Seeing the human in every patient, from biblical texts to 21st century relational medicine

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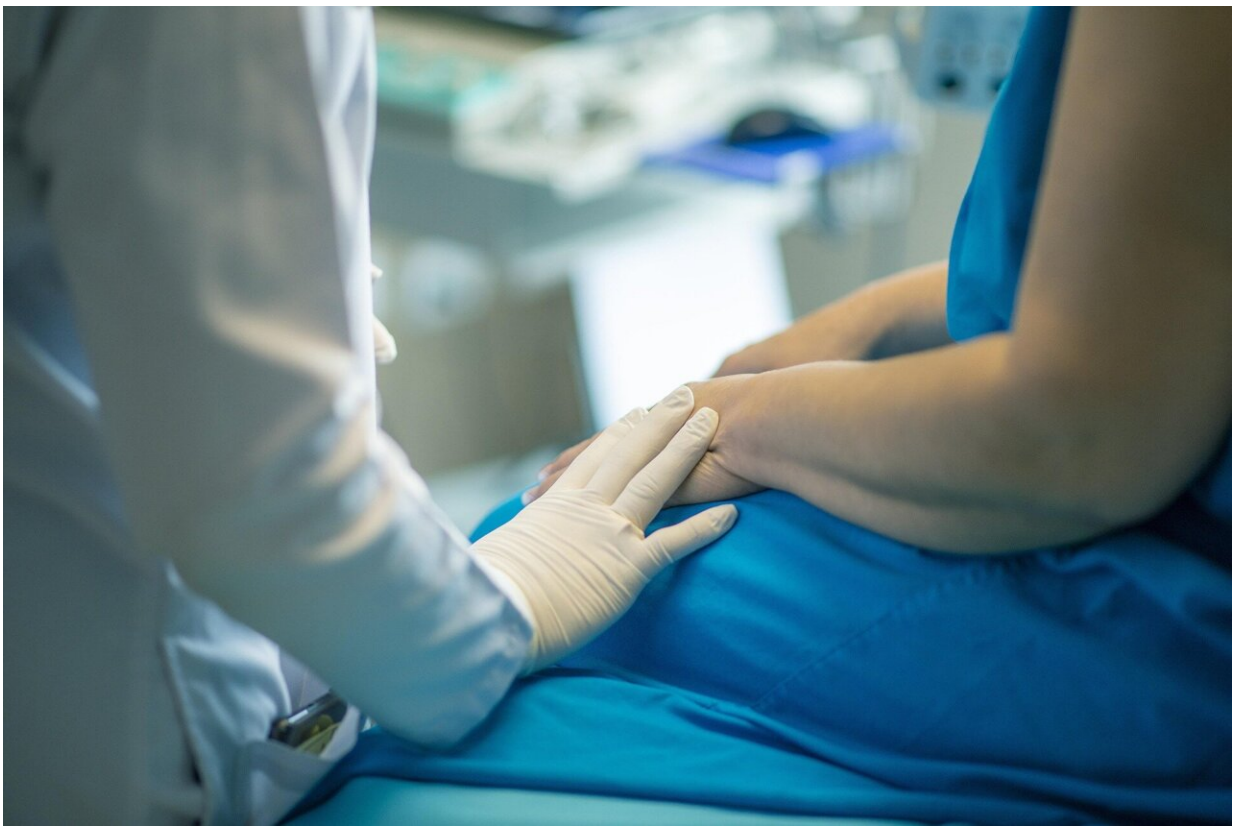

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Patients frequently describe the U.S. health care system as impersonal, corporate and fragmented. One study even called the care delivered to

many vulnerable patients "inhumane." Seismic changes caused by the COVID-19 pandemic—particularly the shift to telehealth—only exacerbated that feeling.

In response, many health systems now emphasize "relational medicine": care that purports to center on the patient as a human being. Physician Ronald Epstein and health communication researcher Richard Street describe "patient-centered care" as advocating "deep respect for patients as unique living beings, and the obligation to care for them on their terms."

In 15 years as a primary care physician, I have seen the effects of dehumanizing medical care—and the difference it makes when a patient feels they are being respected, not just "treated."

Though "relational medicine" may be a relatively new phrase, the basic idea is not. Seeing each person before you as someone of infinite value is fundamental to many faiths' beliefs about medical ethics. In my own tradition, Judaism, "person-centered care" has roots in the biblical Book of Genesis, where the creation story teaches that "God created the Human in God's own image." As a medical educator, I teach students how to turn these abstract ideas into concrete clinical skills.

Divine dignity

Traditional Jewish law sets rules that shape my understanding of these skills. As the influential French sage Rashi wrote in an 11th century commentary on the Bible, it is forbidden to publicly embarrass a person "so that their face turns white," even while rebuking them. For doctors today, this might mean taking care not to inflict shame on a person with a stigmatized illness like substance use or obesity.

The Bible forbids wronging or abusing strangers not once, not twice, but

36 times—a reminder not to "other" people or obscure their basic humanity. A similar value appears in the 18th century Physician's Prayer , written by the German-Jewish physician Marcus Hertz, who states, "In the sufferer, let me see only the human being."

American Rabbi Harold Schulweis used the concept of "covenant"—a holy, mutual agreement—as a model for the bond between physician and patient, working toward a common goal. This idea inspired my own book, "Healing People, Not Patients."

Similar connections between medicine, respect and religion are found in other traditions, as well. A 1981 Islamic code of medical ethics, for instance, considers the patient the leader of the medical team. The doctor exists "for the sake of the patient … not the other way round," it reminds practitioners. "The 'patient' is master, and the "Doctor' is at his service."

Seeing and hearing the whole patient

In undergraduate classes that I teach for future health professionals at the University of Pittsburgh, we focus on communication skills to foster dignified care, such as setting a shared agenda with a patient to align their goals and the provider's. Students also read "Compassionomics," by medical researchers Stephen Trzeciak and Anthony Mazzarelli, which aggregates the data showing caring's impact on the well-being of patients and providers alike.

However, even health professionals steeped in these practices can encounter people whose humanity they struggle to see. Students wrestle with a classic article about "the hateful patient" and practice an exercise called the "second sentence." This asks providers to look beyond their first impressions of a patient they might have trouble treating with compassion, imagining a "second sentence" that humanizes the person in

front of them.

The course evaluation is based on a project in which students interview a friend, relative or neighbor about their experience of illness and care. Ultimately, they identify one element of the person's care that could have been improved by attending more to the person's individual needs and listening to their story.

One student recounted her brother's experience after he suffered a serious sports injury. The trauma team followed protocol precisely, but this meant that they did not register him screaming in pain, telling them that what they were doing was making him feel worse. Only in the hospital did doctors discover that those screams were a clue to a specific injury that should have received radically different care in the field, which could have been caught earlier had the team attended more closely to his words.

His sister explored the medical literature on when EMS needs to break its own rules to care for a complex patient, and she suggested her own mnemonic—stop-ask-listen-evaluate (SALE)—for how to make "breaking protocol" one of the options in the protocol itself.

Another student related his father's experience living with chronic illness. His condition frequently deteriorated because of delays in refilling medicine through his regular physician's office. This student pointed to medical literature detailing how pharmacists can be given greater authority to refill medications for chronic diseases, preventing gaps in treatment, which would have saved his father significant hardship.

Listening with both ears

Down the road at Chatham University, I work with physician assistant

students who are about to enter clinic for the first time. These students complete a workshop including many of the same communication exercises, including "listening with both ears": listening not only to the patient, but also to what they themselves say to the patient, considering how it will be received.

Students are encouraged to go home and practice until the words feel natural in their mouths, not scripted or mechanical—just like they drill anatomy facts and suturing skills.

After their clinical year, the students return to reflect. Many of them report using patient-centered skills in challenging situations, such as validating patients' concerns that had previously been dismissed.

Yet they also report a work culture where effective communication is often seen as taking too much time or as a low priority. Sixty years ago, Rabbi Abraham Joshua Heschel and psychiatrist William C. Menninger presented on The Patient as a Person to the American Medical Association. Heschel declared that the profession was suffering from a "spiritual malaria," his term for precisely the "high-tech, low-touch" attitude that my students encounter. The emphasis on technology and a rapid pace of treatment leaves scant room for caring, whether in Heschel's day or ours.

In both programs where I teach, I aim to provide new practitioners with tangible skills that their future patients will experience as real "whole-person care" and not just a slogan on a commercial. Those patients will know that the people caring for them value all of them—their livelihoods, their life stories and the worlds they inhabit.