"'How's My Doctoring? Patient Feedback's Role in Physician Assessment"

Ann Marie Marciarille
“HOW’S MY DOCTORING?” PATIENT FEEDBACK’S ROLE IN ASSESSING PHYSICIAN QUALITY

Ann Marie Marciarille*

ABSTRACT

A society-wide consumer revolution is underway with the rise of online user-generated review websites such as Yelp, Angie’s List, and Zagat. Service provider reviews are now available with an intensity and scope that attracts increasing numbers of reviewers and readers. Health care providers are not exempt from this new consumer generated scrutiny though they have arrived relatively late to the party and as somewhat unwilling guests.

The thesis of this article is that online patient feedback on physicians is relevant and valuable even though it is also uncomfortable for health care providers. This is because the modern physician-patient relationship is sufficiently commercial that physician reputation information is amenable to information sharing in this format. This is also because individual physician-patient feedback highlights the cooperative nature of modern health care delivery and consumption. In an era of chronic disease treatment, health outcome success is often based on the need for an ongoing responsive physician-patient relationship.

This article begins by discussing the availability of online patient feedback on specific physicians and the vision of the modern role of patient that informs it. Next, this article makes the case that patient experience data is empirically relevant to service quality and efficiency. Part of this discussion concerns the interest commercial health insurance and government agencies are displaying in anecdotal patient experience information. Finally, this article considers both whether online anecdotal patient experience information is fair to physicians – grappling with the

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problems of representative data, anonymous posting, practical and legal limitations on physician response, and the unlimited shelf life of online data – as well as whether it is fair to patients – considering the risk of liability for online defamation and the enforceability of gag clauses and prospective copyright assignments for anecdotal reviews of physicians. Throughout, this paper takes the position that this kind of data universe can and should flourish in a way that is fair to all concerned while also producing a public good. Both the values of transparency and fairness can be advanced through the collection and dissemination of anecdotal patient-generated physician reviews.

I. INTRODUCTION

Director Donald Berwick of the Centers for Medicare and Medicaid Services (“CMS”) notes three aims of health care reform: improving the experience of care, improving health, and reducing costs.1 This paper focuses on the first of these, and on the role of patient-experience feedback in assessing physician quality via patient-generated online reviews of physicians on the CMS-sponsored Physician Compare website and on other websites. Anecdotal, user-generated reviews give a different view of patient experience than do standardized validated survey tools. But both see the same underlying issues: consumers’ and physicians’ differing visions of quality, the difference between patient satisfaction and patient experience, and HIPAA’s one-way-street constraints on public “talking back” to unhappy patients.

User-generated feedback on physicians has found multiple fora on the Internet, including: Angie’s List, Yelp, and specialty sites like RateMDs.com. Physician resistance to user-generated web feedback has been concerted, spawning an entire industry of physician Internet reputation defenders.2 The most interesting of these is the Medical Justice Corporation (“MJC”). For an annual fee of several thousand dollars, MJC provides several Internet reputation defense services, including supplying a Mutual Agreement to Maintain Privacy (“MAMP”) document for completion as part of new patient paperwork.3 MAMPs offer physician

3. See e.g., Medical Gag Order, MAKE ME HEAL MESSAGE BOARD (Dec. 10, 2003, 8:57 p.m.) http://messageboards.makemeheal.com/medicine/medical-gag-order-tl141277.html (example of MAMP)
non-disclosure of individual health information in exchange for patient agreement not to review the provider. These agreements have rarely been litigated in the health care context. They make the mistake of conditioning HIPAA compliance on a further contractual provision. These agreements agreements have been the subject of considerable push-back on the validity of this approach. Nevertheless, MAMPs reveal what some physicians think about patient feedback: that they are unfair, overly personalized, and irrelevant. User-generated online reviews are disparaged most forcefully as one-sided, disproportionately focused on “customer service” concerns such as front-desk service, physician/patient time, and patient education. But customer service concerns correlate significantly with better patient adherence, better health outcomes, and lower medical malpractice risk. Physician proponents of MAMPs couch their concerns in terms of provider privacy, raising interesting ideas about the mutuality of privacy in the physician-patient relationship.

CMS’s Physician Compare website struggles with the same issues. By 2019, the Affordable Care Act (“ACA”) requires that physicians must report and the public must have access to physician quality and performance data. The American Medical Association (“AMA”) is lobbying for physician pre-publication review of all information associated with a public listing.

4. Id.
If privacy is more than intimacy, what privacy interest can a physician have in a patient-generated review? Do individual user-generated online reviews involve a privacy interest that is not violated by feedback via standardized, validated survey tools?

All of these questions are related to the fundamental question of who is the relevant quality expert in health care and what is the relevant patient experience quality measure. Is subjecting physicians to user-generated online reviews fair given that the quality of the services provided and the norms within which they are structured, may be more like driving than dating? In short, does the increasing standardization of medicine under widely available protocols and rubrics make the patient their own best second opinion on the quality and quantity of care provided?

This is a “human bites dog” moment in health care, representing a paradigm shift and power shift in the physician-patient relationship. Physicians are suing or threatening to sue their patients for posting online reviews of their patient experience.

Historically, physicians rarely sue their patients (excluding collection). The consensus is that such litigation, or the threat thereof, dampens the intimacy or the trust required for an effective physician-patient relationship. Post-encounter litigation over fees is justifiable because the treatment relationship has terminated, leaving only the need to resolve the business relationship. These new threats of litigation, however, come at the very formation of the physician-patient relationship as physicians wield the litigation stick to rein in freewheeling patient participation on physician review websites.

The mechanisms of threatened control—copyright law, defamation law, and HIPAA—are interesting. But the timing is even more so. Just as an industry arises to police online physician reviews, the federal government pushes its own largest government funded insurance programs to begin to collect patient satisfaction and patient experience data and to make it available online—thus setting up a collision between the irresistible force pushing for increased transparency on patient satisfaction data and the immovable object of physicians closing the examination room door ever more tightly against a society-wide trend toward online

information sharing.

II. IS THE PATIENT A CONSUMER?

Medical patients have been known “patients” in English usage from the term’s first recorded use by Chaucer near the end of the fourteenth century. 17 “Patient” comes from the Latin verb pati, to suffer, through the participle form patientem, for one who is suffering. In Latin this word took on the extra sense of somebody who suffers their afflictions with calmness and composure. 18

Patient-physician relationships have been framed by many metaphors: parent-child relations; seller-purchaser transactions; teacher-student learning; relations among friends; or parties entering into contractual relations. 19 It is not necessary to align an understanding of physician-patient relationships with only one of these models to understand that there are aspects of a service contract relationship to modern physician-patient relations. It has been observed that contract principles govern the inception of the physician-patient relationship but that bargaining power is almost entirely removed from the patient once the relationship is formed, 20 leaving tort law to govern the terms of the relationship. The lack of equitable bargaining power within the physician-patient relationship is attributable to information asymmetry and the curious intimacy of the relationship.

“For most of the history of medicine, the patient has been the embodiment of a diagnosis, the passive target of treatments, the recipient of injections and infusions, and the (hoped for) compliant consumer of medications and follower of orders.” 21 Only very recently has the rise of health care consumerism 22 altered this role. “Medicine is now a major

17. GEOFFREY CHAUCER, The Physician’s Tale, in THE CANTERBURY TALES (1386).
22. Kenneth W. Kizer, Establishing Health Care Performance in the Era of Consumerism, 286 JAMA 1213 (2001) (Health care consumerism is best understood as a consumer empowerment movement attributed to a confluence of sources. “The heightened focus on quality and the rise of health care consumerism are manifestations of numerous interrelated dynamics, especially including the aging of the “baby boomers” and greater prevalence of chronic conditions, the explosion of biomedical scientific knowledge and technology, changes in the prevailing method of health care financing, a recent prolonged period of economic prosperity, widespread concerns about patient safety, return of disproportionate health
industry in which technology has, in many instances, replaced the old standbys of observation, experience, and intuition.” From this perspective, the practice of medicine is a matter of technical expertise and the patient a consumer of technical services. The patient then is patient no longer. Impatient to learn for themselves, an estimated eighty percent of Americans who use the Internet use it to search for health information.

The democratization of medical knowledge has produced a class of patients who purchase and evaluate health care services much the same way they purchase and evaluate other technical services. First, they educate themselves as to price and scope of services. Next, they crowdsource their need for information on quality. Finally, they may report back on their own patient experience, closing the quality-reporting loop. Quality-driven consumers are higher income adults who have the sophistication to access newly democratized medical knowledge. Their drive to health care consumer activation is premised, in part, on the belief that knowledgeable, inquisitive health care consumers will improve the quality of care and of outcomes.

Their drive to health care consumer activations may also be premised, in part, on the experience of caregiving. An estimated sixteen percent of adult Internet users have consulted online rankings or reviews of doctors or other providers and an estimated four percent of adult

care cost increases, and the democratization of medical knowledge consequent to widespread use of the Internet.”.

24. More than one author has observed that the rise of distance medicine has created a dynamic where the physician may have to wait upon the patient. See, e.g., The Patient Will See You Now – New Technology for New Collaborations, MIT Media Lab Presentation, February 23, 2012.
26. KAVEH SAFARI, THOMSON HEALTHCARE’S CENTER FOR HEALTHCARE IMPROVEMENT (2008) (An estimated 19% of American adults are “quality driven consumer,” people likely to research ratings information on hospitals or physicians.).
27. Dina El Boghdady, Some Doctors Try to Squelch Online Reviews, WASH. POST, Jan. 28, 2012 (Though not the way they investigate major consumer purchases. “Consumers spend more time shopping for a refrigerator or car than they do for a health-care plan or doctor.”).
28. Crowdsourcing is the act of outsourcing tasks, traditionally performed by an employee or contractor, to an undefined, large group of people or community (a “crowd”), through an open call. See also Jeff Lowe, The Rise of Crowdsourcing, WIRED MAGAZINE, June 2006, at http://www.wired.com/wired/archive/14.06/crowds.html?pg=1&topic=crowds&topic_set=.
29. The theory of peer production notes that motivations such as personal expression, generosity, reciprocity, and the desire to show off, as well as economic motivations, may be relevant. James Grimmelmann, The Internet is a Semicommons, 78 FORDHAM L. REV. 2799, 2813 (2010).
Internet users have posted a review online of a doctor.\footnote{Susannah Fox & Sydney Jones, Pew Research Center, \textit{The Social Life of Health Information}, at \url{http://pewinternet.org/Reports/2009/8-The-Social-Life-of-Health-Information/01-Summary-of-Findings.aspx}.} An estimated one in five Americans use social media for healthcare information (with three percent favoring social media alone as a source of health care information) and one in four Americans indicate social media will influence future health care decisions.\footnote{One in Five Americans Use Social Media for Health Care Information, \textsc{National Research Corporation Ticker Study} (May 17, 2012, 10:04 AM), \url{http://hcmg.nationalresearch.com/public/NEWS.aspx?ID=9}.} Caregivers, however, are more likely to have consulted online rankings or reviews of doctors and to post one. Twenty-one percent of adult internet users who are caregivers have consulted online rankings.\footnote{Susannah Fox & Sydney Jones, \textit{supra} note 28, at 7.}

The motivations of caregiver Internet users to frequent physicians review sites may be hard to parse. Caregivers are acutely aware that, often, the subjective preferences of patients can be hard to discern. This may make the caregiver group prize the articulated opinions of others as a kind of proxy for the subjective feedback they lack. In addition, a physician willing to work cooperatively with a caregiver may be a precious commodity.\footnote{The Patient Protection and Accountable Care Act, in explicit recognition of this deficit, proposes to evaluate health care professionals, in part, by how well they work with the families and caregivers of patients.}

Finally, consulters of online physician reviews are not evenly distributed throughout the population. Younger and better educated people are disproportionately likely to research in this way as are Californians – the residents of Yelp’s home state are the most habituated of all to searching for online provider reviews, including those of physicians.\footnote{Bazaar Voice, \textit{Social Commerce Statistics}, at \url{http://www.bazaarvoice.com/resources/stats}.}

Activated health care consumers refute the received wisdom that medical insurance markets are not and cannot be competitive, in part, because health care provider pricing is not transparent and because consumers are uncertain on how to measure the quality of medical care.\footnote{Kenneth Arrow, \textit{Uncertainty and the Welfare Economics of Medical Care}, 5 \textsc{Am. Econ. Rev.} 941, 965 (1963).} Flourishing online patient communities developed, in part, to share experiences regarding a specific provider, challenge us to rethink consumer capacity to assess the quality of medical care. Populators of online physician review sites see value in the anecdotal, value in the opinions of other consumers “just like me” and do not necessarily see the
rise other physician quality measures as inconsistent with this value.

A. The Nature of Patient Experience Data

Though one of the three aims of health care reform involves improving the experience of care, there is little consensus on methodology for measuring improvement in the patient experience of care. This is because there is little consensus on how to measure patient experience of care data in the first place. The management adage that you can’t improve what you don’t measure seems particularly apt.

The patient experience of care is really two-dimensional: subjective patient experience and subjective patient satisfaction. Patient experience is such an inherently subjective concern, the drive has been to substitute quality of care data for experience of care data. Quality of care data’s relationship to patient experience of care is nuanced. But there is also a drive to find a place in assessing patient experience of care that makes room for the subjective or the anecdotal. This is further complicated by the fact that, in health care, a customer usually serves as a participant in the services act.

A growing body of research on patient activation, suggests that activated patients – those with the knowledge, skills, and confidence to manage their health and health care – have better health outcomes, in part because of an increased likelihood to follow treatment regimens. Patient activation is a part of patient experience that links to better self-care.

The difference between service quality and service satisfaction in health care may be particularly pronounced. Stated differently, health care service quality has both a technical and a functional aspect. Its technical aspect encompasses the quality of the care provided as measured by optimal outcome. Its functional aspect encompasses the manner in which

38. In this regard, a physician’s role is to help a patient detechnialize health care and rehumanize it as well, by relating it to the patient’s life outside the examination room. RITA CHARON & MARTHA MONTELLO, STORIES MATTER: THE ROLE OF NARRATIVE IN MEDICAL ETHICS (2002).
41. Jun, supra note 40, at 84.
the technical quality is transmitted. The conventional wisdom is that “patients are typically not capable of assessing the technical quality of the care they receive” and so improvements in “perceived quality” focusing on improvements in communication, facilities, and employee service represent the easiest path to perceived quality improvement. But, in fact, patients have strong opinions about the technical quality of the care they receive, the manner in which it is received, and the connection between the two.

Health care services are overwhelmingly delivered individually and privately, indeed confidentially. The quality, cost, and effectiveness of these services are a fitting subject of intense public interest, however, both for the individual and societal drives to higher quality more cost effective care. It is this paradox – intensely private activity with tremendous public consequence – that illustrates the tension between respecting the inherently private and subjective elements to health care services and the inherently public and objective elements to health care delivery and finance reform.

Despite this, patient experience information, based in areas that “research has shown patients value, including ease of scheduling appointments, availability of information, communication with clinicians, responsiveness of clinic staff, and coordination between care providers” has been of interest to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) project, funded and administered by the U.S. Agency for Healthcare Research and Quality (AHRQ), for at least a decade. CAHPS data collection is conducted by an in-office handout survey administered by non-staff personally and an Internet-based survey, both measured against a standardized CAHPS survey conducted through the mail. CAHPS patient experience data, in short, is part of a standardized collection system with a validation process. Interestingly, even under this patient experience data collection regime, CAHPS urges further anecdotal patient experience data collection on its providers, including focus groups, shadowing, and the mining of patient complaint and compliment letters, and comment cards. The individual, the

42. Id.
43. Id. at 96.
anecdotal, seems to find its way back in and to be valued for what it can offer. This may be because the anecdotal and subjective patient experience data has always been relevant to understanding outcomes in treating chronic diseases such as asthma. Successful treatment of asthma, for example, can really only be measured by self-reported, subjective health related quality of life data – the quintessential example of data collection attempting to quantify humanistic health outcomes.

In addition, the vast majority of consumers and providers do not have access to CAHPS data, however. Although CAHPS has begun to accumulate patient experience of care data (known as PEC data) on timely appointments, physician communication with patients, and helpful, courteous, and respectful office staff, and some conclusions have begun to be drawn about the clinical and business case for good patient experience, this information is not available to individual consumers seeking to use it to inform individual health care decision making. Whether the absence of this publicly available information from projects such as CAHPS drives customers to user-review web sites is hard to say but it is apparent that some consumers prefer user-review website anecdotal data to data from validated instruments even when the latter is available. And, it is unambiguous that many more consumers prefer user-review web site anecdotal patient experience data to no patient experience data at all.

It is worth noting that personal recommendations and anecdotes have long shaped patient self-referral patterns for all kinds of professional and technical service providers – including physicians. Word-of-mouth feedback on physician performance has probably existed as long as the physician-patient relationship. Any number of physicians using modern marketing tools to track referral sources note current patients as a fertile

discussion of the value of gathering anecdotal patient experience information.)

47. See E.F. Juniper, Using Humanistic Health Outcome Data in Asthma, 19 PHARMACOECONOMICS 13 (2001).
48. Browne, supra note 45, at 924.
49. See https://www.cahps.ahrq.gov/Consumer-Reporting/CAHPS-Measures.aspx for a complete list of adult ambulatory care quality measures focused on patient experiential data.
50. Browne, supra note 45, at 922.
51. Barbara Balik, et al., Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care, INSTITUTE FOR HEALTHCARE IMPROVEMENT at 17 (2011), at http://camcinstute.org/university/pdf/IHIPatientFamilyExperienceofHospitalCareWhitePaper2011.pdf. (General information about CAHPS project data can be gleaned from CAHPS PEC data reports, such as a University of Pittsburgh Medical Center summary report on hospital care noting that patients always want to be listened to, taken seriously, and respected as a care partner.)
source of referrals.⁵³ But doctors’ marketing efforts have historically not been tied directly to consumer satisfaction.⁵⁴ Reputation, historically, has meant the reputation of a physician among physician peers. And doctors have been mightily interested in this aspect of reputation, as witnessed by the large amount of hospital admitting privilege litigation premised on reputation concerns.⁵⁵ Patients, however, were predominantly expected to use exit rather than voice as commentary on the patient experience. Marketing of physician services, until recently, has been quite limited – of interest to only certain specialties and focused only on certain customer groups. The paradigm for physician to patient marketing was borrowed from the packaged goods media, a one-way dissemination of information presumed to be of interest to the receiving consumers.

The rise of social media, and user-generated content in particular, has transformed the marketplace for physician services. Consumer-generated media blend the use of technology and social interaction for the creation of collective information. Content communities, such as Yelp⁵⁶, represent the flowering of the preference of some consumers to receive reputational and quality information from peers rather than industry experts and academics. The distinguishing characteristics of consumer-generated media are: reach, accessibility, usability, immediacy, and permanence.

Yelp is a California-founded user-generated content rating site. Over the past two years, visits to Yelp.com have increased over 100%.⁵⁷ Yelp’s visitors are still dominated by Californians, with the top five cities by representation including: San Francisco, San Diego, Los Angeles, and San

⁵⁶. Zagat Health Survey Information Now Available to Providers, Anthem Blue Cross, at http://www.anthem.com/ca/provider/r1/r0/r0/pw_a131831.pdf (Zagat’s physician ratings services, by contrast, is less well-developed with limited geographic scope. Zagat offers an interesting contrast to Yelp for how it both solicits patient-generated physician ratings and shapes them. The Zagat online service tool solicits patient ratings on four criteria: trust, communication, availability, and office environment but also allows for open ended comments. Zagat illustrates the seamlessness of open post patient generated physician review world and the interest of commercial insurer’s in such information by marrying the Zagat Health Survey to Anthem Blue Cross and Blue Shield membership.).
Diego reflecting the origin of the site. Marketing studies of purchaser decision influencers demonstrate that the estimated fifty percent of adults who prioritize solicited word of mouth purchase advice are almost matched by the group that gleams purchase advice from webpages and the roughly one-third who prioritize online customer reviews. Interestingly, when marketers study the uptake in online reviews, some health care providers are identified as service sector providers, along with restaurants and dry cleaners.

Despite the emphasis on the public reporting of health care quality data, available health care quality data is often ignored. When patients seeking a new primary care provider were offered web-based physician-level data that included patient experience scores incorporating validated measures of interpersonal quality, appointment access, care coordination, health promotion, and post-encounter patient recommendations, only seventeen percent of all patients availed themselves of the information. Of those, however, fifty-one percent considered patient experience scores as the most useful information and, in particular, interpersonal quality scores and patient recommendations of the primary care provider were found to be the most useful information. Prospective patient reluctance to access the data is based on the perception that the information will not be physician-level quality information—what prospective patients most prize. Patients particularly value information concerning other patients’ experiences with a provider.

Dental services are a natural fit for online reviews for multiple reasons relating to the nature of health insurance in the United States. An estimated 45 million Americans do not have dental insurance. Medicare and basic Medicaid do not offer dental care for adults. The ACA does not

59. Tancer, supra, note 58.
60. Id.
62. Id.
64. Fanjiang, et al, supra note 57, at 1465.
66. Id.
include dental care for adults\(^{67}\) in its minimum coverage requirements. This means a substantial percentage of adult dental care in the United States is paid for out-of-pocket,\(^{68}\) producing a price and quality sensitive constituency for dental services. Despite the fact that higher income individuals are more likely to have dental coverage as part of an employer-based health benefits package,\(^{69}\) the lack of adult dental insurance reaches enough sophisticated consumers to produce a lively marketplace of reviews and ratings for dentists.

Not unlike cosmetic plastic surgeons,\(^{70}\) dentists have had to learn to embrace online reviews. Indeed, the use of online review sites as marketing vehicles is part of the business plan for many newly formed dental practices.\(^{71}\) Because of the lack of insurance intermediary for payment and quality assurance, consumers may be more wary of out-of-pocket funded providers as well. It is not unusual to see a dental office or a cosmetic surgery practice registered with the Better Business Bureau\(^ {72}\), while it is extraordinary to find an insurance-funded health care provider registered as such.\(^{73}\)

Though it is possible to argue that the nature of the medical specialty’s most often deemed “services” by consumers is in some way qualitatively different from those of say, primary care, it is difficult to differentiate between medical specialties in this way. Although cosmetic surgery is undoubtedly intimate, so is childbirth. Though there is a lively online presence reviewing obstetrical services providers, the sheer volume of data pales in comparison to that available for dental services providers.

**B. What Do Patients Want?**

Surprisingly little empirical work has been done to determine what patients want from health care providers. This may be because the answer is deemed — sight unseen—obvious. It may also be because the answer is deemed — sight unseen— unobtainable. Or, it may be that different groups

\(^{67}\) Id.

\(^{68}\) Id.

\(^{69}\) Characteristics of the Covered Group, EMPLOYEE BENEFITS (may 15, 2012, 2:55 PM), http://employee-benefit.blogspot.com/2012/01/characteristics-of-covered-group.html


of patients have different priorities and that these priorities evolve with changes in payor status. What patients want, in short, may be defined by what they do not have.

Low-income Californians, defined as those adults with income below 200% of the federal poverty level, typically lack choice in providers and, as a result, the majority would be interested in switching health care providers if given the freedom to do so. In particular, the sub-group of low-income Californians who lack a personal physician would switch providers to obtain one. The delivery model in many of California’s community clinics, and particularly in Federally Qualified Health Centers, is based on a group delivery model that does not assign an ongoing individual physician to each patient.

But an ongoing relationship with a physician was not the only patient aspiration identified. The five leading factors correlating with low-income Californian patient satisfaction with current health care delivery were: courtesy of staff, patient involvement in medical decisions, the cleanliness of the facility, the amount of time physicians spend with patients, and having a highly regarded personal doctor.

There are limits to how generalizable the desires of low-income Californians are to having regularly assigned doctors, access to appointments over walk-in settings, and to be seen in clean well-run facilities, but the emphasis on improving the experience of care is unmistakable.

Men and women differ in their conceptualizations of the physician-patient relationship, as well. Polling data indicates that, while both sexes are committed to their doctor-patient relationship, men are more open to quantifying the relationship in terms of care provided for dollars earned while women see the relationship as a personal one where data alone cannot capture the patient’s experience with their physician. As women are the family gatekeepers to the health care system and often choose physicians for family members, this discontinuity is particularly significant.

Race may also be salient to understanding different perceptions of the physician-patient relationship. A nationwide survey in 2001 found that

75. Id.
76. Id.
78. Id.
African Americans and Hispanics were more likely than any other groups to feel that they had been treated with disrespect by their physicians and their physicians’ office staff. One study exploring provider verbal dominance and patient provision of information, documented pronounced provider verbal dominance over African American patients and accompanying less patient provision of information. “These differences in patient perceptions, and particularly perceptions of racism, are important irrespective of provider communication and intentions since patient perceptions will affect their interactions within the system.”

C. Are Health Care Providers Service Providers?

1. The Role of Trust in the Doctor-Patient Relationship

An understanding of the doctor-patient relationship as a commercial one taking place in a broader health care marketplace is a thoroughly modern invention. The commodification of health care has contributed to this understanding. Commodification is a product of the rise of standardized fees and standardized delivery. The very forces that have improved access and outcomes, in short, have depersonalized medicine and the experience of receiving medical care.

There is a substantial literature on the role of trust in the framework of the physician-patient relationship. What has been described as “the psychological and emotional realities of trust and illness” is offered as the underpinning of a host of unique features of the physician-patient relationship, including ethical restrictions on physician behavior and abnegation of the physician’s self-interest. There is, however, little discussion of the mutuality of trust in the physician-patient relationship. Whatever else is going on, the introduction of MAMPs into the formation of the physician-patient relationship indicates that physician trust of patients has ebbed. From this perspective, a MAMP may be seen as a sorting device – sign it and you are trustworthy, don’t sign it and you are

81. Id. at 806.
82. Hafferty & McKinlay, THE CHANGING MEDICAL PROFESSION: AN INTERNATIONAL PERSPECTIVE 201 (1993) (It is worth noting that limits on the practice autonomy of individual practitioners do not necessarily limit the collective autonomy of the medical profession. These are two entirely different things.).
84. Id.
not. It is a significant and remarkable break with the presumption of patient trustworthiness that would contemplate the need for such a sorting device.

Online consumer-generated physician review websites are really repositories of reputational information. Reputational information has been defined as “information about an actor’s past performance that helps predict the actor’s future ability to perform or to satisfy the decision-maker’s preferences.” The utility of this definition is in how it captures the duality of reputational information – offering commentary on past performance and predicated on the belief that the best indicator of future performance is past performance.

Online consumer-generated physician review websites are typically mediated systems, where a third party has taken some role in publishing the information. Consumer review sites are the quintessential mediated reputation system. While it is true that consumers can review just about anything online, online consumer-generated physician reviews have been relatively recent entrants into the marketplace.

The online information marketplace has been particularly responsive to consumer-driven demand for physician-specific service reviews. Angie’s List, in its origins a home-service review site, introduced online reviews of health care professionals in July of 2010. Angie’s List does not allow anonymous reviews, however, in the interest of “accountability to both sides.” Because “it is costly for consumers to find and assess the credibility of reputational information. . . reputations systems themselves typically seek to establish their own reputation,” Angie’s List has determined that prohibiting anonymous reviews is the best marker for its reputation system. This is, in part, because Angie’s List encourages service provider responses to reviews – part of the service quality determination hinges on the prompt resolution of customer quality concerns expressed online.

HIPAA notwithstanding, Angie’s List encourages health care professionals to respond to favorable and unfavorable reports. Yelp lets businesses respond to web reviews, though this was not part of its original business model.

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86. Id. at 295.
88. Goldman, supra note 51, at 296.
Consumer review websites are almost entirely unregulated. And consumer-generated physician reviews circulated through social media share all of the distinguishing characteristics of that communication medium. Social media is difficult to monitor, fast moving, less formal, and oddly permanent. Online publishers are statutorily protected from liability for third party content. Internet service providers are generally immunized from liability for third-party content if the liability hinges on characterizing the provider as a publisher or speaker of the offending material. This extraordinary expression of “Internet exceptionalism” means that consumer review websites enjoy a higher degree of protection than do job references.

Individuals have been sued for posting negative online reviews of service providers, however. A San Francisco chiropractor sued a former patient in 2008 for defamation involving a negative Yelp review about a billing dispute. Although the suit was ultimately resolved before trial, the issues raised by such litigation linger on, though only a handful of lawsuits have been filed against Yelpers for posting comments.

Strategic lawsuits against public participation or SLAPP suits are meritless defamation suits filed by businesses against individuals who speak out about them. Although, conventionally, SLAPP suits are targeted at silencing individuals participating in the political process, anti-SLAPP statutes are now being used to defend against suits stemming from online comments. Twenty-seven states have anti-SLAPP statues and a federal bill has been filed creating a federal anti-SLAPP statute modeled on California’s.

2. Commercial Insurers’ Use of Online Doctor Ratings

Commercial health insurers have long been interested in patient experience measures. Kaiser Permanente, in particular, studies patient dissatisfaction as a marker for voluntary disenrollment from their managed

90. Id. at 297.
92. Shiamili v. Real Estate Group of N.Y., Inc. 17 N.Y. 3d 281 (2011)(J. Carmen Beauchamp Ciparick interpreting the Communications Decency Act to distinguish between being a content provider and being a passive conduit of defamatory material).
93. Goldman, supra, note 51, at 298.
94. These are governed by state law and common law tort regulation.
95. Goldman, supra note 51 at 298 citing Wendy Davis, Yelp Reviews Spawn At Least Five Lawsuits, MEDIAPOST NEWS, (Jan 21, 2009); Dan Frosch, Venting Online, Consumers Can Find Themselves in Court, N.Y. TIMES, (May 31, 2010).
96. Frosch, supra note 91.
97. Colorado and Virginia have procedural protections against such suits.
care plans. In one such study, voluntary disenrollment was associated with patient dissatisfaction with care access, practitioner interaction, or overall visit experience.  

An entire cottage industry of health care consultants has grown up around the measuring, gathering, and strategizing around what is known as patient voice data. The sales pitch often promotes “why the patient experience should be a top strategic priority” as a financial imperative.

Physician concern about insurer ratings sites has given rise to litigation over both the methodology of the ratings systems and the inaccuracy of the reporting sites. In *California Medical Association v. Blue Shield of California*, for example, the California Medical Association filed a class action suit against Blue Shield of California for inaccuracies in its Blue Ribbon Recognition Program. Although the Blue Ribbon Recognition Program did not collect anecdotal patient experience data, it did collect data consistency and quality of care of patients needing ongoing care, one of the measures that does matter to patients in quantifying patient experience. Ultimately, the CMA’s challenge to the program was dismissed. Cast by Blue Shield of California as a victory for health care transparency, providers remain concerned that health plan cost rankings are deeply flawed. Consumer perspectives on good value in physician services has not been heavily surveyed for out-patient care but there is some evidence that patients, in the in-patient acute care setting, value patient safety, treatment skill, and responsiveness to patients over good value.

Commercial insurance companies’ interest in anecdotal provider ratings may extend into data and text mining programs, though it is difficult to say if, and how far, this interest may have extended beyond the

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100. Id.
105. Text mining is the extension of data mining’s standard predictive methods to unstructured text, such as Yelp and Facebook.
active data and text mining programs sponsored by pharmaceutical companies, for example.\(^{106}\) Text mining of social media to produce sentiment analysis\(^ {107}\) is referenced in Yelp’s terms of service,\(^ {108}\) an interesting harbinger of the usefulness of Yelp postings to health care quality monitors.

3. The Federal Government’s Interest in Patient Experience Data

The federal government has grown increasingly interested in quality measurement and scoring that includes weighting for patient/caregiver experience. The proposed regulations for the Medicare Shared Savings Program, initiated by PPACA, specifically include patient/caregiver experience as one of seven quality measure domains across which accountable care organizations (“ACOs”) will be assessed.\(^ {109}\) ACOs are integrated care delivery systems designed to produce better health outcomes, coordinate care, and improve the patient experience of care. The most remarkable aspect of the ACO format is that the care will be accountable – measured, studied, and, ultimately, evaluated in novel empirical ways. ACOs will need to measure and report data on obtaining timely care, appointments, and information; physician communication; patient physician rating; health promotion and education; implementation of shared decision making; and functional health status maintenance or improvement. It is noteworthy that data collection on helpful, courteous, and respectful office staff fell out of the proposed ACO regulations by the time they reached their final form but that data remains of interest to the CAHPS survey, meaning it will be collected for informational purposes but not for reimbursement purposes. “How’s my receptionist?” will finally become a question worth answering, though not with an answer worth grading.

CMS interest in some of these measures has been longstanding. The National Quality Forum has already developed reference survey tools to measure physician success in health promotion and education and

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107. Linguist Christopher Potts of Stanford defines sentiment analysis as “the computational study of how opinions, attitudes, emotions, and perspectives are expressed in language, provid[ing] a rich set of tools and techniques for extracting this evaluative, subjective information from large data sets and summarizing it.” http://sentiment.christopherpotts.net/overview.html
demonstrable improvement in patient health status, for example. And the HHS Agency for Healthcare Research Quality (“AHRQ”) has collected and made available a collection of Consumer Assessment of Healthcare Providers and Systems survey and reporting kits culled from various sources. The proposed MSSP regulations specifically require that these pre-existing tools be standardized as the required measures for ACO patient experience assessment.

This is all aggregated data for all providers participating in an ACO. Provider specific data will not be submitted to CMS, though it will surely be available to ACO administrators, including the physician-led governing board. Whether ACOs will review historical patient experience data for their own purposes of evaluating continuing ACO participation remains to be seen. If the patient experience data is understood to be a crucial variable in determining the rate of return for the shared savings in the MSSP, it is entirely possible the data will be scrutinized to the extent it impacts the financial viability of the ACO. This, of course, resonates with the current practice of “economic credentialing” of physicians.

The significance of patient/caregiver experience data for the MSSP program is demonstrated by the weight attached to the data. CMS has proposed that each domain be weighted equally in calculating an ACO’s total performance quality score. In addition, each measure is proposed to be weighted equally within a domain.

Measuring primary care physician performance through patient experience data is fraught with peril. It is necessary to determine whether the patient experiences measured should include only established members of the physician’s panel or unestablished patients as well, and whose definition of “established patient” should prevail.

Consumer or patient perspectives on physician quality may differ from that of insurers. However, they also have some things in common. Insurers have encountered provider-raised barriers against disseminating cost and quality data to consumers. Some providers oppose the dissemination of insurer-generated cost, quality, and service data on the grounds that such data is self-serving at best, and biased at worst. It is a

112. ACO Regulations, supra note 105.
114. Kamala Harris comments to proposed MSSP regulations, Mar. 31, 2011.
reflection of the ongoing tension between providers and payors that little consensus exists on how to measure cost, quality, and service.

This makes the role of the government in standardizing the measurement of cost, quality, and service even more important—both for the role such data can play in administered pricing schemes like Medicare and Medicaid, and for the transferability of these standardized measures to the world of commercial insurance.

CMS has launched a bare bones Physician Compare database. Physicians are acutely aware of the behind the scenes wrangling going on between CMS and medical societies (and hospital associations) over the breadth and depth of these sites, as well as a similar fight over the appropriate use of such insurer-collected data on patient satisfaction. No patient reviews are currently involved in this lightly populated site. By the time it is fully populated, it may look more like Hospital Compare. What is known is that patient surveys will ultimately be required by CMS for Hospital Compare. As a result, this may also ultimately be in the future plans for CMS’s Physician Compare. As part of the ACA, Physician Compare will expand to include quality data in 2013. CMS has also issued a proposed rule allowing organizations, but not individuals, access to this quality data.

And CMS has been collecting in-patient satisfaction data since July of 2011, and actually launching a patient satisfaction-linked Medicare reimbursement change in October of 2012. Hospital reimbursement rates will then be subject to a uniform one percent national withhold that will be re-distributed based on two factors: seventy percent will be based on clinical guideline adherence and thirty percent will be based on comparative performance on a CMS-sponsored patient satisfaction survey. The uniform national withhold will grow to two percent by 2016. The patient satisfaction information surveyed includes questions whether the physicians and nurses communicated well, whether pain was well controlled, whether the hospital room was clean, and whether the hospital was quiet at night. The bar to achieving a bonus payment will be set high, requiring “always good” patient experience ratings and a minimum of nine out of ten overall patient scores.

CMS’s first moves toward taking patient satisfaction into account

when reimbursing hospitals have not gone unnoticed in the popular press. The CMS approved surveys ask about provider communication skills, the adequacy of pain control, the cleanliness of the hospital room and nighttime noise levels. Hospitals are reported to be concerned that they will be evaluated on the basis of hotel-like amenities. The perception that patients will answer the survey questions by answering questions that were not asked calls into question all patient experience and patient satisfaction questionnaires, including those validated. Patients apparently so easily swayed by hotel-like amenities or dissuaded from accurate responses by certain medical conditions – such as depression – cannot be relied upon when reimbursement is at stake. Similarly, geographic differentials based on cultural factors, such as a tendency to find fault and a tendency to praise, may be challenging to factor into what is planned to be a national reimbursement standard.

Although neither Physician Compare nor Hospital Compare involve patient review data (individual or aggregated) at this point, it is worth noting that online doctor-rating sites already offer an important supplement to this kind of site and may address some of the limitations/inadequacies of these sites.

Individual insurers, after all, are and have been for some time collecting patient satisfaction data by post-encounter survey. This data is sometimes made available to other subscribers of that insurance company. This data may sometimes be factored into physician compensation or contract rates. Physicians may be concerned that open post-encounter physician-rating sites may be used by insurers discouraged by low patient response rates to traditional data collection for these same purposes—playing a role in physician compensation or contract rates. The fairness of this may hinge on our comfort level with the “permanent memory bank of the web.” If a physician receives a credible negative review that sparks some improvement in practice or practice management, how will this information be broadcast as widely as the original negative review? Providers are concerned that the negative review will still always be out there in cyberspace. Behavioral psychology data is clear, after all, that we all remember and retain negative experiences at a much higher

118. Id. at D1.
119. ACO Regulations, supra note 104.
120. Id.
121. Id.
122. Id.
123. This is one way to describe Yelp.
rate—meaning negative reviews will contain an intensity lacking in positive reviews and review readers are likely to retain more information from negative reviews.

The fairness and the utility of anecdotal data is sharply limited by its evergreen nature. Alessandro Acquisti’s observation that web postings have an extraordinarily long decay times is particularly poignant when the extraordinarily long decay time may serve as a barrier to health care delivery change.

The desire to capture the anecdotal, tempered by concern that only disproportionately negative anecdotal evidence is likely to be posted, has produced interest in using mystery shoppers to address patient experience data collection in longitudinal surveys. Mystery shoppers are individuals compensated to pose as actual patients through a standardized encounter, providing feedback to their funder. Mystery shopping in health care was only recently—and controversially—in the news as part of a program proposed by HHS to assess comparative access to primary care for individuals with commercial insurance, and individuals with government funded insurance. Provided with a standardized script of symptoms, the proposed project was designed to test whether primary care gatekeeper response to mystery shopper patients differed depending upon the source of health insurance.124

The proposed study was eventually scrapped after considerable resistance from the primary care provider community and from one particularly vocal provider.125 Interestingly, the study was not disparaged for inaccuracy but for non-utility. No one disputed that primary care providers direct their staff to limit the number of traditional Medicare patient appointment slots, or that setting a ratio for the right payor mix in a practice was anything but fiscally responsible.126 What remained untested was whether fiscally appropriate payor mix formulas bled over into reduced access to primary care for some patients—perhaps because it was so evidently true. The opposition to the proposed mystery shopper program was based on revulsion at “spying on” physicians,127 conveniently ignoring that the study was designed to observe and report on physician front desk practices. Indeed, the entire primary care access, mystery

126. Id.
127. Id. (quoting Congressman Tom Price of Georgia).
shopper project was likely to have been conducted with absolutely no direct contact with primary care providers themselves.

The role of medical receptionists as gatekeepers to primary care is undervalued and under-analyzed.128 Designing a study around primary care access that probes the standards by which these gatekeepers permit primary care access to differently insured patients is genius. Receptionists are the intermediaries between primary care providers and patients. “We should be thinking of the relationship not as a two-way one between doctor and patient or nurse and patient, but as a three-way relationship among clinician, patient, and receptionist.”129 In the end, not even “how’s my receptionist?” was a question that could be asked and answered.

There is a sense that reporting on direct observation of physician and physician staff quality by patients is inherently demeaning. It is also an inescapable undercurrent here, even spilling over into the popular press.130 Inviting direct observer or consumer comment on provider behavior implies that the observations of ordinary untrained people are valuable to patients, providers, and payors alike.

Some individuals are troubled by “how’s my driving” type data collection in all contexts. The implication is that each individual scrutinized is at the mercy of all other potential observers – turning us all into critics at large on how others are performing their highly visible work. The assumption here seems to be that work performed in public and as part of interaction with the public (such as driving a truck on a public road) invites public observation of skill and comment on interaction with other unskilled drivers. Part of a truck driver’s job, in short, is to navigate the road in a way that does not call undue attention or concern from others on the road for their own purposes. “How’s my driving” data collection, seen this way, is a measure of unobtrusiveness. The placards solicit attention only if the driving behavior scrutinized was remarkably good or remarkably bad.

Other individuals who are untroubled by “how’s my driving” data collection for truck drivers are troubled by similar models of data collection for professionals. Some of this relates to a vision of professional autonomy, where the very meaning of “professional” conjures up an image of individual judgment exercised with little process-based

128. Pauline Chen, Giving Medical Receptionists Their Due, NEW YORK TIMES, June 30, 2011.
129. Id., (quoting Dr. Jenna Ward, University of York).
130. Jeffrey Goldberg, What’s Your Problem? THE ATLANTIC, September, 2011 at 112 ("Imagine physicians being forced to wear white coats emblazoned with the message DID THAT PROSTATE EXAM HURT TOO MUCH? followed by an 800 number … They wouldn’t allow themselves to be demeaned this way.").
feedback. The culture of medicine has been described as one that is “deeply rooted, both by custom and by training, in high standards of autonomous individual performance and a commitment to progress through research.”\(^{131}\) Alternatively, some of this relates to a vision of health care that focuses on the inherently collaborative nature of the provision of health care services. Under this vision, placing quality observation solely at the feet of the physician seems to negate the mutual task of creating a successful or unsuccessful physician-patient relationship.

The value added by direct observation reports by untrained consumers in the health care context is exactly the same as the value added by direct observation reports by untrained consumers outside of the health care context. We are all experts on the care and concern offered to us in a medical encounter and this remains true even when we are difficult to care about. Indeed, data shows that patients are remarkably good readers of physician non-verbal communication in the clinical encounter, including perceptions of physician attentiveness.\(^{132}\) It is precisely this measure of care and concern – of patient engagement – that is best quantified by the patient in the encounter. This is because patient engagement produces health-seeking behavior in compliant patients\(^ {133}\), the ultimate goal of most health care service encounters.

4. The Inaccessibility of Physician-Identified Medicare Claims Data

Physician-identified Medicare claims data has a storied history of inaccessibility. Providers have staunchly defended the government’s non-access policy. Providers have become inured, as a result, to the government’s adoption of the position that the strongest interest in physician quality and performance data that could be extrapolated from Medicare billing lies with physicians. Physician-specific Medicare billing data access has been much litigated, and much denied to the press and consumer groups,\(^ {134}\) as a result.

Health care reform’s emphasis on increased quality and pricing transparency may represent a countervailing trend. Proposed PPACA-generated Value-Based Purchasing Plan regulations would allow certain

\(^{131}\) Lucian Leape & Donald Berwick, *Five Years After To Err Is Human: What Have We Learned?*, 19 JAMA 293, 298 (2005).


organizations access to Medicare claims data, beginning in 2012, with provider-specific quality and patient care measure data. The information will not be available to individual consumers, however, but to quality-ranking organizations that also have access to commercial insurance records for the same cost and quality review purposes. Qualifying entities would need to demonstrate capacity to keep this physician-specific information secure.  

Medicare’s Value-Based Purchasing Plan is designed to reward providers who, among other things, improve performance on patient satisfaction surveys. Those providers who underperform in the domains of quality, safety, and patient satisfaction will lose reimbursement money.

Medicare’s attempts to standardize and optimize in-patient experience data in the hospital service arena offer some lessons and some warnings for what lies ahead for outpatient providers. The HCAHPS program is CMS’s effort to standardize hospital services patient experience data, publicize the data, and deliver the data in a way that is credible, useful, and practical for the hospital services consuming public.

The twin goals advanced by accumulating patient experience information – accountability and transparency – have only recently begun to supplement the background data state medical boards typically make available, including educational background and board certifications. A few state medical boards offer more, including information on physician discipline.

The National Practitioners Data Bank is a primarily non-public compilation of data on physician and other health care provider discipline, claims, and litigation—all related to medical error. The National Practitioners Database allows doctors to confidentially “talk back” to the claim of error or negligence that has been made against them. And there are varying levels of appeal. This may have helped to shape physician expectations that complaints about quality of service and competence in other fora should be immediately and identifiably answerable. The National Practitioners Database is not a public forum and does not make provider-identified information available to the public; however, it does

make provider-identified information available to privileges committees and potential employers. But no state offers patient experience review data, anecdotally or collectively, on its physician licensing site.

The National Practitioners Data Bank, a compilation of data on physician and other health care provider discipline, quality claims, and error litigation, is necessarily provider specific, however. When a report is made to the NPDB, physicians have the procedural right to “talk back” to the claim of error, negligence, etc. that has been submitted. Indeed, the NPDB posting appeal procedure is multi-level and quite complex. Although the NPDB does not make provider-identified information available to the general public, it does make provider-identified information available to privileges committees, potential employers, etc. Indeed, a query into the data held by the NPDB is the *sine qua non* of due diligence into admitting privileges decisions in some jurisdictions.

Only recently has CMS become interested in the value of such information. CMS has, for some time, maintained a Healthcare Provider Directory, not unlike those found at state boards of medicine. CMS’s Healthcare Provider Directory is Medicare specific information on health care professionals who accept Medicare reimbursement or assignment by specialty and location. CMS’s voluntary Physician Quality Reporting Initiative took this one step further by requiring participating physicians to report data for at least three of the roughly 170 evidence-based quality measures outlined in the program. One of the quality and data measures references an assessment of patient experience and patient, caregiver, and family engagement. Providing this quality measure information for at least eighty percent of patients over the course of a year (however unflattering) earns a provider an incentive payment from CMS that can range as high as two percent of total Medicare reimbursement.

CMS’s Physician Compare program takes this much further. Participation is no longer voluntary, penalties will attach for failure to comply, the information reported will eventually become publicly reported, and the data will eventually be mined to launch a pilot program with higher Medicare reimbursement rates for beneficiaries who use high-quality physicians.

Although Physician Compare is, as of yet, scarcely more than a shell,

provider reaction has been visceral. CMS’s October of 2010 town hall-style meeting to discuss the types of quality information that should be collected and where it should come from was contentious. The AMA observed that CMS’s basic physician directory is riddled with inaccuracies and that physicians should have to opportunity to prior review, comment, and appeal with regard to any data that becomes part of the public review process.  

Consumer advocates are wary of lengthy physician review periods and a Physicians Compare site that might not be “meaningful to consumers.”

Some insight into what CMS might deem as information meaningful to consumers on the Physician Compare site can be gleaned from CMS’s precursor Hospital Compare, Dialysis Compare, and Skilled Nursing Home Compare sites. Each of these sites has a several year track record and a significant history of non-use by consumers. Although the consensus is that the sites are hard to use, there is more diffuse opinion about the role of inaccurate data or incorrect quality measures in producing consumer non-use. Dialysis Compare has become infamous, for example, for its rosy picture of compliance with CMS’s biochemical targets while masking consistently high rates of death and hospitalization. Inartfully calibrated patient experience data collection might also create perverse incentives to value lower quality care over better outcomes.

Hospital Compare offers patient satisfaction measures called “Survey of Patients’ Hospital Experiences” that calculates aggregated patient satisfaction scores for ten areas, including how well nurses and doctors in the hospital communicated with the patient. Apparently, as part of the hospital care team, physicians have been receiving patient satisfaction scores for some time. These results are aggregated to the acute care hospital and not cross-identified as physician-patient satisfaction scores, however.

The most telling critique of Hospital Compare, in particular, is that CMS has emphasized measuring processes rather than outcomes. This may help explain CMS’s ambivalence over individual consumer-generated physician reviews: they are inherently process oriented. Outcome-oriented

142. Id. (quoting Tanya Alteras, associate director of the Consumer Purchaser Disclosure Project).
145. 11/10 article p.2 from Archives of Surgery, authors from U of Michigan (Not sure what this source is)
provider reviews may only make sense when aggregated but process-oriented provider reviews can have value as anecdotal standalone vignettes. Still, high patient satisfaction scores on Hospital Compare measures have been shown to correlate with other high quality care indicators. Patients reporting satisfaction with the quality of their hospital discharge procedure are less likely to return for a preventable re-admission, for example.

Physician Compare will have to decide what the role of anecdotal patient feedback is in the world of evidence-based medicine. It is ironic that physicians—champions of the validity of individualized approaches to practice and the validity of anecdotal evidence—are the fiercest opponents of patient-generated anecdotal evidence on physician performance. This is particularly surprising in light of the fact that most graduates of U.S. medical schools are first trained in clinical skills through the use of anecdotal patient feedback gained from practicing on each other and through the use of standardized patients. Patient feedback from physician or physician-in-training patients and from professional patients is, apparently, less suspect than feedback from real patients. This is, presumably, because it is more informed by the values physicians prize—feedback on the skill and completeness of the exam or treatment. It is unclear whether feedback on the experience of care is equally prized in the medical training context.

What is clear is that, for the general practice of medicine, there is a very limited culture of patient feedback—solicited or unsolicited. It is also clear that a culture of feedback is being cultivated by patients, whether physicians are ready for it or not.

In the general online review world, by contrast, experience-based service reviews are king. The value that a site like Yelp adds is so closely aligned with the posting of individual anecdotal service reviews, that Yelp has developed an algorithm to filter fake reviews. Even fake Yelp reviews are accessible on a segregated page as filtered reviews, reinforcing the idea that even a filtered review may have been inaccurately flagged as fake. Interestingly, the majority of Yelp filtered reviews have been

146. See e.g., Satisfied Patients are the Best Measure of Hosp. Quality, Duke Study Finds, DUKE UNIV. FUQUA SCHOOL OF BUSINESS (Feb. 14, 2011), http://www.fuqua.duke.edu/news_events/releases/satisfied_patients_best_measure/#.Tjmqp6N5mSM.
147. Id.
characterized as “panting five star commendations.”

There is, however, a smaller companion industry selling the writing and posting of convincing negative reviews on Yelp. If online retailers see reviews as sales materials, it is easy to see why an entire industry has arisen to pad online reputations. The Federal Trade Commission rules addressing advertising addressed as editorial content requiring disclosure of a connection between the a merchant and an individual endorsing a product have not been well enforced on the Internet.

One study of deceptive opinion spam was able to develop an algorithm to distinguish fake from real reviews with roughly 90% accuracy. The development of feedback algorithms for reputation tracking systems have gone a long way toward limiting malicious feedback. This makes it more likely, barring professional negative reviewers further nuancing their reviews for hire, that bogus positive reviews of physicians are more common on web-based review sites. The source of negative reviews is most often business rivals and not genuinely disgruntled customers.

Cultivating the art of customer satisfaction – responding to an online negative review so as to persuade the reviewer to modify their content – is the most common response offered to service providers fearful of negative online reviews. Small businesses are routinely advised to monitor online reviews, to solicit them, and to respond to them. “Online reviews are a gold mine of business intelligence.”

The transformation of customer generated online reviews have marked the rise of a standardized selling process, though there are still certain venues where the online reviews are more the conversation of an online community about an experience than a sales product. Online book reviews on Amazon.com, for example, offer a report on the reader’s experience without necessarily offering any predictive value on how a

150. Id. at 2.
151. Id.
156. Id.
product might be used and consumed by others. The extent to which online physician reviews are more like book reviews – reports of individual experiences, interesting and insightful in their own right – than they are like commercial speech helps to shape the response of consumers to projects like Medical Justice.

III. PRIVACY AND INTIMACY IN THE PHYSICIAN-PATIENT RELATIONSHIP

The argument that online patient reviews of physicians are inappropriate because the physician-patient relationship is an intimate one is interesting. There is impersonality inherent to an online review that militates against its use in an intimate relationship. But there is impersonality to all online relationships – service or otherwise – that does not seem to impede the formation of online communities of interest.

What is the physician-patient relationship, after all? Long defined as a fiduciary relationship, it is clear there are elements of genuine human intimacy. We are not yet so estranged from our corporeal selves that a relationship with the physician who tends our physical needs does not also involve a profoundly personal connection that exceeds the limits of the confidential health information conveyed. But whose intimacy is this?

At least some of the physician opposition to consumer generated online physician reviews invokes the privacy interest of the physician in the patient-physician relationship. Privacy interests in health care, of course, typically are associated with patient privacy interests, alone. Identifying a physician privacy interest in the physician-patient relationship requires thinking harder about privacy. Health care privacy, in its most debased form, focuses on personal health care information disclosure to non-authorized third parties. This is the framework of HIPAA. But patients also have claims to other kinds of privacy in the physician-patient relationship, including a privacy interest in nondisclosure of the very existence of the relationship or nondisclosure of the terms of the physician-patient relationship. Operating on the theory that “everybody probably has something to hide from somebody,” an aspect of privacy involves a person’s “right to conceal discreditable facts about

159. There are contractual elements to the physician-patient relationship, as well, something apparent to those physicians who have been billed by their patients for late or missed appointments. See, Kristina Fiore, Time is Money and Some Doctors Are Paying the Price, MedPAGE TODAY, July 7, 2011, available at http://www.medpagetoday.com/PublicHealthPolicy/GeneralProfessionalIssues/27444
himself.‖

Discreditable health-related facts about patients have, for some time, played a role in health care provider selection of patients. Tales of cherry-picking and lemon dropping by health plans and hospitals are legion. The rise of pay for performance on many dimensions, has raised the specter of physicians seeking to select healthier, more compliant patients with the bottom line in mind. Although this raises many interesting ethical and regulatory issues, it is important to remember that the lemon dropping and cherry picking feared might not occur based on publicly available information. Then again, it might. It is estimated that only a third of all hospitals are believed to have specific policies in place regarding the posting of patient information on social media sites, such as Facebook and Twitter.

A. Whose Privacy Is At Stake In Online Reviews?

From one perspective, a physician’s privacy interest in a patient generated online review lies in the fact that it might reveal discreditable facts about the physician. The harder question is whether there is something particularly different about physician behavior disclosed discreditable facts generated in a patient-physician encounter that should cause them to be treated differently. This is especially difficult to justify when it the physician-behavior disclosed discreditable facts relate to the experience of care. A patient should not lose the right to an online opinion about the quality of a physician-patient encounter because a physician claims a privacy right in their professional reputation that trumps the patient’s right to freely express their opinions on the quality of the encounter. But a physician’s assertion of such a privacy right raises the question of whether is there an intimacy to the physician-patient relationship that qualitatively changes the privacy interest involved into one shared by both the physician and the patient. If privacy is about more than information and also about intimacy, what intimacy interest does the physician have in the relationship? Ultimately, professional reputation is more a public good than an intimate and private good. Claiming it as

163. Id.
165. Id. at 755 quoting Julie Inness, Privacy, Intimacy, and Isolation 56 (1992).
the latter only when it is negative, calls the whole claim into question.

Part of what complicates this conversation is the amplifying nature of online physician reviews. This concerns what has been described as “the permanent memory bank of the web.”166 If a physician receives a credible negative review that sparks some improvement in practice or practices management, it can be difficult for the physician to broadcast the corrective action as widely as the original negative review. Physicians are aware that the original credible negative review may linger in cyberspace. If behavioral psychology is correct that we all remember and retain negative experiences at a much higher retention rate, negative reviews will contain an intensity lacking in positive reviews and review readers are likely to retain more information from negative reviews.167

In addition, physicians are concerned that solicited patient satisfaction or patient experience data collected by payors as part of post-encounter surveys may be amplified by the web. This data is already made available by some payors, for example, to other subscribers of that insurance product.168 This data may be factored into physician compensation or contract rates. Physicians may be concerned that open post physician-rating sites (such as Yelp) may be used by payors discouraged by low patient response rates to solicited patient experience and patient satisfaction data – also playing a role in physician compensation or contract rates.

It is unknown whether there a qualitative difference in the patient experience responses generated by patient initiative compared with those generated by third party initiative. Even if the former were more likely to be negative, this would not necessarily mean they were more likely to be inaccurate. There is no evidence that negative reviews are more likely to be inaccurate. What data exists indicates the truth is quite the contrary.169 The only study examining patient evaluations of health care providers in social media sites remarked on the overwhelmingly positive tone of the postings across sites.170

Online poster motivation offers the best correlate for positivity and negativity in online reviews. Those posting as part of online community building and community participation tend overwhelmingly to post positively, those motivated to post what is, in essence, an online complaint letter tend to post negatively. The online complaint letter typically comes without an expiration date. Some of this is just in the nature of reviews and some of this strengthens the idea that there ought to be some expiration date for online reviews: what Alessandro Acquisti calls “decay time.” Online physician reviews are certainly on the rise, contributing to the growth of what has been described as “the permanent memory bank of the web.”

What may be most challenging about the never-forgotten negative reviews is how inhuman and impersonal they are. A posting in internet perpetuity implies that the physician is static – incapable of growth or development. It is physicians, after all, who appear to feel de-personalized by the self-posted non-time limited negative review. Their response has been two-fold: to seize control of the content of the patient-generated online review and to talk back. This article next considers the legal and regulatory parameters on each of these approaches.

B. Your Words, My Property – Copyright Assignment in Reviews

A physician online reputation defense industry has grown around the freewheeling world of online physician reviews. One of these – Medical Justice – has its goal as fighting physician Internet libel and web defamation. Yet, its tools are not libel and defamation law. Its tool of choice is copyright law.

Medical Justice has developed a form contract that, in one iteration, assigns all intellectually property rights in patient online physician reviews to the physician reviewed. The form contract asks the prospective patient to “exclusively assign all Intellectual Property rights, including copyrights” to “any written, pictorial, and/or electronic commentary”

171. Rosen, supra note 162, at 7 (quoting Alessandro Acquisti).
172. Viktor Mayer-Schonberger, DELETE: THE VIRTUE OF FORGETTING IN THE DIGITAL AGE.
175. Rosen, supra note 162.
including on “web pages, blogs, and/or mass correspondence.” The quid pro quo is confidentiality of patient medical information. Medical Justice has been offering its template contracts for sale since 2007 and, while the contracts have undergone several revisions with respect to patient obligations, the premise of each iteration has been constant: patients who sign the contract must give up their rights to public posting of physician reviews, particularly on the Internet. The most recent iteration of the Medical Justice contract is notable for its removal of the offer of “additional privacy protections” in exchange for patient participation.

Designed to bypass Section 230 of the Communications Decency Act, the physician goes directly to the ISP with copyright infringement claims. Medical Justice’s subscriber services include the issuance of these copyright violation takedown notices to enforce this provision. Copyright takedown notices, to the extent they are effective, are far simpler and less expensive than litigation.

Web hosts who are confronted with demands for copyright assignment of online review takedown can either deny web host liability for user content, 17 USC § 512, or comply. It is reported that, though web hosts will often ignore complaints about negative consumer reviews they will usually immediately honor 512(c)(3) takedown notices. This is because the Communications Decency Act bright-line prohibition against defamation liability for posting sites does not extend to the notice and takedown provisions of the Digital Millennium Copyright Act (“DMCA”), 17 USC § 12. The DMCA shields sites from copyright liability only if they comply with takedown requests in an expeditious manner, making these sites more likely to err on the side of cooperation when such takedown requests are received. This trend toward encouraging what has been called “bouncer gatekeeping” also encourages the gaming of the copyright system in this instance, leaving the power to stifle online anecdotal conversation about the quality of care completely in the hands of providers.

The irony is that a section 12 takedown notice may only be sent by a valid copyright owner. Whether an assignment of adhesion, such as that induced by a Medical Justice agreement, is a valid copyright assignment depends on whether a misuse or unconscionability defense could defeat

Although an open forum advocacy website has been launched at DoctoredReviews.com to help patients, doctors, and review sites resist pressure from Medical Justice, it is too soon to tell if the new site has made any difference.

The notice and take down regime of the DMCA does contain a procedure whereby a subscriber whose feels a takedown was incorrect may respond. The first is the right to file a put-back notice with the service provider, containing much of the same information as the initial takedown notice as well as a good faith representation that the takedown notice was incorrect in its identification of infringing content. The “good faith” representation as to non-infringement does set the bar higher than the completely subjective good faith standard of belief of infringement for the original takedown notice. This, in effect, places the burden on the subscriber to engage in some kind of legal due diligence relating to the merits of the takedown notice and the copyright infringement status of the content at issue.

In addition, DMCA safe harbors condition ISP immunity from liability precisely on the taking down of material once the copyright owner has complained, identifying its customers upon receipt of a subpoena, and agreeing to terminate repeat offenders. But there is imperfect protection for vicarious infringement, identifying the safe harbor as available only to an intermediary that does not receive a financial benefit directly attributable to the infringing activity. Yelp and other consumer review sites arguably do receive direct financial benefit from the posting of previously anticipatorily assigned physician reviews. Not, surprisingly, as Mark Lemley has noted, “the effect of the notice and takedown system has been to encourage Internet intermediaries to take down any and all content copyright owners complain of, no matter how frivolous the complaint.”

DMCA takedowns have been studied only lightly. There is evidence that close to a third are legally dubious and that very few people avail themselves of the put back mechanism. The risk of loss of safe harbor

180. April 2011 launch.
protection is too great, as demonstrated by the fact that less than one percent of all takedowns ever receive a putback notice.\textsuperscript{185} As Mark Lemley further notes “[n]otice and takedown mechanisms to rid the Web even of legitimate content, secure in the expectation that ISPs will take everything down rather than risk their eligibility for the safe harbor.”

Even more significantly, though Section 512(f) of the DMCA creates a cause of action for an Internet user whose material was inappropriately taken down, the statute has been interpreted to protect even those with an objectively unreasonable belief in their copyright claim. Section 512(f) targets “any person who knowingly materially misrepresents . . . that material or activity is infringing,” but limits its scope to only those with an objectively unreasonable believe in their copyright claim.\textsuperscript{186} Providing more expansive recovery could do much to deter action by overbearing copyright ownership assertions. At present, “[t]akedowns often mask ulterior motives”\textsuperscript{187}

The only practical constraint on overbroad takedowns from user generated physician review sites, then, is linked to the validity of the original anticipatory copyright assignment. The largest physician review websites are reported to refuse to honor take-down notices based on contracts restricting patient review rights.\textsuperscript{188} RateMDs.com has also reported a refusal to honor such take-down notices.\textsuperscript{189} Yet the agreements endure despite what Jane Baron has described as the problematic nature of information alienability.\textsuperscript{190}

If it is the very form of the agreement that bears scrutiny, it is worth knowing that MAMPS bear more than a passing resemblance to software and electronics End User License Agreements (EULAs). Sometimes called “shrinkwrap” or “clickthrough” agreements, these product licenses often contain anti-public criticism terms where the buyer, in exchange for a license to use the product, agrees to refrain from public criticism of the product. The EULAs may also contain anti-benchmarking terms that prohibit the measuring of the performance of the hardware of software in a controlled, defined environment. EULAs have been criticized as contracts

\textsuperscript{185} Id. at 679-80.
\textsuperscript{186} Rossi v. Motion Picture Association of America Incorporated, 391 F.3d 1000, 1004-05 (9th Cir. 2004)
\textsuperscript{188} Dina ElBoghdady, Some Doctors Try to Squelch Online Reviews, WASH. POST, Feb.1, 2012, at http://www.dispatch.com/content/stories/national_world/2012/02/01/doctors-try-to-squelch-online-reviews.html (citing Chantelle Kark of Yelp).
\textsuperscript{189} Id.
\textsuperscript{190} Jane B. Barron, Property as Control, 20 MICH. TELECOMM. & TECH. L. REV., 367, 382(2012).
of adhesion, unconscionable, and unacceptable under the UCC for the main reason that they offer take it or leave it terms removing customer assent from the exchange. In addition, EULAs have been criticized for undermining fair competition in the marketplace, leaving the only information on certain products as one-sided and potentially biased.\footnote{Annalee Newitz, Dangerous Terms: A User’s Guide to EULAs, ELECTRONIC FRONTIER FOUNDATION (Feb. 17, 2005), https://www.eff.org/wp/dangerous-terms-users-guide-eulas.} EULAs have not been uniformly criticized by the courts, however. When click through agreements have been attacked for restricting consumers’ and the media’s freedom of speech and fair use, these agreements are identified as designed to suppress talk of product defects.\footnote{New York v. Network Associates, 758 N.Y.S.2d 466 (N.Y. Sup.Ct. 2003)}

If it is the context of the agreement that bears scrutiny, it is worth considering whether the special nature of the physician-patient relationship casts light on these anticipatory copyright assignments. A patient in need of medical care is in an extraordinarily vulnerable human position.\footnote{See Kenneth Arrow, supra note 33.} A patient in need of medical care is not a necessarily a participant in a free and open market for medical services. Health care markets are notorious for their distortions. Many factors contribute to provider selection, a number of them involving payor selection of providers via the vehicles of insurer-organized provider panels, steering mechanisms, and tiered co-insurance schemes. This is why, for example, advance waivers of liability for medical negligence are disfavored although it is possible to see binding health care arbitration agreements as one form of anticipatory medical malpractice exculpatory agreement. In this example, as well, we see our ambivalence over physician-patient contracting writ large.\footnote{Eric Goldman, Announcing DoctoreRevies.com, a Website Against Doctors’ Efforts to Squelch Online Patient Reviews, Technology & Marketing Law Blog (Apr. 13, 2011), at http://blog.ericgoldman.org/archives/2011/04/announcing_doct.htm.}

Medical Justice is a Greensboro, North Carolina based company that was founded by Dr. Jeffery Segal, a neurosurgeon. There is also a Medical Justice subsidiary for dentists called Dental Justice. Developed from Jeffrey Segals’ own experience as a medical malpractice defendant, the company evolved into an online reputation defense firm by 2007.

Medical Justice’s anti-review or copyright assignment contracts live on. Medical Justice estimates that about a thousand of its members use the anti-review agreements.\footnote{Sandra Boodman, To Quell Criticism, Some Doctors Require Patients to Sign ‘Gag Orders’, WASH POST, July 21, 2009 at http://www.washingtonpost.com/wp-dyn/content/article/2009/07/20/AR2009072002335.html} It is estimated that several thousand physicians subscribe to Medical Justice’s package of services, including the form
anti-review or copyright assignment contracts used with prospective patients. In part, this may be because these kind of copyright assignment contracts are not unknown to the courts.  

Electronic freedom advocates are also afraid that assignment in advance clauses may become the norm in all professional and trade services contracts, robbing readers of the critical mass of reviews needed to assess the value of the reviews posted and to aid in decision making. Medical Justice counters that there are other, better venues where patients can report bad experiences with physicians. Jeffrey Segal is particularly concerned that:

[T]he sites often make no distinction between outcomes and quality of care as well as customer service. And with customer service, I’m talking about things like availability, trust, communication, what does the office look like and parking. I think if we’re just limited it to those subjective impressions that a patient is expert a opinning on, we think that would be quite good. When you start talking about quality of care and outcome, that’s a very, very complicated subject and makes it much different than talking about roofing and plumbing.

But it is hard to know where, if anywhere, the online sites are that would be allowed to post patient reviews of physician quality of service, given the breadth of the Medical Justice anti-review clause.

In November of 2011, the Center for Democracy & Technology (CDT) filed a complaint with the Federal Trade Commission (FTC) targeting Medical Justice’s sale of MAMPs as a deceptive and unfair

196. Id. (reported enrollment of 2,000).
197. Advance copyright assignments are not unique to the medical arena. Other entities are sensitive to public perceptions of reputation. For example, he Burning Man Organization (“BMO”) uses online ticket terms to require ticket purchasers to assign to BMO advance copyright on any pictures take at the festival. BMO’s strongest defense of these assignment-in-advance clauses is its desire to preserve the noncommercial, community character of the festival. There may be particular concern that prurient interest in photographs from the “clothing optional” festival may change the nature of the event. Even then, a strong argument can be made that “[c]opyright and trademark law were not intended to be used in this way, and the collateral damage to speech and creativity inherent in the restrictions included in the Burning Man ticket agreement is too great.”

199. Medical Justice, supra note 172.
business practice under Section 5 of the FTC Act. Analyzing the alleged deception inherent in Medical Justice’s business model at one step removed, the complaint targets the deceptive business practice of “selling contracts which are themselves deceptive to doctors and patients as to whether they are legally enforceable.” CDT is asking that Medical Justice be barred from selling MAMPs to physicians and alert existing customers that the contracts are “likely unenforceable and illegal” and to surrender all profits earned from the sale of the contracts.

The consumer lack of expertise claim is a common one, not unlike the reaction of the academic community when RateMyProfessors was first launched in 1999. RateMDs.com is a sister site to RateMyProfessors, after all. RateMDs takes the position that physicians cannot be certain that online postings are by current patients and shame themselves with overly zealous policing on online negative reviews.

Noting that much of the online physician review content concerns “bedside manner” and “the front office” has become a truism that has sparked a lively debate about the distinction between quality of patient experience and quality of care. It is unclear whether Medical Justice’s own anti-review language draws such a distinction. And it is apparent that patients do not. “Patient perceptions depend on the context of their health care, what they need and want at the moment, as well as other interactions during an episode of care.”

Humanistic health outcomes, focused on deconstructing the problem of patient nonadherence, are increasingly studied alongside clinical outcomes in some chronic disease arenas. In particular, multiple factors – not only involving exam room time spent but certainly involving waiting room times – influence patient satisfaction. There is an element of mutuality to good patient satisfaction measures, as

203. Id. at 21.
205. Id at 2 (Physician “wall of shame” for removal letters.)
206. Id.
207. Doctor’s (Gag) Orders, supra note 196. Jeffrey Segal notes, “And I think it’s clearly important if we want patients to do well, we need to figure out how to get a message to him or her so they follow instructions. And, we view medicine as a partnership between the doctor and the patient.”
well, showing some correlation with a physician-patient demographic match as well as the duration of a physician-patient relationship. 210

Experience outside the United States may be instructive. In the United Kingdom, patient experience data is solicited and studied on several measures: respectful and dignified treatment, confidence and trust and physician communication skills at answering questions and offering explanations. 211 Under the rubric of patient centeredness, patient perception is routinely captured and quantified for just what it is. 212

It is worth considering whether patient satisfaction or quality of care measures ought to be seen as two parts of the same whole – patient centered outcomes. Just as, under the Affordable Care Act, more effort is to be made to compare the effectiveness of different treatments, 213 it may also make sense to compare the effectiveness of different providers. The effectiveness of individual providers in promoting patient compliance with treatment plans and cooperation with chronic disease protocols is, after all, at the heart of what primary care providers will be accountable for under the new accountable care organizations being piloted under the ACA. 214

One physician who follows patient online review of physicians is struck by the value of the collective intelligence provided in online patient reviews. Noting that, “[w]e seldom get to hear what patients want or value because in the real world disappointed patients rarely tell doctors to their face what they think of them.” 215 Acknowledging that online patient review sites may hold little statistically significant value for evaluating individual physicians, “[t]hese stores are nuggets of qualitative data on patients’ attitudes regarding the quality of care and their needs and preferences in their relationships with their doctors.” 216 From this perspective, the reader is less concerned with the authenticity of any particular review than with the power and force of the aggregated reviews. This tension between physician desire to have objective, verifiable, and uniform rating of physicians 217 and the desire to know what patients really

210. Id.
212. Id.
213. See, e.g., Patient Centered Outcomes Research Institute, http://www.pcori.org/ (An organization designed to inform health care decisions by providing evidence on the effectiveness, benefits and harms of different treatment options for different patients).
216. Id.
217. Julie Deardorff, Doctors: Web Ratings Flawed, CHI. TRIBUNE, Nov. 15, 2010 at
want in a physician-patient relationship is played out in the reaction to the online review sites as much as to the use of medical gag orders. From this perspective, physicians who use medical gag orders to chill or suppress negative online reviews rob their peers of intelligence on patient needs and preferences as much as deprive past patients of a voice and prospective patients of useful patient experience data.

In addition, text mining of unstructured data such as the aggregated content of online sites is in its infancy, enabling provider quality scholars to use sentiment analysis techniques to extract valuable patient experience data from online sites.\(^\text{218}\)

It is telling that Medical Justice’s services do not include a program to suppress all reviews of physician services or practices, only selected negative reviews. The services do include, however, skilled assistance in soliciting and posting positive reviews from selected patients.\(^\text{219}\)

### C. Your Words, My Response – HIPAA’s Constraints on Talking Back

Physicians are bound by professional standards that may prevent a full public response to online physician review sites. In particular, the American Medical Association Ethics Code Section 8.03 indicates:

*Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity: reward or financial gain is a subordinate consideration.*\(^\text{220}\)

Whether Medical Justice non-review contracts violate such general aspirational language is untested.

### D. MAMPS and HIPAA

The use of MAMPS raises interesting and important questions about medical privacy. First, what confidentiality of patient and provider information is the physician offering in exchange for the patient’s anticipatory copyright assignment? Is this HIPAA’s privacy protections or

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\(^{219}\) Mike Masnick, *Medical Justice Caught Posting Happy Reviews of Doctors; Claims It’s Just Helping Patients*, TECHDIRT, June 1, 2011.

\(^{220}\) AMA Code of Medical Ethics Opinion 8.03: Conflicts of Interest.
something more? Second, is the very act of filing a takedown request with an ISP a violation of HIPAA for divulging the existence of the doctor-patient relationship as individually identifiable medical information to a non-authorized entity? Finally, is it HIPAA’s perceived one-sidedness that is driving physician overreaching into patient review posting? Does HIPAA stifle all physician “talking back”? Ought that to be altered if it is, indeed, the tail wagging the dog?

As there is no reported litigation testing the scope of the information privacy exchange in a MAMP, we can only speculate on the scope of the information privacy offered. What we do know is that HIPAA, with or without a MAMP, offers protection of individually identifiable health care information obtained through the physician provider relationship. HIPAA’s privacy rule may not be conditioned on a further contractual provision or waiver.\textsuperscript{221} And a covered entity also may not retaliate against a person for exercising rights provided by the HIPAA’s privacy rule.\textsuperscript{222}

But a MAMP may offer privacy protection that exceeds HIPAA’s floor. The most obvious place to look for standards that exceed HIPAA when considering data flow from a provider to the outside world is to look beyond HIPAA’s privacy protections to HIPAA’s marketing rule, a notoriously leaky container for the personal health information in the commercial sphere. Though the HITECH Act tightens HIPAA’s restrictions on the commercial use of personal health information by extending HIPAA’s scope to a broadened definition of “associated businesses” the same expanded definition has created a wider range of HIPAA sanctioned health care business information sharing possibilities. It is possible the MAMP language references privacy protection from this.

What is known is that the HHS’s Office of Civil Rights, HIPAA’s enforcement agency, has indicated that a covered entity’s obligation to comply with all requirements of HIPAA’s privacy rule cannot be conditioned on a patient’s silence, particularly the kind of silence bargained for in a MAMP.\textsuperscript{223}

\textbf{IV. CONCLUSION}

Physicians and patients assess doctoring quality with the same goals in mind: outcomes, trust, and relationships with patients. But physicians

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{221} 45 C.F.R. § 164.530(h)
\item \textsuperscript{222} 45 C.F.R. §160.316.
\end{enumerate}
\end{footnotesize}
and patients assess doctoring quality through very different experiences: patients value a clean and pleasant physical environment and a respectful office staff as much as physicians value strong clinical skills. Insurers value high-volume standardized efficient practices. As a society we all demand both quality individualized clinical encounters and collective medicine designed to improve population health.224

Conflict between and among these values may be inevitable. For example, time spent personalizing health care explanations for one patient may be seen as detracting from a high volume standardized practice. As a society, we want it all – warmth and efficiency, standardization and personalization, skill and intuition.

Perhaps none of this is new, patients and physicians alike having sorted themselves out by mutual preferences for a very long time. What is new is that all of this is being sorted out in public, indeed online. And this public sorting of various priorities in the delivery of physician care has activated an extraordinarily thin-skinned group of providers225 whose performance anxiety is enhanced by the simultaneous rise of insurer and payor interest in titrating compensation to account for patient experience and patient satisfaction ratings.

The timing of the flowering of a health care culture of patient responsiveness could not be more fortuitous in light of the prioritization of patient-centered care in the ACA and our own increased sophistication in analyzing the clinical encounter.

So it is the rise of the Internet combined with the rise of standardized physician practice that has created the content and the vehicle for patients to publicly – sometimes anonymously—tell physicians precisely what is lacking from their experience of health care.

If we, as a society, are serious about improving the patient experience of health care and attaining patient-centered care as one of the six pillars for an outstanding health care system,226 we will not be too quick to allow legal and regulatory dismissal of online anecdotal patient reviews. A richer

224. See generally MICHEL FOUCAULT, THE BIRTH OF THE CLINIC: AN ARCHAEOLOGY OF MEDICAL PERCEPTION 14 (A. SMITH TRANSLATION) (1963) (Foucault’s examination of the emergence of clinical medicine around the time of the French revolution discusses the rise of our ongoing tension between clinical wisdom and seeing the patient as a portrait of a disease.)


legal and regulatory understanding of the Internet is one place to start. It is imperative that we create a legal and regulatory framework that allows us to listen. Few fora offer as much unadulterated aggregated data on what ails the patient-physician relationship in America.