

The art and science of health care: the personalization of patients

Prof. Pilar León-Sanz



Introduction

In the late eighteenth century, J. Tenon stated that "the state of the hospital measured the nature of a civilization" (1788). In effect, health care institutions reflect the way society structures itself, and vice versa. Healthcare systems illustrate key aspects of human nature, since forms of health care derive from people's values, desires, and projects in a society at any given time. Further, examining the assistance of the poor and the needy allows us to apprehend and deepen our understanding of certain features of society, particularly view on the sick or the weak.

In this presentation, I will begin by explaining how the renewed spirituality of the mendicant orders influenced the culture of medieval cities between the 13th and 15th centuries, when St. John of Duklja (1414–1484) lived, and contributed to shaping a new way of understanding the care of the needy or the infirm. They also influenced the definition of "health" at that time. In the second part, I will explore the evolution of the concept of "caring" for medicine in a more contemporary period. This issue is indebted to this tradition, since, as we shall see, respect for the patient, as a person, was crucial for the configuration of the art and the science of medicine.

Contributions of the Mendicant Orders to healthcare

Franciscan spirituality, based on "true love and charity" as well as the notion of extreme humility, led the Friars, as St. John of Duklja, to identify and commiserate with the dispossessed, which influenced the care provided by society to the poor and sick. It was an occasion of a public manifestation of Christian faith, the way to live the Gospel mandate of love and the teachings of the Sermon on the Beatitudes. In the Middle Ages these were articulated as the six major works of mercy: to feed the hungry, to give drink to the thirsty, to shelter the homeless, to clothe the naked, to visit the sick, to visit those imprisoned (Matthew 25, 31-46), to which was added the mandate to bury the dead. The mendicant orders, such as the Franciscans, developed tertiary congregations which offered lay people the opportunity to live the ideals of religious life, combining ordinary activities with religious practices which would facilitate their obtaining spiritual benefits.

The tertiary mendicant movement was strongly rooted in urban areas of both bourgeois and noble extraction. These people, many of whom were wealthy, developed welfare systems to deal with poverty and mendicancy. Furthermore, they carried out the new social ethics developed by religious orders based on the idea of social responsibility in the face of collective problems and on a new notion of common good. From the fifteenth century, begging was perceived as a source of infection and spread of disease and, ultimately, as a threat to the safety of the community as a whole. Actually, the Franciscan concern for health as a common good, illustrates the value acquired health both private and collective (Arrizabalaga 2014, 33).

Health began to be one of the goods, common or public, most valuable in the cities of the Western Christianity (García Ballester 1992, 120). The deep religiosity of the medieval and modern European society led to the belief that physical and spiritual health were inextricably linked. This did not imply that physical health had spiritual purposes, but that it supported spirituality. This idea is evident in the *regimina sanitatis*, a genre of popular medical literature in the late medieval and modern Europe, which expressively testifies to the ways university physicians regulated the whole life of individuals, in order to preserve their health (Gil-Sotres 1996). For example, Ramon Llull (1233-1315), who probably belonged to the third-order Franciscans, encouraged people to care for their health "because if your own body stays healthy by temperance, you can serve God with all your senses and imagination" (Lull [1313] 2008, vol. 1, 21).

The concern for collective health in medieval communities had at least two more implications. First, the new association of theology, university medicine and health, largely due to the Franciscans and Dominicans, reinforced the status of the physicians trained in the universities. Second, municipalities and emerging states promoted public health measures such as urban sanitation: street cleaning, food control, waste disposal, and so on. Importantly, we see that, throughout the fifteenth and sixteenth centuries, diverse European regions began developing a new kind of hospital. Institutions, known as major or general hospitals, designed to assist orphans, women in labor, elderly people, students or clergy already existed. However, the new hospitals provided a more "specialized" care, based on patients' needs (Henderson, Horden, Pastore 2007). This model of general hospital remained essentially unchanged throughout the Old Regime, until the 19th century. It was a period in which the imperative of Christian charity continued to drive the various welfare and healthcare initiatives.

The development of "medical care"

In this section, I will discuss the development of these ideas in relation to the notion of "curing" observed by the health professionals, and how this term connects with the notion of "caring" for patients.

In general, the attention given to the notion of "care" within western medical ethics has not been nearly as extensive as that given to issues corresponding with freedom, justice, or love. However, it could not be clearly outlined without the support of an account demonstrating activities linked to the human condition. The term "care" contains two meanings, one with an active character and the other passive. In the first, "care" refers to the attitude of attention, devotion, solicitous, diligence and effectiveness in the execution of a task. The passive meaning is related to the feeling of anxiety or preoccupation that overcomes a person burdened with worries. Both meanings intertwine, given that no one can survive without the other, at some level of life.

In Western culture, until the Enlightenment, care had been understood above all in its positive, social sense. Nevertheless, in the nineteenth century, the notion of care as subjective and solely linked to the individual developed. The care of others naturally derived from the care of oneself. The idea of "care"

incorporated the experience of caring and being cared for. Being sick or in need leads someone who is ill to accept the consolation of others. In this context, the health professions emphasize their expression of concern for those who are sick. Heidegger stressed the importance of care as the central point of knowing the significance of one's own humanity. This has influenced numerous authors of the twentieth century. However, the definitive drive to develop an ethics of care came from the publication of the book by Carol Gilligan *In a Different Voice: Psychological Theory and Ethics* (1982). From this point, an ethics of care associated with nursing and its feminine aspect was expanded in important ways (Reich 1995).

In general, professional competency has been essential for the "ethos" of Hippocratic medicine, the basis of western medicine. Due to this, care has been associated with technical and competent care in a substantial part of the history of medicine. Furthermore, the scientific development of successful medicine from the second half of the nineteenth century through a large part of the twentieth century has come to define medical care by measurable scientific data. This led to the idea of objective health and increased the distance between the illness and the patient, marginalizing to a large extent the care of the person and even bringing into conflict the act of "caring" with "curing". Richard C. Cabot (1868–1939), a professor at the Harvard Medical School, articulated an ethics of medical competence that confronted the notion of "taking care" of the patient—referring to the application of scientific-technical knowledge—as opposed to the more humanitarian idea of "caring for," which Cabot applied to non-medical health professionals (Cabot 1926).

Francis Peabody, another Harvard professor and a contemporary of Cabot, offered the contrary point of view. He believed that caring for the patient was something essential for medical practice and doctors were required to do this in order to accomplish the end of medicine. His essay *The Care of the Patient* (Harvard 1927) has been a landmark in the ethics of care of medicine in the twentieth century. Peabody acknowledged that the "enormous mass of scientific material" to which a young doctor must be exposed, the depersonalization of hospital practice, and the medical inclination that transforms organic illness into a mere consequence of clinical anatomy endangers the personal and human aspect of medical art. In order to remedy these urgent problems, he believes that doctors should promote attentive and respectful doctor-patient relationships. The impersonal treatment of an illness lengthens the curing pro-

cess, reducing the effectiveness of the medical treatment. Care, thus, "takes its proper place in the larger problem of the care of the patient" (Peabody, 1927, 880), because medicine "must be completely personal" (Peabody, 1927, 877). The doctor should be attentive to the particular circumstances of each patient, "not from the abstract point of view of the treatment of the disease, but from the concrete point of view of the care of the individual" (Peabody, 1927, 881). Peabody thus emphasizes "the necessity of care in the practice of good clinical medicine" (Peabody, 1927, 882).

This kind of "care" requires attentiveness to the patient's personality, sympathy for the patient's total situation, friendliness that elicits trust, and a consideration expressed in "the little incidental things that you can do for his comfort. These, too, are a part of the care of the patient. Some of them will fall technically in the field of nursing but you will always be profoundly grateful for any nursing technique that you have acquired" (Peabody 1927, 881). His maxim was: "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient" (Peabody, 1927, 882). Following Peabody, numerous doctors have written on the need for care in medical practice (Harris 2009). The medical ethic's inclusion of virtues has had a particular repercussion on care for patients.

As noted earlier, the notion of "caring for" entails acting in a benevolent, as well as altruistic and virtuous, way. In a medical context, "care" entails a basic moral orientation that helps mitigate "technical medicine's dehumanizing" effects. "Objectivity and compassion complement and balance each other", says Edmund Pellegrino (1988). For him, compassion is the "habitual disposition to enter into the predicament of the sick person, to feel something of that predicament with him, and, as a result, to wish to help" (Pellegrino 2003, 14). Without this disposition, it would be impossible to cure in the complete sense of the word. For Pellegrino, "caring for the patient" implies "taking a personal interest in the patient's fate, or taking care in the way we carry out our professional duties, or taking care of the patient's need and concerns." (Pellegrino 2003, 14). This definition of "care" connects with compassion. Perhaps this is so because frequently, on those occasions where it is impossible to cure a patient, doctors recommend that anything that might alleviate and care for the person should be offered: "To be authentic, this end must be defined in terms of the good of the patient, that which restores health, if that is possible, or provides comfort and care if restoration of health is not possible" (Pellegrino 2003, 12).

However, the notion of "care" is not sufficient to constitute the fundamentals of the theory of ethics (Pellegrino 2003, 11). Objectivity in correct and competent attention should be combined with care as much as with compassion. The clinical evaluation of data obtained through the physical examination, biochemical analyses, or invasive technical procedures are the objective element in the doctor-patient relationship. This evaluation aims to be completely objective, transcending emotions or feelings. The doctor cannot be a good doctor if, at this moment or during these procedures, he does not put aside compassion and sympathy, and functions within the boundaries of his involvement with the particular patient's circumstances.

Care and respect

To care involves respectfully addressing and bestowing benevolent treatment. Its opposite would be "maltreatment" or poor use, subjecting those around us to abuse or neglect. In this sense, to deal with someone or something would be identical to respecting (and with caring for) an object or person. In medicine, "respect" is a secular expression of a Hippocratic idea: the *filia iatriké*, an notion profoundly connected to the Christian command for charity, to loving one's neighbour. It also refers to the attitude towards the civil dignity of man. Alan Donagan shows that the philosophical nucleus of the morality of the Judeo-Christian tradition, one that derives from a monotheistic faith, can be condensed into this principle: it is not permissible to disrespect a human being, be it oneself or another (Donagan 1979, 66).

The subjective aspect of respect refers to an attitude of veneration, consideration or deference, the capacity to grasp and process moral values. Only someone who is already respectful has the capacity to comprehend these notions, the same way that sensory deprivation atrophies the intelligence. Respect also implies an objective element that derives from when respect is given; there is a dignity that comes from being respected. In medicine, respect for life is united to an acceptance of vulnerability, of the fragility typical of persons, and the inevitability of sickness and death. Doctors do not have problems with the healthy and strong, but struggle with the ill and debilitated, with people who have lost their physical vigour and mental facilities. The blending of care and respect contributes to medical care that does not discriminate or act paternalistically.

Gonzalo Herranz has repeatedly presented (1985, 2003, and 2008) a positive and fruitful idea for the progress of persons and society, consisting in

understanding the value of the weak. To be weak, in the Christian medical tradition, entitles one to respect and protection. In a way, health confers the capacity to achieve the fullness of humanity. On the contrary, to suffer a chronic and incurable illness can limit the human capacities. A serious or incapacitating illness, to an even greater extent if it is terminal, does not only consist in grave and critical muscular and cellular disorders: it consists principally in the threatening of personal integrity that tests one's humanity. A physician should never forget this truth when he or she cares for the sick.

The following example shows that the study and significance of "care" has already been usefully engaged through the recourse of narratives. Paul E. Ruskín was invited to present a lecture to a class of graduate nurses who were studying the "Psychosocial Aspects of Aging" (Ruskín 1997). He opened his lecture with the following case presentation: "The patient is a white female who appears her reported age. She neither speaks nor comprehends the spoken word. Sometimes she babbles incoherently for hours on end. She is disoriented about person, place, and time. She does, however, seem to recognize her own name. I have worked with her for the past six months, but she still does not recognize me. She shows complete disregard for her physical appearance and makes no effort whatsoever to assist in her own care. She must be fed, bathed, and clothed by others. Because she is edentulous, her food must be puréed, and because she is incontinent of both urine and stool, she must be changed and bathed often. Her shirt is generally soiled from almost incessant drooling. She does not walk. Her sleep pattern is erratic. Often she awakens in the middle of the night, and her screaming awakens other. Most of the time she is friendly and happy. However, several times a day she gets quite agitated without apparent cause. Then she screams loudly until someone comes to comfort her." After the presentation, P. Ruskín asked the nurses how they would feel about taking care of a patient such as the one described. "They used words such as 'frustrated', 'hopeless', 'depressed', and 'annoyed' to describe how they would feel." Ruskín's test ends by circulating among the participants a photo of the referred patient: a beautiful six-month old baby. After the audience protested that they felt themselves tricked by the professor, time was given to consider if their solemn and self-gratifying promise to not discriminate might yield to differences in weight, age, vital perspective, of feelings inspired by the physical appearances of the different patients, or if they need to overcome themselves in these circumstantial details.

Therefore, although there is a current peak in the promotion of a philosophy of care similar to that proposed by Heidegger that prioritizes subjective aspects, it seems necessary, for health professionals at least, to search for a way of viewing the ill in a manner less controlled by feelings. An elderly patient is as worthy of dignity and love as a child. And the ill that spend the last days of their existence incapacitated by dementia or pain merit the same care and attention as those beginning their lives with the helplessness of infancy. Medical ethics recommend that the professional should be guided by the search for the patient's greater good. However, the so-called "best interest" is a concept which, though both ethical and legal, remains vague and therefore admits a great deal of flexibility in its interpretation and applications. There are many doubts on how to bring these criteria about because there is no consensus regarding what exactly the greatest good for a patient entails. In these situations, we unveil paternalistic or protectionist forms of action that might limit the freedom and rights of the incapacitated and minors who in the end need more "care" and protection than others. The liberal position proposes to grant the individual incapacitated by illness or youth autonomy on the care they will receive. The proposed solutions for these dilemmas correspond to more general practices when we consider the responsibilities of the family, legal or professional responsibilities, institutions or society, as the protectors of the interests of those who do not have the capacity to decide. This debate far exceeds the limits of this presentation.

Care and the physician-patient relationship

In 1939, Franz Alexander, one of the founders of psychosomatic medicine in the United States, argued that "There is little doubt that they [the doctors] often had a spectacular curative effect upon the sick, in certain respects even a more fundamental effect than many of our drugs, which we can analyse chemically, and the pharmacological effects of which we know with great precision" (Alexander, 1939, 60). The authority of this statement comes from his belief in the novelty of the approach, at a time when drugs and surgery were becoming more effective. However, since ancient times the therapeutic function of the physician-patient relationship had been emphasized, as the success of the diagnosis and the treatment depend, to a great extent, on a good personal bond between the physician and the patient. On the contrary, if this link does not exist, effectiveness in patient care drops (Peabody, 1930, 45).

It is often thought that scientific development was detrimental to the doctor-physician relationship (Shorter, 1991). Doctors themselves accept this view (Peabody, 1927, 8), and F. Alexander indicated that, in its emphasis on facts and objectivity, science had disregarded the psychological aspects of medicine: "This psychological function of the physician, however, was perhaps never more disregarded than in the last century in which medicine became a genuine natural science based on the application of the principles of physics and chemistry to the living organism. ... The recognition of psychological forces, a psychological approach to the problems of life and disease, appears as a relapse back to the ignorance of the dark ages" (Alexander, 1939, 61). This author insists that physicians must consider the patient as a person and care for him by taking into account the set of factors that make up that individual.

The current relationship between physicians and their patients, with renewed attention to communication and the consideration of socio-environmental factors, reflect the influence of this movement. The affective phenomenon has its own perspective and is an important element in personality, taken as a whole. Today, we often speak of confidence, hope, empathy, and compassion as key elements in the doctor-patient bond. The doctor who inspires such feelings or builds on them increases her healing capability (León-Sanz 2013).

At the same time, the number of medical articles on the importance of communication between the doctor and patient has grown exponentially and there is a movement to emphasize this strategy in the training of medical students. The ethical competence of a physician has been defined depending on: "the capacity to dialogue, the ability to deliberate and the capacity to undertake a critical analysis" (Stéphane, 1998). As a result, there has been an actualization of the importance of considering the person as a whole and the significance of the emotions for health and illness.

We now have substantial medical literature on the therapeutic character of the doctor-patient relationship. These publications remind us that there is no difference between healing and curing in therapeutics (Cassel 1991, 16), between scientific-technical competence and care. Physicians must carry out both operations, attending to the patient as a person who not only has to get better, but also needs to "feel good". The object of the physician's care is the patient, not merely the illness.

An attempt at a conclusion

At the end of this presentation we can point out that those who practice medicine must embody the double condition of carer of people and cultivator of science. This attitude allowed the art of medicine to be considered scientific medicine, given that the influence of the doctor-patient bond could no longer be considered a mere addendum to the treatment, an artistic or personal touch, but rather the main basic therapeutic factor (Alexander, 1939, 60-1, 72).

In the course of a doctor-patient relationship, the physician has to alternate between the perspective of I-you between people and when it is necessary rid himself of this viewpoint in order to focus his attention on the patient-object. In the latter, the patient becomes an object of observation and natural-scientific intervention in order to determine the nature of the pathological process and its corresponding treatment.

Care is related to respect when it contributes to the realization of the person we are caring for; it also involves the capacity to care in order to cure (Yepes Stork 1996, 454). To care respectfully undercuts the carer's servility and attends to the convictions of those receiving the care. "To care" facilitates medical professionals' comprehension of their primary ethical duty, respect for life especially for those who are vulnerable.

"Care" for the sick brings about an acknowledgment of the essential practical and ethical limits of scientific-technological power. We understand better now that neither obstinacy nor abandonment are ethical answers to terminal or poverty-stricken situations. In his influential book *Patient as Person* (1970), Paul Ramsay states that at the end of life, when attempts to cure are no longer appropriate, one must always care – even if one only cares by keeping company and offering comfort – while permissibly withdrawing medical care.

Bibliography:

Ahern S. P., *La compétence professionnelle du médecin et l'enseignement de l'éthique*. CMAJ 1998; 158: 903-905.

Alexander F., *Psychological aspects of Medicine* (1939), in: M. R. Kaufman, M. Heiman (eds.), *Evolution of psychosomatic concepts; anorexia nervosa, a paradigm*. New York, International Universities Press. 1964, p. 56-77.

Arrizabalaga J., *Asistencia, caridad y nueva ética de la responsabilidad colectiva ante la salud y la pobreza en el espacio urbano occidental del Antiguo Régimen*, in: T. Huguet-Termes, P. Verdés-Pijuan, J. Arrizabalaga, M. Sánchez-Martínez (eds.), *Ciudad y hospital en el Occidente europeo. 1300-1700*. Barcelona: Ed. Milenio, p. 27-48.

Cabot R. C., *Adventures on the Borderlands of Ethics*. New York & London: Harper & Bros, 1926.

Cassell E. J., *The nature of suffering: and the goals of medicine*. New York: Oxford University Press, 1991.

Donagan A., *The Theory of Morality*. Chicago: Chicago University Press, 1979.

Engel G. L., *The need for a new medical model: a challenge for biomedicine*. Science. 1977; 196(4286): 129-136.

García Ballester L., *Changes in the Regimina sanitatis: The role of Jewish physicians*, in: S. D. Campbell, B. S. Hall, D. N. Kfauzner (eds.), *Health, disease and healing in medieval culture*. Nueva York: St. Martin's Press, 1992, p. 119-131.

Gil-Sotres P., *Introducción*, in: L. García Ballester, M. R. McVaugh (eds.), *Arnaldi de Villanova Opera Medica Omnia. Regimen sanitatis ad regem Aragonum VIII. X 1*. Barcelona: Publicacions de la Universitat de Barcelona-Fundació Noguera, 1996, p. 471-861.

Gilligan C., *In a different voice: psychological theory and women's development*. Cambridge (Massachusetts): Harvard University Press, 1982.

Harris J. C., *Toward a Restorative Medicine-The Science of Care*. JAMA. 2009; 301(16): 1710-1712.

Henderson J., Horden P., Pastore A., *Introduction. The world of the hospital: comparisons and continuities*, in: *The impact of hospitals, 300-2000*, Berna, Peter Lang, 2007, p. 15-56.

Herranz G., *El respeto, actitud ética fundamental de la Medicina: lección inaugural del curso 1985-86*. Universidad de Navarra, 1985.

Herranz G., *La Deontología Médica y los Pacientes de Alzheimer*. Rev Med Univ Navarra. 2003; 47;2: 37-38.

Herranz G., *La medicina paliativa, ejercicio de ciencia y de humanidad. Cuando ya no se puede curar*. Aceprensa. 100/2008.

León-Sanz P., *El carácter terapéutico de la relación médico-paciente*, in: L. Flamarique, M. D'Oliveira (eds.), *Emociones y estilos de vida. Radiografía de nuestro tiempo*. Madrid: Biblioteca Nueva, 2013, p. 101-130.

Llull R., *Llibre de virtuts e depecats*, I, 4, (ed.), F. Domínguez Reboiras, 23 ed. rev., Palma: Patronat Ramon Llull, 2008.

Peabody F. W., *The care of the patient*. Cambridge: Harvard University Press, 1927. Reprinted, *JAMA* 1927 March 19, 88: 877-882.

Pellegrino E. D., Thomasma D. C., *For the Patient's Good: the restoration of beneficence in health care*. New York; Oxford: Oxford University Press, 1988.

Pellegrino E. D., *The Moral Foundations of the Patient-Physician Relationship, Military medical ethics, volume 1, section i*. Washington, 2003.

Reich W. T. (ed.), *Encyclopedia of Bioethics*. New York: Simon and Schuster, 1995. Care, 319-344.

Ruskin P. E., *A piece of my mind. Aging and caring*. *JAMA* 1997 Oct 22-29; 278(16): 1384.

Shorter E., *Doctors and their patients: a social history*. New Brunswick: Transaction Publishers, 1991.

Tenon J., *Mémoire sur les hôpitaux de Paris*. Paris: Imprimerie de Ph. D. Pierres, 1788.

Yepes Stork R., *Fundamentos de antropología: un ideal de la excelencia humana*. Pamplona: Ed. Universidad de Navarra, 1996.



Professor Wojciech Konstanty Podleski



About myself, autobiographic note:

Europe:

- Doctor of Medicine (1965), Medical Academy in Wrocław
- Doctor of Medicine (1972), Medical Faculty of the University of Lausanne, Switzerland

USA:

- Professor of Immunology, New York State University in Buffalo
- Professor of Medicine, Medical Academy in Denver, Colorado State University

- President, Podleski Foundation Art & Humanity & Medicine
- Consultant, World Health Organization (WHO), Geneva, Switzerland

The most important scientific positions:

- Director of Reference Laboratory for Thyroid Diseases of the Polish Academy of Sciences
- Medical Academy in Wrocław, Director, International Institute of Clinical Immunopharmacology, Allergy and Asthma
- Denver, Colorado, USA, Specialist private medical practice in Allergy, Asthma and Clinical Immunology
- Denver, Colorado, USA, Designated Aviation Medicine Doctor of the Federal Aviation Agency (FAA) of the United States with the authority to promote or remove civil aviation pilots