***Humanities: Art, Language, and Spirituality in Health Care***
Series Editors: Christina M. Puchalski, MD, MS, and Charles G. Sasser, MD

# Dignity in Care: Time to Take Action

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***Abstract***
*Providing* care *for patients and* caring *about patients should go hand in hand. Caring implicates our fundamental attitude towards patients, and our ability to convey kindness, compassion and respect. Yet all too often, patients and families experience health care as impersonal, mechanical; and quickly discover that patienthood trumps personhood. The consequences of a medical system organized around* care *rather than* caring *are considerable. Despite technical competence, patients and families are less satisfied with medical encounters when caring is lacking. Lack of empathy and emotional disengagement from patients typifies health care provider burnout. Caring is the gateway to disclosure; without it, patients are less likely to say what is bothering them, leading to missed diagnoses, medical errors and compromised patient safety. There are also liability issues, with most complaints levied against health care professionals stemming from failures in care tenor. Formal education for health care providers lacks a continued focus on achieving a culture of caring. If caring* really *matters, health care systems can insist on certain behaviors and impose certain obligations on health care providers to improve care tenor, empathy, and effective communication. Caregivers need to be engaged in looking at their own attitudes towards patients, their own vulnerability, their own fears and whatever else it is that shapes their tone of care. Health care professionals must set aside some time, supported by their institutions, to advance a culture of caring—now is the time to take action.* J Pain Symptom Manage 2013;46:756–759. © *2013 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

***Key Words***
*Care, caring, dignity, patienthood, personhood*

"The secret of the care of the patient is in caring for the patient." Those words ring as true today as when they were first delivered by Dr. Frances Peabody in his famous address to Harvard medical students in the fall of 1925. With simple elegance, he reminds us that providing *care* for patients and *caring* about patients should go hand in hand. Although the former refers to evidence-based practices that are applied almost exclusively according to disease-specific considerations, the latter is about our covenantal relationship with patients, allowing them to trust us to always hold their interests first and to be unwavering in our loyalty to what is best for them. The only way to know what is best for patients is to listen to them, to know them, and to begin to understand what matters most to them (D.

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*Accepted for publication: August 7, 2013.*



0885-3924/$ - see front matter
http://dx.doi.org/10.1016/j.jpainsymman.2013.08.004

Meier, personal communication, August 1, 2013). Caring implicates our fundamental attitude toward patients, and our ability to convey kindness, compassion, and respect. Although the world has changed a great deal since 1925, contemporary health care continues to struggle with how to marry care with caring. Modern medicine has expanded its capacity to diagnose, treat, and even cure various ailments that afflict humankind, but all too often patients and families experience health care as impersonal, mechanical, and quickly discover that patienthood trumps personhood. And despite sincere Peabody-esque declarations, which punctuate hospital mission statements, preface annual reports, or feature prominently in materials meant for public consumption, *caring* remains *care's* distant poor cousin.

How ironic that *caring* struggles to maintain a foothold in the caring professions. As medicine has made spectacular gains over the past century, the humanities of care have taken a back seat to things that are seemingly more compelling, like the illusory promise that "all diseases [are] things to be conquered … that medical advances are essentially unlimited … that none of the major lethal diseases is in theory incurable; and that progress is economically affordable if well managed."[1] If only it were the case. That said, the evolution of health care systems built to deliver *promissory* medicine have become, by necessity, more complex, more impersonal, and more technology focused; although they have immense capacity to process patients, and procedures to administer care, *caring*, it would appear, has not been as well thought out.

The consequences of a medical system organized around *care* rather than *caring* are considerable. Despite technical competence, patients and families are less satisfied with medical encounters when caring is lacking. In our own studies, *care tenor*—the tone of care—was an important predictor of whether patients felt that their dignity was upheld toward the end of life.[2] The organization of health care also has implications and consequences for those who work within it. When care is unable to stave off frailty, disability, illness, and death, people trained to protect their patients from these inevitabilities may feel that they have failed, and the emotional price of shouldering that failure can be considerable. Some medical practitioners deal with this by immersing themselves in the technical and skill-based dimensions of their work; or learn to develop an emotional armor that protects them from the sadness, the anxiety, and the grief that invariably accompanies patients and families confronting life-limiting conditions. Lack of feeling empathy or the inability to emotionally engage with patients is a cardinal symptom of health care provider burnout; perhaps, the more we run away from caring and the emotional dimensions of looking after patients, the more we spend our careers feeling chased, hassled and in too many instances, professionally exhausted and ineffectual. There are also patient safety issues related to a paucity of caring. *Caring is the gateway to disclosure*. Patients who do not feel the appropriate care tenor are less likely to say what is really bothering them, leading to missed diagnoses, more medical errors, and squandered opportunities for meaningful and effective clinical encounters. Finally, not being attentive to care tenor can have liability consequences for health care professionals. Studies consistently show that most complaints levied against health care professionals derive, not from medical misadventure, but from a failure to communicate and the absence of caring.[3]

How much attention is paid to achieving a culture of caring? If one looks at requirements for continuing education, it would seem that caring receives no attention whatsoever. Physicians, for example, are required to register a certain number of Continuing Medical Education credits each year to maintain competency; for Canadian medical specialists, this is no less than 40 hours annually with no fewer than 400 hours within a five-year cycle. There is no stipulation, however, that so much as a single hour address something within the realm of caring. I suspect the situation is no different across any of the health care disciplines. One leaves training—having perhaps attended a mandatory lecture or two on communication skills or professional etiquette—with care-specific knowledge and skills, and absolutely no expectation or obligation whatsoever to revisit the issue of caring ever again. There is an assumption that so long as people working in health care have good intentions, are motivated to do good