https://russjcardiol.elpub.ru
doi:10.15829/1560-4071-2019-9-41-43

ISSN 1560-4071 (print)
ISSN 2618-7620 (online)

Delayed help-seeking in acute coronary syndrome — view of a problem in terms of narrative medicine

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The article suggests the reasons for the delayed help-seeking in patients with acute coronary syndrome in terms of individualization of work. For analysis, the approach of narrative medicine was used, that is, a way to conceptualize medical situations using the methods of the humanities, or rather, to understand the disease as an event in the patient's life — his biographical narrative. These categories are important both from the standpoint of ethics and patient orientation, and from the standpoint of health improving through education of the population. A number of attitudes are shown that lead to delay in help-seeking: rigidity of thinking, unwillingness to cause discomfort, atypical manifestations, distrust of medicine and the unknown medical process. In general, the inclusion of a disease in the biographical process occurs through denial of the disease, distrust of medicine and/or healthcare, procrastination. As a solution of these problems, an assessment of the general informational background of patients as society participants and education depending on the social category, is proposed.

Key words: compliance, patient orientation, clinical performance, psychosomatics, sociocultural factors, myocardial infarction, healthcare organization.

Conflicts of Interest: nothing to declare.

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Received: 15.08.2019
Revision Received: 22.08.2019
Accepted: 29.08.2019

For citation: Shaydyuk O. Yu., Kudinova M. A., Taratukhin E. O., Sapunov I. V., Zamyatin K. A. Delayed help-seeking in acute coronary syndrome — view of a problem in terms of narrative medicine. *Russian Journal of Cardiology*. 2019;24(9):41-43. (In Russ.)
doi:10.15829/1560-4071-2019-9-41-43

In a recently published article by Kontsevaya A.V. et al. (2019) considered the problem delayed help-seeking in acute coronary syndrome [1]. The average time from the onset of symptoms to an ambulance call is about 2 hours, with little or no change in the past decades.

Much work is being done to analyze the reasons for this delay, as the potential for reducing the time of arrival of the ambulance team to improve outcomes has already been exhausted. One of the main strategies that can be used is to educate the population about knowledge and suspicion about the symptoms of a severe cardiovascular event. Of course, this is an important part of the work.

It can be carried out on two levels: simple informing and creating a conscious attitude and understanding. The second option requires a better understanding of the processes of personality, the experience of the disease, its picture to formulate more effective ways of informing.

Narrative medicine is a kind of inclusion of ideas and methods of analysis accepted in the humanities (culturology, sociology, anthropology, psychology, etc.) to understand the problems of non-biological (non-biomedical) nature [2]. Narrative is a sequential recital. Taking into account that a person is a biosocial being, it is important to learn to take into account the "social" part of the person, i.e. the world of his personality, symbolic interaction, communication. This is done with the help of psychological quantitative and qualitative methods, such as in-depth and/or semi-structured interviews. In addition, the social sciences view allows decoding the processes taking place in the social environment to offer an explanation of the problems that eventually become part of medical practice and health care parameters.

In our previous study [3] in patients with myocardial infarction, in the form of an in-depth semi-structured interview, a number of paradigms were found that interfered with the time to seek help. In particular, the delay before calling an ambulance ranged from 2 hours to 2 weeks, including the detection of changes in the electrocardiogram when contacting the clinic for another reason. The reasons were as follows: “impossibility to imagine” the development of a myocardial infarction in oneself due to young age and general well-being, playing sports; an idea of health problems due to older age, and not disease; "Distrust of health care", fear of queues in clinics. These and other similar ideas can be detected during a conversation with the patient — during the study or in practice, i.e. when history taking, discussing treatment. But only awareness gives quite a bit in terms of influence on it. Further, we offer the results of a deeper, narrative analysis of attitudes related to procrastination in case of symptoms of the disease, according to the literature and our own data.

The material and methods are described in the previous article [3]. Selected variants of paradigms, semantic intentional constructs, which eventually led to a late help seeking, are shown below.

Rigidity of thought. Difficulty of switching from "healthy" to "sick". In contrast to diseases that usually develop subtly, acute coronary syndrome is a sudden event. In one of the patients, a departure was planned for the next morning, when he felt pain behind the sternum at night. He didn't want to spread panic and was afraid of cancelling the trip. The importance of symbolic filling of cultural practices can be greater than painful symptomatology. For example, a patient who eventually developed myocardial rupture was not called for an ambulance until after midnight. That was because the family was celebrating the New Year's Eve, although the pain syndrome developed one and a half hours before midnight.

"What if it would disappear by itself" is an attitude that takes place if the symptoms do not intensify, and even more so if it decreases. Relation of values: for example, the value of a lost vacation is compared to another value — and if it turns out that life and health are on the scales, the decision will be made in favor of seeking help (“If only I knew...”). But before the diagnosis is made, these data are not available, and therefore the decisions are based on well-being and on known information. The disease may be perceived as invading life, and the rigidity of thinking does not allow us to switch to a new event as being of higher value than current activities. Providing a clear picture of the options for acute coronary syndrome development and the importance of time will allow patients to make more adequate decisions.

Reluctance to make a disturbance. Delicacy, reluctance to attract attention, make a disturbance to relatives, as well as once again call an ambulance, for some patients are a cause of delay. In this case, the patient’s position in the family is taken into account: if he is the “head of the family”, the earner, his health may appear more important than the dependent (and especially elderly) family member, in his own submission.

Atypical manifestations. Acute coronary syndrome does not always take on forms that indicate heart disease. A stereotype of myocardial infarction as a "heart attack" can reduce attention to symptomatology if the disease is manifested, for example, by general weakness. If your heart hurts, the situation is perceived to be more important.

Distrust in medicine. This setting is related to the feeling of danger in relation to the events that occur to the patient when he gets to the clinic. For example, a 70 year old patient refused to be hospitalized if diagnosed with non-ST segment elevation myocardial infarction, and had to take an ambulance to visit her three times, and then visit her every day for a week by district therapist. She explained her refusal to go to the hospital by trusting only "doctors she knows". If it is not possible to “agree” on the place of hospitalization, she prefers to stay at home with satisfactory health. This attitude, of course, causes condemnation, but in the analysis it is clear that the reason is the picture of healthcare formed by the patient as a result of life and social interactions. The formation of a favorable attitude towards doctors and the healthcare system is a serious task that can be solved both in the system itself and at the level of creating its information image.

Unknown medical process. Apart from distrust in medicine, there is a misunderstanding (and fear) of those events that will occur in the case of seeking help. Surgical intervention, painful procedures, risks and side effects are the components of the picture of the disease in case of contact with doctors and the medical institution.

You can find other options for attitudes, for example, regarding gender stereotypes: “a man must endure pain” turns out to be a delay factor in the presence of pain. But on the whole, it seems that the principal options for including the disease narrative in the patient’s narrative are the denial of the disease, distrust of medicine, and procrastination as such, due to the rigidity of the thoughts’ change. A disease event disrupts the patient’s life, i.e. his biographical narrative.

If the patient denies the disease for various reasons, he does not accept the fact or suspicion; both simple ignorance and transcendental categories of fate, god, can play a role in this process. In case of distrust in medicine, idea of medicine as a social institution, one's own experience of interaction, the experience of acquaintances and information from different sources play an important role. Procrastination associated with the psychological phenomenon of intention behavior gap [4] is a more complex motivational and intentional phenomenon in which there are the need for a "critical mass" of motifs that can finally inspire action: to call health workers.

The severer the symptomatology, the more understandable or (eerily) incomprehensible it is, the easier it is to close the gap. In addition, the value of abandoning the planned course of life (going to work, going on vacation, celebrating, etc.) is compared with the perceived risks, which are calculated on the basis of the interpretation of feelings (symptoms) and "medical" knowledge. Even a well-defined diagnosis of myocardial infarction may not be a strong enough reason to abandon plans in favour of hospitalization unless there are clear symptoms and knowledge of the risks of the disease.

Assuming that the patient is an active participant in society, involved in information exchange, it is quite easy to explain the presence of these attitudes. It is accepted, experienced and assimilated material that is offered to the patient from the Internet, media, friends, family, books, movies and other sources. The final picture of medicine and health care is unique for everyone, although it contains some common features for the territory, age group (generation), gender, class, occupation, income, marital status. Accordingly, when planning sociological research to clarify the targeting of health education, it is important to consider the target group with its properties: what is the information agenda of the selected group. Moreover, when providing information within the framework of primary prevention, screening, and medical examinations, it would be desirable for the doctor to differentiate the methods of information. Pre-tested and published materials can help to do this, both in a popular form that reveals the problem of acute coronary syndrome itself and anticipating the attitudes that will make it difficult for the patient to seek help when the event occurs.

Conflicts of Interest: nothing to declare.

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