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Peace in Health Care

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Viewpoint

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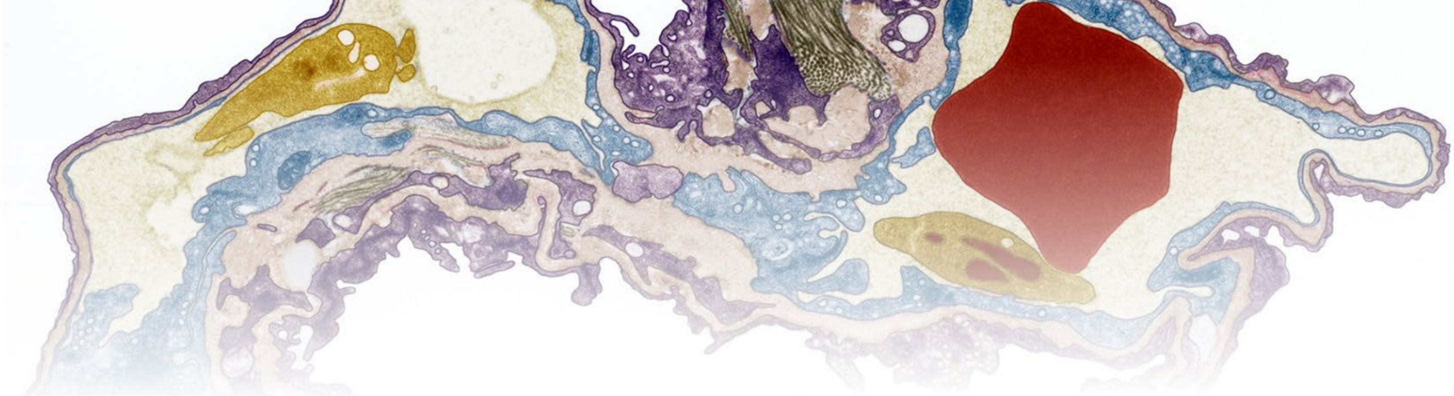

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FROM THE EDITOR

Peace in Health Care

Timothy Nicholas, MA and Grayson Holt, MSW, MA

> *There cannot be health without peace, and there cannot be peace without health.*
> Dr Tedros Adhanom Ghebreyesus, director-general of the World Health Organization[1]

Peace and health are inextricably connected[2]: without one's health, one's capacity for peace and contentment can be compromised; and, without feeling that one can reliably access peaceful states of mind and peaceful environments, one's health is difficult to preserve. This conceptual interrelation between health and peace is not just personal, however, and has long been studied, with academic health research and scholarship to date most often focusing on the interplay between peace and health care in the settings of global conflict, disease, or disaster.[3,4,5,6,7,8]

In recent years, however, academic health ethics discourse has recognized that the concepts of peace and health are more than simply related to one another, with some scholars arguing that peace and health have a fundamentally *causal* relationship.[9] Accordingly, any novel approach to peace in health care not only should be integrative, but also will require explicitly focusing on the amelioration of those obstacles that have prevented peace at individual and community levels, especially by systemically promoting positive socio-ecological drivers of societal health and peace.[9] Ultimately, although the health sector's responsibility to play a role in preserving and promoting peace has been acknowledged, minimal scholarship has explored the nuanced meanings of peace in health care and the causal interdependence of peace and health, leaving questions about how clinicians and health care organizations might efficiently and equitably support peacemaking practices in health care.[10,11,12]

Notably, given that peace is both a shared, global concept and an intimate, personal experience, it may seem challenging for medicine to investigate any specific questions about the role, meaning, or experience of peace in health care because prioritizing peace in health care potentially lacks a clearly defined end. We contend, however, that diverse values that express peace represent broader, more inclusive collections of humanistic perspectives.[13] Accordingly, we believe that assembling diverse viewpoints on meanings of peace in health care can help us conceive of peace as an aspiration of health care rather than as a competency to be achieved.

Peace is a concept that is much larger than health care, but health professionals have vested interests in peace because of the causal dependence of their patients' health on peace. At the level of individual health care, we thus contend that peacemaking demands equitable, patient-centered clinical practices that optimize patient autonomy and dignity, all the while ensuring that patients feel heard, respected, and secure.[14] Moreover, extending the idea of peace through health care to the community level will involve addressing historical injustices and disparities in health care access and outcomes, such as by guaranteeing equitable access to health care resources and services and leveraging responsive health care initiatives that engage in health partnerships, education, and outreach. Lastly, extending peace building to the societal level of health care will require collaboration between health care organizations and policy makers to produce critical research and policies that dismantle adverse socio-ecological health determinants, such as urban heat islands and light pollution, and instead foster proactively healthful and peaceful societal conditions, such as expanded urban green spaces and improved air quality.[15]

Ultimately, given that clinicians and patients alike can sense when they are moving toward or away from peace, we believe that, by exploring patients' feelings of peace or its lack, clinicians can guide more productive, ethical discussions on the experience and amplification of peace in health care, while simultaneously charting clearer paths to provision of increasingly humanistic care that contributes to patients feeling at peace. Pursuing peace as an ethical aim of medicine might not only improve patient experiences at the individual, communal, and social levels of health care, but also help health care professionals envision a more expansive role for medicine in peacemaking by reconnecting them with their own humanity as well as the humanity of those they serve. Via exposure to a myriad of student, clinician, educator, and advocate perspectives, we hope that readers of this issue of the *AMA Journal of Ethics* will recognize the value of peace in health care and aim to establish and maintain health care as an enterprise that aspires to and prioritizes peace as a fundamental value.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Why Is Hospice One of the Few Health Care Environments Structured for Peace?

Grayson Holt, MSW, MA and Johanna Glaser, MD

Abstract

Historically, Western medicine has recognized health care environments as vital to patient well-being and enhanced clinical outcomes. Yet most modern Western hospitals are primarily designed and regulated to promote safety and minimize risk rather than to enhance comfort or serve as therapeutic environments in and of themselves. Hospice stands out as one of the few places within the Western health care service delivery system in which the structures and spaces of caregiving are viewed as key to patient-centered practice. This commentary on a case suggests the importance of designing health care environments that center patient experiences of well-being throughout the lifespan, not just at the end of life.

Case

AC is a 68-year-old man with glioblastoma. After surgery to remove as much of his tumor as possible, he is now undergoing several rounds of radiation and chemotherapy. AC sees his oncologist, Dr M, for follow-up. While in the waiting room, he reads a brochure about hospice and the importance of a peaceful environment for end-of-life care. In his visit, AC reflects on his stressful, uncomfortable surgery and recovery experiences during his inpatient stay. “It doesn’t make sense that hospitals can’t be more supportive places for patients and their families. Why should I have to be in hospice to receive care in peace?” Dr M listens to AC and considers how to respond.

Commentary

To best answer patient AC’s question, it makes sense to first acknowledge that the environment of health care has been recognized as vital to patient outcomes and well-being since the inception of Western medicine. The Asklepíeia of Ancient Greece, often considered the first, rudimentary hospitals, were explicitly designed to serve as healing sanctuaries with access to the natural world, baths, gymnasiums, art, and places of spiritual worship.[1] Likewise, Florence Nightingale, the founder of modern nursing, wrote of a “healthy environment” as a key element of healing. Beyond cleanliness and sanitation, she emphasized the importance of providing patients access to fresh air, natural light, views of natural landscapes, and a healthy diet.[2]

In contrast, modern hospitals are designed and regulated primarily to promote patient safety rather than to serve as therapeutic environments in and of themselves. For example, the Joint Commission, the oldest and largest standards-setting and accrediting body for hospitals in the United States, evaluates the "environment of care" based on the handling of the following: (1) "environmental safety," (2) "security of everyone who enters the facility," (3) "hazardous materials and waste," (4) "fire safety" and emergency preparedness, (5) "medical equipment," and (6) "utility systems."[3] These standards indicate that safety is the primary concern when accrediting hospitals; it is notable that there is no mention of patients' experience of the environment of care or how that environment itself might promote well-being as opposed to simply minimizing potential harm.

Environments and Patient Care

The failure to incorporate patient experience in standards setting in hospital design is important because research suggests that the built environment of hospitals directly impacts patients' experience of care and their health outcomes, such as levels of pain, stress, anxiety, and access to privacy and social support.[4,5,6,7,8] For example, reducing hospital noise and introducing pleasant sounds such as music can reduce patients' anxiety while improving their satisfaction and sleep quality.[9,10] Indoor plants in hospital rooms of patients recovering from surgery can help lower blood pressure and reduce analgesic use,[11] and rooms with windows offering natural views can reduce postsurgical inpatient recovery time.[12] Similarly, rooms with more sunlight have been shown to reduce length of hospital stay after admission for myocardial infarction and bipolar depression.[13,14]

As more studies demonstrate the impact of the built environment on patients' health and well-being, there has been a push to incorporate evidence-based design (EBD) into the planning of health care environments. In the context of health care, EBD is an iterative methodology that uses the best available data on patient outcomes from research and ongoing monitoring of the impacts of design interventions to promote enhanced clinical care.[15,16,17] In addition, EBD considers patients' qualitative experience of care as a key outcome measure.[18,19] As a stakeholder-engaged method that incorporates patient feedback as well as the most up-to-date evidence base, EBD thus lends itself well to expanding the values of hospital design to include more holistic, patient-centered aims. With the aid of EBD, we might begin to conceptualize hospitals as places where patients with acute illness go to receive targeted interventions not merely in an environment that is safe and minimizes harm, but in one that is safe and attuned to their experiences in a manner that enhances clinical outcomes.

Barriers to Peaceful Environments

In addition to having to meet modern hospital accreditation standards that focus on safety, hospitals may, depending on the context and acuity of care, need to prioritize patient safety over comfort. For example, patients undergoing surgery have clear needs for specialized equipment, lighting, and sterility that limit environmental features that could be more soothing. Similarly, patients in the intensive care unit and postsurgical patients require specific interventions and frequent monitoring that govern most aspects of the environment of care. In such cases, the lack of a peaceful environment is largely clinically appropriate. Small changes that benefit patients, however, such as enhanced natural light or views of natural objects, could still be utilized in rooms outside of the surgical suite, as evidenced by the studies cited above.

Health care systems also must balance effectiveness, financing, and efficiency. Hospitals are becoming increasingly expensive to build, with the average cost per square foot increasing by more than 20% between 2019 and 2024.[20] Additionally, they must accommodate complex infrastructure and technologies while adhering to safety codes.[21] The growing influence of private equity in medicine and pressures for financial profit may be a barrier to centering the patient experience in hospital design.[22] Architectural renovations could require temporarily closing otherwise functioning, profitable patient rooms, and improved patient outcomes don't necessarily translate to increased health care profits. These exigencies speak to an interesting point of ethical tension between the ideal role of health care facilities and the pragmatic needs of hospital administration and payment structures.

Scaling Up Patient-Centered Care

As patient AC aptly points out, hospice care stands out as one of the few places in modern Western medicine where the environment of care is carefully considered in a patient-centered way, in keeping with the stated aims and values of hospice and palliative medicine. The Centers for Medicare and Medicaid Services defines palliative care as "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs to facilitate patient autonomy, access to information, and choice."[23] Hospice and palliative medicine thus explicitly takes a holistic approach to patient care and places a high value on patient autonomy. Additionally, hospice and palliative medicine extends the application of the principle of beneficence from primarily fixing illness and injury while minimizing harm (nonmaleficence) to actively working to optimize quality of life.

Hospice, however, is not the only place in modern Western medicine where attention to patient experience is being utilized to promote better patient outcomes. For example, in recent years more attention has been paid to the environment of labor and delivery wards. Birthing centers based on midwifery and wellness models are on the rise,[24] and birthing rooms in traditional care settings employing peaceful elements—such as less clinical-looking décor, scenes of nature projected on walls, and classical music or nature sounds—have been shown to lower rates of preterm births and cesarean sections while increasing rates of successful early breastfeeding and measures of patient satisfaction.[24,25] Similarly, acute care for elders units that are designed for patients over the age of 70 years and that utilize simple interventions, such as minimizing sleep disruptions and promoting access to natural light during the day to reduce delirium, have become increasingly common in hospitals and have been shown to reduce loss of independence in activities of daily living, among other benefits.[26] More recently, hospitals can participate in the Geriatric Surgery Verification Program by implementing 30 evidence-based standards of care for patients 75 years of age and older undergoing inpatient surgery, including by ensuring geriatric-friendly patient rooms.[27]

While it is appropriate to design health care environments suited to patients' specific clinical needs and degree of medical acuity, greater emphasis on patient-centered care need not come at the expense of patient safety, and implementing EBD during hospital construction and reconstruction also need not incur a heavy burden of cost. Incorporating more holistic values in the ethos of hospital design and in the accrediting standards of hospitals could be an important and reasonable step toward promoting a more peaceful environment for patients, their families, and health care workers alike.

Conclusion

Patient AC's question is difficult to answer in a succinct manner because it gets at broad questions about how we conceive of health care environments and patient-centered care beyond hospice and palliative care settings. Yet it offers an opportunity for his caregivers to learn more about his values and work toward better supporting him. In light of this understanding, we suggest the following as good responses to AC:

1. *It must be frustrating to feel that you can't access care in an environment structured for peace while you are pursuing active treatment. Can you tell me more about what makes an environment feel peaceful to you and why peace in particular is important to you in the health care setting?*

2. *Modern hospitals are designed in a way that prioritizes safety, which can mean that the quality of your experience as a patient gets less attention than it is due. Let's brainstorm together how we might make your next hospital stay more comfortable. For example, I've seen patients bring blankets and pillows from home, place photos of loved ones on the wall, or bring music that can be played near the bedside. You might also be able to ask to reduce the number of monitors in your room or have labs drawn or medicines brought later in the morning to help you get more sleep.*

3. *I share your concern about the lack of peace in many of our health care environments. In some cases, though, like when you were directly coming out of surgery, it is appropriate to have a lot of equipment and monitors in the room, which isn't always comfortable for you as the patient. In many cases, though, there are small changes that hospitals could and should try to implement to make the environment more peaceful, such as offering soothing music or working to reduce noise in the hospital rooms once patients are in a more stable condition.*

In conclusion, while it is not always feasible to promote a peaceful environment in health care, extending the application of the principle of beneficence from promoting safety to promoting more holistic and healing health care environments—and in settings beyond end-of-life care—would not only enhance peace but likely result in improved quality of care and patient outcomes. Thus, on ethical grounds and in keeping with the basic goals of health care provision, where changes incorporating a more holistic view of the environment of care can reasonably be implemented, such improvements should be prioritized.

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The case to which this commentary is a response was developed by the editorial staff.

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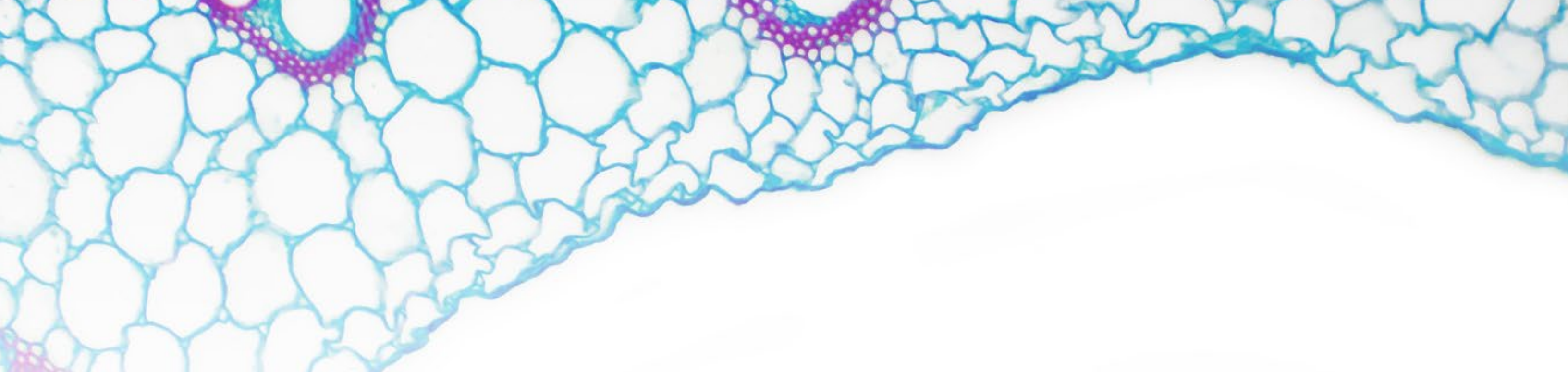

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

What Might It Mean to Have a Right to Bear a Pregnancy Peacefully?

Julia Feinstein, MD, MA

Abstract
This commentary on a case considers how physicians should respond when their patients' health is compromised by physical and social factors. Especially when they are pregnant, patients must feel secure in their access to food and to care provided during appointments.

Case

Dr R is an OB/GYN caring for CC, who is 28 weeks pregnant. CC has high blood pressure and is at risk of developing preeclampsia. Dr R stresses the importance of taking the prescribed medication to help control her blood pressure, resting, and avoiding salt and stress.

CC lives in a historically disinvested, redlined community that faces infrastructural neglect and food insecurity and is downwind from a plant that processes municipal waste. CC takes 2 buses and a train to get to her appointments with Dr R, and recent closure of a critical bus route between CC's neighborhood and affluent areas of the city means that CC must walk to catch the train and second bus to see Dr R.

When CC arrives for her next appointment, her blood pressure is 160/95 mm Hg. "I take my blood pressure medication as prescribed, but, as hard as I try, I struggle to rest and avoid stress. It took me over 2 hours to get here today."

Dr R wonders, "How can anyone gestate peacefully under conditions in which CC lives?" and considers how to respond to CC's concerns.

Commentary

Reproductive justice is defined by SisterSong Women of Color Reproductive Justice Collective as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[1] The patient CC described in the case above encounters several obstacles in her quest to have her child in a safe manner. First, CC lives in a neighborhood still reeling from historic redlining, where environmental hazards are rampant. While the SisterSong definition of reproductive justice mentions parenting children "in safe and sustainable communities," it should also include the human right to bear a pregnancy in a community with access to food, health care, and transportation, a right that CC certainly cannot exercise. In this paper, I will explore this right and the tensions that Dr R experiences as her clinician in trying to address CC's obstacles to peaceful gestation.

Obligations to Pregnant Patients

According to the scope of practice on the website of the American College of Obstetrics and Gynecology, "The combined discipline of obstetrics and gynecology requires extensive study and understanding of reproductive physiology; including the physiologic, social, cultural, environmental, and genetic factors that influence disease in women."[2] The vision of the organization "is an equitable world in which exceptional and respectful obstetric and gynecologic care is accessible to all."[2] Thus, Dr R's role includes supervising a healthy pregnancy from a medical point of view, as well as helping to address the numerous social determinants of health that affect CC's pregnancy. Accordingly, Dr R needs to ask CC not only about her physical symptoms, but also about the social determinants of health, such as environmental hazards, that affect her pregnancy.

Dr R's responsibilities toward CC as her OB/GYN align with the core principles of bioethics set forth by Beauchamp and Childress.[3] The principle of autonomy, which focuses on the right of an individual to self-determination to make informed decisions, dictates that Dr R respect CC's decision to carry a pregnancy safely or her decision to not carry the pregnancy if she so desires. Beneficence refers to Dr R's obligation to act in the patient's best interest in both treating the patient and removing possible harm. In this case, Dr R must both provide medical care and assist in mitigating the challenges that CC faces in her pregnancy and in accessing this medical care. Nonmaleficence, which is the principle of causing no harm, dictates that Dr R refrain from doing harm to CC. In fact, one could argue that allowing CC to continue with her pregnancy in her current conditions could be considered an act of harm and therefore reinforces Dr R's role in ensuring more than just the medical safety of her patient's pregnancy. Justice, which emphasizes equity and fairness, manifests here as reproductive justice, ensuring that CC should have the same opportunity for a safe pregnancy as anyone else, regardless of where she lives. This issue is particularly crucial, given the astronomically high rates of maternal morbidity and mortality in the United States, with severe maternal morbidity being even higher in rural communities, which tend to have high rates of poverty, than in urban communities.[4]

Achieving Peaceful Gestation

While Dr R's role in providing prenatal care is clear, the question remains of the extent to which Dr R can help CC to achieve a safe pregnancy—in particular, of the scope of Dr R's role as an individual clinician and the concrete steps she can take to help CC.

The tension between Dr R's role in providing health care to CC and in addressing social determinants of her health is apparent in possible steps she can take to reduce CC's high blood pressure and factors contributing to it. As a medical practitioner, Dr R can control CC's blood pressure through medications and through increased visits to help track fetal well-being through ultrasounds. CC's high blood pressure could be physiological, either due to CC's chronic hypertension or to preeclampsia caused by her placenta.[5] In either case, it is important to control and track preeclampsia to avoid complications of hypertension during pregnancy, as hypertensive disorders of pregnancy are the leading cause of maternal and perinatal mortality.[5] However, psychosocial stress can also increase blood pressure by increasing cortisol levels.[6] Dr R cannot as easily address CC's psychosocial stress merely with medication. Indeed, part of the care for increased blood pressure during pregnancy includes additional monitoring. For example, weekly antenatal fetal surveillance is recommended for those with controlled chronic hypertension in addition to the 12 to 14 prenatal visits already recommended.[7] CC, whose blood pressure does not appear well controlled, might require even more visits.[8] These additional visits might contribute to further stress for CC, who already struggles to access the clinic in the first place.

Which steps can Dr R take to mitigate this stress and help CC achieve a healthier pregnancy?

Clinician-level actions. Consistent with the bioethical principle of beneficence, it is important that Dr R understand the problems her patients face and provide culturally sensitive care to her patients. While cultural competence can have several definitions, most, such as Betancourt et al's, emphasize the ability of clinicians and systems "to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs."[9] Knowledge of patients' culture should extend beyond intentional beliefs and traditions to include the environments in which they live and how they affect their day-to-day lives and behaviors.[9]

Therefore, providing culturally competent care means that Dr R must not only understand CC's beliefs and traditions but also be aware of resources that exist in her clinic and be able to take advantage of the expertise of others on the care team, such as social workers, who can help address problems that patients face that she might not have time to address herself. For example, it would be important for Dr R to know if there are any transportation resources that CC can use in the short-term, such as a ride service. She can also assess CC for her level of food security and, if needed, try to help connect her with services like the Special Supplemental Nutrition Program for Women, Infants, and Children that can help her access food. Furthermore, she can refer CC to social work or other resources within the clinic. She should also stay up-to-date on issues that are directly affecting the patients at her clinic, such as the current bus route closures, and advocate for her practice to provide resources to mitigate the effects of such events on patients. In addition to staying up-to-date on what affects her patients, she should stay current on literature on innovative approaches to problems faced by her patients. It should be acknowledged, however, that many of these action steps are challenging due to limited clinician time and pressure to see as many patients as possible.

Practice-level actions. Innovative approaches are necessary to help patients overcome structural factors that impede care and that are outside the immediate control of patients and clinicians. There are several methods that have been explored in the literature that Dr R's practice could possibly integrate into care delivery. For example, the COVID-19 pandemic necessitated the innovation of various remote approaches to pregnancy monitoring. Virtual prenatal care has been explored and shown promise for patients and health care clinicians without compromising health outcomes.[10] Reducing numbers of visits has also been shown to not adversely affect pregnancy outcomes for low risk-pregnancies,[10] although patient satisfaction has been reduced.[11] While virtual visits and decreasing the number of visits might be feasible options for low-risk pregnancies, these options would be more challenging for CC, who is already entering pregnancy at higher risk of a poor outcome due to her chronic hypertension.

There are also some innovations that would help with monitoring higher-risk pregnancies. For example, remote self-monitoring of blood pressure, among other measures, has been shown to be a safe alternative to in-person visits.[10] An advanced neonatal epidermal (ANNE) sensor has been developed for pregnancy that monitors vital signs, which could help predict major complications in pregnancy, such as hemorrhage, hypertensive disorders of pregnancy, and sepsis.[4] Given that remote self-monitoring does not increase maternal complications,[10] justice dictates that evidence-based methods be devised that can make prenatal visits more accessible to all, bearing in mind that some people in rural and low-income communities might not have access to the infrastructure necessary to participate in virtual visits.[4] While some of the results reported are only preliminary, CC's practice should stay up-to-date on the literature to provide the most culturally competent care.

Additionally, the fact that Dr R's clinic sees several patients from CC's neighborhood could justify creating infrastructure, such as a clinic, in that area, which would make care more accessible to patients in need. While building a new clinic would be a financial investment, it could ultimately reduce stress for patients by decreasing transportation time to appointments, thereby enabling them to attend more appointments without having to worry about time being lost to transportation that might otherwise be devoted to their jobs or childcare. Such a clinic should be located along public transit routes where many patients live and access neighborhood-specific resources. New infrastructure represents a medium-term solution to providing care for the patients in CC's neighborhood, allowing them to gestate more peacefully. In the long-term, systemic changes should focus on building clinics in diverse urban and rural neighborhoods to reduce patients' travel times to clinics.

Physician as advocate. While Dr R is not responsible for changing the systems of inequity that led to CC's more challenging pregnancy, physicians should continue to advocate for measures that would improve the social conditions of their patients across the socioeconomic spectrum, such as increasing access to care and decreasing health care costs. The American Medical Association *Code of Medical Ethics* recommends that such advocacy be accomplished through "informational campaigns, non-disruptive public demonstrations, lobbying and publicity campaigns, and collective negotiation, or other options that do not jeopardize the health of patients or compromise patient care."[12] It is essential that clinicians continually put patients first in their advocacy in accordance with the principles of beneficence and nonmaleficence, while also seeking justice for their patients and their patients' communities. In addition, clinicians can help their patients register to vote to create change within their own communities.[13] While advocacy can address issues of justice that face patients, physicians already face obstacles to providing optimal patient care. Adding advocacy to physicians' other responsibilities could compound their stress.

Choice Promoting Peace

The multiple stresses of pregnancy necessitate that people be able to choose whether and when to be pregnant. Access to contraception and to abortion are imperative for people to have control over their reproductive lives. The decision of whether to get an abortion is the point at which one consents to pregnancy and all the risk that it entails, since the act of intercourse itself is not directly correlated with pregnancy. Without access to abortion, which is banned or restricted in many states at this time,[14] people are not able to consent to their pregnancies and could be placed in a stressful position of being pregnant on top of managing their other responsibilities, which can include other children. Thus, without access to abortion, people are forced into gestating without peace and in a way that does not honor their bodily autonomy. Indeed, some states, such as Texas and Louisiana, are even criminalizing key clinical responses to miscarriage complications and not allowing exceptions for abortion in medical emergencies unless a patient has a life-threatening condition.[15,16] Legal impediments to abortion could further deprive pregnant people of peace due to fear of complications, even in wanted pregnancies. Thus, access to safe abortion should be one of the many priorities that physicians like Dr R advocate for in order to provide optimal care for their patients like CC and allow them to have peaceful pregnancies.

It is essential for Dr R to look beyond CC's pregnancy to the life that she will create for her child. Will the child be raised in a safe community? What about environmental pollution? Will the family be able to access nutritious and affordable food? Physicians should try to advocate for measures that would reduce stress for all their patients across the lifespan.

Overall, physicians must address patients' social determinants of health in order to provide culturally competent care that reduces their stress and enables them to feel peace. Patients cannot do their best by their physical health unless they feel secure in accessing food, unless they can physically get to their appointments, unless their many sources of stress can be mitigated. Principles of bioethics obligate members of the profession to seek to create better conditions for their patients through advocacy.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians Share Decision Making With Patients Interested in Using Psychedelics to Feel Psychologically Safe?

Jennifer C. Jones, PhD, LCSW and Aisha Mohammed, MFT, LMFT

Abstract
This commentary on a case of a transgender patient interested in using psychedelics to feel more at peace and achieve a sense of psychological safety argues that health care practitioners can help their patients minimize potential harms of psychedelics by providing psychoeducation and resources to identify clinical trials or skilled and knowledgeable psychedelic practitioners. This approach can support patients' agency in their mental health care and ability to foster moments of peace in their lives.

Case

FG is a 33-year-old transgender man who uses the pronouns they/them and has a history of unipolar depression and alcohol use disorder. Through their employer-sponsored health insurance, FG initiates alcohol use disorder treatment. FG also reports that combined selective serotonin reuptake inhibitors and psychotherapy with their psychiatrist, Dr P, have helped, but that their depression symptoms remain debilitating.

Recently, after watching a show about psychedelic mushrooms and cannabinoids and noticing sensory deprivation chambers at their local mall, FG wonders how these approaches could help them find peace of mind more often and more regularly.

At their most recent session with Dr P, FG expressed interest in trying psychedelic mushrooms. "I want more control over my ability to generate peace in my life and in my experiences," FG says.

Dr P, a 60-year-old, cisgender woman who uses the pronouns she/her, considers how to respond.

Commentary

For almost 2 decades, there has been a call for health care practitioners (HCPs) to ask patients directly about their use of complementary and alternative medicine (CAM)—

defined by the National Institutes of Health National Center for Complementary and Integrative Health as "a non-mainstream approach" that is either "used together with conventional medicine" or "in place of conventional medicine"[1]—before prescribing traditional medications (TMs) and making recommendations aimed at preventing adverse drug interactions and better supporting their patients' health choices.[2,3] In particular, HCPs might have patients who report using herbs, body-based treatments, mindfulness meditation, or spiritual practices to support their well-being.[3,4] Given media reports suggesting that psychedelics can help to alleviate symptoms of depression, anxiety, and posttraumatic stress disorder,[5] HCPs might also see patients who are using or considering using psychedelics to complement their TMs or as an alternative to TMs due to side effects or lack of effectiveness. Psychedelics can be considered CAM in that they are also plant-based medicines (eg, psilocybin, ayahuasca, peyote), and some psychedelic practitioners, based on their orientation, view the work and taking of psychedelics as a spiritual practice or intervention and, as such, include spiritual components such as ritual and prayer in their practice. We believe that the therapeutic use of psychedelics to support well-being—which, at this time, is not considered TM—is a CAM that is growing in popularity.

In 2022, *Forbes* reported the results of a study that found that 65% of Americans who identified as having mental health conditions wanted access to psychedelic medicines.[5] Therefore, it is incumbent on HCPs to educate themselves on the risks and benefits of psychedelic use for patients seeking improved mental health, support with substance use, and relief from chronic pain exacerbated by depression, anxiety, or trauma histories.[6,7]

FG, like the respondents in the aforementioned survey, is exploring CAM to support their mental health. Increasingly, HCPs like Dr P are treating patients interested in psychedelics—such as 3,4-methylenedioxymethamphetamine (MDMA), psilocybin, and ketamine—to improve their mental health.[8] When FG shared their desire to use psychedelics with Dr P, they took the risk of having Dr P judge and shame them for wanting to use illicit substances to feel better. Such circumstances give HCPs like Dr P the opportunity to practice their harm reduction[7,9,10] and shared decision-making[11,12,13] skills. The National Harm Reduction Coalition defines harm reduction as "a set of practical strategies and ideas aimed at reducing the negative consequences associated with drug use [and] … is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs."[10] Elwyn et al define shared decision-making as "an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences."[13] Both frameworks require HCPs to exhibit a patient-centered manner by providing information about risks and benefits of different treatments, listening to patients' concerns nonjudgmentally, and including patients in decision-making while being mindful of patients' cognitive and emotional capacities.[11] In particular, a harm reduction approach is useful when discussing psychedelic use with patients because it enables HCPs to discuss the potential risks of various substances (both illicit and licit) without shaming patients and while honoring their agency to make an informed decision.

Before Dr P responds to FG's expressed interest in trying psilocybin, it would be helpful for Dr P to consider the following: (1) any potential biases she may hold regarding legal and illicit psychedelic use, (2) how her and FG's respective social locations as well as the power dynamics in the patient-HCP relationship might affect FG's interpretation of her response, and (3) how to respond to FG's desire for more agency in cultivating peace in their life using a harm reduction and shared decision-making approach.

Relational Power Dynamics

When patients broach subjects that are stigmatic or taboo with their HCPs, it is important that HCPs understand how their opinions and attitudes can impact the patient due to the social power that they hold. This understanding supports the development of psychological safety in the patient-HCP relationship so that patients feel heard, seen, understood, and confident that HCPs' recommendations can be trusted. We understand psychological safety as part of the co-created dynamic between the HCP and the patient, in which the HCP creates a safe space by acknowledging the power dynamics, especially with patients who hold oppressed identities related to, for example, gender, race, class, immigration status, sexual orientation, religion, or age. Psychological safety is further supported by HCPs and patients having a direct conversation about their individual social locations and the ways that their identities are similar and different in terms of the privileges and oppression that they experience. It is important for HCPs to explore how similarities and differences in social locations might affect patients' comfort in disclosing their psychedelic use as well as how patients' experiences of social stigmatization and oppression related to their identities might impact their mental and physical health.[14]

If Dr P has not explored with FG how their similar and different social identities affect their relationship, including transphobic beliefs that FG might project on Dr P due to Dr P's social position, the potential for a rupture in the relationship is increased, particularly when the two discuss topics that might make FG feel vulnerable. FG might easily feel judged or dismissed by Dr P, given her cisgender identity or her other identities that carry privilege. If these subjects have not been previously discussed, Dr P might respond in the following ways:

- *I'm imagining this was not an easy topic to bring up with me, your psychiatrist, whom you might perceive as…* (Dr P would list several self-referring social locations).
- *I've been wondering how it has felt to tell me about your difficulties with depression, considering I do not necessarily deal with some of the stigmas and oppressions that you do.*
- *Are there parts of your experience that you feel like you can't share with me because I'm your doctor and I identify as…* (Dr P would mention one or two social identities that afford Dr P privilege or differ from FG's identities).

A Harm Reduction Approach

Narratives about the "drug-seeking" patient are prominent in medical forums, along with the perception that psychedelics can lead to subsequent psychiatric disorders.[15,16] Given the stigma surrounding drugs and drug use among HCPs and the resulting tendency of patients to conceal their drug use, Dr P could begin the discussion by reassuring FG that it is safe and appropriate to discuss the use of psychedelics in order to dispel any fear or discomfort.[7]

As with any medical intervention, we find that it is useful for an HCP to get an understanding of what the patient is seeking and the motivation behind the question in order to guide the conversation to an outcome that would be useful to the patient. In this case, the patient is seeking "control over my ability to generate peace." Dr P could ask FG about what having peace in their life would entail. Peace, for FG, could denote any number of experiences, including a sense of feeling less impacted by gender identity stigma, relief from alcohol cravings, and moments of not feeling depressed, to name a few.

Depending on how FG answers this question, Dr P could then speak to potential risks and benefits of individual substances, such as psilocybin and ketamine, as well as to FG's underlying desire to access the therapeutic benefits gained through nonordinary states of consciousness (NOSC). In using a harm reduction approach, Dr P would adopt a nonjudgmental attitude towards FG's desire to use psilocybin while also providing information and resources that would minimize potentially negative consequences of psilocybin use. For instance, perhaps after Dr P asks what peace in their life would entail, FG responds that peace involves feeling moments of relief from symptoms of depression. In that case, Dr P could affirm FG's desire for relief from depression, provide psychoeducation about the use of psilocybin to address depression symptoms based on the results of recent clinical trials, and discuss the potential risks and benefits of using psilocybin and psychedelics in general.

Dr P could also explain that psychedelics are powerful medicines with potential to destabilize people during and after use and that psilocybin, although it might not be legal where FG lives, might be accessible through participation in a clinical trial.[6,7] However, if FG still wants to proceed even if there is no opportunity to serve as a research participant, Dr P should stress the importance of working with an experienced and skilled psychedelic practitioner because, even with support, many people find that they experience some level of psychological distress.[16,17] Among psychedelic practitioners, there exists a spectrum of experience and professional training. Some psychedelic practitioners are licensed mental health practitioners, clinicians, chaplains, or body workers who have undergone therapeutically based training programs, and other psychedelic practitioners may not be licensed professionals but have completed training programs either in the United States or abroad that are not restricted to licensed professionals. Psychedelic practitioners may be allowed to work in specific districts, cities, and states that have decriminalized plant-based psychedelics but have regulations specifying the volume of plant-based psychedelics that individuals can possess, the purpose for which the plant-based psychedelic is being used, the type of facility in which the psychedelic-assisted therapy is being administered, or the type or level of training that the psychedelic practitioner must have.[18] In addition, both trained professionally licensed and trained unlicensed psychedelic practitioners may be working as psychedelic practitioners in places where the use of psychedelics is deemed illegal. Criminalization of most psychedelics creates conditions that can make it difficult for many psychedelic practitioners to find trainings with experiential components that enhance skill development and learning and for patients to find skilled and well-trained psychedelic practitioners. Therefore, the risk of psychedelic-assisted therapy is dependent on where the patient lives, what types of psychedelic practitioners they have access to, whether the patient can travel to cities that have a pool of skillful psychedelic practitioners, and other contextual factors.

Dr P could inquire whether FG has the resources to be able to take time off if needed after a session and whether they have supportive people in their life whom they could lean on in case of destabilization. Given some of the risks of psychedelics, such as adverse medical reactions, and the difficulty of accessing psilocybin in a clinical setting that would provide medical screening and monitoring, Dr P could suggest alternative medical and nonmedical means of accessing NOSC, such as ketamine-assisted therapy or mind-body approaches (eg, breathwork) that could fulfill FG's desire to access NOSC benefits. Although further research is needed, several studies suggest that mind-body approaches can produce comparable shifts in consciousness and that they can have a range of therapeutic effects, including enhanced self-awareness and spiritual well-being.[19]

Dr P could also help manage FG's expectations of what psychedelics and, by extension, NOSC, can actually do by giving FG a sense of what is required in terms of preparation and integration. Integration is a process in which patients implement and incorporate the key insights gained in the NOSC experience in their day-to-day lives.[20] Dr P can explain that, unlike pharmaceutical medicines that can have a biomedical impact regardless of the patient's intent, the effectiveness of NOSC, whether induced by psychedelics or mind-body approaches, is significantly influenced by the patient's active engagement in both preparatory sessions (during which the patient gains clarity on their intentions) and integration sessions. Although patients can experience an abatement in symptoms and immediate positive effects after the experience, ongoing integration is necessary to internalize the insights gained in the NOSC and to make lasting change.

Finally, Dr P could provide suggestions on how to find an appropriate psychedelic practitioner. For example, Dr P could direct FG to online resources that detail what questions to ask potential psychedelic practitioners.[7]

Conclusion

For many, NOSC facilitate connection with a sense of peace, self-compassion, love, and connectedness, which often mitigate symptoms related to depression, anxiety, and trauma. Dr P's patient, FG, is exploring the use of psilocybin in combination with psychotherapy in the hope that this alternative treatment will alleviate their symptoms of depression without the side effects often experienced when using selective serotonin reuptake inhibitors. FG wants to feel more agency when it comes to feeling at peace and hopes that the use of psilocybin, in combination with psychotherapy, will offer them the control that they are seeking. When FG, who continues to feel debilitating depression, broaches the topic of using psilocybin during the therapy session, Dr P has an opportunity to employ both harm reduction and shared decision-making skills to support FG in examining their desire to use psilocybin in combination with psychotherapy to gain more peace in their life and in their experiences.

To make sure that Dr P responds to FG's statement in a way that supports FG in their exploration and does not make them feel judged, Dr P needs to first explore any biases or stigma that she has regarding psychedelics and psychedelics' medicinal uses. Then Dr P can explore with FG how they feel about sharing their interest in psilocybin use with her in light of the similarities and differences in their social locations and the privileged role that she occupies as an HCP. If Dr P can navigate the conversation with FG regarding their interest in psilocybin, providing FG with time to discuss what they know about the risks and benefits of psychedelic-assisted therapy and providing resources so FG can learn more, it would create the opportunity for Dr P and FG to build more trust and for FG to feel more in control of their mental health care.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Using Music to Teach Health Professions Students to Listen Closely and Promote Peace

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Abstract

Promoting peace with patients requires clinicians to be skilled in helping patients feel safe, respected, and heard. Close listening is a teachable skill set that enables clinicians to focus sensory attention on a patient and to cultivate space for reflection before speaking. While communication skills are taught in health professions education, close listening is rarely formally emphasized as an equally important skill. This article draws on musical arts education methods to suggest strategies for teaching close listening that can be applied to peace promotion in patient care.

Not every patient can be saved, but his illness may be eased by the way the doctor responds to him.
Anatole Broyard[1]

Clinical Close Listening

To provide patient-centered care, enhance patient dignity, and relieve patient suffering, physicians must promote peaceful health care environments where patients feel heard and understood by those caring for them.[2] Fostering such peaceful environments starts foremost with physicians listening to their patients. Nevertheless, while 87% of physicians self-identify as “good listeners,”[3] studies demonstrate that physicians ask for their patients’ agendas only 36% of the time, and, when they do inquire, they interrupt their patients after a median of 11 seconds or an average of 36 seconds.[4,5] It is thus no surprise that consumer websites, such as Healthgrades and WebMD, abound with criticisms of physicians’ deficiencies in communication skills, with patients often perceiving their physician as “too busy to listen and too distant to care.”[6] While many systemic reasons—from insurance pressures to hospital schedules—can affect patients’ perceptions of physician listening, we need to ask whether physicians are actually taught to be good listeners in the first place.

According to patients, physician listening is a defining feature of a “good” doctor that is perceived not only (1) to increase data gathering and diagnostic accuracy but also (2) to create and maintain good patient-physician relationships and (3) act as a healing and therapeutic agent in itself.[7] Physician listening skills—such as the use of reflective listening, wherein physicians restate a patient's comment in order to demonstrate empathy and ensure shared understanding—have been shown to be correlated with patient feelings of physician-supported autonomy,[8] as well as medication adherence in diabetic patients.[9] Moreover, a curricular review of physician empathy training found that the physician skills and behaviors that elicited an increase in patient-perceived compassion included "(1) sitting (versus standing) during the interview; (2) detecting patients' non-verbal cues of emotion; (3) recognizing and responding to opportunities for compassion; (4) non-verbal communication of caring (e.g. eye contact); and (5) verbal statements of acknowledgement, validation, and support."[10] Interestingly, the review's authors also highlighted that all the empathy trainings included in their review had considered the role of listening in developing the aforementioned skills and behaviors, with the authors explicitly noting the need for future curricula to focus on educating physicians on the particular importance of listening.[10] Given the key role that listening plays in patient-perceived compassion and the significant correlation between patient-perceived empathy and greater patient satisfaction, strengthened patient enablement, decreased thoughts of litigation, lower patient anxiety and distress levels, and better clinical outcomes for diabetes,[11,12,13] improving physician "close listening" skills seems a promising approach to amplifying peaceful patient experiences.

Close Listening Skills in Medical Education

According to the Association of American Medical Colleges (AAMC), oral communication skills, including listening skills, are considered requisite professional competencies for admission to medical school.[14] Once admitted, however, listening skills are not explicitly tested or routinely taught to medical students. While sincere efforts have been made to instruct and assess listening skills in medical education, a 2020 review found that historical teaching methods employed to improve the listening competence of medical students, such as standardized patient encounters or objective structured clinical examinations, placed little emphasis on specific listening skills, were insufficiently standardized, and would benefit from medical educators' increased collaboration with specialists from other fields, such as the arts and humanities.[15,16]

At the same time, as acknowledged by the 2020 AAMC report, "The Fundamental Role of the Arts and Humanities in Medical Education" (FRAHME), the arts and humanities have been explicitly called upon to develop medical student skills and attitudes.[17] The most common arts and humanities approaches have dealt with "close reading" pedagogies, such as narrative medicine, and "close looking" pedagogies, such as Artful Thinking or Visual Thinking Strategies. In fact, 71% of the arts and humanities modalities used in medical education to date have been from visual art, literature, or writing-related categories, while the musical arts have composed just 3% of modalities used.[18] Nevertheless, while arts and humanities medical education curricula related to close looking and close reading skills have been widely developed and implemented, no such standardized curriculum yet exists in medical education for the teaching of close listening skills.[19]

This imbalance is perhaps unsurprising, given that both close reading and close looking pedagogies have been shown to be teachable concepts, with reviews demonstrating that close looking education can facilitate the development of clinical observational skills, while close reading education can result in the modification of skills, attitudes, and knowledge.[20,21] Notably, claims have been made regarding the transferability of close reading skills to close listening skills via improved quality of perceptive attention.[22] However, these claims have been problematized for conflating orality with literacy, as literary close reading skills are distinct from the dynamic, oral close listening skills required during real-time, interactive physician-patient encounters.[23]

Given the documented need for greater physician listening skill training, the lack of a standardized close listening curriculum for medical education, the novel AAMC curricular recommendations contained in the FRAHME report, the musical arts' gross underrepresentation in medical education, and the musical arts' refined, professional approach to close listening, we propose a new approach to teaching listening in medical education. The musical arts can be uniquely leveraged to train medical students as close-listening peacemakers in health care by fostering the skillful formation of medical student motivations, behaviors, speech acts, and responses to high-stakes tension and conflict. In turn, these attitudes and skills can promote the consequential peace of mind and body that patients and doctors alike feel when they are being heard.

Teaching Close Listening

The historical connection between music and medicine has been long established: Apollo was the god of healing and music; and it was to Apollo that Hippocrates dedicated his exalted oath, asserting "there is art to medicine as well as science."[24] This connection between art and medicine resonates today, as it is estimated that at least 70% of medical students have received some musical training,[25] which might be reflected in the prevalence of choirs, a cappella groups, small instrumental ensembles, and musical theater programs in medical schools.[19]

In fact, limited evidence suggests that students with a music education who enter medical school might outperform their peers in certain areas. For example, learning the skills of listening to lung sounds is frequently difficult for medical students, with many experiencing awkwardness, uncertainty, pressure, and intimidation; however, those students "who had studied music reported finding it easier to be attentive to the frequency and rhythm of body sounds and find ways to describe them."[26] Beyond exhibiting this listening skill, medical students with a music background have been shown to have higher levels of empathy than those without a music background, and physician trainees who took a "music and medicine" course regarded the course as an academically valid approach to humanism training.[27,28]

In sum, despite the limited empirical evidence of the value of music in medical education, there still exists a significant repository of academic claims regarding the usefulness of music in developing physician attitudes and skills.[29] For example, medical students engaging in music-based educational interventions have reported that these pedagogies support professional identity formation, enhance reflective capacity, increase interest in human dimensionality, develop critical thinking and openness to new perspectives, and improve ability to appreciate nonverbal interactions.[30,31,32,33] Additionally, academic medicine scholars have posited that the musical arts might contribute to medical education through musical-medical lessons on shared concepts like improvisation, performance, and ensemble.[34,35] These claims encompass a broad range of benefits—from improved communication, auditory, improvisational, and interviewing skills to increased coping abilities, greater self-awareness, increased metacognitive capacity, and greater tolerance of and appreciation for ambiguity.[34,35,36,37,38,39]

Nevertheless, given the gap between what is claimed about the affordances of music and what has been explicitly demonstrated in medical education research, further investigation into the ability of music to develop clinical close listening skills is indicated.[29] As such, we propose that an ideal musical close listening skills framework for medical education must address both the attitudinal elements of close listening and the behavioral skills required of close listeners. While we do not have space to offer a formal framework here, we suggest elements of music education pedagogies that can be offered in medical training in close listening skills.

In consideration of the key attitudinal orientations required of both musical and clinical close listening skills, a first lesson might pertain to affective listening, embodied cognition, holistic attention, or internal and external self-awareness of how one's self or instrument is engaging in the encounter.[40] For example, students might generate a collective word cloud of affective terms to describe what they each heard after listening to a particular musical work, with subsequent conversation demonstrating the diversity of responses and inducing reflection on how one's individual identities and circumstances might have shaped one's unique hearing experience in the setting of a common stimulus. In addition to affective listening, another important listening attitude concerns the concept of ego surrender and learning to "play second fiddle" as a way of centering patient voice and bolstering patient autonomy. As an example, in an interactive listening exercise with a live music group, musicians can demonstrate the unique and integral roles of each ensemble member, underscoring the critical and often understated role that harmonists (or physicians) play in supporting and accompanying a soloist's (or patient's) melody, especially during times of musical (or medical) dissonance and uncertainty. A final listening attitude concerns curiosity; musical and medical practitioners need to remain curious, to vigilantly examine the unique voices in their ensemble and their contribution to the ensemble's collaborative sound. A lesson in this concept might entail asking students to pay special attention to the collective, contextual interactions of the different "voices" in the room as they are sequentially added to a piece of music, one instrument at a time. Examining how novel "instruments" or pieces of clinical information can dynamically alter a musical theme or illness narrative can help students develop a heightened respect and appreciation for their unique role in contributing to a patient's diagnosis, treatment, and understanding of illness. Moreover, embracing curiosity in this manner might combat selective attention bias and foster tolerance for ambiguity—important physician characteristics that can affect physicians' ethical behavior and patient care—thereby encouraging physicians not only to listen for heuristic keywords that can enable them to draw down a list of possible diagnoses, but also to listen more broadly, to listen for the unexpected, to listen past the illness and to the patient.[35,41]

Teaching key behavioral components of close listening skills might include not only attitudinal lessons but also training of particular actions, such as "playing" the rests—durations of silence indicated in musical notation—and leveraging dedicated silence to foster space for ambiguity processing and narrative co-construction. These behaviors might be taught through a live small ensemble performance wherein musicians explain their use of measured silence or "rests"—by highlighting their use of intentional pauses and breaths to ensure simultaneity of attention, space for reflection, and opportunity for thematic co-construction—before tasking students with envisioning how similarly dedicated silences and deliberate pauses might be applicable to clinical situations of uncertainty. Additionally, musicians might offer specific behavioral lessons in nonverbal communication by demonstrating how they leverage cues, shared breathing, or alterations in their eye contact, head movements, facial expressions, or body positions to facilitate optimal dialogue in real time. Students might practice this lesson through a storytelling exercise wherein a pair of students alternate between dedicated storyteller and listener roles, with the listener paying special attention to how their nonverbal communication behaviors might modify psychological distance and convey understanding, validation, or support to the storyteller. Finally, it is vital to master the technical listening behaviors required to "build ensemble" and "play together," which may translate to using established clinical communication tools that optimize peaceful physician-patient interactions. For example, musicians could demonstrate how established musical devices like imitation, repetition, motion, counterpoint, or call and response aid the harmonious co-construction of a work's musical theme. They could then offer parallels for how established clinical communication tools, such as the elicitation of patient agendas and the use of teach-back strategies, reflective statements, empathic statements, and summary statements, might play critical, technical roles in harmonizing the physician-patient "performance."

Ultimately, applying the musical arts-inspired, close-listening attitudes and behaviors detailed above to medical education can promote physicians' close listening and improve physician-patient interactions. By ensuring that clinician attention is centered on the patient and that space for ambiguity processing and narrative formation is cooperatively built and maintained with intention, patients will have the room to speak, be heard, and feel at peace. Given that music education has recognized methods of instilling these attitudes in and teaching these skills to students, medical education should draw upon these lessons to develop an interprofessional curricular framework that addresses both the attitudinal and behavioral components required of skillful close listeners.

Promoting Patient Peace

The musical arts—and specifically musical education—have been underutilized in medical education, yet they offer a rich repository of pedagogical strategies to teach valuable close listening skills. Patient-perceived physician listening skills and actions are measurably connected to a myriad of downstream benefits for clinicians—from increased patient satisfaction to decreased litigation. Most importantly, physicians' close listening skills serve patients well; they are correlated with lower patient anxiety levels and better outcomes. Patients' hope for peace provides an opportunity for health care professionals to help patients feel safe, respected, heard, and confident that their concerns are being attended to. To promote this peace for patients, we need to draw on music education to teach close listening attitudes and behaviors in medical education.

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HEALTH LAW: PEER-REVIEWED ARTICLE

Government Obligations and the Negative Right to a Healthy Urban Environment

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Abstract

Urban development often generates noise and light pollution, reduces green space, produces heat islands, and increases population density that can exacerbate crime, disease transmission, anxiety, and stress. This article argues that individuals and communities have rights to not have their space impinged upon by urban plans, designs, or development. This negative right means governments have ethical obligations to develop infrastructure that mitigates adverse health consequences, preserves natural environments, safeguards ecological well-being, and promotes peace and public health.

Public Health and Urban Development

As of 2020, US urban areas housed 80% of the population.[1] Urban dwelling potentially confers significant advantages on residents compared to their rural counterparts: better wages, greater educational opportunities, and enhanced access to health care. However, some evidence suggests that select US cities have more than 3 times the incidence of tuberculosis as the US population excluding those cities, due in part to greater population density, and that urban development is associated with higher rates of homicide, air pollution from indoor and outdoor sources, anxiety and depression, and sleep disorders resulting from noise and light pollution.[2,3,4,5,6,7,8] Moreover, neighborhood clearance undertaken for new developments, shopping centers, or highways—often promoted as urban revitalization—frequently requires the relocation of residents, leading to feelings of isolation, difficulties locating secure and safe housing, and reduced economic opportunities.[4]

Government action often facilitates such development and revitalization projects, directly or indirectly. We argue here that individuals and communities have a negative right to not have their space impinged upon by government-facilitated action or development that adversely affects their health (eg, development through government purchase and use or purchase and sale to a private developer). We argue further that this negative right suggests an ethical obligation on the part of municipalities and states to consider the state of knowledge relating to the built environment, to build in such a way as to avoid harmful health effects, and to incorporate elements that will enhance individuals' and communities' health and sense of peace. We first discuss government's role in facilitating urban development and its potential harms.

Government's Role in Urban Development Harms the Health of Marginalized Groups

Eminent domain. Local, state, or federal government can acquire privately owned land through eminent domain, a legal mechanism that permits the government to take private property and convert it for "public use" or "public welfare" in the "public interest" in the belief that it will lead to accrual of "expected public benefits."[9,10,11,12,13] Often effectuated with a bias toward business and private interests, eminent domain has led to the greatest adverse social, economic, and health impacts in low-income neighborhoods: community rupture, residents' relocation and loss of economic opportunities, and the transformation of neglected development-designated lots into vacant sites of gun violence, dumping, and substance use.[11,13,14] Even when eminent domain has been exercised to revitalize blighted or slum areas, the destruction of substandard housing has often not led to construction or replacement of public or low-income housing but instead to private redevelopment of the area.[13]

Zoning. Zoning law, originally developed as a strategy to manage the development of urban areas and protect the public's health, later became a tool enabling those with greater economic and political power to implement and sustain segregation, leading to a diversion of investment from and a reduction in services in segregated areas and the use of many of these locales as sites for illegal dumping and storage of hazardous materials.[15,16] Zoning laws have also been implicated in the development of adverse health outcomes.[15,17] The greater exposure of low-income populations and populations of color to poor environmental quality has resulted in their bearing a disproportionate health care burden, variously referred to as environmental injustice or environmental racism.[16,18]

Redlining. The practice of redlining was utilized by the Federal Housing Authority from 1934 until the passage of the Fair Housing Act in 1968.[19] Redlining entailed the designation of predominantly African American neighborhoods as not creditworthy, thereby discouraging banks from lending in those areas and perpetuating racial segregation.[19]Although redlining ceased in 1968, its resulting adverse health effects—once manifest in a tuberculosis inequity—continue to be evident today in these areas relative to non-redlined areas in a higher prevalence of preterm births, a higher incidence of violent crimes, an increased risk of late-stage cancer diagnosis, and a higher percentage of adults reporting poor mental and physical health.[20,21,22,23,24]

General Health-Harming Effects of Government-Facilitated Development

Noise pollution. Noise pollution is a major problem in all developed countries and is one of the primary mechanisms leading to a reduction in quality of life.[25,26] In the United States, it was estimated in 2013 that 104 million persons experienced noise levels sufficiently high to put them at risk of noise-induced hearing loss.[27] Noisy environments have been associated with decreased quantity and quality of sleep; the resulting stress increases blood pressure and might increase risk of cardiovascular morbidity.[28] Continuous sound exposure could also lead to psychological stress and annoyance.[29,30] Exposure to aircraft and road traffic noise are associated with annoyance, sleep disturbances and high blood pressure, and, among children, reductions in learning ability, reading comprehension, motivation, and long-term memory.[5,31,32,33,34] Evidence also suggests a causal connection between background noise pollution and increased rates of violent crime.[35] Research designed to assess racial/ethnic and socioeconomic inequalities in exposure to noise pollution found that the most highly segregated geographical subdivisions, regardless of their racial composition, experienced the highest estimated noise exposures, which may contribute to health disparities.[36]

Light pollution. Adequate outdoor lighting increases environmental safety for drivers and pedestrians; facilitates the use of outdoor spaces after dark for work, leisure, and transit; contributes to a peaceful community by increasing individuals' sense of security and reducing anxiety; and can reduce violent crime rates.[37] However, nighttime artificial lighting has also been linked to adverse health effects, including a disruption of circadian rhythms, sleep disorders, and increased risk of some forms of cancer.[38,39,40] Moreover, research findings indicate that Asian, Hispanic, and Black Americans experience mean exposures to health-harming light pollution that are roughly double that of White Americans.[41]

Light and noise pollution also have a significant effect on wildlife, which invokes our responsibility as stewards of nature, but stewardship also carries downstream risks to human health. Bright lights alter insect populations and pollination behavior, which can disrupt local agriculture.[42,43] The sensitive eyesight and hearing of nocturnal creatures, such as owls and bats, can be impaired by artificial noise and light, thereby hampering their ability to locate prey, such as mosquitoes and rodents, which are vectors of human disease.[44,45,46]

Urban heat islands. Built-up developments can impinge on their surroundings through another mechanism: heat. Exposure to excess heat causes discomfort and loss of productivity; can exacerbate chronic health conditions, including lung, heart, and kidney disease; can worsen mental health outcomes, including by increasing suicide risk; and can worsen pregnancy outcomes.[47,48,49] Heatwaves are currently recognized as the most significant cause of weather-related mortality in the United States, with the intensity and frequency of such events increasing due to climate change.[50,51] Elderly persons, infants, those with disabilities and chronic illnesses, and those experiencing homelessness are particularly vulnerable to heat-related injury and death.[52,53]

Urban environments are consistently warmer than neighboring rural areas in the same regional climate due to variations in the landscape. Building materials utilized in urban areas, such as asphalt and concrete, increase temperatures by absorbing solar radiation and emitting it as heat, in contrast to how vegetation reflects sunlight, creates shade, and provides evaporative cooling. Tightly packed buildings reduce airflow; the resulting increase in population density contributes body heat, hot exhaust from vehicles, and energy utilization. Such built-up environments create urban heat islands (UHIs), which elevate temperatures during the day and maintain higher temperatures at night.[54,55] Given the negative health effects of excess heat, particularly during heatwaves, people have a negative right not to be exposed to UHIs.

UHIs are prominent around industrial areas and major roadways,[56] which are commonly government facilitated, and have been found disproportionately in low-income communities.[57] Multiple studies have found higher temperatures and decreased vegetation in postal codes and census tracts with lower per capita income and higher percentages of racial and ethnic minorities.[58,59,60] Historical injustices have contributed to these disparities: formerly redlined urban neighborhoods across the United States experience temperatures that average 2.6 higher than non-redlined neighborhoods.[54,61] The lasting effects of redlining on UHIs suggest that the heat burden from contemporary development projects borne by minoritized and low-income groups will persist for decades to come, likely becoming more pronounced with climate change, and perpetuate existing health and economic disparities.

Gun violence. Gun violence is also an insidious threat to public health and peace. The rise in gun violence across US rural and urban communities threatens peace by eroding social cohesion and undermining public health through senseless morbidity and mortality.[62,63,64] Nationwide data indicate that, between 2014 and 2019, firearm injuries in gentrifying neighborhoods increased by an additional 26% above the baseline increase in non-gentrifying neighborhoods.[65] As such, "renewal" efforts have not only failed to construct peaceful built environments that mitigate adverse environmental health conditions but also increased exposure to community violence.

On one level, gun violence disrupts the sense of quiet and security essential for well-being in urban areas, shattering the peace and tranquility vital for community resilience and emotional health. Exposure to the trauma of community gun violence also leads to pervasive anxiety and fear among residents, particularly among children,[66,67] and can lead to significant mental health disparities by increasing "levels of psychological distress, depression, suicidal ideation and/or psychotic experiences."[68] Quiet, safety, and peace in this context are not mere aesthetic values but fundamental determinants of urban health.

Potential Solutions

Stewardship of the ecological conditions for health and peace ultimately necessitates government effort and leadership and collaborative approaches to mitigate the adverse effects of development and to optimize community safety, health, and peace.[69] The intentional building of green spaces into urban built environments is one way to achieve these goals. Urban green spaces produce a durable and economical cooling effect that can extend several hundred meters beyond the space itself.[55,70,71] Research indicates that green spaces can be proactively integrated into the design and planning of large-scale development projects to offset their heat burden on the surrounding community.[72,73,74,75] Green spaces confer additional community benefits by improving air quality; reducing noise pollution; providing peaceful spaces for recreation, exercise, and socialization; serving as community gardens; and reducing crime.[76,77] Development of urban green space planning indices in accordance with the principle of distributive environmental justice holds promise for the ability of city planners and government policy makers to reach specific goals related to enhancing greening interventions in urban areas.[78] Green spaces can also help mitigate negative effects of urban development on wildlife by increasing biodiversity and improving resilience of ecosystems.[46]

In addition to building urban green spaces, governmental entities must ethically consider the current state of knowledge in designing nighttime lighting. Possible solutions that provide adequate illumination while minimizing harmful effects include streetlamp shades to prevent light from shining into residential windows and warm-color bulbs to decrease eye strain and circadian rhythm disturbances.[79]

In line with various organizations that have argued that cooling is a basic human right, akin to water or heating in the winter, some municipalities have enacted heat action plans (eg, extending public pool hours, opening cooling centers during heat events, or legally requiring housing providers to maintain a maximum indoor temperature).[80,81,82] Although air conditioning protects vulnerable persons' microclimates, it contributes additional heat to the surroundings and is not a sustainable solution to UHIs.[83]

In sum, governments have an ethical obligation to utilize sustainable design techniques, including the use of green spaces, to minimize and mitigate UHI effects and to avoid impinging on individuals' and communities' negative right to a peaceful and healthy environment.

Conclusion

We have argued that individuals and communities have a negative right to not have their environment impinged upon by development that has been shown to adversely affect their health, safety, and sense of peace. Much of this development is occasioned directly or indirectly by government entities through mechanisms of eminent domain, zoning, and private sale. Accordingly, the government has ethical obligations to develop interventions, such as the establishment of green spaces, which will ameliorate, if not eliminate, such conditions. Developing such interventions will not only serve to respond to the present issues at hand caused by urban "renewal" and gentrification but also allow policy makers to begin addressing and interrupting the perpetuation of historical racial and ethnic socioeconomic inequalities that have brought forth environmental conditions—from tormenting heat to stray bullets—that prevent peace.

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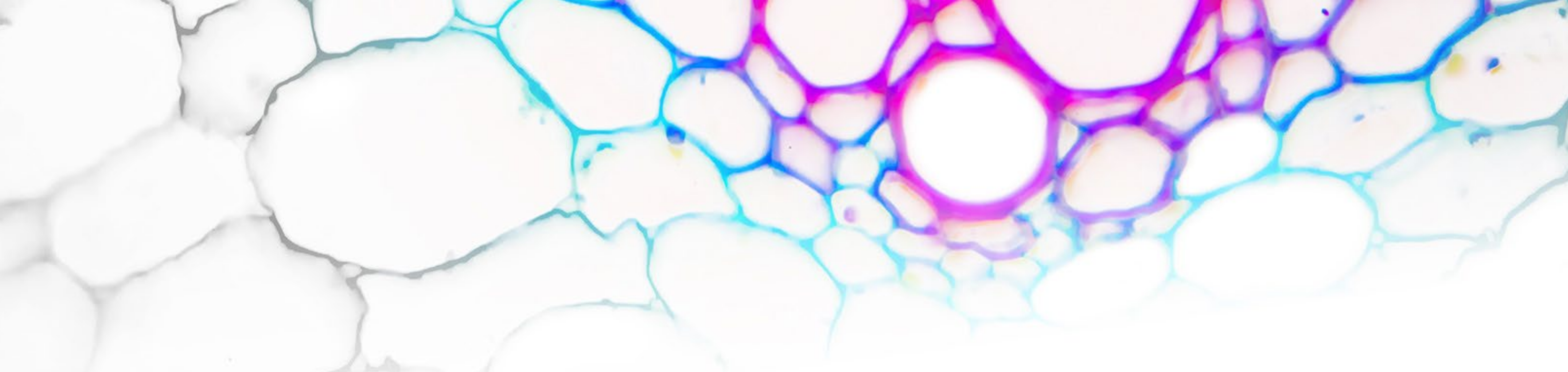

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

How Should We Expand Access to Psychedelics While Maintaining an Environment of Peace and Safety?

Zachary Verne and Jeffrey Zabinski, MD, MSW, MA

Abstract

Psychedelics have long been used by individuals seeking peace and a sense of wellness. This article examines widespread adoption of ketamine as a proxy for psychedelics. For ketamine, there is a need to protect vulnerable persons from exploitation that should be balanced against risks of hypermedicalization. This article suggests strategies for striking such a balance, including by carefully differentiating between persons with psychiatric illnesses, such as treatment-resistant depression, who could benefit from psychedelics, and persons using psychedelics for peace and wellness under careful guidance.

Wellness Pursuits in Clinical Settings

Various methods are used to achieve an individual sense of peace and wellness in modern clinical and nonclinical settings, including meditation, prayer, dietary changes, self-reflection, and substance-mediated peace experiences. These practices have varying degrees of published evidence to support their efficacy, but virtually all methods of attaining peace are heavily marketed—sometimes with strong claims to being the correct, or even the only, method of attaining peace if properly followed. The marketing of personal peace and wellness can take advantage of the vulnerabilities of people who are desperate to feel better at any cost and who might in fact be seeking these resources during an episode of psychiatric illness. A wide variety of clinicians, therapists, coaches, guides, and other leaders in health and wellness practices are positioned to wield their credibility over these practices for personal gain. Often, those who are critical of the medicalization of psychedelic experiences have just as much—or more—financial incentive to market their methods. In this article, we discuss the case of ketamine treatment to explore the ethical obligations of health professionals to be aware of the benefits, detriments, and economic interests at play in the growth of modern psychedelic administration as a peace and wellness practice.

Brief History of Psychedelics

Psychedelics are a heterogeneous group of compounds that produce a profound effect on mood and consciousness. Historically, psychedelics have been defined exclusively by 5HT-2A receptor antagonism, with recent debates considering a broader definition that includes compounds that induce psychedelic-like experiences (such as ketamine, cannabis, and 3,4-methylenedioxymethamphetamine, or MDMA).[1] While systematic evaluation of psychedelics' therapeutic benefit primarily started in the mid-20th century in Western medicine, many psychedelic compounds have been utilized by Indigenous communities for centuries.[2] Extensive research in the 1950s and 1960s led to greater interest in utilizing these compounds alone or in conjunction with psychotherapy to treat psychiatric illness.[3] With the discovery of lysergic acid diethylamide (LSD) and the isolation of other psychedelic compounds, research on the potential therapeutic benefits of psychedelics continued until the passage of the Controlled Substances Act of 1970, which criminalized the majority of psychedelic compounds.[4] A resurgence of scholarly work at the beginning of the 21st century has resulted in renewed interest in the clinical use of psychedelics, accompanied by considerable popular interest in psychedelics not only to treat psychiatric illness, but also to facilitate peace and wellness practices in diverse settings and for other uses outside of the clinical context, including recreational use.

There is growing consensus within the psychiatric field supporting the use of psychedelics in clinical practice, potentially representing a substantial shift in perspective.[5] This growing support has coincided with the biotechnology sector's renewed interest in commercializing psychedelics and in developing new psychedelic compounds for clinical use.[6] Most medications with psychedelic potential are still only in an investigational stage of development—except ketamine, which was approved by the US Food and Drug Administration (FDA) in 1970 for use as an anesthetic agent and was later found to induce an acute mental state similar to that of classic psychedelics.[7,8] Given widespread clinical use of ketamine, we contend that it is a compelling proxy for the coming wave of potential psychedelic treatments. Furthermore, aspects of the commodification of ketamine practices could offer a cautionary tale about the ethics of access to psychedelics.

Ketamine Use and Commodification

Due to ketamine's ubiquitous use as an anesthetic, its incorporation in clinical practice for other indications following early displays of efficacy has been rapid. Currently, intravenous racemic ketamine and intranasal esketamine (an enantiomer) are used in clinical practice for treatment-resistant depression, defined as depression that persists despite trials with 2 conventional antidepressive regimens.[9] Recommending ketamine to patients, however, is complicated by access, variable quality of programs and treatments, patient ability to pay out of pocket, and potential for recreational use.

Ketamine's use as a peace and wellness adjunct as well as its use in the clinical setting is restricted by its regulatory and legal status, which results in substantial costs to people looking to access this treatment. Racemic ketamine remains an FDA Schedule III controlled substance indicated only for use in induction and maintenance of anesthesia. Administration of racemic ketamine in the wellness or psychiatry realms falls under off-label use, with little-to-no insurance coverage. Intranasal esketamine received FDA approval in 2019 for use in adults with treatment-resistant depression, in combination with conventional antidepressants.[10] Although FDA approval may have improved esketamine's potential for insurance coverage, treatment prices for both esketamine and racemic ketamine remain upwards of $500 or more per session, often with protocols that include up to a dozen sessions or more.[11,12]

Ketamine's growth in the mental health sphere has been rapid, and it is now offered in a variety of settings—including clinics associated with major health centers, clinics run by large corporations, and independent mental health clinics—and can be taken at home, with or without virtual monitoring. The numerous settings in which ketamine is offered raise considerable concerns about the consistency and quality of treatment.[13] These concerns include the level of experience of the clinicians administering the infusion, access to medications to manage complications, and access to a prescribing clinician to manage complications. The variable quality of treatment is best exemplified by the difference between receiving ketamine in an experienced infusion center with clinicians available to manage complications and receiving ketamine in the home setting. Complications of ketamine administration that might require clinical management or closer observation include transient blood pressure changes, oversedation, and lightheadedness.[14] Clinics in which ketamine is administered without significant infusion experience or guardrails might have the benefit of lower maintenance costs but could compromise patient safety. Restricting ketamine use only to clinical environments with greater resources and experience, however, could limit access as well as increase costs for the patient.

The growth of access to ketamine is in no small part due to private interest in managing treatment-resistant depression and other psychiatric illness, which incurs tens of billions of dollars in direct and indirect costs annually.[15] The variety of settings in which ketamine is offered, financial interests in marketing ketamine, and substantial advertisement of ketamine services by private equity-funded ketamine startups makes it difficult for physicians to responsibly recommend treatment centers, and so they rely primarily on reputation. The increased prescribing of ketamine, though well intentioned, has led to marketing for many off-label indications, and at times patients might be getting treatments when there is no clinical indication at all.[16]

Contextualizing Psychedelic Use

Current concerns about ketamine treatment, access, and recreational use can serve as a proxy for those of other psychedelics as they are submitted to the FDA for approval for psychiatric indications. There has been a huge growth of interest in legislation concerning decriminalization and rescheduling of psychedelics over the past decade, as exemplified by the first-ever 2023 congressional hearing on psychedelic-assisted psychotherapy for use in military veterans.[4,17] As these medicines become FDA approved, questions remain about insurance coverage and the potential expense incurred by people who might be in a vulnerable state and who could instead choose to access less reliable sources of these medicines outside of the regulated market. As exemplified by cannabis in New York State, the unregulated market dominates consumption when price is a concern, despite increased availability of regulated products.[18] It is also likely that clinicians and private companies will develop and market their own methods of psychedelic administration without substantial evidence to support them—mirroring practices that have proliferated with ketamine. These risks might be mitigated by credentialing or licensing and by requiring implementation of a Risk Evaluation and Mitigation Strategy (REMS) program. REMS is an FDA program that provides closer monitoring of and guidelines for administration of medications with potentially adverse effects.[19] This program could mitigate some risks related to quality and safety of administration, and a REMS program has been in place for intranasal esketamine since its approval in 2019.[20] A highly regulated market provides greater protections but comes at the cost of potentially restricting access and reducing the number of sites capable of administering the drug. Despite the pitfalls of a more regulated market for psychedelics, an unregulated market allows opportunistic practitioners to prey on those seeking treatment or wellness pursuits at any cost.

Examining the dual clinical and other uses of psychedelics might further aid our understanding of the evolving regulatory environment of psychedelics in general. Nonclinical uses of psychedelics are those that have not reached a particular evidence-based standard that is the result of the typically rigorous pharmaceutical approval process. Both recreational use of psychedelics and personal use of psychedelics for peace and wellness fall under nonclinical use, but the latter might have therapeutic potential similar to that of psychedelic use in a clinical environment. However, the home or community environment for nonclinical uses of psychedelic experiences, even if therapeutic, would not offer the clinical responsiveness and protections of formalized clinics. Special protections and considerations in psychedelic treatment and use are critical for people with severe psychiatric illness or who have significant medical complexity. However, if psychedelic usage is only kept within the confines of specific clinics, there is a risk of gatekeeping, leaving vulnerable people seeking peace and wellness—regardless of whether they carry a psychiatric diagnosis—to pay a high price. Price is of great concern in general when it comes to psychedelic treatment, and there is interest in developing alternatives to traditional treatment that offer greater affordability and increased access, such as group-based treatment.[21] While research is still ongoing, there is also a popular perception that psychedelics benefit the wellness of healthy individuals as well as those with psychiatric disease.[22] Thus, it is worth distinguishing between people who might benefit from psychedelics to treat specific illnesses in a more controlled clinical setting and people who might benefit from psychedelics as a peace and wellness pursuit. Both might receive treatment in regulated clinics, but the latter might bear unnecessary costs if other psychedelics follow the route of ketamine.

The interplay between safety and access is further complicated by a subset of patients who might experience psychological harm from long-term use of psychedelics, such as anxiety, social disconnection, or depersonalization.[23] These potential harms might necessitate closer long-term monitoring of patients who experience complications as well as closer monitoring during psychedelic administration. Is it possible to have safe, appropriate access for patients who are at higher risk while working toward ethical and safe use outside of traditional clinical settings? Extending access might require creative solutions, group-based treatment, new types of treatment models, or development of psychedelic medicines that can be adapted to different settings. It should start with discerning which patients are at higher risk and need treatment in a clinical setting and which patients might be able to safely use psychedelics in less controlled environments.

Conclusion

The landscape of psychedelic experiences for treatment and for peace and wellness pursuits is evolving rapidly. What guidance should clinicians and therapists give to patients who are interested in these medicines? Additional education, with an emphasis on harm reduction, will be critical for all involved in the clinical setting and, in particular, for psychiatrists. There are many well-intentioned clinicians offering treatment with unproven products or making claims in the peace and wellness space that are not justified by the literature. Clinicians have a responsibility to educate patients and caution against perceptions that these medicines are a panacea, as well as to give clear safety recommendations for patients with clinically and psychiatrically complex illnesses. As clinicians develop and market their own methods of psychedelic administration, guidelines, limitations, and licensing will be necessary to maintain patient protection.

Determining the risks and benefits of psychedelic use for people who have been—and who have not been—diagnosed with a psychiatric illness is a complex challenge, but one with great promise in the pursuit of peace and wellness, as well as within the scope of clinical treatment. These determinations are inextricably intertwined with issues of inequality in access, marketing and risks of false promises, off-label use, and gatekeeping in medicalization that could delay or prevent crucial benefit for people who are in need.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

When a Patient Leaves Your Care, How Do You Want Them to Feel?

Veronica Olaker, MPH, Kurt C. Stange, MD, PhD, and Pauline Terebuh, MD, MPH

Abstract
Peacefulness is a potentially healing inner state that can be fostered by skilled interpersonal interactions. Skilled interactions in health care are those in which clinicians focus on making patients feel seen and heard and that their needs are important and can be met. But data collected in health care encounters tend to place value on consumerism and commodification, both of which undermine clinicians' capacities to skillfully interact with patients in ways that support patients feeling comfortable, if not peaceful. Motivating peace for patients means shifting patterns of how some data are valued relative to other data; this article suggests data measures that can facilitate a shift toward clinical encounters with more capacity for more peaceful interactions.

Peace and Healing

"Peace-fullness" within and surrounding a person can be healing. Peace in health care means being seen and cared for as your real self. Wouldn't it be wonderful if health care, and the systems and society that support it, fostered a healing peacefulness in those providing and receiving care?

However, the experience of being a patient in the US health care system too often is one of frustration, fear, and confusion. At the same time, it is an experience of privilege, given the social, financial, structural, and other barriers that prevent many people from accessing care. Even if a patient can afford and access care, the practice of modern medicine often does not lend itself to peace. We cannot expect patients to feel anything more than swirling eddies of peace, given the turbulent fragmentation of the current state of health care,[1] in which hyper-specialization leads to patients with complex illnesses seeing several specialists with little coordination between them.

At the systemic and societal levels, American health care represents the commodification of human suffering.[2] The cost of health insurance in the United States continues to rise, alongside increasingly profit-driven health care and health insurance systems.[3] Privatization is expanding concurrently, as 48% of Medicare beneficiaries in 2022 were enrolled in private insurer-run Medicare Advantage plans.[4] As Dr Bernard Lown, renowned cardiologist and Nobel laureate stated in his 2007 article, "A public service has been transformed into a for-profit enterprise in which physicians are ‘health care providers,’ patients are consumers, and both subserve corporate interests.”[2] In the United States, patient experience surveys at their inception created a financial incentive for hospitals to obtain higher survey scores,[5] which calls into question if and how these data should be used to inform interventions aimed at peace rather than profit.

How might a health care system approach interventions to cultivate the foundations of peace for patients and their loved ones? We explore in this article the downsides of the current use of patient experience survey data; how peace can be cultivated at the clinician, systems, and patient level; and how patient data can be used to inform the possibility of greater peacefulness.

Patient Survey Data and the Broader Context

While patient experience surveys can raise patients’ voices in health care and lead to improvements in patient care, many such surveys are informed by the concept of a patient as a satisfied or dissatisfied consumer.[6] This focus reinforces the commodification of health care. Being treated and valued as a consumer of a commodity is not likely to foster a sense of peace among patients. Being treated as purveyors of commodities to be bought by or sold to consumers and investors is not likely to support clinicians in their role as healers, as clinicians require healing and peace if they are to be healers for their patients.[7] Indeed, consumerism and commodification are a source of burnout among those providing care and dissatisfaction among those receiving care.[8,9]

To support peace, we must look further upstream than the patient’s report of their satisfaction with a single clinical interaction. We must consider the myriad of barriers that prevent a patient from even making it to that clinical encounter. Systemic racism, ableism, sexism, homophobia, transphobia, stigma surrounding many diseases, weight-based stigma, cost of care, access to care—all of these factors and many more stand in the way of patients receiving equitable care. If we look to survey data, we are only getting the perspectives of patients who can receive care and are able and willing to complete a survey. Such data, aggregated and presented as metrics that create winners and losers among health care practitioners, quickly become something to game rather than a source of reflection and a means to positive interaction.[10] Because this approach glosses over the individuality of patients’ experience, it cannot meaningfully inform interventions on peace, since peace will be achieved differently for different people.

In sum, most of the widely used surveys capture how the patient felt about the interaction they just had but don’t assess the crucial contextual barriers to and drivers of their state of peace.

- Can a pregnant patient feel peaceful if they are waiting for the government to decide whether or not their physician can legally perform their needed abortion?
- Can a transgender patient feel peaceful if they are having to uproot their entire lives to move to a state that has not yet prohibited health care for them?
- Can a patient with a chronic illness feel peaceful if they are wondering if they can afford their medication?
- Can a patient with substance use disorder and HIV feel peaceful if they’re avoiding care because of the stigmatization of their health concerns?

- Can a Black patient feel peaceful when contemplating the shockingly inequitable odds of their infant dying and contributing to the persistent disparity in Black-White infant mortality?[11]

These are only a few examples of the immense barriers to peace that patients face, and we gain only limited insight, at best, on these barriers from patient surveys.

Steps to Increase Patient Peace

So, what can we do to turn the ship of a fragmented, greedy system?[12] Placing less emphasis on patient satisfaction data to reward performance[13] and instead moving control to and supporting decision making at the on-the-ground level of the practice and the clinician is a helpful antidote to currently rampant health care worker burnout,[14] as is meaningful patient interaction. What healing might emerge for patients, clinicians, health care systems, and society if we addressed the barriers to peace in healing and health? We have interrogated our own experience for some hopeful directions, which we share here.

Clinician level. Peace may be cultivated when a clinician is steady in presence and engagement and walks the journey with the patient; calls to check in shortly after a patient begins a new recommended treatment; does not leave the patient feeling like an item on a checklist before moving on to the next task; prioritizes and gives careful thought to what really makes a difference for the patient; engages the family caregiver in conversation about a loved one; encourages the patient to reach out any time with questions or concerns; slows down and listens, helping to lessen the degree of separation from them that a patient may feel; focuses on practices that reduce ego involvement in order to engage fully, sometimes even playfully, to meet patients where they are and really connect with them; makes a daily, conscious effort to show respect to every patient; intentionally thinks about what a patient has gone through to come and see them and recognizes that the patient's time is just as valuable as theirs; and recognizes the system of barriers that their patient faces and considers these barriers as they partner with the patient to form a treatment plan.

Systems level. A health care system can create space for peace when the system invests in supporting development of relationships between clinicians and patients on the front lines of health care rather than treating patients only as a problem to be solved or as sources of revenue; all members of the team recognize that their work is in support of the patient; relationships are prioritized over productivity; privacy and trust are honored; the safety of both patients and staff is actively supported and prioritized; efforts are made to address health disparities and upstream causes of disease and of factors contributing to patients' health care journeys; there is concern for the wellness of health care practitioners; and resources for patient advocacy are a priority.

Patient level. Patients can use their experience of their mind, body, and social selves to be aware when health care settings are not fostering peace. They can ask for settings to be more conducive to peace and healing, seek other situations, or request an advocate to be in their corner as they search for the health care situation that brings them the peace they deserve.

Roles of Data in Peace

To avoid doing more harm than good, meaningful measures must be used in environments that support personal and collective action at the interface between healer and patient[7,15,16] and that provide system-level support for healing, peaceful relationships.[5] The Person-Centered Primary Care Measure, which assesses what matters from the perspective of patients and their primary care clinicians, is a potentially helpful antidote to impersonal care.[17] As a more data-driven approach, natural language processing, which uses machine learning algorithms to analyze textual data,[18] could lead to better understanding of how to facilitate patient peace by rooting data analysis in the context of the actual words used by the patient and clinician over time. Natural language processing also could be applied to surveys that prompt patients to write narrative-form responses—but only as a starting point for consideration by a real person of how to apply such data to a real human interaction. However, narrative-form responses ask more of patients and would require more complex data analysis. Aggregate data can at best be a partial answer to facilitating patient peace. More crucially, the focus should be on the person in need of healing and the person attempting to help.[2]

Conclusion

Peacefulness can heal.[7,15,16] Healing and peace are needs of our patients, our health care workforce, and society. Information—from surveys or from talking and listening—can be a part of the needed peace movement. But to turn information into knowledge and knowledge into understanding—and in rare but desirable moments of peace, to turn understanding into wisdom[1]—we need systems that support the personalization and contextualization of information and that foster the humanity, not the commodification, of healers and the receivers of health care.[19]

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Why Prospective Bereavement Counseling Is Crucial for Peace-Finding After Loss

Ramona Fernandez, PhD, MEd

Abstract

Bereavement counseling is often offered as a referral following an adverse event or after identification of lingering grief. This article proposes the value of prospective bereavement counseling when a person can reasonably anticipate loss to support anticipatory grief and facilitate supportive continuous care planning for patients experiencing loss. This article positions bereavement counseling as care aimed at finding peace by offering a framework of dimensions of peace, opportunities to foster peace in clinically important moments, and guiding questions to facilitate this clinical outcome in health care settings.

Loss

The scope of bereavement counseling for peace need not be limited to death and end-of-life or palliative care. It also encompasses non-death loss, ambiguous loss, and anticipatory grief.[1,2,3] For example, someone with dementia might have experienced numerous non-death losses—which also affect their loved ones—prior to experiencing the death of a loved one. The value of prospective bereavement counseling is its recognition that grief begins the moment that loss becomes a possibility, thereby offering health professionals multiple opportunities to foster peace in health care. This article discusses dimensions of peace in health care, opportunities to foster peace in clinically important moments, and questions clinicians can ask patients to help facilitate this clinical outcome.

Concept of Peace in Health Care

Peace—understood as an ethos, a sentiment, a state, a feeling—is a challenging concept to operationalize, but, for the purposes of this article, it might be useful to view the concept of peace as encapsulating the following dimensions: an absence of conflict; an emotional and psychological state of being peaceful; an environment that represents peacefulness; a state of being in harmony (relational and systemic); and existential alignment of values with goals of care for quality of life.

Clinicians and health care workers likewise have multifaceted roles: as champions and co-creators of peacefulness; as mediators of conflicts; as promoters of peace as a goal of care; as co-collaborators with patients, their loved ones, and staff to achieve *meaningful* goals of care; and as educators and advocates working toward systemic shifts.

Here, the focus is on opportunities to foster peace in clinical moments, rather than focusing on specific patient populations.

Clinically Important Moments for Fostering Peace Modeled on Bereavement Counseling

The following represent clinically significant moments—critical and often emotionally charged—in which hope, trust, fragility, compassion, and uncertainty collide.

Noticing opportunities for peace. Sometimes a critical moment can be as simple as noticing and asking the patient, "Are you at peace?" This clinically important, open-ended question about what is important to the patient for holistic quality of life and care[4,5,6,7] is more specific than asking, "How are you feeling?"

Breaking bad news.[8,9,10] Having to break bad news is an unavoidable task when the situation is medically futile (ie, no reasonable benefit of treatment is possible) or when the risks of treatment significantly outweigh the benefits. The ethical duty to do no harm is often met with a tsunami of emotions upon the patient's hearing words such as "I'm sorry, there nothing more to be done." Objectively speaking, "nothing more" is not precisely accurate language—there are still things to be done in working toward *different goals of care*, although such language is sometimes necessary for the reality of the bad news to cognitively register for the patient. Bereavement counseling at this juncture would offer supportive management of shock and distress and facilitate the patient's acceptance of the current reality.

Trust and therapeutic alliance.[5,8,9,10,11] Moments that are ripe for shock, emotional magnitude, feelings of devastation, and an implied sense of defeat also give birth to loss and resulting grief. These are also critical moments for therapeutic alliance. How we handle these critical moments fosters clinical trust or distrust and peace or emotional dysregulation. Patients can be sensitive to perceived dismissal of their heightened emotions. Timely collaborative care with psychosocial health professionals can bolster trust and peace—like a cocoon in the midst of chaos.

Perceived failed intervention and recalibration.[1,2,3,4,5,6,7,12,13,14] What is really happening in these moments is that the (original) goals of care have changed. Referrals to supportive counseling allow a platform for calibrating a readjustment of expectations. Such moments involve having to make an abrupt U-turn from the original goals to the prospective goals of care. When the patient sets quality-of-life care goals and receives multidisciplinary primary care soon after the loss, the fostering of peace is underway. Such multidisciplinary primary care might entail having a point-of-care person on the team to discuss issues that arise, plant seeds for adjustment to the new normal, and attend to anticipatory grief work and management of future regrets. Hospice and palliative care, oncology, and many specialties that routinely encounter loss already follow a dual-track approach: managing anticipation of death and maximizing quality of life.

System navigation and referrals for future care planning. Bereavement is not time or location dependent—the readiness to attend to loss and grief can be experienced some time after the precipitating event. The introduction of bereavement counseling and referrals allows resources to be placed within reach and to be taken up as and when needed. For most patients and loved ones, having these referrals in hand reduces the psychological burden of having to navigate systems on their own later.

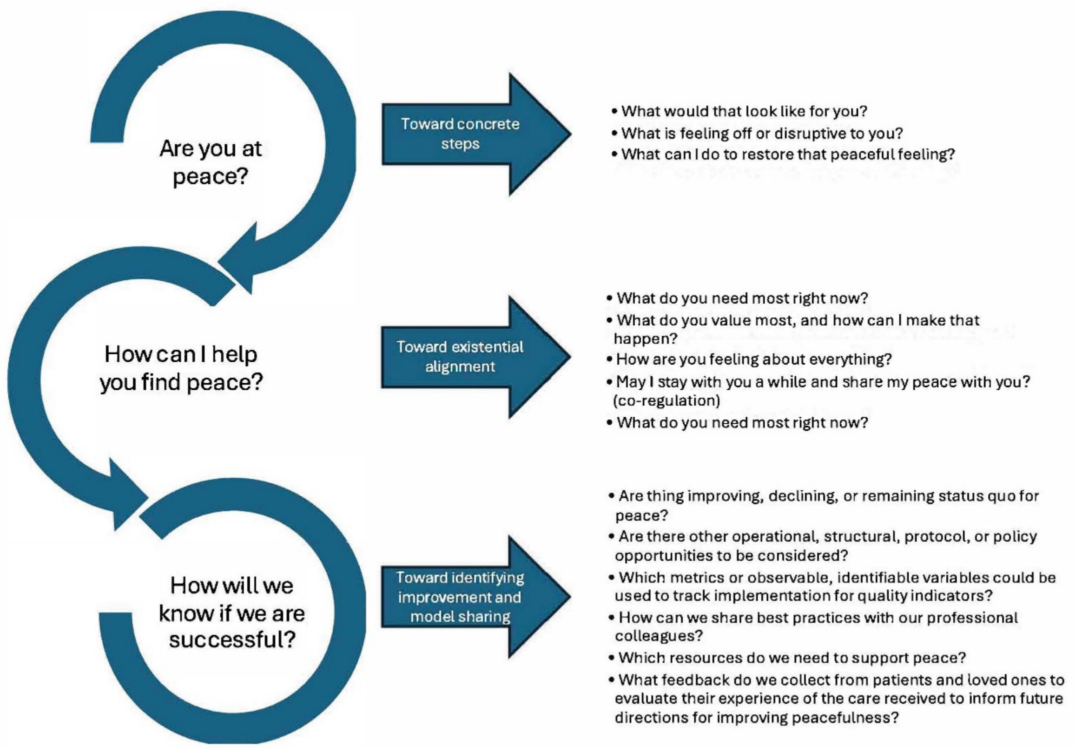
The initial referrals will follow different care pathways based on whether death is anticipated, such as in palliative care, or due to an unexpected traumatic event. Similarly, referrals can be expected to differ based on who the referral is for (eg, adult vs child, patient vs loved one). At this stage, the goal is not so much "prescribing" peace as building a scaffold to support the transition to other avenues for continued healing.

Guiding Questions

Constructing clinical outcomes for existential aspects of healing is a challenge. However, as an exemplar, the bereavement counseling community took the existential concept of *meaning-making*[4] (transforming sorrow into purpose) and created a constructivist therapy methodology, replete with skills, tools, and outcomes, and backed by research.

Treating peace as a constructed clinical outcome based on the proposed multifaceted dimensions would enable development of a curriculum for teaching compassionate clinical skills. Theoretical concepts like peace can be translated into goal-oriented questions in practice that target what the patient needs. In particular, health professionals can identify actionable steps during *clinically important moments* by eliciting input from patients about what is meaningful to them—their values, hopes, and expectations—to foster peace. Too many questions can become burdensome, however; so, to foster peace, health professionals must distill the complexity of peace into questions that elicit information relevant to actionable goals, as proposed in the Figure.

Figure. Guiding Questions for Translating Peace Into Goals of Clinical Practice



- What would that look like for you?
- What is feeling off or disruptive to you?
- What can I do to restore that peaceful feeling?

- What do you need most right now?
- What do you value most, and how can I make that happen?
- How are you feeling about everything?
- May I stay with you a while and share my peace with you? (co-regulation)
- What do you need most right now?

- Are thing improving, declining, or remaining status quo for peace?
- Are there other operational, structural, protocol, or policy opportunities to be considered?
- Which metrics or observable, identifiable variables could be used to track implementation for quality indicators?
- How can we share best practices with our professional colleagues?
- Which resources do we need to support peace?
- What feedback do we collect from patients and loved ones to evaluate their experience of the care received to inform future directions for improving peacefulness?

This approach offers several benefits. Inviting patient input fosters clinician beneficence, enhances patient dignity and autonomy, and can reduce potential harms arising from misalignment of goals of care and patient values. In a world focused on aggressive intervention, meeting the need for existential healing promotes both peace and effective resource allocation. Positive outcomes of health care that promotes peace include continuity of care, interdisciplinary collaboration, integration of evolving goals of care into the care plan, warm therapeutic referrals to community care for patients and their loved ones, and the perception by patients and their loved ones that clinicians have gone above and beyond what was expected. For clinicians, positive outcomes of health care that promotes peace include sharing of emotionally intensive clinical duties, creation of a buffer against compassion fatigue and vicarious trauma from continual exposure to loss, and acknowledgement of the toll of bearing witness. Peace in health care cannot ignore the needs of care professionals.

Summary

Although most of the foregoing discussion has been on clinically important moments as opportunities for fostering peace at the level of the patient-clinician relationship, the actual implementation of the framework hinges on operational support from institutions and systems that value the clinical significance of compassionate interventions.

The number of clinicians experiencing burnout, who are frustrated by their unrecognized and undercompensated labor in fostering peace and compassion, might compel scholars to refine outcomes metrics to champion a vision of peace. Specifically, some of the metrics important to health administrators, such as those related to quality improvement, staff burnout, patient satisfaction, and fundraising, might be relevant for fostering peace.

The promotion of peace in health care extends beyond a single definition of what peace is or ought to look like in multiple dimensions, just as health is more than the absence of illness or disease. Thus, the goal of peace is an affirmation of positive existence.

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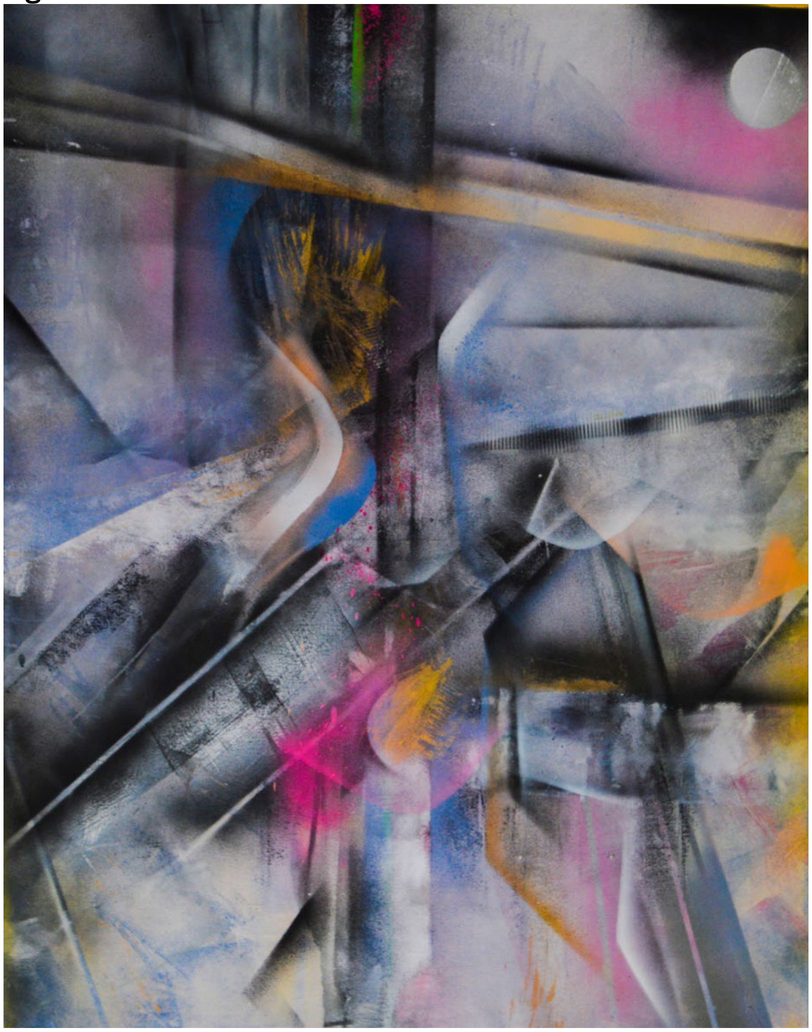
ART OF MEDICINE

Tonal Imprints From Procedure to Prognosis

Shahina Jaffer

Abstract
Three mixed media, acrylic, ink, and airbrush paintings explore an image-guided interventional radiological procedure and hopeful prognosis.

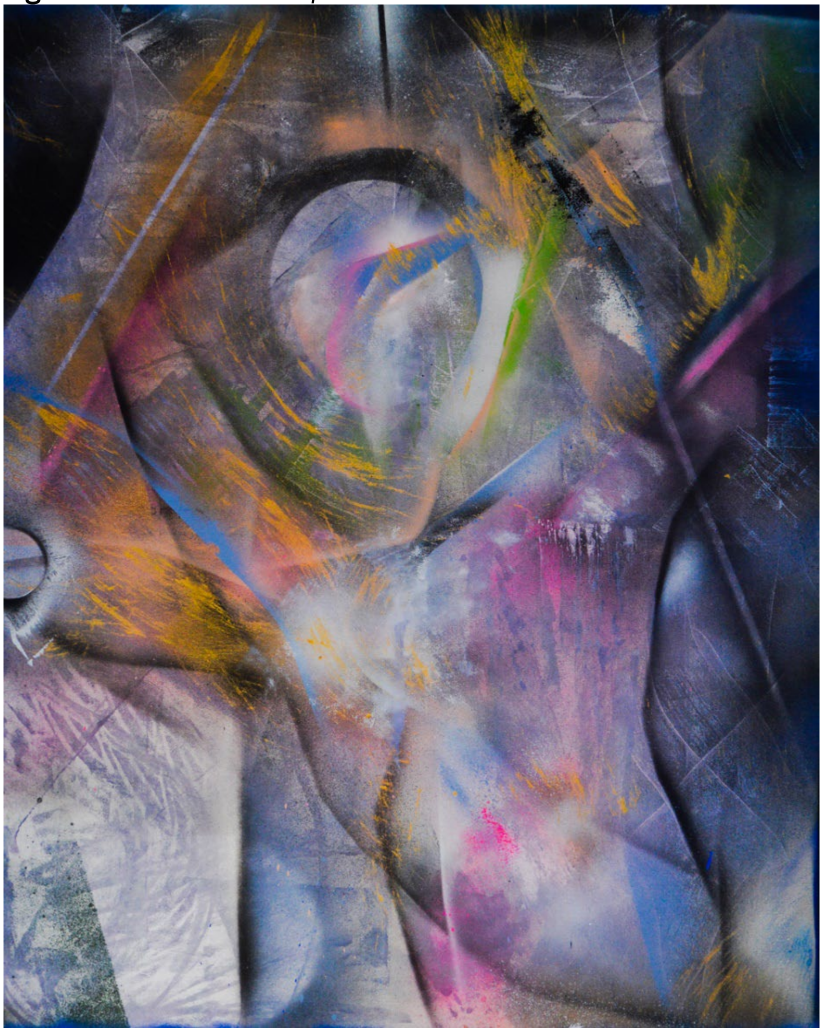
Figure 1. *Holler*



Media
81 cm x 100 cm; mixed media, acrylic, ink, and airbrush.

Caption
Holler is an emotional tapestry, centered on the artist's receipt of an initial prognosis and her preoperative experience. Heavily influenced by abstract expressionism—known for its emphasis on spontaneous, gestural expression—*Holler* suggests a battlefield of emotions, where color tonality is key: deep blues suggest introspection, while vibrant pink suggests urgency of an illness narrative unfolding. Each brush stroke is a whisper, perhaps, of fear, hope, and resilience.

Figure 2. *Wires and Whispers*



Media
81 cm x 100 cm; mixed media, acrylic, ink, and airbrush.

Caption
Wires suggest sound waves resonating, as if from a musical instrument, to transcend their physical origins. Pastel and dusky colors might evoke a viewer's sense of familiarity with hues of everyday life. Markings on the canvas, akin to whispers, symbolize the broader connections wires serve to forge between illness and healing.

Figure 3. *The First Tonal Imprint*

Media
81 cm x 100 cm; mixed media, acrylic, ink, and airbrush.

Caption
The First Tonal Imprint exemplifies a technique of layering paint, suggesting the precision sought by interventional radiology, in which a human body is penetrated without surgical incision for purposes of healing. Shapes within the painting gently unfold: dilation balloons are attached to catheters, and stents keep vessels open during procedures. Coils have a unique representational role here, too, suggesting an interplay of restriction and expansion as a radiologist manipulates vessels at different stages of a

procedure. Filters on one large vessel—the inferior vena cava, in particular—in the painting represent a bridge between containment of and liberation from illness.

Shahina Jaffer is an alumna of London's St Martin's School of Art whose work has been exhibited in London, Barcelona, New York, Mexico City, Genoa, and at the virtual Burning Man 2020 festival. She is also an accomplished artist and TEDx speaker. More of her artwork can be found at Saatchi Art.

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ART OF MEDICINE

Our Masks

Megan Hildebrandt, MFA

Abstract
In this short animation, the artist and her daughter discuss wearing masks during the COVID-19 pandemic. Her daughter's statements reveal one way a child processed growing up with masks and masking.

Figure. Still from *Our Masks*, 2021

Click here to view the video.

Media
Hand-drawn still from an animation.

This animation depicts a conversation between my daughter, June, then 9 years old, and me. We discuss what it is like to wear masks nearly all the time, and she talks about which styles of mask she favors. One key theme that recurred in conversation with friends and colleagues during the COVID-19 pandemic was disruptions in the everyday lives of our children. My family's goal during this period was to maintain, as much as possible, a sense of calm and safety in our children's lives.

In this animation, June's voice and lived experience of the COVID-19 pandemic are given the same importance and weight as mine. This equality is important to represent ethically and aesthetically, perhaps as a correction to when we fell short, culturally, by not always listening closely to how our children were feeling during those years. Looking back now, many of us consider possible “learning losses” our children suffered during those years spent learning remotely.

Perhaps other mothers find themselves and their own children in conversations like the one represented here in hand-drawn animation.

Megan Hildebrandt, MFA is an associate professor of practice in the Department of Art and Art History at the University of Texas in Austin. She received her BFA from the Stamps School of Art & Design in 2006 and her MFA in studio art from the University of South Florida in 2012. Hildebrandt has exhibited nationally and internationally, including at the Painting Center, New American Paintings, the Baltimore Museum of Art, Arlington Arts Center, HEREarts Center, Latitude 53, Johns Hopkins Medical Center, the LIVESTRONG Foundation, Hyde Park Art Center, the Torpedo Factory, and Collar Works.

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VIEWPOINT

Roles of Quiet in Health Care Organizations

Christy A. Rentmeester, PhD

Abstract
This anecdote of one regional academic health network's reputational demise suggests what might be learned about tendencies of undervaluing chaplaincy expertise, peace, and quiet in the everyday operations of professional caregiving.

Pastoral Care

A fine regional academic health center had a long-standing reputation for reliable service to its diverse rural and metropolitan area communities and was well-known for its chaplaincy program. Press Ganey scores (widely regarded in the health sector as measures of patient satisfaction) were high year-over-year in this organization, and nearly everyone attributed this in no small part to bedside care delivered by its chaplains. The chaplaincy program's national renown was a product of its thoroughgoing commitment to spiritual pluralism and its success in connecting with patients, including those who signaled *no religious affiliation* or who, at least upon admission to the hospital, expressed *no interest* in receiving pastoral care services.

Those of us doing clinical ethics consultation in this organization knew the chaplains well and worked closely with them. Nearly everyone in the organization also knew the chaplains as a cadre of clinicians with numerous graduate degrees in a variety of disciplines who didn't complain much about their low pay. They were also known to take a jocular tone about the cultural obsession with "leadership" that plagued the early-mid 2000s: *If you have to talk so much about being a leader, you might not have as many followers as you think.* The chaplains were this organization's proverbial truth-tellers, and they were well respected for their candor, at least for a while.

Organizational Ambition

One summer, the resignation of 2 long-time vice presidents in the organization gave key senior managers long-awaited opportunities to hire for ambition. Nearly overnight—or so it seemed to many of us—this trusted regional health network sought transformation and aggressively sought to become a level I trauma center. A 24-hour on-call neurosurgeon was hired—a necessary but not sufficient condition for level I trauma centerhood—as if an organization could build an egg by erecting a shell. In quick succession, the organization's new strivings toward level I status were heavily promoted; the phrases *capital campaign* and *strategic planning* became common, despite the vacuous mysteriousness of their meaning or purpose.

Funds were diverted and redirected. Three new executives were hired. One was particularly Loud and wore gem-studded cuff links that were hard to miss and seemingly worn *because* they were hard to miss. This particular exec walked the halls of various service sites of the organization, their Big Watch clinking against their cuff links. Unsurprisingly, they looked past me as I said my name when we were introduced, and they nearly missed grasping my extended hand during an awkward wine and cheese reception. The organization's traditionally mission-oriented priorities became visibly overwhelmed by its appetite for "limelit" lauds from Becker's and by its desire for a listing as the Top of Something in *US News and World Report*, fed amply by highly produced, brightly lit, shot-from-below power poses of clinicians with their arms crossed.

Extroversion and Exile

Despite some of the organization's new senior managers' displays of kin-keeping in the small ethics unit and the chaplaincy program, the chaplaincy program quickly dimmed from vibrant to a waning, struggling flicker. Many of us saw the proverbial writing on the proverbial wall. If you've ever had the experience of having to leave an organization because you have a sneaking suspicion that your and your immediate colleagues' expertise is at increasing risk for diminished valuation, then you know that one of the things often written on that wall is some variation on the sentiment: *Extroversion is now a job requirement.* Perhaps this happens because, when an organization's attention is directed prominently and purposefully outward, decimation of departments and personnel practicing the internal focus needed to reliably convey sincerity and to forge the kind of connection worth looking people in the eye for can be more easily obfuscated and thus, perhaps, more likely to be missed and less likely to be resisted or problematized.

Dissolution of the ethics unit was no surprise to those of us familiar with these patterns of organizational behavior by which work of restoration and healing that needs peace and quiet is undervalued. More tragic for this organization is that the chaplaincy program was gutted quickly, decisively, and thoroughly. After I left the organization, I learned how the organization changed over the next few years. Reportedly, the organization's Press Ganey scores plummeted quickly, too. The organization hired more risk managers, possibly if not probably because the organization's general counsel could afford, for many years, to blithely take for granted the slow, steady application of anti-litigant balm that was a key practical side effect of so many chaplains' quiet work with patients. It was thought by clinicians I knew, who stayed in the organization for a few years, that patients who needed (and once had) access to a chaplain to talk to about their frustration or painful surprise about outcomes they might not have wanted or anticipated were now expressing their grief by suing.

Having to lawyer up was not the only apparent consequence of the organization's exile of its chaplains. Perhaps a few in the organization finally realized their error when patients in the communities served by the organization also appeared to be migrating to other networks for their health care. But a main ethics upshot here is that this organization's chaplains' labor was invisible and undervalued. Career chaplains, most of whose demeanors exuded the quiet intensity of astute emotional intelligence and whose presence was minimal in decibel but keenly felt by patients who needed their help reorienting themselves to their illness and injury experiences, were the organization's Peace Agents. And they, too, were gone.

Peace in Professional Caregiving

Unsurprisingly, the organization's level I trauma center ambitions were, reportedly, abandoned after several additional personnel departures. After much public embarrassment and ridicule, an eggshell was acknowledged as hollow, as an exterior that would not hold. The organization continues to this day to grasp at any remnants of its now long-gone reputation as a regional center once defined by chaplains who were key to the work of healing, of peace work in professional caregiving.

Like most questions I ask my students, *What are ethical and clinical roles of quiet in health care?* is more interesting, and perhaps more important, as a question than any of its most common answers. Insightful answers to this question likely suggest that peace or quiet or both should be operational ethical values in the collective strivings of organizations in the health sector, especially among educators and clinicians who have opportunities to endorse spiritual care as fundamental to healing. One thing I learned from working in this organization is that healing is a collective endeavor done with the hands, hearts, and heads of many individuals from many disciplinary backgrounds who probably do their most critical work with patients when it's quiet.

Christy A. Rentmeester, PhD spent several years as a tenured professor of health policy and ethics and is now managing editor of the *AMA Journal of Ethics*. She works with a team of stellar colleagues who work daily with students and clinicians to generate journal-based and multimedia content about cross-disciplinary, ethically complex clinical and health policy questions. Dr Rentmeester is a philosopher by background whose fellowship training is in clinical ethics and health humanities. She has published numerous peer-reviewed articles, most exploring some feature of moral psychology; served on ethics consultation call teams, ethics committees, human subject review boards, health professional licensure boards; and holds a faculty appointment in the Neiswanger Institute at the Loyola University Chicago Stritch School of Medicine.

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