The Journal of Health Design

FROM THE EDITOR

From the Editor: Treat people, not patients

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The Journal of Health Design, Melbourne, VIC, Australia

To Cite: Jiwa M. From the Editor: Treat people, not patients. JHD. 2020;5(2):259–261.

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SUMMARY

Dr Michael Fratkin, an American palliative care physician and Health Design podcast guest, remarked that he has no “patients”, only “people”. His approach echoes an important point—namely, the context in which the person’s problem arises always matters. Some doctors don’t take time to explore context during their consultations—but they should because every “patient” is a person with a story.

Key Words
Health design, art of doctoring, patient consultation, doctor-patient relationship, patient advocacy

INTRODUCTION

So much of what matters in health care occurs before the patient even enters their doctor’s consulting room. What always counts is the context in which their problem arises. As doctors we know so little about that. Sadly, it becomes apparent after a few minutes in the consultation that some doctors don’t make the effort to explore this aspect in the patient’s history. This was brought home to me recently when I developed a very painful, immobile shoulder overnight. Only I know that I sleep in the “prone stomach sleep pillow snug position”:

> *This is the most dangerous sleeping position because the lateral deltoid of the shoulder capsule is under its greatest load with the shoulder in flexion and external rotation, particularly when the body is in sleep mode. This may also lead to a weakened overstretched groin as it remains in external rotation comparatively to the straightened leg throughout the night.*[1]

As a family doctor I have diagnosed capsular tendinitis, the resulting injury, countless times in my career. Yet I can’t ever remember, even once, asking any patient about their preferred sleeping position. As always, context is everything. Knowing this fact, my doctor could have advised me that the problem might recur and helped me prevent a recurrence.

Similarly, much of what impacts on the outcome for patients is easily remedied. The Health Design podcast guest Amy Ma[2] pointed out that breastfeeding women who accompany their baby into a hospital in her part of Canada are not entitled to a hospital meal while they nurse their baby. By contrast, a hospitalised baby who is bottle fed is provided with infant formula feed. That makes no sense. How can a hungry mother intent on doing her best for her child feed her baby, and who decided on such a policy? Thankfully, patient advocates like Amy are calling this out for the nonsense it is, along with the many other bureaucratic glitches that undermine the positive impact of health care on people’s lives even when the technical aspects of that care are rated the best.

Michael Fratkin's[3] responses to my questions in our recent conversation were pure poetry. Dr Fratkin, a palliative care physician, says he has no "patients" only "people". Perhaps my favourite portion of our exchange was his explanation of how he achieves the best results for the people who seek his help. He said he stops trying to project an image of himself. He actively remains curious about what matters to that person. The art of doctoring mandates that as doctors we start with ourselves and our own hang-ups that might get in the way of our ability to be of value to the people who seek our help. There is no policy or directive required for doctors to start there in order to improve outcomes for patients. Better health by design requires attention to the "actors" in the art of doctoring and that includes the doctors as well as the person on the other side of that encounter.

Lillian Leigh[4] and Dana Deighton[5] were both diagnosed with cancers that famously have a dismal prognosis. That they are alive and well and able to tell us their story would be a miracle except that they are both remarkable, resilient, and resourceful people who were destined to discover that science already has the capacity to offer a better prognosis. For me it heralds the dawn of a new age where people with specific problems will be able to navigate their own journey through innovations. This may be the way that medical science will finally find its way from bench-top to bedside. What is acknowledged is that the treatment that is offered as standard care may already be out of date in the context of new discoveries.[6] We will continue our conversations with people whose lived experience tells us so much about how medicine is evolving when we are now so well connected on line.

We're pleased to bring you our second issue of 2020. We present "The value and challenges of continuity of care," a clinical insight in which the author shares personal experience about how, when continuity of care (CoC) principles are not followed, the results can be traumatic for patients and families. Her brother—for whom continuity of care collapsed and left her brother in a worse position medically, emotionally, and mentally—has highlighted for her that the theory of CofC does not always match practice in large public hospitals.

"'Not another leaflet please': Improving the delivery of physical activity information and interventions for people with breast cancer" is an article about an experience-based co-design (EBCD) project at a UK cancer centre that aimed to improve the guidance and delivery of physical activity (PA) for people with breast cancer. The EBCD project identified areas of unmet need for staff and patients and enabled the cancer centre to prioritise four areas for service improvements—messaging about PA from healthcare professionals, timing of messaging, individualizing information, and peer discussion.

"Bridging the Australian medical-dental divide" is a systematic review, which found that many primary care doctors in Australia had low levels of knowledge, education and training, and confidence in managing a variety of dental and oral complaints. Many Australian GPs have only minimal formal dental education and training, yet they feel obliged to provide assistance to patients with these presentations, especially in emergency situations. The solution to providing equitable and accessible dental care in Australia, the authors argue, is not straightforward and will require multiple approaches, including further formal dental training for primary care doctors. The optimal solution, the authors conclude, is “Denticare”, a government subsidised dental plan for Australians.

In “Monitoring and alleviating the effects of pressure-related injuries for spinal surgery—a need for improvement?”, the authors discuss the critical problem of pressure injuries (PIs), a common surgical complication. Currently, monitoring and alleviating PIs is not possible during lengthy spinal and orthopaedic surgeries, especially if a patient requires x-rays. The authors identified critical design requirements and an appropriate product design specification for a new device to help monitor and alleviate PIs in a surgical setting.

At *The Journal of Health Design*, we believe small changes can have a big impact—changes need not be expensive or time consuming to be effective. We also believe in “better health by design.” We’re committed to publishing, sharing, and promoting what healthcare practitioners, patients, designers, architects, and other innovators are doing to improve the delivery of health care despite constraints. The Health Design Podcast continues to feature thought leaders, practitioners, and recipients of health care doing exciting things and who have inspiring stories to tell.

Contact us at editor@journalofhealthdesign.com to recommend a podcast guest or to share information about someone doing great work to improve the patient experience and health outcomes. Remain engaged, keep reading, and let us know how we’re doing. Follow us on Twitter @JHDinfo.

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