ELEVATING PHYSICIAN–PATIENT RELATIONSHIPS IN THE SHADOW OF METRIC MANIA

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ABSTRACT

Today, medical and health institutions devote significant time and resources to documenting, measuring, and reporting various metrics. These metrics are used to improve various aspects of care, from efficiency and quality to safety and access. Unfortunately, too often, medical and health institutions overemphasize metrics that are easily captured but too simplistic. As a result, insufficient attention is devoted to crucial, albeit complex and difficult to measure, facets of care. Physician–patient relationships are among the primary casualties resulting from the widespread penchant for overly simplistic metrics. This Article develops a strategy for improving such relationships. I suggest that enhancing physicians' interpersonal skills can improve physician–patient rapport and mitigate the negative consequences resulting from placing too much weight on simplistic metrics. The strategy provided here is not a panacea for the broader problems posed by overemphasizing certain metrics. But, this Article can inform a larger project aimed at becoming wiser about how data and metrics are used in all aspects of medicine and health care.

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INTRODUCTION

Information is a critical component of good health outcomes.[1] For this reason, health and medical systems collect and analyze vast amounts of information to improve the quality, efficiency, and safety of the care they provide.[2] In the United States, there

1. *See, e.g.*, NAT'L ACAD. OF ENG'G & INST. OF MED., BUILDING A BETTER DELIVERY SYSTEM: A NEW ENGINEERING/HEALTH CARE PARTNERSHIP 63 (Proctor P. Reid et al. eds., 2005) (discussing the importance of information exchange in medical treatment).

2. *See, e.g.*, Barry G. Saver et al., *Care that Matters: Quality Measurement and Health Care*, PLOS MED., Nov. 17, 2015, at 1–3, https://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.1001902&type=printable (discussing the widespread use of metrics to assess and revise the delivery of health and medical services). While health systems focus mostly on entire populations, medical systems are focused primarily on individual patients rather than entire populations. *See Public Health and Medicine: Distinctions Between Public Health and Medicine*, HARV. T.H. CHAN SCH. PUB. HEALTH, https://www.hsph.harvard.edu/about/public-health-medicine/ (last visited Jan. 7, 2020).

is a strong trend toward using large amounts of data to develop metrics that measure the degree to which certain interventions achieve various health goals (e.g., improved quality of care, enhanced patient experiences, expanded access to care, research breakthroughs, and more).[3] Despite these noble intentions, an intense focus on collecting and analyzing data—which is a practice I refer to in this Article as metric mania[4]—has important and often underappreciated effects on medicine and health care.[5] Specifically, metric mania tends to overemphasize data that can

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3. The overemphasis on metrics is part of a broader phenomenon in medicine. Over the past several decades, medicine has transformed from a mostly independent profession into one dominated by large corporations. This phenomenon was presciently predicted by Paul Starr. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 421–49 (1982) (discussing the factors that Starr believed would force the medical profession to become dominated by large for-profit corporations); *see also* TIMOTHY J. HOFF, NEXT IN LINE: LOWERED CARE EXPECTATIONS IN THE AGE OF RETAIL- AND VALUE-BASED HEALTH 24, 136 (2017) (noting that large organizations that are intensely resource sensitive and business oriented now dominate the delivery of medical care in America). Coinciding with this change has been a commitment to maximize the efficiency and quality of medical care. *See, e.g.*, Irene Fraser et al., *Improving Efficiency and Value in Health Care: Introduction*, 43 HEALTH SERVICES RES. 1781 (2008) (discussing widespread efforts by stakeholders throughout America's medical system to promote efficiency in the delivery of care). A variety of techniques are now used to achieve this goal. *See* HOFF, *supra* at 11. Such techniques include financial incentives for medical institutions and patients to choose low-cost medical treatments, administrative processes to discourage unnecessary medical interventions, increased cost sharing, limiting patients' length of hospital stays, and more. *See* Michael E. Porter & Thomas H. Lee, *The Strategy that Will Fix Health Care*, HARV. BUS. REV. (Oct. 2013), https://hbr.org/2013/10/the-strategy-that-will-fix-health-care. These techniques each deserve individualized attention, but one tool commonly used to maximize efficiency and quality is the focus of this Article: documenting various medical metrics to promote quality and efficiency. *See id.* Although analyzing metrics plays an important role in reducing inefficiencies and promoting the quality of medical interventions, it is only one aspect of a broader phenomenon in medicine's increasingly corporate and commercial ethos. *See id.*

4. The overemphasis on documenting, measuring, and reporting a variety of health data has been given several short hands. *See, e.g.*, HOFF, *supra* note 3, at 29 (discussing "metric fever"); JERRY Z. MULLER, THE TYRANNY OF METRICS 29 (2018) (referring to the overemphasis on metrics to track and manage performance as "the tyranny of metrics").

5. *See, e.g.*, HOFF, *supra* note 3, at 9, 47, 61, 95 (discussing the detrimental effects that overemphasizing broad performance metrics has on patients and the physician–patient relationship); MULLER, *supra* note 4, at 6 (suggesting that although metrics "are a potentially valuable tool, the virtues of accountability metrics have been oversold, and their costs are often underappreciated"); Saver et al., *supra* note 2, at 10 (discussing how emphasizing "easy to measure" health metrics in medical and health care does not strongly correlate with improved health outcomes and tempts physicians to "game" the system). The overemphasis on metrics is partly the result of a broader phenomenon demonstrated over the past several decades as medicine has evolved from a mostly independent profession into one dominated by large corporations. *See supra* note 3 and accompanying text.

be quickly captured and analyzed, and this practice often fails to consider critical—albeit complex and difficult to measure—facets of medicine.[6] Space prohibits an exhaustive discussion of, and a comprehensive response to, metric mania, but patient-satisfaction surveys (PSSs) provide a useful illustration of this broader phenomenon and its consequences.[7] Research conducted in the early 1980s indicated that patient satisfaction leads to improved compliance with treatment plans and enhanced health outcomes.[8] Shortly thereafter, scholars and medical professionals began leveraging this research to develop programs to increase patient satisfaction, which was thought to lead to better compliance with treatment plans and improve health outcomes.[9] Taking note of the premium medical professionals were placing on metrics measuring patient satisfaction, commercial entities developed surveys to gather information regarding patient satisfaction and advise medical professionals on how to improve their scores on such surveys.[10] Over the years, the prevalence of PSSs increased.[11] The metrics produced by these surveys are now used to measure the quality and efficiency of care, and they are a factor in determining physician compensation.[12]

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6. *See* Saver et al., *supra* note 2, at 2–3, 7 (discussing problems with an overemphasis on time- and cost-effective data gathering over patient-centered, outcome-based metrics that focus on the long term).

7. *See* discussion *infra* Section II, notes 64–94 and accompanying text.

8. *See* discussion *infra* Section II, notes 67–71; *HCAHPS: Patients' Perspectives of Care Survey*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalhcahps.html (last modified Oct. 15, 2019, 11:28 AM). Areas valued by patients include "ease of scheduling appointments, availability of information, communication with clinicians, responsiveness of clinic staff, and coordination between care providers." Katherine Browne et al., *Measuring Patient Experience as a Strategy for Improving Primary Care*, 29 HEALTH AFF. 921, 922 (2010).

9. *See* Gregory C. Pascoe, *Patient Satisfaction in Primary Health Care: A Literature Review and Analysis*, 6 EVALUATION & PROGRAM PLAN. 185, 189 (1983) (discussing research indicating that patient satisfaction contributes to certain health behaviors).

10. Richard Bolton Siegrist Jr., *Patient Satisfaction: History, Myths, and Misperceptions*, 15 VIRTUAL MENTOR 982, 982 (2013).

11. *See id.*

12. *HCAHPS: Patients' Perspectives of Care Survey*, *supra* note 8; *see* HOFF, *supra* note 3, at 10, 23; Alexandra Junewicz & Stuart J. Youngner, *Patient-Satisfaction Surveys on a Scale of 0 to 10:*

Although information plays an important role in the delivery of quality care, focusing too narrowly on simplistic metrics while overlooking some of medicine's more complex aspects can have serious consequences.[13] For example, the questions posed in PSSs[14] are vague, fail to distinguish between patients' opinions regarding individual physicians and the health system more generally, refer to specific points in time rather than ongoing relationships, and more.[15] Such over-simplifications create opportunities for medical institutions and professionals to "game" the surveys by satisfying the criteria being measured while devoting insufficient attention to the health of patients.[16] Additionally, an excessive focus on overly simplistic metrics permits the complex relational aspects of care to be ignored, and ignoring such aspects can have detrimental effects on patients' health outcomes.[17] Yet another consequence is that insofar as

Improving Health Care, or Leading It Astray?, 45 HASTINGS CTR. REP., May–June 2015, at 43–44; *see also* Browne et al., *supra* note 8, at 922 (providing examples of areas of care that patients value).

13. *See* MULLER, *supra* note 4, at 169–73; *see also* Sandra G. Boodman, *How to Teach Doctors Empathy*, ATLANTIC (Mar. 15, 2015), https://www.theatlantic.com/health/archive/2015/03/how-to-teach-doctors-empathy/387784/.

14. For example, "Are you pleased with the way your provider communicated with you?" or "On a scale of 1 to 10, how satisfied are you with your provider?" *HCAHPS: Patients' Perspectives of Care Survey*, *supra* note 8.

15. *See* HOFF, *supra* note 3, at 29, 59; *Physicians Dissatisfied with Patient Satisfaction Surveys*, MED. ECON. (Nov. 10, 2016), http://www.medicaleconomics.com/medical-economics/news/physicians-dissatisfied-patient-satisfaction-surveys [hereinafter *Physicians Dissatisfied*].

16. *See, e.g.*, Stephen M. Campbell et al., *The Experience of Pay for Performance in English Family Practice: A Qualitative Study*, 6 ANNALS FAM. MED. 228, 232 (2008) (discussing how the practice of pay-for-performance metrics incentivize physicians to pay more attention to meeting their own metrics and less attention on the best interests of the patient); Meredith B. Rosenthal & Richard G. Frank, *What Is the Empirical Basis for Paying for Quality in Health Care?*, 63 MED. CARE RES. & REV. 135, 149–51 (2006) (providing evidence that under pay-for-performance regimes, medical professionals may intentionally alter their diagnoses to increase reimbursement).

17. *See, e.g.*, Frans Derksen et al., *Effectiveness of Empathy in General Practice: A Systematic Review*, 63 BRIT. J. GEN. PRAC. e76, e78, e80–82 (2013) (finding that the psychological process of one party sharing that party's feelings and experiences—and having a discussion about those feelings and experiences—is an important aspect of medical care and one with implications for health outcomes); Richard L. Street et al., *How Does Communication Heal? Pathways Linking Clinician-Patient Communication to Health Outcomes*, 74 PATIENT EDUC. & COUNSELING 295, 296–99 (2009) (describing the features of physician–patient communication that can influence health outcomes); Walter F. Baile & Joann Aaron, *Patient-Physician Communication in Oncology: Past, Present, and Future,* 17 CURRENT OPINION ONCOLOGY 331, 331–35 (2005) (noting the importance of communication skills in "comprehensive oncology care"); Sherrie H. Kaplan et al., *Assessing the Effects of Physician-Patient Interactions on the Outcomes of Chronic Disease*, 27 MED. CARE S110,

PSSs negatively affect physician–patient relationships, which physicians and patients view as essential features of good medical encounters, such surveys fail to identify and promote important aspects of medicine affecting patient satisfaction.[18] In short, although metrics "are . . . potentially valuable tool[s]," their virtues "have been oversold, and their costs are often underappreciated."[19]

Despite the problems stemming from overemphasizing simplistic metrics like patient satisfaction, metric mania[20] is here to stay for the foreseeable future. This is so for a variety of reasons, some of which are broadly supported (e.g., measuring data in health care and medicine can lead to many important breakthroughs) and others that are more contentious (e.g., using metrics to assess the quality and efficiency of care has become a big business that pervades the U.S. health and medical system).[21]

S112–13, S118–19 (1989) (discussing studies on the effectiveness of physician–patient communication on patients with chronic diseases); James E. Orth et al., *Patient Exposition and Provider Explanation in Routine Interviews and Hypertensive Patients' Blood Pressure Control*, 6 HEALTH PSYCHOL. 29, 36–40 (1987) (discussing research indicating physician–patient communication affects health outcomes in patients with hypertension).

18. *See, e.g.*, HOFF, *supra* note 3, at 67–73, 100–35 (commenting on the important role that trust and communication play in physician–patient relationships); Mark A. Hall et al., *Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter?*, 79 MILBANK Q. 613, 613–14 (2001) (discussing trust as the defining characteristic giving therapeutic encounters meaning and promoting effectiveness).

19. MULLER, *supra* note 4, at 6.

20. The over-reliance on PSSs is an example of medicine's tendency to focus on oversimplified indicators that are easily measured, but it is only one example. Other examples abound of efforts to harness large amounts of data (e.g., efforts to improve the quality of care, tailor treatments to specific patients, reduce inefficiencies and costs, expand access to care, promote innovation, and more) to provide customers (i.e., patients) with cheaper and faster access to a service. HOFF, *supra* note 3, at 10, 46, 63.

21. *See supra* note 3 and accompanying text (illustrating the various interests fueling the rise of data collection and analysis in health care); *see also* discussion *infra* Section I (illustrating how the use of metrics to improve the quality and efficiency of care has come to dominate the U.S. health and medical system); HOFF, *supra* note 3, at 25 (discussing the deep roots "metric fever" has implanted in America's health care system); THE NEW INSTITUTIONALISM IN ORGANIZATIONAL ANALYSIS (Walter W. Powell & Paul J. DiMaggio eds., 1991) (discussing the pervasiveness of using metrics to analyze quality in various institutions, including the U.S. health and medical systems); Maxwell Gregg Bloche, *The Invention of Health Law*, 91 CALIF. L. REV. 247, 251–53 (2003) [hereinafter *The Invention*] (commenting on the legal, regulatory, and cultural dynamics contributing to the pervasiveness of economic-oriented reasoning in the health care space); Thomas H. Lee, *The Pain that Results from Pain Measurement*, NEW ENG. J.

This Article does not undertake the ambitious project of providing a comprehensive response to the widespread penchant for overemphasizing simplistic metrics. Instead, I make the narrower case for devoting more attention to medicine's relational aspects in the shadow of metric mania. Specifically, I aim to demonstrate that encouraging physicians to participate in training designed to enhance their interpersonal skills can improve physician–patient rapport and mitigate the negative consequences resulting from overemphasizing PSSs.[22] The strategy provided here is not a panacea for the broader problems posed by placing too much weight on simplistic metrics. But, this Article can inform the larger project of becoming wiser about how data and metrics are used in all aspects of medicine and health care.[23]

This Article will illustrate my proposal in greater detail by proceeding in five parts. Part I provides a brief illustration of how the intense emphasis on documenting, measuring, and reporting large amounts of data developed over the years. Part II illustrates how PSSs, which are examples of the broader phenomenon of metric mania, oversimplify and harm physician–patient relationships. Part III illustrates how medical professionals can improve their relationships with patients. Part IV suggests that teaching physicians to improve their rapport with patients can have several benefits. Part V anticipates and responds to a few challenges facing efforts to improve physician–patient rapport in the shadow of metric mania.

MED. CATALYST (May 25, 2016), https://catalyst.nejm.org/the-pain-that-results-from-pain-measurement/ (discussing the benefits and drawbacks of data measurement in medicine).

22. Various institutions have begun developing courses to teach medical professionals how to improve their relationships with patients. *See* Boodman, *supra* note 13.

23. *See* Lee, *supra* note 21 (discussing the value created by various efforts to measure data in health care, and noting the need to become wiser about how such data are evaluated).

I. A BRIEF ILLUSTRATION OF MODERN MEDICINE'S PENCHANT FOR METRICS

For centuries, medical professionals have collected and analyzed data.[24] Metrics derived from such data have informed efforts to improve a variety of distinct, yet related, strands of medicine and health care (e.g., enhance the quality of care, tailor treatments to specific patients, reduce inefficiencies and costs, expand access to care, promote innovation, and more) in America and beyond.[25] This Article does not provide a comprehensive discussion of how data and metrics have been used across these various strands throughout history. Instead, I gesture toward the problems resulting from overly simplistic uses of data and metrics by discussing a few examples of this broader phenomenon. A useful—albeit somewhat arbitrary[26]—place to begin a discussion of this issue is with Congress's enactment of Medicare and Medicaid, which kicked off a spate of efforts to analyze data and develop metrics to improve the quality of care.[27]

Enacted by Congress in 1965, Medicare was designed to address the medical needs of aged persons, and it established standards of care for such patients.[28] Pursuant to that program's

24. *See, e.g.*, Richard F. Gillum, *From Papyrus to the Electronic Tablet: A Brief History of the Clinical Medical Record with Lessons for the Digital Age*, 126 AM. J. MED. 853, 853 (2013) (discussing the history of collecting information to inform improvements in medical care).

25. Mohammad Adibuzzaman et al., *Big Data in Healthcare—the Promises, Challenges and Opportunities from a Research Perspective: A Case Study with a Model Database*, 2017 AMIA ANN. SYMP. PROC. 384, 384, 391 (2017) (discussing the promises of big data in medicine); Eugene C. Nelson et al., *Using Data to Improve Medical Practice by Measuring Processes and Outcomes of Care*, 26 JOINT COMMISSION J. QUALITY IMPROVEMENT 667, 667–78, 681–83 (2000) (commenting on the various ways data can be used to improve medical care).

26. Throughout American history and beyond, various efforts have been undertaken to measure and promote the overall quality of health care. *See, e.g.*, Dennis McIntyre et al., *Overview, History, and Objectives of Performance Measurement*, 22 HEALTH CARE FINANCING REV. 7, Spring 2001, at 9–11 (discussing efforts by early American health and medical institutions to distinguish themselves through quality and performance metrics).

27. *See* Barbara S. Klees et al., *Brief Summaries of Medicare & Medicaid: Title XVIII and Title XIX of the Social Security Act*, CENTERS FOR MEDICARE & MEDICAID SERVICES 4–5 (Nov. 1, 2009), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2009.pdf.

28. *See* Youssra Marjoua & Kevin J. Bozic, *Brief History of Quality Movement in US Healthcare*, 5 CURRENT REVIEWS MUSCULOSKELETAL MED. 265, 266 (2012).

requirements, the federal government began conducting evaluations of the degree to which medical professionals and institutions satisfied Medicare's criteria.[29] To carry out such evaluations, the government established reviewing entities.[30] Professional Standards Review Organizations (PSROs), created in 1972 and replaced by the Peer Review Program in the 1980s, were early examples of entities charged with carrying out such evaluations.[31] These pilot projects assessed the degree to which hospitals and medical personnel satisfied various metrics (e.g., sufficient credentials for staff, around-the-clock nursing, the availability of services, the quality of services and the personnel administering them, the necessity of services, and more).[32] The results of the assessments informed the development of novel strategies for improving care, and new metrics were created to assess these fresh approaches.[33]

Non-profit initiatives supplemented the federal government's efforts to measure and assess quality-of-care metrics.[34] For example, the Joint Commission on Accreditation of Hospitals was established in 1951 to provide voluntary accreditation to hospitals.[35] The Joint Commission, which later changed its name to the Joint Commission on Accreditation of Healthcare Organizations, was given more influence in 1965.[36] At that time, the federal government determined that hospitals meeting the Joint Commission's standards satisfied the conditions for

29. *See* John M. Luce et al., *A Brief History of Health Care Quality Assessment and Improvement in the United States*, 160 W. J. MED. 263, 265 (1994).

30. *See* Cynthia Weinmann, *Quality Improvement in Health Care: A Brief History of the Medicare Peer Review Organization (PRO) Initiative*, 4 EVALUATION & HEALTH PROF. 413, 414 (1998); Marjoua & Bozic, *supra* note 28, at 266.

31. Marjoua & Bozic, *supra* note 28, at 266; *see* Weinmann, *supra* note 30, at 414.

32. Clark C. Havighurst & Randall Bovbjerg, *Professional Standards Review Organizations and Health Maintenance Organizations: Are They Compatible?*, 31 UTAH L. REV. 381, 396 (1975).

33. Marjoua & Bozic, *supra* note 28, at 266.

34. *See id.*

35. Michael G. H. McGeary, *Medicare Conditions of Participation and Accreditation for Hospitals*, *in* MEDICARE: A STRATEGY FOR QUALITY ASSURANCE: VOLUME II SOURCES AND METHODS 292, 293 (Kathleen N. Lohr ed., 1990).

36. Timothy Stoltzfus Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C. L. REV. 835, 853 (1983).

participation in Medicare.[37] From 1965 and throughout the 1970s, the Joint Commission evaluated a number of metrics (e.g., compliance with laws, quality assurance procedures, and satisfactory medical records practices) to determine whether to accredit organizations providing health and medical care.[38] In 1987, the Joint Commission adopted more rigorous accrediting standards.[39] The revised standards adopted by the Joint Commission were informed by Avedis Donabedian's influential 1966 article, which provided a useful and highly replicable model for examining various data to determine the quality and efficiency of care.[40] That model focused on assessing three aspects of care: outcomes, structure, and processes.[41] Various data (e.g., cleanliness of medical facilities, organization of staffing, records processes, qualifications of administrative staff, and compliance with laws) comprise the metrics determining whether these aspects of care are satisfied.[42]

The Donabedian model's influence extended beyond the Joint Commission. Shortly after that article was published, the Institute of Medicine (IOM) was established.[43] The IOM launched several initiatives aimed at harnessing data to evaluate and improve the delivery of care.[44] For example, in 1989, the organization that would become the Agency for Healthcare Research and Quality (AHRQ) was created.[45] The AHRQ studies various

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37. McGeary, *supra* note 35, at 292.

38. *Id.* at 294–95.

39. Mark R. Chassin & Margaret E. O'Kane, *History of the Quality Improvement Movement*, *in* TOWARD IMPROVING THE OUTCOME OF PREGNANCY III 4 (2010), http://www.marchofdimes.org/toward-improving-the-outcome-of-pregnancy-iii.pdf.

40. *See generally* Avedis Donabedian, *Evaluating the Quality of Medical Care*, 44 MILBANK MEMORIAL FUND Q. 166 (2005), *reprinted in* 83 MILBANK Q. 691 (2005) ("This paper is an attempt to describe and evaluate current methods for assessing the quality of medical care and to suggest some direction for further study.").

41. McGeary, *supra* note 35, at 311.

42. *Id.* at 294–95.

43. Harold J. Fallon, *The Institute of Medicine and Its Quality of Healthcare in America Reports*, 113 TRANSACTIONS AM. CLINICAL CLIMATOLOGICAL ASS'N 119, 119–24 (2002) (discussing the history of the Institute of Medicine, which was founded in 1970).

44. Marjoua & Bozic, *supra* note 28, at 267.

45. *Id.* (noting the predecessor to the AHRQ was the Agency for Health Care Policy and Research).

data to assess the effectiveness of clinical guidelines, processes, and health outcomes.[46] Similar organizations have developed over the years.[47] The National Committee for Quality Assurance (NCQA), for example, was established in 1990 to assess the performance of physicians, health plans, and medical groups by measuring data collected through a mix of surveys, medical charts, and other metrics reported by organizations providing care to patients.[48] Included among the factors evaluated by the NCQA are the effectiveness of care, the cost of a given intervention, and patient satisfaction.[49] In 1994, the Department of Veterans Administration developed the National Surgery Quality Improvement Project to collect data on the risks and outcomes of various procedures, and such data was used to set performance benchmarks.[50] In 1995, the Foundation for Health Care Accountability was created to develop quality-measurement guides to assess the effect various interventions have on patients.[51] The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry made dozens of recommendations in 1998; those recommendations were aimed at strengthening measurable objectives in America's health and medical system.[52] Based on that Commission's recommendations, a coalition of stakeholders from the public and private sectors established the National Quality Forum in 1999 to promote public reporting and quality measurement.[53]

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46. Richard Kronick, *AHRQ's Role in Improving Quality, Safety, and Health System Performance*, 131 PUB. HEALTH REP. 229, 229 (2016).

47. *See* McIntyre et al., *supra* note 26, at 14–16.

48. *See id.* at 14.

49. *Id.*

50. *See* Pascal R. Fuchshuber et al., *The Power of the National Surgical Quality Improvement Program—Achieving a Zero Pneumonia Rate in General Surgery Patients*, 16 PERMANENTE J. 39, 39 (2012).

51. McIntyre et al., *supra* note 26, at 15.

52. Mary Darby, *Health Care Quality: From Data to Accountability*, NAT'L HEALTH POL'Y F. 3, 3–4 (1998), https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1002&context=sphhs_centers_nhpf.

53. *NQF's History*, NAT'L QUALITY F., http://www.qualityforum.org/about_nqf/history/ (last visited Jan. 14, 2020).

The widespread penchant for using metrics to enhance the quality and efficiency of care continued into the 2000s.[54] "Pay-for-performance" (P4P), for example, is an umbrella term that refers to programs that emerged in the early 2000s to measure and promote quality and efficiency in the delivery of care.[55] P4P programs are designed to collect and measure data to assess whether physicians and health care organizations perform well on a number of standardized metrics.[56] From 2003 to 2009, the Centers for Medicare and Medicaid Services (CMS) participated in a P4P project to assess the degree to which financial incentives can improve the quality of care patients receive.[57] Additionally, the Patient-Centered Affordable Care Act (ACA) of 2010 established a number of initiatives that were inspired by P4P programs.[58] The Hospital Value-Based Purchasing (VBP) Program, for example, was created by the ACA to incentivize hospitals and medical personnel to adhere to clinical best practices and improve their scores on PSSs.[59] Tying physician compensation to patient satisfaction and performance, which is a practice that will be discussed in Section II, is one example of the Hospital VBP Program's efforts to leverage carrots and

54. *See infra* notes 55–61 and accompanying text.

55. *See* Todd Clark et al., *Toward the Stick (from the Carrot): The Evolution in Medicaid MCO Pay-for-Performance Programs*, EXECUTIVE INSIGHTS, 2017, at 1; PAY FOR PERFORMANCE IN HEALTH CARE: METHODS AND APPROACHES 1, 7–8 (Jerry Cromwell et al. eds., 2011) [hereinafter PAY FOR PERFORMANCE].

56. *See* Clark et al., *supra* note 55, at 1; PAY FOR PERFORMANCE, *supra* note 55, at 1–2 (noting that P4P programs, value-based purchasing systems, and similar programs have become widespread in the health care industry).

57. Julia James, *Pay-for-Performance*, HEALTH AFF. 1, 2 (Oct. 11, 2012), https://www.healthaffairs.org/do/10.1377/hpb20121011.90233/full/healthpolicybrief_78.pdf (discussing various programs aimed at lowering the cost of health care by incentivizing physicians to improve the quality of their services); *see* HOFF, *supra* note 3, at 25–64 (describing efforts to lower the cost of health care through programs measuring the "outcomes" and "value" of health care).

58. James, *supra* note 57, at 3; *see What Is Pay for Performance in Healthcare?*, NEW ENG. J. MED. CATALYST (Mar. 1, 2018), https://catalyst.nejm.org/pay-for-performance-in-healthcare/.

59. *See The Hospital Value-Based Purchasing (VBP) Program*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html (last modified Nov. 19, 2019, 8:30 PM).

sticks to improve the quality and efficiency of care.[60] Another program established by the ACA is the Hospital-Acquired Condition Reduction Program, which reduces payments to hospitals failing to meet certain performance standards.[61]

These examples are only a few of the many indications that modern medicine is typified by a number of efforts to document, measure, and report on health metrics.[62] Although the discussion in this section has focused largely on efforts to improve the quality of care, data and metrics have been used for a variety of other purposes in the medical profession.[63] For example, data and metrics have been leveraged to improve the speed and availability of care.[64] Similarly, data has been collected, and metrics developed, for the ostensible purpose of increasing access to care by reducing costs and improving efficiencies.[65] Each of these distinct, yet related, strands deserve significant attention. But, this Article does not provide a comprehensive

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60. *See* Tim Doran et al., *Impact of Provider Incentives on Quality and Value of Health Care*, 38 ANN. REV. PUB. HEALTH 449, 452, 454 (2017).

61. *See Hospital-Acquired Condition Reduction Program (HACRP)*, CENTERS FOR MEDICARE & MEDICAID, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program (last modified July 16, 2019, 2:45 PM).

62. Presently, Medicare is the chief proponent of rapidly expanding programs aiming to tie the dollars paid to medical providers to performance on a variety of performance metrics. *See What Are the Value-Based Programs?*, CENTERS FOR MEDICAID & MEDICARE SERVICES, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html (last modified Dec. 18, 2019, 6:47 PM); HOFF, *supra* note 3, at 26.

63. These additional purposes include analyzing data to tailor treatments to specific patients, reduce inefficiencies and costs, expand access to care, promote innovation, and more. *See* Adibuzzaman et al., *supra* note 25, at 384; Nelson et al., *supra* note 25, at 667; *see also supra* note 5 and accompanying text.

64. HOFF, *supra* note 3, at 57; *see also* Kate Monica, *UCLA Health Using Microsoft Azure to Improve EHR Data Integration,* EHR INTELLIGENCE, (June 4, 2019), https://ehrintelligence.com/news/ucla-health-using-microsoft-azure-to-improve-ehr-data-integration (discussing tech giants' partnerships with medical institutions and the access tech giants receive to patient health records for the stated purpose of developing advanced analytics tools to analyze health records and help physicians diagnose and predict medical conditions); Jonah Comstock, *Apple Reveals 39 Hospitals to Launch Apple Health Records*, HEALTHCARE IT NEWS (Mar. 29, 2018, 2:53 PM), https://www.healthcareitnews.com/news/apple-reveals-39-hospitals-launch-apple-health-records (same); Melanie Evans & Laura Stevens, *Big Tech Expands Footprint in Health*, WALL STREET J. (Nov. 27, 2018, 7:04 PM), https://www.wsj.com/articles/amazon-starts-selling-software-to-mine-patient-health-records-1543352136 (same).

65. *See supra* note 3 and accompanying text.

discussion of every thread. Instead, I will gesture at the broader effects of metric mania by discussing a particular quality-of-care metric: patient satisfaction. Although patient satisfaction is an important aspect of medicine and health care, physician–patient relationships and the health of patients suffer when the rich complexities of care are overlooked as a result of overly simplistic conceptions of patient satisfaction.[66]

II. PATIENT-SATISFACTION SURVEYS: AN EXAMPLE OF METRIC MANIA'S EFFECT ON PHYSICIAN–PATIENT RELATIONSHIPS

Patient satisfaction originally developed as a health care concept.[67] Medical researchers hypothesized that dissatisfied patients were less likely to comply with treatment plans and attend regular check-ups.[68] Research indicates that a consequence of failing to comply with treatment plans is decreased health outcomes, which further exacerbate patient dissatisfaction.[69] Scholars posited that increasing patient satisfaction could lead to better compliance with treatment plans and improved health outcomes.[70] "Appointment keeping" and use of recommended medication became popular measures for professionals to track and promote in an effort to improve patient care.[71] Taking note of the premium medical professionals were placing on metrics to measure patient satisfaction, commercial entities developed surveys to measure patient satisfaction and advise medical professionals on how to improve their scores on such surveys, which were touted as quality-of-care metrics.[72]

66. *See* Pascoe, *supra* note 9, at 189; *supra* notes 13–19.

67. Junewicz & Youngner, *supra* note 12, at 44.

68. *See, e.g.*, Pascoe, *supra* note 9 (discussing research indicating that patient satisfaction contributes to certain health behaviors).

69. Junewicz & Youngner, *supra* note 12, at 45.

70. *See* Pascoe, *supra* note 9, at 185, 189 (discussing research indicating that patient satisfaction contributes to certain health behaviors).

71. Brian Williams, *Patient Satisfaction: A Valid Concept?*, 38 SOC. SCI. & MED. 509, 510 (1994); *see* Rainer S. Beck et al., *Physician-Patient Communication in the Primary Care Office: A Systematic Review*, J. AM. BOARD FAM. PRAC., Jan.–Feb. 2002, at 35–36; Derksen et al., *supra* note 17, at e78–e80.

72. Siegrist, *supra* note 10, at 982.

Over the years, the prevalence of PSSs increased.[73] By 2002, the interest in tracking patient experiences had "spread to the federal government."[74] In that year, the CMS and the Agency for Healthcare Research and Quality developed a survey asking patients to rate their experience in various areas.[75] The Deficit Reduction Act of 2005 required that this survey be used when determining whether hospitals receive Medicare reimbursements.[76] In 2006, the CMS implemented the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to measure patients' perspectives on the care they receive.[77] Composed of over two-dozen items (including substantive questions and those designed to screen or control for analytical purposes), HCAHPS surveys are designed to capture a variety of aspects of patients' experiences.[78] For example, patients are asked to report on the ease with which they were able to schedule an appointment, the responsiveness of clinical staff, the cleanliness of medical facilities, whether the noise level in the hospital environment is acceptable, and more.[79] Enacted in 2010, the ACA increased the weight given to these surveys when determining reimbursement rates.[80] The federal government's endorsement of these surveys contributed to their

73. *See id.*

74. Junewicz & Youngner, *supra* note 12, at 45.

75. *HCAHPS: Patients' Perspectives of Care Survey*, *supra* note 8.

76. *Id.*

77. *Survey of Patients' Experiences (HCAHPS)*, MEDICARE.GOV, https://www.medicare.gov/hospitalcompare/Data/Overview.html (last visited Jan. 14, 2020); *see The HCAHPS Survey—Frequently Asked Questions*, CENTERS FOR MEDICARE & MEDICAID SERVICES 1, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HospitalHCAHPSFactSheet201007.pdf (last visited Jan. 14, 2020) [hereinafter *HCAHPS Survey FAQ*].

78. *HCAHPS Survey FAQ*, *supra* note 77.

79. *See* Browne et al., *supra* note 8, at 921; *Survey of Patients' Experiences (HCAHPS)*, *supra* note 77.

80. Junewicz & Youngner, *supra* note 12, at 45; *see HCAHPS: Patients' Perspectives of Care Survey*, *supra* note 8; Bobbie Berkowitz, *The Patient Experience and Patient Satisfaction: Measurement of a Complex Dynamic*, 21 ONLINE J. ISSUES NURSING (Jan. 31, 2016), http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-21-2016/No1-Jan-2016/The-Patient-Experience-and-Patient-Satisfaction.html.

growing popularity in the health care industry.[81] Based on the feedback from PSSs, some health care providers have attempted to improve patient satisfaction by providing "valet parking, live music, custom-order room-service meals, and flat-screen televisions. Some [offer] VIP lounges to patients in their 'loyalty programs.'"[82]

To be sure, patient satisfaction is important, and the collection and analysis of information plays an important role in evaluating and improving care. However, studies suggest that PSSs fail to capture the complexity of the correlation between patient satisfaction and good health outcomes.[83] The factors captured by PSSs are undoubtedly relevant to the short-term satisfaction of patients.[84] But, the reasons for patient satisfaction matter a great deal in determining whether patient satisfaction will translate into good health outcomes in the long run.[85] A variety of superficial factors (e.g., a warm welcome at a hospital's reception desk, a quiet hallway, or free coffee in the waiting room) could produce short-term satisfaction in patients. However, there is little evidence indicating that patients who report being more satisfied because of such factors will be more likely to trust and communicate with their physician, comply with treatment plans, and enjoy good health outcomes.[86] There is a stronger correlation between good health outcomes and the sort of patient satisfaction resulting from sound physician–patient relationships, which are founded on good communication and

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81. *See Patient Satisfaction Surveys*, NEW. ENG. J. MED. CATALYST (Jan. 1, 2018), https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0288.

82. Alexandra Robbins, *The Problem with Satisfied Patients*, ATLANTIC (Apr. 17, 2015), https://www.theatlantic.com/health/archive/2015/04/the-problem-with-satisfied-patients/390684/.

83. *See, e.g.*, Joshua J. Fenton et al., *The Cost of Satisfaction: A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality*, 172 ARCHIVES INTERNAL MED. 405, 409 (2012) (noting that research findings indicate that patient satisfaction correlates with physicians' fulfillment of patient requests that do not promote the long-term interests of patients); Robbins, *supra* note 82 (using the story of a patient who complained that the hospital did not give him enough pastrami on this sandwich to illustrate the unrealistic expectations of patients as a factor skewing the usefulness of patient satisfaction surveys).

84. *See* Fenton et al., *supra* note 83, at 409.

85. *See id.*

86. *See id.* at 408–09; *see also* Robbins, *supra* note 82.

trust.[87] As Section III will illustrate, such relationships are far more complex and challenging to produce than free coffee in a hospital's waiting area.[88] Hence, because PSSs tend to focus on superficial satisfaction metrics rather than the long-term relational aspects of care that are strongly correlated with good health outcomes, they encourage medical professionals to satisfy their patients with "low-hanging fruit," such as nice televisions or quiet hallways, and this practice tends to ignore the more complex relational aspects of medicine.[89]

In addition to finding that the patient-satisfaction metrics on PSSs are not effective in promoting good health outcomes, studies indicate that patient health could be harmed when PSSs incentivize physicians to satisfy their patients according to the vague metrics identified on such surveys.[90] When physician pay is tied to performance on PSSs, physicians report feeling more pressure to please their patients in potentially harmful ways, such as by inappropriately prescribing opioids.[91] According to a survey conducted by the Ohio State Medical Association and the Cleveland Clinic Foundation, over seventy percent of physicians interviewed suspected that patient-satisfaction surveys are responsible for the over-prescription of controlled substances.[92] Additionally, pressuring physicians to perform well on PSSs suppresses the incentive to raise subjects that patients

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87. *See* Nicola Brennan et al., *Trust in the Health-Care Provider-Patient Relationship: A Systematic Mapping Review of the Evidence Base*, 25 INT'L J. FOR QUALITY HEALTH CARE 682, 682, 686 (2013).

88. *See* discussion *infra* Section III.

89. HOFF, *supra* note 3, at 10. Other examples abound of efforts to harness large amounts of data to create quick innovations (e.g., applications promoting access to on-demand care from ZocDoc, wearable devices to track health information, and more) to provide customers (i.e., patients) with cheaper and faster access to a service. *See id.* at 10, 46, 63.

90. *See Physicians Dissatisfied*, *supra* note 15 (noting "[t]he danger [relating to PSSs] . . . comes if physicians pursue high satisfaction scores at the expense of the appropriate care").

91. *See id.*; Joan Papp & Jason Jerry, *Patient Satisfaction Surveys Need to Better Address Pain Management: Fighting Opioid Epidemic*, AMA (Mar. 18, 2016), https://www.ama-assn.org/delivering-care/opioids/patient-satisfaction-surveys-need-better-address-pain-management-fighting.

92. Papp & Jerry, *supra* note 91 ("[Seventy-four] percent [of the physicians] reported that they felt an increased pressure to prescribe opioids because of the perverse pain management incentives in the patient satisfaction surveys.").

might find displeasing.[93] A study conducted by Joshua Fenton revealed that doctors are less likely to raise a concern in response to a patient's request for a medically inappropriate treatment if the physician's pay is tied to satisfaction surveys.[94]

Despite the problems stemming from such surveys, PSSs and similar metrics are here to stay for the foreseeable future.[95] This is so in part because measuring data in health care and medicine can lead to many important breakthroughs and because using metrics to assess the quality and efficiency of care is a big business that pervades the U.S. health and medical system.[96] This is not to say that a case cannot be made for devoting more attention to the relational aspects of medicine, even if doing so must be done in the shadow of metric mania.[97] Section III provides a strategy for doing just that.

III. A STRATEGY FOR IMPROVING PHYSICIAN–PATIENT RELATIONSHIPS

I suggest physicians can devote more attention to the complex relational aspects of medicine and enhance their rapport with

93. *Patient Satisfaction Linked to Higher Health-Care Expenses and Mortality*, U.C. DAVIS HEALTH (Feb. 13, 2012), https://health.ucdavis.edu/publish/news/newsroom/6223/ [hereinafter *Patient Satisfaction Linked*] ("Providers who are too concerned with patient satisfaction may also be unwilling to bring up uncomfortable issues such as smoking, substance abuse or mental health, which may then go unaddressed.").

94. *See* Fenton et al., *supra* note 83, at 405–06. For example, a doctor could avoid voicing concerns about a patient's weight or smoking habit if doing so could offend the patient and result in poor marks on a survey. *See Patient Satisfaction Linked*, *supra* note 93.

95. *See supra* note 3 and accompanying text (discussing the strong trend in the United States toward using large amounts of data to develop metrics that measure the degree to which certain interventions achieve various health goals); *see generally The Invention*, *supra* note 21, at 250–53 (discussing the legal, regulatory, and cultural dynamics contributing to the pervasiveness of economic-oriented reasoning in the health care space).

96. *See supra* note 3 and accompanying text (illustrating the various interests fueling the rise of data collection and analysis in health care); *see also* HOFF, *supra* note 3, at 25 (discussing the deep roots "metric fever" has implanted in America's health care system); *The Invention*, *supra* note 21, at 250–53 (commenting on the legal, regulatory, and cultural dynamics contributing to the pervasiveness of economic-oriented reasoning in the health care space); *supra* Section I (discussing how the use of metrics to improve the quality and efficiency of care has come to dominate the U.S. health and medical system); Lee, *supra* note 21 (discussing the benefits and drawbacks of data measurement in medicine).

97. *See infra* Section III.

patients by learning to improve their interpersonal skills. Programs designed to teach such skills in the medical context are part of a growing effort to help physicians develop healthy relationships with their patients.[98] A discussion of Oncotalk, which is one example of such efforts, will help illustrate how training physicians to improve their interpersonal skills can enhance physician–patient relationships.[99] Physician–patient relationships involve many elements, but two core features typify them: communication and trust.[100]

A. *Training to Improve Interpersonal Skills and Enhance Physician–Patient Relationships*

Oncotalk was a program developed by the founders of VitalTalk, which is a non-profit organization offering courses that teach physicians how to improve their interpersonal skills.[101] This course, along with others like it, was designed to provide physicians with the skills needed to establish trust and facilitate

98. *See, e.g.*, *About*, COLUM. U. NARRATIVE MED., https://www.narrativemedicine.org/about/ (last visited Jan. 14, 2020) [hereinafter *About Narrative Medicine*] (noting the importance of "empathic interviewing, reflective practice, narrative ethics, self-awareness, and creating and sustaining healing intersubjective contact with patients and colleagues" in the health care context); *Why Empathy Training?*, EMPATHETICS, http://empathetics.com (last visited Jan. 14, 2020) (suggesting that empathy can be taught, and physicians can use this skill to improve their relationships with patients). These courses are sometimes referred to as teaching physicians the skill of "clinical empathy." *See* JODI HALPERN, FROM DETACHED CONCERN TO EMPATHY: HUMANIZING MEDICAL PRACTICE 70, 72–73, 81 (2001) (providing an explanation of clinical empathy in Chapter Four). Because empathy is a complex concept, and its appropriate role in the practice of medicine is a matter of debate, I suggest that courses like Oncotalk are best understood as opportunities for physicians to learn how to improve their relationships with patients, and I do not discuss the concept of empathy here. *See About Us*, VITALTALK, https://www.vitaltalk.org/about-us/ (last visited Jan. 14, 2020).

99. *See* Anthony L. Back et al., *Efficacy of Communication Skills Training for Giving Bad News and Discussing Transitions to Palliative Care*, 167 ARCHIVES INTERNAL MED. 453, 453–54 (2007) [hereinafter *Efficacy of Communication Skills Training*] (discussing Oncotalk, a communications skills workshop, as a way to increase the efficacy of communication skills for oncology fellows).

100. *See generally* HALPERN, *supra* note 98, at 67–99 (explaining how empathy helps facilitate trust and communication between doctors and their patients); THROUGH THE PATIENT'S EYES: UNDERSTANDING AND PROMOTING PATIENT-CENTERED CARE 75–76, 89 (Margaret Gerteis et al. eds., 2002) (same).

101. *About Narrative Medicine*, *supra* note 98; *see Efficacy of Communication Skills Training*, *supra* note 99 and accompanying text.

communication with their patients.[102] Oncotalk-like courses typically begin with the presentation of a hypothetical in a seminar-type setting.[103] After reviewing the facts of a hypothetical (which typically involves a strained relationship), students are invited to identify the factors that led to the breakdown in the relationship between the physician and patient.[104] In scenarios where ineffective communication contributed to a strained relationship, students are encouraged to have a conversation with their patients.[105] Facilitating good communication requires a conversation about the patient's life, values, condition, symptom experience, etc.[106] This discussion may reveal that the patient has significant concerns about how his condition will affect the broader aspects of his life. A painter, for example, receiving a diagnosis of a condition that will dramatically affect the use of his hands will likely be more distraught than a different patient who receives the same diagnosis but does not rely as much on the use of his hands in his personal and professional life.[107] Indeed, to varying degrees, ill patients "fall[] out of their normal place in life," and this disruption can have a significant effect on every aspect of the patient's lived environment, including social, professional, and familial aspects of life.[108]

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102. *See* Anthony L. Back et al., *Training Clinicians with Communication Skills Needed to Match Medical Treatments to Patient Values*, 67 J. AM. GERIATRICS SOC'Y S435, S436–38 (2019) [hereinafter *Training Clinicians*] (illustrating a number of courses designed to improve communication and trust between physicians and patients).

103. *See, e.g.*, *About Narrative Medicine*, *supra* note 98 (describing workshops "led by a trained facilitator" to practice active listening, eye contact, and other skills in the clinical setting); *Efficacy of Communication Skills Training*, *supra* note 99, at 454 (discussing the interpersonal skills taught in seminar-like settings for medical professionals hoping to improve their ability to communicate with patients).

104. *See generally Efficacy of Communication Skills Training*, *supra* note 99 and accompanying text.

105. *See id.*

106. *See generally* Muhammed Jawad Hashim, *Patient-Centered Communication: Basic Skills*, AM. FAM. PHYSICIAN, Jan. 1, 2017, at 29 (providing an "overview of patient-centered communication techniques for physicians").

107. *See id.* at 31–32.

108. HANS-GEORG GADAMER, THE ENIGMA OF HEALTH: THE ART OF HEALING IN A SCIENTIFIC AGE 42 (Jason Gaiger & Nicholas Walker trans., 1996).

Having learned through the aforementioned dialogue that the patient is a painter, the physician could anticipate that a diagnosis affecting the use of the patient's hands could be devastating. Oncotalk-like courses can teach physicians the importance of appropriate non-verbal signals in situations involving the communication of traumatic information. Alerted to the impact the diagnosis may have on this patient, the physician may notice non-verbal communication (e.g., a furrowed brow, looking down, or slumping body posture) indicating the patient's feelings in response to the news. Oncotalk-like courses can inform physicians that in response to such signals, it is not appropriate to stand over a patient, clipboard in hand, and list the patient's treatment options immediately after delivering a diagnosis. Instead, the physician could learn to recognize the importance of "try[ing] to be present and to use non-verbal queues [sic] to" care for the patient.[109] Upon noticing the patient's non-verbal signals, the physician can respond appropriately by not smiling, pausing to allow the patient to process the information, and pulling up a chair instead of standing over the patient.[110] By reflecting on examples like the one above, physicians can learn to weave the ethical aspects of clinical judgment in with the ones that are merely biomedical.[111] The process of reasoning through case studies helps young medical professionals, and those more experienced, understand the importance of verbal and non-verbal communication in the physician–patient relationship.[112]

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109. *See* Ruhi Tyson, *What Is Excellence in Practice? Empirical Explorations of Vocational Bildung and Practical Wisdom Through Case Narrative*, VOCATIONS & LEARNING, Apr. 7, 2017, at 29.

110. *See id.* at 27–30.

111. Lauris Christopher Kaldjian, *Teaching Practical Wisdom in Medicine Through Clinical Judgement, Goals of Care, and Ethical Reasoning*, 36 J. MED. ETHICS 558, 560–62 (2010) ("Consistent with such views, . . . reflective habits such as self-monitoring and mindful practice can be understood as part of a clinician's attempt to look truthfully at a clinical situation on the assumption that our mental processes and inner experiences have the potential to influence the way we perceive the concrete clinical circumstances we encounter.").

112. Tyson, *supra* note 109, at 30 ("When this everyday process works and relations are strengthened we stand better prepared for the more difficult conversations and events that we all experience in life."). Practical wisdom involves "the enactment of . . . different conversational techniques, and different understandings of contexts." *Id.* at 32.

This sort of communication also plays an important role in establishing trust.[113] A discussion about the patient's experience of a condition can help establish the physician as a person who cares about the patient's goals and wants to know more about how the disease is preventing the patient from achieving his aims.[114] This exchange dispels notions that the physician might be adverse to the patient's interests, and dispelling adversarial notions facilitates the development of trust.[115] Together, communication and trust establish the core of good physician–patient relationships.[116] The trust and communication lying at the heart of such relationships can help facilitate the exchange of information the physician needs to provide the best care.[117] Additionally, good physician–patient rapport increases the likelihood that patients will comply with the treatment plan developed through collaboration with the physician.[118]

Oncotalk-like courses involve not only theoretical learning in seminar rooms, but also hands-on training.[119] Hands-on experience with patients is critical to gaining the ability to respond appropriately when communicating with patients about their goals.[120] The skills needed to develop good relationships with patients are cultivated through repeated and reflective practice; they cannot be mastered by learning the elements of an abstract theory, by reading a self-help book, or by attending a weekend seminar.[121] Practice will take years, and it must occur in the

113. *See* Gerald B. Hickson & A. Dale Jenkins, *Identifying and Addressing Communication Failures as a Means of Reducing Unnecessary Malpractice Claims*, 68 N.C. MED. J. 362, 363 (2007).

114. *See* Susan Dorr Goold & Mack Lipkin, Jr., *The Doctor-Patient Relationship: Challenges, Opportunities, and Strategies*, 14 J. GEN. INTERNAL MED. (SUPPLEMENT) S26, S26–27 (1999).

115. *See id.* at S27.

116. *See* Sagit Mor & Orna Rabinovich-Einy, *Relational Malpractice*, 42 SETON HALL L. REV. 601, 610–11 (2012).

117. *See id.* at 616–18; *see also* discussion *infra* Section IV.B.

118. Junewicz & Youngner, *supra* note 12, at 44; Robert Gatter, *Faith, Confidence and Health Care: Fostering Trust in Medicine Through Law*, 39 WAKE FOREST L. REV. 395, 400–01 (2004); *see also* discussion *infra* Section IV.B and accompanying text.

119. *See Efficacy of Communication Skills Training*, *supra* note 99, at 453–54; *see also* Kaldjian, *supra* note 111, at 562.

120. Kaldjian, *supra* note 111, at 558.

121. *See, e.g.*, Rod MacLeod, *How Good Do You Have to Be?*, J. PALLIATIVE CARE & MED., Jan. 2015, at 1 (Practical wisdom "includes the ability to make judgments and reach decisions

presence "of experienced clinicians" who are capable of teaching by example.[122] Similar to mandates that physicians remain abreast of the latest in medical technology by periodically attending seminars, physicians could be required to attend Oncotalk-like training on a regular basis.[123] More experienced physicians could even lead seminars for younger clinicians and help trainees practice engaging with patients while learning from mistakes they make along the way.[124] In this way, the sustained engagement with Oncotalk-like training is akin to continuing medical education or coaching.[125]

B. *Beyond Training: Recognizing the Additional Resources Needed to Improve Interpersonal Skills*

Although knowing how to improve relationships with patients is important, factors other than know-how affect physician–patient relationships in important ways.[126] Metric mania's

without being unduly influenced by unnecessary considerations, fears, or personal attachments."); Elliott Sober, *The Art and Science of Clinical Judgment: An Informational Approach*, *in* CLINICAL JUDGMENT: A CRITICAL APPRAISAL 29 (H. Tristram Engelhardt, Jr. et al. eds., 1979); *see also* Kaldjian, *supra* note 111, at 561 (The close relationship "is also suggested by the way clinical judgment is formed within a community of practitioners defined by standards of professionalism that are themselves dependent on virtues." (footnote omitted)).

122. Kaldjian, *supra* note 111, at 562 (Training clinicians to respond to patients in a practically wise way takes "years of practice in the company of experienced clinicians, who, as role models, are able to demonstrate practical wisdom by example."). Repeated practice is needed to develop the sorts of virtues taught in Oncotalk-like courses. *See generally* Nancy Sherman, *The Habituation of Character*, *in* THE FABRIC OF CHARACTER: ARISTOTLE'S THEORY OF VIRTUE 159 (1991) (discussing the importance of practice and habituation in developing new skills, including skills regarding the demonstration of certain character virtues).

123. Of sixty-seven listed jurisdictions, informational materials indicate that sixty-four have implemented statutory or administrative requirements that physicians complete some continuing medical education to maintain licensure. *See Continuing Medical Education Board-by-Board Overview*, FED'N ST. MED. BOARDS, http://www.fsmb.org/siteassets/advocacy/key-issues/continuing-medical-education-by-state.pdf (last updated Nov. 20, 2019).

124. *See* Kaldjian, *supra* note 111, at 560–61. Doing so will also enable physicians to maintain their interpersonal skills and remain abreast of the latest research on this subject.

125. Kathryn I. Pollak et al., *Coach, Don't Just Teach*, NEW ENG. J. MED. CATALYST (Jan. 17, 2019), https://catalyst.nejm.org/coach-teach-communication-coaching [hereinafter *Coach, Don't Just Teach*].

126. *See* Lotte N. Dyrbye et al., *Burnout Among Health Care Professionals: A Call to Explore and Address this Unrecognized Threat to Safe, High-Quality Care*, NAT'L ACAD. MED. PERSPECTIVES, July 5, 2017, at 2.

pressure to increase efficiency in the medical and health care context often means physicians are required to do more with less.[127] Partly as a result of these pressures, physicians across America are experiencing high levels of burnout and job dissatisfaction.[128] Multiple factors—including isolation stemming from a lack of community, excessive workloads, process inefficiencies, and more—drive physician burnout.[129] When physicians are dissatisfied and experiencing burnout, the quality of care they provide decreases, and their relationships with patients suffer.[130]

In response to this reality, hospital administrators can offer physicians resources to promote their effectiveness and reduce burnout.[131] Easing clerical burdens, for example, can reduce the amount of time physicians must devote to administrative tasks—either at home or on the job—and increase their attention to clinical care.[132] Reductions in clerical work can be achieved by hiring staff to shadow physicians, take notes, and

127. *See, e.g.*, *id.* at 3 (discussing physician burnout resulting from a variety of factors, including excessive workloads); Leslie P. Scheunemann & Douglas B. White, *The Ethics and Reality of Rationing in Medicine*, 140 CHEST J. 1625, 1626–27 (2011) (discussing rationing in health care).

128. *See, e.g.*, JAMIE RYAN ET AL., THE COMMONWEALTH FUND, PUBL'N NO. 1831, PRIMARY CARE PROVIDERS' VIEWS OF RECENT TRENDS IN HEALTH CARE DELIVERY AND PAYMENT 9–10 (2015) (noting that physician dissatisfaction with market trends in health care is contributing to nearly half of primary care physicians considering early retirement); Dyrbye et al., *supra* note 126, at 2–3 (discussing driving factors contributing to the extent of burnout among health care professionals).

129. *See* Richard M. Ryan & Edward L. Deci, *Self-Determination Theory and the Facilitation of Intrinsic Motivation, Social Development, and Well-Being*, 55 AM. PSYCHOLOGIST 68, 70, 73–76 (2000) (discussing the detriment to quality of performance of professionals from lack of motivation caused by negative reinforcement and contingent rewards as well as reduced patient compliance with therapies and treatments when connectedness is lacking in the physician–patient relationship).

130. *See* Dyrbye et al., *supra* note 126, at 2.

131. *See* Lucette Lagnado, *Hospitals Address Widespread Doctor Burnout*, WALL STREET J. (June 9, 2018, 7:02 AM), https://www.wsj.com/articles/hospitals-address-widespread-doctor-burnout-1528542121.

132. Tait Shanafelt et al., *Relationship Between Clerical Burden and Characteristics of the Electronic Environment with Physician Burnout and Professional Satisfaction*, 91 MAYO CLINIC PROC. 836, 844 tbl. 3, 846 (2016) [hereinafter Shanafelt et al., *Relationship*]; *see* Dyrbye et al., *supra* note 126, at 3.

document appointments.[133] Hiring staff to perform such tasks is cost effective, according to Stanford Hospital Chief Wellness Officer Tait Shanafelt, because doing so enables physicians to spend more time seeing patients.[134]

Additionally, hospitals can promote community among physicians to help them feel less isolated, which is another factor contributing to physician dissatisfaction and burnout.[135] Interspersing gathering places throughout hospitals and encouraging medical professionals to meet at such locations on various occasions can improve community among physicians.[136] Hospitals can also encourage groups of physicians to meet for occasional dinners at local restaurants.[137] A randomized trial at Mayo Clinic provides an example of how this strategy can be implemented.[138] Pursuant to the trial, groups of approximately half a dozen physicians at Mayo Clinic were provided with the opportunity to attend bi-weekly dinner meetings at a restaurant off-campus—those gatherings were referred to as COMPASS (Colleagues Meeting to Promote and Sustain Satisfaction) groups.[139] Mayo Clinic covered the cost of the dinners, and participants discussed the "virtues and challenges of being a physician" for the first twenty minutes of the gatherings.[140] Initiatives like the COMPASS program can be implemented more

133. *See* Lagnado, *supra* note 131; *see also* Tait Shanafelt, *Physician Burnout: Stop Blaming the Individual*, NEW ENG. J. MED. CATALYST (June 2, 2016), https://catalyst.nejm.org/videos/physician-burnout-stop-blaming-the-individual/ [hereinafter Shanafelt, *Physician Burnout*].

134. Lagnado, *supra* note 131; *see* Tait Shanafelt & John H. Noseworthy, *Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout*, 92 MAYO CLINIC PROC. 129, 137–38 fig. 4 (2017) [hereinafter Shanafelt & Noseworthy, *Executive Leadership*].

135. *See* Shanafelt & Noseworthy, *Executive Leadership*, *supra* note 134, at 137–38.

136. *Id.*

137. *Id.* at 138.

138. *Id.*

139. *See* Colin P. West et al., *Intervention to Promote Physician Well-being, Job Satisfaction, and Professionalism: A Randomized Clinical Trial*, 174 JAMA INTERNAL MED. 527, 528 (2014); Shanafelt & Noseworthy, *Executive Leadership*, *supra* note 134, at 138.

140. Shanafelt & Noseworthy, *Executive Leadership*, *supra* note 134, at 138.

broadly to ease the burdens on physicians and improve physician–patient relationships.[141]

The interpersonal skills learned through participation in Oncotalk-like courses can provide physicians with the tools needed to improve their relationships with patients.[142] Additionally, generous wellness programs and administrative support can go a long way toward easing various burdens impeding the ability of physicians to improve their relationships with patients.[143] It is worth noting that these are not the only benefits coinciding with the strategy outlined in Section III. As discussed in the next section, improved physician–patient relationships can have several auxiliary benefits.

IV. AUXILIARY BENEFITS OF IMPROVING PHYSICIAN–PATIENT RELATIONSHIPS

Executing the strategy laid out in Section III could yield many benefits, such as the satisfaction patients and physicians receive from their encounters, the restoration of a patient's equilibrium that is lost as the result of illness, and more.[144] Benefits like these are directly related to the ethos of medicine, which is concerned with healing relationships.[145] In addition to such benefits,

141. *See id.* at 138 (describing the widespread use of the COMPASS program within one year of its implementation); *see also* Philip J. Moore et al., *Medical Malpractice: The Effect of Doctor-Patient Relations on Medical Patient Perceptions and Malpractice Intentions*, 173 WEST J. MED. 244, 244–45, 248 (2000) (finding that positive physician–patient relationships were much less likely to be correlated with a malpractice claim).

142. *See* Baile & Aaron, *supra* note 17, at 331, 333 (supporting the notion that learned interpersonal skills can be used to influence desirable patient outcomes and improve physician–patient relationships).

143. *See* Lagnado, *supra* note 131 (discussing efforts to improve physician wellness, although many of these efforts are still failing to relieve the burdens physicians face daily).

144. *See* David C. Thomasma, *Establishing the Moral Basis of Medicine: Edmund D. Pellegrino's Philosophy of Medicine*, 15 J. MED. & PHIL. 245, 248–50 (1990) (discussing the relational aspects of care and the disorientation in one's life that results from illness); GADAMER, *supra* note 108, at 42–43 (same).

145. *See* Thomasma, *supra* note 144, at 248 ("Medicine is neither science nor art, but a *technê iatrikê*, a practical discipline of healing. Thus, medicine is not theory about the body or how the body works, so much as theory about practice, about the ways in which doctors and patients, other health professionals, and institutions interact to bring about healing. Within this context anatomy, physiology, and the other sciences assist both understanding and practice.").

executing the strategy identified in this Article could yield several advantages that are useful in providing medical care but that are only indirectly connected to the essence of medicine. Lower financial risks and overhead costs, reduced administrative burdens, and more are among the examples of indirect benefits resulting from the strategy endorsed by this Article.[146] Spacing prohibits an exhaustive discussion of all of these direct and indirect benefits, but a few stand out.

A. *Reduced Malpractice Risk*

One benefit of improved physician–patient rapport is reduced malpractice risk for medical professionals. To establish a malpractice claim, patients must prove that their injuries resulted from the negligent acts of their physicians.[147] A physician acts negligently by failing to take the amount of care that a reasonably prudent physician would take to prevent injury to others.[148] A common way for negligence to be established is by pointing to some physical evidence of an injury caused by a physician's failure to satisfy the relevant medical standards.[149] A malformed limb, for example, could indicate that a physician

146. *See* Moore et al., *supra* note 141, at 249 (discussing the possibility of reduced costs associated with litigation through improving physician–patient communication).

147. Mor & Rabinovich-Einy, *supra* note 116, at 607. Put more technically, establishing a malpractice claim requires that the patient satisfy the tort elements of duty, breach, causation, and damages. *Id.*

148. *See* Pannu v. Jacobson, 909 A.2d 178, 192 (D.C. 2006) ("'Establishing the standard of care is essential to a prima facie case of negligence because physicians are not expected to be perfect . . . ; they are liable in negligence only when their behavior falls below that which would be undertaken by a reasonably prudent physician,' and there is a causal relationship between that behavior and a plaintiff's injury." (quoting Burke v. Scaggs, 867 A.2d 213, 217 (D.C. 2005))). Although the general negligence rule concerns the conduct of a reasonably prudent non-physician, in the malpractice context, negligence is measured by the standards of the medical profession, which are established by the medical profession itself. Dionne Koller Fine, *Physician Liability and Managed Care: A Philosophical Perspective*, 19 GA. ST. U. L. REV. 641, 656 (2003). The standard level of skill, knowledge, and care physicians are expected to practice is developed by "leaders in the medical profession and the interaction of physicians through peer-reviewed journals and professional meetings." *Id.*

149. *See* Robert I. Field, *The Malpractice Crisis Turns 175: What Lessons Does History Hold for Reform?*, DREXEL L. REV., Fall 2011, at 20 (discussing the use of physical evidence of injuries in a successful malpractice claim).

failed to act with a reasonable level of care in setting a patient's bone.[150]

Sometimes, however, an adverse event could occur even in the absence of negligence or a medical error.[151] In such circumstances, the existing malpractice regime does not promote open communication between physicians and patients.[152] Physicians may attempt to limit their malpractice risk by truncating their communication with patients because they fear that providing patients with too much information following an unsuccessful procedure could supply patients and their families with evidence to be used against the physician in a malpractice claim.[153] When communication is disrupted, the physician–patient relationship breaks down and patients and their families are likely to become frustrated by the lack of information about an undesirable medical outcome.[154] Without effective communication and support, patients and their families could lose trust in medical professionals.[155] When trust is lacking, patients and their families may be less likely to agree with the judgment of medical professionals regarding whether a mistake had occurred in the care they received.[156] For example, if medical professionals are not forthcoming about the details of their care, patients may decide to sue their physicians because of a desire to obtain more information about the details surrounding an adverse medical

150. *Id.* (discussing how a plaintiff can use a malformed limb as physical evidence to prove a physician deviated from accepted standards).

151. *See* David H. Sohn, *Negligence, Genuine Error, and Litigation*, INT'L J. GEN. MED., Feb. 15, 2013, at 49 ("Not all medical injuries are the result of negligence.").

152. *See, e.g.*, Dale C. Hetzler et al., *Curing Conflict: A Prescription for ADR in Healthcare*, DISP. RESOL. MAG., Fall 2004, at 6–7 ("There are many breakdowns in delivering care and communication—and the fear of liability and lack of a complete explanation for what occurred create barriers to a full discussion."); Carol B. Liebman & Chris Stern Hyman, *A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients*, HEALTH AFF., July/Aug. 2004, at 23–24 (acknowledging the "mismatch between what patients want and what physicians provide following an adverse event or medical error").

153. Mor & Rabinovich-Einy, *supra* note 116, at 604.

154. Christine W. Duclos et al., *Patient Perspectives of Patient-Provider Communication After Adverse Events*, 17 INT'L J. FOR QUALITY HEALTHCARE 479, 482–83 (2005).

155. *See id.*

156. *See id.*

event.[157] Hence, a paradoxical result of limiting communication in such instances is increased malpractice risk.[158]

In addition to withholding information, to avoid being sued for failing to provide a treatment that could be considered beneficial, some physicians practice "defensive medicine," which is roughly defined as the practice of prescribing unnecessary tests and treatments.[159] These unnecessary treatments are expensive, and they are not prescribed with an eye toward improving the health of the patient.[160] Rather, they are prescribed to reduce the chances of malpractice litigation that may arise because they did not provide an expensive treatment or test that has even a remote chance of being slightly beneficial.[161] Ironically, defensive medicine leads to an increased likelihood of facing a malpractice suit.[162] This is because prescribing unnecessary treatments to protect the physician's interests while placing undue financial burdens on patients undermines trust between doctors and patients.[163] As discussed above, decreased trust harms

157. *See* Kathleen M. Mazor et al., *Communicating with Patients About Medical Errors: A Review of the Literature*, 164 ARCHIVES INTERNAL MED. 1690, 1694 (2004); Mor & Rabinovich-Einy, *supra* note 116, at 609–10.

158. A variety of sources support this assertion. *See, e.g.*, David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 944 nn.280–81 (2005) (listing several sources commenting on the role that poor physician–patient relationships play in increasing malpractice risk); Mor & Rabinovich-Einy, *supra* note 116, at 604, 604 n.18 (citing several sources supporting the assertion that breakdowns in the physician–patient relationship increase malpractice risk). A random selection of 1,452 malpractice claims found that approximately one-third of malpractice lawsuits are not connected to errors in the technical aspects of medical care. David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2031 (2006).

159. Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN. L. REV. 667, 684 (2006).

160. *See id.*

161. *See id.* at 685.

162. *See* Kristin E. Schleiter, *Difficult Patient-Physician Relationships and the Risk of Medical Malpractice Litigation*, 11 AMA J. ETHICS 242, 243 (2009).

163. Marshall B. Kapp, *Medical Error Versus Malpractice*, 1 DEPAUL J. HEALTH CARE L. 751, 759 (1997) (citing Jean H. Ritchie & Sally C. Davies, *Professional Negligence: A Duty of Candid Disclosure?*, 310 BRIT. MED. J. 888 (1995)).

physician–patient relationships and increases the malpractice risk of medical professionals.[164]

The role that poor communication and lack of trust play in malpractice claims highlights the importance of interpersonal skills taught by Oncotalk-like courses.[165] These skills were "once dismissively known as 'good bedside manner' and traditionally regarded as far less important than technical acumen."[166] However, an increasing focus on technical mastery and meeting the standards established by metric mania has made medicine increasingly impersonal, and this trend has caused patients to feel less connected with their doctors.[167] Some malpractice insurers have taken note of the connection between improved interpersonal skills and reduced malpractice risk.[168] For example, a Minneapolis-based malpractice insurer, MMIC, urges its physicians to participate in Oncotalk-like courses.[169] MMIC believes it will be able to reduce the amount of money it spends defending physicians in malpractice claims by requiring the doctors it insures to take advantage of courses that teach them how to improve their interpersonal skills.[170] Another example of a medical liability insurer promoting such courses is the NORCAL Group,

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164. *See* Mazor et al., *supra* note 157, at 1694 (discussing the relationship between breakdowns in the physician–patient relationship and malpractice risk); *supra* note 158 and accompanying text (listing several sources commenting on the role that poor physician–patient relationships play in increasing malpractice risk).

165. *See* Boodman, *supra* note 13.

166. *Id.*

167. Mitchell J. Nathanson, *It's the Economy (and Combined Ratio), Stupid: Examining the Medical Malpractice Litigation Crisis Myth and the Factors Critical to Reform*, 108 PENN. ST. L. REV. 1077, 1080 (2004). Further, the phenomenon of metric mania pressures physicians to focus more on what is being measured, and the foregoing discussion demonstrated that the relational aspects of medicine are not adequately captured by metric mania. *See supra* Section II and *infra* Section IV.C.

168. *See* discussion *infra* notes 169–72 and accompanying examples.

169. Boodman, *supra* note 13. Similarly, a Massachusetts-based malpractice insurer requires its medical professionals to participate in online courses to improve their ability to satisfy patients. *See* Zack Budryk, *Patient-Centered Care Requires Physician Empathy Training*, FIERCEHEALTHCARE (Mar. 10, 2015, 4:13 PM), https://www.fiercehealthcare.com/practices/patient-centered-care-requires-physician-empathy-training.

170. Boodman, *supra* note 13.

which is a California-based insurer.[171] NORCAL Group's website touts the ability of Oncotalk-like programs to improve the ability of physicians to communicate with their patients.[172] The lead taken by malpractice insurers in identifying the potential for reducing malpractice risk by taking advantage of Oncotalk-like courses can be emulated across the medical profession to improve physician–patient rapport.

B. *Better Health Outcomes for Patients*

Another benefit of the strategy endorsed by this Article is that improved physician–patient relationships can lead to better health outcomes for patients. The relationship between a physician and patient plays a significant role in the delivery of medical care.[173] Poor physician–patient rapport decreases the likelihood that such patients will comply with their treatment plans and attend regular check-ups with their physician.[174] A consequence of failing to comply with treatment plans is decreased health outcomes.[175] Poor physician–patient relationships also lead to decreased trust and communication, which inhibits the ability of physicians to obtain all relevant information about their patients' conditions.[176] High-quality medical care hinges on the ability of physicians to solicit necessary information that is relevant to the diagnosis and treatment of their patients'

171. *About NORCAL Group*, NORCAL GROUP, https://www.norcal-group.com/about (last visited Jan. 17, 2020).

172. *Improving Physician Empathy: Techniques and Training Resources*, NORCAL GROUP (Oct. 2. 2018), https://www.norcal-group.com/library/improving-physician-empathy-techniques-and-training-resources.

173. *See* M. Robin DiMatteo, *The Physician-Patient Relationship: Effects on the Quality of Healthcare*, 37 CLINICAL OBSTETRICS & GYNECOLOGY 149, 157 (1994) (discussing the importance of physicians' interpersonal skills in determining whether patients will perform certain health behaviors, such as making follow-up appointments and complying with treatment plans).

174. Junewicz & Youngner, *supra* note 12, at 44; Gatter, *supra* note 118, at 400–01.

175. Junewicz & Youngner, *supra* note 12, at 44–45.

176. Mor & Rabinovich-Einy, *supra* note 116, at 617.

conditions.[177] The ability of physicians to obtain such information is linked to good physician–patient relationships.[178]

To be sure, it takes a significant amount of time, resources, and effort to maintain and improve these relationships.[179] However, when stakeholders embrace an overemphasis on metrics like PSSs, they oversimplify the complex relational aspects of care for the sake of developing quick solutions.[180] Without a focus on the complex relational aspects of care, easily measured metrics receive too much focus, and this practice can do more harm than good. As illustrated by the example in Section II, when a physician is treating a patient for chronic pain of some sort, the physician could receive high marks on a PSS by prescribing an opioid requested by the patient.[181] But, if that patient has a history of addiction, it may be in the best interest of the patient to expend valuable time and resources to establish the rapport necessary to change a patient's behavior and lifestyle habits rather than writing a prescription. Establishing the rapport needed to have such difficult conversations will be challenging, but doing so can go a long way toward improving the long-term health outcomes of patients.

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177. *See, e.g.*, Baile & Aaron, *supra* note 17, at 331 (noting the importance of communication skills in "comprehensive oncology care"); Derksen et al., *supra* note 17, at e81 (finding that the psychological process of one party sharing that party's feelings and experiences, and a discussion about those feelings and experiences, is an important aspect of medical care and one that has positive implications for health outcomes); Kaplan et al., *supra* note 17, at S110 ("Physician–patient communication has traditionally been recognized as important to the practice of clinical medicine," and "patients appear to value information from their doctors highly."); Orth et al., *supra* note 17, at 29 (discussing research indicating physician–patient communication affects health outcomes); Street et al., *supra* note 17, at 295 (describing the features of physician–patient communication that can influence health outcomes).

178. Mor & Rabinovich-Einy, *supra* note 116, at 617.

179. HOFF, *supra* note 3, at 67.

180. *Id.* at 9, 47, 61, 95. Although efforts to perform well on patient-satisfaction surveys and other metrics are connected to Medicare reimbursements, the time and effort needed to establish trust, respect, and effective communication between doctor and patient involve behaviors that are not tied to economic incentives. *See* M. GREGG BLOCHE, THE HIPPOCRATIC MYTH: WHY DOCTORS ARE UNDER PRESSURE TO RATION CARE, PRACTICE POLITICS, AND COMPROMISE THEIR PROMISE TO HEAL 57 (2011); Walter Ling, *Prescription Opioid Addiction and Chronic Pain: More than a Feeling*, 173 DRUG & ALCOHOL DEPENDENCE S73, S74 (2017).

181. *See supra* Section II.

C. *Enhanced Experiences for Physicians and Patients*

As mentioned above, patients desire good relationships with their physicians.[182] Patients expect that their values, preferences, and anxieties will be respected in medical encounters.[183] Providing such respect involves enlisting the patient and, as appropriate, her family members in making decisions about the type of care most appropriate for that patient.[184] Addressing these various aspects of medical care requires a solid physician–patient relationship founded on trust and open communication.[185] The importance patients place on the relational aspects of care has been widely documented.[186] For example, interviews with patients revealed that, "[f]or patients, the best relationships with their doctors involved . . . trust, listening, emotional bonding, friendship-like connections at key times, mutual respect, accountability, and a physician who served as an expert advisor."[187]

Like patients, physicians report that they receive a significant amount of purpose and workplace satisfaction from their relationships with patients.[188] Physicians believe that the psychological and emotional connections established with patients are crucial aspects of medicine.[189] "[T]he words trust, respect,

182. *See, e.g.*, Hall et al., *supra* note 18, at 613–14 (discussing trust as the defining characteristic giving therapeutic encounters meaning and promoting effectiveness); HOFF, *supra* note 3, at 100–35 (proposing that patients find the best relationships with their doctors when those relationships are built upon trust, listening, mutual respect, and other factors).

183. Michael J. Barry & Susan Edgman-Levitan, *Shared Decision Making—The Pinnacle of Patient-Centered Care*, 366 NEW ENG. J. MED. 780, 780 (2012).

184. *See id.*

185. *See* HOFF, *supra* note 3, at 69–70, 73, 100.

186. *See supra* notes 158, 167, and 182 and accompanying text.

187. HOFF, *supra* note 3, at 100.

188. *See, e.g.*, Kathryn I. Pollak et al., *Effect of Teaching Motivational Interviewing Via Communication Coaching on Clinician and Patient Satisfaction in Primary Care and Pediatric Obesity-Focused Offices*, 99 PATIENT & EDUC. COUNSELING 300 (2016) [hereinafter *Communication Coaching*] (discussing the improved clinician satisfaction resulting from better communication between physicians and patients); HOFF, *supra* note 3, at 67–73, 197 (discussing interviews with physicians that elicited positive and prideful responses from physicians when prompted with questions regarding their relationships with patients, referring to feelings of trust and respect that lead to a strong union between doctor and patient). *But see Coach, Don't Just Teach*, *supra* note 125.

189. *See* HOFF, *supra* note 3, at 100.

friendship, partnership, and communication" have been consistently used by physicians to describe the "effective, satisfying doctor–patient relationship."[190] These studies indicate that good relationships with patients are important to physician satisfaction.[191]

D. *Increased Scores on Patient-Satisfaction Surveys*

This Article has highlighted the harms resulting from overemphasizing surveys like PSSs.[192] An ironic knock-on effect of leveraging Oncotalk-like training to improve physician–patient relationships is that doing so can improve PSS scores.[193] An example of the strategy endorsed here has been utilized by Southwest Airlines, which has enhanced passenger satisfaction by providing its employees with training to improve their interpersonal skills.[194]

Southwest teaches its employees how to treat customers well by providing them with a variety of training programs.[195] Some of the most important training programs Southwest employees receive concern de-escalation tactics.[196] Similar to Oncotalk-like courses, de-escalation training teaches airline employees that trust and communication are at the heart of good

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190. *See id.* at 69, 71; Ryan & Deci, *supra* note 129, at 76.

191. *See, e.g.*, HOFF, *supra* note 3, at 71 (noting that an important aspect of physicians' work involves the ability to relate to their patients on a deep emotional and psychological level); Jennifer Fong Ha et al., *Doctor-Patient Communication: A Review*, 10 OCHSNER J. 38, 39 nn.1, 5–7, 9, 13, 15, 18, 19, 22, 25, 26, 28–30 (2010) (citing several studies indicating the importance of good physician–patient relationships in physician satisfaction); Chad Saley, *2019 AAFP/CompHealth Physician Happiness Survey*, COMPHEATLH (Mar. 19, 2019), https://comphealth.com/resources/physician-happiness-survey/ (discussing a survey of over 5,000 physicians indicating that physicians place a tremendous amount of value on their relationships with patients).

192. *See supra* Section II.

193. *See id.*

194. *See* Amy Elisa Jackson, *Why Southwest Says Soft Skills Reign Supreme*, GLASSDOOR (Dec. 4, 2018), https://www.glassdoor.com/blog/southwest-bptw19/.

195. *See id.*

196. Ron Lieber, *How Do Airline Workers Learn to Deal With You?*, N.Y. TIMES (Apr. 22, 2017), https://www.nytimes.com/2017/04/22/your-money/how-airline-workers-learn-to-deal-with-you.html.

relationships.[197] Like the development of trust between physicians and patients, establishing trust between airline employees and passengers begins with good communication.[198] Communicating effectively helps Southwest's employees resolve conflicts and persuade customers to comply with airline policies.[199] For example, if an employee requests that a passenger check her bag, de-escalation training can teach the employee that providing the customer with an explanation as to why the request is being made can help establish trust. The reason the bag may need to be checked is because the aircraft's overhead racks are full, and unless all luggage is safely stowed, the plane cannot take off and arrive at its destination on time. The Southwest employee might learn through de-escalation training that a discussion about the reason for checking the bag can communicate that the employee and the customer have the shared goal of arriving at their destination on time.[200] This exchange helps dispel notions that the employee might be adverse to the customer's interests—dispelling adversarial notions facilitates the development of trust and improves the overall relationship between the customer and employee.[201]

As with Oncotalk-like courses, simply providing physicians with the requisite skills to improve their relationships with customers will not be enough to accomplish this goal. An important supplement to these courses is removing, or at least mitigating, the factors impeding the ability of Southwest employees to devote the time and energy needed to improve their rapport with customers. Managers at Southwest Airlines

197. *Cf.* HALPERN, *supra* note 98, at 81 (explaining how empathy helps facilitate trust and communication between doctors and their patients).

198. *Id.*; Lieber, *supra* note 196.

199. Lieber, *supra* note 196. The skills learned to accomplish these goals include using voice modulation to avoid escalation of conflicts. *Id.* The use of a sarcastic tone, employees learn, can cause an already exasperated customer to become more agitated and less likely to comply with the airline employee's requests. Similarly, a cheery tone is inappropriate when the message the employee is delivering is, "Your flight has been cancelled." *Id.*

200. Goold & Lipkin, *supra* note 114, at S28 fig.1.

201. *See id.* at S27, S28 fig.1; *see also* HALPERN, *supra* note 98, at 70; Hickson & Jenkins, *supra* note 113, at 362.

believe treating employees well will translate into better care for customers.[202] Southwest cares for its employees by ensuring they are not overworked and have the resources needed to do their jobs well.[203] These resources include generous leave packages, health benefits, and wellness programs.[204]

As it turns out, the airline's strategy of treating employees well and providing them with de-escalation training has worked.[205] Southwest is regularly rated as one of the best airlines in terms of employee-customer relations.[206] Physicians can take a page from Southwest's book to improve their rapport with patients. The success at Southwest indicates that the interpersonal skills taught in Oncotalk-like courses can lead to increased patient satisfaction and high PSS scores. Granted, an important difference is that Southwest employees aim to improve their communication and trust with passengers for self-

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202. *See* Stan Phelps, *Southwest Airlines Puts Its Heart into the Customer Experience*, PURPLE GOLDFISH THINK TANK (Sept. 26, 2016), https://purplegoldfish.com/southwest-airlines-puts-heart-customer-experience/.

203. *See WorkPerks*, SOUTHWEST AIRLINES, http://view.ceros.com/direct-path-health/southwest-airlines-workperks/p/1 (last visited Jan. 17, 2020).

204. *Southwest Careers*, SOUTHWEST, https://careers.southwestair.com/benefits (last visited Jan. 17, 2020). Southwest stresses the importance of working with a warrior's spirit, a servant's heart, and a fun-loving attitude. Phelps, *supra* note 202. These three qualities ensure that from the start, the employees at Southwest possess a drive to succeed and a desire to put others, including co-workers and customers, first. *See* Julie Weber, *How Southwest Airlines Hires Such Dedicated People*, HARV. BUS. REV. (Dec. 2, 2015), https://hbr.org/2015/12/how-southwest-airlines-hires-such-dedicated-people. When employees are surrounded by co-workers who are driven and selfless, they are more likely to "feel positive[ly] about their company, the workplace . . . and, optimally, the customers." Michael Lowenstein, *Flying High and Well-Grounded: How Virgin and Southwest Practice Airline Employee Ambassadorship*, BEYOND PHIL. (Nov. 14, 2017), https://beyondphilosophy.com/flying-high-well-grounded-virgin-southwest-practice-airline-employee-ambassadorship/. Flight attendants, for example, have been rewarded by Southwest for entertaining passengers with jokes and rap routines during flights. Adam Grant, *Faking Your Emotions at Work*, TED: WORKLIFE (Apr. 2018), https://www.ted.com/talks/worklife_with_adam_grant_faking_your_emotions_at_work#t-1952138. When employees are enjoying their co-workers and having fun on the job, studies show that they are naturally more inclined to treat customers better. *See id.*

205. *See* Kristin Robertson, *Southwest Airlines Reveals 5 Culture Lessons*, HUM. SYNERGISTICS INT'L (May 29, 2018), https://www.humansynergistics.com/blog/culture-university/details/culture-university/2018/05/29/southwest-airlines-reveals-5-culture-lessons.

206. *Southwest Airlines Ranks Highest in Customer Satisfaction Among Low-Cost Carriers in North America According to J.D. Power*, SOUTHWEST (June 15, 2018), http://investors.southwest.com/news-and-events/news-releases/2018/06-15-2018-155031252.

interested reasons, such as ensuring a timely departure and overall business success, but physicians seek better communication and trust with their patients because doing so is part of a healing relationship that is not governed by the self-interest of physicians. Despite this difference, de-escalation training and Oncotalk-like courses provide very similar interpersonal skills that can improve relationships.[207] Further, like the benefits offered to Southwest employees to ensure they have the energy to apply the interpersonal skills they learn, physicians can be offered the sort of wellness packages discussed in Section III.B.

V. ANTICIPATING A FEW CHALLENGES TO IMPROVING PHYSICIAN–PATIENT RELATIONSHIPS

At this point, it is worth acknowledging a few challenges facing the strategy suggested in Section III. This Article will not provide an exhaustive discussion of these and other questions regarding the strategy advocated here. Instead, I gesture at a few challenges that stand out and suggest that a more comprehensive discussion of these and other issues will accompany a future project to address the broader phenomenon of metric mania.

First, the training required to enable physicians to develop better rapport with their patients will require a great deal of cognitive effort.[208] Commentators have noted the neurobiological limitations on our abilities to process new information.[209]

207. *See, e.g.*, Timothy Gilligan, *Improving Communication Skills at a Large Academic Medical Center Video Transcript*, U. TEX. MD ANDERSON CANCER CTR. (May 14, 2013), https://www.mdanderson.org/transcripts/icare-ace-20130514-gilligan.htm (explaining the importance of de-escalation skills to physicians).

208. *See, e.g.*, Gregg M. Bloche & Kevin P. Quinn, *Professionalism and Personhood*, *in* 7 PERSONHOOD AND HEALTHCARE 347, 349–52 (David C. Thomasma, David N. Weisstub & Christian Hervé eds., Boston: Kluwer Academic 2001) (describing the emotional toll and information-processing strain that clinical work imposes on physicians).

209. *See, e.g.*, CHARLES DANIEL BATSON, ALTRUISM IN HUMANS 186–87 (2011) (discussing the cognitive limitations of empathetic behavior); ANTONIO DAMASIO, DESCARTES' ERROR: EMOTION, REASON, AND THE HUMAN BRAIN 166–72 (1994) (discussing the role experience plays in creating mental shortcuts enabling us to move through the world without conducting an intricate cost-benefit analysis when faced with routine decisions); Bloche & Quinn, *supra* note 208, at 350 ("As problem-solvers, we are constrained by our 'bounded rationality,' that is, our

Our minds are not capable of processing all of the information they receive at any given point in time.[210] Attending to the relational aspects of medicine must be balanced against complex biomedical considerations, sorted, and directed appropriately.[211] Critics of the strategy endorsed by this Article may worry that medical professionals simply do not have the cognitive capacity to attend to the complex relational aspects of medicine amidst the already cognitively demanding environment of clinical education and practice.[212]

A possible response to this challenge is to acknowledge such cognitive constraints and stress the importance of early intervention and education. Practicing these skills early—in medical school or before—will assist in the development and refinement of these abilities down the road.[213] To cope with information overload, our brains develop shortcuts with the help of various forms of education to identify categories of information and stimuli that warrant certain reactions.[214] A crude example is moving quickly to avoid falling objects. Upon developing the disposition—which is acquired partly through a process of learning and partly through reflexive behaviors guided by

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inability to process more than a small portion of the data we encounter. We perceive and process information we encounter by sorting it (consciously or unconsciously) into categories we have learned that carry meanings and trigger judgment and action." (citations omitted)).

210. *See* BATSON, *supra* note 209, at 187; Bloche & Quinn, *supra* note 208, at 350. To manage what can sometimes be an overload of information, some of which is more or less relevant to the treatment task at hand, physicians sift through that information and organize it into a useful format that will assist in their treatment of the patient. *See* Bloche & Quinn, *supra* note 208, at 350. The SOAP mnemonic—subjective, objective, assessment, plan—drilled into medical students is an example of an effort to help medical professionals organize information and sift through details that are more and less relevant. *See* Patrice M. Weiss et al., *Expanding the SOAP Note to SOAPS (with S for Safety): A New Era in Real-Time Safety Education*, 1 J. GRADUATE MED. EDUC. 316, 316–18 (2009) (suggesting safety should be added to the traditional SOAP method as it is an integral part of the physician–patient interaction).

211. *See* Bloche & Quinn, *supra* note 208, at 350.

212. *See id.*

213. *See* Sherman, *supra* note 122, at 165 (commenting on the important role training early in life and the shaping of intention and desires plays in developing character virtues); DAMASIO, *supra* note 209, at 177, 179 (discussing the importance of experience and interaction with the environment in the cognitive and affective development of children and adolescents).

214. *See* DAMASIO, *supra* note 209, at 177.

"landmarks laid down by . . . genes"[215]—that falling objects may cause us harm and that "avoiding them or stopping them is better than being hit," we acquire neural connections that prompt an automatic reaction to move rapidly to avoid such objects without excessive deliberation.[216] A similar process underpins our interpretation of non-verbal communication (e.g., facial expressions).[217] Whereas learning to attend to certain facial cues takes more cognitive effort early on, it eventually becomes automatic.[218] The same process can assist in the development of the faculties needed to attend to medicine's relational aspects. Learning to recognize—and respond appropriately to—important relational aspects of medicine will require more cognitive effort when first learning to do so, but it can become less cognitively demanding over time.[219] To be sure, the demands of Oncotalk-like courses can be great for residents and more experienced physicians who are already strained by contemporary medicine's pressures to do more with fewer resources.[220] This is not to say that more experienced clinicians cannot acquire the skills taught in these courses.[221] But, this recognition does suggest that the environmental, cognitive, and biological landscape for acquiring such skills will be different for medical professionals at various stages in their respective careers.[222]

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215. DANIEL C. DENNETT, FROM BACTERIA TO BACH AND BACK: THE EVOLUTION OF MINDS 165 (2017).

216. *See* DAMASIO, *supra* note 209, at 167.

217. *See id.* at 148–49 (discussing the difficulty in fooling others with a fake smile given that we have come to recognize the facial muscles involved in "genuine" smiles).

218. *See id.* at 141–49.

219. *See, e.g.*, José M. Muñoz, *Somatic Markers, Rhetoric, and Post-Truth*, 8 FRONTIERS PSYCHOL., July 2017, at 2–3 (discussing the learned responses and cognitive shortcuts made possible by repeated exposure to various situations and stimuli).

220. *See* HOFF, *supra* note 3, at 159–60 (discussing the institutional pressures on physicians to see more patients and increase efficiency).

221. *See* DAMASIO, *supra* note 209, at 179 (noting that "the accrual of somatically marked stimuli ceases only when life ceases, and thus it is appropriate to describe that accrual as a process of continuous learning").

222. *See, e.g.*, *id.* at 184 (discussing the variety of shortcuts the brain develops early in life based on rewards and punishments, and how these developments dramatically affect our future decisions and values).

Second, it is worth noting that the strategy presented in this Article does not remove the incentives for physicians to perform well on PSSs by engaging in the problematic behaviors mentioned in Section II. Through training provided by Oncotalk-like courses, physicians could acquire the skills to improve their relationships with patients.[223] However, such medical professionals could be Stepford-like physicians who appear to possess all sorts of wonderful character virtues but, in reality, are only interested in improving their PSS scores.[224] For example, because physicians' pay is tied to their performance on surveys measuring a patient's satisfaction with their care, a physician might learn to behave in ways that are superficially pleasing to patients but harmful to their long-term health. A doctor could avoid voicing concerns about a patient's weight or drinking habit if doing so could lead to hurt feelings and poor marks on a survey.[225]

Acknowledging this possibility, it is important to stress that Oncotalk-like courses should cultivate character virtues.[226] Without such virtues, physicians who participate in Oncotalk-like training courses could acquire the skills needed to improve their relationships with patients but lack the disposition to act in their patients' best interests. For this reason, it is important for Oncotalk-like courses to focus on the cultivation of physicians' character so that medical professionals possess the virtues needed to fortify themselves against pressures to use the skills they learn for their own benefit rather than the patients'

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223. *See* Daniel E. Epner & Walter F. Baile, *Difficult Conversations: Teaching Medical Oncology Trainees Communication Skills One Hour at a Time*, 89 ACAD. MED. 578, 578–79 (2014).

224. *See, e.g.*, RONALD DE SOUSA, THE RATIONALITY OF EMOTION 55 (1987) (discussing the possibility of "acting" as if one is affected in a certain way without actually feeling the way one purports).

225. *Physicians Dissatisfied*, *supra* note 15, at 2.

226. *See infra* notes 227–31 and accompanying text; Sandra G. Boodman, *Teaching Doctors How to Engage More and Lecture Less*, WASH. POST (Mar. 9, 2015), https://www.washingtonpost.com/national/health-science/teaching-doctors-how-to-engage-more-and-lecture-less/2015/03/09/95a98508-ae30-11e4-9c91-e9d2f9fde644_story.html.

interests.[227] Developing character virtues, like acquiring interpersonal skills, requires the education "of an apt pupil with the right teacher."[228] Oncotalk-like courses can cultivate such virtues by encouraging physicians to focus their attention on, and deliberate about, the ethos of medicine.[229] Although medicine does involve "theory about . . . how the body works," it is primarily concerned with "the ways in which doctors and patients, other health professionals, and institutions interact to bring about healing."[230] Various contexts will present physicians with questions about how to adhere to medicine's healing ethos, and the practice made possible through repeated encounters with such situations can instill medicine's healing ethos in physicians. Over time, responses to situations that were once new, but have become more familiar, move from requiring significant conscious reasoning toward more habituated reflexive actions.[231] The training provided by Oncotalk-like courses can also serve as the foundation upon which medical professionals can base their deliberations about, and responses to, new dilemmas.

Much more can be said about these challenges, others like them, and the responses I have suggested. The task of doing so can be taken up by a future project devoted to the much broader problem of overemphasizing metrics in other aspects of

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227. *See generally* Sherman, *supra* note 122, at 159–60 (discussing the importance of practice and habituation in developing new skills, including skills regarding the demonstration of certain character virtues).

228. THOMAS STEARNS ELIOT, *The Aims of Education*, *in* TO CRITICIZE THE CRITIC AND OTHER WRITINGS 63 (1965) (commenting on education, which is a collaborative process that requires significant effort, reflection, and revision on the part of both pupil and teacher); *see also* Roger T. Ames & Henry Rosemont, Jr., *From Kupperman's Character Ethics to Confucian Role Ethics: Putting Humpty Together Again*, *in* MORAL CULTIVATION AND CONFUCIAN CHARACTER: ENGAGING JOEL J. KUPPERMAN 22–23 (Chenyang Li & Peimin Ni eds., 2014) (discussing the concept of moral selves being constructed through practice in daily life rather than being bestowed at birth); Sherman, *supra* note 122, at 168–69, 179, 191–92 (explaining the Aristotelian conception of character being developed through experience, practice, and revision based on individual cases that arise throughout life and guidance from a reliable teacher).

229. *See* Thomasma, *supra* note 144, at 246, 248 (suggesting that medicine is governed by an ethic concerned with healing and good physician–patient rapport).

230. *Id.* at 248 (describing medicine as a mode of practice rather than merely an anatomical theory).

231. *See* Sherman, *supra* note 122, at 177–78.

medicine. The strategy presented in this Article can inform that future project.

CONCLUSION

Collecting information is an important aspect of good medical care. Analyzing large amounts of data can contribute to many important medical breakthroughs and improve care for individuals and entire communities.[232] Although an intense focus on such data can yield many benefits, overemphasizing metrics that are too simplistic induces medical professionals and institutions to turn a blind eye to critical, albeit complex and difficult to measure, facets of medicine. The example of PSSs helps illustrate metric mania's overemphasis on PSSs and other simplistic metrics. Such surveys devote inadequate attention to physician–patient relationships, which are critical aspects of good care and are among the complex aspects of medicine that receive inadequate attention as a result of metric mania. Despite the problems stemming from PSSs, this metric and others like it are here to stay for the foreseeable future. For these reasons, advocates of devoting more attention to medicine's relational aspects must to do so in the shadow of metric mania.

I suggest that from under this shadow, a strategy for increasing the emphasis on improving physician–patient rapport can be developed. Physicians can enhance their relationships with patients by participating in training designed to enhance their interpersonal skills. Various institutions have begun developing courses to teach physicians how to improve their relationships with patients and mitigate the aforementioned pitfalls associated with overemphasizing simplistic metrics.

The strategy laid out in this Article does not resolve the broader problem of metric mania afflicting other areas of the U.S. health and medical system; but, it can highlight the

232. *See* Paul B. Ginsburg et al., *The Opportunities and Challenges of Data Analytics in Health Care*, BROOKINGS INST. (Nov. 1, 2018), https://www.brookings.edu/research/the-opportunities-and-challenges-of-data-analytics-in-health-care/.

important role that physician–patient relationships can play in both the patient-satisfaction context and the development of a more comprehensive strategy to become wiser about collecting, storing, and using such data and metrics.