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Recognizing and strengthening the humanistic dimension in medical practice

Reconocer y potenciar la dimensión humanística en el acto médico

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Abstract

The training of a humanistic physician involves education in values, through which it is possible to integrate knowledge with good practice.

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Based on a study conducted to review the elements to be considered in the training of a humanistic physician, the quality of bioethics training in medical schools was evaluated. This article describes the story of a physician who recounts how his patients have shaped his professional profile. Excerpts from an interview with a cardiologist who is a member of an interventional cardiology service at a high-complexity hospital are highlighted. His account of his experience allows us to appreciate and find value in the affective and emotional relationship that clinical practice entails.

Keywords: bioethics, education, medical practice, medical humanism.

A man who fully assumes his responsibility
toward a human being who is waiting for him,
or toward a job that remains to be done,
will not squander his life.
He knows the "why" of this life
and will be able to endure all the "hows" to which he will be subjected.

Victor Frankl

1. Introduction

Technological developments in medicine, applied to the prevention, diagnosis, and treatment of diseases, have added precision and speed to their contributions, but at the cost of losing the most important aspect of human relationships, which is simply *being close, being present, being* (1) Paradoxically, these scientific and technological advances create a distance between doctor and patient, a loss of closeness and availability in practice (2). Is it possible to adopt an evaluative and scientific approach to clarify and reverse this position in patient care? (3).

Training a humanistic doctor involves educating them in values that enable them to integrate knowledge with good practice. The transmission of scientific knowledge must be harmonized with the needs of the patient, not only explaining or demonstrating, but

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also inspiring the appropriation of values that humanize practice through meaningful interventions (4), for example, enabling and sustaining patient autonomy, enhancing it through joint decision-making. Establishing a relationship of mutual trust and responsibility, considering all dimensions of the person, avoiding simply diagnosing and prescribing pharmacological regimes or highly complex treatments; recognizing the suffering person, instilling affection and support, respect for the patient and their family; fostering solidarity with colleagues and the healthcare team.

The technique used to evaluate, and professional intuition can be linked through communication and narrative skills, which are necessary to carry out a humanized medical practice. These skills allow for the development of continuous improvements in the therapeutic alliance and enable a communication process that strengthens the doctor-patient relationship (5).

With the aim of reviewing the elements to be taken into account in the training of a humanistic physician whose care places the patient at the center[1], a study conducted in 2024 evaluated the quality of bioethics training in medical school.[2] It was a long and in-depth study, which allowed for in-depth conversations with some of the doctors who graduated from the Pontificia Universidad Católica Argentina (UCA) medical school and, based on their accounts, verified the relationship between bioethical training and the performance of doctors, both in terms of their appreciation and their personal commitment. Although the results of the study have been described in detail in another article (2), this paper outlines the account of one doctor. Looking back, he describes how his professional profile was shaped by his patients: self-aware, he recognizes himself as the cause of his actions and his being; he describes the value and meaning of his profession, his respect for his patients and for himself, and his

[1] Evaluation of bioethics training at the UCA medical school. Analysis of the first 10 cohorts of graduates. Doctoral thesis. Faculty of Medicine, Pontifical Catholic University of Argentina.

[2] Pontifical Catholic University of Argentina. Faculty of Medical Sciences.

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personal reality in each therapeutic intervention that connects him with the patient as a person.

Excerpts from one of the interviews with Augusto, a cardiologist who is part of an interventional cardiology service at a high-complexity hospital, are highlighted. The account of his experience provides an opportunity to appreciate and find value in the affective and emotional relationship that clinical practice possesses. He shares his personal discovery with the reader and invites them to accompany him in his assertion: it is possible to turn to love in the medical act. His account warns that expressing a vocation for service with affection and a commitment to the patient can be considered key factors in achieving therapeutic success. Everything changes when we look for the human face in all pain. The doctor can see himself in the other, and his practice becomes more humane. It is not just a matter of treating the patient's body and the disease, but of caring for the situation of illness that a person is experiencing.

> ...the seriously ill patient at the end of life is the most important patient. When I was in R 1 of the medical clinic, I was called about a patient I had in my ward who was hospitalized with leukemia. Leukemia usually has a very agonizing end. They called me because I was in charge of that ward, and they called me asking for instructions, and I told them, "Give him morphine, give him morphine." I was a first-year resident, I was completely overwhelmed. When I arrived at the ward the next morning, the patient had died. I returned to the ward just as the family was there, crying, and they said to me (here the interviewee becomes emotional and his voice breaks), 'No one came to see him, no one came to see me." I was never the same again. That's when I understood that it wasn't about the disease, but about the patient and his family.

The beginning of the meeting was indicated with the question: *Is there a common element, a characteristic, in the clinical practice of a graduate physician who has received training in bioethics?* As the interview progressed,

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more specific and detailed questions were asked. Among the topics addressed were the responsibility of resident physicians in their daily practice, values, empathy and trust, the doctor-patient relationship, facing the pain of others and taking responsibility, respect for superiors, working with nurses, end-of-life scenarios and decision-making, communication with patients' families, confidentiality, and the importance of working in an interdisciplinary team (2).

The three parts of the interview, namely Orientation, The Doctor as a Person, and The Clinic, could be identified with the questions *Where to? With what? How?*

2. Orientation and Distinctive Values[3]

> ...I think there is something distinctive that marked a path [...] and I really believe that we have many more tools, and that happened to me as a resident trainer, realizing how well trained I was [...] we have talked on several occasions about how much the university prepared us for these types of conversations, to face, to contain, and I think that sets us apart, the naturalness with which we talk about certain topics is something that I highlight. The ease with which one can talk about the end of life, for example. We talked about it so many times! On one side, on the other, there are so many talks, you heard it five years in a row, and then it becomes familiar, and you wonder when others talk about it, how can you find it difficult to face this? How can you not talk about this? […] Giving quality of life, respecting the patient, saying no to aggressive treatment, you start to see that it's part of you, it's an embodied value.

Discovering and considering the person as the center of all actions is the guidance we receive, making it our own and embodying it allows

[3] Second point of the guidelines for the creation of the medical degree program: "to value the tradition of the Catholic University embedded in the very origins of the University as an institution".

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us to rationally deduce fundamental principles for humanized clinical practice (6,7). Training in bioethics is a necessary resource that imbues medical practice with an essential dimension, highlighting the importance of constantly nourishing oneself with an existential and philosophical reading of the nature of human beings in light of values. The ability to effectively justify and argue in defense of and respect for human dignity is evidence of an academic approach that is in dialogue with today's world. In contrast to pragmatic utilitarian positions that give subjectivities and individualisms what they demand, there is an affirmation of the understanding of the reality of the person in their ontological and axiological dimensions. Together with an anthropological foundation, the application of a triangular and interdisciplinary method, and the enunciation of its own principles, the effectiveness of a solid criterion is demonstrated, which allows for discernment between what is technically and scientifically possible and what is ethically permissible (8).

This makes it possible to outline a profile of the medical profession that highlights the importance of being present and available at the patient's bedside. Value-based training aims to bring about a profound change in each future professional when they practice medicine. It instills a practice that always seeks the good of the patient, so that when the doctor receives them, they are able to integrate their life story into a specific context and explore the meaning of the illness in that person's life. It is a personal challenge to find in patients the same concepts that they have researched so extensively throughout their career: how each sick person is an opportunity to verify the unique value that the concept of health acquires when it includes the purposes and aspirations of each patient and not just the absence of disease.

It is hoped that training in values will not be reduced to blind obedience or compliance but will enable future doctors to embark on a journey towards personal fulfillment, discovering themselves in their work. Medical practice requires going through processes, even periods of uncertainty, in which each person can see what is happening

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to them until they become someone different from who they were at the starting point.

3. The physician as a person

> […] with patients, the conflict is how far we want to go with this patient, what we want to offer them, and there I have arguments that are mixed with my own personality. If you look deep down, everything is bioethical in medical practice. […] A 95-year-old patient, a patient who was resuscitated for 50 minutes on the street, who you know there is not much more to do for, to what extent do we see something more than the laboratory and how can you not see the patient in front of you? Talk to them, hold them, check their surroundings... that is a daily discussion. […] In communication, manners, I learned that you have to start by saying hello, shaking hands, looking them in the eyes, and then you also find the family. There are those who see you and want to hug you, others keep their distance. I usually try to make them feel comfortable, let them know that I am available to assist them...

Physicians' engagement with the clinical setting, their capacity to establish bonds, and their professional stance are all shaped by the vulnerability inherent to the human condition. The way they interact with both their peers and their patients affects and transforms them internally. Being aware of their own vulnerability allows them to reframe how much they can be affected by the pain of others, which leads to openness and permeability to suffering, subjective transformation, and communication with others. It is through recognizing himself as a vulnerable subject that he is able to relate to and recognize the vulnerability of the sick. Being aware of his own fragility enables his solidarity with those who suffer and drives his protective, loving, and respectful intentions toward the vulnerability of others. Openness to others from one's own vulnerability allows for an

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encounter that is often characterized by pain, but which nevertheless gives meaning to the intention to heal and leads to the possibility of generating a humanizing character in one's art (9).

It is important to recognize that the attitudes of physicians in their personal lives affect the lives of others, their patients. Caring for them implies adopting a personal stance in defense of life, respect for autonomy, freedom, and responsibility for both parties in decision-making, suffering, pain management, pharmacological treatments offered, end-of-life care, and the proportionality of technical procedures. Following a path that rediscovers the most important aspect of the medical profession, which is caring for people, cannot happen without emotional involvement: the ability to be moved by the patient's experience of pain and suffering, the importance of establishing a therapeutic alliance that transforms into a bond that enriches both parties.

It will not always be necessary to address complex ethical dilemmas; often it is everyday problems that present opportunities to distinguish one's practice: calling someone by their name, saying good morning, smiling, being trustworthy and available. Advancing in the understanding of a person's diagnosis and illness without neglecting the way they inhabit the world: how they communicate, how they make decisions. We must consider that the patient's symptoms transcend the disease, modulated not only by biological factors but also by cognitive, socioeconomic, psychological, and spiritual issues.

> [...] I always tell this story because it left a lasting impression on me. She didn't care if the patient died. She knew he was going to die, they had told her twenty times, and I didn't care because he was an easy patient, 'give him morphine because there's nothing else we can do', but there was everything to do, I had to go and calm the woman down, because you treat both of them and you realize that, from then on, I have something: I took it upon myself to visit every terminal patient and their family, and I felt comfortable with the discussions I might have about the end of life, being able to explain, show them what they were

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> doing, even if it was 20 times. That's a medical explanation, but I think you have to be clear as a person that it's important. I had no idea. The message I received was that it was just a matter of administering morphine, and that's what I did, but the message should have been (and a senior resident told me this), "This is wrong." I understood that later [...].

Restoring health, healing the sick, and caring for them in their fragility involves establishing a relationship of trust based on the personal qualities and values of the physician. The medical profession, when practiced within a framework of humanity, is distinguished by physicians who are trustworthy, strong in the face of each patient's adversities, honest and fair in their decisions, respectful of the vulnerable condition of the sick, empathetic, and objective in their actions. Their medical act is then the result of a balanced combination of the anthropological dimension, the discipline of their training and professional practice, and the social context that surrounds them, the latter regulating technical, economic, administrative, and socio-political variables. The medical act is humanized when it consists of mutual recognition from which it is possible to care for the other. By recognizing themselves as fragile, vulnerable, and dependent persons, they can see that, while technical and scientific knowledge is necessary and helpful in treating illness, it is not possible to care for and accompany others without a human approach and accompaniment, especially in certain situations, such as chronic illness, the dying process, mental illness, and disability.

4. The clinic

Simply asking questions is how we begin to explore the patient's suffering. This action requires time to encourage the expression of fears related to the illness, ideas about the diagnosis and treatment offered, the manifestation of the functionality affected by the illness, and the personal significance given to it, along with expectations for

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improvement. Exploring suffering undoubtedly requires the establishment of an initial therapeutic alliance, a tacit contract based on trust, which in itself promises therapeutic effects. Of course, this alliance must be followed by the establishment of adequate communication between the doctor, the patient, and their family, which must be maintained throughout the treatment and evolution of the disease. Relevant factors will play a role in establishing this communication: preserving the privacy and intimacy of each person will provide the necessary framework to guarantee confidentiality; containing and clarifying situations of distress, fears, and often despair in the face of an unexpected diagnosis; offering understanding of each person's illness and strengthening the commitment to a possible treatment; providing timely and effective information to assist in decision-making, respecting the patient's choices, and even participating in clinical procedures that may facilitate access to care. This communication will strengthen the doctor-patient relationship, establishing a bond between them. Only under these conditions will it be possible to enter into the privacy and intimacy of the sick patient, with an empathetic attitude and a willingness to listen and provide support. The medical act is transformed by empathic listening, which allows us to share emotions with others and differentiate them minimally from our own feelings. Empathy allows us to understand the behavior of others by knowing how they think; it implies a way of accessing the thoughts of the other person. An empathetic person can identify themselves, locate themselves spatially, and be aware of the place from which they perceive reality. They have the ability to mentally decentralize themselves, feeling with someone else. The awareness of *being outside the other person and having to reach them* is a prerequisite for empathy. The importance of this particular bond of mutual responsibility has already been mentioned in other writings.

> [...] there are patients with whom you have to be different, more informal, stay a while, hug them, make contact, touch them a lot, and that way they feel more contained [...] There is a resource that, if I see that it has a religious element, I always tell

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> them that I am going to pray for their family members, and that part calms them down. I always say to my residents: you have to close a chapter here, of life, of family, and you have to make an effort to ensure that this person closes the story well; nobody likes to close it badly. It is different if a doctor explains that they did everything they could, that they are fighting to save his life, and you can see that he is moved, than if he comes out and says coldly: yes, he died.
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> You have to take your time, especially in the hospital ward. [...] They give him morphine because there's nothing else, they can do, but there was everything they could do. I had to go calm the woman down, because you treat both of them and you realize that. From then on, I have something:
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> I made it my responsibility to visit every terminal patient and their family, and I felt comfortable with the discussions I might have about issues that arise at the end of life, being able to explain, to show them that a lot is being done to alleviate the pain, even if I have to say it twenty times. That's a medical explanation, but I think first you have to be clear as a person about how important that is.
>
> […] when you think there is nothing more you can do, there is a lot more to do, to accompany them, listen to them, care for them.

The clinic described is active, aiming to alleviate pain and suffering while maintaining both an emotional connection and a cognitive assessment of the patient's situation. The practices offer the possibility of seeing things from the perspective of the sick person, of understanding how they feel and why they react the way they do, which enables more humane care, bringing the doctor closer to their patient and framing the assistance in terms of improving the quality of care without fear of involving their emotions. Empathetic kindness in the medical act reflects the processes of accountability and reparation that characterize a humanistic physician. Professional training that only provides accurate diagnoses, prudent prognoses,

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and timely treatments without going beyond symptoms and diseases to address the person was noted as incomplete. Good practice requires focusing on the patient and establishing a bond with them. At this point, it is worth noting the characteristic of bonds to transform the subject, who becomes different after encountering the other. It is important to emphasize that bonding is not how two people do something together, but rather that in a bond we discover the most intimate aspects of our lives in another person. That is why bonds imply a transcendence, a crossing of what a subject believes himself to be. Bonding with the patient makes it possible to avoid the expression of withdrawal into oneself and reduces the anxiety that critical situations generate in the physician. It is through an empathetic bond that the doctor identifies how the patient perceives their suffering and their degree of involvement, what mental resources they have to avoid distancing themselves from this suffering, perhaps trying not to reveal their own helplessness, how they recognize their own emotions in order to show sensitivity and respect without losing their medical professionalism.

Specialized techniques could help to mitigate the emotional distance between the doctor and the patient, which is generated by the doctor's own vulnerability in the face of suffering. However, in order to avoid this, it is necessary to allow, without fear, the expression of confusing emotions, discussion, and the processing of doubts among professionals, especially when this involves decisions that lead to a closer relationship with the patient and understanding where previously there was only diagnosis; caring where previously there were only technical interventions.

We have never ceased to convey to our medical students that medical practice is passionate. And we describe passion as that which drives them, that which will make them insist on hope precisely where they find desolation. We maintain that passion is the force that contradicts despair; it is the force that seeks to find meaning in the chaos of illness. Exclusively human, passion cannot be replaced, but it is not necessary to lose perspective. Tempering passion will help doctors get closer to their patients and make their care warmer.

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Those who suffer need to feel that they are talking to a human being, while at the same time being someone else. Their suffering is not trivialized, and along with their pain, the doctor receives it in a unique and individual way. The patient's pain is considered a personal creation, a message crying out to be heard. The patient's subjectivity is reflected in what they say, and the doctor, passionate about their work, will not forget that each word is also imbued with that person's history. Transforming the pain and suffering of the sick will depend on finding, together with the patient, the words that allow them to narrate the unspeakable, what physical illness may have condemned to oblivion or silence.

The stories that are told, how they are told, and why they are important to tell matter. Including the patient's life story is an essential resource for understanding the whole person. Listening will allow us to organize the chaos caused by the illness, give space for uncomfortable emotions and feelings to be integrated, and enable joint decision-making.

5. Conclusion

Augusto's story highlights an education whose pillars transcend university life and unfold in his professional life: an empathetic attitude in his relationship with patients, authenticity in front of his peers in the hospital, reflected in his honesty and loyalty to his values and convictions; openness to affection toward the sick, which enables compassionate care; loyalty and fidelity to the patient's decisions, integrity in conduct, carried out with rectitude; respect for the patient's environment and family, consideration for their personal and individual pain, and care for those who suffer. Augusto tells us about his experience, stories he has lived with patients that describe his practice in his early years. He recounts a series of actions he carried out as a resident, describes situations that transformed him, and provides us with a dynamic account of events in which he interacts not only with his patients but also with his peers and superiors at the

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hospital. He reflects on his actions and, in sharing them, his humanized practice is revealed, expressed, and offered as a compass. A humanized clinical practice is formulated: based on respect for the suffering of others, centered on absolute responsibility in decision-making, and guided by care for the dignity of the person.

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