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COMMENTARY

The Evolution of Patient Experience: From Holistic Care to Human Experience

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ABSTRACT

Patient experience has evolved as a critical concept and outcome in health systems internationally. Evolving from consumer-led movements, coupled with shifts in the positioning of patients among clinical professions, the global focus on patient experience is now evident in nationally mandated measurement tools, the creation of dedicated institutional leadership roles, and outlets such as the Patient Experience Journal. By critically analysing the pivotal factors and milestones that have shaped its evolution throughout healthcare history, this review provides an in-depth exploration of the evolution of patient experience. In doing so, the review provides a critical analysis of the application of patient experience in health systems and future directions required to drive change for improvement.

Keywords: Patient experience, Human experience, Perceptions, Culture, Improvement

1. The Evolution of Patient Experience

Over the years, healthcare has undergone profound transformations, propelled by ground-breaking medical discoveries, advanced understanding of diseases, improvements in therapeutic practices, and the advent of cutting-edge technology. Parallel to these medical breakthroughs, there has been a significant evolution in our understanding of the patient experience. Whilst the notion of patient experience is not new, its understanding and implementation within healthcare have greatly deepened, reflecting a more nuanced appreciation of its importance in delivering quality care. The dynamic nature of our comprehension of the patient experience was previously discussed in the article, “Rebalancing the Patient Experience: 20 years of a pendulum swing.” The author contends that certain outdated practices may need to be abandoned in favour of new approaches, noting that the focus on metrics has, at times, detracted from the direct support of patients and staff, and underscored the need for a reassessment of priorities.

In the inaugural issue of Patient Experience Journal (PXJ), Dr. Irwin Press shared a similar view, suggesting that over the last 40 years, the view of patient experience has evolved from one of risk management and advocacy to one where cultures of experience must now be built with intention to ensure and sustain positive outcomes for patients and families. He reflects on the formalization of an experience industry in healthcare from the early 1980s, offering what is a very early view of human experience as we address it today.

“A culture of patient experience will exist when all in healthcare unquestioningly accept that it benefits not just the patient, but everyone involved in the medical enterprise. It will exist when everyone – both public and provider – accepts that the patient’s personal experience is as much a part of “care” as are the diagnostic procedures, surgeries, therapies and medications administered.”

That same inaugural issue of Patient Experience Journal explored the foundational definition of patient experience.
experience that ties to many of the ideas that Press noted, *the sum of interactions shaped by an organization's culture, that influence patient perceptions across the continuum of care*. This definition has held steadfast at the heart of the experience conversation over the last decade. In revisiting the definition in a follow-up article in 2021 the authors concluded that its essential elements have consistently remained unchanged and called for a broader view of human experience in healthcare. Yet, there is still some confusion within the healthcare profession, with “patient experience” and “patient satisfaction” often mistakenly used interchangeably. This issue reflects a lingering focus of providing care to patients, rather than collaboratively with them.

This review aims to deepen our comprehension of the patient experience by critically analysing the pivotal factors and milestones that have shaped its evolution throughout healthcare history. Moreover, it seeks to explore how these factors can drive action and facilitate change for improvement. Whilst the timeline provided offers a broad perspective on the evolution of patient experience, we also recognize that it may not encompass every milestone. We do believe, however, that by learning from our past, we can pave the way for the next phase of patient experience, striving to enhance outcomes for patients, caregivers, and the communities served by healthcare.

### 1.1. The roots of holistic medicine

In the pre-modern era, the concept of health was viewed by medicine as a balance of body, mind, and spirit, a perspective rooted in traditions like traditional Chinese medicine, Ayurveda, and Native American practices. Prominent figures, such as Hippocrates in Europe, championed this approach to “holistic care,” emphasizing the need for observation and listening for diagnosis and treatment.

Years later, Gallen, a Roman anatomist, tied illness to more than just physical occurrences, but emotional shock. This link of Hippocratic-Galenic medicine was grounded in the idea of the whole person, suggesting a connection between each patient’s body, mind, and personality and the outside world.

The focus on holistic care persisted into the Middle Ages, with physicians relying on sensory evaluations and patient stories to guide medical care. The idea of engaging patients as more than just objects of care is rooted in thousands of years of medical and nursing history. In more recent history, the idea of holistic and person-centered care was reinforced by healthcare leaders who advocated for its importance in healthcare. In the 1700s and 1800s, historical healthcare leaders, such as Samuel Bard and Florence Nightingale, advocated for treating patients as whole individuals, considering their emotional and psychological well-being, rather than only focusing on symptoms or diseases. Additionally, they emphasized the importance of a therapeutic healthcare environment to promote healing and recovery.

While these contributions laid the groundwork for a person-centered approach in medicine and nursing, it is important to acknowledge the complex historical contexts surrounding these figures, including their connections to slavery and views on race and class. These aspects contrast with contemporary understandings of inclusivity and equity in healthcare, as outlined in modern declarations like the Declaration for Human Experience.

### 1.2. The rise of the medical model

The 19th century saw a pivotal shift in medical treatment attitudes with the emergence of the medical model, transitioning from a focus on the patient to a concentration on the disease. This shift, driven by significant advancements in medical knowledge, such as germ theory and the invention of technologies like the microscope, marked a departure from valuing individual illness experiences to prioritizing the identification and treatment of specific diseases. Consequently, the patient perspective began to be overshadowed by pursuit of a more ‘objective’ approach to healthcare, in which patients were seen more as cases to be diagnosed and treated rather than individuals with unique perspectives and needs.

This evolution led to a diminished emphasis on the subjective experiences of patients, as the clinical priority moved towards diagnosing pathologies and implementing treatments, sidelining the patient’s own account of their health journey. Furthermore, a significant social divide in healthcare emerged, with wealthy patients receiving care at home and poorer individuals being treated in hospitals. This disparity further perpetuated the power imbalance between patients and clinicians, particularly in hospitals where the difference in social status was more pronounced.

Around this time, the discipline of Psychology began to acknowledge more deeply the role of psychological factors in tackling health issues. The pioneering work of Sigmund Freud on personality and the unconscious marked a significant step toward a holistic care approach. This illustrated a gradual shift back to focusing on the patient’s individual experiences and
requirements, laying the groundwork for the emergence of person-centered care in later years.

1.3. The influence of humanistic psychology

The impact of psychotherapy continued to influence the evolution of patient experience, which included the impactful work of American psychologist Carl Rogers. With the development of humanistic psychology, which emphasizes the consideration of the whole person and individual uniqueness, Rogers introduced “client-centered therapy” (later re-named “person-centered therapy”) which highlighted the importance of the therapeutic relationship between the clinician and the patient in achieving positive outcomes. This approach cultivated a collaborative relationship between the clinician and the patient, acknowledging their interactions as a vital aspect of recovery. It promoted a client-centered model, whereby the clinician acts more like a guide in the patient’s journey of self-discovery, rather than an expert with all the answers. Later, these ideas gained further prominence in other areas of healthcare, reinforcing the value of partnership and collaboration between clinicians and patients for therapeutic interactions.

In the 1940s, the establishment of the National Health Service (NHS) in the United Kingdom marked a significant step towards enhancing healthcare equity. With its inception, there was a swift expansion in hospital-based medicine alongside a rise in medical specialization. The NHS was founded on the principle of offering comprehensive healthcare to every citizen, irrespective of their economic background. Consequently, the NHS aimed to reduce disparities in healthcare access and quality, which had previously exacerbated the power imbalance between patients and clinicians. This initiative also influenced the evolution of community-based General Practitioners (GPs), steering them towards embracing a patient-centered approach in their care delivery.

1.4. The emergence of patient-centered care

In the 1950s and 1960s, Michael Balint, a physician, and his wife Edith Balint, a social worker, began to apply the relational concept of patient-centered care in the context of general healthcare practice. This era saw an increasing recognition of the importance of integrating medical and psychological aspects of care to address patients’ unique needs and experiences more effectively. The Balint’s provided training for GPs to prevent a “split” between attending to physical and psychological well-being. They introduced the term “patient-centered care” in their 1969 article, “The Possibilities of Patient-Centered Medicine.” During the 1970s, the movement towards patient-centered care received a significant push from professionals outside the conventional medical model, including GPs, psychologists, and healthcare consumers themselves. The role of GPs in advancing person-centered care practices began to solidify. In 1972, the Royal College of General Practitioners released a pivotal article titled “The Future General Practitioner,” highlighting the importance of doctors who treat the “whole person”—looking beyond just the disease to consider the full spectrum of patient health.

The push for person-centered care was notably advanced by healthcare consumers, exemplified by the founding of Planetree in 1978 by Angelica Theriot, who was motivated by her dissatisfaction with hospital experiences. Although her clinical care was satisfactory, the lack of privacy, comfort, information access, and family visitation led to the realization that healthcare must address more than just clinical symptoms. The Planetree model emphasized the importance of family support, architectural design conducive to healing, and information accessibility, inspiring changes such as open medical records, flexible visitation policies, and creating hospital environments focused on privacy and comfort.

1.5. Patient advocacy & a focus on patient satisfaction

The emergence of New Public Management (NPM) principles in the early 1980s in the UK significantly
transformed contemporary healthcare management and performance evaluation. NPM involved integrating private business principles into public healthcare systems, with an emphasis on cost-effectiveness, accountability, and a customer-centric approach to service delivery.  This contributed to a significant change in the way that healthcare systems operate and evaluate their performance, which may still be evident with increased focus on performance measurement and rewards (“pay for performance”). Additionally, whilst NPM is based on the belief that service delivery aspects can be quantifiable, the task of defining and measuring objectives in the public sector is inherently complex, nuanced, and not readily quantifiable.

The growing conversation on patients’ rights was also emerging in healthcare organizations, with the formal publication of a Patients’ Bill of Rights published by the American Hospital Association (AHA) in the early 1970s. This was preceded just a few years earlier by the formation of the first known Patient Representative Department at Mount Sinai Hospital in New York. Established through the vision of Ruth Ravich, this also led to the birth of an entire profession around Patient Advocacy to address the issue of patient concerns and complaints and led to the founding of the Society for Healthcare Consumer Advocacy, later a formal membership group in the AHA and now the Patient Advocacy Community in The Beryl Institute.

As part of this increasing focus on the healthcare consumers’ needs, “patient satisfaction” emerged as a key metric for measuring healthcare performance. It was identified that satisfied patients were more likely to follow treatment plans, have better clinical outcomes, and be less likely to file malpractice lawsuits. Accordingly, management positions were expanded to support complaints management and resolving patient concerns, with healthcare organizations focusing even more intentionally on patient advocacy, communication, and engagement strategies.

In the early 1980s, several research firms were established to tackle the challenge of quantifying patient satisfaction in healthcare, including three still actively engaged in various ways in the experience community today – Press Ganey, PRC, and NRC Health. By creating standardized survey tools, these organizations expanded the ability to gather patient input and significantly enhanced the precision and trustworthiness of patient satisfaction metrics. In that same period, the Picker Institute was founded, highlighting the gap between healthcare’s technological advancements and its focus on patient needs. In 1987, the Picker Institute partnered with Harvard researchers to develop the Picker Principles, outlining eight key dimensions of patient-centered care. These principles emphasized the importance of engaging patients in their own care, recognizing their individual needs, ensuring clear communication, and promoting a supportive care environment, which significantly boosted research and interest in patient-centered care.

1.6. The critical conversation on quality

The 1990’s saw the expansion of efforts to engage patient voices with the establishment of the Institute for Patient- and Family-Centered Care (IPFCC). The organization advocated for the engagement of Patient and Family Advisors (PFAs) and the establishment of patient and family advisory councils (PFACs) in healthcare settings, with the intention of involving patients and their families in the decision-making process to improve healthcare delivery and outcomes. The concept of a healthcare partnership was grounded in an emerging foundational principle for clinician-patient relationships: “Nothing about me without me.”

In 1999, the landscape of healthcare quality improvement experienced a pivotal shift following the Institute of Medicine (IOM)’s publication of “To Err is Human: Building a Safer Health System.” This report shed light on the critical need to tackle systemic flaws within healthcare settings that lead to errors and adversely affect patient safety, advocating for a shift in focus from blaming individual healthcare providers to examining and improving the systems in which they operate. Following this report, healthcare organizations initiated a range of measures to bolster patient safety and reduce errors, including utilising patient-reported feedback to identify health safety issues.

That same year, the publication of “The Experience Economy” introduced a shift in thinking, stressing the value of experiences beyond just consumer satisfaction. The authors argued that in a competitive market, businesses offering superior experiences could charge more and achieve greater financial success. This may be particularly relevant for healthcare systems that rely upon attracting consumers and patient payments, such as US-based systems. The change broadened the focus from satisfaction metrics to a more comprehensive and nuanced understanding of
customer experience. Ultimately, this represented a move away from traditional emphasis on patient satisfaction towards a broader focus: the \textit{“patient experience”}.

\subsection*{1.7 Mandating patient experience measurement}

The connection between person-centered care and the overall quality of healthcare services was notably underscored by the IOM in its 2001 landmark report, \textquote{\textit{Crossing the Quality Chasm}}.\textsuperscript{42} In this report, the IOM identified six domains of quality, explicitly including patient-centeredness as a key aspect of healthcare quality.\textsuperscript{43} Ultimately, this critical point marked a significant shift towards strengthening the association between patient experience and healthcare quality.

The worldwide growth in sharing knowledge and measuring patient experience gained momentum as the Picker Institute expanded its efforts from the US into the UK. This heightened emphasis on understanding patient experiences prompted the creation of innovative tools and methodologies for evaluation, with the Picker Institute developing the first national survey program on behalf of NHS and the Care Quality Commission (CQC) in 2002.\textsuperscript{44,45} This patient survey, comprising 15 items, marked the onset of mandatory national patient experience surveys as part of evaluating healthcare quality.\textsuperscript{44}

Whilst the concept of patient experience gained traction, patient satisfaction concurrently grew as a pivotal metric for evaluating healthcare quality. To evaluate patient satisfaction, numerous healthcare organizations adopted established metrics originally designed for evaluating customer satisfaction in other business settings. A primary example of this is the Net Promoter Score (NPS), a tool that gained prominence through its introduction in the 2003 Harvard Business Review article, \textquote{\textit{The One Number You Need to Grow}}.\textsuperscript{46} This article showcased NPS as a powerful and simple metric for assessing customer satisfaction, applicable across various service industries. NPS shifted the paradigm from merely satisfying customers to cultivating customer loyalty (with a focus on \textquote{Promoters}) and exceeding expectations, thus broadening the scope beyond traditional customer satisfaction metrics.\textsuperscript{47}

This shift also introduced the concept of loyalty into the healthcare conversation and underlined the reality that patients are not passive participants in a healthcare encounter, but active partners who experience healthcare. Experience is what people live though, what they perceive, and inspires the stories they share with others. Healthcare organizations were prompted to think about how they provided more comprehensive experiences, which framed positive perceptions and stories shared. This evolution paved the way in some healthcare systems for the incorporation of hospitality-oriented practices and an emphasis on service excellence in the healthcare industry. For example, this focus is explored in the 2004 book, \textquote{If Disney Ran Your Hospital: 9 1/2 Things You Would Do Differently}, which proposed leveraging Disney’s acclaimed service standards to enhance the healthcare experience.\textsuperscript{48} Notably, these strategies have particularly resonated in cultures where consumerism plays a significant role in healthcare choice and in healthcare organizations around the world that seek to attract patients with an elevated experience encompassing the quality of care. Nonetheless, many healthcare organizations realize that people deserve to be treated with the respect and comfort essential to healing and effective care, and these ideas have underlined opportunities to elevate this practice of expanding care beyond just clinical practice.

In 2005, the momentum towards measurement was further amplified with the National Quality Forum’s endorsement of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in the United States. This tool, a joint initiative by the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), was developed to evaluate patients’ perspectives on hospital care.\textsuperscript{34,46} The Deficit Reduction Act instituted the public disclosure of HCAHPS ratings, making it mandatory for hospitals to publish their HCAHPS scores to secure full Medicare compensation.\textsuperscript{49} Linkage of HCAHPS scores to financial outcomes bolstered transparency of performance data, with the aim of providing the public with clearer insights into the quality of healthcare services.\textsuperscript{45} The need to reflect performance results transparently, at least as reflected by these scores, stirred an increased focus on identifying best practices for improving patient experience and the expansion of consultation services established to guide patient experience improvements.

To support the achievement of strategic goals and organizational objectives, various healthcare organizations created senior roles that were dedicated to overseeing and improving the patient experience. This shift was notably demonstrated by the Cleveland Clinic’s adoption of the \textquote{Patients First} philosophy in 2004.\textsuperscript{50} Signalling a commitment to the philosophy of patient-centered care, the Cleveland Clinic
pioneered the role of Chief Experience Officer (CXO) and established the Office of Patient Experience. This strategic decision showcased how healthcare organizations could deliberately improve key patient experience indicators, such as HCAHPS scores, by investing in dedicated leadership and affirming their commitment to patient-centric strategies.

Another key driving force promoting the centrality of patient experience was a paradigm shift towards ‘value-based care’ in a broader move away from funding healthcare activity into funding care outcomes. The book “Redefining Healthcare: Creating Value-Based Competition” by Porter and Teisberg initiated discussions about the notion of “value” in healthcare, adopted from the business sector as a response to escalating medical costs, especially in the United States. In 2007, the conversation on value-based care gained momentum when presented in the context of the Triple Aim framework for providing high-value care. This framework delineated three core objectives for enhancing the US healthcare system, one of which was improving the individual experience of care. This development linked patient experience with the fundamental goals of healthcare. In the same year, the UK’s National Health Service (NHS) released “High Quality Care for All,” which identified “patient experience” as an essential component of healthcare quality. The report reinforced why this was important, saying, “Quality of care includes quality of caring. This means how personal care is – the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patient satisfaction with their own experiences.”

Requirements for public reporting of healthcare outcomes gained traction in response to emerging evidence of healthcare-associated harms and unwar-ranted clinical variations. With this came increased transparency about patient experience outcomes, with public reporting of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) commencing in 2008. In the context of increasing competition among healthcare providers in the US, this may have strengthened motivation for healthcare organizations to dedicate focus on improving patient experience outcomes. Public reporting of HCAHPS data further reinforced the relationship between patient experience and value-based care, as HCAHPS measures were integrated into Value-Based Purchasing (VBP) under the Patient Protection and Affordable Care Act of 2010. This legislation required that hospital payments be tied to clinical processes and patient experience, thus offering substantial financial incentives for improving patient experience (“pay for performance”).

1.8. Fostering patient experience leadership & research

The emphasis on patient experience started to expand worldwide, with a growing movement to create global networks to exchange insights and cultivate a community among leaders dedicated to patient experience. In 2010, The Beryl Institute was established as a global community of healthcare professionals dedicated to sharing knowledge and proven practice for improving patient experience. The institute’s work gathered professionals from around the world to establish the core definition of experience. It extended the definition to include the conversation on experience as created through personal interactions – human being to human being – which built upon the cultures of healthcare organizations. It also worked to stress that experience was not just about the measures of one clinical encounter but reflected the “sum of all interactions” at all touchpoints across the continuum of care. The work of the Institute stressed the criticality of an integrated perspective, reaching beyond the idea of survey results as the sole indicator of an individual’s experience. Experience is inclusive of all people encounter on their healthcare journey, and it is reflected in much more than scores. It is in the choices they make, the stories they tell, and the outcomes they realize. The collaborative community cultivated through the Institute led to the framing of patient experience as a distinct professional field, providing a gathering place for like-minded professionals and champions, developing a foundational body of knowledge, encompassing education, research, and proven practices, and fostering the eventual development of professional certification for patient experience professionals via its sister organization, Patient Experience Institute.

In 2011, the UK NHS further positioned patient experience as an issue of national importance by developing a national strategy introduced in the Patient Experience Framework. This comprehensive guide underscored a national commitment to elevating patient experience, thereby emphasizing the pivotal role of patients and their families with shaping and delivering healthcare services. Similarly, Australia implemented the rollout of the National Safety and Quality Health Service Standards (NSQHS). Originating from a focus on quality and safety, these standards were developed by the Australian Commission on Safety and Quality in Health Care to serve as a comprehensive framework for assessing
quality in healthcare. Notably, Standard 2, titled “Partnering with Consumers,” mandated healthcare institutions to robustly engage with consumers in all stages of healthcare, from design and delivery to evaluation, emphasizing the importance of patient feedback and positioning consumer collaboration at the core of healthcare accreditation. Despite the apparent benefits of establishing these frameworks, skepticism remains about the extent to which these theoretical and policy advancements have been effectively applied in practical settings to bring about meaningful and sustained healthcare improvements.

In 2014, a significant milestone in patient experience research was reached with the launch of Patient Experience Journal (PXJ) by The Beryl Institute. This journal was created to provide a dedicated space for research into patient experience, and its inaugural issue introduced a standardized definition of patient experience. This advancement helped to establish patient experience as a professional field and assisted in standardizing the concept for a global audience. In the same year, it was suggested that the Triple Aim model should expand to include the enhancement of healthcare providers’ work lives. This proposal highlighted the importance of employee well-being and encourages a healthcare culture that values collective experiences - with patients, families, and healthcare staff.

Globally, the momentum towards enhancing patient experience measurement continued to grow, with developments in non-western countries. In 2015, China launched the National Healthcare Improvement Initiative (NHII), aiming to improve patient experiences and leading to the creation of the standardized Chinese Patient Experience Questionnaire (CPEQ). The same year, the UK implemented the NHS “Friends and Family Test”, using a modified version of Net Promoter Score, which contributed to the formation of a mandated national survey for patient experience. Two years later, in Australia, the Australian Commission on Safety and Quality in Health Care created the Australian Hospital Patient Experience Question Set (AHPEQS). However, in contrast to the US and UK, this survey was not mandated for use by Australian healthcare organizations.

1.9. Elevating the human experience

The recognition emerging through this history was about the fundamentally relational nature of care. That healthcare is not simply about diagnosis or disease, safety checklists, or quality processes. Rather it must take on an integrated view that acts on what matters to patients, families, and care partners, the needs and vulnerabilities of the healthcare workforce, and the communities served by healthcare institutions around the world. The linking of these ideas, the human experience, was part of conversations in The Beryl Institute community as early as 2015 and was formalized in two key papers.

The first, _The State of Patient Experience 2017: A Return to Purpose_, shared, “In an environment where we clearly base all work on human beings caring for human beings, we are ultimately addressing and impacting the human experience in our midst... as we remain committed to patient experience, we must address the reality of the human experience that is central to healthcare overall.” The second, _To Care is Human: The Factors Influencing Human Experience in Healthcare Today_ reaffirmed the cultural influence of patient experience and highlighted the humanity underlying this work. The report emphasized that the culture of healthcare involves caring for all people, patients, family members, and healthcare staff alike, and that enhancing the well-being of those who work in healthcare is essential for achieving positive patient outcomes.

The COVID pandemic underscored the interconnected experiences of patients, healthcare workers, and the communities served by healthcare organizations, revealing the complexity of these relationships in unprecedented challenges. In the research paper, _Human Experience 2030: A Vision for the Future for Healthcare_, released just as the pandemic broke, these essential elements were reaffirmed. The pandemic highlighted the importance of healthcare staff well-being, and its connection to health system performance, further accentuating the relevance of the human experience. In 2021, the article “Re-examining ‘Defining Patient Experience’: The Human Experience in Healthcare,” advocated for the need to move beyond a singular focus on patient experience to the integrated view of human experience. This broader and inclusive perspective acknowledges and appreciates the diverse experiences and well-being of patients, families, and healthcare professionals influenced by healthcare services.

As shared in that paper, “The human experience – encompassing patient, workforce, and community experiences – is not a move away from the foundational definition of patient experience but rather the positive and natural expansion of it.” This was further reinforced in the Declaration for Human Experience,
which was grounded in key ideas elevating the experience conversation to one that stood on a commitment to address equity and dismantle disparities in the communities healthcare serves, to care for the needs and vulnerabilities of the healthcare workforce, and to address what truly matters to patients, families, and care partners. These ideas are built on one final commitment, one that calls for shared learning and collaboration. This final value has been essential to the successful evolution of the field, as it is in the sharing of ideas, knowledge, and lessons learned that we have evolved our efforts in experience to the heights it has been able to reach. It is a commitment we believe is essential to building on our history from here.

As we have explored, the natural emergence and expansion of experience as a central concept in healthcare is built on centuries of history grounded in the humanity at the heart of healthcare. A focus on human experience is the natural evolution of a field focused on caring for human beings and committed to ensuring the best in outcomes for all it serves.

2. Conclusion

In looking back on the evolution of patient experience, we journey from its basic roots to a sophisticated understanding of each patient’s unique needs, feelings, and perspectives. This transformation was fuelled by a concerted effort—combining the expertise of medical and nursing leaders, with advancements from general practitioners and psychologists, and significantly enriched by critical insights from patients and their families. Such collaboration has guided us toward the global focus on patient experience, as evidenced by the development of nationally mandated measurement tools (like the HCAHPS and Friends and Family Test), the creation of pivotal leadership roles (such as Chief Experience Officers), and the development of research and evidence-based practices (such as Patient Experience Journal).

Additionally, the incorporation of business strategies, notably prevalent in healthcare systems of the West, has significantly reshaped the industry. This evolution has positioned patient experience as both a strategic focus and the essential indicator encompassing quality, safety, and person-centered care. Yet, despite progress in quantifying patient experiences, a significant void remains in the commitment to substantive enhancements. This gap underscores a concerning truth: in some sectors, patient experience is treated more as an optional consideration than the core of healthcare delivery.

As we conclude this commentary, we revisit the words of Dr. Irwin Press from the inaugural issue of this journal—words that echo with as much significance today as they did ten years ago:

“The point is the keys to improving patients’ experience of care are neither obvious nor effortless. Hospitals and other providers have to work at it.”

In conclusion, the journey to elevating patient experiences is neither linear nor devoid of challenge. It demands a relentless pursuit of excellence, a commitment echoed in the words and actions of healthcare advocates across generations. As we continue this collective journey, we bear the responsibility to harness the wisdom of our history to advance the global efforts in patient experience. Ultimately, our achievements in improving patient experiences are not just milestones but stepping stones. They move us toward a global future where patient-centric care, and a commitment to the human experience it influences, is the norm - not the exception.

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