ILLINOIS STATE MEDICAL SOCIETY

Resolution 01.2019-15
(A-19)

Introduced by: Jerrold B. Leikin, M.D., ISMS Member

Subject: Use of Patient or Co-worker Experience/Satisfaction Surveys Tied to Employed Physician Salary

Referred to: Council on Economics

Whereas, patient or coworker observation experience surveys are increasingly used by healthcare centers in evaluating physician clinical care and are often tied to physician salaries; and

Whereas, these patient surveys focus on patient perspectives and brand management while not addressing any specific quality metrics of complicated clinical care; and

Whereas, coworker observation metrics have not been validated as a reliable monitoring tool for patient care or clinical professional behavior; and

Whereas, patient or coworker experience surveys depend upon active responses and thus may exhibit reporting bias due to complaints frequently unrelated to the providers' actual clinical care; and

Whereas, it has been demonstrated that higher patient satisfaction scores are associated with higher health care and prescription expenditures; and

Whereas, patient satisfaction utilization can promote job dissatisfaction, attrition, and inappropriate clinical care (the very opposite of high value clinical care); and

Whereas, patient surveys or coworker observation metrics are not conducted nor evaluated in a peer-review environment; and

Whereas, these surveys and metrics are performed anonymously and thus cannot be adequately addressed by the clinician; and

Whereas, these metrics are usually utilized to only negatively impact an employed physician salary in a punitive manner (with no potential for positive impact); and

Whereas, a clinician's overall work product cannot be distilled to a few numerical metrics; and

Whereas, health care centers may publish the results of patient or coworker surveys regarding individual providers in an effort to be "transparent"; and

Whereas, it is apparent that patient satisfaction surveys or coworkers' observation reporting symptoms produce "scores" that are not related to any clinical quality metric and have questionable validity and are often taken out of context; therefore, be it

RESOLVED, that the Illinois State Medical Society oppose any association between anonymous patient satisfaction scores (e.g. "loyalty scores"), or the coworkers' observation reporting system, and employed physician's salaries; and be it further

RESOLVED, that the Illinois State Medical Society oppose any publication of anonymous patient satisfaction scores or coworkers' observation reporting system directed at an individual physician; and be it further

RESOLVED, that this resolution be forwarded to the American Medical Association House of Delegates for adoption.

References:

1. Mehta SJ. Patient satisfaction reporting and its implications for patient care. AMA J Ethics. 2015; 17(7): 616-621
2. Berg S. In patient satisfaction scores, what role does bias play? www.ama-assn.org. Sept 18, 2017
3. Zusman EE. HCAHPS replaces Press Ganey survey as quality measure for patient hospital experience. Neurosurgery. 2017; 71(2): N21-N24
4. Zgrerska A, Rabago D, Miller MM, et al. Impact of patient satisfaction ratings on physicians and clinical care. Patient Prefer Adherence. 2014; 8:437-446
5. Webb LE, Dmochowski RR, Moore IN, et al. Using Coworker Observations to Promote Accountability for Disrespectful and Unsafe Behaviors by Physicians and Advance Practice Professionals. Jt Comm J Qaul Patient Sat. 2019; 42(4):149-1964
6. Martinez W, Pirchert JW, Hickson GB, et al. Qualitative Analysis of Coworkers' Safety Reports of Unprofessional Behavior by Physicians and Advanced Practice Professionals. J Patient Saf. 2018.doi:10.1097/PTS.0000000000000481

7. Boothman RC. Breaking Through Dangerous Silence to Tap an Organization's Richest Source of Information: Its Own Staff. Jt Comm J Qaul Patient Sat. 2016; 42(4):147-148
8. Leikin JB. Employed Physicians' Bill of Rights. Chicago Medicine. March 2016; page 3

Fiscal Note:
N/A

Existing ISMS policy related to this issue:

ISMS recognizes the necessity of audits and surveys to review the appropriateness of medical services rendered. However, respect for personal privacy and confidentiality must be maintained with utmost priority under all circumstances. Additionally, local medical staff audits and determinations as to management must be respected. In this regard, ISMS recognizes audit processes as performed by organizations who have demonstrated compliance with the aforementioned principles. In contrast, audits and surveys not performed by recognized organizations, or those performed in violation of the above principles, will not be condoned. (HOD 1980 Amended; Last BOT Review 2011)

House of Delegates adopted Substitute Resolution 11 (A-12), which directed that the Illinois Delegation to the AMA submit a resolution directing that the AMA work with the Centers for Medicare and Medicaid Services (CMS) to support the development of an accurate and meaningful evaluation tool to assess pain control and management during hospital and emergency department visits as well as remove reimbursement decisions that are related to such subjective questions. (HOD 2012)

ISMS supports the AMA Principles on Maintenance of Certification, which are as follows: AMA Principles on Maintenance of Certification (MOC): 1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content. 2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation. 3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by each board for MOC. 4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones). 5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that

permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. 6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey would not be appropriate nor effective survey tools to assess physician competence in many specialties. 7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities. 8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation. 9. The AMA affirms the current language regarding continuing medical education (CME): "By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician's Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A)." 10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. (HOD 2014)