask what you thought was best for you?”⁶¹ A supplemental item on the CGCAHPS survey similarly addresses whether the provider asked “what you thought was best for you.”⁶² Certainly, eliciting the patient’s perspective is essential to shared decision-making and important to health care quality, yet placing such an emphasis on the patient perspective risks giving patient-satisfaction surveys the power to pressure providers to “satisfy” their patients at all costs.

Moreover, an emphasis on patient satisfaction as an indicator of health care quality may drive health professionals to cater to patient wishes, prescribing unnecessary treatment at a patient’s request. Aleksandra Zgierska describes the pressures on physicians to fulfill the requests of opiate-seeking patients for unnecessary, and possibly harmful, pain medications. As Zgierska explains, “[P]hysicians who comply with unreasonable requests may find themselves in the role of ‘customer service’ providers rather than medical professionals or healers; physicians who do not comply with patient requests may be the recipient of poor ratings on patient-satisfaction scores, possibly resulting in emotional, financial, and professional penalties.”⁶³ Should a physician refuse an unreasonable patient request, the patient may become angry. And despite

the physician’s efforts to explain the reasons for her refusal, the patient may feel like a recipient of standard care and leave dissatisfied.

Evidence suggests that patient-satisfaction surveys do indeed pressure providers to administer inappropriate care. A recent study revealed the powerful effect of patient-satisfaction ratings on physicians’ treatment decisions. Of the physicians surveyed, 48.1 percent “always” or “often” practiced inappropriate clinical care due to patient-satisfaction surveys.⁶⁴ Fifty-five percent had ordered inappropriate tests, 51.1 percent had prescribed inappropriate antibiotics, 48.1 percent had prescribed inappropriate narcotics, 17.6 percent had performed inappropriate procedures, and 33.6 percent had inappropriately admitted patients to the hospital. These data suggest that patient-satisfaction surveys place very real pres-

sure on physicians, often leading to care that is unnecessary and possibly harmful.

Pressure to tell patients what they want to hear and to accede to unreasonable patient requests may increase the provision of unnecessary care, diminish health care resources, and undermine the professionalism and morale of physicians.

sure on physicians, often leading to care that is unnecessary and possibly harmful.

Telling patients what they want to hear. Providers sometimes must deliver bad news. Patient-satisfaction surveys may encourage health care providers to tell patients what they want to hear, holding back important information. A recent study by Jane C. Weeks and colleagues suggests that the threat of low patient-satisfaction scores may lead providers to permit, or even encourage, false beliefs among their patients. In the study, cancer patients who harbored overly optimistic beliefs that they would be cured by chemotherapy gave their physicians’ “communication skills” more favorable ratings.⁶⁵ This finding is counterintuitive, as

can be difficult for patients, as well as physicians. The discomfort associated with these topics may lead some patients to give lower ratings to physicians who bring them up.

better physician communication should facilitate better understanding and more accurate beliefs among patients. To the contrary, the finding suggests that patients perceive physicians more negatively when they deliver bad news, no matter how sensitively and honestly. Given this, physicians who strive to satisfy their patients may be tempted to withhold information or to spin a prognosis favorably. It is indeed plausible that some physicians would go so far as to promote false hope in an effort to improve their patient-satisfaction scores. Physicians might also avoid discussion of some important topics that tend to be unpleasant. Conversations about end-of-life care such as do-not-resuscitate orders, advance directives, and the possibility of hospice are critical to ensuring that patients receive the kind of care they want in the future. Yet such conversations

Indeed, the very nature of health care (not to mention some of the best health care) may involve physical, mental, or emotional discomfort. A provider who recommends a behavior change to a patient may risk a poor evaluation simply because “behavior change often requires an individual to feel uncomfortable with his or her current behavior.”⁶⁶ As few people like to be told bad news or made uncomfortable, certain situations are bound to leave some patients dissatisfied and some providers with low patient-satisfaction scores.

How Might Patient-Satisfaction Surveys Impact the Future of Health Care?

Decreasing health care quality, increasing health care costs. It's reasonable to predict that telling patients what they want to hear and acceding to unreasonable patient requests for unnecessary care may each lead to lower health care quality and higher health care costs. False beliefs or misinformation from physicians renders patients less able to make beneficial health care decisions. Patients who harbor false optimism about the likelihood that chemotherapy will cure their cancer, for example, may make an ill-informed decision to undergo it. In subjecting themselves to ill-informed treatment, patients are more likely to suffer risks than enjoy benefits. The seemingly benign administration of unnecessary antibiotics exposes patients to the unnecessary risk of side effects and contributes to antibiotic resistance. Prescribing unnecessary opiates poses only risks, such as drug addiction. As patients suffer complications and side effects without enjoying any benefits, health care costs will rise. The provision of unnecessary care is also a waste of health care dollars and limited resources. Not only is providing unnecessary care wasteful in itself, but there is also the collateral expense of treating the complications and side effects that might follow. Indeed, evidence supports a direct relationship between patient-satisfaction results and health care costs. A recent study by Joshua J. Fenton et al. found that higher patient-satisfaction results are associated with more inpatient admissions, increased prescription costs, and higher overall health care costs.⁶⁷

Undermining efforts to reform the health care system. The tension and incongruity between patient satisfaction and the provision of quality, affordable care for all may compromise the success of efforts to reform the U.S. health care system. The PPACA seeks to promote "quality, affordable health care for all Americans."⁶⁸ It also

increases the importance placed on patient-satisfaction scores. The PPACA requires that HCAHPS scores be used to calculate value-based incentive payments to hospitals.⁶⁹ However, the PPACA also strives to hold down health care costs by eliminating unnecessary care. Indeed, official government websites state that the PPACA "focuses on driving a smarter health care system focused on the quality, not quantity of care."⁷⁰ It is questionable whether the PPACA's emphasis on patient satisfaction will permit the achievement of such cost-cutting goals. Simply put, promoting health care affordability may require the elimination of wanted but unnecessary care, which may decrease patient-satisfaction scores.

In short, by posing risks that extend beyond exam rooms and hospitals, patient-satisfaction surveys may have unintended effects. Patient satisfaction is an important, valuable element of good health care, yet some uses and consequences of patient-satisfaction surveys may be problematic. Pressure to tell patients what they want to hear and accede to unreasonable patient requests may increase the provision of unnecessary care, diminish health care resources, and undermine the professionalism and morale of physicians. Ultimately, patient-satisfaction surveys may lead health care astray, undermining the provision of optimum care for all.

Notes

1. B. Williams, "Patient Satisfaction: A Valid Concept?," *Social Science and Medicine* 38, no. 4 (1994): 509-16; M. P. Manary et al., "The Patient Experience and Health Outcomes," *New England Journal of Medicine* 368 (2013): 201-03; A. Zgierska, D. Rabago, and M. M. Miller, "Impact of Patient Satisfaction Ratings on Physicians and Clinical Care," *Journal of Patient Preference and Adherence* 8 (2014): 437-46.
2. Williams, "Patient Satisfaction."
3. S. U. Linder-Pelz, "Toward a Theory of Patient Satisfaction," *Social Science and Medicine* 16, no. 5 (1982): 577-82, at 578.
4. Institute of Medicine, Committee on Health Care Quality in America, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, D.C.: National Academies Press, 2001).
5. G. Elwyn et al., "Implementing Shared Decision Making in the NHS," *BMJ* 341 (2010): 971-75, at 971.
6. J. T. Chang et al., "Patients' Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care," *Annals of Internal Medicine* 144, no. 9 (2006): 665-72, at 665.
7. J. L. Tucker and G. M. Munchus, "The Predictors of Quality Care," *Military Medicine* 163, no. 11 (1998): 754-57, at 756.
8. P. Johansson, M. Oléni, and B. Fridlund, "Patient Satisfaction with Nursing Care in the Context of Health Care: A Literature Study," *Scandinavian Journal of Caring Sciences* 16, no. 4 (2002): 337-44.
9. D. J. Owens and C. Batchelor, "Patient Satisfaction and the Elderly," *Social Science and Medicine* 42, no. 11 (1996): 1483-91, at 1489.
10. Williams, "Patient Satisfaction," 514.
11. Owens et al., "Patient Satisfaction and the Elderly," 1489.
12. S. N. Bleich, E. Ozaltin, and C. K. Murray, "How Does Satisfaction with the Health-Care System Relate to Patient Experience?," *Bulletin of the World Health Organization* 87, no. 4 (2009): 271-78.
13. G. C. Pascoe, "Patient Satisfaction in Primary Health Care: A Literature Review and Analysis," *Evaluation and Program Planning* 6, nos. 3-4 (1983): 185-210.
14. Williams, "Patient Satisfaction," 570.
15. *Ibid.*, 510.
16. Press Ganey, "Press Ganey: Our Mission," 2015, accessed February 18, 2015, <http://www.pressganey.com/aboutUs/ourMission.aspx>.
17. R. B. Siegrist Jr., "Patient Satisfaction: History, Myths, and Misperceptions," *Virtual Mentor* 15, no. 11 (2013): 982-87.
18. Centers for Medicare & Medicaid Services, "Patients' Perspectives of Care Survey," last updated September 25, 2014, accessed February 18, 2015, at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html>.
19. *Ibid.*
20. *Ibid.*
21. *Ibid.*
22. *Ibid.*
23. Press Ganey, "Inpatient Insights: Improved Quality, Increased Loyalty, Greater Profitability," accessed April 9, 2014, at <http://www.pressganey.com/ourSolutions/patient-voice/census-based-surveying/inpatient.aspx>.
24. H. Vuori, "Patient Satisfaction—Does It Matter?," *Quality Assurance in Health Care* 3, no. 3 (1991): 183-89, at 183.
25. Hospital Consumer Assessment of Health Care Providers and Systems, "HCAHPS Survey," accessed March 15, 2014, <http://www.heahpsonline.org/files/>

- HCAHPS%20V9.0%20Appendix%20A%20-%20Mail%20Survey%20Materials%20(English)%20March%202014.pdf; Consumer Assessment of Health Providers and Systems, “CAHPS Clinician and Group Surveys: 12-Month Survey 2.0,” September 2011, at https://cahps.ahrq.gov/surveys-guidance/docs/1351a_Adult-12mo_Eng_20.pdf.
26. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, “About the CAHPS Cultural Competence Item Set,” updated May 1, 2012, accessed February 18, 2015, at https://cahps.ahrq.gov/surveys-guidance/docs/2312_about_cultural_comp.pdf.
27. In-Center Hemodialysis CAHPS Survey, “Medicare In-Center Hemodialysis Survey,” updated January 19, 2015, accessed February 26, 2015 <https://ichcahps.org/SurveyandProtocols/SurveyMaterials.aspx#catid2>; Home Health Care CAHPS Survey, “Home Health Care CAHPS Survey,” 2013, at <https://homehealthcahps.org/SurveyandProtocols/SurveyMaterials.aspx#catid2>.
28. In-Center Hemodialysis CAHPS Survey, “Medicare In-Center Hemodialysis Survey.”
29. Hospital Consumer Assessment of Health Care Providers and Systems, “HCAHPS Survey.”
30. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, “About the CAHPS Cultural Competence Item Set,” May 2012, at https://cahps.ahrq.gov/surveys-guidance/docs/2312_about_cultural_comp.pdf.
31. Consumer Assessment of Health Providers and Systems, “CAHPS Clinician and Group Surveys: 12-Month Survey 2.0,” accessed February 18, 2015, <https://cahps.ahrq.gov/surveys-guidance/cg/instructions/12monthsurvey.html>.
32. Hospital Consumer Assessment of Health Care Providers and Systems, “HCAHPS Survey.”
33. In-Center Hemodialysis CAHPS Survey, “Medicare In-Center Hemodialysis Survey.”
34. Hospital Consumer Assessment of Health Care Providers and Systems, “HCAHPS Survey.”
35. In-Center Hemodialysis CAHPS Survey, “Medicare In-Center Hemodialysis Survey.”
36. Data.Medicare.Gov, “Official Hospital Compare Data,” at <https://data.medicare.gov/data/hospital-compare>, accessed February 17, 2015.
37. Zgierska et al., “Impact of Patient Satisfaction Ratings on Physicians and Clinical Care.”
38. U.S. Department of Health and Human Services, Bureau of Primary Health care, “Patient Satisfaction Survey,” at <http://bphc.hrsa.gov/policiesregulations/performance/measurements/patientsurvey/surveyform.html>.
39. Hospital Consumer Assessment of Health Care Providers and Systems, “HCAHPS Survey.”
40. Consumer Assessment of Health Providers and Systems, “CAHPS Clinician and Group Surveys: 12-Month Survey 2.0.”
41. A. Donabedian, “Evaluating the Quality of Medical Care” (originally published 1966), *Milbank Quarterly* 83, no. 4 (2005): 691-729, at 692.
42. A. Donabedian, “The Quality of Care: How Can it be Assessed?,” *Journal of the American Medical Association* 260 (1988): 1743-48, at 1743.
43. H. Vuori, “Patient Satisfaction—An Attribute or Indicator of the Quality of Care?,” *Quality Review Bulletin* 13, no. 3 (1987): 106-8, at 106; Vuori, “Patient Satisfaction—Does It Matter?”
44. C. H. Fung et al., “Systematic Review: The Evidence That Publishing Patient Care Performance Data Improves Quality of Care,” *Annals of Internal Medicine* 148, no. 2 (2008): 111-23; N. A. Ketelaar et al., “Public Release of Performance Data in Changing the Behaviour of Healthcare Consumers, Professionals or Organisations,” *Cochrane Database of Systematic Reviews* 9, no. 11 (2011): CD004538.
45. Chang et al., “Patients’ Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care,” 605.
46. S. Edgman-Levitan, interview (“on patient-experience measures and their relationship to health outcomes”), *New England Journal of Medicine*, audio, 368 supplement (2013), <http://www.nejm.org/doi/full/10.1056/NEJMp1211775>.
47. Manary, “The Patient Experience and Health Outcomes.”
48. T. Parsons, “The Sick Role and the Role of the Physician Reconsidered,” *Milbank Quarterly* 53, no. 3 (1975): 257-78, at 257.
49. Williams, “Patient Satisfaction.”
50. *Ibid.*, 513.
51. Hospital Consumer Assessment of Health Care Providers and Systems, “HCAHPS Survey.”
52. Consumer Assessment of Health Providers and Systems, “CAHPS Clinician and Group Surveys: 12-Month Survey 2.0.”
53. Home Health Care CAHPS Survey, “Home Health Care CAHPS Survey,” updated January 26, 2012, accessed February 18, 2015, <https://homehealthcahps.org/SurveyandProtocols/SurveyMaterials.aspx#catid2>.
54. U.S. Department of Health and Human Services, “PPACA: Read the Law,” accessed April 9, 2014, <http://www.hhs.gov/healthcare/rights/law/index.html>.
55. J. I. Merlino and A. Raman, “Health Care’s Service Fanatics,” *Harvard Business Review* 91, no. 5 (2013): 108-16.
56. N. F. Geiger, “On Tying Medicare Reimbursement to Patient Satisfaction Surveys,” *American Journal of Nursing* 112, no. 7 (2012): 11.
57. A. Coulter, “Patient Engagement—What Works?,” *Journal of Ambulatory Care Management* 35, no. 2 (2012): 80-89.
58. Merlino et al., “Health Care’s Service Fanatics.”
59. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, “About the CAHPS Cultural Competence Item Set.”
60. *Ibid.*
61. Centers for Medicare & Medicaid Services, “CAHPS Survey for Accountable Care Organizations (ACOs) Participating in Medicare Initiatives,” 2014–2015, accessed February 18, 2015, <http://acocahps.cms.gov/Content/Survey.aspx>.
62. CAHPS Clinician and Group Surveys, “Supplemental Items for the Adult Surveys 2.0,” May 2012, at https://cahps.ahrq.gov/surveys-guidance/docs/2357a_adult_supp_eng_20.pdf.
63. A. Zgierska, M. Miller, and D. Rabago, “Patient Satisfaction, Prescription Drug Abuse, and Potential Unintended Consequences,” *Journal of the American Medical Association* 307 (2012): 1377-78.
64. Zgierska et al., “Impact of Patient Satisfaction Ratings on Physicians and Clinical Care.”
65. J. C. Weeks et al., “Patients’ Expectations about Effects of Chemotherapy for Advanced Cancer,” *New England Journal of Medicine* 367 (2012): 1616-25.
66. N. E. Ervin, “Does Patient Satisfaction Contribute to Nursing Care Quality?,” *Journal of Nursing Administration* 36, no. 3 (2006): 126-30, at 127.
67. J. J. Fenton et al., “The Cost of Satisfaction: A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality,” *Archives of Internal Medicine* 172, no. 5 (2012): 405-11.
68. U.S. Department of Health and Human Services, “PPACA: Read the Law,” accessed April 2014, at <http://www.hhs.gov/healthcare/rights/law/index.html>.
69. Centers for Medicare & Medicaid Services, “HCAHPS: Patients’ Perspectives of Care Survey,” April 2013, accessed February 21, 2014, <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQuality-Initiatives/HospitalHCAHPS.html>.
70. U.S. Department of Health and Human Services, “How the Health Care Law Benefits You,” accessed April 9, 2014, at <http://www.hhs.gov/healthcare/facts/bystate/Making-a-Difference-National.html>.