

# Wellness for all

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TriRegional Dialysis Symposium

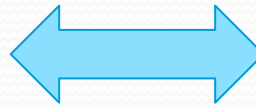
# Ideal patient is unconscious



# Where is The Patient?



# Dynamics of Illness Process



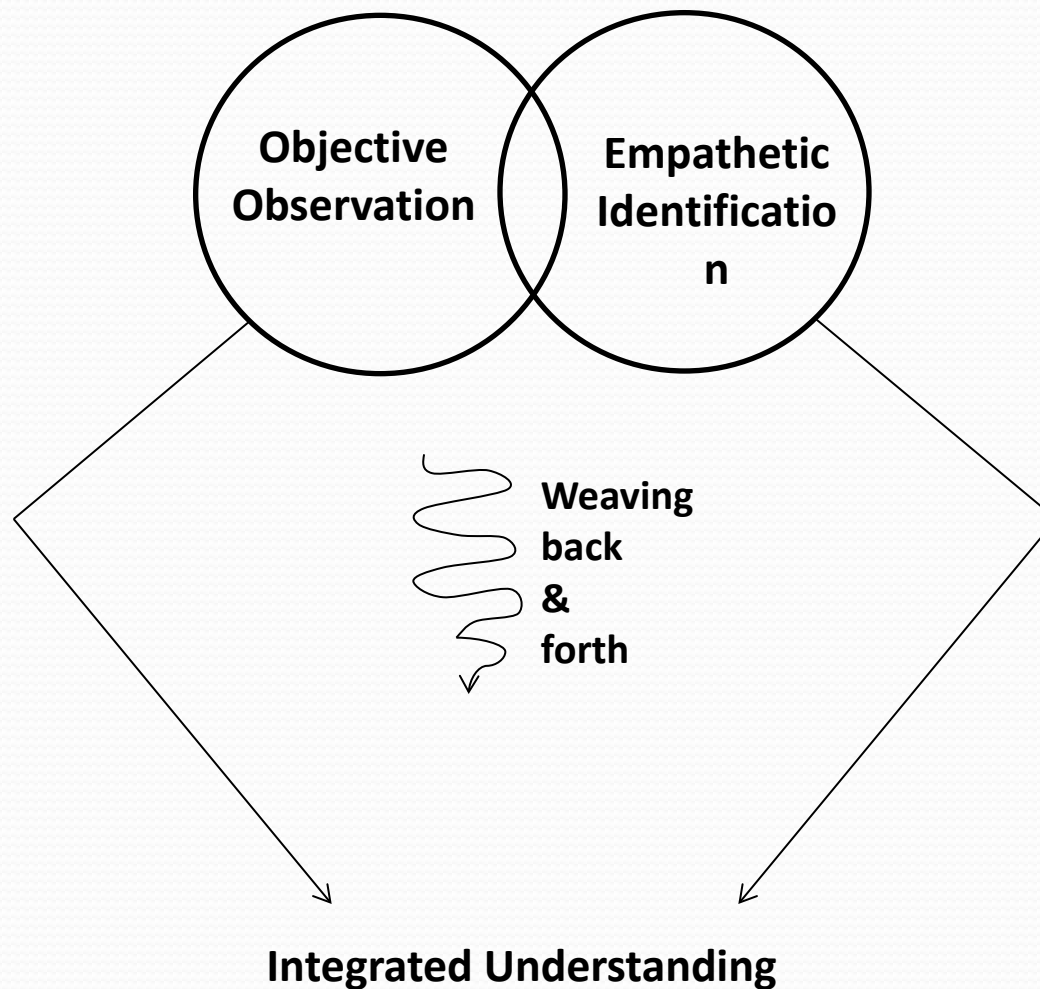
# The Social Context of Illness



*“Families struggle with chronic illness, not individuals”*



# Connecting with Patients





# What is Patient-Centeredness?

*“Nothing about me without me.”*

Valerie Billingham, *Through the Patient's Eyes*, Salzburg Seminar Session, 1998  
J Charlton, *Disability Oppression and Empowerment* 2000



# Patient Satisfaction Surveys

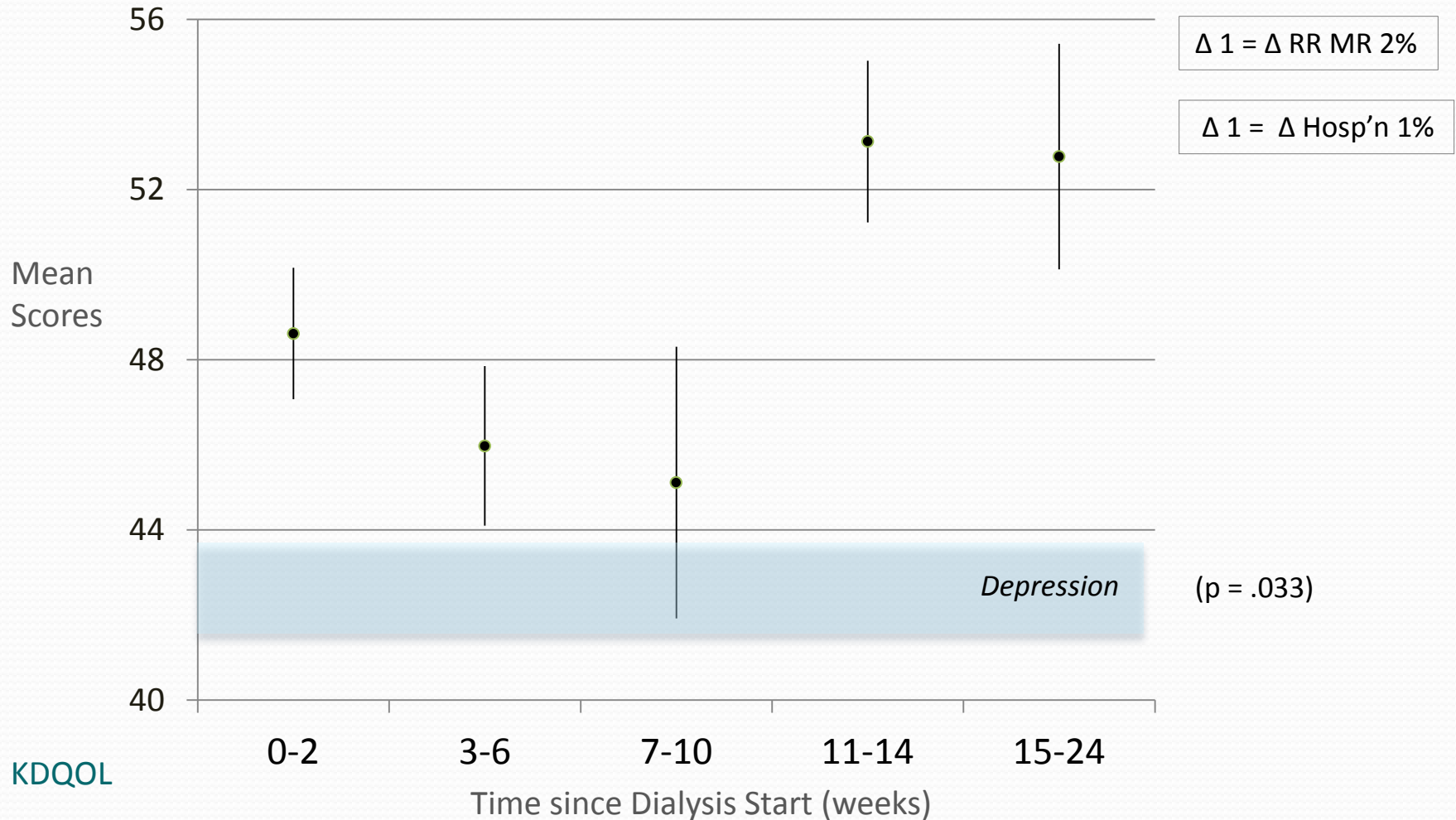
1. “To what extent care provided has met patient’s expectations and preferences”
2. Dimensions:
  - Respect for patients
  - Coordination of care
  - Information, communication, education re: illness
  - Involvement of family, friends
  - Emotional support (relieves fears, anxieties)
    - Most important factor influencing patient experience

# Perception of Received Emotional Support

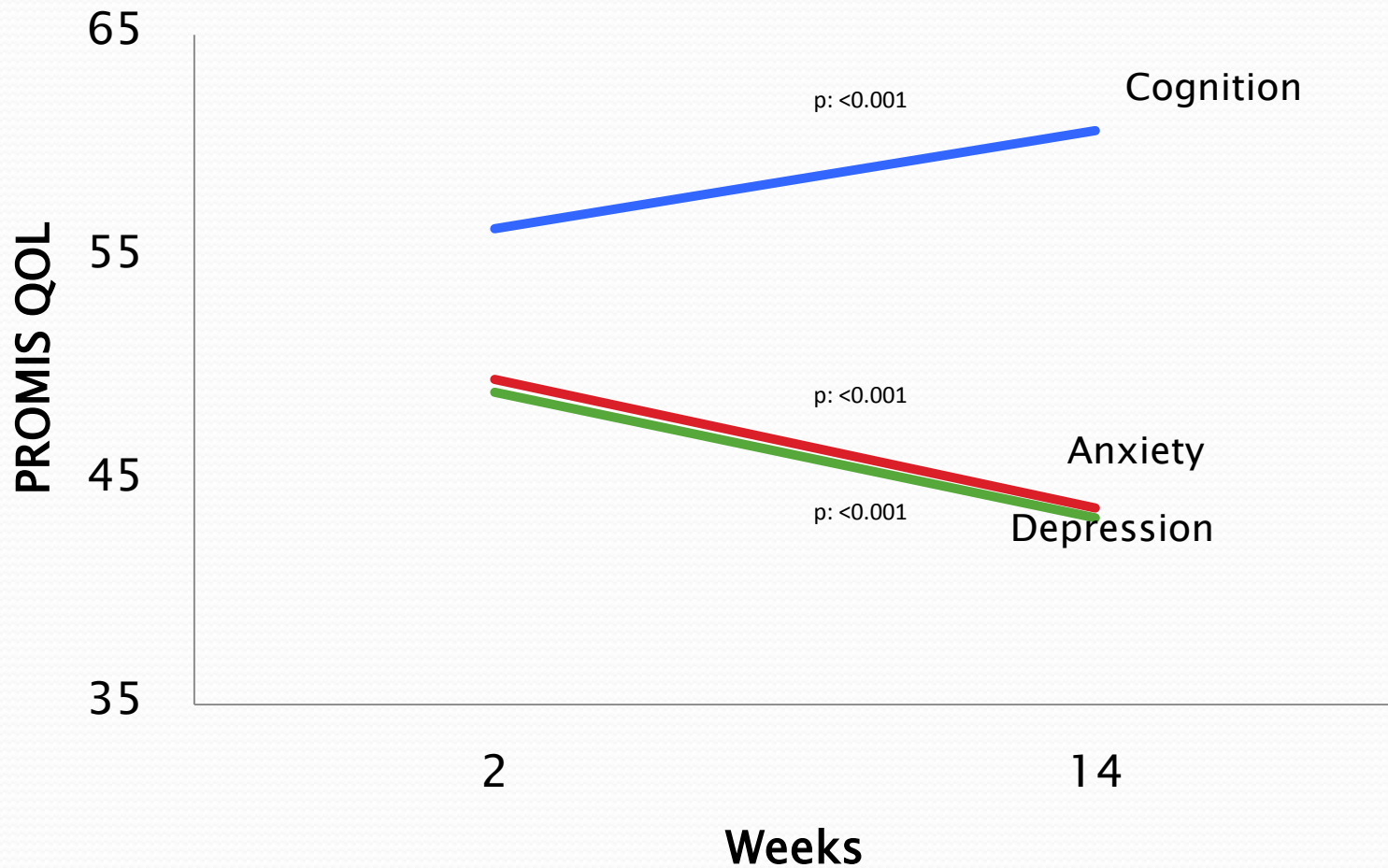
1. Empathy: *how* vs. *what* care delivered
2. Informative communication: *conversation*
3. *Being present* and available: time, being thought of
4. Inspiration and *hope*: “we see it all the time”
5. *Personalization*: unique needs met, 2 human beings
6. *Supportive gestures*: physical contact, eye contact, smile, sitting, humour
7. *Ambient environment*: mood generated by people in a certain area e.g. dialysis

Qualitative evaluation: 25 hospitalized patients, ON community hospital

# Perception of Mental Health



# Shift in Barriers to Learning



A photograph of a hospital hallway. On the left wall, there are three lines of blue text: "← Dialysis Transition Care", "Outpatient", and "Physical Therapy". A blue arrow is positioned to the right of "Physical Therapy", pointing left. The hallway has a light-colored floor, a handrail, and a paper towel dispenser on the right wall.

← Dialysis Transition Care

Outpatient

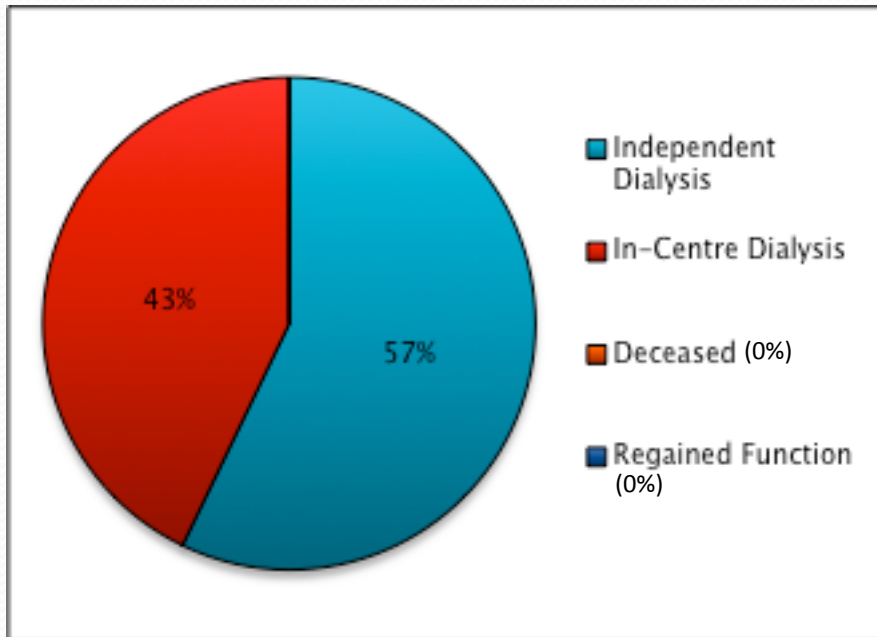
Physical Therapy



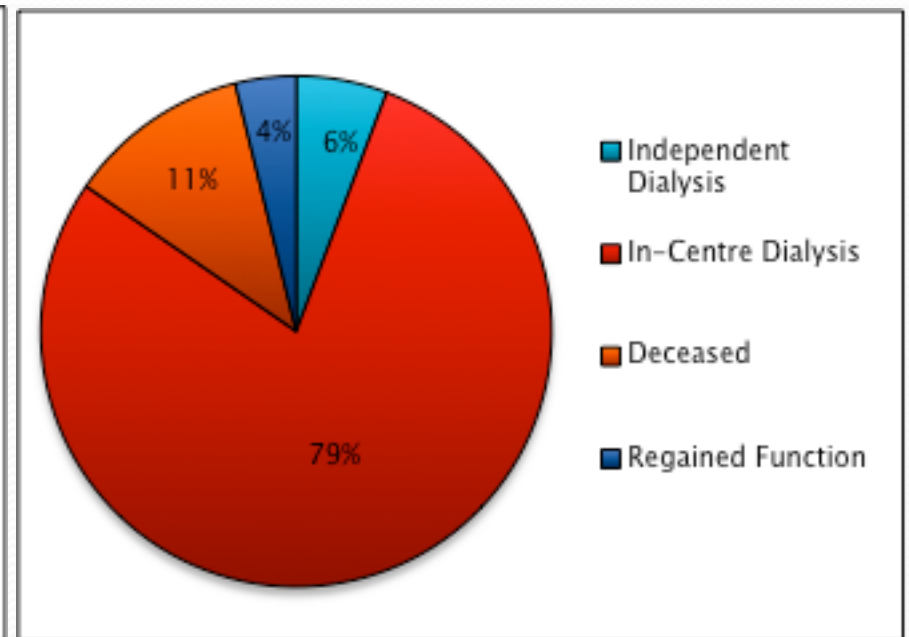
# Unplanned Starts

## Dialysis Modality within 6 Months

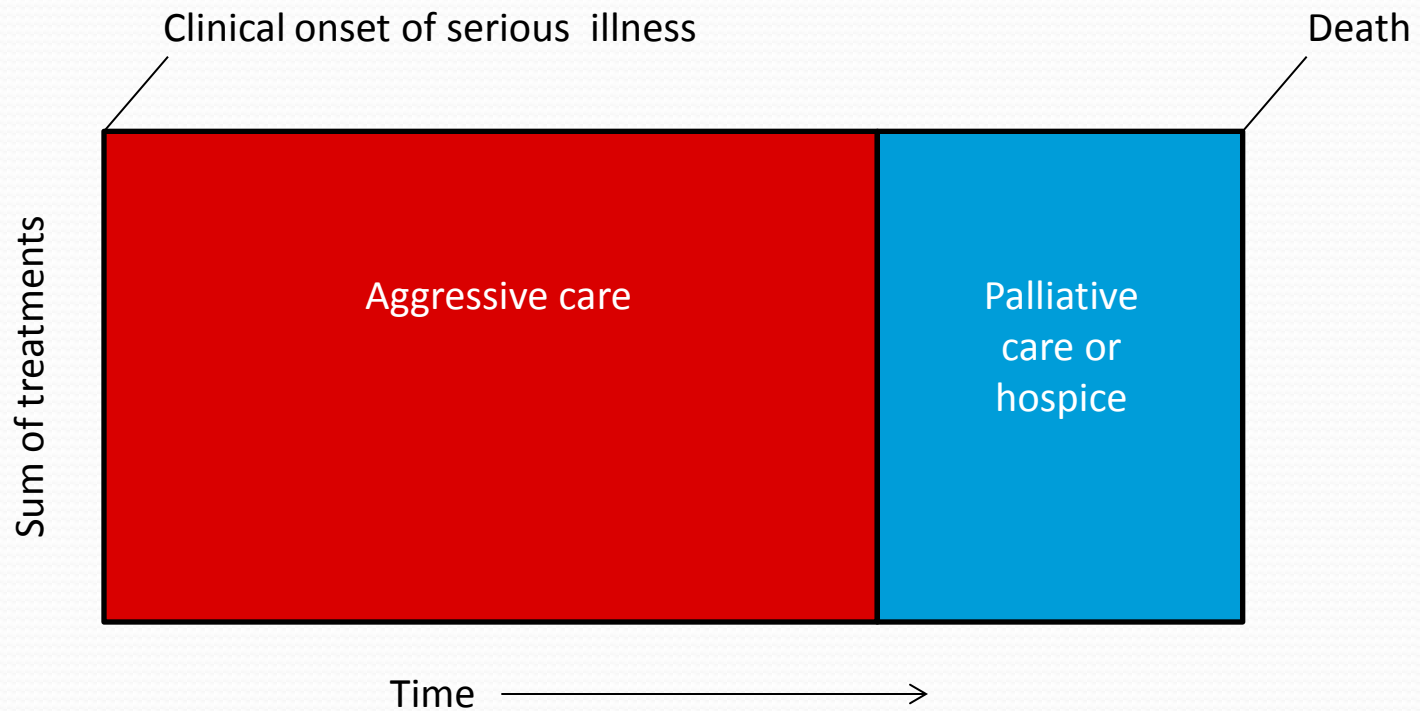
With Transitional Care Unit



Without Transitional Care Unit

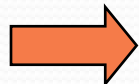
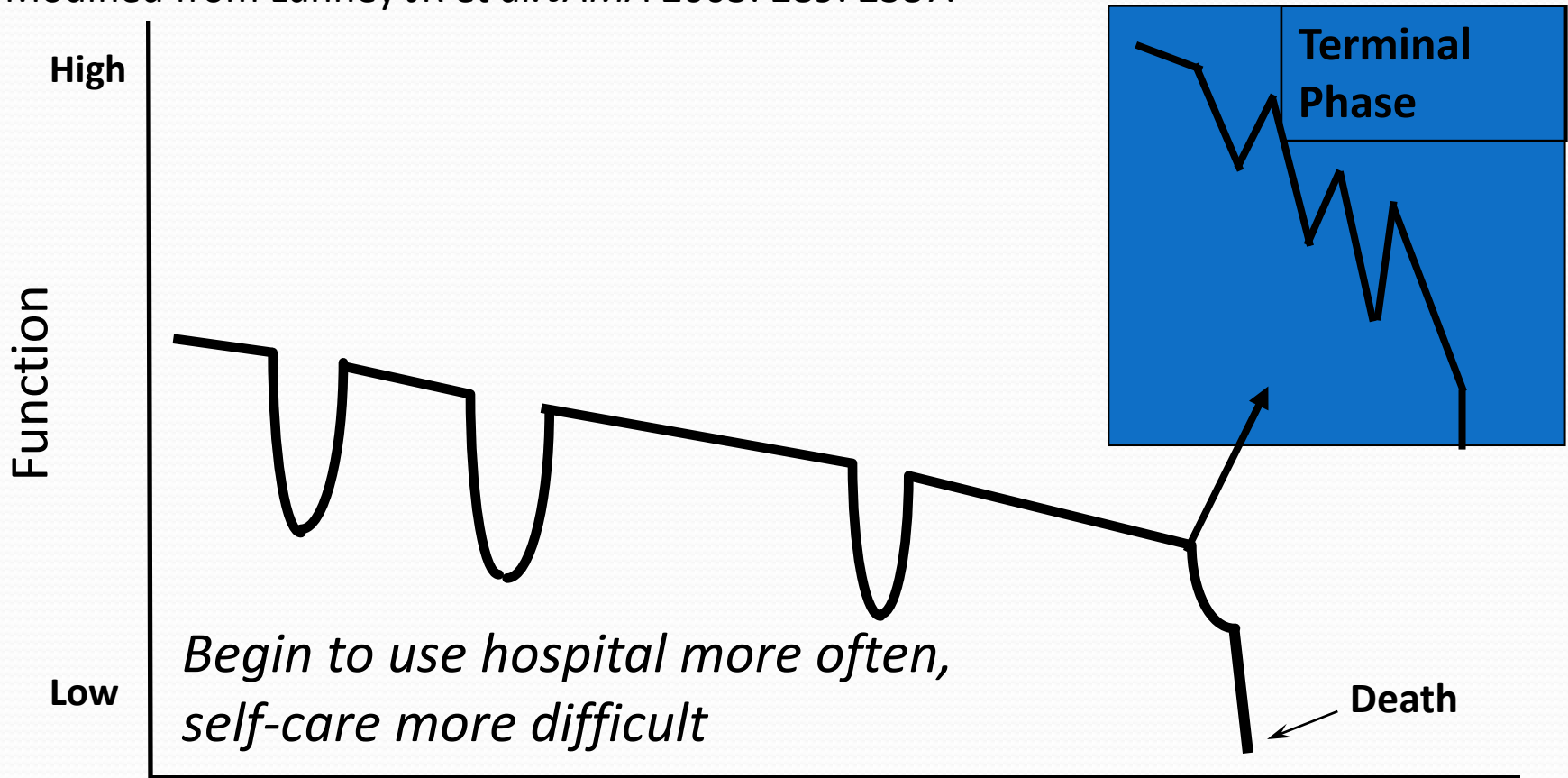


# Care Near the End of Life: Conventional Model



# End Stage Organ Failure: Approaching End of Life

Modified from Lunney JR et al. *JAMA* 2003; 289: 2387.

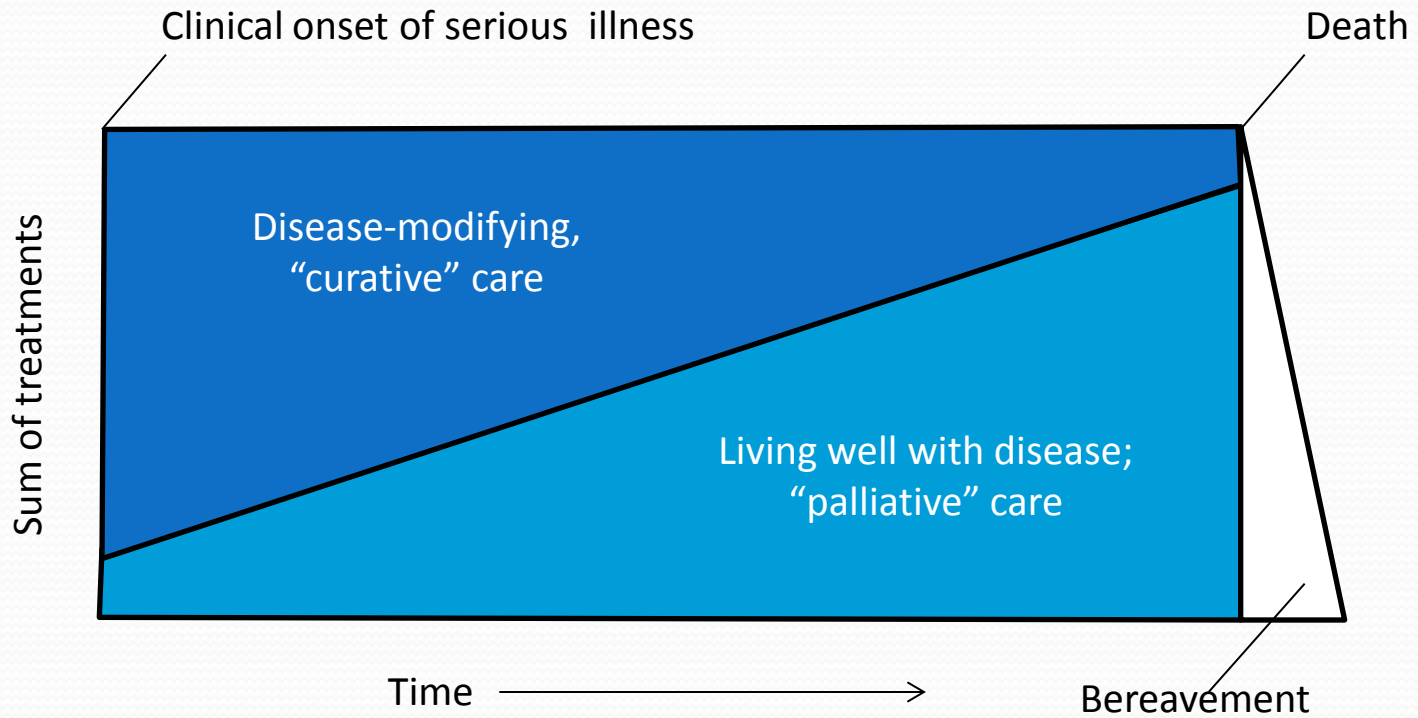


Time ~ 2-5 years.

*Death usually seems "sudden"*



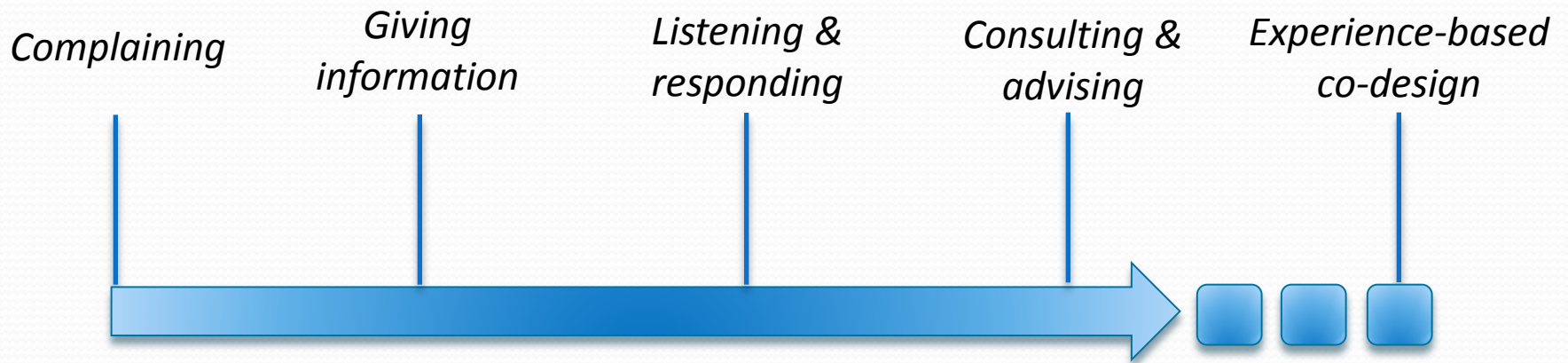
# Care Near the End of Life: Improved Model



# Patient-Centered Care

- Recognizes uniqueness of each patient: body, mind, spirit and community all considered
- Care customized according to pt needs and values
- Sets goal: living with illness, rather than curing
- Promotes self-management
- Needs are anticipated (less reactive)
- Promotes caring for healers
- Promotes research methods that evaluate care models
- *NOT: enhanced patient experience, infrastructure changes*

# The Continuum of Patient Influence



Bate & Robert. *Quality and Safety in Health Care*. (2006)

# Caregiver Response

- Staff may experience stress, regression and conflict
- *Acute* illness – enhances caregiver confidence
- *Chronic* illness – not curable: arouses sense of helplessness, loss of self confidence, “burn out”
- Issues/reactions reproduced in staff

# Burnout

*“A syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do people work”*

Maslach, 1982

“Burnout: The cost of caring”

# Burnout definition

## 1. *Emotional Exhaustion*

- Depletion of resources
- Lack adaptive resources
- Main contributor: job stress

## 2. *Depersonalization*

- Cynicism
- Disengagement
- Detached from job
- Callous, uncaring

## 3. *Reduced Personal Accomplishment*

- Diminished perception of work ability

# Dialysis nursing burnout

1. Workload: cannot complete tasks
2. Inadequate support:
  - Lack of management support
  - No professional development
  - Ineffective communication
3. Patient care:
  - Violence
  - MD interactions
  - Blood borne infection
  - Interactions with patients

# Reducing job stress

1. Participation in practice decisions
2. Encouraging autonomous practice
3. Stable leadership: viable, accessible, responsive
4. Psychological support:
  - Support networks
  - Team building
  - Open lines of communication
  - Staff reward
  - Routine (not reactionary) debriefing



# Caveats

- Patients feel vulnerable majority of time
- “Bizarre” behavior usually without explanation; mainly due to internal ebb and flow, a reflection of vulnerability
- Making connection paramount
- Try listening “without purpose”
- Keep it open ended, respect “patient’s schedule”
- Foster psychosocial culture in renal “village” (patients, staff, family, machines)