Filozofski savjetnik

ČASOPIS ZA FILOZOFSKU PRAKSU · HRVATSKO UDRUŽENJE ZA FILOZOFSKU PRAKSU

SVEZAK Vol. I BROJ Br. 3 GODINA 2026 NAKLADNIK HUFP, Zagreb

PHILOSOPHY · BIOETHICS· ORIGINAL SCIENTIFIC ARTICLE

Say 'No' to 'Yes' Men: The Mandate Against Tying Physician Compensation to Patient Satisfaction Scores

Nathaniel A. Mattera · *The University of Illinois College of Medicine**

Primljeno: 4. 8. 2026 · Prihvaćeno: 19. 8. 2026

ABSTRACT

Basing physician compensation on Patient Satisfaction Scores (PSSs) violates the four foundational principles of clinical ethics and leads to demonstrable, real-world harms to patients. The pressure to secure a high score incentivizes physicians to prioritize patient desires over objective medical truth, undermining shared decision making and informed consent (violation of autonomy). It also encourages acquiescence to patient demands, resulting in unnecessary care such as unwarranted opioid prescriptions, excessive diagnostic testing, and procedures, low-value care that increases the risk of side effects, addiction, and harm (violation of beneficence and non-maleficence). Tying compensation to subjective scores further leads to unjust distribution of resources by encouraging over-utilization of costly services for non-clinical reasons, and empirical studies show PSSs contain systemic patient bias against female and racially underrepresented physicians, translating prejudice directly into pay inequity (violation of justice). These ethical breaches produce concrete clinical harms: up to 70% of providers change their initial treatment plan due to PSS concerns, and almost half report that PSS pressure promotes inappropriate care, including unnecessary prescriptions and tests, driving up healthcare costs and contributing to physician burnout and attrition. Basing compensation on patient satisfaction transforms the fiduciary patient-physician relationship into a transactional customer service model. PSSs are a flawed and harmful metric for compensation and ought to be reduced to safeguard evidence-based care, uphold the duty to do no harm, and ensure justice and equity in healthcare.

KEYWORDS: patient satisfaction, epistemology, lived experience, knowledge, principlism

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* With special thanks to Dr. Timothy Murphy

Modern clinical ethics rests on the four pillars of principlism: autonomy, beneficence, non-maleficence, and justice. These principles serve to center the patient and prevent iatrogenic and structural harm. Defining elements from a physician's oath, such as the duty to do no harm, are an attempt to make these principles actionable and tactile. Though the impulse to center the patient and hold the physician accountable is laudable, the means of doing so may cause unintended harm and incentivize the very behaviors such structures seek to deter. In particular, linking physician compensation to patient satisfaction scores violates all four pillars of clinical ethics and demonstrably harms both patients and physicians. Principlism is the foremost approach to biomedical and clinical ethics in Anglo-American healthcare, and it arose out of a need for clear guidance around ethical decisionmaking.[1] A practical organizational ethics framework requires some semblance of universality, and thus principlism draws upon Kantian normative principles. However, since different members of the care team have competing priorities and philosophies (e.g., the physician's desire to aggressively treat the patient's illness may run afoul of the trauma advocate's desire to prevent further stress to the Pt), they require overarching tenets to unite them and coordinate care.

Principlism as it exists today was first conceptualized in the 1976 Belmont report, written by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.[2] It was further codified by Beauchamp and Childress (1979), and borrows a mix of deontology and utilitarianism—the former for components of universality and the latter for components of allocative justice.[3] Critics of principlism raise three major objections that merit discussion. First, principlism only works for a subset of clinical encounters. It cannot be applied in instances where a patient is incapacitated or underage.[4] The established convention, however, is to algorithmically follow advanced directives, verified wishes, and the guidance of the incapacitated patient's next-of-kin.[5] This convention being clear and considered, it seems reasonable to challenge the critics behind objection one to propose a superior method for the care of incapacitated (or underaged) patients, or else to explain why an alternative ethical framework would not also need to resolve this question. Second, critics argue that the principles are not equally applied, and one may

[1] Trimble M. Ethics - A matter of principle? Ulster Medical Journal. 2024 Dec; 93(2): 83-86. Epub 2024 Dec 11.
[2] The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research. The Belmont Report. Ethical principles and guidelines for the protection of human subjects of research. Washington, DC: US Department of Health, Education and Welfare; 1976.
[3] Beauchamp T and Childress J. Principles of Biomedical Ethics. 1979.
[4] Huxtable R. For and against the four principles of biomedical ethics. Clinical Ethics. 2013; 8(2-3): 39–43.
[5] Avci E. Protecting Incapacitated Patients' Rights and Best Interests. Indian Journal of Palliative Care. 2023 Oct-Dec; 29(4): 343-347.

inconsistently take precedence over another.[6] The basic form of this argument has low validity, since it faults the principlism's application rather than its essence. The stronger version forwards the notion that the principles can have internal tension in certain situations which may not be resolved. These harshest opponents insist that the primacy of the principles is all but null since they are critically vulnerable to interpretation.[7] The point of contention is that principlism is meant to help practitioners make clear decisions, but it seems insufficient to consistently and definitively settle ethical issues in practice.

This argument flows smoothly into the next, which is: Principlism fails to capture a "common-sense morality"—namely, it is not a true ethical framework.[8] There are not enough principles for it to be a proper normative framework. Moreover, it does not resolve the internal tension between deontological claims and utilitarian claims.[9] These critics are in fact correct, but this is actually not a failing. Principlism does not aim to offer a true moral framework or define morality. Doing so would undermine its purpose: to draw together roles with disparate professional ethics and unify them around a few fundamental absolutes that guide their efforts and protect patients. Principlism is a practical consensus, not a moral framework. Proponents of principlism agree on this aspect: Bioethical philosopher H. Tristam Englehart acknowledges that his own religious beliefs inform his moral approach to medicine, reaffirming the need for a consensus among the morally diverse.[10] Ethicist Raanan Gillon further emphasizes that principlism is a compromise rather than a true moral framework by arguing that it steers practitioners safely between the two moral extremes: relativism and imperialism (Gillon 2003, 309).[11]

Regarding the consensus, principlism is not a top-down approach that directly settles ethical disputes. Rather, it is the animating spirit behind the highest levels of professional bodies and legal regulators within healthcare.[12] Principlism is not the "rules"; it is the template for the rules. This distinction seems semantic, but is in fact critical. Because principlism informs the approach to solutions and legislation rather than directly dictating those entities on a case-by-case basis, it is still possible to form organization-wide consensus and identify clear resolutions to ethical questions.

[6] Huxtable. For and against the four principles of biomedical ethics. 2013. 39–43.
[7] Harris J. In Praise of Unprincipled Ethics. J Med Ethics. 2003; 29(5): 303–6.
[8] Walker, T. "What principlism misses." Journal of Medical Ethics. 2009; 35(4): 229–31
[9] Green RM. Method in bioethics: A troubled assessment. Journal of Medical Philosophy. 1990; 15(2): 179–97.
[10] Cf. Engelhardt HT. Foundations of Bioethics. 2nd ed. Oxford: Oxford University Press; 1995.
[11] Gillon R. Ethics needs principles—four can encompass the rest—and respect for autonomy should be "first among equals". Journal of Medical Ethics. 2003; 29(5): 307–12.
[12] Jonsen AR, Siegler M, Winslade WJ. Ethics: A practical approach to ethical decisions in clinical medicine. 8th edition. McGraw Hill; 2015.

Because principlism now underpins the bulk of Anglo-American healthcare laws and practices, this discussion will not attempt to further critique or justify its adoption. Rather, the aim of this paper is to bring attention to practices within Anglo-American healthcare that run afoul of the system's own purported ethics. Particular among these is the practice of altering physicians' compensation due to a physician's patient satisfaction scores. For the purpose of this discussion, any rule, practice, or enticement that is sufficiently systemic and opposes a tenet of principlism can be said to "violate" principlism.

Patient satisfaction scores (PSS) fall under the "quality factors" umbrella, and increasingly impact physician compensation. Between 2019 and 2025, quality factors' contribution to total physician pay grew from 10% to 16%.[13] A 2022 survey of physician professional societies revealed that 77% of physicians' employers tracked PSSs and explicitly incorporated them into compensation (22%) and performance reviews (36%).[14] The scores themselves are composites of institution-specific metrics and HCAHPS scores (colloquially known as "Press-Ganey" scores), delivered to patients via questionnaire.[15] Medicare gives physicians the opportunity to opt-into its Merit-based Incentive Payment System (MIPS) for an "outcome-based pay adjustment."[16] Clearly, these metrics are embedded into the incentive structure of both the private and public sectors, and physicians who do not want to engage with them are swimming against the institutional current. The American Medical Association does in fact advise against tying physician compensation to subjective measures, but the justification frames the issue as one of physician autonomy rather than clinical ethics.[17]

To begin, tying PSS to compensation violates the ethical principle of non-maleficence by inducing higher rates of addictive substance prescriptions and unnecessary testing exposures. Patients demonstrably score physicians more favorably when they prescribe opiates.[18] This effect extends to other potentially addictive medications: a 2017 study confirmed a significant positive correlation

[13] AMN Healthcare, 2025 Review of Physician and Advanced Practitioner Recruiting Incentives. 12 August 2025. Accessed 18 August 2026, https://www.amnhealthcare.com/amn-insights/physician/whitepapers/2025-review-of-physician-and-advanced-practitioner-recruiting-incentives/.
[14] Schneider BJ, Ehsanian R, Kennedy DJ, Schmidt A, Huynh L, Maher DP. The effect of patient satisfaction scores on physician clinical decision making: A possible factor driving utilization of opioid prescriptions, magnetic resonance imaging, and interventional spine procedures. Interventional Pain Medicine. 2022 Feb 3; 1(1).
[15] Press Ganey, "HCAHPS 101: What HCAHPS Surveys Mean for Hospitals," Press Ganey (blog), November 3, 2022, https://www.pressganey.com/resources/blog/hcahps-101-what-hcahps-surveys-mean-for-hospitals/.
[16] Centers for Medicare & Medicaid Services, "CAHPS for MIPS Survey," last modified April 29, 2025, https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems/cahps-mips.
[17] American Medical Association, "D-385.958 Physician Payment," AMA PolicyFinder, accessed April 13, 2026, https://policysearch.ama-assn.org/policyfinder/detail/D-385.958?uri=%2FAMADoc%2Fdirectives.xml-0-1276.xml.
[18] Sites BD, Harrison J, Herrick MD, Masaracchia MM, Beach ML, Davis MA. Prescription Opioid Use and Satisfaction With Care Among Adults With Musculoskeletal Conditions. The Annals of Family Medicine Jan 2018, 16 (1) 6-13.

between physicians' rates of prescribing benzodiazepines, stimulants, and other narcotics, and those physicians' Press-Ganey scores.[19] Physicians themselves are aware of this trend, and adjust their care plans accordingly; when surveyed, over half of respondents noted that their PSSs decreased when they refused unnecessary prescriptions or imaging, and one third of respondents prescribed an opiate medication to mollify patient concerns.[20] These patterns are concerning because they go against clinical judgement. It is one thing for a physician to account for patient preferences and accept input in order to arrive at the best possible care plan with confidence that the patient will adhere to it. It is another thing entirely when the physician feels pressured to alter a care plan and expose the patient to potential harm due to financial pressure. Opiate addiction is one of the most well studied public health phenomena in recent memory, and unnecessary prescribing contributes to this ongoing crisis.[21] Likewise, unnecessary imaging such as MRIs, though not physically harmful, represents a very real financial burden on both the patient and the healthcare system.[22]

Unnecessary testing not only violates the duty of non-maleficence, but also interferes with the duty of beneficence. Extraneous testing delays timely care at worst and inundates the patient with unnecessary, confusing, or falsely encouraging information at best. The looming threat of poor PSSs pressures physicians to mince words or indulge unconstructive fantasies. Moreover, it undermines physicians' power to advocate for patients. Consider cases where an incapacitated patient has an ambiguous advanced directive, and the physician and healthcare proxies (such as family) must work together to determine next steps. Though the physician may identify that a possible care plan offers little gain for the patient and will certainly subject him or her to agonizing pain, the physician may not feel empowered to speak up and crush the family's hopes, since they will shortly be filling out a survey rating the care their loved one received. A skeptical reader will argue that it is physicians' responsibility to maintain integrity and resist such enticements, but it stands to reason that it is likewise the responsibility of physicians' employers to prevent, not encourage, such enticements in the first place.

Given thus that physicians' care plans are susceptible to impairment due to PSS-based pay metrics, it follows that two harms may arise. First is an unfair calculus of care distribution. A face value framing of clinical justice boils down to each patient receiving the care they need, in order of

[19] Berkovich E, Leff AJ. Physician Characteristics and Treatment Modalities in Relation to Patient Satisfaction Scores in Outpatient Primary Care Practices. Working Paper 2019-02.
[20] Schneider et. al. The effect of patient satisfaction scores on physician clinical decision making.
[21] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269
[22] Kjelle E, Brandsæter IØ, Andersen ER, Hofmann BM. Cost of Low-Value Imaging Worldwide: A Systematic Review. Appl Health Econ Health Policy. 2024 Jul;22(4):485-501.

severity—that is, fair distribution of resources. The topic becomes contentious when a hospital's resources are insufficient and a decision must be made regarding whose care is prioritized. The following cases survey leading accounts of justice and examine how they interact with an impaired physician.

Case 1: A "complete lives" framing might prioritize young patients who haven't yet had the chance to live a complete life.[23] This framing can mean that either—all other conditions being equal—the younger of two patients receives the resource, since they have more life ahead of them, or that the patient with a better prognosis for quality of life receives the resource, since they have more "quality-adjusted life-years" (QALY) to enjoy. In the former instance, it is easy to see how the impaired physician is positioned to violate justice by diverting resources from the younger patient to the elder, or else split the resource so that each patient receives an insufficient amount, out of fear for a vindictive PSS from the unlucky family or patient. In the QALY instance, the physician is empowered further, since QALY calculations include a psychosocial component that relies on the healthcare provider's assessment.[24]

Case 2: A "social value" model might look at an individual's societal contributions in order to extrapolate his or her future usefulness to humanity, and prioritizing "high contributors."[25] Once again, this model's weakness is its subjective component; a compromised physician can unbalance the committee consensus on which patient offers more social value, throwing weight behind the one who will leave a more flattering PSS, or else contribute to the physician's gain in some other way.

Case 3: An egalitarian framing might argue that all criteria are problematic, and only a lottery system can impartially allocate resources. At first glance, it would appear that this framing is resistant to the impaired physician's tampering. However, key to the lottery system is the determination of which patients will participate. Suppose the resource being distributed is the last remaining ventilator; the physician's task will be to identify which patients are experiencing enough breathing difficulty to require mechanical ventilation. It is now clear that the impaired physician only needs to remove the obstacle of the other patient, allowing the chosen patient to receive the ventilator by default.

These cases' common thread indicates that clinical allocative justice, in order to be met upon the patient, requires both the physician's assessment of patient needs and consequent treatment

[23] Persad G, Wertheimer A, Emanuel EJ. Principles for allocation of scarce medical interventions. Lancet. 2009 Jan 31; 373(9661): 423-31.
[24] Prieto L, Sacristán JA. Problems and solutions in calculating quality-adjusted life years (QALYs). Health Qual Life Outcomes. 2003 Dec 19; 1:80.
[25] Rescher N. The Allocation of Exotic Medical Lifesaving Therapy. Ethics 1969 79:3, 173-186.

recommendations be unimpaired. Over half of surveyed physicians report that PSS pressure promoted inappropriate care, leaving this key criterion unmet.[26]

The second justice-related harm is also distribution-related, but more nebulous: systemic bias. Marginalized patients face disproportionate barriers when utilizing healthcare, and this extends to patient satisfaction surveys. Working-class children develop a sense of "constraint" with physicians early on, accepting information and direction rather than negotiating over the treatment plan.[27] Patients' learned passivity represents a potential barrier to engagement in other healthcare domains, such as survey completion. A more direct barrier is the simple issue of literacy; patients with low or absent literacy will struggle with or fail to complete surveys. The result is that physicians will not receive any feedback from these patient populations, skewing data in unpredictable ways. Dismissive or prejudiced physicians may escape detection while considerate and inquisitive physicians may go unrewarded. In fact, marginalized patients are merely one example of the failure of surveys to capture physicians' value and distribute healthcare justly. Much research has been devoted to survey respondents, revealing that those with neutral feelings are often non-responders, and those with strong positive or negative feelings are far more likely to respond.[28] Just resource allocation is based upon clinical judgement, which is in turn based off of clinical evidence. This evidence is shaped by patient data, which includes satisfaction surveys. When foundational data is warped by structural barriers and sociological confounders, it becomes impossible to guarantee that the downstream decisions are truly just.

Finally, PSS-contingent compensation violates the principle of patient autonomy. Principlism's autonomy is not precisely lifted from Kant, but it does use one of his key assumptions: All patients are rational and morally responsible.[29] This assumption is the fetter that binds informed consent to autonomy. For a rational agent, comprehension of choice becomes prerequisite to moral, autonomous action.[30] Clinical autonomy, then, is state-dependent, requiring the satisfaction of conditions such as liberty, independence, and crucially, informed consent (Treiger-Bar-Am 553-561).[31]

[26] Zgierska A, Rabago D, Miller MM. Impact of patient satisfaction ratings on physicians and clinical care. Patient Prefer Adherence. 2014 Apr 3; 8: 437-46.
[27] Lareau A. Unequal Childhoods. University of California Press, Sep 11, 2003: 140.
[28] Cf. Goyder, J. (1988). The Silent Minority: Non-respondents In Sample Surveys (1st ed.). Routledge.
[29] Secker B. The appearance of Kant's deontology in contemporary Kantianism: Concepts of patient autonomy in bioethics. Journal of Medicine and Philosophy. 1999: 24(1): 43–66.; Elsner AM, Rampton V. "Accompanied Only by My Thoughts": A Kantian Perspective on Autonomy at the End of Life. Journal of Medical Philosophy. 2022 Dec 23; 47(6): 688-700.
[30] Kant I. Critique of Practical Reason. Translated by Thomas K. Abbott, Dover Publications, 2004: Theorem IV, Ak 5:33; Kant I. Groundwork for the Metaphysics of Morals. Oxford University Press. 2019: Ak. 6:237-8.
[31] Treiger-Bar-Am K. In Defense of Autonomy: An Ethic of Care. NYU Journal of Law and Liberty. 2008: 550-598.

Thus, when expounding on patients' autonomy, Beauchamp treats understanding as choice's *sine qua non*.[32] Therefore, proving that PSS-contingent pay violates autonomy is the weak case, and proving that it violates informed consent is the strong case, since the former is consequent to the latter.

Efforts to please the patient (and thereby influence PSS) run afoul of informed consent. This is because patients buy into the physician, not particulars of a treatment plan. Except in cases where the patient is a physician him or herself, it is not reasonable to expect the patient to comprehend all minutiae of the plan. There is invariably some ceiling of complexity that will require the patient to trust the physician in order to proceed with the treatment.

Beauchamp and Childress cite Annette Baier's noncognitive account of trust explicitly, wherein trust is vulnerability, and reliance on another's goodwill (Beauchamp 39-40).[33] Hall et al (2001) throw weight behind this idea, arguing that it is quite plausible for an individual to assume his physician has his best interests at heart, and to therefore trust the physician—regardless of the latter's skillfulness as a clinician—merely on the basis of demeanor and assumed intentions.[34] Mayer et al (1995) echo this idea, finding that high perceptions of an individual's capability and good intentions provoke others to trust that individual far more.[35] In short, Beauchamp and Childress endorse the idea that a patient's trust is founded on the physician rather than the specifics of the treatment to which they are consenting. Indeed, patients do not tend to recall details of treatments once they have consented, suggesting that the true foundation of their consenting trust is elsewhere.[36] It follows, therefore, that when a physician feels pressured to present a care plan that contradicts his or her clinical judgement, that physician betrays the patient's trust. Moreover, since the patient's consent is premised upon that trust, it is accurate to say that the physician misleads the patient, thus violating the patient's autonomy.

It is worth noting that the impaired physician destroys public trust in the medical profession. As PSS become more institutionalized, the potential opportunities and inducements for impairment increase. Just as a lonely individual might attempt to suspend disbelief and pretend that a paid escort is indeed smitten with him, so too must the hospital patient drown out her own misgivings that her physician might not truly care about her and is merely feigning concern in order to increase his salary

[32] Faden R and Beauchamp T. A History and Theory of Informed Consent. Oxford University Press. 1986.
[33] Baier, Annette. "Trust and Antitrust." Ethics 96, no. 2 (1986): 231–60.; Cf. Beauchamp & Childress Principles of Biomedical Ethics. 1979.
[34] Hall MA, Dugan E, Zheng B, Mishra AK. Trust in physicians and medical institutions: what is it, can it be measured, and does it matter? Milbank Q. 2001; 79(4): 616-17
[35] Mayer RC, Davis JH, and Schoorman FD. 1995. An Integrative Model of Organization Trust. Academy of Management Review; 20: 357.
[36] Fortun P, West J, Chalkley L, Shonde A, Hawkey C, Recall of informed consent information by healthy volunteers in clinical trials, QJM: An International Journal of Medicine, Volume 101, Issue 8, August 2008, Pages 625–629

bonus. In either case, the trusted party is induced to lie for financial gain, and the deceived party is left with the bill.[20] Allocative injustice is not cheap; overuse was the highest-expense category in a 2019 survey of wasteful healthcare spending.[37]

It is now clear that any linkage between PSS and physician pay violates all four pillars of clinical ethics and introduces the potential for harm. So far the conversation has focused on harms to the patient, but what of the physician? PSS inequities are in fact a prominent cause of structural harm against physicians. When filling out PSS surveys, patients do not leave their biases at the door. After correction for education, years in practice, and region, female physicians still receive lower average scores than identical male counterparts.[38] Non-white physicians, as well as physicians in certain specialties, receive lower average PSSs as well, to an extent that researchers conclude that Press-Ganey scores have no bearing on physician competence.[39] Moreover, there is a positive correlation between PSS and physician-patient race concordance, introducing another opportunity for bias against physicians—particularly non-white physicians—who are race-discordant with their patient populations.[40] In fact, even in race-concordant scenarios, physicians of color received lower scores than their white colleagues.[41] The prevalence of PSS and their influence over compensation and professional reviews transforms them into a conduit for societal biases to cross into healthcare. Competent and motivated non-white, non-male physicians will find their advancement and financial means limited by structural prejudices in the very populations they serve.

The downstream effects will shape healthcare for the worse. Facing such biases, non-white physicians will be disinclined to practice in rural, conservative areas, where older white, male patients are most prone to reward race and gender concordance via PSS.[42] These areas are already underserved, and rural health deserts will continue to grow. Pay and patient-feedback disparity between specialties

[37] Speer M, McCullough JM, Fielding JE, Faustino E, Teutsch SM. Excess Medical Care Spending: The Categories, Magnitude, and Opportunity Costs of Wasteful Spending in the United States. American Journal of Public Health. 2020 Dec; 110(12): 1743-1748.
[38] Rogo-Gupta LJ, Altamirano J, Homewood LN, et al. Women physicians receive lower Press Ganey patient satisfaction scores in a multicenter study of outpatient gynecology care. American Journal of Obstetrics and Gynecology. 2023; 229(3): 304.e1–304.e9.
[39] DeLoughery EP. Physician race and specialty influence Press Ganey survey results. Neth J Med. 2019 Dec;77(10):366-369. PMID: 31880269.
[40] 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.
[41] Shaw NM, Hills N, Holler J, et al. The impact of patient-physician racial and gender concordance on patient satisfaction with outpatient clinic visits. J Racial Ethn Health Disparities. 2024;11(4):2083–2092.
[42] Ibid.

is also a concern (pediatricians receive lower PSS than their peers), further disincentivizing medical graduates from high-demand primary-care specialties.[43]

The additional measurable effect of growing PSS reliance is physician burnout.[44] The phenomenon is observable without correcting for race, gender, and specialty, so it is no stretch to imagine that physicians who identify with aforementioned marginalized demographics are susceptible to even higher rates of attrition. Burnout guts the physician workforce, and if none of the evident harms due to PSS-linked pay impress employers, they must at least concede that burnout hurts their bottom line.[45] Physicians cite loss of autonomy, micromanagement, and a data-over-people culture as leading reasons for burnout—all of which underpin the discussion around PSS reliance.[46] In truth, PSS metrics are not so much the cause of the problems facing physicians, but rather a logical capstone on the corporate edifice slowly crushing the profession.

The imperative question, now, is whether or not PSS metrics ought to be dispensed with. Evidence that there is no concordance between favorable PSS and positive patient outcomes further pressures the issue.[47] In addition, patients who reported higher PSS, though they utilized emergency services less frequently, nonetheless faced higher costs and increased mortality.[48] Moreover, hospital-level value-based purchasing has demonstrably failed to show improved outcomes when financial incentives are on the line.[49] It follows that extending that logic downwards is similarly futile. However, removing patients' recourse against dismissive or dangerous physicians is also objectionable. A proposed middle ground must reconcile the need to amplify patients' voices with a means to reduce the potential for harm to both patient and physician. Therefore, it appears insufficient to simply do away with PSS; instead, it is best to re-evaluate how PSS inform hospital teams.

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[43] Schneider BJ, Ehsanian R, Schmidt A, Huynh L, Kennedy DJ, Maher DP, Haring S. The effect of patient satisfaction scores on physician job satisfaction and burnout. Future Sci OA. 2020 Nov 12;7(1):FSO657.
[44] Ibid.
[45] Cimbak N, Stolarski A, Moseley J, ONeal P, Whang E, Kristo G. Burnout leads to premature surgeon retirement: a nationwide survey. J. Surg. Res. 02(03), (2019).
[46] Fred HL, Scheid MS. Physician Burnout: Causes, Consequences, and (?) Cures. Tex Heart Inst J. 2018 Aug 1;45(4):198-202.; Ariely D, Lanier WL. Disturbing trends in physician burnout and satisfaction with work-life balance: dealing with malady among the nation's healers. Mayo Clin Proc. 2015;90(12):1593–6.; Gidwani R, Nguyen C, Kofoed A, Carragee C, Rydel T, Nelligan I et al. Impact of scribes on physician satisfaction, patient satisfaction, and charting efficiency: a randomized controlled trial. Ann Fam Med. 2017;15(5):427–33. doi: 10.1370/afm.2122; Chen Q, Beal EW, Okunrintemi V, et al. The association between patient satisfaction and patient-reported health outcomes. J Patient Exp. 2019; 6(3): 201–209.; 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 Mar 12;172(5):405-11.
[47] Edwards A, Evans R, White P, Elwyn G. Experiencing patient-experience surveys: a qualitative study of the accounts of GPs. British Journal of General Practice. 2011 Apr; 61(585): 157-66.
[48] Fenton et. al. The cost of satisfaction. 405-11.
[49] Edwards et. al. Experiencing patient-experience surveys. 157-66.

Many of the direct paths to harm and ethical violations can be blocked off by uncoupling PSS from physician compensation. Instead of tying PSS to one individual's performance, the surveys should be reworked to apply more broadly to the patient's perception of a healthcare encounter. This does not necessarily require a wholesale rewrite of the forms; at minimum it merely means uncoupling compensation from physician-specific quality markers. Rather than populating a spreadsheet to quantify salary bonuses, the patient's answers should be explored using qualitative methods and presented to the care team as a whole. Adapting the morbidity and mortality conference format to salient patient testimonies would prime teams to collaborate on the intangibles of the patient experience and promote holistic discussions.

One alternative approach is sentiment analysis—automated qualitative coding for transcripts of patient encounters. Inquiries suggest that applying it to healthcare is feasible and possibly preferable.[50] Notably, studies predating the recent AI LLM proliferation showed sentiment analysis lagging behind other methods of data analysis.[51] However AI agents have greatly increased the scope and accessibility of large-scale data analysis. Real-time qualitative coding of patient-encounter transcripts is no longer idealistic, but feasible. Subsequent investigations of sentiment analysis have shown that it captures nuances and connections that might otherwise have been missed.[52] Because of its broad lens, sentiment analysis does not merely identify which aspects of care were perceived positively or negatively, but also characterizes the connections between negative emotions, like anger and fear, and places them back in their clinical context. In a study of patients' and families' experiences during sepsis events, sentiment analysis showed which aspects of the experience correlated with the most negative emotions.[53] Under a traditional PSS model, the spouse of a sepsis patient might have channeled their frustration and fear into a poor review for the physician; under a sentiment analysis model, the care team would have identified that broaching the subject of death was the source of many of the spouse's negative feelings, and the team would have been better equipped to address such concerns or ameliorate the care conversation.

[50] Alemi F, Jasper H. An alternative to satisfaction surveys: let the patients talk. Qual Manag Health Care. 2014 Jan-Mar; 23(1): 10-9.
[51] Zunic A, Corcoran P, Spasic I. Sentiment Analysis in Health and Well-Being: Systematic Review. JMIR Medical Informatics. 2020 Jan 28; 8(1): e16023.
[52] Vought V, Vought R, Herzog A, Habiel MM. Application of Patient Sentiment Analysis to Evaluate Glaucoma Care. Ophthalmol Glaucoma. 2024 May-Jun; 7(3): 316-322.
[53] Ntiamoah M, Xavier T, Lambert J. Sentiment Analysis of Patient- and Family-Related Sepsis Events: Exploratory Study. JMIR Nurs. 2024 Apr 1; 7: e51720.

The PSS ethical question is a consequence of the problem that PSS and similar quality-improvement measures set out to solve: How can hospitals deliver better quality healthcare while keeping the patient centered? Qualitative methods are a natural choice for any experience- or narrative-forward approach. Whether they are implemented as a morbidity/mortality-style conference or as automated coding for each encounter, they further the goal of centering patient narratives while removing the ethical pressure on physicians. Healthcare administrators may also be grateful for this off-ramp; the current PSS format already faces scrutiny for its constraints and potential for harm.[54] Critics point fingers at administrators' increased spending on superficial details such as decorations and meals—investing in a perception of quality care rather than the real deal.[55] The practice and administration of medicine and healthcare are an immense undertaking that reward patience but reject band-aid solutions. Healthcare is primed for something more human.

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