MIND AND BODY: KEY CONCEPTS IN A DIALECTIC RELATIONSHIP

Dario Manfellotto

Abstract

This article explores the evolution of the doctor-patient relationship, emphasizing the importance of empathy, communication, and mutual respect. It underscores the patient's right to autonomy and informed consent as central to ethical medical care. The narrative illustrates how historical and artistic representations of physicians reflect shifting attitudes in healthcare. Integrating body and mind is highlighted as essential for effective treatment, with hope playing a therapeutic role. The text critiques the growing influence of technology and artificial intelligence in care, urging human-centered approaches. It addresses challenges posed by frailty, complexity, and loneliness in modern medicine. The nocebo effect is examined as consequence of communication, affecting treatment outcomes. Legal frameworks like Italian Law 219/2017 are cited to support patient-centered care. The article emphasizes the hospital as a place of healing, community, and dignity. Ultimately, it argues that hope, personalized, human, and spiritual, remains a fundamental element of healing.

Keywords: Doctor-Patient Relationship, Hope in Healing, Mind-Body Integration, Informed Consent, Humanized Medicine

I believe there is no one who questioned the principle that the patient has the right to decide on his or her own health, thus creating the care condition closest to his or her way of living and thinking.

To do this, it is appropriate to talk about the qualities required of a doctor.

First, there is the need to build a good relationship of the doctor with the patient and with the family members or care staff.

In this sense, the value of the doctor's clinical work is fully realized in

10.69080/TheFutureOfHope.51-63

their ability to inspire and cultivate hope—a universal need that arises in all individuals, whether religious or secular, when confronted with a health issue. This feeling and this ability to live optimistically, setting oneself health perspectives, is essential to face the disease in the best way and contribute to the effectiveness of treatment.

The relationship between body and mind appears to be fundamental in patient care, because it is not possible to deal with only one of the two components, but the doctor must know how to reconcile and integrate the needs of one and the other.

To do this, I would like to talk about the evolution of the doctor-patient relationship in the historical evolution of medicine.

Some images effectively represent the figure of the doctor.

In the first image (Fig 1) the doctor feels the patient's pulse with a paternalistic air and talks to a family member[1].

Fig. 1. - *Visit of the Doctor by Jan Steen*, *1661*

[1] J. Steen, *Visit of the Doctor*, 1661, oil on canvas, Rijksmuseum, Amsterdam. https://www.rijksmuseum.nl/en/collection/SK-A-2342.

10.69080/TheFutureOfHope.51-63

In another painting, "*The Doctor*" by Samuel Luke Fildes[2] from 1891 (fig 2), the doctor is seated near the bed of the sick woman, in this case a small girl with her parents close to each other, heartbroken and destroyed by grief. The doctor in some way expresses his substantial difficulty, dedicating concentration and affection and above all time, but demonstrating great helplessness from the point of view of diagnosis and therapy.

Fig 2. - *The Doctor" by Samuel Luke Fildes, 1891*

Another very well-known image is that of a very young Picasso who in 1897 made a painting entitled "*Science and Charity*"[3] (fig 3) in which once again the elegiac image of the doctor sitting next to the bed, who feels the pulse of the pale and suffering patient and near her a nun, who probably holds the patient's son in her arms and offers the patient a drink.

[2] S. L. Fildes, *The Doctor*, 1891, oil on canvas, Tate Britain, London. https://www.tate.org.uk/art/artworks/fildes-the-doctor-n01522.

[3] Pablo Picasso, *Science and Charity*, 1897, oil on canvas, Museu Picasso, Barcelona. https://www.museupicasso.bcn.cat/en/collection/science-and-charity.

10.69080/TheFutureOfHope.51-63

Fig 3. - *Science and Charity, by Pablo Picasso, 1897*

All these images have defined the type of doctor-patient relationship and its evolution over the years through various visions and approaches:

- An elegiac vision
- a mystical religious vision
- a paternalistic approach and vision
- a contractual-type approach and vision, such as the most modern one in which the doctor-patient relationship is based on a sort of agreement on the therapy program and the objectives of the treatment
- a business- and profit-oriented vision
- finally, a relationship mediated by technology and artificial intelligence

The problem is what the future offers us.

In other words, in the doctor-patient relationship, will the role of the doctor, his presence, his mediation and his ability to dialogue, and above all to listen, remain fundamental, or, as some fear, will machines and artificial intelligence be able to replace the human and professional figure of the doctor?

10.69080/TheFutureOfHope.51-63

Or will the physician remain indispensable for effectively engaging with both the physical and psychological dimensions of the patient? All this has also gone hand in hand with the evolution of the *"healing"* and then hospital structure, which in the history of medicine has gone from a place of isolation and hospitalization of patients mainly suffering from infectious and communicable diseases (which had to be kept away from the rest of the population) to places where medicine must be practiced in an increasingly professional and hopefully effective way.

But also in the past, as in Greek and Roman medicine, there were activities that focused on emotions and tended to arouse the patient's hope, such as the so-called *theophanies* and the various events that were organized within the places of treatment, with the simulated apparitions of the gods between fumes and disguises, in order to psychologically stimulate the patient and to act on the hope of healing.

More modernly, hope and great attention to the psychological and organic well-being of the patient (*mind and body*) has become more and more part of that process of *humanization of the hospital* that has so much affected the activity of religious hospitals in particular, with the fundamental figure of Father General of the Brothers of St. John of God, Pierluigi Marchesi, who already in the Eighties began to work for a more humane hospital.

Father Marchesi claimed that the humanized hospital is wide open to relatives and friends of the patients. That the humanized hospital has a very precise map of power. That the humanized hospital believes in teamwork. That in the humanized hospital there is a continuing education of health workers. That the humanized hospital is a family home, that is, a community that faces with seriousness and pain, that does not fear the defeat that produces and induces hope in people. It is the fulcrum around which the professional, emotional, intellectual life of professionals, patients, relatives revolve. The humanized hospital is the domus in which the patient feels at home, accepted, understood and helped in all fundamental needs.[4]

[4] P. Marchesi, *Rinnovarsi per umanizzare*. Documento redatto dal Priore Generale Fra Marchesi, Ordine Fatebenefratelli. Citato in: "Fra Marchesi: i principi dell'ospedale umanizzato", *Fatebenefratelli* (15 giugno 2019).

10.69080/TheFutureOfHope.51-63

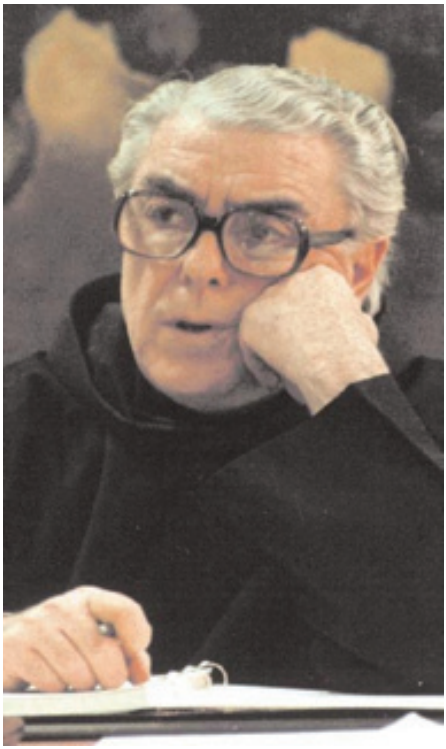

Fig 4. - *Pierluigi Marchesi (1929-2002)*[5]

Father Marchesi's reflections have become increasingly appreciated and in fact there is now widespread awareness that the good organization of health facilities contributes to the improvement of the quality of care.

Unfortunately, however, even today, good organization is not an *Essential Level of Assistance (LEA).*

It is like saying that although there is a constitutional right to health protection, there is no right to this protection taking place in an organizational context that can increase the probability of having good care. In other words, to take care of the body and mind at the same time to ensure the best care. LEAs are now defined in terms of technologies

[5] Foto di Fra Pierluigi Marchesi (ca. anni '70), fotografia, Archivio Centro Studi e Formazione Fra Pierluigi Marchesi – Fatebenefratelli.

10.69080/TheFutureOfHope.51-63

(e.g. a drug therapy approved by AIFA), or in terms of procedures, such as screening, but the quality of the organization underlying the provision of that service is not defined as LEA.

Regarding the medical-patient relationship, some very inspired and fundamental words were written by Marguerite Yourcenar, in her novel "*Memoirs of Hadrian*" of 1951, to describe the relation between the emperor Hadrian and his doctor:

> This morning, I went to my doctor, Hermogenes, who recently returned to the Villa from a long trip to Asia. He had to visit me on an empty stomach, and we agreed to meet early in the morning. I have laid aside my cloak and tunic; I lay down on the bed. I spare you details that would be as disagreeable to you as they are to me, and the description of the body of a man who is advancing in years and is about to die of dropsy of the heart. Let's just say that I coughed, breathed, held my breath, according to Hermogenes' instructions, alarmed despite himself by the rapidity of the progress of the disease, ready to attribute the blame to the young Giolla, who treated me in his absence.
>
> It is difficult to remain emperor in the presence of a doctor; it is also difficult to preserve one's own human essence: the doctor's eye sees in me only an aggregate of humors, a poor amalgam of lymph and blood. And for the first time, this morning, it occurred to me that **my body**, a faithful companion, a sure friend and known to me more than **the soul**, is only a devious monster that will end up devouring the master.
>
> Enough... my body is dear to me; he served me well, and in every way, and I will not spare him the necessary care. But, by now, I no longer count, as Hermogenes maintains, on the prodigious virtues of plants, on the precise dosage of those mineral salts that he went to procure in the East.
>
> He is a fine man; yet, he has given me vague formulas of comfort, too obvious to be believed; he knows well how much I hate this kind of imposture, but medicine is not practiced with impunity for more than thirty years.
>
> I forgive this faithful one of mine for his attempt to hide death from me[6].

[6] M. YOURCENAR, *Memoirs of Hadrian*. Translated by Grace Frick, Farrar, Straus and Giroux, 1954.

10.69080/TheFutureOfHope.51-63

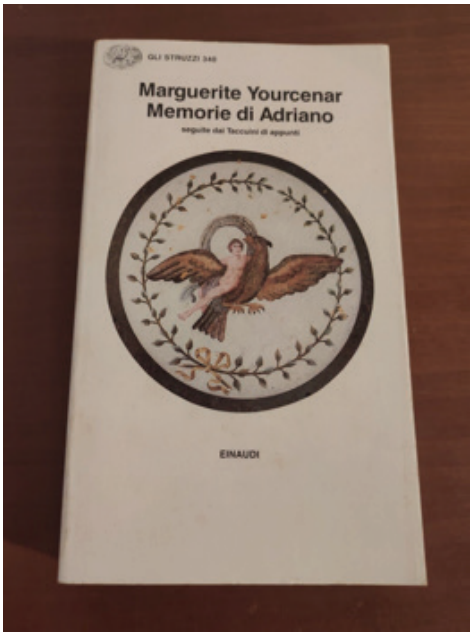

Fig 5. - *Marguerite Yourcenar, "Memoirs of Hadrian", 1951*

Cardinal Gianfranco Ravasi in a recent article in "Il Sole 24 ore" in September 2024 , commenting on the words of Annibale Caro: «Everyone would like to be cured of bodily ills, but they cannot. Everyone would like to heal the ills of the soul, but they don't want to», so wrote:

The frenetic care of the body, which in our days relies on an impressive consumption of medicines or cosmetic surgery, fitness and so on, cannot stop the subtle ramifications of lethal diseases. Mortality is our common identity card and it is necessary to walk with our eyes open towards that border. On the contrary, the soul is often given little care. It is left to stiffen without quenching its thirst. His illnesses, which are the vices, do not worry us that much. It is allowed to lack that food that makes it live, as St. Catherine of Siena said: "the soul is a tree made for love and therefore can only live on love[7].

[7] G. Ravasi, *Così la Bibbia divenne bestseller*, *Domenica*, *Il Sole 24 Ore*, 15 settembre 2024.

10.69080/TheFutureOfHope.51-63

Finally, Pope Francis, commenting on the "*Small lexicon of the end of life*" (2017) of the Pontifical Academy for Life, writes that «the individual functions of the body, including nutrition, especially if affected in a stable and irreversible way, must be considered in the overall framework of the person and his or her bodily dimension. But if technocratic logic becomes prevalent, the human body risks to be interpreted and administered as a set of organs to be repaired or replaced». _

In this line we can interpret Pope Francis' statement, when he asserts that the «technological interventions on the body can sustain biological functions that have become insufficient, or even replace them, but this is not the same as promoting health. A supplement of wisdom is therefore needed, because today it is more insidious to insist on treatments that produce powerful effects on the body, but sometimes they do not benefit the integral good of the person».

These words strongly support the need to consider together mind and body for the best and the most correct clinical approach.

From a strictly legal point of view, the relationship between body and mind and the fundamental mediation of the doctor through a correct relationship with the patient is regulated by Italian Law 219-2017 which speaks of informed consent and the living will, underlining that «no health treatment can be started or continued without the free and informed consent of the person concerned, except in cases clearly provided for by law».

It is also emphasized in the law itself that «the time of communication between doctor and patient constitutes time of care».

These are words that the law defines very precisely, to underline how the treatment process must always be the expression of the patient's free conviction, in a virtuous and very constructive relationship with his or her doctor.

Complicating these problems must also be considered the role of conditions such as *complexity* and *frailty*, which are two different medical concepts.

Complexity is defined as the presence of intricate composite conditions and the degree of complications of a system or a system component.

Frailty, on the other hand, defines a vulnerable state of health that derives not only from clinical complexity but also from the interaction, which is also complex, of medical, physical, mental, nutritional and even social problems.

10.69080/TheFutureOfHope.51-63

The result is a reduced ability to respond to the stress of the disease and also a reduction in the patient's functional performance. In this context, a reduced cognitive capacity of the patient may also coexist, which makes it very difficult, if not impossible, to express informed consent to treatment and the need for prior express consent, or legal representative.

In the frail patient there is also a close relationship with loneliness, as defined by Megan Brooks:

> Loneliness is widely recognized as a health risk factor, linked to conditions like cardiovascular disease, psychiatric disorder and increased risks for stroke and dementia. A large UK biobank study provides compelling evidence that loneliness may be a potential surrogate marker rather than a causal risk factor for most diseases. Instead, loneliness may act as a surrogate marker, explained by factors such as socioeconomic status, health behaviors, depressive symptoms, metabolic factors and comorbidities. These factors explained more than 79% of the associations between loneliness and disease.[8]

In the patient in general, but particularly in the complex patient with comorbid conditions and polypharmacotherapy, as those typically followed by internal medicine doctors, such as myself, much attention must be paid to the effects of drugs.

While *the placebo effect* is well known and has been well studied, much less is known about its counterpart, the so-called *nocebo effect*, which can be of considerable importance due to its impact on the effects of therapy and on public health.

The nocebo effect is defined as the induction or worsening of symptoms induced by sham or active therapies. This is a situation in which a patient develops side effects or symptoms that may occur with a drug or other therapies, simply because they think they might occur.

For example, in a clinical trial, patients who are not receiving a certain active treatment but who are told what side effects of active treatment may occur, may experience the same side effects as patients who are given active treatment, simply because they expect them to occur.

There are numerous examples and the underlying mechanisms are on the one hand psychological, such as conditioning and negative expectations;

[8] M. Brooks, "Loneliness/Disease Link Debatable?" *Medscape Medical News*, 24 settembre 2024.

10.69080/TheFutureOfHope.51-63

on the other hand neurobiological ones that call into question the role of hormones such as *cholecystokinin*, *endogenous opioids* and *dopamine*.

Nocebo effects can modulate the results of a given therapy in a negative way just as *placebo effects* can do so in a positive way.

Verbal and non-verbal communication also contains numerous negative unintentional suggestions that can trigger a *nocebo response.*

All of this raises the important question of how doctors can administer informed consent and minimize the risks associated with the *nocebo effect.*

According to Luana Colloca external and internal factors intervene in this phenomenon.

To better explain, Colloca describes these factors with some examples:

> Verbal suggestions (e.g., the treatment has been stopped), prior experiences (e.g., exposure to increased painful intensities), social observation (e.g., seeing someone suffering from a side effect), mass psychogenic modeling (e.g., believing wind turbines induce headache), treatment leaflets (e.g., list of side effects), patient-clinician communication (e.g., "this procedure is going to be painful"), contextual cues (e.g., smelling a chemotherapy), and overall clinical encounters are examples of external factors that trigger nocebo reactions. In contrast, negative mood and emotions, negative valence factors, maladaptive cognitive appraisal, personality traits, somatosensory features, and omics are among the internal factors that can share nocebo responsivity[9].

If we then refer to aspects that in a religious environment like this must be kept in mind, a lot of discussion, but also a lot of research concerns the possible effects of prayer or, as the great Italian scientist Umberto Veronesi wrote on the Fondazione Veronesi Blog in 2012 , whether prayer can also have a therapeutic power.

> I am often asked if prayer can also have a therapeutic power. If you observe the myriad of old and new cults (including the fashionable ones of the New Age) many people claim to draw strength and well-being from them, especially when prayer is strongly ritualized, and the repetition of syllables or mantras obtains in those who pray an effect of estrangement, contact with what seems another dimension. This can be explained in the light of what we know about the biochemistry of the brain (for example, it is known that falling in love, a psychic emotion, raises dopamine levels, which induces a state of well-being), and therefore it is reasonable to say

[9] L. Colloca, "The Nocebo Effect," *Annual Review of Pharmacology and Toxicology* 64 (2024): 171-190.

10.69080/TheFutureOfHope.51-63

that prayer has a certain beneficial effect. The case of those who claim to replace the medicine with prayer is different, with an absolutely irrational and dangerous fideism (not faith).

This is what has happened in the United States, where more than 300 people have died because they abandoned any treatment to turn only to a purported healing power of prayer. The most serious thing is that among these victims of an irrational decision there are also children, which reminds me anguishing of the cases of leukemic children who could have been cured and who were handed over by their parents to the "Di Bella cure". International scientific journals are also dealing with this matter and have already shown that alleged scientific studies on the therapeutic power of prayer were weak and inconsistent, and started from false premises[10].

Regarding this matter, after sixty years of activity, the Journal of Religion has published "*A Bibliometric Analysis of the Journal of Religion and Health: Sixty Years of Publication (1961–2021)*[11].

In 1961, the Journal of Religion and Health (JORH) commenced publishing articles that examined modern religious and spiritual philosophy in relation to psychology and health. This research paper retrospectively analyses the journal's content. It provides insight into JORH's publication trends, citation records, prominent themes, authors' collaborationand its aggregate contribution to the field of religion and health. Over time, the number of publications, citations and downloads of JORH articles have substantially increased, as has the journals' prominence and diverse contributions to the study of religion, spirituality and health.

And in this sense, to conclude this article, reference cannot be missing to how much body and mind are interconnected, but how much Hope plays a fundamental role in the healing process of a patient, regardless of religious confession or political faith, becoming part of the patient's experience.

The Jubilee of 2025 is all dedicated to Hope, referring to Encyclical *Spe Salvi* of by Pope Benedict XVI (2007) and finally to the bull of indiction for the 2025 Jubilee.

Pope Francis resumes the teaching of St. John XXIII, who spoke of

[10] https://www.old.fondazioneveronesi.it/magazine/i-blog-della-fondazione/umberto-veronesi/pregare-fa-bene-ma-non-guarisce.

[11] C. Lindsay B., et al. *"A Bibliometric Analysis of the Journal of Religion and Health: Sixty Years of Publication (1961-2021)." Journal of Religion and Health*, vol. 62, no. 1, 2023, pp. 8–38, doi:10.1007/s10943-022-01704-4.

10.69080/TheFutureOfHope.51-63

the "medicine of Mercy", and of Paul VI who identified the spirituality of Vatican II with that of the Samaritan. The Bull explains, furthermore, various salient aspects of the Jubilee: firstly, the motto, "Merciful like the Father", then the meaning of pilgrimage and above all the need for forgiveness.

«SPE SALVI facti sumus», in *hope* «we were saved», says Saint Paul to the Romans, and likewise to us (Rom 8:24).

«According to the Christian faith, "redemption", salvation, is not simply a given. Redemption is offered to us in the sense that we have been given hope, trustworthy hope, by virtue of which we can face our present: the present, even if it is arduous, can be lived and accepted if it leads towards a goal, if we can be sure of this goal, and if this goal is great enough to justify the effort of the journey.

Now the question immediately arises: what sort of hope could ever justify the statement that, on the basis of that hope and simply becauseit exists, we are redeemed? And what sort of certainty is involved here?»

Hope, as it was written in an interesting and ironic article published by JAMA in 1990, must be considered as a real medication, even like a drug.

In this article, hope is defined as what "*gets us out of bed in the morning*", and has its clinical pharmacology, its pharmacokinetics, its indications, its mechanism of action. Above all it has no contraindications, can be provided not in a standard dose and must be administered individually according to the needs and abilities of health professionals.

A careful analysis of the aspects of verbal and non-verbal communication and what develops in the doctor-patient relationship and in the patient's body-mind relationship can help and suggest the best way for the provision of hope.

Hope, as this 1990 article by William Buchholz concludes, can be used as a real drug for the best treatment of a patient.

10.69080/TheFutureOfHope.51-63