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“Humanizing” means “making human” in two ways:

- (a) Making what a human being lives through human (and not brutal, inhuman, etc.)
- (b) Making the ones who live, human, i.e., ensuring that individuals behave humanly with themselves and especially with others

As a result, the dignity [1] of a human being (that his/her life is given value to and is such that it is worthy to be lived) derives from his/her living experiences worthy of a human being and by his/her behaving in a manner worthy of a human being.

But what defines a “human”? Under what conditions we can consider “human” the life of a human being? When can we say that a human being is behaving in a human way towards another human being?

Being human can be defined in objective terms, in subjective terms, or in intersubjective terms.

In *objective terms*, the human can be defined as a *biological being* who, through evolution, came to possess a brain which is more evolved than all other living beings and who is the only one in possession of self-awareness and language.

In *subjective terms*, the human can be defined as a *personal being* characterized by a biography that makes him/her unique and not comparable with any other personal being.

In *intersubjective terms*, the human can be defined as a *human being*, i.e., firstly belonging to a species precisely humankind, characterized by an original and

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unsurpassed interconnection *between* all minds, all languages, all self-awarenesses, and all the biographies.

In other words:

- (a) The conditions of the human being can depend on *objective* factors (the functioning of the brain, self-awareness, and the use of language that rely on it), that is, the human will be the sum of the products of the human brain, the human will correspond to objective rationality characteristics pertaining to men's thoughts, *and this is something that concerns all men and belongs to all men and also something that does not belong to anyone in an exclusive manner.*
- (b) The conditions of the human being may depend on *subjective* factors (the lived biographical experience of every person), so that the human will be what each one, from his/her point of view, tells themselves they are, and everyone will be a man or a woman in their own way, and this is *something that pertains to everyone as it belongs to them.*
- (c) The conditions of the human may depend on *intersubjective* factors (the meanings arising from encounters between individuals), so that the human will be the *ensemble of what the other strikes in us and affects us without belonging to us*, that which is "beyond" the objective rationality of our thought and "beyond" the particular perspective of our personal biography.

In fact:

- There are those who feel that they are men only if their brains are functioning, if they have self-awareness, and if they can express themselves; otherwise, they consider their life "inhuman" and unworthy of being lived (*being men therefore means being normal, functioning, and as biological beings belonging to a certain species*).
- There are those who feel men as long as they recognize themselves, until they feel themselves, regardless of the objective functioning of their brain, a realistic self-awareness and a normal way of expressing themselves (indeed, sometimes it's just a little bit of madness, a distorted self-awareness, and a particular way of expression that leads to a unique and unrepeatable identity). For them, life becomes inhuman and unworthy to be lived when they no longer feel themselves, whatever this means (*being men therefore means being someone distinguishable from all others, with a proper identity which makes one feel oneself*).
- There are those who feel men when they encounter others and feel that something about these individuals concerns them as also something about them concerns others. They feel this way regardless of the fact that others are similar or different from them when it comes to biological functioning or personal identity, i.e., irrespective of belonging to the same category of biological beings (the clever or the stupid) or personal beings (pleasant or nasty people) (*being human therefore means being there for someone else and not only for oneself*).

The truth is, of course, that these three dimensions of the human “make” man all together, but there is no concrete humanity that does not necessitate some sort of “hierarchy” to be established between them. This is so because in the absence of such a hierarchy, man could not be educated to be “human” but would become so chaotic and in a conflictual manner without any hope of becoming truly human, i.e., to organize in a harmonious unity all his/her dimensions.

In contemporary western culture, after centuries of prevalence of the personal being on the biological being and of the biological being on the human being, the hierarchy that tends to prevail is that which places the biological being before the personal being and the personal being before the human being. But the personal factor is still very strong especially in Latin subcultures.

The most evident consequence of this is the prevalence of scientific knowledge (according to which to know man, it is essential to know the functioning of the brain, neuroscience) on “humanistic” knowledge (according to which to know man, it is essential to know the feelings of each man or of mankind in general).

The consequence of this setting when it comes to healthcare is that when an individual falls ill or suffers, in my opinion, it would be desirable to promote an “ethical prevalence” of the human being on the personal being and of the personal being on the biological being.

The first consequence for those who become ill is to become a “clinical case,” which can be inserted into a statistic, the only way to take into consideration their characteristics as something *that belongs to all of us and affects us all*, with an individual variability of a quantitative type with respect to a “normal” distribution in the population. In this way, the personal characteristics which make ill people unique (their personality and biography) and human (their interpersonal relationships) are pushed into the background. This is inevitably followed by a certain degree of “depersonalization” and “dehumanization.” Not too much damage is done if this depersonalization and dehumanization lasts for a short time and if in this time, through the techniques of medicine, the goal of healing is reached. On the other hand, when medicine reaches its limit, and there is a failure to heal the individual, depersonalization and dehumanization can be prices that are too high to pay in terms of “loss of dignity of life” for patients who base their value on the “personal feeling of being themselves and unique” and on those who base it “on the consideration of others.”

The prices to be paid and the manner in which they are paid have been outlined previously in the “Manifesto for the humanization of medicine” [2]:

...In sickness, we all live the *insult* to the integrity of our body (integrity that is the basis of the possibility to build a personal history) and the *humiliation* in the pride to exist (pride that is the basis of the ability to respect and to be respected). And when we are ill, we all invoke a medicine that has the power to heal, to alleviate pain and to prevent the threat of death. But medicine is not able to counteract this offense and this humiliation, if not in the rare cases in which it helps us to achieve a complete and lasting healing. This is so because, in order to help us, Medicine is in possession only of its technical power. As if to say that to overcome the offense that disease incurs to the dignity of the person and the humiliation to the dignity of man, Medicine possesses an uncertain and therefore anonymous statistical

power to restore health. However, it is the insult and humiliation of the illness that the uncertain power of the doctor is unable to effectively overcome, because it almost never heals permanently. This injury and humiliation will be able to be counteracted if Medicine will give the offended person and the humiliated humanity of the ill a moral value higher both than that of the personal being and of the humanity of the healthy person and also of Medicine itself. In other words, the doctor should recognize the *moral majesty* of the ill precisely in the offense, in the humiliation that the disease inflicts, therefore putting his/her technique to the service of the sick person's dignity as a person and as a man!

But what gives dignity to the sick, as a person and because they belong to the human race? This is what every human being shares with all other human beings and that what gives it meaning with his/her personal differences but it also goes beyond these differences. This is about the possibility that every sick man has to stir in another human being the responsibility of taking care of him/her by asking him/her for help.

It then becomes important to *empathize* with patients in order to be inspired by them (allow them to tell) to do and say what could “compensate” the loss of dignity of life determined by depersonalization and dehumanization. It is a concrete operation of appreciation; it refers to everything that gives value to each one of us as a human being, regardless of our biology and of us “being a person.” Simone Weil [3] stated that the value of each person, whoever he or she is, is based on their “desire for good.” This is what was described in the cited “Manifesto for the humanization of medicine” [2] in the following manner: “It is important to ensure that the moral superiority of the ill (compared to those who assist them) is also recognized by the ill people themselves, placing as a focal point of the doctor's care the restoration of the ill person's dignity even when (and especially when) it is not possible to achieve this objective through healing. For this to occur, it is essential to ensure that the training of doctors (and the entire medical staff) is no longer predominantly technical and that they are no longer blackmailed economically but that they are trained to become what they always have been and what they always wanted to be in their most authentic and most noble vocation: the guardian of life and the dignity of the ill person in spite of any economic compatibility and kind of power whatsoever. It is also important to aid those who are momentarily healthy and gain awareness that when the offense and humiliation of disease occur, for everyone sooner or later, it is possible to adopt more effective defensive strategies than medical technologies: the sharing of a collective moral principle that those who suffer “are worth more morally” than those who do not suffer or those who suffer for them, a principle that can inspire the responsibility of a doctor capable of a technical act which is not self-sufficient but always at the service of the sick person and the humanity of the ill person.”

It is not difficult to articulate what has been said so far in terms of practical assistance as long as doctors do not find themselves facing “choices” that may cause them distress (basically, when and to what extent to refrain from active therapies and when to limit themselves to supportive care or palliative care) [4].

In this respect, the example of “intensive therapy” is the clearest and most “inclusive” example, given that in all diseases that are life threatening, when the situation is aggravated, it must be decided if there is a need for “intensive therapy” and, if so, up to what extent it should be carried out.

The intensive therapy units are among the healthcare places in which more frequently and dramatically there is the problem of what is the “right thing” for the ill person, due to the difficult choices (both therapeutic and not therapeutic) which are imposed every time there is a comparison of different interests, different knowledge, different sensibilities, and different ethics on life and death. *Humanizing* intensive therapies means (as in every healthcare context) during the first attempt to manage gradually to “do as much good as is possible” for everyone (patients, caregivers, and healthcare providers): both in the cases of a “lesser” choice like making the departments more accessible or leaving them closed to the family members as they most often are to this day and age and also in the cases of “greater” choices, such as the interruption of therapies (both artificial and not), to let patients die without hope or to continue to provide care fostering hope which is more or less illusory.

Perhaps rightly so, or perhaps because in our culture it cannot be done otherwise, when defining the “good” which humanizes therapeutic choices, we tend to re-propose also in medicine the model which *Plato* originally presented in “Filebo” [5], one of the dialogues which is not very well known. In this dialogue, Socrates searches, together with friends, the “true good” for mankind. In summary, the conclusion Plato reaches is the following: the true good for man is the happiness (or pleasure) in life to which the truth must be added. Without this truth, any happiness would become false; the supreme good is the “proportion” that makes the mixture of pleasure and knowledge become “good,” and this composition is always necessary in order to obtain goodness.

What also could we intend saying when talking about “proportioned care,” if not that it should be a proportioned mixture of interventions which really increase the well-being of everyone, that is, it makes others feel better and that it is truthful?

If anything, this issue, already present during the times of Plato, refers to whether the proportionality is obtained “ethically” through a virtue which he intended more or less as being wisdom, moderation, alleviation, or equilibrium, or if it is obtained through mathematical principles and their application of the phenomenological field.

This depends on the reply given to the following question: *the medical care needs to be proportionate, but proportionate to what?*

In our culture, there has been a dispute between two fields which has lasted some centuries, between two criteria to “proportion” medical care: the biological criteria and the personal criteria. Here they are in detail:

- I. From the point of view of the biological knowledge, medical care is proportionate if it is commensurated to its end and it results as being effective; it is not proportionate if it is not efficient when it comes to its finality. For example, feeding a patient who is in an irreversible coma is “proportionate” if it is done to keep him/her alive and it is “not proportionate” if it is done to make him/her come out of the coma. But who decides the finality of an interventional medical treatment? This is precisely the limit of this criterion: it is valid *if* no subjective aspects interfere with the certainty of the objective finality of the medical care

(when it comes to this example, up to the point when someone does not want to use artificial nutrition not to keep the patient in the coma alive as a scope in itself, but to consent that a cure is discovered in order to awake the patient from the coma). However, the value of the humanization of the biological proportionality needs to remain present in order for goodness to be produced for everyone, whenever there is a medical care, in which there is a shared finality and which is also efficient in improving the objective condition of patient and as a consequence of the caregivers and healthcare providers.

- II. On the other hand, from the point of view of the awareness, that is, the intentionality of the people (*patients*, *caregivers*, and *healthcare providers*), a cure is proportioned if commensurated to the way these subjects are aware of the conditions (whether they accept them or they deny them) and their expectations. For example, feeding a patient who is in an irreversible coma is “proportioned” for who accepts the condition of life in a coma (either because there is an instrumental belief that the patient might wake up the day after or because the same value is continued to be attributed to the life of the patient in coma); on the other hand, it is “not proportioned” for those who refuse the condition of life in a coma and who desire that this life ends as soon as possible. But who is right? Both, from the subjective point of view until they remain “separate” in the private life. The limit of this personal criterion when it comes to the choice of healthcare consists precisely in this: it is an individual criterion which requires a “pluralistic” community, made up of individuals with different rights and duties, that is, with different subcultures which need to be very tolerant between themselves and also kept rigorously separate; otherwise, they will be in constant “civil war.” Also in this case, however, there remains the value of humanization of the personal proportionality of healthcare, since benefits are produced for everyone every time healthcare is commensurated to the people’s reaction and to their expectations, and it is provided in such a way “not to hurt anyone else.”

In summary:

- (a) The proportionality of healthcare, in the way it has developed in our culture, is made possible, on the one hand, by the ever-developing capacity of objective science to measure the *efficacy* of healthcare, measuring them to a standard, and on the other hand, by the capacity to assist and to allow to emerge the intentionality and the expectations of the ones receiving healthcare in an empathic manner, by commensurating the healthcare provided.
- (b) The limits of the proportionality of healthcare are, on the one hand, dependent on the limits of science in predicting their own developments and, on the other hand, by the irreducible conflicts of the different personal points of view.

Therefore, a “sense of proportions” needs to be developed, by following the platonic indications of wisdom, a “sense of proportions” both on behalf of science (in a way in which one should proceed with moderation, prudence, and humility) and also on behalf of the single people (in a way that they should act in a poised and

tolerant way towards others when they have a different point of view, making sure that the civil war between different points of view is not external and irreducible).

Will this suffice? And *if* it shouldn't suffice, are there any other alternatives?

In order to discover this, we must ask ourselves if the *human criteria* can show us another way, different from the ones which are proper of the two ways of pursuing well-being illustrated previously.

The biological healthcare humanizes the existential conditions of the actors of the intensive therapy units (or of healthcare places of this kind) through their objective efficacy in making patients feel better or less worse, that is, bringing "in themselves" their beneficial value, increasing the *well-being of everyone and of nobody* in particular, *the well-being on average*.

Care on a personal level humanizes to the point that it corresponds to the subjective manner of becoming aware (by accepting or refusing) the need to receive healthcare and to the degree of realizing the corresponding expectations, that is, to what extent well-being is identified in that which is good "*for someone*."

The human dimension characterized by identifying what is good in what is *good for everyone and for each one at the same time* is clearly left out. And it is precisely by taking into consideration this third dimension that the pursuing of good can be seen as being different both from the biological and personal dimensions. In other terms, the good can be pursued through "human healthcare" that (instead of being based on efficiency that corresponds to the satisfaction of objective needs or the adherence of the intentionality to be treated of the single patients, which corresponds to the satisfaction of the unique and non-repeatable needs of a single person) are based on the concept of taking on ourselves the *responsibility* "for all the others" of their own good, first and foremost and irrespectively from having the availability of objective and adequate means or knowing subjective ways of becoming aware (accepting or refusing) of situations and expectations which are relative to them. This is about a human dimension, which in our culture is neglected also on a theoretical point of view. This is so in spite of the fact that these healthcare situations in which someone pursues the well-being of another person, and therefore humanizes the situation, taking care not only of his/her needs but also of the needs of everybody else, without knowing if there will be the "power" to act and "before" knowing who is the other person being helped as a person. It is true as Severino [6] states in one of his writings that nobody knows what is the absolute good, but it is clear to everyone that good which is so in the indifference for everyone or only for someone cannot be called as "good" whatever it is. Thus, a dimension of the good appears which is irrespectively of its "what" is, and it consents us not to turn away from looking for the good, with the excuse that it is not possible for us to understand its essence¹.

¹For now, we must resign ourselves to what has always happened: the winning force has been called truth, justice, and law. For this reason, it is pathetic to invoke an absolute good. Nowadays, the dominant culture is not capable to resolve these problems. They are resolved in a practical, political manner.

This is a criterion of humanization in which there is no concern of commensurating healthcare to the standards of efficiency and not even of prorating it to the “who” is the single recipient, but it is based on something which comes “before” (the responsibility that one feels who is committed to provide healthcare) and is incommensurable (consisting in the commitment of considering the points of view of all the others without seeing what is convenient, that is, adopting an attitude which is “without calculating” of someone who is committed to do good for others in a disinterested way, by being disinterested about what extent he/she will be able to do it and without knowing the first intentionality and expectations of the person to whom the good is being done). This is the human dimension which contradicts the platonic model of the “true good,” dethroning the value of measure and proportion, both when there is *calculation* and *quantification* and also when there is *qualification* and *personalization*.

It is a humanization that is completely different from the Promethean Humanism (that consists in giving man “false hopes” making him ignore “when” death will arrive) and from the Christian one (which consists in giving man the hope of a life after death) which gave rise to the crises in our period.

The Promethean Humanism fails because it does not manage to keep together the two gifts that Prometheus makes to men: fire and the false hopes based on the ignorance of time of death. The “fire” of the proportionate and technically efficient healthcare has in fact become incompatible with the false hopes of therapeutic persecution.

Also Christian humanism fails as it tries to validate the false Promethean hopes in a perspective focalizing on new technological progress, instead of residing faith in a redeeming God, who is perhaps already dead.

Only the imbalance in responsibility, which is based on placing before oneself the other and everyone else (aiming to conciliate the good of everyone and each one), could allow us to overcome this block every time the two proportionalities possible (the technical-biological and the personal one) encounter their limit.

What does this mean concretely/in actual terms?

First of all, it means that every time science ignores the “when” of its efficacy, we can still humanize the situation of those who suffer (i.e., pursue their well-being) taking on just the same the responsibility to help them “before” knowing what and when we will be able to objectively do so. For example, we cannot scientifically predict when we will be able to make someone wake up from a persistent vegetative state, but we can still help those who need to do it, taking on the responsibility to help them and thus getting involved in their “infinite desire” to make them wake up and involve them in the “study” without time limits (the necessary time that it will take) to reach this result.

Secondly, it means that every time a person does not accept his/her condition or would like something that is impossible in order to hope to accept it, we can still humanize the situation by still taking on the responsibility of helping them, even though we do not know if we will be able to meet their expectations.

For example, if the doctors who were taking care of Eluana Englaro [2, 7] had taken on the responsibility of her father’s request to make her die, instead of

defending themselves behind their technical duties, denying him help, and even condemning him morally for this request of making her die, the human involvement which would have been determined “between” them would have spontaneously limited the will of Beppino Englaro, making possible to allow a dialogue which was previously not possible, between the two contrasting violences of causing death and forcing to live ².

In other words, this “humanism of disproportionate responsibility” will be able to unlock a new possibility: *to pursue the good of everyone and of each one*, which does not mean making a calculated average of what is objectively available and not even favoring the particular good of who imposes himself/herself on others (by using some force or with the power of complaint), but rather sharing, all of us, the responsibility of doing the “right thing” for everyone, continuing in this search for good in infinity even after having done what could have been done in the given circumstance. In other terms, what can be done objectively and also what the interpersonal situation imposes that needs to be done, will be done, but in the perspective of the infinite research of “justice” for everyone, that is the good for everyone and for each one.

An example.

The healthcare provided needs to be proportionate (in the two senses indicated above) even in the situations of clinical irreversibility (such as the persistent vegetative state or *terminality*), but one needs to be able to call into question the choices made every time that new knowledge changes the standards of care and a subject reacts in a particular way. And we can clearly manage to do so only if the time of efficiency (the time of the standard good) and the personal one (*the time of the subjective good*) are inscribed in an infinite time (*the time of the good for everyone and for each one*, the necessary time, i.e., the time of desire). By pursuing in infinity the “right thing,” we can sustain the damage derived from the inevitable limits of the choices based on the objective awareness which is always partial and those based on individual preferences which are not valid for everyone.

Expressing in more simple terms all that has been said up to here, we can say, reaffirming what we are trying to say in this chapter, that the *human* pursued in the humanization can be defined in objective, subjective, and intersubjective terms.

In objective terms, the human being can be defined as a *biological being* who, thanks to evolution, uniquely possesses a more evolved brain when compared to all other living beings, self-awareness, and language.

²The Englaro case is, in some respects, similar to the Terri Schiavo case, only with a less conflictual family. Eluana lived in a vegetative state for 17 years after a car accident, until her death caused by the interruption of the artificial ventilation. Eluana’s father, Beppino Englaro, had tried for 17 years to get recognized to the Italian law the right of his daughter not to be kept alive artificially and therefore to be allowed to die, arguing that Eluana would not have wanted to live in a vegetative state. Since there was no biological testament, Beppino Englaro made himself guarantor of the will of his daughter together with his wife and he sought to corroborate this position through the testimonies of the friends of his daughter.

In subjective terms, the human being can be defined as a *personal being*, characterized by a biography which makes him/her unique and not comparable to any other personal being.

In intersubjective terms, the human being can be defined as human, that is, first of all belonging to a species, precisely the human one, characterized by a primary and insuperable interconnection between all minds, all languages, all self-awarenesses, and all biographies.

Naturally, these three dimensions of the human “make” man all of them three together, but there is no concrete humanity which does not necessitate to establish some kind of “hierarchy” between them.

After centuries of prevalence of the personal being on the biological one and of the biological on the human one in western contemporary culture, the tendency which tends to prevail is the one which places the biological being before the personal one and the personal one before the human one. But the personal factor remains extremely strong especially in the Latin subcultures.

The consequence of this when it comes to intensive therapy units is that the ill, since they have been profoundly affected in their biology by illness and traumas (mostly justifying in this way the hierarchy of the human which makes the biological dimension prevail), more than in any other healthcare context, have the risk of being “reduced” to biological beings. This means that their condition is humanized only from a biological perspective. For this reason, when “humanizing” care for human beings, it is necessary to take into consideration: (1) his/her personal dimension (what makes him/her feel like a person, his/her wishes and the ways of telling himself/herself what is happening) and (2) his/her human dimension (what makes him/her feel “one like all others,” on the basis of the value attributed to him/her as a person despite the impairments sustained).

Naturally, the same partial humanization of healthcare can also interest the family members of the patient and the healthcare personnel when there is a tendency to disregard the human dimensions in the interventions. More specifically:

- (a) The *intensive therapy* unit care is “humanized” for the family of the patients (other than indirectly improving the biological conditions of the ill): when they are helped to overcome stress and the traumas which can be inflicted in a highly stressful and traumatizing environment; when they are helped to personalize their participation to life in an intensive therapy unit allowing them, as much as possible, to choose how and when they visit, so that they feel as much as possible at home and thus guaranteeing the maximum collaboration on assistance; and when a positive moral value is attributed to whichever request is made from the family members, in order to establish with them an empathic communication based on a respectful welcoming of the request in itself. In this manner, the impression is given that the staff which assist support whichever request and it is possible to ask for something even when it is not allowed.
- (b) The intensive therapy unit care is “humanized” for the healthcare personnel (besides improvements through objective professional training): when they are helped to deal with feelings of inadequacy and helplessness of who does not

manage to do what they should without being indifferent, an *indifference* which makes them suffer less but which can lead to a more or less prominent abandoning of the patients and their family resulting in a dehumanization of the condition; when they are helped to appreciate the uniqueness of the patients who cannot express themselves or to personalize the participation of family members in the daily life of the unit, without identifying themselves to the point of behaving *as if* they themselves were in their place; and when they are helped to attribute a *superior moral value* to the patients in order to make them feel human despite of their biological and personal conditions and to establish an empathic communication with their family, in which there is the ability to respect their requests even when it is not possible to fulfill them. Finally, also not to regress to a personal concern or a technical indifference in the cases, they discover themselves as being not sufficiently disinterested in the help of the patients and/or their family.

This is the beginning of the “human” pursuit to ensure that this evermore broad and complete humanization is possible in its concrete dimensions.

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Clinical Psychology and Congenital Heart Disease
Lifelong Psychological Aspects and Interventions

Callus, E.; Quadri, E. (Eds.)

2015, XII, 199 p. 16 illus. in color., Hardcover

ISBN: 978-88-470-5698-5