Open doors, closed ports:
can medicine suggest something to society?

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Summary. Western countries are today experiencing a profound mutation of their immigration policies. Integration and hospitality have been taken over by closure and rejections. The policy of "closed ports" gained ground as never before. Traditionally, hospitals have imposed rules and restrictions to patients and visitors, ruling and limiting the space and the time offered. In the last two decades, though, a radical change in perspectives of some medical centres allowed a profound transformation of hospitals from closed realms to open spaces where communication and interaction with visitors is desired and encouraged. The policy of "open doors" became widespread and showed benefits in a lot of ways. Noticeably, a profound asymmetry exists between the idea of "closed ports" and "open doors", both representing – albeit in different contexts – opposite solutions for similar issues. It is possible to make a comparison? Can medicine suggest something to society?

Porte aperte, porti chiusi: la medicina può suggerire qualcosa alla società?

Summary. Negli ultimi anni i Paesi occidentali stanno vivendo una svolta nelle politiche riguardanti l'immigrazione. Rispetto all'idea di accoglienza e integrazione si è imposta quella della chiusura e dei respingimenti. La politica dei "porti chiusi" ha guadagnato consensi come mai prima d'ora. Consensualmente, negli ultimi decenni, anche alcune realtà ospedaliere in differenti Paesi hanno vissuto una svolta. Da luoghi chiusi si sono trasformati in luoghi aperti. Da strutture di cura con molte limitazioni per i visitatori (in termini di spazio e di tempo) si sono trasformate in strutture che hanno reso semplice l'accesso a chi viene in visita ai pazienti. La politica delle "porte aperte" in ospedale si è diffusa e ha dimostrato grandi vantaggi sotto più punti di vista. Pur con le dovute cautele, esiste un'asimmetria tra i "porti chiusi" e le "porte aperte". Si tratta di soluzioni opposte a problemi per certi versi simili in contesti differenti. È possibile tentare un confronto? La medicina può suggerire qualcosa alla società?

Western countries are today experiencing a profound mutation of their immigration policies. Integration and hospitality have been taken over by closure and rejections. In the last few months, former Italian Deputy Prime Minister has battled against harbouring of emergency ships rescuing migrants in the Mediterranean Sea. Barbed wire and walls are becoming a familiar reality in many European countries that are experiencing this new immigration wave. On the other side of the Atlantic Ocean, the construction of a much larger and fortified border wall between Mexico and USA is frequently invoked.

These choices are driven by the common fear of an invasion and the subsequent danger for the economy, for the security and for the native culture[1].

Traditionally, hospitals have imposed rules and restrictions to patients and visitors, ruling and limiting the space and the time offered.

In the last two decades, though, a radical change in perspectives of some medical centres allowed a profound transformation of hospitals from closed realms to open spaces where communication and interaction with visitors is desired and encouraged. Through a slow and painful rite of passage, the idea of an "open doors" hospital has succeeded in some realities. It has challenged strenuous concerns about infection spreading, loss of privacy and obstruction of clinical activities, suggesting an open model of communication and collaborations with visitors.

The open hospital model has thus produced positive effects on the relationship between health professionals, patients and their families by building a safe and shared work environment, and by improving the perceived quality of the hospitalization and reducing the anxiety related to it[2].

The inconsistency of concerns on infection spreading has been proven in subsequent studies[3]. Furthermore, the improvement of some clinical endpoints was listed among the beneficial effects of the new model[4].

Noticeably, a profound asymmetry exists between the idea of "closed ports" and "open doors", both representing – albeit in different contexts – opposite solutions for similar issues.

It is possible to draw a parallelism between the "closed ports" and "closed doors" systems. Economic and security issues (such as falling in jobs opportunities, rising crime and new diseases) are the core arguments of integration and hospitality opponents. Similarly, the risk of infections was used as example of an immediate complications deriving from the hospital free access model. As previously mentioned, this risk was found to be inconsistent, and health professionals had to realize that they were mostly responsible

for infection transmission. The enemy was surprisingly found to be inside the system – not outside – and solutions had to be found by promoting virtuous behaviour among the medical staff.

Similarly, fears of health risks related to migrations are widespread. The common myth of diseases carried by migrants was shown to be unfounded by epidemiological data[5,6]. The so called "healthy migrant effect" teaches us that only the youngest and healthiest ones would attempt the journey, therefore the incoming foreign population is usually in good health. If anything, the social and economic inequalities that many migrants face in our countries are responsible for the transition to the "exhausted migrant effect" that leads to a deterioration in health conditions. Once again the core issue lies within the system: diseases proliferation is strongly sustained by inhospitality.

The parallelism takes us to a second, more nuanced, aspect of the discussion. Those who support the rejection of migrants raise as a further argument the fear of losing their identity and contaminating their values. On the one hand, this implies that our value system is considered so weak and fragile that it may not survive contamination. On the other hand, the idea of integration being a form of pollution – therefore to be avoided at all costs – reflects the lack of willingness to compare one's values with those of others.

The pivotal challenge that healthcare professionals had to face with hospital openings was redefining their role. This obviously required an effort – cultural rather than technical – and the acquisition of new skills. The ability to resolve conflicts, to accept criticism and objections in a constructive manner, to deal with unpleasant or uncomfortable issues, to communicate effectively even in stressful conditions has become a new core skills of the profession.

Initially, some interpreted this effort as a loss in terms of autonomy, independence, professional identity and trustworthiness. Facts, however, showed the opposite. In most places where the new model was adopted, only a small proportion of professionals would revert back to the previous system. The great majority, on the contrary, recognized the usefulness of the open behaviour not only for patients and family members, but particularly for the healthcare team.

It is clear that – in order to build an open hospital, as well as to achieve an open society – a system of rules is needed. However, we have the impression that the lack of existing rules is often an excellent excuse for not addressing the issue while defending borders and exclusion behaviours.

We are aware that the parallelism presented here concerns very different contexts but it seems to us that some aspects are somehow comparable.

In open hospitals, health professionals, patients and visitors, once in close contact, have realized that they have common interests and values.

Wouldn't it be the same for an open society?

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References

1. Saracci R. Insidiosa barbarie. Recenti Prog Med 2018; 109: 367-8.
2. Chapman DK, Collingridge DS, Mitchell LA, et al. Satisfaction with elimination of all visitation restrictions in a mixed-profile intensive care unit. Am J Crit Care 2016; 25: 46-50.
3. Malacarne P, Corini M, Petri D. Health care-associated infections and visiting policy in an intensive care unit. Am J Infect Control 2011; 39: 898-900.
4. Fumagalli S, Boncinelli L, Lo Nostro A, et al. Reduced cardiocirculatory complications with unrestrictive visiting policy in an intensive care unit: Results from a pilot, randomized trial. Circulation 2006; 113: 946-52.
5. Khan MS, Osei-Kofi A, Omar A, et al. Pathogens, prejudice, and politics: the role of the global health community in the European refugee crisis. Lancet Infect Dis 2016; 16: e173-7.
6. Migration and health: key issues. WHO. Available on https://bit.ly/2FdsNtC (last accessed july, 2019).

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