Unmasking disparities: the challenge of diversity, equity, and inclusion in Press Ganey surveys

Editorial

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Abstract

Data on minority group physicians from diverse racial/ethnic backgrounds is sparse and not reported by PG metrics at the national level. While PG metrics typically concentrate on the individual, patterns and trends are clearly discernible at the group level and comparison of groups to capture patterns may yield results hitherto unknown. One could even envisage using AI to capture any trends, differences, and comparative figures to build databases for the future. It is time to retool PG surveys to fit the modern U.S. healthcare workforce and be inclusive, and not selective at the individual level.

Press Ganey (PG), established in 1985 by Irwin Press and Rod Ganey, is a survey metric used as a measure of quality clinical care and provides, among other analyses, individual physician ratings on a quantitative scale. However, due to concerns about its effectiveness, PG faced criticism and was replaced in 2012 by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). This change was motivated by the need for a more reliable metric. For physicians with poor ratings in PG surveys, a significantly negative impact on their compensation, performance, and job retention are possible outcomes. However, a prospective cohort study revealed that higher patient satisfaction scores were associated with increased mortality and prescription drug expenditures among patients,[1] which challenges the conventional wisdom of obtaining patient satisfaction scores.

Internal medicine, general surgery, pediatrics, family medicine, and obstetrics and gynecology have minority physician representation ranging from 17% to 23% according to a report published in 2017.[2] It is critical that PG metrics capture data specifically among these minority group(s) physicians as issues of diversity, equity, and inclusion (DEI) are linked to long-term prognosis of U.S. healthcare. It is evident that DEI data is crucial not just for benchmarking progress in healthcare, but such numbers must be collated to reflect annual trends in physician performance for minority healthcare providers as a group. If those scores consistently show a declining trend compared to white physicians born in the U.S., it will be important to probe the causes and address them or risk losing the relevance of PG metrics for a large segment of healthcare workers. Data on minority group physicians from diverse racial/ethnic backgrounds is sparse and not reported by PG metrics at the national level. While PG metrics typically concentrate on the individual, patterns and trends are clearly discernible at the group level and comparison of groups to capture patterns may yield results hitherto unknown. One could even envisage using AI to capture any trends, differences, and comparative figures to build databases for the future.

Despite the Association of American Medical Colleges (AAMC) reporting that 20.6% of physicians are Asian, 6.9% are Hispanic, and 5.7% are Black or African American, PG metrics are unavailable for one-third of physicians in minority groups and inter-group comparisons are unavailable. Trends for physicians whose native language is not English are unavailable too, but they form around 60% of non-U.S.-born medical graduates matching into residency programs in the U.S. each year.

A cross-sectional analysis conducted at an urban academic center between 2014 and 2017, involving 117 589 PG surveys, demonstrated that racially/ethnically discordant patient–physician pairings had significantly lower odds of receiving the maximum patient experience compared to concordant pairings.[3] This type of information argues against public reporting of PG scores for individual physicians and could exacerbate racial stereotypes, while flouting the concept of DEI. It perhaps discourages patients from choosing minority physicians as their first choice of care providers. A study conducted at the Mayo Clinic[4] found that 75% of patients would choose and 88% would avoid a physician based *solely on online ratings*, negatively impacting the public reporting of PG surveys. This is tantamount to being disqualified from participation in a race even before it begins.

No PG report has explored patient perceptions of care in settings from physicians of diverse race/ethnicity/gender backgrounds and from non-English speaking countries. Considering that immigrants make up more than 18% of the U.S. healthcare workforce, this is a significant oversight. Another study at the Mayo Clinic[5] suggested that PG metrics vary based on skin color, with white physicians receiving higher ratings, more positive comments, and fewer negative comments compared to their counterparts. However, removing PG ratings from public view is unlikely due to requirements from the Centers for Medicare and Medicaid Services (CMS) and the National Committee on Quality Assurance for public reporting of patient satisfaction data.

To address these concerns, CMS should reconsider its policy on PG surveys and instruct healthcare facilities not to publicly report individual physician data, as it does not provide racial inclusivity for minority physicians. Options might include reporting of collective data for an institution, department, or division instead of individualized data. An alternative solution could involve independent third-party verification and validation of PG surveys for physicians, along with specific guidelines to improve scores. Recognizing DEI issues requires comparing measured outcomes among peers of diverse backgrounds, which can serve as a necessary first step in combating negative stereotypes and unconscious bias among patients toward their physicians, specifically if one group compares unfavorably on a consistent basis.

Other general problems with PG surveys

Critics of PG surveys have raised several concerns, including the potential for skewed results based on physician characteristics such as race,[5] sex, and specialty, as well as nonresponse and unconscious bias among patients, nonrandomization, and small sample sizes in studies. In their quest for better scores, some physicians may resort to overprescribing medications or ordering unnecessary tests, compromising evidence-based care. Additionally, survey questions focusing on patient experience may not adequately capture provider-specific behaviors that can guide improvement, resulting in a lack of actionable feedback for physicians.

It is the nature of physician surveys to preserve the anonymity of patients' responses. The surveys follow the Health Insurance Portability and Accountability Act (HIPAA) guidelines and while this ensures that patients can voice their concerns freely, individual providers with a lack of feedback regarding specific instances to change their course are left in the lurch. Consequently, generalized recommendations such as "listen more," "show empathy," or "explain choices better" provide some insights but lack the granularity necessary for struggling providers to improve their performance. As there are no patient-specific "identifiers" for low-scoring physicians to rectify their behavior, attitude, or bedside manner toward a specific patient, it is a nonstarter from a physician perspective. For the patient, anonymity and HIPAA rules provide the perfect construct to voice their concerns but that very norm translates into a minefield for the physician. It recalls an adage by John Fowles, "For what good science tries to eliminate, good art seeks to provoke—mystery, which is lethal to the one, and vital to the other."

References

1. Fenton JJ, Jerant AF, Bertakis KD, Franks P. The cost of satisfaction: a national study of patient satisfaction, health care utilization, expenditures, and mortality. *Arch Intern Med.* 2012;**172**(5):405–411.
2. Marco CA, Nelson LS, Baren JM, et al. American Board of Emergency Medicine Report on Residency and Fellowship Training Information (2016–2017). *Ann Emerg Med.* 2017;**69**:640–652.
3. Takeshita J, Wang S, Loren AW, et al. Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings. *JAMA Netw Open.* 2020;**3**(11):e2024583.
4. Burkle CM, Keegan MT. Popularity of internet physician rating sites and their apparent influence on patients' choices of physicians. *BMC Health Serv Res.* 2015;**15**:416.
5. DeLoughery EP. Physician race and specialty influence Press Ganey survey results. *Neth J Med.* 2019;**77**(10):366–369.