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The first commandment: do not take anything for granted

El primer mandamiento: no hacer suposiciones

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The quality of healthcare has been analyzed from different standpoints over the last 60 years. In Muir Gray's[1] view, a very significant paradigm shift has occurred in the last few years regarding the definition of quality. Although there is undoubtedly a need to evaluate the structure, the process and the result (Donabedian) of effectiveness (Cochrane) and of safety, it seems nowadays clear that a definition of quality cannot ignore the patient's perspective. Porter[2] claims that high-quality healthcare must be seen by the patient as a value-adding service. Considering the value of the service provided involves a radical paradigm shift as value is defined by the recipient rather than by the provider of the service. The patient's experience has now become the third pillar of quality[3]. High-quality care must be safe (a *sine qua non* condition as unsafe care cannot be associated with quality), effective (it must result in some objective benefit) and value-adding from the patient's perspective.

The study by Morillo-Verdugo *et al.*[4] makes perfect sense as it deals with the foundational elements of quality in healthcare, analyzing them from the patient's point of view. In the first place, the authors make it clear that there can be no specialists in complexity. Complex cases can only be successfully approached by multidisciplinary teams. An example of interdisciplinary cooperation is the involvement of pharmacists in the so-called "patient-centered prescription model"[5,6]. Lack of coordination has its consequences as it results in medication errors, particularly in polymedicated patients with multiple morbidities and in cases where changes are made to the prescription[7].

The second noteworthy aspect about the article is its interest in evaluating the patient's experience. Although taking into consideration the patient's viewpoint is of the essence, it is even more crucial to systematically use the patient's feedback to adjust clinical practice[8]. Tools are available to evaluate the patient's experience and, above all, to evaluate the impact of health providers' interventions[9].

The third virtue of the paper by Morillo-Verdugo *et al.*[4] is their spot-on identification of practical problems. A recent article in *The Economist*[10] on the lessons learned from the COVID-19 pandemic highlighted a few very important elements. The first one was self-organization. The pandemic has brought to the fore the need to organize healthcare based on coordination of local resources, self-organization requiring acceptance of a certain degree of variability, which the authors describe. The second teaching is the importance to focus on the patients' needs. The article provides a clear-headed identification of the patients' needs: information, personal treatment, therapeutic education, and collaboration. The third important aspect is the possibility of remote care, also pointed out by the patients in Morillo-Verdugo *et al.*[10]. The last lesson mentioned by the article is the need to move fast.

In the Spanish context, there may be a certain amount of uncertainly as to our ability to respond fast to needs which may not be critically urgent, but which are nevertheless important, such as interventions by multidisciplinary teams. Paradoxical as it may seem, a certain variability in the way multidisciplinary teams do their job could be of use. A one-size-fits-all approach is inefficient because needs are diverse, and resources are not homogeneous. Healthcare responses should always be local. Attention to variations in the healthcare model may be helpful along the learning process and lead to the adoption of new solutions. Two considerations about variability are in order here: although the healthcare model must be variable, variability should not be "intense" (whether there is a pharmacist on the team or not) and the variability of results should be minimized.

Two important challenges emerge from the article. The first one has to do with the idea of humanization. The advantages of the "industrialized" medical model (based on metrics and incentives) have been called into question for many years and a profound reflection is taking place at the present time on the impact of digitization[11]. The interest in humanizing the care provided to patients is part of this movement. Use of the term humanization makes me ask myself two questions. The first one if whether the expression "humanizing care" has a shared meaning. I personally do not think it does. In my view, "humanization" should be defined by very specific traits, such as *proximity,* as suggested by Pere Casaldàliga (1928-2020), *kindness, conversation* and *respect of plurality,* which are key to integrate diverse worlds in a common space. These could be some of the elements allowing a shared understanding of the term "humanization". The second aspect is highly subjective. When speaking about "humanizing" care we could be giving the impression that we, as healthcare providers, are the ones that improve the care provided to patients. However, "humanization" should "impregnate" the whole ecosystem and, as such, it should also result in an improvement of the treatment given by organizations to professionals. Improving the patients' experience is not possible if the professionals' experience is not improved too. Against this background, the results of the survey carried out by the Morillo-Verdugo *et al.* points to a few aspects that need improving, such as the treatment given to patients and the need to clarify the professional role of hospital pharmacists and to enhance their communication skills.

Finally, it is essential to determine the point of view from which the patients' experience should be evaluated to permit a correct identification of all the players that should be involved. Patient associations are a very important source of knowledge. If the analysis is carried out from the point of view of health policies, associations may constitute valuable interlocutors. Nevertheless, the degree of participation of patient associations in Spain is too low to actually make meaningful a change in specific services. A recent study estimated that less than 5% of patients are members of an association[12]. Improving a service also requires listening to all its users (regardless of whether they are members of an association or not) as well as patient associations. Given the difficulties inherent in identifying patient "representatives", it is essential to define archetypes (groups of patients with common needs) and guarantee a high level of diversity (different phases of the same disease) and plurality (listening to people with different values). It is essential to avoid stigmatization, promote inclusion, and see things from a gender perspective from the outset. Listening to the patient's voice also means taking into consideration the point of view of caregivers. Listening to patients often requires using a wide range of strategies (focus groups combined with surveys, for example). This approach was used by the Hospital Clínic in Barcelona to improve their program aimed at educating insulin pump users[13]. The final result was an improvement of the educational program and the creation of a follow-up committee with the participation of patients.

In a nutshell, the patients' perspective can be approached in different ways, but the first commandment should be to never to take anything for granted. When in doubt, asking questions is usually a good alternative, as exemplified by the work by Morillo-Verdugo *et al.*[4].

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