REVIEW

The management of chronic diseases is a major challenge for modern health systems: an integration of concepts and strategies concerning patients, doctors and health care

Konstantinos A Paschos

Consultant Surgeon, General Hospital of Drama, Greece and Health Care Management MSc course, Hellenic Open University, Department of Surgery, General Hospital of Drama, Greece

ABSTRACT

The successes at treating infectious diseases during the twentieth century increased life expectancy and resulted in the substantially growing rate of chronic diseases (CD)s. As human population is aging globally, CDs tend to become the primary health menace and a heavy burden for modern health systems (HS). CDs require long-lasting treatment, while they influence patient expectations from health services. Moreover, they complicate doctor-patient relationships and make more difficult the patient satisfaction. States, organizations and citizens work towards the promotion of quality in health and seek new strategies that upgrade and improve the provided services.

Although CDs are usually incurable, the patient expectations increase, because they become well-informed, consumerism in health develops and high technology introduces new applications. The doctor's authority is in doubt, while the patient's active role in medical treatment becomes more and more important. The patient-centered health services appear to bring a new era in HS and promote quality. Chronic patients demand impeccable professionalism nowadays, respect from doctors and nurses, as well as modern infrastructure and successful results. The challenges for HS are multiple in the twenty-first century; they require new strategies in medical education, the development of new skills and close cooperation of professionals, patients and societies.

Keywords: care, chronic disease, health services, patient satisfaction, relationship

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INTRODUCTION

Chronic disease (CD) is defined as a pathological condition which lasts or is expected to last a year or longer, requires ongoing cure, limiting what health professionals are able to offer and do. Additionally, the consequent tissue damage may be irreversible and very difficult to improve. CDs constitute a rising menace to

human health and the primary concern of healthcare systems (HS) throughout the world nowadays. Also termed non-communicable diseases, they account for more deaths than all other maladies together, estimating to reach 52 million deaths in 2030, compared with 38 million in 2012 [1,2]. This tragic outcome is mainly attributed to four diseases: cardiovascular and chronic pulmonary diseases, cancer and diabetes mellitus. It has to be noted that almost 42% of the patients who succumb to CDs worldwide are younger than 70 years (premature deaths) and almost half of them lived in low and middle income countries (Figures 1, 2) [3,4].

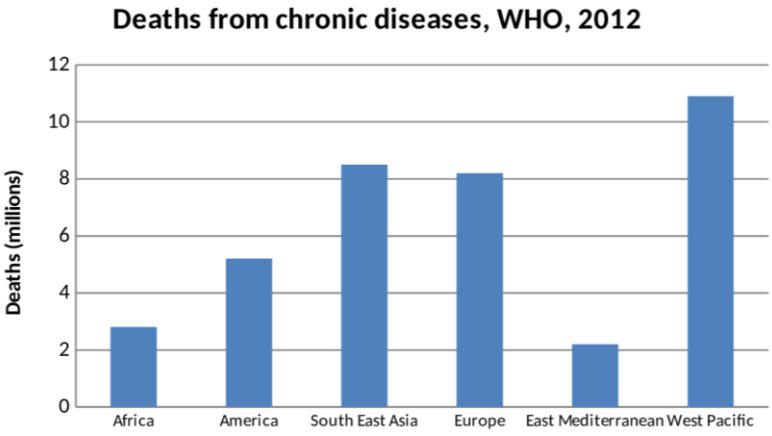

Figure 1. Total deaths from chronic diseases, as per region, as reported by WHO [2]

Interestingly, CDs are a rising risk that challenges modern HS because individuals suffering from them require ongoing, long-term care and hospital stay, high-cost treatment, and are threatened by low quality of life and high morbidity. Furthermore, as chronic patients tend to visit more often the health structures, they are the most demanding and fastidious users that may harshly criticize the HS [5-7].

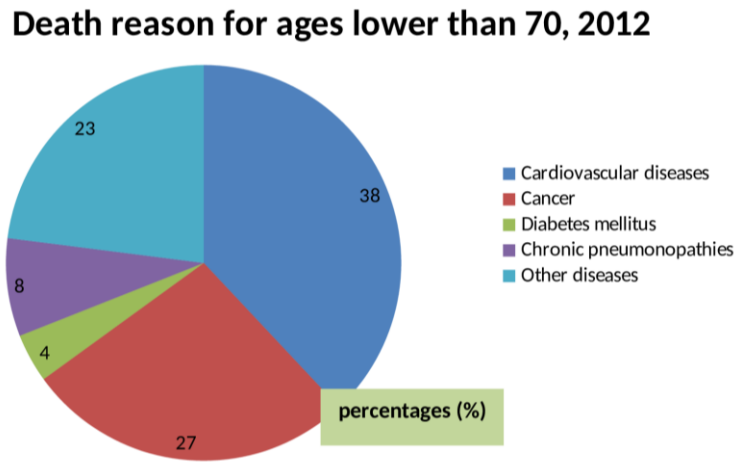

Figure 2. Death rates per reason globally, ages below 70 years, during the year 2012 [2]

Thirty years ago, human societies tended to accept health services without considering the ability of choosing or commenting, also expressing their gratitude for what they had received. This situation has radically changed nowadays; people in the western-developed world are well-informed in their majority and they demand equality, credibility, health services and products of high quality. Moreover, they are determined to satisfy their special-personal needs and refuse to accept plans and approaches that do not comply with their expectations [8,9]. In an era of intense consumerism in health services and products, in conjunction with the dramatic increase of CDs, quality in health is pursued by societies, organizations, politicians, professionals, as well as users of HS. This special general interest for quality is attributed to the high cost of hospital operation which does not

correspond to the desirable general health level, but also to the high educational status of the citizens in developed countries and the easy access of the public to detailed medical information. Furthermore, quality in health attracts great interest because of the formidable progression of biomedical knowledge, the exploitation of high technology in every health sector and the recent long period of prosperity and affluence in the developed world [10-12].

The fact that the doctor's authority is questioned nowadays, and HS are usually negatively appraised, changes the relationships among patients and doctors. Concurrently, world population aging increases the prevalence of CDs and the need for health services, promoting a general dissatisfaction of users who constantly demand more. Although, high quality is always the target, reduction of financial cost is also a matter of high priority, as well as the cost-effectiveness results and doctors appear to play a critical role in this difficult interrelation [13,14].

In a world of globalization and financial crisis, governments and organizations attempt to face the challenges and improve the patient satisfaction from health services. The proper training of medical and nursing personnel, the engagement of high technology, the adoption of medical protocols and the control of financial cost may maintain and improve quality. Furthermore, the respect of patients, solidarity and courtesy constitute prerequisites that may seal the difference in modern HS [15,16].

CHRONIC PATIENT EXPECTATIONS FROM HEALTH SERVICES AND HEALTH PROFESSIONALS-CONSUMERISM IN THE HEALTH SECTOR

At the onset of the twentieth century, advances in HS and public health considerably reduced the prevalence of infectious diseases, which constituted the main object of medicine and health-related sciences in the previous centuries. In the second half of the twentieth century, medicine mainly in developed countries became proficient at treating acute episodes and HS adopted accordingly. However, the beginning of the twenty-first century signaled a new era for HS. The successes at treating infectious diseases considerably increased life expectancy and resulted in an unprecedented growing rate of CDs. Thus, a new challenge appeared: HS should aim to primarily provide care for individuals with chronic pathological conditions (Figure 3) [17,18].

The medical care of chronic patients is a challenge, due to the increasing prevalence of non-communicable diseases, their exceptional or sometimes unique pathology and symptoms, their difficult and time-consuming treatment, but also due to the special characteristics of these patients. Moreover, the modern era of information offers multiple sources of communication and education creating excessive expectations to the patients, who are influenced by a general spirit of consumerism in health matters. Consequently, they always remain unsatisfied and constantly seek a different medical opinion, a revolutionary therapy [19,20].

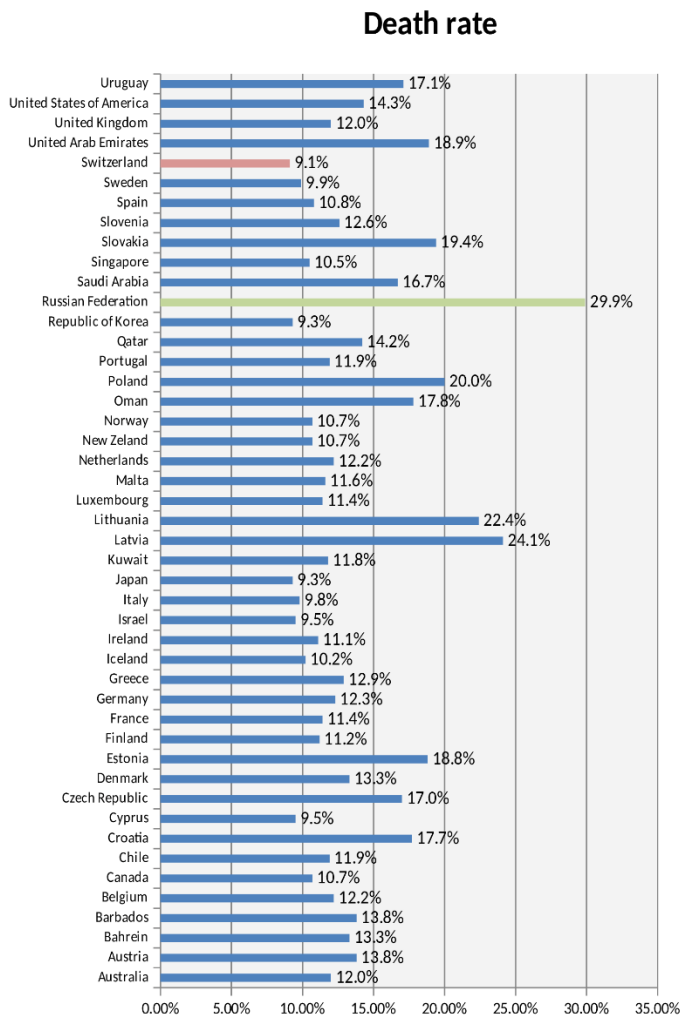

Figure 3. Death rate from 4 main chronic diseases (cardiovascular diseases, cancer, chronic pneumonopathies and diabetes mellitus) for ages 30 to 70 years (%), in countries of high gross domestic product (GDP) (World Bank classification), 2012. Values from 9,1% for Switzerland to 29,9 for Russia [2]

Patient expectations arising from chronic disease characteristics

The most common CDs are chronic pulmonary and cardiovascular diseases, arthritis, diabetes mellitus, epilepsy and seizures, which usually present slow progression, while the patients may keep a relatively normal life for a long period. Also, malignant diseases (cancers) that usually have a bad prognosis, slow or fast deterioration following diagnosis, may cause serious disabilities, while their current pharmaceutical treatment is usually seriously toxic [21,19].

Due to the nature of these diseases, chronic patients have to set multiple limitations on their lives, suffer from perpetual stress and insecurity, experience various levels of constant pain; all these unpleasant conditions and factors undoubtedly test one's resilience and psychological endurance. Furthermore, they have to follow complicated and difficult therapeutic courses, while they depend on doctors whom they have to meet, consult and believe for very long periods [22].

Chronic patients anticipate that doctors and nurses may provide detailed and comprehensible information, while they hope for a relationship of trust mainly with their doctors. They expect courtesy, respect and discretion. They are particularly interested in their pain relief and want their lives to be as normal as possible; they eagerly desire to delay the potentially lethal course of their disease and to control any destructive consequences. Young patients in particular anticipate making plans for their future, to follow a decent profession, to relate with the opposite sex and have a family, to avoid isolation and social exclusion [23,24]. Interestingly, an epidemiological study by Oskay-Ozcelik et al. performed in Berlin [25], including 617 patients with breast cancer who were under adjuvant therapy, revealed that the disease may be described with the term

fear (68%), challenge (58%), new values (42%), rare opportunity (39%) and death (36%).

Taken into consideration the specific nature of CDs and the difficult life of chronic patients, the role of health professionals appears crucial. Apart from classic medical education that supports successful diagnosis, multiple additional elements of clinical training and skills are necessary for the treatment of CDs. Most importantly, doctors and nurses should consider psychological parameters and act with high sense of responsibility and humanism [26].

Patient expectations originating from modern consumerism in health

Information sources for the public on health matters are increased exponentially nowadays, offering unlimited access to health data, as well as to numerous electronic sites of private or public health institutions. Consequently, old beliefs such as "the doctor orders and the patient acts" are outdated, and health users become more and more active, demanding, well-informed. The current emerging model is an uncomplicated co-operation between doctor and patient, where the patient may take crucial decisions and ask the doctors for details on every aspect of their disease [11,27].

Moreover, the explosive increase of high technological applications in medicine and the continuous announcement of new therapeutic modalities cause a constant investigation for expensive medical applications and treatment from the patient's part. Interestingly, patients may anticipate the cure of incurable diseases and therapies without complications. Occasionally, expectations may become unreasonable and then conflicts among patients and doctors become inevitable. Subsequently, patients search a second or third medical opinion, aiming to discover the appropriate therapy. Although the doctor's status has been reduced nowadays and his authority is questioned, health remains precious for individuals and as medical issues are rather incomprehensible to non-specialists, the majority of patients still follows carefully their doctor's instructions (Figure 4) [28,27].

The current circumstances and social reality compel medical professionals to follow a continuous education, protect and seek quality and strictly adhere to professional ethics. Also, they should familiarize with new approaches of sick individuals where communicative skills have critical value and understand that they should treat spirit and body inextricably. Notably, patients are more satisfied if they feel that they are the center of interest in the HS and tend to indicate a better compliance with therapeutic instructions [28,19].

FACTORS THAT IMPEL PATIENTS TO SEEK MEDICAL TREATMENT

The time and the determination of the patient to seek medical assistance are influenced by multiple factors, which could be divided as follows: directly related to the disease's nature, idiosyncratic (character-personality) and social [19].

	Total "Good"		Total "Bad"		No opinion	
	Nov-Dec 2013	2013-2009	Nov-Dec 2013	2013-2009	Nov-Dec 2013	2013-2009
EU28	**71%**	**+1**	**27%**	**-1**	**2%**	**=**
LT	65%	+25	33%	-25	2%	=
HU	47%	+19	51%	-21	2%	+2
MT	94%	+13	6%	-11	0%	-2
PT	55%	+13	44%	-12	1%	-1
LV	47%	+10	50%	-12	3%	+2
IE	62%	+9	35%	-8	3%	-1
DE	90%	+4	9%	-4	1%	=
SI	73%	+4	26%	-4	1%	=
EE	73%	+3	25%	-3	2%	=
IT	56%	+2	42%	-2	2%	=
LU	90%	+2	9%	-1	1%	-1
PL	32%	+2	62%	-5	6%	+3
BG	29%	+1	68%	=	3%	-1
EL	26%	+1	74%	-1	0%	=
AT	96%	+1	4%	-1	0%	=
BE	97%	=	3%	=	0%	=
CZ	79%	=	21%	=	1%	=
DK	87%	=	12%	-1	1%	+1
CY	73%	=	28%	=	1%	=
NL	91%	=	9%	=	0%	=
RO	25%	=	73%	+4	2%	-4
FL	94%	=	6%	=	0%	=
UK	95%	-1	14%	+1	1%	=
FR	88%	-3	11%	+3	1%	=
SK	50%	-3	49%	+3	1%	=
ES	77%	-4	22%	+5	1%	-1
SE	86%	-4	13%	+3	1%	+1
HR	59%	NA	40%	NA	1%	NA

Figure 4. Health quality in 28 countries of EU. Romanians (red color) are the most pessimistic, Greeks follow (blue color). In each category the first column depicts data from 2013 while the second column the period 2009-2013

AT: Austria, BE: Belgium, BG: Bulgaria, CY: Cyprus, CZ: Czech Republic, DE: Germany, DK: Denmark, EE: Estonia, EL: Greece, ES: Spain, FI: Finland, FR: France, HR: Croatia, HU: Hungary, IE: Ireland, IT: Italy, LT: Lithuania, LU: Luxemburg, LV: Latvia, MT: Malta, NL: Netherlands, PL: Poland, PT: Portugal, RO: Romania, SE: Sweden, SI: Slovenia, SK: Slovakia, UK: United Kingdom

CDs that are accompanied by intense pain, rashes and/or weakness complicate an individual's normal life (limit mobility, sensibility, etc.) and definitely impel patients to seek medical treatment. On the contrary, CDs characterized by active and remission phases, especially at the initial stages, such as cardiovascular diseases or diabetes mellitus, may encourage complacence [29-31].

Female and aged patients tend to seek medical assistance more promptly than male and younger ones. Men usually face disease as a token of weakness; therefore, they tend to postpone a visit to a health institution. Similarly, younger patients have greater physical reserves which render them more resistant to symptoms, permitting delays and beliefs such as "the future can't be difficult" and "nothing bad may happen now" [19,32]. Past experience of a sickness is a reliable factor of directly seeking medical assistance when a pathology appears or recurs, as well as chronic conditions which train the patient in the accurate recognition of pathological symptoms. Unstable anxious characters tend to easily resort to doctors, present low threshold of pain and great sensitivity to every change they observe on their bodies. Concurrently, these people are more sensitive in messages from the media and obey immediately to instructions of direct search of medical assistance in case of a certain disease [33-35].

Social factors also influence how and when a sick individual seeks medical assistance. Superior social classes and people with higher education tend to easily access health systems, are able to find the appropriate doctor and fluently communicate with medical professionals. Moreover, internet access appears to be a daily habit predominantly for superior social classes with higher education [36,37], offering more appropriate evaluation of pathological symptoms and comprehension of the value of prevention. Patient's relatives and friends may also encourage one's visit to a doctor or hospital, when they become aware of one's health problems. Similarly, other factors

including financial rewards from a medical insurance, pensions for CDs or the provision of a sick leave may also motivate an individual to seek medical assistance. Additionally, easy access to public transport, proximity to health structures and past positive experience of health services may exert the same influence [35,38].

On the contrary, lack of trust on health systems and doctors, fear of social isolation and stigma following the diagnosis of a CD such as cancer or the public disclosure of bad life habits as reasons of a disease (e.g. smoking, unhealthy diet, multiple sexual partners) inhibit patients to resort to health services. Under these circumstances, patients usually postpone a visit to health professionals and when they decide to act (e.g. visit a doctor) the disease has progressed, and the prognosis becomes unfavorable [39-40].

PATIENT-DOCTOR INTERRELATIONSHIPS: RELATIONSHIPS OF CONFLICTS, "DOUBLE BIND" SITUATION

The end of the 20th century has signified considerable changes in healthcare communication. Increasingly, health professionals expected individuals to become more active in looking after their own health, while health programs and education promoted the patient role to maintain good health and prevent illness. Concurrently, new clinical beliefs and practices appeared that soon prevailed, suggesting that the physician's communication style constitutes an essential factor that may predict patient satisfaction and compliance; similarly, health professionals may substantially contribute to the activation of patient's self-healing powers through quality communication [41].

These fundamental changes that placed the patient in the center of HS induced a considerable attention to the nature of the relationships between patients and health professionals. Taken into consideration that doctors represent the most powerful profession in HS, sociological and other studies mainly focused on patients' encounters with them. The patient-doctor relationships may be described with different ways and be influenced by multiple factors [42,43]. Freidson described them as conflicts, meaning that two different worlds are met and interact. These conflicts develop from the different perceptions, priorities, experiences and beliefs of each part [44,45].

The patient from one side expects the doctor to be polite, educated, sympathetic and capable of finding the appropriate solutions to their health problems. The patient believes that the doctor will spend as much time as needed and will allocate all the necessary personnel and infrastructure (usually high technology) in order to directly relieve their patients. Sick individuals do not usually take into serious consideration the time that they visit a health institution, the patients also present there, the waiting list; totally focused on their problems, they demand immediate attention, priority and care [46,47]. From the other side, the doctor usually has to treat a great number of sick people in a busy Emergency Department, follows an exhausting long schedule, sometimes being hungry, sleepless and very

tired. Also, the doctor has to take the patient's medical history posing questions that may appear irrelevant, while at the same time decides promptly for the appropriate laboratory exams protecting the patient from unnecessary radiation, blood tests, vein punctures etc. Similarly, the doctor aims not to encumber overwhelmingly the HS and has always to adhere to official scientific guidelines [48,49].

Considering the patient-doctor different viewpoints, conflicts appear anticipated. Patients may complain about doctor's indifference, prompt-faulty estimation and lack of humanism. Conversely, doctors describe patient visits at the Emergency Department for chronic or minor health issues, hostile behavior from patients and their associates, the patients' excessive interest in their personal problems rather than the problems of other sick individuals. However, the common practice is that patients do not openly challenge their doctors even when they are dissatisfied with their treatment and tend to negotiate attempting to improve the conditions and gain some control in the therapeutic process. Furthermore, doctors rather retain their dominant role, although attempting to understand the patient concerns, keep balance and avoid unnecessary disagreements [50,51].

Bloor and Horobin, studying these relations of conflicts place the patient in a situation of "double bind". This situation occurs as follows: doctors anticipate that patients may be well-informed and knowledgeable about health matters, so as to enable them to correctly evaluate their symptoms, identify serious ones that require an expert's opinion and avoid visiting the hospitals without a serious reason. On the other hand, when a sick individual decides to seek medical assistance, they should respect, obey and carefully follow every instruction from the medical personnel. Within these conditions lies the "double bind". Unfortunately, these elements in doctor-patient relationships are rarely present, and subsequently patients as well as doctors appear worried and/or disappointed [52]. Consensus is more likely to occur when both parties share common social origins, class locations and cultural backgrounds. In the most usual cases of dissimilar socio-cultural profiles, patients should attempt to avoid strict criticism, while doctors should use their skills and expertise for the benefit of their patients at all times [53,54].

MEASURES OF PROMOTION AND REINFORCEMENT OF CHRONIC PATIENT SATISFACTION FROM CURRENT HEALTH SERVICES

The patient satisfaction from health services and professionals depends on multiple factors, including longevity and seriousness of the disease, educational and social status, age, knowledge on health matters. Interestingly, it is primarily associated with the quality of services, which constitutes main concern of human societies globally, but mainly in developed countries [55,51].

Multiple studies attempted to investigate the fundamental issue of quality in the organization and provision of healthcare services. Undoubtedly it is associated with an

attractive-pleasant environment, where patients rest and relax. As far as health professionals are concerned, quality is promoted by their courtesy, understanding, credibility and diligence. Concomitantly, impeccable professionalism, effective use of the existing sources and avoidance of errors [56,57]. Importantly, Avedis Donabedian introduced the prevailing model for effective health services and the evaluation of their quality, proposing three basic parameters [58]: structure (infrastructure, equipment, employees), procedure (actions by medical and nursing personnel, therapeutic choices aiming to recovery-cure) and outcome (treatment results, well-being of sick individuals following medical treatment).

Analyzing the aforementioned quality parameters by Donabedian, structure may be improved through easy access, good maintenance, meticulous cleaning and attractive decoration of the buildings (Emergency Department, medical Departments, Outpatient Clinics). Chronic patients and their relatives specifically need highly esthetic buildings and interior areas, internet access, clean restaurants and recreation areas, as they have to spend plenty of time in health institutions for long periods. Moreover, structural quality is supported by the use of high technology applications, manifold training of doctors and their associates and adherence to widely accepted protocols. Notably, financial parameters should always be a priority, as there are no endless resources [59-61].

Considering the parameter of procedure, quality demands impeccable professional attitude and appearance, politeness, friendliness, respect of human decency. Doctors in particular ought to provide enough time to their patients for information and communication, also pursuing the personal contact with sick people and their relatives. From the initial acquaintance with a patient, the medical history, the physical examination, till the administration of medications or the performance of surgical techniques, doctors should always remember that they are on "home" territory, whereas the patient stands on "foreign" ground, faced with unfamiliar and sometimes terrifying processes. It is understandable that most of sick individuals adopt a passive role, get confused, afraid and miserable [62,63]. They totally depend on doctor's will and skills; doctors must control their dominant role and always behave in the best interests of their patients. In modern patient-centered HS the doctor should be an attentive listener, allowing the patient to unfold their story, thus acquiring a general picture of the patient's life-world and placing the illness in a wider social context; then treatment may be more successful and patients more satisfied. Notably, sex, color, social class or religious discriminations provoke protests and dissatisfaction, downgrading health services [64,65].

The third parameter, meaning the course of the disease and the treatment outcome, probably constitutes the most important one, and the first motif of patient satisfaction. Successful medical interventions, prompt recovery and cure are always crucial targets of HS. The personnel's professionalism, the high sense of duty, continuous evaluation, organized operation, co-ordination and inspired

administration, all contribute substantially to successful-effective health services [41]. Similarly, the active participation of patients and associates through proposals and remarks promote quality, while public campaigns urge individuals to take up immunization, reduce alcohol consumption, quit smoking, adopt healthier diets or take regular exercise. Moreover, volunteerism and cooperation among health institutions could discover new targets, offer qualitative upgrading in health services inducing patient satisfaction [66,67].

A recent study demonstrated that the three most important criteria associated with health quality for the public were medical education and training, effective treatment and the use of modern technology [68]. Obviously, the human factor attracts the public's main interest, when HS are evaluated. Predominantly doctors and nurses should understand their crucial role and act accordingly. Successful results and the available infrastructure follow in the list, depicting the importance of organization, administration and financial resources. Their combination with capable personnel may support and maintain effective HS, in the new era of CDs [69].

CONCLUSIONS

CDs constitute the main reason of morbidity and mortality worldwide, they present increasing incidence and increasingly affect younger people. However, aged people predominantly suffer from CDs and considering the global population aging, these diseases (cardiovascular, pulmonary, diabetes mellitus, cancers etc.) tend to expand and dominate. The burden for health structures is becoming crucial, the response of health professionals to increased health needs is getting difficult and consequently patients are dissatisfied.

While CDs are usually complex and/or incurable, public expectations remain high. Patients are well-informed on health matters through the media and the internet nowadays, technological advantages promise-introduce new therapeutic choices, while health consumerism promotes the patient's interference into medical and nursing work. The doctor's authority is questioned, patient-doctor relationships are tested, while social status, economic power and education affect attitudes towards HS and their professionals.

States, organizations and citizens seriously study and desire the patient satisfaction nowadays. The latter is associated with health service quality, medical education, health professional behaviors and of course with diagnostic and therapeutic results. Despite the global financial crisis, contemporary HS are more well-equipped and organized against the disease as never before. What is requested and anticipated is adaptation to the special issues of CDs, the appropriate application of new technological advances, respect of human decency. Successful treatment of chronic diseases may improve quality of life for the majority of patients and may pave the way for a new era in healthcare.

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ΑΝΑΣΚΟΠΗΣΗ

Η αντιμετώπιση των χρόνιων ασθενειών αποτελεί πρόκληση για τα σύγχρονα συστήματα υγείας: αναφορά σε απόψεις και στρατηγικές που αφορούν ασθενείς, ιατρούς και τη φροντίδα υγείας

Κωνσταντίνος Α Πάσχος, MD, MSc, PhD

Μεταπτυχιακό Πρόγραμμα Διοίκησης Μονάδων Υγείας, ΕΑΠ, Χειρουργός, Γενικό Νοσοκομείο Δράμας

ΠΕΡΙΛΗΨΗ

Οι επιτυχίες στη θεραπεία των λοιμωδών νόσων τον 20ο αιώνα αύξησαν το προσδόκιμο ζωής και οδήγησαν στην αξιοσημείωτη αύξηση της εμφάνισης των χρονίων νόσων (ΧΝ). Καθώς ο ανθρώπινος πληθυσμός γηράσκει παγκοσμίως, οι ΧΝ τείνουν να αποτελέσουν τη νούμερο ένα απειλή για την υγεία των ανθρώπων και μια σοβαρή επιβάρυνση για τα σύγχρονα συστήματα υγείας (ΣΥ). Οι ΧΝ απαιτούν μακροχρόνιες θεραπείες, ενώ επηρεάζουν τις προσδοκίες των ασθενών από τις υπηρεσίες υγείας. Επιπλέον, περιπλέκουν τις σχέσεις ιατρών-ασθενών και δυσχεραίνουν την ικανοποίηση των ασθενών. Πολιτεία, οργανισμοί και πολίτες εργάζονται προς την κατεύθυνση της προαγωγής της ποιότητας στην υγεία και αναζητούν νέες στρατηγικές ώστε να αναβαθμίσουν και να βελτιώσουν τις παρεχόμενες υπηρεσίες.

Ενώ τα χρόνια νοσήματα είναι συχνά ανίατα, οι προσδοκίες μεγαλώνουν καθώς η ενημέρωση των πολιτών διευρύνεται, ο καταναλωτισμός στην υγεία εξαπλώνεται και η υψηλή τεχνολογία εισάγει συνεχώς νέες εφαρμογές. Η αυθεντία του ιατρού αμφισβητείται, ενώ η ενεργή συμμετοχή του ασθενούς στην ιατρική φροντίδα γίνεται ολοένα και πιο σημαντική. Οι υπηρεσίες υγείας με κέντρο τον ασθενή φαίνεται να φέρνουν μια νέα εποχή στα ΣΥ και προάγουν την ποιότητα. Οι χρονίως πάσχοντες απαιτούν άμεμπτο επαγγελματισμό σήμερα, σεβασμό από ιατρούς και νοσηλεύτριες, όπως επίσης σύγχρονες υποδομές και επιτυχή αποτελέσματα. Οι προκλήσεις για τα ΣΥ είναι πολλαπλές στον 21ο αιώνα και απαιτούν νέες στρατηγικές στην ιατρική εκπαίδευση, την ανάπτυξη νέων δεξιοτήτων και στενή συνεργασία επαγγελματιών υγείας, ασθενών και κοινωνιών.

Λέξεις ευρετηρίου: φροντίδα, χρόνια πάθηση, υπηρεσίες υγείας, ικανοποίηση ασθενών, σχέση

Παραπομπή

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Συγγραφέας αλληλογραφίας: **Κωνσταντίνος Πάσχος,** E-mail: kostaspaschos@yahoo.gr