Is modern medicine ill with dehumanization?

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"Anyone who has been admitted into a hospital or undergone a procedure, even if cared for in the most appropriate way, can feel as though they were treated like an animal or object," says Harvard University psychologist and physician Omar Sultan Haque. Health care workers enter their professions to help people; research shows that empathic, humane care improves outcomes. Yet dehumanization is endemic. The results can be disastrous: neglect of necessary treatments or prescription of excessive, painful procedures or dangerous drugs.

What are the causes and effects of dehumanization in medicine? And what can be done about it? In *Perspectives in Psychological Science,* a journal of the Association for Psychological Science, Haque and co-author Adam Waytz at the Kellogg School of Management of Northwestern University synthesize diverse literatures to distinguish when dehumanization is useful from when it is not. Then they recommend "simple, cheap, and effective" changes to "make medical institutions more humane and ethical, as well as efficacious in the service of improved health," says Haque.

The structures of institutions and the psychological demands of providing care can cause professionals to treat patients as less than human. "Deindividuation"—doctors as a sea of white coats; patients as half-naked bodies in smocks, identified by their disease or procedure ("the gallbladder in Room 38")—allows staffs to avoid taking responsibility for each patient. "Impaired patient agency" refers to medical staffs' treatment of patients as incapable of planning their own care, which is both infantilizing and demoralizing.

"Dissimilarity"—hierarchies of power, differences of race, class, and gender between staff and patients—have roots outside the hospital. Nevertheless, they cause miscommunication and alienation, even maltreatment. None of these practices serves good medical care.

More complex are dehumanizing practices that may aid care. Diagnosis and treatment might necessitate "mechanization"—breaking the body into organs and systems. Scaling back empathy can diminish staff stress and burnout. Even moral disengagement can be adaptive. From giving a shot to slicing into the flesh to perform surgery, medical care often requires inflicting pain or invading the boundaries of the body in violation of deeply held human taboos. And patients may die after even the best of care. For the professional, guilt could be paralyzing.

Still, the authors argue, dehumanization is useful only in "specific contexts," such as acute care. Waytz says, "Dehumanization's functionality varies wildly across specialities from pediatrics to orthopedic surgery, so future research is needed to determine when dehumanization is most prevalent and most detrimental." In the meantime, the authors offer numerous humanizing fixes: Call patients by name, not numbers; discourage labeling people as diseases; personalize hospital rounds and pre-surgical preparation; eliminate opaque surgical masks; affix photos to CT scans and biopsies. Include patients in care planning. Let them choose their gowns—and design those gowns so they're no so humiliating. Increase physician diversity and hire people with good social skills. And, for med schools, perhaps most radical: Eliminate the "white-coat ceremony" when graduates don the mufti of the elect.

Finally, "we should train medical professionals to think of themselves as mortal – sharing a common humanity and vulnerability with their patients," says Haque. Although dehumanization can be useful, "even functional dehumanization should be viewed like a potent, salutary, but

dangerous drug that can have disastrous side-effects" when overprescribed.

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