Editorial

When Patient-Centered Care *Isn't*

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In medicine today, there's a new kid on the block—"patient-centered care."[1] That phrase captures attention, conveys righteousness, and connotes individualized care. On closer examination, however, all is not as advertised.

A Paradox

Hidden within the patient-centered rhetoric is a paradox.[2] Despite being bombarded with surveys, post-encounter telephone calls,[3] and requests to speak up about their medical care,[4,5] patients find that their complaints often are ignored and rarely lead to improvements. Two shortcomings underlie this paradox:

1) Current approaches to health care put the burden on patients to voice their concerns. But patients usually don't complain, even when they believe that things have gone seriously wrong.[3-5] Many remain quiet, convinced that their opinions do not matter or that mere mention of a problem will provoke retaliation and poor care.[2,4,5] To minimize or eliminate these barriers to communication, healthcare systems and providers must take primary responsibility by building an environment in which patients and family members feel safe in expressing their concerns and are confident in the knowledge that their opinions will be welcomed and will improve their care.

2) When patients do raise issues, most healthcare institutions are not prepared to respond satisfactorily, in real time. This deficiency reinforces patients' belief that speaking up is not worth the effort or the risk. Ideally, the institutional response should be immediate and should include steps to correct the faults and to prevent recurrences.[2,5]

A Patient Speaks Up

Having recently undergone surgery for spinal stenosis, I wish to add that experience to this discussion. My operation was a success, but my postoperative care did not serve me well. As part of the routine of checking vital signs, a patient-care assistant awakened me from a restful sleep at midnight and at 4 AM. In fact, I was bothered every 4 hours around the clock for the same purpose, whether I was sleeping, eating, watching television, reading, or visiting with family or friends. As a result, I soon became angry and unforgiving and refused to have my "vitals" checked during the night. To keep peace in the family, however, I cooperated during the day.

From my standpoint, the situation was ironic. What I got, I didn't need. And what I needed, I didn't get. To be specific, the "vitals" routine in my case was more of a harassment than a necessity. Furthermore, when I urgently needed a urinal or someone to help me get into or out of bed, I often had to wait 15 to 20 minutes (and sometimes longer), despite pressing the call button repeatedly and speaking with up to 3 different individuals over the intercom.

Although these concerns are minor in the grand scheme of things, they become monumental when one considers that most hospitalized patients in the civilized world experience the same or similar difficulties.

Protocol-Driven Care

Contrary to what many healthcare professionals believe, vitals and vital signs have different meanings, and those terms should never be used interchangeably.[6] Vitals refer to vital organs such as the heart, lungs, liver, and brain. Vital signs refer to the

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signs of life: pulse rate, respiratory rate, blood pressure, and body temperature. For the past 2 decades, oxygen saturation has been the fifth vital sign.[7]

Think about it. Hospitalized patients who have no life-threatening illness, who are not in special-care units, and who are afebrile and hemodynamically stable, do not need their vital signs checked more than once a day. Yet, even if the doctor were to order *no* recordings of vital signs, the nursing staff would still measure them at least 3 times daily.[6] Nursing manuals and policies invariably require such action, regardless of the patient's condition. Any attempt to interrupt this herd mentality[8] meets with firm resistance from nursing supervisors, hospital administrators, and members of the medical staffs. There is nothing patient-centered about this mindless monitoring. It does, however, typify protocol-driven care.

Looking Back

In fairness, the persons charged with my postoperative care were courteous, friendly, and (for the most part) respectful. They were simply understaffed—at least in terms of being able at all times to respond promptly to each patient's personal needs. This type of understaffing is a prominent issue in many hospitals these days. In addition, many patient services are shut down on weekends. Such cost-effective measures benefit the hospital but adversely affect the patient. More important, this widespread cost-cutting disregards the Oslerian principle of putting the patient's welfare first, *always*.

Parting Thoughts

Before the advent of modern technology, healthcare delivery was always patient-centered and generally successful to boot. But soon thereafter, a litany of developments handcuffed medical practice: federally mandated regulations, insurance company constraints, health maintenance organizations that force physicians to process patients in assembly-line fashion, lawsuits that lurk around every corner, and reams of requisite paperwork. And as if these deterrents were not enough, the recent endemic use of electronic medical record-keeping compels many physicians to focus more attention on a computer screen than on the patient, during the limited time that they spend together.

Consequent to these various intrusions, we have become a profession in retreat, plagued by bureaucracy, by loss of autonomy, by diminishing prestige, and by deep personal dissatisfaction. I believe, therefore, that "patient-centered care" not only attempts to cope with today's medical problems, but also hopes to recapture the glory days of yesteryear. To achieve those goals, the new kid on the block must repair the chinks in the armor, else the neighbors won't extend their welcome.

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