Patient-Centered Care. Humanization of Coronary Care Units

Atención centrada en el paciente. Humanización en unidades coronarias

We are gradually immersed in a more effective, individualized, technological medicine, with an incredibly fast growth of knowledge and advances.

How to establish the doctor-patient relationship has been modifying in such a way that changes have been unnoticed, and if we now observe from a distance, we can describe a form of care that is quite different from how we learned it or how we believe it should be.

Because things were not always better in the old days. From a current, contemporary perspective, we have had patronizing and even authoritarian attitudes, suffered by our patients. However, it was the usual practice at that time, and it is difficult to judge the same attitudes in moments which are so far apart.

In the doctor-patient relationship, it is possible to get positive and negative results. Our gestures, words and attitudes can help promote healing, improve anxiety, and relieve pain and distress, but at the same time, we can create more fear, fantasies, and finally adverse outcomes.

Yet, this relationship is uneven since, on the one hand, we are doing something for which we have studied and been trained, and we do it in a local environment (our office or the hospital), and under favorable conditions for doctors. However, all is new for the patient, who does not know what to say or ask and what the context is, resulting in an asymmetric relationship of knowledge based mostly on trusting someone he may not even know, and sharing intimacy or perceptions that had never been verbalized before.

We do not refer only to the patient, since, in general –and luckily mostly– he is supported by his affective bonds: family, partner, children, parents, or siblings. Thus, the patient's perspective is associated both to himself and his family, who to a different extent but coincidentally, value healing and suffer from poor medical care.

Let's think about patient care in a Coronary Care Unit (CCU), where I have been working for many years.

From the patient's perspective, he is definitively in an unfamiliar situation (regardless of why he is in the CCU). The first thing that happens on admission is to be welcomed by doctors and nursing staff. Is it common for us to introduce ourselves with our first and last name? In general, the patient is told common phrases, is asked for patience, and is assured everything will be fine. Secondly (and I wonder why in all the cases), the patient is naked, without his underwear. There is no room for shyness and inhibitions. And worst of all, the patient, despite feeling uncomfortable, accepts it as normal and necessary.

How many times do we sit at the patient's eye level? How many times during hospitalization do we touch the patient (and move away from the accurate, scientific information of blood tests, x-rays, ultrasounds, etc.)? How many times during hospital stay is the patient called by his first name?

Are we in a position to say that we respect patient's rights and dignity?

Is the patient aware of his rights as such? Do we give the patient the chance to recognize and assert them?

From his perspective, the patient feels he is in a strange place. He may believe that asking for help would be disrupting the work of others. He understands that lights on and the noise level on nighttime shifts is logical and normal because he is in the CCU. He understands that the food he should eat is settled, and he does not feel entitled to ask for something different.

What can we say about effective communication? The way we relate with the patient and his family is irregular, both verbally and gesturally. Our words often seem technical, difficult; our silences or gestures, solemn; and sometimes there is poor participation in decision-making and treatments.

How many patients know the name of their nurse and their treating physician? How many times a week has the patient been called by his name during hospital stay? Does the patient emotionally feel our active listening, our empathy, our understanding?

We should all foster a paradigmatic change in medical care. We should think more and put ourselves in the place of the patient and his family, and thus feel what they feel. They are simple, natural actions, which have been lost over time. These actions can be applied in almost all health care facilities. Our attitude will be contagious and imitated by our peers.

PROPOSALS

Open doors: Families can visit their relative at any time of the day and stay with him in an organized manner. This contributes to the emotional support of the patient and his family. We should not feel we are being watched if we work accordingly. They can

contribute to the patient care if we involve and guide them on how to do it.

This resolution would also help us in consultation requests. How many times have we gone to a closed CCU and rung the bell for the door to be opened, waiting for an irritating length of time?

Effective communication: listen to the patient, contact him emphatically, with compassion. Sit at the patient's eye level, make eye contact. Touch him, let him feel we are there. Introduce ourselves with our first and last name. Tell him what our role is. Explain and share with him what we are planning for his daily care in the coming days. Ideally, doctors and nurses should convey the idea of a health care team. Give the patient the chance to ask. Guide him about what questions he could ask. Respect his right 'to know' or 'not to know'.

Patient welfare: we must respect the dignity of others. There is no need to be naked. Ensure night rest with silence and lower light intensity. Do not wake the patient to wash him or take blood samples at dawn. Implement effective pain management establishing the parameters and the approaches on how to relieve it.

Respect patient's personal and religious habits. Be attentive to solve any problem that might arise.

These are absolutely simple and achievable actions for both doctors and nursing staff.

We could ask ourselves why we are worried about the 'humanization of coronary care units'. And precisely, we would find the answer when be observe how our patients are, how we take care of them, and how they and their families value us, and we would arrive to the conclusion that we have moved away from the ideal. We are not discussing specific medical care, although this also means healing.

On occasions, patients send moving thank-you letters to the health care teams because they have cured or improved their condition. Pride is even greater when those letters express the patients' gratitude for having been treated with respect and dignity.

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