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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

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

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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]

References

1. Stange KC. The problem of fragmentation and the need for integrative solutions. *Ann Fam Med*. 2009;7(2):100-103.
2. Lown B. The commodification of health care. *PNHP Newsletter*. Spring 2007:40-44. Accessed September 23, 2024. https://pnhp.org/system/assets/uploads/2016/05/sp2007newsletter-1.pdf
3. Branning G, Vater M. Healthcare spending: plenty of blame to go around. *Am Health Drug Benefits*. 2016;9(8):445-447.
4. Levitt L. Increasingly privatized public health insurance programs in the US. *JAMA Health Forum*. 2023;4(3):e231012.
5. Friedel AL, Siegel S, Kirstein CF, et al. Measuring patient experience and patient satisfaction—how are we doing it and why does it matter? A comparison of European and US American approaches. *Healthcare (Basel)*. 2023;11(6):797.
6. Block RG, Puro J, Cottrell E, et al. Recommendations for improving national clinical datasets for health equity research. *J Am Med Inform Assoc*. 2020;27(11):1802-1807.
7. Scott JG, Cohen D, Dicicco-Bloom B, Miller WL, Stange KC, Crabtree BF. Understanding healing relationships in primary care. *Ann Fam Med*. 2008;6(4):315-322.
8. Heston TF, Pahang JA. Moral injury or burnout? *South Med J*. 2019;112(9):483.
9. Edwards ST, Marino M, Balasubramanian BA, et al. Burnout among physicians, advanced practice clinicians and staff in smaller primary care practices. *J Gen Intern Med*. 2018;33(12):2138-2146.
10. Stange KC, Etz RS, Gullett H, et al. Metrics for assessing improvements in primary health care. *Annu Rev Public Health*. 2014;35(1):423-442.
11. Singh GK, Yu SM. Infant mortality in the United States, 1915-2017: large social inequalities have persisted for over a century. *Int J MCH AIDS*. 2019;8(1):19-31.

12. Berwick DM. *Salve lucrum*: the existential threat of greed in US health care. *JAMA*. 2023;329(8):629-630.
13. Zgierska A, Rabago D, Miller MM. Impact of patient satisfaction ratings on physicians and clinical care. *Patient Prefer Adherence*. 2014;8:437-446.
14. Edwards ST, Marino M, Solberg LI, et al. Cultural and structural features of zero-burnout primary care practices. *Health Aff (Millwood)*. 2021;40(6):928-936.
15. Scott JG, Warber SL, Dieppe P, Jones D, Stange KC. Healing journey: a qualitative analysis of the healing experiences of Americans suffering from trauma and illness. *BMJ Open*. 2017;7(8):e016771.
16. Scott JG, Scott RG, Miller WL, Stange KC, Crabtree BF. Healing relationships and the existential philosophy of Martin Buber. *Philos Ethics Humanit Med*. 2009;4:11.
17. Etz RS, Zyzanski SJ, Gonzalez MM, Reves SR, O'Neal JP, Stange KC. A new comprehensive measure of high-value aspects of primary care. *Ann Fam Med*. 2019;17(3):221-230.
18. Leeson W, Resnick A, Alexander D, Rovers J. Natural language processing (NLP) in qualitative public health research: a proof of concept study. *Int J Qual Methods*. 2019;18:1609406919887021.
19. Stange KC. A science of connectedness. *Ann Fam Med*. 2009;7(5):387-395.

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