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Dehumanization as an Ethical Issue in the Health Services Sector

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Abstract
What is the main reason for the unethical behavior of workers in the health services sector, whose primary mission is to offer services to people and who have an ancient and strong connection with ethics. Alternatively, what is the main reason for this perception in patients, rather than the absence of such behavior? Does the dominant paradigm in the health sector, which negates the humanity of patients, facilitate unethical behavior in addition to benefits? If so, how can it be resolved? In this study, which seeks to answer these questions, the recently popular concept of dehumanization is investigated from various perspectives based on the literature on business ethics in the health services sector. In this study, a conceptual framework for dehumanization is developed, attitude and perception aspects of the concept is examined, and research methods in the business ethics domain is investigated. Furthermore, animalistic and mechanistic types of dehumanization, vertical and horizontal dimensions of dehumanization, as well as sectoral, organizational, and relational reasons for dehumanization are discussed. Finally, recommendations are proposed to eliminate the negative effects of dehumanization.

Keywords
Professional Ethics, Business Ethics, Medical Morality, Medical Ethics, Health Services, Dehumanization

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Conceptual Framework of Dehumanization

The term "dehumanization," which is equivalent to "bestializing, not holding in esteem, social exclusion, and ostracism" in the Turkish scientific literature, has not received much attention in scientific publications in Turkey. We were unable to find Turkish scientific studies on dehumanization as a phenomenon that emerges in the relationships between health services sector staff, especially doctors and nurses, and patients. The aim of this study is to examine dehumanization within the context of business ethics in the health services sector; it intends to emphasize why it has emerged, without accusing a sector or vocation. A deductive approach is adopted to identify positive and negative effects and contribute to the discussion of this issue by offering recommendations to eliminate negative actions.

There are two aspects of dehumanization, namely the "dehumanizer" and "dehumanized." There are also two aspects, namely "*dehumanization attitude*" and "*dehumanization perception*." From a health services sector perspective, dehumanization attitude refers to the conscious or unconscious attitude of healthcare personnel toward a patient. Dehumanization perception refers to patients' feelings that such attitude is directed toward them, regardless of whether the attitude has occurred.

The term "dehumanization" as an attitude refers to a person's partial or total denial of the humanistic features of a correspondent person or group (Oliver, 2011). The concept of dehumanization was investigated as a factor that legitimates acts of violence emerging between individuals or groups (Haslam & Loughnan, 2014). Through their dehumanizing attitudes, those who direct acts of violence toward others deny the humanitarian identities of such people. These attitudes are based on perceived differences between them and their victims, and acts of violence are conducted through a decreased feeling of pity on victims.

The attitude of dehumanization emerges by denying the humanity and dignity of correspondents, their feelings, and compassion for them (Opotow, 1990). Correspondents subjected to moral exclusion are isolated from values, rules, and evaluations pertaining to justice. Consequent to exclusion through

dehumanization, people may disengage the moral dimension of their acts against correspondents (Bandura, 1999), may neutralize the moral content of these acts (Sykes & Matza, 1957), and even "ordinary" people may act without conscience by legitimizing the unethical action.[1]

Until the 2000s, the term "dehumanization" was used to explain morally intense actions such as violence and war crimes. More recently, it is used to investigate relationships in business life, and has become a key focus area for business ethics researchers. In addition, calls for scientific research have increased (e.g. Trevino, Weaver, & Reynolds, 2006). An increasing number of studies are now conducted within the health services sector, wherein business ethics is vital (see Haque & Waytz, 2012 for a review).

Like all ethical issues, it is difficult to measure dehumanization, and almost impossible to observe the variable as it is attitude or perception. Furthermore, it is likely that quantitative measurement tools such as self–report questionnaires will be affected by bias such as social desirability. Therefore, researchers tend to try different methods like scenario-based decision making (e.g. Lammers & Stapel, 2010), social experiments (e.g. Gwinn, Judd, & Park, 2013; Twenge, Baumeister, Tice, & Stucke, 2001; Waytz & Epley, 2012), functional magnetic resonance imaging (fMRI) (e.g. Harris & Fiske, 2006; Jack, Dawson, & Norr, 2013) and some novel tools such as implicit association test (IAT) (e.g. Capozza, Andrighetto, Di Bernardo, & Falvo, 2012; Martinez, Rodriguez-Bailon, & Moya, 2012). Dehumanization recently adopted a business ethics perspective, and as such, qualitative studies aimed at developing new models are needed to strengthen the theoretical base and conduct research in various sectors.

1 A striking example of this transformation is the Stanford Prison Experiment conducted by Philip Zimbardo, which impacted the field of psychology. University students were divided into prisoner or prison guard roles in an artificial prison located in the basement of a faculty building. The experiment, which first ran according to plan, became uncontrollable over time as guards began mistreating prisoners. The experiment was ended on the sixth day. Zimbardo's consequent book shows that ordinary, even good people may demonstrate demonic behaviors depending on their roles and social norms in the environment, as is the case in the transformation of Lucifer, mentioned in the Bible as the most privileged angel, into a devil (see Zimbardo, 2008).

Types and Dimensions of Dehumanization

The attitude of dehumanization can be viewed in two ways (Haslam, 2006). The first is animalistic dehumanization, the attitude of denying the features that distinguish people from animals such as high cognitive capacity, niceness, and ethical sensitivity. The second is mechanistic dehumanization, the attitude of denying the features that distinguish people from non-living things, such as robots. These features include vital agency and emotions.

Aligned to this dual model, which numerous studies support (e.g. Haslam, Kashima, Loughnan, Shi, & Suitner, 2008; Jack et al., 2013; Martinez et al., 2012), the act of viewing correspondents as animals in mass violence actions can be described as animalistic dehumanization. Furthermore, the act of viewing correspondents in the field of technology and medicine as cold, passive, and mechanical, and seeing no qualitative difference between them, can be described as mechanistic dehumanization (Haslam, 2006; Haslam & Loughnan, 2014).

In addition, researchers note two dimensions of dehumanization. In the vertical dimension, the correspondent is rated as "low" or "high" in terms of emotional intimacy (warmth) for the actor and achievement regarding material indicators (competence).[2] Using the fMRI method, Harris and Fiske (2006) found that people exclude and dehumanize correspondents ranked at the lowest end of this vertical scale, which is based on warmth and competence. In the horizontal dimension, the distance between correspondent and actor and the absence of any relations between them are effective. This type of dehumanization is evident in the health services sector (Haslam & Loughnan, 2014). Health personnel emotionally distance themselves from patients'/correspondents' pain and in so doing, deny their humanitarian features such as vital agency or emotions (Leyens, 2014).

2 Accordingly, for example internationally successful national sportsmen are ranked highest on the vertical scale in term of both warmth and competency (high – high), while homeless drug abusers are at the bottom of the vertical scale in terms of both warmth and competency (low – low) (Harris & Fiske, 2006).

Reasons for Dehumanization

Elements causing dehumanization in the health services sector can be discussed in three categories: *sectoral, organizational, and relational.*

Sectoral Reasons

The act of dehumanizing patients by health personnel may be a conscious choice or an involuntary result of work conditions in the sector and widespread applications in the work environment (Haque & Waytz, 2012). Pawlikowski (2002) asserts there are characteristic reasons for dehumanization specific to the health services sector.

Dominant Approaches in Medical Science: Traditional medical schools deemed the human as a part of the whole and as a whole in himself. This integrated approach's place was taken by a reductionist and isolationist approach in the modern period (Canton, 1980). In addition to its benefits, the modern paradigm paved the way for dehumanization by ensuring a situation in which doctors isolate patients from their psycho–social world and reduce them into a diseased organ or an impaired gene (Pawlikowski, 2002). Addressing more recent criticism against this approach, the bio-psycho-social patient-centered medical approach focuses on traditional or supplementary alternative medical methods, prioritizing a holistic evaluation of patients including their feelings, ideas, values, and needs. Yet, the bio-medical evidence-based medical approach, the dominant paradigm in medical training and clinical practices, prioritizes the best evidence to guide decisions regarding appropriate treatment. As such, the uniqueness of patients as humans is neglected, and the approach focuses instead on positivist and economic viewpoints (Bensing, 2000; White III & Chanoff, 2011). This approach is a major reason for dehumanization in health practices (Haque & Waytz, 2012; Haslam, 2006). An ideal model for patient-centered and evidence-based medicine that can synthesize the advantages of these approaches is an opportunity for ethics in terms of balancing benefits.

Intensive Technology Use: The act of listening to a patient's heart or chest using a stethoscope and not the ears in the 1700s and the act of using a blood pressure monitor in the early 1900s has been discussed in terms of dehumanizing patients by distancing them from doctors (Bailey, 2011). The number of these discussions—both positive and negative—is increasing alongside growing technology use. Positive arguments focus on the timesaving features of technology in terms of expediting patient examinations, facilitating access to patient data, and ensuring a humanitarian doctor-patient relationship (Shortliffe, 1993). However, this optimism is often only partially evident, and especially in some medical fields like radiology and pathology, due to the heavy technology use, patients are sometimes perceived as cold, lifeless beings disconnected from their social and emotional contexts (Haslam, 2006; Opotow, 1990).

Advanced Level of Division of Labor and Specialization: The terms "division of labor" and "specialization," defined by Plato in the 4th century B.C. as a necessity, was defended by Adam Smith through his "productivity" in alignment with discussion on the industrial revolution in the 18th century, and criticized by Karl Marx in the 19th century through his concept of "alienation." Today, especially in the health services sector, experts have become individuals "who know more and more about less and less until he knows everything about nothing," according to Ghandi. Those criticizing this statement contend that over-specialization subdivides treatment into pieces –even for a single disease-, thus preventing continuity, decreasing the quality of communication between experts from various fields, and negatively impacts patients, especially those with more than one chronic disease (Detsky, Gauthier, & Fuchs, 2012). While division of labor and specialization can positively impact performance, it can cause dehumanization by preventing a holistic patient outlook (Pawlikowski, 2002).

Infrastructure Problems: According to a report published by the OECD (2013), despite numerous improvements in the health sector since 2000, Turkey still has bad conditions regarding doctors, nurses, and the number of beds. This increases the workload of health personnel, and thus, the waiting period for patients. On the other hand, the time and quality of health services are decreasing. Low-quality services to patients generate the perception of

being dehumanized. Furthermore, health personnel may exhibit dehumanizing behaviors toward patients, because of constant high levels of stress emerging from overly workload. Tired doctors view their patients as bodies, not as humans (Haslam & Loughnan, 2014). In one study on obstetricians and gynecologists working in a high-stress environment, 15% reported having "hardened" against people's problems; 25% reported being more a "technical personnel" and less a "person" in the workplace, and 33% reported becoming more violent—almost daily—after working for a while. Further results indicate that 25% of doctors feel they should be rough so as not to lose their jobs (Bortoletti et al., 2012).

Organizational Reasons

Part of dehumanization can be attributed to the features of a hospital as an organization. The first feature is the hospital's organizational culture. Organizational culture is defined as the body of common values, beliefs, and actions held by organization members that lead their conduct (Schermerhorn, Hunt, Osborn, & Uhl-Bien, 2010, p. 366). Like a pyramid, the impacts of organizational culture emerge in three layers from top to bottom (Schein, 2010): (*i*) Visible elements such as rituals, language, physical elements, observed behaviors; (*ii*) Espoused values and targets related to right/wrong and good/bad; and (*iii*) Underlying assumptions and beliefs that constitute the unconscious. In a hospital, these three layers of organizational culture can impact the dehumanization of patients.

Language: The preferred words, concepts, idioms, and styles regarding speech in the workplace may make it possible to dehumanize correspondents by affecting emotional processes related to the ethical evaluations of people. The language used in organizations commonly veils the ethical content of decisions and behaviors, creates ethical blind spots, and causes inappropriate moral decisions (Bazerman & Tenbrunsel, 2011). In a study[3], some participants were read a sample of an ethical dilemma with fatal results in their mother tongue, while others were read the ethical dilemma in a well-known foreign language.

3 This study is a version of the well-known "trolley problem" in making ethical decisions. See Thomson (1985) for a discussion of the problem.

They were then asked to make a decision. In contrast to the "mother tongue" group, results indicate that most of the "foreign language" group made only rational or pragmatic moral decisions (Costa et al., 2014). Using an occupational language full of foreign words and referring to patients using impersonal terms and abbreviations, bed numbers, the names of diseases, or the name of the diseased organ, creates a culture in hospitals that removes emotional processes that may help health personnel notice the humanitarian aspects of patients, dehumanizes patients by veiling the morality of decisions, and generates dehumanization perception[4] (Haque & Waytz, 2012; Leyens, 2014). Language that does not emphasize correspondents' humanitarian features dehumanizes them in terms of both attitude and perception (Haslam, 2006).

Physical Elements: Patients and personnel can be dehumanized through hospitals' interior and exterior architectural design, layout, measurements, preferred (or non-preferred) furniture, decor, color selection, inscriptions, signs and symbols in the building, health personnel's uniforms, and patients' clothing (e.g. clothes revealing any part of the body) (Haque & Waytz, 2012).

Observed Behaviors: According to social learning theory, people learn through modeling observed behaviors of others to generate complex behaviors (Bandura, 1977). In organizations, the observed behaviors of leaders/managers and in-group colleagues modify ethical decisions and the behaviors of employees who do not have a strong ethical identity (Trevino, den Nieuwenboer, & Kish-Gephart, 2014). In the health services sector, wherein the master-apprentice relationship is very important, student health personnel who witnessed professors and hospital managers enacting dehumanizing behaviors toward patients may develop the same attitude. Likewise, colleagues' dehumanizing behaviors toward patients create a similar impact by generating a negative subculture. A study conducted in the health services sector determined that colleagues and managers' ethical behaviors significantly impact the ethical behaviors of health personnel (Deshpande, Joseph, & Prasad, 2006).

4 The terms "the patient died" and "the patient has passed" used to refer to a dead patient have quite different meanings (in Turkish) and affect our ethical choices. If it is not easy for a doctor to say "my mother has passed" while mourning, he/she should consider the impact of language used both on the patient and the patient's relatives.

Espoused Values and Targets: Many organizations embody this element as the mission, vision, values, and the more recent ethical code in documents shared with workers and the public. However, what matters is not the act of sharing these with workers, but that workers share these values and targets. In Turkey, almost none of the health institutions have a private ethical code. Possibly, this is because, due to very ethical nature of their job, health services occupational groups have binding professional ethical codes. However, it is important that how much these codes have place in organizational culture. One study found that even the health personnel who prepare an ethical code for their own institutions do not adopt it. One participant defined the ethical code as "one of the things that we have, but we do not use in daily life" (Montaya & Richard, 1994).

Underlying Assumptions and Beliefs: This element is generally shaped by the founder or leader and adopted by those participating in the organization during the socialization period (Schein, 2010). This element, at the bottom of the organizational culture pyramid, is not seen, but felt. In addition, it has the greatest impact on dehumanization. Today, unless the dominant philosophical approach in most segments of the health sector that focuses on disease or even doctors (Bensing, 2000) is abandoned and the patient-centered approach adopted, it does not seem possible for patients to be free from dehumanization.

Performance Management: In environments where performance systems comprise only quantitative targets, people instrumentalize correspondents by ignoring their humanitarian features to achieve their targets. As the power they have increases, this action is increasingly practiced (Gruenfeld, Inesi, Magee, & Galinsky, 2008). Quantitative targets create the performance pressure, and this is especially felt in private health institutions in Turkey. It is also felt in public health institutions because of the "performance-based supplementary payment system" enforced in 2004. A report on the workshop conducted by the Turkish Medical Association (TTB-UDEK Ethical Study Group, 2011) states that the structure of the performance system, mainly based on a transaction score, emphasizes quantity and not quality, and "strains the responsibility of health personnel to be attentive to life, health and peace of person", and "the integrated approach can not be protected both in medical training and

practice." Thus, this system does not correspond to the "humanitarian aspect of doctor-patient relationships and to doctors' morality and humanitarian values." Health institution managers, who take advantage of those patients whose social insurance pay for the treatment at private health institutions within the "Health Transformation Program" framework, dehumanize patients by forcing health personnel to perform medical transactions whether they are necessary or not.[5] A Turkish study found that 42.5% of participants complained that "doctors do not pay as much attention to patients, as they pay to their own gains." This indicates patients' perceptions of dehumanization in the process of monetary gain (Çarkoğlu & Kalaycıoğlu, 2012).

Relational Reasons

Power Distance: This emerges between the doctor and patient, because of the information asymmetry stemming from the doctor's expertise and hierarchical superiority arising from the doctor's entitlement regarding the patient's body (Haque & Waytz, 2012). It was confirmed that, very like prison guards in Zimbardo's (2008) prison experiment, people who have a perception of possessing high power in the workplace dehumanize those deemed to have less power (Gwinn et al., 2013). One study determined that health personnel perceived as having higher power (doctor versus nurse, specialist versus assistant) tend to dehumanize patients more than others (Lammers & Stapel, 2010). Researchers thought that health personnel with higher power act this way to justify more difficult decisions.

High Status: Members of different status groups may demonstrate different ethical attitudes. For example, it was found that people from a low socio-economic status group have more pro-social inclinations (e.g. generosity, charity, reliability, helpfulness) than higher status groups (Piff, Kraus, Cote, Cheng, & Keltner, 2010). Research determined that participants have less dehumanization attitude toward correspondents from the same socio-economic status than they have toward those from different statuses (Leyens et al., 2001). Another study

5 For example, the number of MR imaging in Turkey doubled in the period from 2008 to 2011, leading to our ranking as number 3 in the world (OECD, 2013).

revealed that those from higher status groups have dehumanizing attitudes toward those from lower status; however, those from lower status groups do not share this attitude toward those from higher status groups (Capozza et al., 2012). Doctors' socio-economic statuses may cause them to dehumanize patients, especially those from lower socio-economic statuses.

Gender, Ethnicity, Religious Beliefs, and Cultural Differences: Despite ethical codes, patients may be discriminated against based on their differences, or at least the patient may feel this way. In a US study, African-Americans, Hispanics, and Asians reported receiving lower-quality health services than white people, noting that health personnel discriminate against them (Lee, Ayers, & Kronenfeld, 2009). In a study conducted in Turkey, most doctors stated that there was no discrimination against patients (Şahinoğlu-Pelin & Arda, 1998). However, in reality, cases of discrimination are experienced[6], and this should be the topic of further study. Dehumanization is usually not obvious, but implicit as an unconscious product. However, correspondents perceive this attitude even when the one who exhibits this attitude is unaware of it. A study using the implicit association test on a group comprising mostly university students determined an unconscious discriminative inclination of them against black people. They dehumanized black people by equating them with monkeys, linked them to more crimes than they linked the white people, and considered using violence (including the death penalty) against black people as just, while they did not consider so against white people (Goff, Eberhardt, Williams, & Jackson, 2008). The mostly implicit discriminative attitudes of health personnel toward patients may dehumanize them, and when perceived, this may damage the health personnel-patient relationship (Hausmann et al., 2011).

In-group Relationships: Strong in-group relationships may have a reverse effect as dehumanizing those considered "outsiders." One study found that people dehumanize those viewed as outsiders if they are satisfied with close in-group relationships (Waytz & Epley, 2012). Health personnel, satisfied with in-group social relationships, may demonstrate dehumanizing behaviors toward patients who are "outsiders" to the group, while they do not show the same

6 It is known that some people receive bad service or no health services from health personnel just because they are wearing a head scarf, being drunk or using drugs, having a special gender, not being able to speak Turkish, not smelling good, or being transsexual.

toward other health personnel or in-group patients. Patients and their relatives waiting for a transaction, examination, or treatment at the hospital may feel dehumanized after witnessing in-group patients being examined and cared for without waiting.

Communication Type: If patients perceive they are being stigmatized based on their disease, they may start viewing themselves as not patients, but as the disease. As such, the patient may be passive toward the doctor's actions, which hinders the patient's role as a participant in diagnosis and treatment. Consequently, patients may begin perceiving themselves as being dehumanized (Haque & Waytz, 2012).

Moral Distress: The dissonance emerging when people know the morally right thing to do but somehow do not/can not demonstrate that behavior for various reasons, may cause moral distress (Raines, 2000, p. 30 as cited in Kalvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004). For example, if a doctor knows that vaginal delivery is healthier than caesarian delivery, yet performs a caesarian without medical reason—but for the performance system—for the mother who also wanted vaginal delivery, that doctor has a moral distress because of the dissonance between knowledge and behavior.[7] Festinger (1957) contends that people are not able to continuously carry the stress caused by this cognitive dissonance, and they may choose to relieve it in various ways. One method is to change attitudes that are not consistent with behavior. If health personnel, who conduct unethical medical practices, dehumanize patients, they can escape moral distress which emerges as a result of dissonance, because they cannot see the ethical side of that behavior (Haque & Waytz, 2012).

Low Empathy: Low empathy, which refers to shallow perceptions and a lack of emotional richness toward correspondents, implies restricted human relations. The common features of psychopaths, who do not demonstrate sound ethical decisions and behaviors, include intelligence, success in their careers, and yet a lack of empathy for their victims, despite their knowledge about ethically right or wrong behaviors. They perform cruel acts by ignoring the feelings of those

7 In accordance with the OECD (2013) report, Turkey is among those countries with a high caesarian delivery rate. One reason is the dehumanization of mother and baby in many incidents, and their health conditions are ignored as evident in unnecessary surgery.

they harm, in other words, by dehumanizing them (Lerner, 2009). In an fMRI study, participants were asked to read moral and amoral scenarios, and then to make decisions regarding third persons. Substantially more activation was observed in the empathy related parts of the brains of participants who read the moral scenarios and made decisions, compared to those who made decisions after reading the amoral scenarios. In other words, a sense of empathy is important in ethical decisions (Reniers et al., 2012). Furthermore, empathy has an important impact on health services. It was found that medical students with higher empathy levels are more competent in learning patient history, performing standard physical examinations, and clinical abilities, compared to other students. In addition, doctors with more empathy ensure better patient satisfaction, their patients tend to be more accepting of recommendations for treatment (Haslam, 2007), and they have a higher rate of recovery from disease (Hojat et al., 2011). However, it was determined that the empathy levels of doctors decrease during medical training and over the course of their careers (Neumann et al., 2011). The resultant lack of empathy causes mechanical dehumanization toward the patient (Haslam, 2006).

Effects of Dehumanization

In addition to several and important negative effects of dehumanization in the health services sector, there are also positive effects. Dehumanization is evident in other occupations (e.g. the military); however, the only field in which positive ethical effects are evident is the health sector. That said, positive effects are only related to attitudes.

Facilitating Difficult Decisions

Haque and Waytz (2012) state that the acts of understanding patients' feelings through empathy and solving a cognitive problem related to the solution of the disease use the same nerve fields in the brain. Thus, lessening the empathy load by dehumanizing the patient increases the cognitive source capacity of the

health personnel used in critical decisions. In order health personnel to make decisions about practices which are helpful for patient, while being painful, dehumanization attitude has a functional role (Haslam, 2006).

Protection from Burnout

The job performance and compassion satisfaction of health personnel increases as they adequately empathize with patients in appropriate situations (Conrad & Kellar-Guenther, 2006). However, it was also confirmed that health personnel, especially in emergency services, intensive care units, oncology, and psychiatry departments may experience compassion fatigue and burnout syndrome, because they continuously empathize with patients who have emotional stories (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). In such cases, dehumanization attitude may prevent this and increase the performance of health personnel (Vaes & Muratore, 2013).

The negative effects of dehumanization manifest in attitudes and perceptions.

Moral Distress

Moral distress, a reason for referring to dehumanization attitudes, may be the result of this attitude in some cases, as well. For example, the acts of nurses continuing to provide care services to patients connected to life support units, despite not believing in any benefit, may cause moral distress, as they may think they dehumanize the patients and maintain their pain (Russell, 2012). Health personnel who implement redundant transactions on patients to achieve performance goals may experience moral distress, because they instrumentalize and dehumanize them for their own gains.

Aggressive Behaviors

Patients perceive dehumanization when their existence is excluded. Patients' relatives feel the same when they think that someone they deem important is ignored (Bastian and Haslam, 2010). Furthermore, they are disturbed and become angry when they consider themselves treated like an object without human features (Bastian & Haslam, 2011; Haque & Waytz, 2012). People who perceive themselves as dehumanized want to punish those who demonstrate this attitude; consequently, they act aggressively (Moor et al., 2012; Twenge et al., 2001).

Worldwide and in Turkey, cases of violence are reported mostly in the health services sector. As such, health personnel are 16 times more subject to violence than other occupational groups (Büyükbayram & Okçay, 2013). In a study conducted by İlhan et al. (2013), 63% of patients said they attribute the aggressive behaviors toward health personnel to long waiting periods for examinations, 43% mentioned not being satisfied with treatment, 42% mentioned receiving a bad prognosis, and 42% mentioned communication problems. Furthermore, 23% of participants considered violence against health personnel as appropriate in some situations, and 20% thought that health personnel deserved violent treatment. Reasons given included insufficient attention, having information withheld, bad attitudes, yelling at patients, and having to wait to be examined.[8] While the perception of dehumanization triggers aggression, the increasing dehumanizing attitudes of health personnel subject to violence toward all patients and patients' relatives may also cause dehumanization and result in a vicious cycle.

Decrease in Satisfaction, Trust in Health Personnel and Successful Treatment

Dehumanization decreases satisfaction with and trust in health personnel, patients' active participation in diagnosis and treatment, and adaptation to treatment (Haque & Waytz, 2012). Patients who perceive dehumanization due to discrimination and receiving low-quality health services do not want to go

8 This article, "Violence towards Health Personnel from the Eye of Society," highlights important findings regarding self-criticism in terms of health services. But the authors deny using such findings, and defend themselves by accusing others. In another study on health personnel subjected to violence (see Sucu, Cebeci, & Karazeybek, 2007), it is also disappointing that only 8% of health personnel ask themselves after experiencing violence, "Why me?"

to hospital and tend to delay this need (Lee et al., 2009). This may increase the severity of the disease and the load on the health system.

Recommendations

Measures can be taken on an individual, organizational, and governmental level to remove negative impacts without removing the positive impacts of dehumanization in the health services sector.

First, on an individual level, health personnel should use empathy and cognitive abilities in a balanced way (Haque & Waytz, 2012). For example, doctors should suppress empathy to ensure a successful surgery; however, they should demonstrate high levels of empathy toward patients and patients' relatives during examinations. Similarly, a psychiatrist should avoid empathy in acute crises, while demonstrating empathy to patients during therapy.

Researchers outline the benefits of increased empathy and decreased dehumanization. In one study 15 radiologists were asked to evaluate radiographs by viewing photos of patients taken. After three months they were asked to evaluate the same films without seeing the photos. The study determined that while seeing the photos, doctors' empathy levels increased and they read the films more sensitively, finding five times more symptoms than the other time (Turner & Hadas-Halpern, 2008). In another study, intensive care unit patients' photos were placed next to their beds. It was found that doctors and nurses were more likely to perceive the patient as an individual, increase communication with the patient, and clarify patient care targets (Andersson, Hall-Lord, Wilde-Larsson, & Persenius, 2013).

In addition, on the individual level, the quality and quantity of communication with patient can be enhanced. During patient care, visits, or before an intervention, health personnel should emphasize obtaining personal information in addition to information on the disease without stigmatization (Haque & Waytz, 2012). When patients are cared for as unique people, and not just one in a similar patient group, they feel cared for as an individual identity.

Dehumanization perceptions can be removed by supporting patients, especially those with chronic diseases such as diabetes, heart disease, rheumatism, and MS. As such, health problems should not be emphasized, but their importance in a larger life world highlighted, and patients should be encouraged to remember they have a continuous life story that includes the past and future, not merely a life based only on the disease (Todres, Galvin, & Holloway, 2009).

On the other hand, the act of dehumanization can be decreased by giving credit to the patient experiencing the disease, as much to the doctor's findings and technology related to the disease, not objectifying them, and gaining their participation in taking health initiatives. An integrative approach that includes traditional, supplementary, and alternative medical methods, rather than over-reductive causality in the diagnosis and treatment of disease, may decrease the mechanistic dehumanization of the current system (Todres et al., 2009).

To stop acts of unconscious dehumanization, health personnel can eliminate subconscious discriminative attitudes toward patients through awareness practices. Harvard University medical professor White III who as African-American witnessed dehumanization toward patients in the health services sector, proposed that health personnel be sensitive toward patients' cultural and individual differences, evaluate them as unique individuals and not stereotypes, approach them as family members or friends, and notice environmental stress elements (e.g. performance pressure, workload, etc.) and the partiality produced by the subconscious, which hinders implementing this approach (White III & Chanoff, 2011).[9]

The first organizational precaution to take to prevent the negative effects of dehumanization is structural amendments at the schools where health personnel are trained before entering the workplace. For example, Pawlikowski (2002) asserts that current medical education should be more humanized, and draw from the social sciences such as ethics, philosophy, history, sociology, and even literature to improve health personnel's awareness toward patients. However, this is not enough, as the impact of medical training on doctors is

9 White III's book includes important ethical findings for practitioners in the health services sector. In the book, White II, a doctor who bore witness to the fight for the civil rights of African-Americans in the US, narrated his experiences from his childhood to when he became a professor at Harvard.

not limited to formal, written syllabus. Hafferty and Franks (1994) emphasize an implicit syllabus of the school culture, which socializes students at medical schools. The behavioral effect of this syllabus is more important. Thus, in these schools, we should highlight "who we are," which builds our ethical identity as much as "what we are" above the written syllabi for anatomy, physiology, and biochemistry. By starting at the Ministry of National Education (MoNE), Council of Higher Education, and school administration, all parties including instructors and students should demonstrate awareness, ownership, participation, patience, and efforts toward this change.

To decrease dehumanization in the health institutions in which graduates work, all layers of organizational culture—i.e. beliefs and assumptions regarding the quality of health services, espoused values and targets, and visible elements-must be reconfigured. To this end, all personnel, especially managers, should share the common understanding that people are at the core of health services. A value system should be built around this understanding and shared by workers. In addition, there should be an aims-targets unity emerging from this system around which all processes, practices, and physical elements are designed. For example, a caring environment in hospitals should be provided to ensure patients sense belonging, not separation. Furthermore, this environment should be constructed for the patients making them feel familiarity and peace, rather than feeling like strangers (Todres et al., 2009).

A study on the gynecology unit of a university hospital in Canada found that personnel exhibited an anthropocentric values system; managers were willing to provide humanitarian childbirth services. Patients' satisfaction as well as their safety and comfort were key focus areas, the beliefs and needs of patients from different cultures were respected, family members were included in care services, visiting and companionship practices were flexible, and patients and their relatives felt valued. Here the hospital was designed like a hotel, and all these features were appreciated and perceived as facilitating elements in the health services (Behruzi, Hatem, Goulet, Fraser, & Misago, 2013).

In the Benin Republic, a project was initiated by the hospital administration of a Maternity and Children's Hospital to overcome the dehumanizing effects

of organizational culture. In the project, the current work environment was transformed into a more humanitarian one, and workers received regular training on this topic. Some workers found the change difficult, and while others remained unresponsive at first, they later embraced the outcomes of the project with administration's support. When the project concluded, they reported improved quantitative performance regarding complications and the need for drug treatment, and qualitative improvements such as enhanced communication with patients, increased satisfaction of patients and workers, workers' increased self-reliance and self-respect, increased self-awareness of their and others' behaviors, increased moral satisfaction, and improved work motivation (Fujita et al., 2011).

As evident in this example, a performance management system in the institution can be designed so as not to put pressure on personnel. It is possible to transform the current dehumanizing structure by improving both private and public hospitals. In the Ministry of Health's publication on the performance system in the health services sector (Ministry of Health, 2006), the outcome of the health system is defined as the "direct happiness of people." Also it is mentioned that "patient satisfaction should be considered when determining performance award scales" (p. 31), but it is not clear why performance evaluation scales attach almost no importance to patient satisfaction.[10] Evaluating the performance of health services through the number of implemented practices could yield undesired results such as prioritizing quantity over quality. The deficiencies of the performance management system that cause dehumanization behavior should be removed, and a performance management policy giving importance to enhancing the quality of the health sector should be offered to patients.

The policies that the Ministry of Health may develop and consequent practices may decrease acts of dehumanization toward patients. The first is activating a family physician practice that can follow patients' problems closely. They can lead patients and coordinate other physicians when specialized practice is required (Pawlikowski, 2002). The health institution's manpower and

10 The sentence continues as "A measurement which only depends on the perception of patient can't be enough in health sector where there is a high information asymmetry and in societies where the education level is low" (p. 31) and this is an upsetting indicator of low value given to senses and emotions of people; in other words, it is an indicator of dehumanization which is made via Ministry.

technical conditions should be improved, and personnel's workload should be diminished. Work-duty-work practices should be eliminated, especially in emergency services, wherein dehumanization is most evident, and the capacity to offer high-quality services should be increased. Finally, accesses to home care services for patients who are disabled or old should be facilitated.

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