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PRESIDENT'S COLUMN

HOLDING ON TO THE HUMANITY IN MEDICINE

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This experience (of poll watching) has been making me think a lot about our shared humanity and the importance of seeing it not only in special moments like Election Day but also in every day. And not only as we navigate our democracy but also in how we navigate our work in medicine. As part of staying in touch with our shared humanity, doctors will need to stay in touch with their own. This doesn't come easily. We get busy in our work and become transactional, rather than relational, in our interactions with our teams and patients.

I have a friend who ran for Louisiana legislature and it drew me in to our democratic process in a way that my prior tours of public service did not. In support of his campaign, I had the chance to go door to door, canvassing his district in New Orleans. I met people from all walks of life. We talked about their concerns and hopes for their neighborhood and kids. Sometimes, we just talked about simple things like the weather or the Saints. It was a granular, rewarding experience that reminded me how diverse our humanity is, yet how much we all have in common.

Also, as part of my volunteer experience with his campaign, I *poll watched* on Election Day. I suspect most people haven't done this, and it was my first time. It means sitting in the polling station from its opening until early afternoon to record who is voting so the candidate can track which supporters are and are not coming to the polls. I was so moved by the experience and saw so much kindness that my heart is full of joy for a long time to come. I saw humanity helping one another. Showing respect. Treating each other with dignity. It made me so glad to be a part of my community and of our shared humanity.

It started with the poll workers and leaders who were boundlessly cheerful, helpful, yet also serious about their work. They reminded me of the highest-performing medical team I have ever seen. They worked together to solve problems (and a lot come up) without ego or hierarchy. More experienced members helped the new team members. And they were intentional about making eye contact with each other, listening, and respecting input even from the first timers.

Their spirit of respect and humanity spilled over into the mood of the entire day. I watched hundreds of people file in to vote. They came alone but often were with their kids, moms, siblings, neighbors, and friends. People from across the political, social, and economic spectrum. It was a sea of diversity. Young, old, mobility challenged, priests, nuns, jocks, hipsters (not that these are mutually exclusive categories). Neighbors greeted each other with warm hugs. There were first-time voters like a young girl who had just turned 18 who came in with her dad. The volunteers make a big "to do" about first-time voters with congratulatory shouts.

This experience has been making me think a lot about our shared humanity and the importance of seeing it not only in special moments like Election Day but also in every day. And not only as we navigate our democracy but also in how we navigate our work in medicine. As part of staying in touch with our shared humanity, doctors will need to stay in touch with their own. This doesn't come easily. We get busy in our work and become transactional, rather than relational, in our interactions with our teams and patients. Maintaining a focus on shared humanity also means we will need to respect the time and emotional space of our patients.

To me, understanding the humanity of our patients is the same as our more wonky way of describing their humanity—as their social determinants of health. Sometimes we don't want to ask about a patient's social determinants, the daily circumstances of his humanity, because we don't know what to do with the information. It isn't that we don't want to understand and appreciate him as a person, as a human being, it is just that we feel ill-equipped to support him in addressing challenges in a

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"person context," like food insecurity. We are much more comfortable addressing shared clinical goals, such as an HgbA1c of 7.0%. Achieving a clinical goal of controlled A1C takes more than giving the right drug at the right time—it also means our patient needs access to affordable, healthy food. This latter "social goal," access to affordable healthy food, is likely to be a priority for our patients over a medical approach to achieving diabetes control. In addition to being a barrier to disease management, our exclusive focus on clinical goals may cause patients to think we are looking at them as only a disease, and not as human beings.

Antoinette Schoenthaler, a qualitative researcher at New York University, has done work looking at the importance of relationship-centered conversations in the clinical environment that help connect with the humanity of our patients. This means asking people about their lives, social situations, and the context in which they live, learn, work, and play. In her work, she is reminding us of something more powerful than structured approaches, like surveys that query our patients about domains of social determinants of health. Dr. Schoenthaler is reminding us that simply treating our patients like people, asking about their humanity and not only their disease can have an impact on their health. For example, her research has shown that talking to our patients improves their sense of agency and ability to follow their agreed-upon care plan for high blood pressure.[1] She is telling us in her research what we intuitively know: our patients understand if we can't solve every challenge they face. They just want us to care. Francis Weld Peabody said it well, "*The secret of caring for the patient is caring for the patient*".

Years ago, when I was in the Robert Wood Johnson Generalist Physician Faculty Scholar Program, one of my colleagues was Med/Peds physician Dr. Saul Weiner who was looking at the issue of "failure to contextualize" our patient's as a medical error. Prescribing insulin to someone for uncontrolled diabetes may seem like the right clinical choice—unless the doctor understands the patient's context—that they are homeless. He was ahead of his time in many ways, since medicine had not yet begun to embrace the concept of understanding and addressing the social determinants of health. Over the years, Saul has done extensive research that has led to the development of strategies for helping us to heed William Osler's call for us to "treat the patient with the disease" and not only the "disease." He has created a framework that defines failure of the physician to contextualize care plans as a medical error. His work includes a set of resources for physicians and learners as they navigate their busy clinical work.[2]

I don't want to oversimplify how challenging it is to maintain our own humanity as we navigate our responsibilities as physicians, leaders, educators and researchers. Physician stress and burnout is real. But if we look to the science, it is telling us that a pathway forward for us as individuals and as a profession is that being intentional about looking at the humanity of our patients, understanding their context, their social goals in addition to their medical ones, will help us be in touch with our own humanity. Just as in our democracy, it will take all of us, doing our part to keep the humanity in medicine.

References

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2. Weiner S, Schwartz A. Contextualizing care. http://www.contextualizingcare.org/resources/. Accessed November 15, 2019.

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