influenced by disease prevalence in the screened population. Assuming the best reported performance of screening mammography (95% sensitivity and 97% specificity), we can think of 2 scenarios, each with 1000 screened patients. If we first assume a disease prevalence of 50%, mammography would yield 475 true-positive and 15 false-positive results for a PPV of 99% (Table). However, with a disease prevalence of 10%, the test will yield 95 true-positive and 26 false-positive results, for a PPV of only 27%. Increasing the sensitivity to 99% will only improve PPV by 1%. Thus the clinical utility of a screening test can be enhanced by improved selection of the screened population rather than by increased test sensitivity.

We agree with Dr Keller that women be offered choices for breast cancer screening and that importantly, these choices be informed by potential benefits, limitations, and harms.

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Patient Satisfaction as a Quality Metric Promotes Bad Medicine

To the Editor: The overuse of antibiotics is a well-known public health issue. The research by Meeker et al.,1 “Nudging Guideline-Concordant Antibiotic Prescribing: A Randomized Clinical Trial,” is a simple yet elegant way to help combat the problem of inappropriate antibiotic use. As discussed in their report, there are many reasons that physicians overprescribe antibiotics. However, there is a more recent cause for such behavior that threatens to disrupt any progress made toward more appropriate prescribing: the use of patient satisfaction as a surrogate for quality.

The Centers for Medicare & Medicaid Services has begun using patient satisfaction as a quality metric, with financial implications as an end result.2 This is a perfect example of good intentions leading to bad policy and resulting in bad patient care.

When a patient presents to an office for acute respiratory symptoms, many have done so with the predetermined belief that antibiotics are necessary. The physician not only must weigh the appropriateness of antibiotic use but also must consider how “satisfied” the patient is with their care. No antibiotics may be good medicine, but it can have a negative impact on patient satisfaction.

I spent many years of my professional career providing patients the Centers for Disease Control and Prevention (CDC) handout on appropriate antibiotic use, reviewing each section of the document with them. My patient satisfaction rate was on average 88%. Because of the patient satisfaction as quality push that began a few years ago, I made one change to my 22 years in practice. If I was seeing a patient who made it clear they were seeing me to obtain an antibiotic prescription, “I get sinus infections all the time and Dr Jones always gives me an antibiotic,” I too gave them a prescription for an antibiotic, and not the CDC handout. My patient satisfaction score has not been below 93% since.

Am I proud of my patient satisfaction score? No. I had to practice bad medicine to achieve it. But then, that is the point. It is imperative that stakeholders understand the unintended consequences of using patient satisfaction as a quality marker. In 2012, Fenton et al.3 published an article that should be mandatory reading for all policy makers and stakeholders. They found that patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality.4

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