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Hospital Settings and Dehumanization: Systematic Review

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Abstract

Background: The concept of dehumanization is not new to psychology, but in recent years the study of the phenomenon in the field of health has begun. By dehumanization, we mean the removal of humanness from the other human being. Purpose: The purpose of this review is the bibliography background in the field of health in order to investigate if there is dehumanization. Method: The methodology that has been used is the review of literature from 2002 to 2019 with keywords in the databases: Google scholar, Pubmed, PsycInfo and Scopus. Results: The use of language by health professionals can comfort or dehumanize the hospitalized patient. Workload, bureaucracy, and profit-oriented economic policies can also lead to dehumanization. The difference in socioeconomic characteristics between doctors and patients can also contribute to the dehumanization of the hospitalized patient. Medical education that focuses on the affected organ rather than the holistic treatment of the patient, the overuse of technology, and the failure to discriminate against the patient can also contribute to dehumanization. Conclusion: It can be seen from the literature review that there is dehumanization in the hospital settings and it is suggested measures be taken to deal with the phenomenon.

Keywords

Hospital Settings, Dehumanization, Patients, Health Professionals

1. Introduction

Many researchers have argued that medical practice is becoming increasingly more inhuman, dominated by impersonal technologies and economic imperatives (Haslam, 2006). Several patients have experienced dehumanization in such

to the extent that it causes a crisis within healthcare systems, the crisis that is proving disastrous not only for patients, but also for professionals, families, and the systems themselves (Post, 2011). In modern medicine, the practitioner-patient relationship is widely considered to be a key feature of high-quality care. The spread of impersonal technologies and economic imperatives, however, has put this relationship under increased pressure (Vaes & Muratore, 2013) taking care of patients is reductive, i.e. focused on the affected organ and not holistic (Dolan, 2007).

Many studies have shown that a patient-centred approach to human is associated with positive outcomes (Haslam, 2007) for both patients as well as for the workers. The success of medicine can dazzle many and lead to the belief that the most important thing, or almost the only thing important thing in medicine is scientific knowledge. In this way, slowly lose the other basic principles of the profession based on the human relationship with patients and the care of patients' interests (Ceriani Cernadas, 2013). A previous study that took place in Sotiria Hospital in Athens, Greece showed that the health professionals dehumanize mechanistic the hospitalized patient (Lekka et al., 2021). Furthermore, research in the same hospital pointed out that the hospitalized patient doesn't dehumanize (Lekka et al., 2022).

2. Language and Dehumanization

In medical environments, behaviors are sometimes observed that offend the dignity of patients, for example: health professionals who talk like an infant when addressing the elderly, and health professionals who engage in various forms of aggressive behavior when interacting with the mentally ill. Health professionals are treated differently in patients belonging to their own or another racial/ethnic group. One of the causes of these degrading, aggressive and racist behaviours is the unconscious attribution of a lower human condition to patients (Capozza et al., 2016).

Also, poorly chosen and carelessly used words can hurt. These words can harm by negatively affecting patients' emotions, damage relationships with patients, and change the way the specialist perceives the patients who are cared. Patients are people, not "cases", and patients are much more than the sum of their individual diagnoses (Leopold et al., 2014). Research findings suggest that medical students during their studies use pejorative terms to describe the patient, e.g. plant (Dans, 2002). The language can act as a powerful lever to start and maintain the dehumanization process. In medicine, derogatory terms such as "plant" (Dans, 2002) or even the labeling of individuals by their disease ("diabetic"), can dehumanize patients.

3. Characteristics of the Hospital and Dehumanization

The neoliberal market ideology, with its organic approach to the individuals and the commercialization of health care, creates a corrosive effect that alienates cli-

nicians from their patients and causes the marginalization of palliative care practice. The tension between efficiency and patient-oriented care has become more pronounced in the current economic climate, at a time when the limits of medical have widened and expectations for healthcare have increased. There is research data on the broad negative effects of milder dehumanizing attitudes and behaviors. The dehumanisation of others leads to increased anti-sociality towards them in the form of increased aggressive behaviour such as bullying (Obermann, 2011) and harassment (Rudman & Mescher, 2012), as well as hostile behaviours avoidance such as social rejection (Martinez et al., 2011). This increased hostility and aggression are accompanied by reduced moral performance in those dehumanized (Opotow, 1990; Haslam & Loughnan, 2014) and therefore are deemed less worthy of protection from harm (Gray et al, 2007; Bastian & Haslam, 2010).

In a recent survey of doctors in the USA, a high number of patients were found to be satisfied with their relationship with the patient. But only a third of the doctors surveyed said that they have enough time to communicate fully with their patients and treat them. Time face to face between the patient and the doctor has been reduced by the bureaucracy and administrative tasks and the complexity of dealing with co-morbidities conditions requires more time to be devoted to data collection and test results, leaving less time to listen to the results of the people's stories (Ciechanowski, 2010).

In addition, healthcare staff may display inhumane attitudes towards patients due to consistently high levels of stress resulting from excessive workloads (Coşkun, 2015). Tired doctors see their patients as organs, not as people (Haslam & Loughnan, 2014), with the result that the patient is not treated as a bio-psycho-social entity but as a suffering organ.

4. Socio-Economic Characteristics and Dehumanization

Research data indicates that 57% of medical students in Australia come from high socio-economic backgrounds, a phenomenon that can lead to a form of "ego-centrism" that fundamentally affects how one sees and interacts with other individuals and groups (Geiger & Jordan, 2014). In general, social groups, including the "poor", are seen as more hostile, less intelligent, and less reliable, and they are less motivated and cause more feelings of disgust and contempt (Fiske et al., 2007).

The gap between social groups is widening (Figueras et al., 2008). Factors such as unfavorable working and living conditions have a negative impact on the health of mainly the poorest social groups. Although these groups have a multitude of needs, receive limited health benefits, as opposed to the economically well-off population. These parameters reproduce inequalities and in the case of Greece, burden the operation of the National Health System. The economically weaker groups, who also have more health care needs to be covered, are obliged to expect or receive lower quality benefits (OECD, 2009). So the public hospital

units are mainly used by patients who have low incomes, who usually have no other choice, while the citizens with high incomes have the possibility to make use of private transport health services or private insurance (Pappa & Niakas, 2006).

5. Medical Education and Dehumanization

The evidence-based biomedical approach, with a dominant example in medical education and clinical practice, gives priority to better evidence to guide decisions about appropriate treatment (Pawlikowski, 2002), while ignoring the specific patient who is suffering from the disease (Vogt et al., 2014). Dehumanization in medicine also comes from factors inherent to the functional requirements of the medical profession. An example is the diagnostic and therapeutic thinking toward patients sometimes follows the rules of mechanical systems consisting of interacting parts.

Treating people as mechanical systems often leads to a particular form of dehumanization in which the others are seen as incapable of emotional responsiveness or interpersonal warming (Pawlikowski, 2002; Haslam, 2006; Miles, 2012). Mechanization also is because it is necessary to solve problems by decomposing people and their symptoms in normal systems and subsystems (from organ systems to organs, to tissues, to cells, to molecules). The association of pathophysiology with findings and symptoms often occurs at a level of abstraction that ignores the mental states of the patients (Haque & Waytz, 2012), while a finding must be understood within the environmental context of one or more physiological systems, such as in relation to the general condition of the patient taken as a whole (Tauber, 2008).

Medical education seems to place great emphasis on the diagnostic and therapeutic approaches to the disease and the doctors in training spend a lot of time, either in the laboratories or in the clinics of hospitals, towards achieving the above objective. But in doing so they lose valuable information from the history of each person who comes to us for as a result, they find it difficult to understand the patients' need for personalized care.

6. Technology and Dehumanization

In certain medical fields such as radiology and pathology, due to the high use of technology, patients sometimes become aware of cold, lifeless beings disconnected from their social and emotional context (Haslam, 2006). The great development of technology goes hand in hand with excessive medical specialization, which subdivides the treatment into parts, thus preventing the then, reducing the quality of communication between experts from various areas, and adversely affecting patients, particularly those with more than one chronic disease (Pawlikowski, 2002; Detsky et al., 2012). So, while the division of labor and specialization can have a positive impact on the performance, and can cause dehumanization, prevent a holistic approach to the patient's perspective (Pawli-

kowski, 2002).

Advances in technology and biotechnology are opening up new, previously unforeseen therapeutic potential, but it also creates new ethical problems (Pawlikowski, 2002). Medical decision-making is particularly important, as is one of the most prominent areas where they have begun to apply mediated technologies and are widely used. Psychological research has shown that distance can affect many different aspects of decision making, such as self-control, willpower, self-control, willpower negotiating behavior, and ethical decision making. Greater psychological distance elicits abstract representations of an event, while shorter distance elicits more specific representations (Lee et al., 2015).

The theory of the social distance of power predicts that the relationship with less strong people will be less responsive to the needs of others and generally the behavior towards others is characterized by less humanity (Waytz & Schroeder, 2014). Experimental findings regarding decision-making through telemedicine show that self-perceptions had a significant main effect on decision-making and a significant interaction of self-perceptions and meaningful communication. Participants with interdependent self-perceptions took significantly more risky decisions (dangerous drug versus surgical surgery without anaesthesia), while 100% recommended the addition of a dangerous drug when they consulted their advisors through videoconferencing, while only 66% recommended the dangerous medication in face-to-face communication.

Participants with independent perceptions did not formulate different recommendations for treatment in communication face-to-face versus videoconferencing (Lee et al., 2015). Technology and medical devices also play an important role in fundamental role in the provision of modern healthcare and therefore can have a great impact on the patient's dignity. Some argue that technology can be a serious phenomenon of dehumanization, especially in the context of healthcare (Haslam, 2006). The entry of health information technology could erode human interactions in clinical care, and can lead to loss of privacy or misuse of personal information (Bailey, 2011).

7. Deindividuation and Dehumanization

The term de-personalization is used in the sense of replacement of individual identity from the collective. Deindividuation dehumanizes in two ways, through de-individualization of the perceived person or through de-personalization of what the person perceives (Haque & Waytz, 2012). In clinical practice, the doctor dehumanizes the patient and caregiver of his patient. On the other hand, patients who ask for help can to appear as impersonal bodies and not individuals who require it empathy (Haque & Waytz, 2012). Patients usually consider doctors as "empty containers" without emotions, due to their functional role regarding their health (Schroeder & Fishbach, 2015).

Also, non-discrimination practices, the destruction of patients' agency and perceived differences between caregivers and patients are de-individualized.

Non-discrimination (patient is considered lost in a group and anonymous) comes from the fact that in hospital settings patients are dressed in a similar and impersonal way. This institutional practice, which leads to assimilation, prevents the search for temperaments features thus limiting the discovery of features uniquely human or human characteristics in individual patients. So non-individualization leads, according to the theory of the mind, to the perception of patients with less agency and experience (Capozza et al., 2016).

8. Conclusion

The literature review shows that the patient is dehumanized during hospitalization and therefore measures should be taken either for prevention or for the treatment of this phenomenon in a hospital context. These measures concern the education of health professionals, clinical practice, administration, social policy, and research.

At the clinical level, taking a patient's history humanizes physicians, medical students, and health professionals in general. History can promote intercultural dialogue between medicine and the humanities as a platform for addressing cultural dialectic concerns raised by the new dominance of biomedicine (Warner, 2013), also by taking history the doctor enters into patients and offer themselves as partners in their care (Pickersgill, 2013; Charon et al., 2016). Also, the therapeutic relationship is an effective and important communication tool, reduces stress, improves the patient's ability, increases attachment to treatment, and reduces complaints. At the same time, it enhances the doctor's health, well-being, and professional ability (Haque, 2019). The therapeutic relationship is an important prognostic indicator of a patient's faith in the therapeutic process (Borrell-Carrió et al., 2004; Post, 2011). Providing compassionate care adds an element of stronger emotional response and deeper awareness of the patient's experience (Post, 2011). Compassion often occurs naturally and can be as quick and easy as a gentle or reassuring touch (Chochinov, 2007; Chadwick, 2015).

At the administrative level must be taken action against discrimination. Strategies to reduce interdisciplinary discrimination can mitigate the harmful effects of discriminatory health inequalities. Such strategies are based on the multiple categorization and complexity of social identity that leads to the intention to support, and equality in health services (Prati et al., 2016a, b).

Social policy measures include: subsidizing more money in the health sector and the accessibility of all people to the health system and the successful coverage of its needs.

Finally, with regard to medical education, we could add humanities courses, communication skills workshops, and medical history taking based on narrative techniques, and narrative writing.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

Bailey, J. E. (2011). Does Health Information Technology Dehumanize Health Care? *The Virtual Mentor, 13,* 181-185. https://doi.org/10.1001/virtualmentor.2011.13.3.msoc1-1103

Bastian, B., & Haslam, N. (2010). Excluded from Humanity: The Dehumanizing Effects of Social Ostracism. *Journal of Experimental Social Psychology, 46,* 107-113. https://doi.org/10.1016/j.jesp.2009.06.022

Borrell-Carrió, F., Suchman, A. L., & Epstein, M. R. (2004). The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry. *Annals of Family Medicine, 2,* 576-582. https://doi.org/10.1370/afm.245

Capozza, D., Falvo, R., Boin, J., & Colledani, D. (2016). Dehumanization in Medical Contexts: An Expanding Research Field. *Testing, Psychometrics, Metrology in Applied Psychology, 23,* 545-559.

Ceriani Cernadas, J. M (2013). The Road towards a More Humane Medicine. *Archivos Argentinos de Pediatria, 111,* 274-275. https://doi.org/10.5546/aap.2013.eng.274

Chadwick, R. (2015). Compassion: Hard to Define, Impossible to Mandate. *British Medical Journal, 351,* Article No. h3991. https://doi.org/10.1136/bmj.h3991

Charon, R., Hermann, N., & Devlin, M. J. (2016). Close Reading and Creative Writing in Clinical Education: Teaching Attention, Representation, and Affiliation. *Academic Medicine, 91,* 345-350. https://doi.org/10.1097/ACM.0000000000000827

Chochinov, H. (2007). Dignity and the Essence of Medicine: The A, B, C and D of Dignity Conserving Care. *British Medical Journal, 335*, 184-187. https://doi.org/10.1136/bmj.39244.650926.47

Ciechanowski, S. P. (2010). As Fundamental as Nouns and Verbs? Towards an Integration of Attachment Theory in Medical Training. *Medical Education, 44,* 122-124. https://doi.org/10.1111/j.1365-2923.2009.03578.x

Coşkun, A. (2015). Dehumanization as an Ethical Issue in the Health Services Sector. *Turkish Journal of Business Ethics, 7,* 29-51. https://doi.org/10.12711/tjbe.2014.7.2.0160

Dans, E. P. (2002). The Use of Pejorative Terms to Describe Patients: "Dirtball" Revisited. *Baylor University Medical Center Proceedings, 15*, 26-30. https://doi.org/10.1080/08998280.2002.11927811

Detsky, A. S., Gauthier, S. R., & Fuchs, V. R. (2012). Specialization in Medicine—How Much Is Appropriate? *Journal of American Medical Association, 307,* 463-464. https://doi.org/10.1001/jama.2012.44

Dolan, B. (2007). Soul Searching: A Brief History of the Mind/Body Debate in the Neurosciences. *Neurosurgical Focus*, *23,* 1-7. https://doi.org/10.3171/FOC-07/07/E2

Figueras, J., McKee, M., Lessof, S., Duran, A., & Menabde, N. (2008). *Health Systems, Health and Wealth: Assessing the Case for Investing in Health Systems*. WHO Regional Office for Europe. https://www.euro.who.int/__data/assets/pdf_file/0009/83997/E93699.pdf

Fiske, S. T., Cuddy, A. J., & Glick P. (2007). Universal Dimensions of Social Cognition: Warmth and Competence. *Trends in Cognitive Science, 11,* 77-83. https://doi.org/10.1016/j.tics.2006.11.005

Geiger, K. A., & Jordan, C. (2014). The Role of Societal Privilege in the Definitions and Practices of Inclusion. *Equality, Diversity & Inclusion, 33,* 261-274. https://doi.org/10.1108/EDI-12-2013-0115

Gray, M. H., Gray, K., & Wegner, M. D. (2007). Dimensions of Mind Perception. *Science, 315,* 619. https://doi.org/10.1126/science.1134475

Haque, M. (2019). Importance of Empathy among Medical Doctors to Ensure High-Quality Healthcare Level. *Advances in Human Biology, 9,* 104-107. https://doi.org/10.4103/AIHB.AIHB_44_18 https://www.aihbonline.com/article.asp?issn=2321-8568;year=2019;volume=9;issue=2;spage=104;epage=107;aulast=Haque;type=0

Haque, O. S., & Waytz, A. (2012). Dehumanization in Medicine: Causes, Solutions, and Functions. *Perspectives on Psychological Science, 7,* 176-186. https://doi.org/10.1177/1745691611429706

Haslam, N. & Loughnan, S. (2014). Dehumanization and Infrahumanization. *Annual Review of Psychology, 65,* 399-423. https://doi.org/10.1146/annurev-psych-010213-115045

Haslam, N. (2006). Dehumanization: An Integrative Review. *Personality and Social Psychology Review, 10,* 252-264. https://doi.org/10.1207/s15327957pspr1003_4

Haslam, N. (2007). Humanising Medical Practice: The Role of Empathy. *The Medical Journal of Australia, 187,* 381-382. https://doi.org/10.5694/j.1326-5377.2007.tb01305.x

Lee, K. M., Fruchter, N., & Dabbish, L. (2015, February). Making Decisions from a Distance: The Impact of Technological Mediation on Riskiness and Dehumanization. In: *Proceedings of the 18th ACM Conference on Computer Supported Cooperative Work & Social Computing* (pp. 1576-1589). https://doi.org/10.1145/2675133.2675288

Lekka, D., Richardson, C., Madoglou, A., Orlandou, K., Arachoviti, V., Karamanoli, V. I. et al. (2022). Study of the Association of Insecure Attachment with the Dehumanization and Self-Dehumanization of Patients Hospitalized With Psychotic Disorder and Organic Disease. *Cureus, 14,* Article ID: e21445. https://doi.org/10.7759/cureus.21445

Lekka, D., Richardson, C., Madoglou, A., Orlandou, K., Karamanoli, V. I., Roubi, A. et al. (2021). Dehumanization of Hospitalized Patients and Self-Dehumanization by Health Professionals and the General Population in Greece. *Cureus, 13,* Article ID: e20182. https://doi.org/10.7759/cureus.20182

Leopold, S. S., Gebhardt, M. C., Potter, B. K., & Wongworawat, M. D. (2014). Editorial: Words Hurt—Avoiding Dehumanizing Language in Orthopaedic Research and Practice. *Clinical Orthopedics Related Research, 472,* 2561-2563. https://doi.org/10.1007/s11999-014-3802-8

Martinez, A. G., Piff, P. K., Mendoza-Denton, R., & Hinshaw, S. P. (2011). The Power of a Label: Mental Illness Diagnoses, Ascribed Humanity, and Social Rejection. *Journal of Social and Clinical Psychology, 30,* 1-23. https://doi.org/10.1521/jscp.2011.30.1.1

Miles, A. (2012). Person-Centered Medicine—At the Intersection of Science, Ethics and Humanism. *The International Journal of Person Centered Medicine, 2,* 329-333.

Obermann, M. L. (2011). Moral Disengagement in Self-Reported and Peer-Nominated School Bullying. *Aggressive Behavior, 37,* 133-144. https://doi.org/10.1002/ab.20378

OECD (Organization for Economic Co-Operation and Development) (2009). *Economic Surveys: Greece, 2009* (pp. 1-15). Organization for Economic Co-Operation and Development.

Opotow, S. (1990). Moral Exclusion and Injustice: An Introduction. *Journal of Social Issues, 46,* 173-182. https://doi.org/10.1111/j.1540-4560.1990.tb00280.x

Pappa, E., & Niakas, D. (2006). Assessment of Health Care Needs and Utilisation in a Mixed Public-Private System: The Case of the Athens Area. *BMS Health Services Re-*

search, 6, Article No. 146. https://doi.org/10.1186/1472-6963-6-146

Pawlikowski, M. (2002). Dehumanization of Contemporary Medicine: Causes and Remedies. *Neuroendocrinology Letters*, *23*, 5-7. https://www.nel.edu/userfiles/articlesnew/NEL230102E03.pdf

Pickersgill, M. D. (2013). From 'Implications' to 'Dimensions': Science, Medicine and Ethics in Society. *Health Care Analysis, 21,* 31-42. https://doi.org/10.1007/s10728-012-0219-y

Post, G. S. (2011). Compassionate Care Enhancement: Benefits and Outcomes. *The International Journal of Person Centered Medicine, 1,* 808-813.

Prati, F., Crisp, J. R., Meleady, R., & Rubini, M. (2016a). Humanizing Outgroups Through Multiple Categorization: The Roles of Individuation and Threat. *Personality and Social Psychology Bulletin, 42,* 526-539. https://doi.org/10.1177/0146167216636624

Prati, F., Crisp, J. R., Pratto, F., & Rubini, M. (2016b). Encouraging Majority Support for Immigrant Access to Health Services: Multiple Categorization and Social Identity Complexity as Antecedents of Health Equality. *Group Processes & Intergroup Relations, 19,* 426-438. https://doi.org/10.1177/1368430216629814

Rudman, A. L., & Mescher, K. (2012). Of Animals and Objects: Men's Implicit Dehumanization of Women and Likelihood of Sexual Aggression. *Personality and Social Psychology Bulletin, 38,* 734-746. https://doi.org/10.1177/0146167212436401

Schroeder J., & Fishbach, A. (2015). The "Empty Vessel" Physician: Physicians' Instrumentality Makes Them Seem Personally Empty. *Social Psychological and Personality Science, 6,* 940-949. https://doi.org/10.1177/1948550615597976

Tauber, A. I. (2008). Medicine and the Call for a Moral Epistemology, Part II. *Perspectives in Biology and Medicine, 51,* 450-463. https://doi.org/10.1353/pbm.0.0034

Vaes, J., & Muratore, M. (2013). Defensive Dehumanization in the Medical Practice: A Cross-Sectional Study from a Health Care Worker's Perspective. *British Journal of Social Psychology, 52,* 180-190. https://doi.org/10.1111/bjso.12008

Vogt, H., Ulvestad, E., Eriksen, T.E., & Getz, L. (2014). Getting Personal: Can Systems Medicine Integrate Scientific and Humanistic Conceptions of the Patient? *Journal of Evaluation in Clinical Practice, 20,* 942-952. https://doi.org/10.1111/jep.12251

Warner, H. J. (2013). The Humanizing Power of Medical History: Responses to Biomedicine in the 20th-Century United States. *Procedia—Social and Behavioral Sciences, 77,* 322-329. https://doi.org/10.1016/j.sbspro.2013.03.090

Waytz, A., & Schroeder, J. (2014). Overlooking Others: Dehumanization by Comission and Omission. *Testing Psychometrics Methodology, 21,* 251-266. https://www.tpmap.org/wp-content/uploads/2015/11/21.3.2.pdf