

VIEWPOINT

Reducing the Trauma of Hospitalization

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US health policy analysts and payers are currently focused on the high rate of hospital readmission for patients who have been recently discharged. This issue is a particular concern for people older than 65 years and thus has become a focus of Medicare, which has implemented incentives to reduce 30-day readmission rates. Hospitals that fail to meet targets will be financially penalized.¹ Acting on common sense, rather than evidence and a firm understanding of the causes of readmission, many suggest that rates could be reduced if hospitals only increased efforts to improve transitional care. Work began with greater attention to the cause of hospitalization and also on improved communication at the time of discharge and shortly thereafter.

Although these actions are sensible, data have suggested that the issue is more complicated. Only a minority of patients treated for common conditions such as heart failure, chronic obstructive pulmonary disease, and pneumonia are readmitted for precisely the same problem.² It seems that patients who leave the hospital have their physiological balance disrupted and are subsequently susceptible to a broad range of acute medical problems.

The depersonalizing and stressful hospital atmosphere that exposes patients to incessant loud noises, a lack of privacy, awakenings in the middle of the night, and examinations by strangers who fail to identify themselves may be an important contributing cause of transient vulnerability that has been characterized as "post-hospital syndrome."³ It may be meaningful that this term is similar to posttraumatic stress disorder, implying that the solution starts with ways to reduce the trauma of the hospitalization. What would it take for hospitals to become truly healing environments? Are some principles so clear that action should be taken now rather than after years of study? This Viewpoint offers suggestions for consideration.

Trauma-Reducing Innovations in Hospital Care

Promote Personalization

Hospitals and health care personnel should use techniques to ensure that patients are respected, such as helping each patient feel like an individual. When possible, processes should be eased; or applying lessons from pediatric hospitals with regard to allowing increased flexibility, providing comforts to accommodate family members, and having a cheerful decor. The patient perspective deserves attention; for example, consultants should make appointments so patients can plan around the meeting, perhaps facilitating attendance of family members. Also, patients should be encouraged to wear personal items of clothing. They do not need to be in positions where they can be readily exposed to examiners throughout the day. This would help

patients maintain their self-esteem and orientation and would also remind their care professionals to recognize them as people.

Ensure That Patients Receive Enough Rest and Nourishment

Hospitals should prioritize ensuring that patients have an environment conducive to sleep, with efforts to maintain their circadian rhythm and reduce needless nighttime disruptions and pervasive sounds of monitor alarms. They should also pay close attention to nutrition and prioritize creating opportunities to provide nutritionally appropriate, appetizing food served at the intended temperature. The imposition of a draconian, unsavory diet (like one without salt) should be avoided when nutrition is so important for a catabolic patient. Sleep deprivation and poor nutrition should be considered toxic to the patient—a harmful exposure to be avoided.

Reduce Stress, Disruptions, and Surprises

Stress is also toxic and can emanate from uncertainty, unforeseen events, and anxiety. Patients should be given a schedule for the day. There should be tools to help them understand the roles of their health care professionals. Patients should know the name of and be able to recognize their physician of record (known in some hospitals as the most responsible physician). Clinicians and other care professionals should announce themselves before entering the patient's room and wear easy-to-read name badges with a description of their roles. Every person who enters the room should sign a logbook so patients and their families know exactly who has visited. Electronic systems can be created so names are recorded automatically (such as using chip technology in identification badges) when a member of the hospital staff enters and leaves the room. Doors to patient rooms should be closed to reduce noise and give privacy. Patients should not share rooms or bathroom facilities with other patients to prevent strangers from overhearing personal information and avoid transmission of infections.⁴ The challenge of providing privacy requires improved mechanisms of detecting when patients need assistance. The simple call-button technology can certainly be improved in the 21st century and accountability for response times can be part of every institution.

Eliminate Unnecessary Tests and Procedures

Blood draws should not be considered innocuous. There is no need to routinely order blood work daily for all hospitalized patients. Electronic health systems have developed order sets that frequently encourage excessive phlebotomy and these must be adjusted to permit easy cancellation of unnecessary tests. Even tests that

seem innocuous like routine urine cultures in asymptomatic patients can cause problems if positive results lead to prescribing antibiotics inappropriately.

Decrease Random Medication Alterations

The practice of on-call physicians making rushed judgments to alter or add medications in response to transient problems, such as elevated blood pressure or heart rate, should be modified. The physiological stress of starting new medications in this fashion exposes patients to undesirable drug interactions and adverse effects.

Encourage Activity

Deconditioning should also be considered toxic. Attention to physical activity and physical therapy for all conditions should begin as soon as possible, a practice that has become routine following orthopedic procedures such as knee and hip replacements. Even a few days of bed rest for older individuals can threaten their independence.⁵ All patients who are physically able should be encouraged to leave their rooms and eat in groups with other patients or visitors. In addition, social programs and activities should be provided.

Provide a Postdischarge Safety Net

Follow-up appointments should be made prior to patients leaving the hospital, with clear communication of who will see them, when and where the follow-up visit will happen, and the name of a specific person (and method for contacting) should problems arise. Patients should be clearly informed about who will take ownership over their care once they leave the hospital. The phrase "Someone will call you ..." should be replaced with "I will call you and here is how

you can find me if you need me." Provision of this kind of information should be varied to accommodate transient cognitive dysfunction—the fog that may occur after the trauma of hospitalization—that may exist at the time of discharge.

Conclusions

This agenda will certainly take effort. Some hospitals, particularly in some major US metropolitan areas, have already implemented many of these suggestions by designing floors that deliver first-class amenities while charging patients additional fees, establishing the feasibility of doing so. Perhaps some of the money that hospitals are spending on delivering excessive technology could be diverted to make hospitalizations less traumatic for everyone, possibly improving outcomes at the same time. Information technology such as identification badge chips and scheduling programs to inform patients when consultants will see them may help. However, the principal innovation has to start by having those who run hospitals look at the experience from the patients' perspective rather than the perspective of those who are providing care. This transition may require expertise from other customer-oriented industries outside of health care. Re-engineering the process of hospital care will involve rethinking many of the traditional procedures and technologies such as obtaining daily blood work and nighttime vital signs, maintaining continuous intravenous access, and using vital sign and infusion alarm systems that continuously alert caregivers with irritating noises and beeps. Once those steps have been taken, hospitals can implement changes that may well have important benefits in helping patients recuperate from illness without requiring a prolonged period of recovery that stems from the way that care was delivered.

ARTICLE INFORMATION

Published Online: May 1, 2014.
doi:10.1001/jama.2014.3695.

Conflict of Interest Disclosures: Both authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Krumholz reports board membership with UnitedHealthcare and grants or pending grants with the Centers for Medicare & Medicaid Services, Medtronic, and Johnson & Johnson. Dr Detsky reports no disclosures.

Additional Contributions: We thank David O. Meltzer, MD, PhD, University of Chicago; Mary E. Tinetti, MD, Yale University; and

Gurpreet Dhaliwal, MD, University of California, San Francisco, for comments on an earlier draft of this article. None of these individuals received compensation for their contribution.

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