Centers for Medicare & Medicaid Services (CMS) Merit-Based Incentive Payment System.

In our Viewpoint, we very clearly distinguished between patient satisfaction as a component of quality as a domain and the measures being used today to assess this construct in clinical care. Unfortunately, the Letter by Lee does not separate these 2 issues. Evidence to support the importance of patient satisfaction as a domain, such as our 25-hospital study, does not address the question of the validity of patient experience measures used in clinical care today because the data in the 25-hospital study were from 2001-2006.

In the social science literature, traditional psychometric questions of validity in instrument design have moved to the question of whether a measure is fit for the purpose for which it is being used. On this question, the CG-CAHPS clearly fails. First, the instrument was not designed to evaluate the performance of individual physicians. CMS acknowledges this: “CAHPS surveys follow scientific principles in survey design and development. The surveys are designed to reliably assess the experiences of a large sample of patients.”3 In other words, the CG-CAHPS measures were not designed to assess the patient experience of individual physicians. Second, as the use of CG-CAHPS has expanded to large groups of physicians, the ceiling effects of the measure greatly reduce any utility of reporting and assessing the data provided by this instrument. This issue was the subject of the data analysis in our Viewpoint.1

Lee highlights the opportunities available to collect actionable insights from patients using more modern methods of data collection than paper surveys. We agree that there are significant opportunities in this space, but the need is to replace rather than supplement the current instruments and measurement approaches. Here, however, we are limited by the current infrastructure devoted to implementing the CAHPS instruments on the part of hospitals and practices, as well as by CMS rules that preclude the assessment of alternative patient satisfaction surveys before CAHPS surveys are administered.4 These factors are formidable barriers to innovation in this space.

The problem is not that the clinical community is concerned about feedback. Rather, it is the measurement community that must be open to critical evaluation of their measures and the harm that poor metrics cause to physician and patient communities.

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Conflict of Interest Disclosures: Dr Schulman reported holding a patent assigned to the University of North Carolina. No other disclosures were reported.


CORRECTION

Author Affiliations Omitted: In the Original Investigation titled “Effect of Direct Transportation to Thrombectomy-Capable Center vs Local Stroke Center on Neurological Outcomes in Patients With Suspected Large-Vessel Occlusion Stroke in Nonurban Areas: The RACECAT Randomized Clinical Trial,” published in the May 10, 2022, issue of JAMA, 2 authors, Sònia Abilleira, PhD, and Mercè Salvat-Plana, RN, were missing affiliations. Both of these authors were listed as affiliated with the Stroke Programme, Catalan Health Department, Agency for Health Quality and Assessment of Catalonia, Barcelona, Spain, but should have additionally been listed as affiliated with CIBER Epidemiology and Public Health, Barcelona, Spain. This article has been corrected online.


Error in Figure: The Original Investigation titled “Effect of Low-Concentration Atropine Eyedrops vs Placebo on Myopia Incidence in Children: The LAMP2 Randomized Clinical Trial,” published in the February 14, 2023, issue of JAMA, included an error in Figure 1 that indicated an incorrect number of participants included in the primary outcome analyses in the placebo group, a duplicate reference, and an incorrect funding number. These errors have been corrected online: Figure 1 now indicates the correct number of participants analyzed, the duplicate reference was removed, and the correct funding number is now included in the funding section.