editors' letter

A journal about patient experience

Joan Escarrabill[1,*], Guillem Marca [2], Tino Martí[3]
[1]Hospital Clínic de Barcelona, [2]Universitat de Vic-Universitat Central de Catalunya, [3]CASAP

*escarrabill@clinic.cat

OPEN ACCESS

Citation: Escarrabill J, Marca G, Martí T. (2018) A journal about patient experience. XPA & Health Com. 1

Editor: Joan Escarrabill, Hospital Clínic, Barcelona, España.

Published: 15 Septiembre de 2018

Funding: The authors received no specific funding for this work.

Clinical practice has evolved dramatically over the past two hundred years. Early practice was entwined with authoritarianism. During the 18th and 19th centuries, military hospitals provided a good learning place: in the hierarchical setting, soldiers, renowned for their discipline and not easily embarrassed, made it easy to perform physical examinations. Paternalism gradually entered clinical practice, but it was nurses (Florence Nightingale 1820-1910) who introduced the idea of care (without going against the aim of cure). At the end of the 20th century, interest in patient autonomy was exemplified with the concept of informed consent.

In parallel, evaluation of the quality of clinical care has seen some significant paradigm shifts: the Donabedian model (structure, process, and outcomes) was completed with the idea of effectiveness (Cochrane) and clinical safety.

The clinical paradigm shifts and the move toward evaluating quality of care share a common denominator: they have generally been defined from the professional perspective, without taking into account that of the patient.

If we are certain that the current paradigm of quality is VALUE, we must agree that the magnitude of this value can only be defined from the perspective of the patient. The value of a service can only be defined from the perspective of the user, not from that of the provider.

We are therefore interested in PATIENT EXPERIENCE. We must consider the patient's experience to know if we are doing things properly. We must consider the patient's experience to identify unmet needs and to be able to plan healthcare services alongside patients. We must consider the patient's experience to understand what tools are most useful for receiving their feedback.

Consideration of the patient's experience does not mean replacing those professionals who have clinical and decision-making responsibilities; quite the opposite: it should help those involved in decision-making to make the most suitable choice.

In this process of incorporating patient experience in the evaluation and design of services we must consider some key points:

- We should not make assumptions about patient preferences. Leave any prejudices to one side and do not assume that we know what the patient needs or wants. There is a simple solution to this: rather than assuming anything, ask.
- We should not base current assessments on past beliefs. Stereotypes do not add value to healthcare. Prejudices based on where patients come from, their educational level, or age, besides being unfair, are also completely biased.
- We should not assume that the patient knows nothing. The imbalance of knowledge is one of the paradigms that maintains the status of the medical profession. Particularly in the case of chronic diseases, the patient's knowledge is highly important. Of course, some technical aspects remain the domain of professionals, but patients know the best strategies for dealing with their disease in everyday life (the real world). Ultimately, the patient may not know everything, but they know what they do not like.
- There is a series of skills useful for both participation in the organization of services and for managing the disease. In addition, there are skills that are learnt over time. Patients need not know everything from day one to be able to manage their disease.
- Systematic collection of feedback. It is easy to avoid the opinions that distort one's reality, yet you only need ask. But we should ask with a view to making changes. There is no point in identifying problems if we do not plan to look for solutions

Communication is a key element in the process of generating VALUE. Most questionnaires report that many of the issues relating to healthcare professionals centre around communication problems. Is communication really the problem or is it simply a pretext to hide other problems? Either way, if we want to talk about patient experience, we cannot do so without talking about communication.

LISTEN. This is the first change in attitude that must occur, every day, and with clarity and determination. We must always listen to the patient (and those involved in their care).

XPA & Health communication will focus on this, an area that can be imprecise (satisfaction is subjective), sometimes uncomfortable (opening the door to criticism has its consequences), and always enriching (transforming reality is much more inspiring than simply analysing it).

XPA & Health communication will strive to be a rigorous publication dealing with human experiences that can be difficult to express in other formats.

XPA & Health communication will look from a different angle at problems faced

by patients, carers, and professionals, in an open, transdisciplinary and critical manner.

XPA & Health communication will aim to understand, in order to innovate.

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