People First – Caring for the Person Produces Better Outcomes

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1. Terminology – Summary

The subject that I have been suggested to treat as a challenge has TWO notions:

- that of 'Care' and
- that of 'Better outcomes', for us physicians; hence, that of 'Cure', in its remunerative perspective.

'Care'

- is not the prerogative of medical practice;
- it is an intrinsic characteristic of human beings (parents, educators, teachers, friends, priests, psychologists...), the dimension of care appears as the essential counterpart of the ontological weakness of Man, who requires and hopes from 'another' for a solicitude adapted to his dignity.
- Care has always been a sign of humanization and humanity. Many recent paleo-anthropological discoveries have confirmed the existence of intentional burials of Neanderthals of all ages and have ascertained the survival of several individuals, despite severe disabilities. These discoveries of much more than 100,000 years ago show that our predecessors shared with modern Man the truly human characteristic of mutual support and social attention, in short, care. (1).

'Cure'

- is specific to medical practice; until recently, in its working, it unites 'cure' and 'care'.
- The 'cure' is rather linked to professionalism, scientific rigour, and technical skill in diagnostics and therapeutics.
- In this exercise, 'care' brings the intensity of the human relationship between patient and physician.

The culture of 'care', of human relations, and particularly with regard to the medical 'cure', has undergone profound changes over the past three decades. But to fully understand the present and the future, it is always essential to understand the past.

2. Current observations from a historical perspective

From 'synthetic', holistic, and humanistic in the era of Hippocrates, medicine has become more and more 'analytical' over time, less humanistic, to be openly 'transhumanist' at present, that of man repaired, modified, even enhanced.

According to 'synthetic' medicine, the sick man and his illness form an organic whole.

According to 'analytical' medicine, the illness is seen as exogenous to the patient. Its cause is an external agent that can be located, isolated, separated (Bacon, Descartes, Vesalius, Harvey, Claude Bernard…).

This evolution has occurred in both diagnostics and therapeutics; and in surgery and medicine.

As for 'transhumanist' medicine, it follows the ideology which affirms that it is possible and desirable to increase, enhance, and exceed, through science and technology alone, the current human capacities: physical, intellectual, cognitive and emotional, as well as psychological, considered as a transitional and rudimentary stage in an evolutionary process.

Their techno-prophecy is:

- to become 'amortal', i.e. to extend life indefinitely, without eliminating the end, and
- to create a new 'transhumanist' species, that of man enhanced by technology.

Thus, from an often spiritual notion, 'care' has become devoid of any reference to transcendence.

As for 'cure', it is becoming more and more technical.

2.1. Current technological revolution in medical ‘cure’

Artificial Intelligence has taken up, is taking up, and will take up even more space in the ‘cure’.

‘Artificial intelligence’ refers to all the theories and techniques used to create machines capable of simulating certain procedural functions of the human intelligence.

The medical ‘cure’ and ‘care’ are currently undergoing a formidable technological revolution.

The physician currently faces a digital deluge of information that far exceeds his capacity to absorb it.

AI will be useful and ultimately indispensable in the diagnostic process, in the establishment of the treatment plan and essential in the prognosis.

IN FACT, HOW DO WE WORK AS PHYSICIANS?

Based on the data we collect, we try to recognize a profile in order to come to a diagnosis: we will simply compare this established profile with those we know.

When we then select a therapeutic approach, we have already solved a mathematical equation with multiple variables.

However, this number of variables is necessarily limited by our cognitive abilities.

We also have to assign a relative weight to them, very often intuitively.

Thanks to its computing power, speed, and memory, recognizing a profile is very simple for AI.

However, the problem of the quality of the data entered must be resolved beforehand, as the model would be totally distorted by inaccurate, incomplete, and inadequate data. We would be faced with a standardization of false standards.

Hospital structures also benefit and will benefit even more in the near future from these analytical tools, which are initially descriptive, but which are evolving very rapidly towards predictive tools.

Hospital authorities will have a major responsibility in terms of investments and data governance.

Our profession as physicians must adapt constructively to the presence of AI.

From medical history taking to a medical chatbot, today’s physician must adapt in the anamnesis. Apart from the standardized questions asked by a chatbot, the physician must exercise his gifts of empathy and understanding of each human person, in his entirety and culture, to provide the AI with the exact data, in order to obtain a highly accurate diagnosis from it.

The AI is involved in the diagnostic process including the collection of clinical symptoms, the request, reception, and interpretation of additional examinations (biological examinations, imaging…).

It takes part in the diagnosis, as well as in the choice of treatment.

2.2. ‘Cure’ and ‘care’ are subject to the economic constraint of hyper-efficient profitability.

The financial investments by GAFAMA (Google, Apple, Facebook, Amazon, Microsoft, Alibaba) and NATU (Netflix, AirBnB, Tesla, Uber), as well as their Chinese counterparts, are unparalleled.

According to a report of the Davos Economic Forum published in July 2018, the players in this new economy together represent 5.9 trillion dollars (1 trillion: one thousand billion dollars).

2.3. Medical ‘cure’ and ‘care’ are increasingly focused, in an equivocal way, on the autonomy of the human person.

- there is the precipitate development of the particular rights of users.
- there is the transition from a ‘paternalistic’ to an ‘individualistic’ view of the relationship with people, especially those who are vulnerable and fragile.
- there is the currently accepted societal slogan:
    - To medicine: management of the body
    - To justice: arrangement of the contract between the owner of the body and his service provider!

3. The meaning of Medicine: The Human person (2)

If the medical profession has changed, it is changing at an accelerated rate today, and will change again, the true objective over time, of medicine, has been, is, and will be the 'Human Person'.

3.1. Suffering of the 'I'

Whether it is physical or bodily pain, psychological, relational or existential suffering, it is an I who suffers, it is the person who suffers. Everyone experiences suffering at one time or another, because everyone is vulnerable and fragile. This weakness, attested by suffering, is ontological, that is, embedded in the very being of the person. And it will always be necessary to take care of this weakness and listen to its richness!

Today, the weakness of the human condition is faced with a high-performance, efficient, dominant techno-science that leads us to mastery, that shapes our way of being, permeates our mentality, and makes us dependent on it.

3.2. Weakness of the human person

Human weakness is manifested as an omnipresent reality that accompanies man from the beginning to the end of his life and accompanies our changing society and the current demographic explosion.

In the quantitative evolution of human populations, there are two major periods of accelerated expansion.

The first period of great human population growth, initiated by the Neolithic Revolution, when man went from predator to producer, saw the world population increase from about ten million inhabitants to about 250 million at the beginning of our era; which corresponds to an average doubling of the population in 2500 years.

The second period of human population growth corresponds to the current explosion.

It began during the Renaissance and was caused by the scientific and industrial revolutions. By 1600, there were about 600 million people on earth. This number has increased more than tenfold over the past 400 years. The growth rate gradually increased to a maximum in 1970 and allowed the population to double in just 33 years. This period of irreversible demographic transition is leading man towards a way of life further away from the one to which evolution had adapted him until now.

New weaknesses appear to be linked to

- the change in demographic structure, with a continuous increase in the proportion of elderly and disabled people; linked to
- the juxtaposition of young and poor countries on the one hand and rich and old countries on the other;
- the growing separation of man and nature, which is his original environment; linked to
- the massive loss of belief in the supernatural that structured his life; and linked to
- the discovery that the new technological powers at man's disposal have now partly turned against him.

These new and perpetually renewed weaknesses, attested by suffering, are not simply the symptoms of a pathology that would be a disease, a trauma, an infertility, a behavioural disorder, a broken social bond; but an indication of an ontological weakness, embedded in the very being of the human person, and which will always require care. Weakness and care can be compared with the two sides of a coin: the presence of one requires the intervention of the other.

3.3. Call for a 'bigger soul'

Faced with the omnipresence of technology, and the new weaknesses that always appear, a call is heard: to seek a 'bigger soul', according to Henri Bergson's prophetic formula from 1932. (3) It is in this way that medicine must find a new approach to treat today's and tomorrow's patients, human beings of all times, with the most effective outcomes. It is currently necessary in our medical profession to be particularly creative in the exercise of support, of care, of mediation between technology and humanity, of translating one's capacities to meet the expectations of the other.

The fragile being is paradoxically strong because it carries within it a capacity for adaptation and a strengthening interiority. The confrontation between technology and the fragile person calls for ethical reflection and behaviour that must be built together, according to Paul Ricoeur, with three aims: the good of the person, the good of the members of the group to which they belong, and the good of just institutions. (4)

In order for reason to proceed wisely, an ethical construction, three elements of our being, must be taken into

consideration:

- we are responsible beings,
- we are related beings,
- we are beings for others, for the other, who flourish by being there for the other; and beings who have the ability to be loved

3.4. Developing patient resilience

Faced with the objective and scientific 'reality' of the 'weakness' of the living and of human beings, the question of 'meaning' arises. There are two possible answers: either the negation of meaning or the opening to a positive meaning.

The negation of meaning leads to:

- either thoughts valuing strength and a whole range of representations of the 'superhuman', the 'transhuman' and 'posthuman', leading imperceptibly to harmful eugenic policies;
- or thoughts that artificially, automatically, and superficially value fragility, as they occur in classical forms of dolorism, minimizing negativity and the tragic consequences of fragility.

Openness to a meaning that can help the human person to live the experience of fragility in which he or she is immersed: disability, chronic illness, bereavement, suffering... can release forces of 'love' that 'value' the Human Person and contribute to the qualitative evolution of Human Society, in other words to the Common Good.

That which can open up the depths of a man's heart and the meaning of his life and nature, goes along a path that may not be immediately visible.

Not everyone will commit to it at the same time, with the same ease! Discovering this path is not something you do on your own! It is important to be helped!

While there is certain progress in the management of diseases, the technicality of scientific medicine tends to reduce the doctor-patient interactions to an inventory of objective performances of essential biological functions. However, the patient expects something else from the physician.

While he is certainly not indifferent to the suffering of his body, to the threat that an illness poses to his future and that of his entourage, he also expects the physician to teach him to live with the disease, especially if it is chronic.

But then how can we help our patients to develop resilience?

Resilience is a dynamic and interactive process in patients, between themselves, their family, and their environment, that allows them to develop a new and fulfilling pathway, by changing the representation of reality that hurts them.

To do this, we must go through empathy and listening.

By ignoring our impulses and repulsions, we can represent and accept ourselves, without judgment and with empathy, what the person gives us to see, hear, guess, and resonate with their emotions.

If we think we have succeeded, we should check it by rephrasing it: "if I understood correctly, you wanted to tell me...".

Empathy is naturally based on good listening.

Listening is about making the other person's words resonate, about giving them consistency.

It is only to the extent that they are listened to that the words truly take on their meaning.

It is through listening that we will learn from patients, what hurts them, the representation they give, as well as the wealth they have before them.

For listening to be fruitful and beneficial for the patient, it is important to respect the patient's rhythm.

Some expressions: "I put myself in your shoes – It is all in the past; now we have to forget – We have to stay positive!" are commonly used to express our empathy for the patient and yet, despite good intentions, they can be harmful with regard to the acceptance of the patient's suffering.

Resilience is a long-term process.

It is only by allowing time to do its work that from disability, illness, grief, suffering, a ‘new’ form of life can be born, can be reborn.

You have to give time time.

For the ordeal to be bearable, it will have to be experienced day after day.

Sufficient for a day is its own evil, every day has its share of challenges, but also its share of courage to face them. We must help patients accept what today has to offer them as a resource, and to confidently leave behind the day that is coming to an end. Even in the worst conditions, man has the ability to detach himself from it with humour. Let’s be receptive and interactive! Supporting each patient in their inherent and inviolable dignity, by adapting the powerful technology at our disposal, to each of them, is the best solution to the challenge: ‘Caring for the Person produces better outcomes’!

4. Take-home message

- Transform the cure by inserting a care.
- Use the latest technologies and leave room for the Human Being.
- Translate technical words into human words:

Make the physician a translator of scientific-technical language into the language of the heart.

References:

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