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Objectivity and Realism for monitoring COVID 19 in Brazilian Health Facilities: a four-month follow up of two local hospitals and several nursing homes

Objetividade e Realismo para monitorar COVID 19 em Instituições de Saúde Brasileiras: seguimento de 4 meses em dois hospitais e vários residenciais de idosos

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Abstract

The current COVID-19 pandemic makes us live in a difficult and unprecedented time. With each passing day, the care of the health team itself is essential. Not only physical care, but also mental health. The authors describe their experience in disseminating recommendations through short videos that help professionals to maintain an objective view of the reality they are experiencing. SOBRAMFA team, integrated by doctors and educators, provided a fourth month follow up monitoring COVID 19 patients in two community hospitals and in several nursing homes entrusted to take care for. Thus, tabulating daily the evolution of patients - the hospitalized, the deceased and, very importantly, the discharge of the recovered - provides a sense of reality. The real and active presence of us, SOBRAMFA physicians, with the ability to lead the health team and to communicate with families, patients and fellow doctors portrays an effective attitude that shapes a new business model and a posture of excellence, which is suitable to different clinical settings.

Keywords: COVID 19, Monitoring Strategies, Nursing Homes, Communication Skills, Objectivity.

Resumo

A atual pandemia COVID-19 nos faz viver em uma época difícil e sem precedentes. Cada dia que passa, o cuidado da própria equipe de saúde é fundamental, não apenas cuidados físicos, mas também saúde mental. Os autores descrevem sua experiência na divulgação de recomendações por meio de vídeos que auxiliam os profissionais a manter uma visão objetiva da realidade que estão vivenciando. A equipe da SOBRAMFA, integrada por médicos e educadores, fez um acompanhamento ao longo de quatro meses dos pacientes com COVID 19 em dois hospitais comunitários e em vários residenciais de idosos a eles confiados. Deste modo, tabulando diariamente a evolução dos pacientes - os hospitalizados, os falecidos e, muito importante, a alta dos recuperados - proporciona um sentido de realidade. A presença real e ativa dos médicos da SOBRAMFA, com capacidade de liderar a equipe de saúde e de se comunicar com familiares, pacientes e colegas médicos mostra uma atitude efetiva que configura um novo modelo de negócios e uma postura de excelência, aplicável aos diferentes cenários clínicos.

Palavras-chave: COVID 19, Estratégias de Monitorização, Residenciais de Idosos, Habilidades de Comunicação, Objetividade.

TAKING CARE OF THE HEALTH TEAM

The current COVID-19 pandemic makes us live difficult and unprecedented times.[1] The efforts of all health professionals, each one with his/her own competencies, are essential. While researchers and scientists struggle to

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find therapeutic resources that can be effective, those on the frontline devote their best efforts to the clinical care of affected patients.[2] It is worth asking what the role of those involved in medical education would be at this moment to collaborate in the global crisis.[3,4]

With each passing day, the care of the health team itself is essential. Not only physical care (for which all possible measures must be taken in each case), but also mental health. Or put more simply, it is crucial to raise the morale of those who deal daily with this threat of unprecedented proportions. A discouraged, pessimistic doctor, with no perspective is also an element of crisis, since this causes insecurity in patients – even more than what usually comes to them from the media – and does not help the health team in any way. The realistic view of the facts requires a true recovery of the proportions that each one experiences.

Family medicine, dealing with both the emotional and the scientific side of medicine on a daily basis, plays a central role in tackling this pandemic.[5] Seeking to collaborate in this sense, our private institution of family practice in Brazil, ***SOBRAMFA - Medical Education and Humanism***,[6] in which we act as physicians and professors, has transmitted recommendations through short videos[7,8] that help professionals to maintain an objective view of the reality they are living. In addition to helping with a realistic perspective, the videos address aspects of affective education and how to calibrate emotions to help with the ethical decisions that daily practice entails.

An excessive and disproportionate concern with the global problems that the world is facing does not help – even hinder – each health professional to take care of his/her own responsibilities in the specific sector he/she is in charge of at the moment. It is necessary – as a recent publication warned – to think globally but act locally.[9] In this sense, the world leaders in combating the pandemic[10] warned that although we are all facing an enormous challenge, no one should bear the burden of feeling responsible for the global health of the planet. Thus, the advice is to have respect for the global threat, but to keep focus on our own scenario. Objectivity and realism, therefore. Global anxieties do not help.

OBJECTIVITY AND REALISM: A PORTRAIT OF DAILY REALITY

Global information, which is available to anyone, being important in health policies, is not really relevant for every single professional who has to face his/her own challenges on a daily basis. Such information can even generate an anticipated concern and further distract professionals from their own responsibilities. It is possible – to adapt an old saying - that too much focus on the forest can prevent you from seeing the trees that need help.

Knowing how to provide a realistic view of the situation experienced in the daily scenario, supporting the health team always, as well as patients and families, are the main and most important help that crisis management requires.

Objectivity implies in providing a daily picture of our particular reality. Thus, it is essential to tabulate daily the evolution of patients cared for by each one of our doctors - the hospitalized ones, the deceased ones and, very importantly, the recovered ones who were discharged. This provides a sense of reality.

SOBRAMFA's team is responsible for the medical care of about 650 guests distributed in several nursing homes and works in two small hospitals in monitoring chronic patients with comorbidities or in palliative care. Chart 1 and 2 show the daily evolution of patients entrusted to the care of our team. A realistic and numerical view of our “own courtyard” helps us to keep the focus on the responsibilities and functions that must be developed by health professionals.

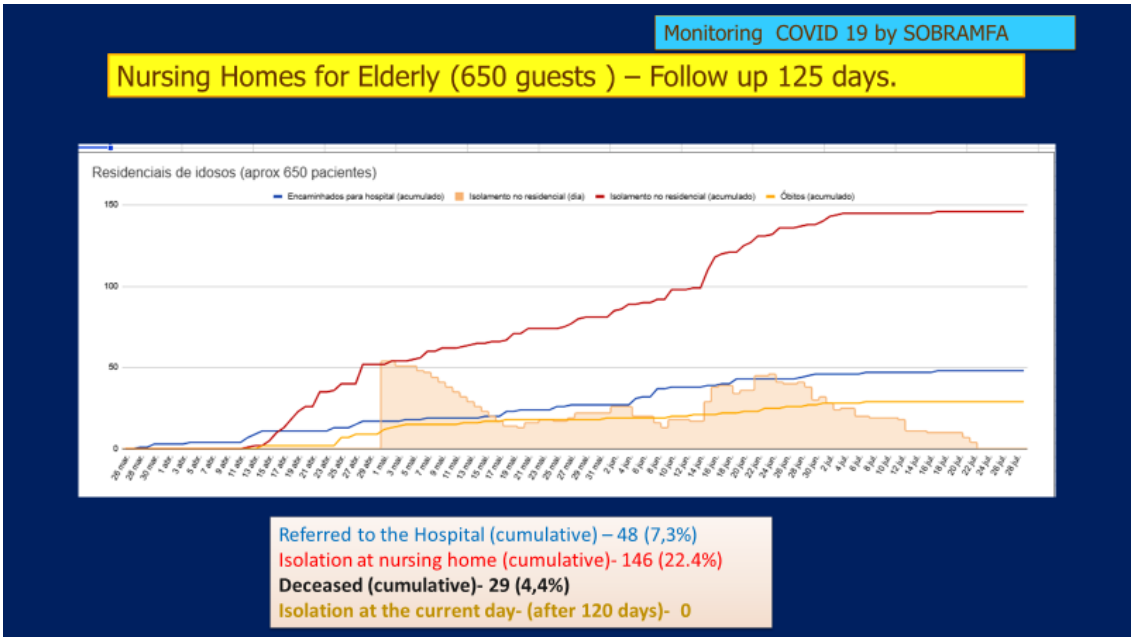

Chart 1. Nursing Homes for Elderly -Follow up 4 months. **Source:** SOBRAMFA Files

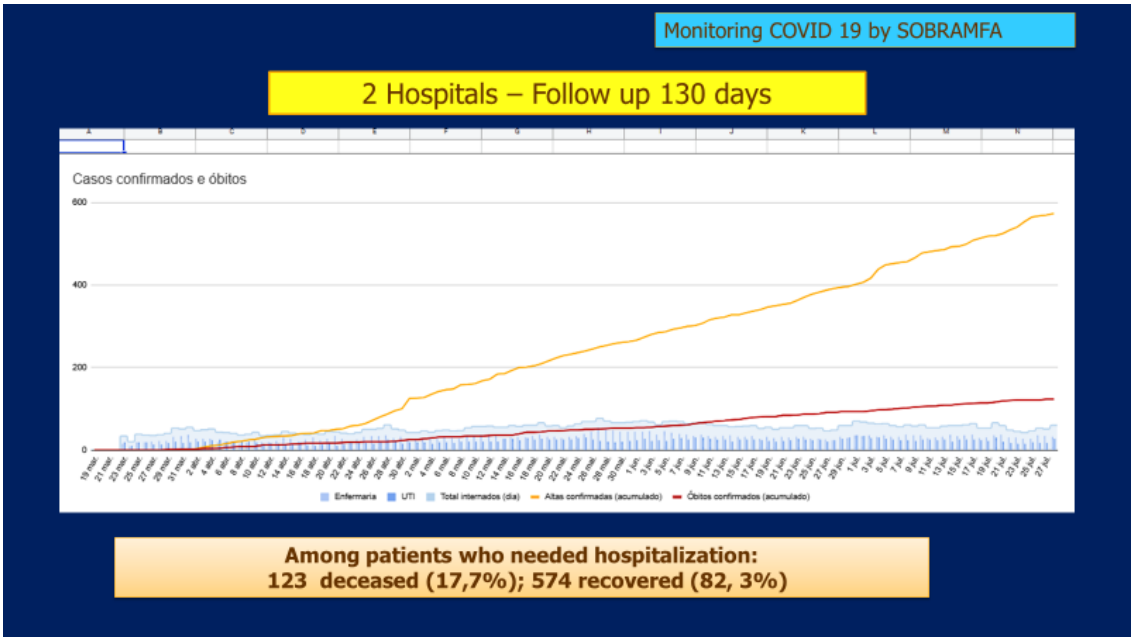

Chart 2. Four Months Follow in two community hospitals. Source: SOBRAMFA Files

It is not our goal to outline an epidemiological study of the behavior of the pandemic, nor to establish the basis for therapeutic protocols, aspects that are directly up to researchers and public health. It is about showing a picture of the everyday reality experienced in our current work scenario.

ACTIONS THAT MAKE THE DIFFERENCE

As the COVID-19 epidemic arrived in Brazil three weeks after the European countries and the United States, we realized that we were facing something totally new, a disease whose story was still being written. So, we started studying the reports and actions made in those countries and realized that nursing homes for the elderly constituted

a weak point that deserved great attention. Experiences reported about nursing homes in which they waited for clinical signs to take actions such as isolation, treatment or referral to hospitals and had terrible results with more infected, sick and deceased patients[11-14] represented a great teaching for us. We also learned that, in addition of closing the house for visits, using personal protective equipment and training the staff on how to use it, conducting periodic testing of all patients and employees regardless of symptoms started making the difference at the nursing homes from countries in which the pandemic was more advanced.

Concerning the hospitals in which we work, we do not have the role of accompanying hospitalized patients in infirmaries or ICUs for the treatment of COVID-19. However, some patients we care for developed the disease. In that case, we continue to accompany them while being treated with the Infectology or ICU team, especially providing support, guiding and information to their families. We also continue to treat patients who had been cured of COVID-19 but have other illnesses that required attention and out-patients with mild forms of COVID-19. From the need to do the best for such patients and their families, a constant commitment to update ourselves on this disease arose, what is done at our weekly scientific meetings. This way, the following actions were established by our team to be adopted in clinical settings – nursing homes, hospitals and outpatients care:

- The early closing of nursing homes to visitation: from the 20th of March, the resident guests remained isolated from any and all family members visits. The only contact of the guests has been with the health professionals (doctors and nursing staff), who acted properly protected according to the protocols adopted globally.
- The nursing homes residents – even asymptomatic ones – were tested for COVID-19, which allowed isolating the ones whose tests were positives, avoiding contact with the rest of the community.
- Providing the maintenance of the unit and focus of the entire nursing homes health team on a daily basis by a precise guidance in each case which contemplates the management of the uncertainties risen at this time. The crisis affects - as already mentioned – the health team itself, which feels insecure in the face of an unknown threat. It is the doctor's role to inspire serenity and professionalism to ensure efficiency.
- Personalized communication with patients and families: family isolation from nursing homes guests is a huge challenge that we must deal with daily. It is not enough to “shield” the residential to visitation, it is necessary to explain, to inform the families, to clarify doubts, and to show the reasons for all these measures, especially for the families of critically ill patients who had to be referred to the hospital. In this case it is essential facilitating contact with the doctors who had to look after the elderly when hospitalized. Regarding hospitalized and outpatients of the hospitals in which we provide care, in addition to individualized care according to the clinical method of patient-centered medicine, we adopt the same concern in transmitting good quality information to patients and families.
- Preparation of scientific and broadcasting material: the publication of our experiences in national[3] and international journals,[4,7] as well as the elaboration of explanatory videos[8] made our actions transparent and available to the scientific and assistance community that wanted to take advantage of them. The follow-up graphs (as shown in Charts 1 and 2) have been sent daily to the health teams, managers, and scientific community.

THE ADDED VALUE IN EARNINGS MANAGEMENT: AN APOLOGY FOR COMMUNICATION

Regarding nursing homes, the results presented in Chart 1 show that the measures taken over these 4 months were reassuring, as they depict a situation quite different from that reported initially in nursing homes in Europe and USA. Of the 650 guests, only 7,3% (48) needed to be referred to the hospital. Deaths (most occurred in the hospital) were 29 (4.4%). 146 (22,2%) patients keep isolated in the nursing home, and at this moment all of them are recovered. So, such numbers are encouraging, especially considering that it is a population of high average age and risk. it is worth mentioning that many of the elderly who tested positive for COVID-19 remained asymptomatic and evolved well.

The explanation for this management that we consider to be excellent comes from the daily and constant presence of SOBRAMFA's medical team, including weekends and holidays. It is known that the institutionalized

elderly care sector lacks the real and active presence of the physician, whose action is often represented only by regular visits to cover complications. Thus, many of the necessary actions end up being delegated to the nursing team. In our country, a nursing home is rarely served by a doctor every day. We must also add the communication skills proper to our medical management to coordinate the nursing team, and to meet the family's requests in the usual way.

Although we are not responsible for the COVID-19 treatment units in the hospitals where we work, we consider it is essential to keep us informed about the data regarding COVID-19, for the reasons already explained before. So, when we receive the daily bulletins from each hospital, we organize and update the data as it is shown in graphs 1 and 2. This help us to apprehend the true dimension of the problem within our own circle of influences, avoiding disruptions arose from the excess of information, often misinterpreted, transmitted by the media which insistently replicates the statements of the World Health Organization (WHO) and the Brazilian Ministry of Health and the results of international clinical studies. Over time, we have also started sharing such graphs with health teams and managers, which we believe has helped each one to do his/her own job, without unnecessary distractions. It is obvious that this does not exclude the constant need of scientific updating for an adequate clinical practice.

Certainly, this search for clinical excellence through scientific updating led to the adoption of conducts that resulted in the good results obtained in the management of COVID-19 in nursing homes. The sharing of consolidated data in nursing homes with the managers and the entire health team also brought serenity to daily work, removing the nightmare that everyone foresaw from the news initially released about the situation in other countries.

The behavior and the response of the professionals to face the crisis that the world is experiencing reveals weaknesses in the current models of health education. We contemplate heroism combined with insecurity, and even recklessness, a deformed knowledge in which the evidence is diluted amid media information and the sensationalistic bombardment of social networks. The ability to communicate, which in these moments would be one of the most necessary skills, is far below what is desired in healthcare professionals. It is worth remembering that classic comment: “every system is perfectly designed to produce the results it offers”[15]. We cannot just complain about the product; we must revise the manufacturing process, which is certainly defective.

A more in-depth reflection on the doctors' training process has already been drawn up with the suggestive name that the order of factors does change the product[16] here meaning that the order in which is summarized the doctor's role, contains an important educational mistake. What can be expected when the recommended order for the physician to act is to heal, relieve and, ultimately, comfort? The logical thing is to think that the most important progress is made from the main goal to the detail. When it is not possible to cure it is necessary to relieve it; and when relief is not possible, it remains to provide comfort. Proceeding in this sequence inevitably presents relief and comfort as a consolation prize for the doctor who is faced with an incurable, painful, terminal illness. The product resulting from this equivocal process - the doctor - has important deficiencies.

In times of crisis like this one we are undergoing, in which healing is far from being manageable, the relief and comfort – for patients and families – that should be expected from professionals is not exercised, because we do not know how to do it properly. A Hippocratic-Copernican turn in medical education would be necessary to avoid this misunderstanding that leads to important formative deficiencies. While comforting is something that should always be done, due to the extremely high prevalence, healing has a much lower prevalence. The medical education process must include this proportion to produce better doctors. Doctors who always know how to comfort and according to the cases and illnesses they encounter, they also know how to cure when it is possible. That is, the order of factors changes the product.

CONCLUSION: EFFECTIVE MANAGEMENT IMPLIES PRESENCE AND PROFESSIONALISM

There was no magical solution to obtain these results. Only the real and active presence of us, SOBRAMFA doctors, with the ability to lead the health team, and to communicate with families, patients and fellow doctors with whom we eventually had to interact. A simple and effective attitude that shapes a new business model and a posture of excellence, which is suitable to different clinical settings.

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