Editor's letter

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Dear Colleagues and Friends.

A new year! I will start with gratitude for your support for our readers as well as our reviewers. Your ongoing support is revolutionizing the field of patient experience by bringing in more research and best practices.

Just last week I received an email saying that one of the best practices of another healthcare system was that it moved from being physician-centric to patient-centric. I felt a pang of disappointment in my chest—mainly because this didn't feel revolutionary. We have been talking about patient-centeredness for a very long time. Then a little bit of frustration hit me. Why are we polarizing healthcare to either focus on its employees or its patients? We must advance the dialogue.

The term "patient-centeredness" rose to fame in a 2001 IOM report (1). The report talked about patient-centeredness as an important component for change and this meant aligning patient preferences with their care. Other well-meaning, popular terms like "shared decision-making" and "patient engagement" have also emerged. At the same time, calls for addressing burnout in healthcare have increased and many groups are working hard at improving the burden of the system on clinicians. Both are real, valid, and needed.

The true opportunity, however, exists in striving for relationship-centered care (RCC). Many of you have heard me use this term. Beach and Inui wrote a sentinel paper, which should be a required read for all patient experience professionals; it reviews the four components of RCC, which especially have more relevance today (2).

Rather than review them here, let me give you an example. A 54 year old male with multiple sclerosis with moderate lesion burden in his brain and cord has chronic pain. He has tried many anti-epileptics and medications to ease his pain, but the only thing that works for him is Percocet, which he received from his prior neurologist. He has just recently become my patient and he is requesting multiple refills for Percocet. I am not comfortable prescribing the dose and medication he has requested. But, if I am practicing patient-centeredness, should I give it to him since it's "his preference"? Or if I am feeling doctor-centered, should I have a conversation with him about a more medically appropriate choice and not fulfill the request? What happens to patient satisfaction scores if I set boundaries and limits that run contrary to what the patient wants? There is, of course, no answer. The truth lies in the nuances all clinicians face daily. We try to build a relationship to understand the patient and their needs and perspective, while also maintaining integrity in our practice and set effective boundaries. Both parties are likely to suffer, or already are, and suffering do not discriminate.

So let's stop this binary patient-centered or doctor-centered dialogue and focus on what both sides value; mutually beneficial relationships with one another grounded in trust and compassion. Leaving one party out undermines their value.

As the final piece from Richard Bruce Hovey in this edition highlights, we are "occasionally a patient, always a human." At our best we must be person-centered, and relationship-centered whenever possible.

Adrienne Boissy, MD, MA
Editor-in-Chief

References

1. IOM (Institute of Medicine). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C: National Academy Press; 2001.
2. Beach MC, Inui T. Relationship-centered care. A constructive reframing. Relationship-Centered Care Research Network. J Gen Intern Med. 2006 Jan;21 Suppl 1:S3-8.

ON THE COVER

Bramstedt KA. 2014. *Art is Good Medicine 2014 Exhibit*. Salvataggio Press: AU. ISBN-13: 9780992597702, pages 9-11, e-book, https://itunes.apple.com/au/book/art-is-good-medicine/id911676429?mt=11

Artist is Monica Sahih. The art was created when she was a second year medical student at the Bond University Medical Program in Queensland, Australia. "The different media used in the design of *The Holistic Doctor's Hand* were selected for specific reasons. Wood, a warm but solid supporting material, was used to represent the warmth and support one should receive when obtaining medical care. Built upon this wood, is an overlay of photographic images that illustrate some of the factors a doctor must consider when providing individualized patient care. A sepia tone was selected for all images to factor in an element of time and history. Within the doctors hand there is a foam sphere symbolic of the patient. Paint and ink was used on this sphere to describe the physical, philosophical, and spiritual values of the patient. On both the patient sphere and doctor's palm a heart is painted. Finally, on the doctor's wrist a plaster has been placed [signifying one's own susceptibility as a doctor to ill health, despite a holistic consciousness of the possible ailment at hand.]".

Katrina Bramstedt, Clinical Ethicist and Professor
In 2014, she started a medical humanities program for medical students, which has several components designed to improve the observation skills of future physicians. In addition to a compulsory mixed media art assignment for second-year medical students, there is the voluntary option for students to display their artwork in an exhibition that is open to the university at large, as well as to the local community. Details about the art curriculum are located at this link: http://journalofethics.ama-assn.org/2016/08/imhl1-1608.html Her personal website is www.AskTheEthicist.com