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CLINICAL CASE
Do Secret Shoppers Have a Place in Medicine?
Commentary by James C. Loden, MD, and Richard C. Frederick, MD

The staff at Urban Clinic had gathered for a morning meeting. Jim, the executive director, waited until everyone had coffee and had found a place to sit. Then he began, "Today I want to brief you on a new quality program. We're going to try a mystery shopper technique starting as soon as we can. You've probably heard about how this works in retail stores. I think it could help us improve patient satisfaction and office efficiency.

"What happens is, some trained market researchers will call the office to see how the phone system works and how the staff handles the calls. They'll make appointments and they'll arrive early and observe the staff and the environment. A few of them—pretty good actors I might add—will actually go through with a physician encounter.

"When we get the results from all this, we'll know a lot more about how to improve the quality of our patient experience. Any questions or comments?"

George, one of the internists, said, "It sounds okay Jim, but we're not exactly running a Wal-Mart here, are we?"

"Well, we aren't the first to try this. Massachusetts General has been running a similar quality improvement program for 8 years," said Jim.

"I'm still skeptical; we haven't got the money that some large institutions have, and it doesn't seem totally fair to be so devious," George mused.

Other staffers worried about the additional time it would take and who would be blamed or even fired if the results were bad.

Jim closed the meeting by saying he'd take all the comments into account before they rolled out the final version of the program. "Thanks for your input. Remember, we're in a competitive marketplace. And we owe it to our patients to do our best on all fronts."

Commentary 1
by James C. Loden, MD

For the last 2 years I have employed "secret shoppers" to evaluate Loden Vision Centers, a Nashville-based practice that employs three ophthalmologists and two

optometrists. Sixty percent of the practice revenue comes from insurance and Medicare, and 40 percent, from elective refractive surgery. There are approximately 53 other physicians in the area with whom we compete for clients.

Given this competitive practice environment, we are constantly looking for ways to improve our client-to-client referrals. Many ophthalmology journals discuss marketing and practice growth strategies. One article that particularly caught my attention was about a company that conducted ghost-shopping in medical settings. As founder and managing partner for Loden Vision Centers, I had had suspicions that the staff was not always as mindful about service and other patient satisfaction markers when a supervisor was not present. I questioned whether we—and I include myself in this—were really delivering the high-quality care that I perceived we were. These nagging concerns led me to try a ghost-shopping program. After we were assessed, several deficiencies (and several successes) were identified. In one instance, I thought we were weak in a particular area, but this was not borne out in the evaluation.

Results of Our Experience

There were a couple of areas we learned we could improve on, and at least one where no change was needed.

1. *Directions*. More than 50 percent of our secret shoppers reported difficulty or great difficulty finding our offices. Although it is easy for me to get there—I drive to work everyday—we found that many people struggled just to locate the building. In response, we made our maps easier to read, improved Internet directions to the facilities, and posted pictures of the offices on our web site.

2. *Employees don't always perform as trained.* Some of my suspicions were validated. The secret shoppers found that employees did not always wear name tags, introduce themselves, explain how or why tests were being performed, or tell clients in the exam room who would be coming in next and the approximate time of the doctor's or technician's return before leaving the room. I learned that I consistently left the exam room without asking clients whether they had any questions.

3. *A few positives*. We learned, for example, that we didn't need to upgrade our reception area. We had contemplated a major renovation of this space and it was estimated to cost at least $50,000. Before proceeding with these plans, we asked our secret shoppers for their recommendations. We found that our facility more than met expectations for our type of practice, and no facility upgrades were recommended.

Making the Decision to Use Ghost Shoppers

In our case scenario, we see a confrontation between Jim and George. Jim wishes to improve patient care and the patient experience, but George is skeptical of using secret shoppers to achieve this goal.

I believe that the decision to employ a secret shopper should not be a group decision but one made by the practice manager and senior managing partner who alone should know that secret shopping is going to occur. I would also suggest that the office manager not be told the times and dates of the visit so that a true evaluation of day-to-day operations can be made. It is our experience that when staff are told they are going to be assessed within a certain time frame, they maintain a high level of care for that period and then gradually return to their old habits.

When the results of the secret shopping visits are available, the initial evaluations should be discussed in a staff meeting and presented in a positive light. During this meeting, the areas where improvement is needed should be talked about and corrective steps decided upon. A second round of secret shopping should be performed to see whether the staff has implemented the changes that came about after the initial assessment. Punitive action should not be considered unless there is repeated failure to act in accordance with established performance guidelines.

I do not believe that words such as "devious" and "spying" are accurate in describing secret shopping. *Employees, including doctors, are paid to do specific tasks; if they choose to perform at a level that is less than acceptable, they need to improve or find other jobs.* It is the responsibility of management to assure a quality client experience—and this experience is affected by all employees, from the one with the lowest salary rank to the most senior partner. In fact, I think it is more devious to allow an underperforming facility to make health care decisions for a client than to use secret shoppers as a quality improvement tool. I side with Jim, who says we owe it to our clients to do our best.

Assessing the Case

The complaints lodged by George are typical of comments made by uninformed, noncompetitive physicians and employees. The fees charged by secret shopping companies are nominal compared to the gross income lost due to poor client experiences. During the entire shopping process, a practice may lose three to five billable patient encounters per physician. This is a miniscule amount of time and it can help you to serve your clients significantly better in the long term. To use time and money as an excuse not to engage in secret shopping is short-sighted behavior.

George's comment that "we're not running a Wal-Mart here, are we?" shows the lack of business acumen that I see in so many of my fellow physicians. No, we aren't and shouldn't be a discount store, but we *are* a business. If we can't make money, we can't keep the doors open. In these days of declining reimbursement fees, if we want to run a successful medical practice, we must provide better, more efficient care than the physicians we are "competing" against. We must look to the retail industry at

times for ideas on how to judge whether doctors and staff alike are delivering the care that clients, partners, and other staff members deserve.

The number of elective surgery procedures I perform has increased by 100 percent since instituting secret shopping because our client-to-client referrals have increased. I credit much of this to the experience of secret shoppers, which helped our office improve client experiences before, during, and after their operative procedures.

For practices and facilities that are not in competition for potential clients, secret shopping still makes ethical and financial sense. Overhead costs are quickly driven up by employees who perform their job inefficiently. In fact, there are times when employees may take histories and perform tests and labs in a way that could adversely affect diagnosis and outcomes. From a physician standpoint, even if you have a line of clients or patients at the door, do you really want a physician partner who is either short and curt with them or inefficiently verbose?

No matter the size or the makeup of your practice, I think you will find the experience of using secret shoppers rewarding and insightful rather than unethical and devious, as many who are uninformed about the practice predict.

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Author Disclaimer
Dr. Loden has granted permission to the secret shopper company he employed to post a statement of his satisfaction with, and intent to continue using, their services on their web site. He received and will receive no payment or discounted services for this testimonial.

Commentary 2

by Richard C. Frederick, MD

The use of a secret shopper to assess the delivery of patient care raises many ethical dilemmas, including the effect that this practice has on the patient-physician relationship, the stewardship of scarce health care resources, impact on the care given to patients, and exposures (e.g., to radiation, blood products, etc.) for physicians, staff, and the sham patient. This practice highlights the crisis of medical professionalism—failure to view the physician as a professional. Finally there is the huge question about the consequences of using deceit in a field where truthfulness is a core virtue. Introducing this competitive market tactic reduces the practice of medicine to a business model and will imperil both the members of the profession and its patients.

Trust

The traditional patient-physician relationship requires that both parties be open and honest. Edmund Pelligrino has defined the patient-physician relationship as a healing relationship that places a much higher fiduciary responsibility on the parties involved than a simple agreement or business contract [1]. The labels that we give to the parties involved reflect this; we are patients and physicians, not customers and providers. The difference is more than semantic [2]. The business adage "let the buyer beware" is reprehensible if applied to medical care. Trust and honesty on the part of both patient and physician are implicit in that covenantal relationship.

In our case scenario, appointments and time will be taken away from real people with real needs and illnesses so that sham patients can be seen. In some instances sham patients have presented to overcrowded emergency rooms with chest pain [3]. This type of complaint mobilizes a rapid and coordinated response from the entire health care team, leading to others' being triaged to lesser importance. How could the hospital administration defend this exercise to someone who suffers an adverse outcome while waiting his turn behind the person who is only pretending to be sick? Moreover, how would we justify using a hospital bed with all its attendant resources for a fake illness [4]? Again, what if that bed or the primary care nurse or respiratory tech were needed for a real patient waiting for care? The medical-legal implications are not inconsequential. Radiologic and laboratory testing are an integral part of our diagnostic tools. Consider the scenario where a nurse or lab tech gets a needle stick while treating this "planted" patient and develops hepatitis or HIV.

Institutional Review Boards (IRBs) are in place to protect our patients when human subjects research is proposed. The use of any form of deceit in medical research has been looked at with some suspicion by IRBs because of the history of ethical abuses in research [5]. I believe that the same level of concern should apply to this sort of patient encounter tool.

Medical Professionalism

Medical professionalism is in crisis [6], and the situation will only get worse if we use deceit in daily practice. Ethics in business is desirable. Ethics in medicine is essential. Patient advocacy is not an option for physicians; it is a necessity. Society recognizes this and has allowed the profession to be largely self-regulating. It is interesting—and sad—that in our case, this same level of autonomy is not granted intraprofessionally.

The executive director in our scenario informs the staff physicians that the "secret shopper" program is going to happen with or without their assent. These types of top-down declarations reduce physicians to tradespeople, and not professionals, and the distinction between the two is significant [7].

Concerns about the use of secret shoppers have led the Illinois State Medical Society to ask the American Medical Association to further explore these practices [8]. Assessing our effectiveness in real patient encounters is important, and it is being

done in a variety of ways that have proved effective and that do not endanger patient welfare. Peer QA, feedback from colleagues, and post-encounter surveys such as the Press Ganey questionnaires are helpful evaluation tools. In Peer QA, patient charts are routinely reviewed by other physicians, both internal and external, to asses the quality of care given. The Press Ganey survey allows institutions to assess the same concerns that secret shoppers assess, but relies on real patients. Use of these measures has resulted in behavior changes and has positively affected market share in this competitive environment [9].

One wonders how effective the secret shopper can be in assessing physicians' most important roles. If these people are not sick, frightened, tired, and vulnerable like real patients, how helpful is their appraisal to the physician whose patients *are* frightened and vulnerable? Although it is becoming a lost art, our response to real suffering continues to be an essential part of our care [10].

Finally, we teach our residents and medical students that when we are not truthful with our patients, we violate their trust. We also put into question the next physician's truthfulness. We have all heard a patient say, "Those doctors at that institution lied to me, so I trust none of them." In reality maybe only one physician lied, but all are tarred with the same brush. Trust is fragile, and, once violated, it is hard to restore. But trust goes both ways. Are we physicians not human too? Once we are fooled by these "good actors," will there be an element of doubt about the legitimacy of the next patient with a similar complaint? I work in an emergency room and have been lied to frequently, but not by my administration or the executive director of my group. Cynicism, already a problem in medicine, will only be made worse by the use of official deceit. As physicians in a profession where high ethical standards are essential, deceit, however well meaning, is not a tool we should use.

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