Dehumanization of medicine and healthcare

A discussion paper for medical professionals and leaders in the PEI healthcare sector

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"We cannot solve our problems with the same thinking we used when we created them" – Albert Einstein

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Executive Summary

The problem

This paper reflects on a growing concern in modern healthcare: the gradual loss of human connection between patients, clinicians, and the systems meant to serve them. Using recent tensions between physicians and health administrators on Prince Edward Island as an example, it suggests that both doctors and patients are feeling increasingly unseen, unheard, and undervalued.

On one side, physicians are striving to provide compassionate, person-centered care while also protecting their own well-being. Many feel overwhelmed by administrative burdens, constrained by system demands, and disconnected from the deeper purpose of their work. On the other side, patients face long wait times, difficulty accessing care, and a sense that they are being treated as cases rather than people. In this way, both groups experience what we can describe as "dehumanization."

This trend is not unique to healthcare. Across society, human interaction is being replaced or reduced—whether through automation, self-service technologies, or digital systems. While these changes often improve efficiency, they can also erode relationships and diminish our sense of shared humanity.

The causes

The paper draws on research that identifies several drivers of dehumanization in medicine. These include treating patients as categories rather than individuals, limiting patient involvement in decisions, focusing narrowly on biological systems, and emotional distancing by clinicians. While some degree of detachment can be necessary for clinical decision-making, the balance between objectivity and empathy is increasingly strained.

System-level factors also play a role. Organizational pressures for efficiency, reliance on a purely biomedical model, and broader economic influences can unintentionally reduce opportunities for meaningful human connection. Over time, this creates an environment where both care providers and patients feel alienated.

A key idea introduced is the concept of "low trust tax." When trust breaks down within a system—between clinicians, administrators, and the public—it leads to inefficiencies, increased workload, and poorer outcomes. Conversely, high-trust environments foster cooperation, reduce friction, and improve both morale and performance.

Solution: 4 "keys" to rehumanize medicine and healthcare

Despite these challenges, the paper offers a hopeful path forward. It emphasizes the need to "rehumanize" healthcare by restoring relationships, trust, and a shared sense of purpose. At its core, this begins with a simple but profound principle: care rooted in genuine concern for others.

Four areas for growth ('keys'), are proposed—personal and organizational—focused on integrity, discipline, connection, and meaning. These are not quick fixes, but long-term commitments that require effort from individuals, institutions, and leaders alike.

Importantly, the paper calls for humility and reflection, including acknowledgment of past policy decisions that may have contributed to current tensions. Rebuilding trust will likely require honest dialogue, accountability, and a willingness to listen.

In closing, the message is both sobering and encouraging. While modern healthcare systems are highly advanced, their effectiveness ultimately depends on preserving the human relationships at their core. By intentionally choosing empathy, trust, and shared purpose, there remains a real opportunity to move toward a more compassionate and sustainable model of care.

Background

The current standoff between Prince Edward Island family physicians and Health PEI is likely reflective of a larger trend in medicine, and healthcare in general: ***dehumanization***.

The doctors want the opportunity to provide humane person-centred care, with empathy and emotional presence … while also guarding their own humanity from moral injury, family neglect, and unwellness. These two poles are being driven apart in PEI (and much of Canada) by pressures from bureaucrats to address the legitimate primary care needs of the public. In our Canadian context, that means spending healthcare tax dollars effectively and efficiently. But in that pressure, doctors report feeling disrespected and stripped of their autonomy and agency, less than human—*dehumanized*.

Meanwhile patients, unable to reach a human voice at their doctor's office, or losing their family doctor, or awaiting a callback from 811, or sitting in an ER for hours, feel devalued and uncared for. Also *dehumanized*.

Healthcare is not the only industry experiencing depersonalization and dehumanizing. A friend, a retired broadcaster, speaks of taking calls in a community radio studio when a crisis happened in the town. Now, much of the day, he says, in most community stations, there is no human in the studio, the radio stream computer driven, leaving no way to draw the community together in an emergency as before.

And what about retail? Scanning your own groceries and pumping your own gas. And Amazon, Wayfair, and Temu.

In a thought-provoking book (2025), *Against the Machine: On the Unmaking of Humanity,* British writer Paul Kingsnorth calls these modern cultural trends, "the machine." He writes,

> *A cultural revolution has been brewing; a 'culture war', as we have all learned to call it. We know the battle lines of this by now, and maybe we have all chosen our sides. But I began this book with an intuition: that the roots of this culture war were much deeper than they looked. That it was related in some way to that Machine that had stalked me all my life.*

A machine—void of soul or heart—non-human. Although he sees this originating back with the Enlightenment, he says, "a vacuum created by the collapse of our old taboos [in the 1960s] was filled by the poison gas of consumer capitalism … we have become slaves to the power of money, and worshippers of the self."

Other writers also warn of the “machine,” which can now also be viewed through the AI lens. While we have become disenchanted in the West, Artificial General Intelligence (AGI) is believed by some to be a messianic saviour to save us from ourselves … or according to others, possibly doom our planet into oblivion. These are the warnings by Meghan O’Gieblyn in *God Human Animal Machine* and by Adam Becker in *More Everything Forever.* Here is what technocrats like Ray Kurzweil and Elon Musk believe: “Superintelligent AI and human-machine hybrids will usher in a utopia, end scarcity, and make biomedical discoveries that will allow us to live forever or nearly so.”

“Human-machine hybrids” – after dehumanization comes transhumanism.

Philosopher Martin Buber, anticipating these trends wrote his *I and Thou* (1923) book, where he said “I-Thou” involves authentic reciprocal engagement (human to human), versus “I-It” which treats others as objects to be used, analyzed, or categorized. He worried about the latter.

Dehumanizing Healthcare

The dehumanization of medicine and healthcare in both Canada and the US has become an increasingly discussed concern[1] among patients, clinicians, and policymakers alike. While both our countries have highly advanced medical systems capable of remarkable technological and scientific achievements, many argue that the human dimension of care—empathy, relationship, and individualized attention—has been steadily eroded.

The ongoing current crisis here on PEI (a fourth family doctor just announced practise closure) should pause us all for some deeper, even existential, reflection. Even before the Covid-19 pandemic, researchers and ethicists were starting to explore the effects of dehumanized and institutionalized healthcare on both patients and providers.

A seminal paper on the topic was published in 2012, and the authors postulated six potential contributors to dehumanization in medicine:[2]

1. *Deindividuating practices* – an individual becomes immersed in a group and therefore anonymous (in our PEI context 93 physicians signed a letter as a group, but none agreed to an interview). Studies show that soldiers in matching uniforms diminish feelings of personal culpability for action. Patients can also become grouped as labels or diagnostic categories (e.g. an addict, “frequent flyer,” etc.)
2. *Impaired patient agency* – patients due to injury, or substance use, or cognitive decline may not be given agency in the decision making of their care (“animalistic dehumanization” the authors write).

3. *Dissimilarity* – manifested in one of three ways: 1) patients due to illness become less similar to one's prototypical concept of human, 2) labeling of the patient as an illness and thus it becoming their identity, 3) power asymmetries common to the physician-patient dyad.
4. *Mechanization* – thinking of patients as mechanical system made up of interacting parts; connecting pathophysiology to findings and symptoms often occurs at a level of abstraction that disregards patients' mental states. This is the biomedical model based on Cartesian dualism.
5. *Empathy reduction* – medical professionals must find a balance between detachment to enable higher level problem solving with genuine compassion and empathy for the suffering. They are not mutually exclusive in highly self-aware clinicians.
6. *Moral disengagement* – procedures can inflict pain and clinicians may need to suspend themselves temporarily from their role in committing harm. Once again, not mutually exclusive in those with high self-awareness.

In this paper, Haque and Waytz go on to suggest solutions to offset these six risk factors. Readers are encouraged to read the source document. They do conclude that more research is needed. I will provide suggested solutions to our PEI context below.

Other authors have weighed in on. In a paper entitled *Compassion in 21st century medicine: Is it sustainable?*[3] Dr. Paquita de Zulueta of Imperial College, London, also highlighted three contributors to dehumanization in medicine: 1) mechanistic organizational systems of care, 2) biomedical paradigm, 3) neoliberal market ideology.

In point 1, again the "machine" metaphor, like Kingsnorth's, comes up. I have also written before about the debunked biomedical model (point 2) that still underpins much of modern medical care.

And about point 3, she writes,

> *The neoliberal market ideology, with its instrumental approach to individuals and commodification of healthcare creates a corrosive influence that alienates clinicians from their patients and severely curtails the scope for compassionate practice. The tension between efficiency and patient orientated care – although they need not be mutually exclusive – has become more acute in the current economic climate, at a time when the boundaries of medicine have broadened and expectations for healthcare have risen. This has created an unsustainable dynamic within which alienated healthcare professionals struggle to fulfil their healing roles and patients experience abandonment and more anxiety.*

The "neoliberal market ideology" may be more applicable in the for-profit healthcare system of the US, but both Kingsnorth and Zulueta are Europeans (Ireland and UK). We share the same

economic climate, and it was exactly that realization in the 1990s that began the ‘us versus them’ warfare, just now blowing up in our faces.

The cost dehumanization and lack of trust

In a CBC interview with Mitch Cormier, and in a written post, I reflected on what I saw as 5 reasons for family doctors’ excessive administrative load. I thought of it as a “30,000 feet view.” Now, in this article I reflect with even a wider and higher view.

The labour dispute that became very public is very indicative of what Stephen M.R. Covey (Jr) in his book *The Speed of Trust* (2006), calls a low trust tax. Basically, the lower the trust in an organization, the higher the “tax” inconspicuously being levied (costing time, labour, and productivity).

The 80% Tax (Nonexistent Trust)	
In the organization	In personal relationships
* dysfunctional environment and toxic culture (open warfare, sabotage, grievances, lawsuits, criminal behavior) * militant stakeholders * intense micromanagement * redundant hierarchy * punishing systems and structures	* dysfunctional relationships * hot, angry, confrontations or cold, bitter withdrawal * defensive posturing and legal positioning (“I’ll see you in court!”) * labeling of others as enemies or allies * verbal, emotional, and/or physical abuse

Figure 1

Unfortunately, using Covey’s diagnostic criteria in Figure 1, right now, our PEI health system is suffering from an 80% tax (which makes sense given the backlog, the waits, the unprofessional behaviour, lawsuit threats).

High trust organizations have an opposite “tax” – a “dividend,” as in Figure 2 below:

The 40% Dividend (World-class Trust)	
In the organization	In personal relationships
* high collaboration and partnering * effortless communication * positive, transparent relationships with employees and all stakeholders * fully aligned systems and structures * strong innovation, engagement, confidence, and loyalty	* true joy in family and friendships, characterized by caring and love * free, effortless communication * inspiring work done together and characterized by purpose, creativity, and excitement * completely open, transparent relationships * amazing energy created by relationships

Figure 2

Why oh why, can we not, in this tiny province achieve that? As Mahatma Gandhi said, "The difference between what we are doing and what we're capable of doing would solve most of the world's problems."

How do we rehumanize healthcare?

Impressed by an incredible local restaurant that in my opinion has the best food and service on PEI, I asked the owner what her secret to success was. She answered with one word: "Love."

Love your people, and your customers.

Simon Sinek famously puts it this way: "*Leadership is not about being in charge. Leadership is about taking care of those in your charge*"

Or Jim Collins, author of *Good to Great*: "*True leadership is the art of getting people to want to do what must be done.*"

After a long personal existential journey, Paul Kingsworth ends his book like this,

> *That the age of the Machine is not after all a hopeless time. Actually, it is the time we were born for. We can't leave it, so we have to fully inhabit it. We have to understand it, challenge it, resist it, subvert it, walk through it on towards something better. If we can see what it is, we have a duty to speak the words to those who do not yet see, all the while struggling to remain human.*

I am going to suggest **4 Keys to Sustainable Compassionate Healthcare** based on the four human intelligences that I learned from the late Stephen R Covey (Sr) in *The 8th Habit* (his leadership sequel to his world famous *7 Habits of Highly Effective People*). All four keys MUST be applied to unlock the fortress we build around ourselves and our institutions. They are individual keys for our own growth and healing from the inevitable brokenness and traumas we bring to our workplaces, and these keys are writ large for governments, organizations, faith communities, and families.

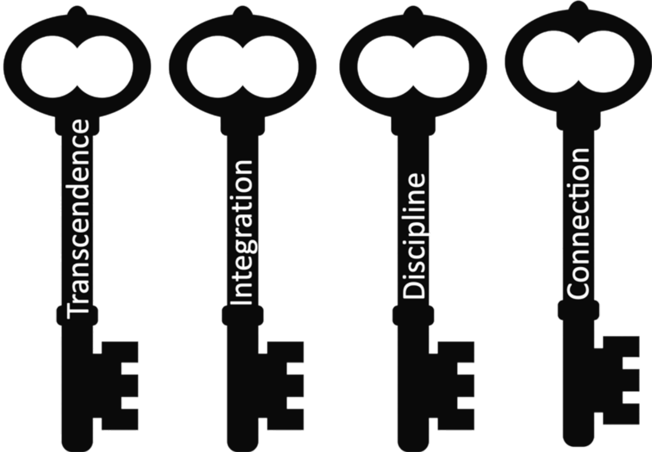

Figure 3

Here is a brief overview in Table 1 below:

Table 1

Key (4 intelligences)	**My brokenness**	**My growth**	**Our growth (together)**
Integration (IQ)	Schism of psyche into "parts" (unhealed trauma)	Wholeness, character, integrity, self-leadership	Unity, organizational greatness, empowerment
Discipline (PQ)	Sloth, self-indulgence (trying to find comfort for my distress)	Vitality, resilience, grit, health	Alignment of systems & structures, thriving workforce
Connection (EQ)	Isolation, loneliness, individualism	Belonging, trust, compassion	Teamwork, synergy, role clarity
Transcendence (SQ)	Purposeless, inadequacy, shame	Virtue, meaning, calling, fortitude	Modeling (lead by example) Mission/Vision Values

I will be expanding on each key in subsequent papers. The first one, Integration, may not be obvious to readers unfamiliar with the now gold standard of being "trauma informed." A good introduction to this is the work by Dr. Richard Schwartz in the Internal Family Systems (IFS) model (see his book, *No Bad Parts*).

Closing challenge to leaders

In closing, here is what I believe MUST be the first step on PEI. We need an apology moment from our political leaders (of all colours).

Before I explain, here is another quote, this one by G.K. Chesterton:

> *"The whole modern world has divided itself into Conservatives and Progressives. The business of Progressive is to go on making mistakes. The business of Conservatives is to prevent mistakes from being corrected."*

In the 1990s the governments of the day (federal Liberals under Jean Chrétien, and PEI Liberals under Catherine Callbeck), made the conscious decision to ration healthcare (to reign in the escalating expenses), over the backs of family doctors who were expected to be the "gatekeepers." The US versus THEM started here on PEI with a 7.5% rollback and the hated "complement system" (rules around where you could practise on PEI, with 50% penalty for non-compliance). Medical school enrollments were reduced; nurses were advised to find work in the US.

This is my public call for our political leaders to stand up and apologize (on behalf of their forbears) to our profession for making these decisions.

Finally, Kingsnorth's final thought: "*People, place, prayer, the past. Human community, roots in nature, connection to God, memories passed down and on. These are the eternal things."*

Compassionately and humbly submitted,

Hendrik Visser, MD
April 9, 2026

Further Reading and Endnotes

Becker, Adam (2025). *More Everything Forever: AI Overlords, Space Empires, and Silicon Valley's Crusade to Control the Fate of Humanity*

Buber, Martin (1923). *I and Thou*

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Covey, Stephen R. (2004). *The 8th Habit: From Effectiveness to Greatness*

Kingsnorth, Paul (2025). *Against the Machine: On the Unmaking of Humanity*

O'bieblyn, Meghan (2022). *God Human Animal Machine: Technology, Metaphor, and the Search for Meaning*

Schwartz, Richard (2021). *No Bad Parts: Healing Trauma and Restoring Wholeness with the Internal Family Systems Model*

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[1] Hoogendoorn CJ, Rodríguez ND. Rethinking dehumanization, empathy, and burnout in healthcare context. *Curr Opin Behav Sci.* 2023 Aug;52:101285.
[2] Haque, O. S., & Waytz, A. (2012). Dehumanization in Medicine: Causes, Solutions, and Functions: Causes, Solutions, and Functions. *Perspectives on Psychological Science*, *7*(2), 176-186.
[3] Zulueta P de. Compassion in 21st century medicine: Is it sustainable? Clinical Ethics. 2013;8(4):119-128. doi:10.1177/1477750913502623