Humanity in the caring relationship

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Introduction

Many factors, including those related to the progress of medicine, its costs and increasing specialization of different disciplines, risk negatively affecting the maintenance of that human dimension, which is essential in the care relationship, and compromising the fundamental holistic view of the patient (1-2). The scientific literature has long emphasized the need to accompany technical training, which is indispensable in the curriculum of the health professional, with sound ethical skills necessary to confront the continuing dilemmas of medicine and to develop intervention skills that respect the otherness and dignity of the person seeking care (3, 4).

In the face of the risks of the growing technologization and bureaucratization of care, the call of John Paul II on the essentiality of "people who are distinguished not only by recognized professionalism, but also by a marked sense of humanity, understanding, friendship and love, in such a way that the sick person feels morally supported and comforted in a difficult moment of his life, such as that of a stay in the hospital," is as relevant as ever (5).

These considerations are necessarily reflected in the identification of the "business model" to be pursued in the organization of services, because in the social and health sector the culture of discarding could creep in that debases and forgets the centrality of the sick person. The call to be vigilant must be particularly strong when dealing with elderly patients, people suffering from serious, chronic and disabling diseases, as well as psychiatric patients, since the corporate model in health care, if adopted indiscriminately, instead of optimizing available resources, risks increasing inequalities (6). Optimizing resources means using them in an ethical and supportive manner without penalizing the most fragile, but on the contrary making a greater effort to ensure that it is precisely the most fragile who benefit from more facilitated access and care (7, 8).

Certainly, the call for the humanization of medicine may be a paradox: how can a discipline that has always been rooted "in man" and "for man" need humanization?

However, the great possibilities of medicine increasingly may lead one to seek and, even, claim the health, healing and keeping a person alive at "any" cost, forgetting the uncertain character of medical science and the criterion of appropriateness that denies the moral admissibility of the disproportionate medical act (qualifying as mere overkill).

Such a view also forgets the inescapable fragility of the human condition and, consequently, the fact that death occurs not only because of inefficiency or medical mistake, but as an inescapable consequence of human existence itself.

Such considerations should therefore guide the fundamental goals of the medical profession: to heal the sick person or, at least, to try to effectively affect the evolution of the disease; to alleviate the painful symptoms, especially when the disease is in an advanced stage; and always and everywhere to care for the sick person in all his human expectations.

These goals are moreover well summarized in the various codes of ethics of the medical and health care profession, which value the dimension of welcoming the sick person, regardless of the possibility of therapeutic intervention, in accordance with the broader and more qualifying vision of care (9).

Therefore, to develop a medicine always anchored and centered on the person, the co-presence of certain

fundamental elements is necessary (10). First, the preliminary recognition of "the other" as a person, deserving of profound respect and to be considered in his or her totality and integrity.

Health care activity must never lose sight of the profound unity of the human being in its composition and interaction of all its bodily and spiritual functions and also affective, relational, intellectual and cultural (11). In this respect, Medical Humanities can contribute to a more holistic and careful view of health and disease (12).

Secondly, it is essential to build a true and appropriate therapeutic community, with the identification of a common and shared task of the doctor-patient relationship, today increasingly complex and articulated, since it is enriched by different professional figures.

The literature has long pointed out the terminological polyvalence of the term "care" of which two are the most relevant: one to "cure" is all internal to the medical field with the meaning of therapy, treatment and, also, healing, while the other to "care" refers to solicitude, thoughtfulness and anxiety for the fate of another person. Essential dimensions that, necessarily, require an inseparable intertwining.

Third, the diversification and acceptance of the respective roles is essential: on one side the caregiver, on the other side the one who needs to be cared for. In this case too, the intertwining of the knowledge and skills of the interlocutors must be indissoluble and trust becomes the glue element of this articulated relationship.

Trust becomes the glue element of this articulated relationship. The element of trust, moreover, is increasingly anything but taken for granted and requires commitment and training on the part of health professionals (13).

The health worker-patient relationship

The time of care represents the epicenter of the doctor-patient relationship: it requires preparation, continuous updating, experience, and above all, listening. It is not a mere technical act, performed by a "body mechanic", as if it were the repair of a mere broken object to be reassembled. The physician, while making use of increasingly precise, advanced and sophisticated technologies, operates in a human relationship of help directed to a person who delivers into his hands not only his body and his illness, but his whole person, his experience, his history, his values, his beliefs, his fragility and his hopes.

In fact, the patient's trust in the doctor is not only confidence in his scientific competence, but also reliance on his humanity and sensitivity: "it is a pact of care based on trust." The result is a great responsibility of all personnel called to care (14).

The possibility to use more and more effective and sophisticated tools for the benefit of those who suffer should imprint the exercise of the medical profession with a dimension of shared humanity, because the sick need understanding, constant encouragement, accompaniment and even consolation.

Such awareness should lead one to always remember that "illness can be an opportunity for encounter, for sharing, for solidarity" (15).

Respect for the value of life, understanding of the suffering and anxieties of the sick person finds an irreplaceable implementation in approaching those who suffer not only in their physical dimension, but also in their spiritual dimension, remembering that "This closeness to the other - closeness in earnest and not feigned to the point of feeling them as someone who belongs to me [...] overcomes all barriers of nationality, social background, religion [...]. It also overcomes that culture in a negative sense according to which, whether in rich or poor countries, human beings are accepted or rejected according to utilitarian criteria, particularly social or economic utility" (16).

The physician's identity and commitment, therefore, is based not only on his science and technical competence, but also, and above all, on his compassionate attitude that "suffers-with" and that, therefore manages to empathize with the patient and understand the experience of suffering of both body and spirit, since "Compassion is in a sense the very soul of medicine" (17).

In a psychological perspective, compassion is also the desire to alleviate the other's suffering or, at least, to reduce it, since "at the root of the capacity for compassion is letting oneself be touched-not infected, but touched-by the other's suffering and, instead of

shunning the experience of the other's pain because it is too strong [there is] knowing how to make this feeling the impetus to act with care" (18). In the most critical situations, marked by both physical and psychic pain, that closeness, even if only physical, and that existential, emotional and spiritual sharing that the sick person feels on par with care can also become consolation (19).

However, compassion can induce an excessive and dangerous involvement with the other that must be well managed, in order to avoid, both an undue and dangerous identification of self with the other's suffering (which could also lead to "burnout" that would alter caring capacities), and the risk of establishing an excessive distance that leads to indifference toward the other.

The role of the team

The relationship with the patient involves a plurality of figures who necessarily interface and integrate to offer, even in different emergency contexts, an extensive and integrated cure (20).

In the care relationship, the nurse has *in primis* a role of assistance and physical and very particular proximity to the patient, and with him the social and health worker.

Thanks to them, and all the rest of the staff, the hospital can become not only a place of care, but also a human place par excellence, where every patient, despite suffering, is treated with dignity and can also benefit from the closeness of family and friends as fundamental resources for the integral care of the person (21).

In addition to the figures of health care professionals, who are often in direct contact with relatives, there are also other figures who are essential to the management of care activities-such as administrators, technicians and researchers-who, while working behind the scenes, integrate their activities with those of clinicians, also enabling the adoption of innovative solutions to improve patient adherence to therapy, promoting its sustainability, development and improvement in terms of cost-effectiveness (22).

In addition, alongside clinicians and more than twenty types of health professions, volunteers can also be present at the side of the sick person and can offer great support to the sick person and his or her care-givers.

In the doctor-patient relationship outside the hospital, a major role is also played by the pharmacist, who often also acts as an intermediary between the treating physician and the sick person and who, therefore, should also possess adequate ethical skills to deal with the various issues of care of the patient.

Communication as a moment of care

One of the most current ethically critical issues in clinical ethics is that of communication with the patient during the stage of care (23). It is a typically "human" aspect of medicine, because it indicates the interpersonal relationship in which two human beings, albeit with different roles, enter into communication, synergy and embark on a path of trust, also called "therapeutic alliance."

The literature emphasizes the importance of careful communication that respects the individuality of the person. Genuine techno-scientific progress cannot wither interpersonal relationships, renege on reciprocity, gift and communion, on the contrary, "these elements instead confer additional value, must once again become an indispensable part of the professional background of every health care provider, as they constitute a non-secondary aspect of the therapeutic plan, indeed perhaps they are its essence" (24).

With regard to communication, medical psychology offers important suggestions for health care provider and patient to arrive at a "put-in-common" a "communication" that is not limited to a mere transmission of data and technical information, however relevant, but that is directed to actually make the person of the possibilities of treatment and to make an informed choice based on a careful assessment of risks and benefits.

This entails not only "what" to tell the patient, respecting the criterion of completeness and truthfulness of information, but also "how" and "when" to tell, since the physician must know how to speak not to the sick

person but with the sick person and, above all, must know how to listen.

In this communicative context, narrative medicine assumes importance since "the narrative of illness becomes a story that the sick person tells, and others 're-tell' to give coherence to important events and the long course of suffering" (25).

Good medical practice also comes through understanding the narratives that all those who experience illness - patient, family, friends, colleagues - make of illness and pain. It is important for those around the sick person to witness this life story, to value interpretation and to recognize the value of the subject and his or her narrative. It is not just a matter of listening quietly, or worse, distractedly, but of entering into respectful conversation to make a "co-narrative," a narrative together.

Patient and physician together construct the narrative by enriching it with elements that together they detect as important: facts, feelings, diagnosis, effects of treatment, life change, labors, hopes, perspectives. And "by storytelling, one understands, one heals" (26), that is, one becomes more fulfilled men and women; here it is not a matter of healing from the disease, convincing oneself that evil is not there, but of healing in spite of the disease and, even, because of it.

Narrative medicine fully recovers the interpersonal relationship, highlighting how the doctor-patient relationship is, first and foremost, an encounter between people, between a competence and a trust.

Conclusions

Humanization of medicine is not an autonomous and additional dimension to the scientific dimension that characterizes only its technical aspects. Rather, it is the heart, the soul of an exercise of science capable of always maintaining an participatory listening to the patient's plea for help not only related to his specific infirmity, but also to his psychological and spiritual condition (27, 28).

There is a need to engage in a "re-personalization" of medicine, which, leading once again to a more unified consideration of the sick person, favors the establishment of a more humanized relationship with him, that is, one that does not tear the link between the psycho-affective sphere and his suffering body.

In conclusion, the physician would not fully respond to his vocation if, using the latest advances in research and clinical practice, he did not also add to his scientific and practical activities "his human heart," implementing a style of proximity to the sick person "to be able to assist him with human warmth in the face of the anxieties that beset him in the most critical moments of illness.

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