Data rich, meaning poor

Modern healthcare prides itself on precision, standardisation, and efficiency. Yet, paradoxically, both patients and clinicians increasingly experience care as fragmented, impersonal, and exhausting. Nowhere is this tension more visible than in primary care, where continuity of care has become more difficult to sustain in increasingly fragmented systems [1].

In Türkiye, family medicine has undergone rapid and large-scale reform over the past two decades. Access has improved, preventive services have expanded, and key public health indicators have advanced (2). But alongside these successes, a quieter problem has emerged: a growing gap between what is measured and what actually matters to patients. This is not merely a technical issue, it is a problem of meaning (3).

Primary care systems today are increasingly structured around performance indicators, clinical pathways, and digital prompts. These tools are valuable, but they subtly reshape the clinician's role—from someone who interprets a patient's experience to someone who processes clinical data (4).

Having more data about a patient is not the same as understanding their situation.

In everyday practice in Türkiye, this shift is tangible. High patient volumes, short consultations, and checklist-driven encounters mean that clinicians often meet formal requirements of care while missing the patient's lived reality. The result is a paradox: data-rich, but meaning-poor medicine.

Primary care has traditionally been the domain of generalism—the ability to integrate biomedical knowledge with the patient's life context. However, current systems prioritise what can be standardised and measured, while undervaluing what must be interpreted.

A hermeneutic approach offers a necessary corrective. It shifts the focus from "What is the diagnosis?" to "What does this illness mean for this person?" It asks clinicians to engage with narratives, fears, and expectations, not as optional extras, but as central components of care (5).

Consider a common scenario: a patient presents repeatedly with non-specific pain. Investigations are normal, and guidelines suggest reassurance or referral. Yet a more interpretive approach may reveal caregiving burden, financial stress, or unresolved trauma. Without engaging these dimensions, care becomes repetitive, inefficient, and ultimately ineffective.

There is a persistent assumption that meaning-making takes time and reduces efficiency. In reality, the opposite may be true. A slightly longer consultation that uncovers meaning may reduce unnecessary investigations, referrals, and repeat visits. Meaning is not a luxury, it is a form of system efficiency (5).

This has important implications for Türkiye. High utilisation in primary care is often interpreted as a problem of access or patient behaviour. But it may also reflect a failure to address the meaning behind symptoms (5). When care does not resonate with patients' lived realities, they return—not because the system is accessible, but because it is insufficient.

The rapid digitalisation of healthcare further intensifies this tension. Algorithmic decision-making and remote consultations risk weakening the relational space between patient and clinician. Yet it is precisely within this space that care becomes meaningful.

If primary care is reduced to a series of transactions, it may remain efficient, but it will cease to be care.

Türkiye's family medicine system has achieved significant structural success (2). The next phase of reform should not only refine metrics or expand services, but restore the interpretive dimension of care.

This does not require abandoning evidence-based medicine. It requires integrating evidence with interpretation, ensuring that clinical decisions are not only scientifically valid, but meaningful to the person in front of us.

Because ultimately, healthcare is not only about solving problems, it is about making sense of them.

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Author bio:

Dr. Hakan Yaman is a family physician and former academic based in Türkiye. His work focuses on primary care systems, health policy, and medical humanities.