Virtual Mentor

ETHICS CASE
Physician-Rating Websites
Commentary by James E. Sabin, MD

Dr. Jones is a family practitioner in a suburban Chicago group practice. At a staff meeting, he recently learned from a colleague that some patients of their practice have been rating their physicians on a popular doctor-rater website. Several of the physicians are concerned about the low ratings they received.

The next day during his lunch break, Dr. Jones decides to look to see if he has been rated. He is shocked to find that he has only been rated only 2 out of 5 stars. Specifically, he has received the lowest possible scores in "Time spent with patient" and "Helps patient understand his/her condition." He realizes this score is based on the ratings of only 2 patients. Dr. Jones is disappointed because he strives to provide the best care possible for his patients, and he thought he had great relationships with all of them.

Exploring the site further, Dr. Jones thinks, *these ratings are subjective and largely based on measures not directly in the doctor's control, anyway!* For example, patients are asked to rate doctors on mostly nonclinical criteria such as waiting time, rapport, and patient satisfaction. The site rating system also seems to prioritize treating diseases over watchful waiting.

He stops his Internet search when his next patient, Mr. Jenkins, comes in for a regular checkup. Dr. Jones asks him whether he has heard of the rating website. Mr. Jenkins replies, "Sure I've heard of it—haven't you seen the commercials?"

Mr. Jenkins has had a cough for the past 2 days and asks for antibiotics. Dr. Jones, in a hurry because he is quite overbooked that afternoon, believes Mr. Jenkins has a simple viral infection. He thinks, *I never prescribe antibiotics in this situation, even though some doctors might, and they don't seem indicated this time. But Mr. Jenkins already knows about the website, and might be upset that I'm not dealing with his symptoms. What if this guy rates me poorly for not following his request? Could stuff like this drive future patients away from my practice?*

Commentary
Web-based physician-rating sites are rapidly expanding in number and scope. One site, RateMDs, grew from rating 2,475 physicians in January 2005 to rating 112,024 in January 2010, representing approximately 16 percent of all practicing U.S. physicians [1]. Another site, HealthGrades, claims 7 million visits per month. A recent study of 500 randomly chosen urologists found that 80 percent had at least

one online rating [2]. And Medicare's Physician Compare website will start to include physician quality reports in 2014.

Further expansion is inevitable. According to the Pew Internet project, 85 percent of U.S. adults use the Internet. Of this group, 72 percent reported that they had looked for health information online during the past year [3]. But, while 8 in 10 Internet users have researched a product or service online, to date only about 20 percent have consulted patient reviews of clinicians and medical treatments. And while 32 percent have posted a review of a non-health-related product or service, only 3 to 4 percent have reviewed a clinician, hospital, or treatment. From the perspective of digital entrepreneurs, online physician rating is a market with substantial growth potential.

Discussion of the Case
Dr. Jones, who has only recently learned about online physician-rating sites, is stunned by his poor 2-star rating. Like most physicians, he works hard and takes pride in what he does. We physicians are socialized into having a strong sense of responsibility. This is as it should be, given the impact of our work. As a result, we're vulnerable to shame when our performance is criticized. The 2-star "grade" bruises Dr. Jones's self-image and creates a narcissistic injury.

His initial reaction, while understandable, is not constructive. He gets defensive and blames the poor rating on factors "not directly in the doctor's control." But the factors he cites—waiting time, rapport, and patient satisfaction—are matters over which he does have substantial control. If his defensive reaction persists, Dr. Jones will not be able to learn from the ratings as the quality improvement movement teaches us to do—reflected in the aphorism "every defect is a treasure."

Dr. Jones's reaction to Mr. Jenkins's request for an antibiotic is driven by his anxiety and sense of vulnerability. His clinical assessment is that Mr. Jenkins has a viral upper respiratory infection for which an antibiotic is not indicated. But in his anxious state he falls into what cognitive therapists call "catastrophizing." He imagines that (a) Mr. Jenkins will rate him poorly if he does not prescribe the antibiotic, (b) this will lead to more poor ratings on the website, ultimately (c) causing a loss of patients in the future. It's as if his whole future turns on whether or not he prescribes a nonindicated antibiotic for Mr. Jenkins.

Let's hope that Dr. Jones has learned to monitor his subjective reactions and not to act impulsively. He should not prescribe the antibiotic. He should explain his thinking to Mr. Jenkins and respond to Mr. Jenkins's questions and concerns. In the absence of new information suggesting that an antibiotic is called for, he should seek a negotiated agreement with Mr. Jenkins about how to proceed.

Doing this will take time. It won't be an easy afternoon for Dr. Jones. He's overbooked, and taking time for the valuable exchange with Mr. Jenkins will put him behind in his schedule. But achieving "efficiency" either by writing a prescription he

doesn't believe in or failing to capitalize on the teachable moment in Mr. Jenkins's care is the wrong way to go.

The anxiety and the harried afternoon of practice create a teachable moment for Dr. Jones and his group practice colleagues, too. A constructive response would involve:

1. Acknowledging and addressing the psychological impact of a poor public rating. This initial rating comes from two patients in a large practice, but the public nature of the web can make the rating feel like a spotlight of shame. Dr. Jones won't be able to deal with the situation in a productive manner until he can get past his hurt and anxiety.

2. Seeing what can be learned from the patients' feedback. The case tells us that Dr. Jones "thought he had great relationships with all of [his patients]." But the case also tells us that Dr. Jones feels hurried, which isn't at all unusual in a busy primary care practice. It's not surprising that some patients felt their time with Dr. Jones was too limited and did not allow for adequate explanation of their conditions. Apparently others in the group received similar ratings.

3. Strategizing with colleagues about constructive responses to their patients' concerns. Insofar as Dr. Jones and his colleagues accept that their patients are truly concerned about time and understanding, they can consider the underlying causes. There are probably many. Can the actual time spent with patients be extended by reengineering flow? Can adjuvant supports like educational handouts and videos be created for common issues such as Mr. Jenkins's request for an antibiotic for a viral infection? Are there communication skills that can be strengthened? Can patients in the practice be enlisted in the quality improvement process? A thoughtful collegial analysis of the poor ratings the group has been getting will almost certainly point to constructive actions.

Underlying Ethical Issues
Web-based physician-rating sites should be seen as part of a multidecade cultural shift in the relationship between physicians, patients, and society. In the era of paternalism, doctors were idealized in paintings by Norman Rockwell and dramas like *Dr. Kildare*, and patients were expected to follow "doctor's orders." In the era of consumerism, doctors were taken off the pedestal, and power shifted to patients, who rate the physician on websites and demand antibiotics for viral upper respiratory tract infections. But a system in which "patient's orders" reign is just as lopsided as one that puts "doctor's orders" in the driver's seat. The desirable state is collaboration, a goal medical students are now educated about from the first day of medical school.

Online rating systems can be a thorn in our sides, but they are not going away, and we physicians will have to learn to live with them. In his recent book *Establishing, Managing, and Protecting Your Online Reputation: A Social Media Guide for Physicians and Medical Practices* [4], Dr. Kevin Pho advises physicians to use social media to cultivate a positive image of themselves and their practices. Organizations like Medical Justice [5] and Physician's Reputation Defender [6]

monitor web ratings for their clients and advise how best to use Google, Facebook, Twitter, and other social media sites. Done right, developing an active presence on the web is consistent with responsible professionalism.

The American Medical Association and other professional organizations can and should advocate for responsible governance of the sites. As examples, sites could be asked not to post ratings for individual physicians unless a minimum number—perhaps 5 or 10—have been received and to take reasonable care to ensure that competitors are not masquerading as disgruntled patients posting critical comments.

Given that public assessment of quality of care and patient satisfaction is both desirable and inevitable, the best response to haphazard for-profit websites will be the development of scientifically valid, carefully developed, responsibly managed public sites. Such sites will be a source of anxiety for us, but could be developed in ways that allow for physician response. When a book receives a negative review, it is common for authors to explain why they believe the review is mistaken. Patients are entitled to objective information on quality and satisfaction. And as anxiety-provoking it may be for us physicians, we should receive that kind of feedback as well.

Some physicians have asked patients to sign a "contract" promising not to write on public websites as a requirement for being treated. The impulse to do this is entirely understandable, but for two reasons I have advised colleagues against taking this step. First, it introduces an element of antagonism and distrust into the patient-doctor relationship. Second, it's highly unlikely that such a contract has legal standing.

Insofar as heightened transparency about quality and satisfaction lead to more attentive communication with patients and better explanation of our diagnoses and treatment proposals, it is all to the good. But there's also a downside. Just as malpractice litigation can foster defensive medicine, online ratings can encourage behaviors like prescribing an antibiotic for a viral infection to avoid getting a "bad grade" from our patients. We know that patients tend to equate more tests and treatment with better care and more costly interventions with better quality. Insofar as defensive practice caters to misguided beliefs of this kind, rating sites could, paradoxically, lead to worse and more costly practice.

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