Dehumanization in Intensive Care Medicine

Edited by

Iacopo Cappellini, Guglielmo Consales and Chiara Nuti

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Introduction

In the high stress environment of Intensive Care Unit (ICU), healthcare professionals are requested to provide advanced medical treatments, but are also deeply engaged in decisions that have ethical and humanistic implications, often under extreme emotional and psychological pressure.

This book is dedicated to the crucial intersection of ethics and humanization of care in the ICU. It explores how care providers can balance the complexities of medical intervention with the dignity, humanity and emotional well-being of patients and their families.

The aim of this book is to provide both theoretical foundations and practical frameworks that enable healthcare providers to make ethically appropriate decisions in the context of a patient-centred care system.

Patients in the ICU often face life-threatening conditions that require immediate and aggressive interventions. In such situations, ethical dilemmas frequently arise about initiation, withholding or withdrawal of life support, informed consent and respect of patient autonomy, particularly in cases involving surrogate decisions. Moreover, questions concerning the "quality of life" often ensue, mandating a careful consideration of the cultural and spiritual values of the patients and their next of kin, especially when dealing with end-of-life problems.

Humanization of care is essential in the potentially depersonalising atmosphere of the ICU, acknowledging the physical, emotional and spiritual needs of patients and their families. In this book, the concepts of empathy, respect, communication and shared decision-making will be emphasized. Indeed, "humanization of care" does not merely mean courtesy and kindness. Rather, it highlights the importance of involving patients and families in care decisions and is based on the integration of humanistic values into medical practice. By doing so, emotional and psychological needs of patients are addressed, ultimately improving clinical outcomes.

Effective communication is a cornerstone of both ethics and humanization in ICU care, especially in today's multiethnic and multicultural world. Healthcare providers must take into account the cultural and religious values of patients and families, respecting every different perspective. This "cultural competence" should be an integral part of the core curriculum of intensivists and nurses, and specific training should be incorporated into ICU educational programs.

In the challenging environment of the ICU, medical technology and ethical dilemmas intersect, affecting patients and families and making the work of healthcare professionals particularly stressful. This book tries to help in reducing the gap between technology and human needs, offering a roadmap to deal with the complexities of the ICU while maintaining a patient-centred care approach.

Guglielmo Consales, MD
Co-editor

Chapter 1
The Evolution of ICU Care

By Lucia Zamidei

The recent COVID-19 pandemic has highlighted worldwide the importance of the Intensive Care Unit (ICU) as the highly specialised ward where specifically trained staff offer comprehensive care, constant monitoring and emergency interventions to unstable, severely or potentially severely ill patients.

This chapter will not only shed the light on both medical and nursing staff who were pioneers in the birth of the ICU, but it will also pin down the most significant landmarks in the critically ill patients care.

Historical Perspectives

It is often claimed that the first ICU in Europe dates back to 1952, when a dedicated ward was set up in a Danish hospital aiming to positively ventilate patients affected by bulbar paralysis due to a poliomyelitis epidemic.

Less well known, however, is the fact that it is Florence Nightingale the one who should be celebrated for creating the earliest model of ICU.

During the Crimean War in the 1850s, it dawned on this professional nurse that, in order to ameliorate the outcome of the

most severely injured British soldiers, they should be segregated in beds as close as possible to the nurse station so as to receive "more intensive nurse care".

The pioneering contribution of Florence Nightingale to the creation of ICU is undeniable and her prototype was further improved in 1923 by Walter Dandy, a trainee student of Professor Harvey Cushing and well-renowned successor in his own right.

He organised the first three-beds postoperative ICU at Johns Hopkins Hospital in Baltimore, Maryland, arguing that neurosurgical patients should have been managed in a specialised and separated site within the hospital, under the care of trained nurses and physicians.

Similarly, two surgeons, Dr Martin Kirshner and Dr Ferdinand Sauerbruch, established in the early 1930s in Germany the "wachstationen", the so called "recovery room", where postoperative high-risk patients could receive personalised care by specialised staff.

Indeed, these units acted as a role model for the "shock units", established during World War II to provide the initial support for military casualties.

The medical and technological advances of the post-World War II era, particularly the development of anaesthesia, mechanical ventilation and antibiotics, set the stage for a more specialised approach to critical care.

On that account, postoperative ICUs developed in civilian hospitals worldwide, allowing a better outcome of patients

submitted to highly invasive surgical procedures such as cardiac surgery.

However, it should be stressed that, in all these circumstances, the provision of specialised care with lifesaving interventions was based only on vital signs, checked by professional nurses, who staffed these units only for an average of 8 hours/day.

Moreover, it was not until the 1950s that these units provided special care of severely ill medical patients.

This paradigm shift occurred when, in 1952, Copenhagen was struck by a serious poliomyelitis epidemics, which, as a consequence of bulbar paralysis, precluded spontaneous ventilation of the victims.

In Blegdam Hospital the influx of patients requiring respiratory support was overwhelmingly high (almost up to three hundred in very few months) and in that time only one tank ventilator (a negative pressure generator called "iron lung") and six cuirass ventilators were available.

In such a scenario, Dr Mogens Björneboe, on behalf of Blegdam Hospital's chief physician Dr Lassen, contacted the trained in Boston anaesthetist Dr Björn Ibsen.

Dr Mogens Björneboe and Dr Björn Ibsen had previously faced with a case of congenital tetanus: the newborn eventually died but in these unfortunate circumstances Dr Björn Ibsen had the possibility to gain confidence with positive pressure ventilation throughout tracheostomy outside the operating theatre.

On 27 August 1952, Dr Björn Ibsen had the brainwave to submit to positive pressure ventilation Vivi E, a 12-year-old girl affected by polio-related bulbar palsy.

A mixture of oxygen and air was delivered through her tracheostomy tube by a manually compressed vented rubber bag, while a soda lime canister included into the circuit was responsible for exhaled carbon dioxide adsorption.

The girl was successfully rescued and, on the grounds of this success, all paralytic poliomyelitis patients admitted to Blegdam Hospital were grouped in three speciality wards and managed by applying positive pressure ventilation: the first three modern ICUs were born.

Daily, under the supervision of anaesthetists and dedicated nursing staff, 70 patients on average were simultaneously hand-ventilated by over 250 tireless medical students.

As a result, within few months the mortality rate from bulbar poliomyelitis dropped from 85-90% to less than 15%.

On this account, Dr Björn Ibsen is commonly defined as "the father" of both the modern ICU and the intensive care medicine.

Since he understood that securing a proper ventilation was the key element to keep alive patients with vital organ failure, multidisciplinary ICUs sprung up all around the world to treat not only severe forms of polio but also whatever disease inducing respiratory failure.

Moreover, by the late 1950s and early 1960s, several other speciality devices for treatment of single organ failure such as the dialysis machines, the AC electrical defibrillators and the newborn incubators evolved and prompted the wide expansion of both cardiac (coronary) care units and neonatal intensive care units.

Nevertheless, in that time, all these sites lacked not only the multisystem life support devices but also real time monitors and measurements that nowadays characterise the current ICUs.

Recent Advances and Milestones

Were it not for technology, the modern ICU wouldn't have distinguished themselves from their ancestors in the Nightingale or Dr Björn Ibsen era.

It was 1959 when the first two contemporary ICU were born. They were the one spearheaded by Dr Max Harry Weil in Los Angeles at the University of Southern California and the other directed by Dr Peter Safar at the University of Pittsburgh.

Both centres served as leaders in initiating the present era of ICU, as they implemented continuous monitoring of electrocardiogram, blood pressure, pulse, breathing, complementing them by the measurement of central venous pressure, circulation times, cardiac output and blood results obtained in an on-site STAT laboratory.

Giving the fact that monitoring systems and bedside measurements would facilitate prompt diagnosis and intervention with titrated therapies, this approach revolutionised the care of critically ill patient.

Over the following decades, multidisciplinary ICUs using multiorgan support methodologies and devices have become the norm rather the exception and nowadays digital displays integrated with modern computer systems have gained a role of paramount importance.

Moreover, a better knowledge of human physiology has led to a "less is more" shift in a great deal of intensive care interventions, such as invasive ventilation, endovenous sedation and blood transfusion, to mention but a few.

Since December 2019, almost seven decades after the poliomyelitis pandemic in Copenhagen, healthcare systems have been significantly stressed by the COVID-19 pandemic.

Due to a surge of critically ill patients affected by acute hypoxaemia that could culminate in acute respiratory distress syndrome, ICUs have been challenged significantly.

Nevertheless they have shown remarkable adaptability, highlighting the commitment to improve that is the most valuable take home message learnt by Dr Björn Ibsen, the "father" of ICU.

Ethical dilemmas in the ICU

The increasing reliance on technology, protocols and efficiency could potentially overshadow the human aspects of care.

As a consequence, the risk of depersonalization in high-tech environments calls for renewed attention to the values and ethical principles that should underpin intensive care.

Clinicians increasingly face dilemmas related to treatment limitation, quality of life considerations, and end-of-life decision-making. The traditional model of care—where the physician is the principal decision-maker—has gradually shifted towards shared decision-making, with increased attention to patient autonomy, advance care planning, and family engagement.

Alongside this, the humanization movement in ICUs gained traction. Emerging research in the 1990s and 2000s began documenting the psychological and emotional toll of ICU stays on patients and their families, including post-intensive care syndrome (PICS), anxiety, depression, and post-traumatic stress. This brought a new awareness that outcomes in critical care should not be limited to survival metrics, but also encompass psychological well-being, communication quality, and person-centeredness.

In conclusion, the evolution of ICU care is not only a story of medical and technological innovation but also one of ethical awakening. Today's intensive care must aim to balance cutting-edge treatment with a profound respect for patient dignity, individual narratives, and emotional realities. As the field continues to grow, it is imperative that the humanity of the patient remains at the center of ICU care.

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Chapter 2
The Challenge of Dehumanization in ICUs

By Chiara Nuti and Iacopo Cappellini

Defining Dehumanization in the ICU Context

In critical care, **dehumanization** refers to the erosion of a patient's personhood – the treatment of an individual as an object or a set of medical problems rather than as a human being with dignity, autonomy, and identity. This concept has deep roots in psychology and ethics. Psychologically, dehumanization entails denying someone the qualities that make them human – for example, treating them as mindless or impersonal objects (sometimes termed *mechanistic dehumanization*) or, in other contexts, as subhuman or animal-like (*animalistic dehumanization*). Ethically, it is linked to a failure to honor the intrinsic **dignity** and autonomy of the person. To dehumanize a patient is, in essence, to **"deny [their] humanity"** and to regard them as a means to an end (a body to be treated) rather than an end in themselves. In the ICU setting, this often manifests as an overt or subtle mindset that the critically ill patient is *"just a body in a bed"* rather than a whole person – a mindset with profound consequences for care quality and ethical integrity.

A structured definition of ICU dehumanization can thus be formulated as follows: it is the set of attitudes, behaviors, and systemic features that **objectify** critically ill patients, stripping away their identity and subjectivity. Classic signs include losses of

personal identity (patients becoming known by room number or diagnosis), loss of privacy and dignity (exposure of the body, invasive procedures without sufficient explanation or consent), and loss of voice or agency (inability of patients to communicate or make decisions about their care). Such dehumanization is not always deliberate; it often arises from institutional norms and clinician coping mechanisms. Research in psychology underscores that certain **inherent features of medical settings** predispose to dehumanization, such as *de-individuating practices* (e.g. identical gowns and patient IDs replacing names), *impaired patient agency* (when illness or sedation robs patients of the ability to act or speak), *mechanization* (an emphasis on numbers, machines, and body parts over the person's story), and *empathy reduction* (emotional blunting by staff as a response to stress). All of these are frequently present in intensive care. As Haque and Waytz (2012) observed, the hospital environment and the routines of clinical practice can unintentionally foster a "routine dehumanization," unless active steps are taken to counteract it. In critical care, where technological lifesaving measures dominate, the risk is especially pronounced.

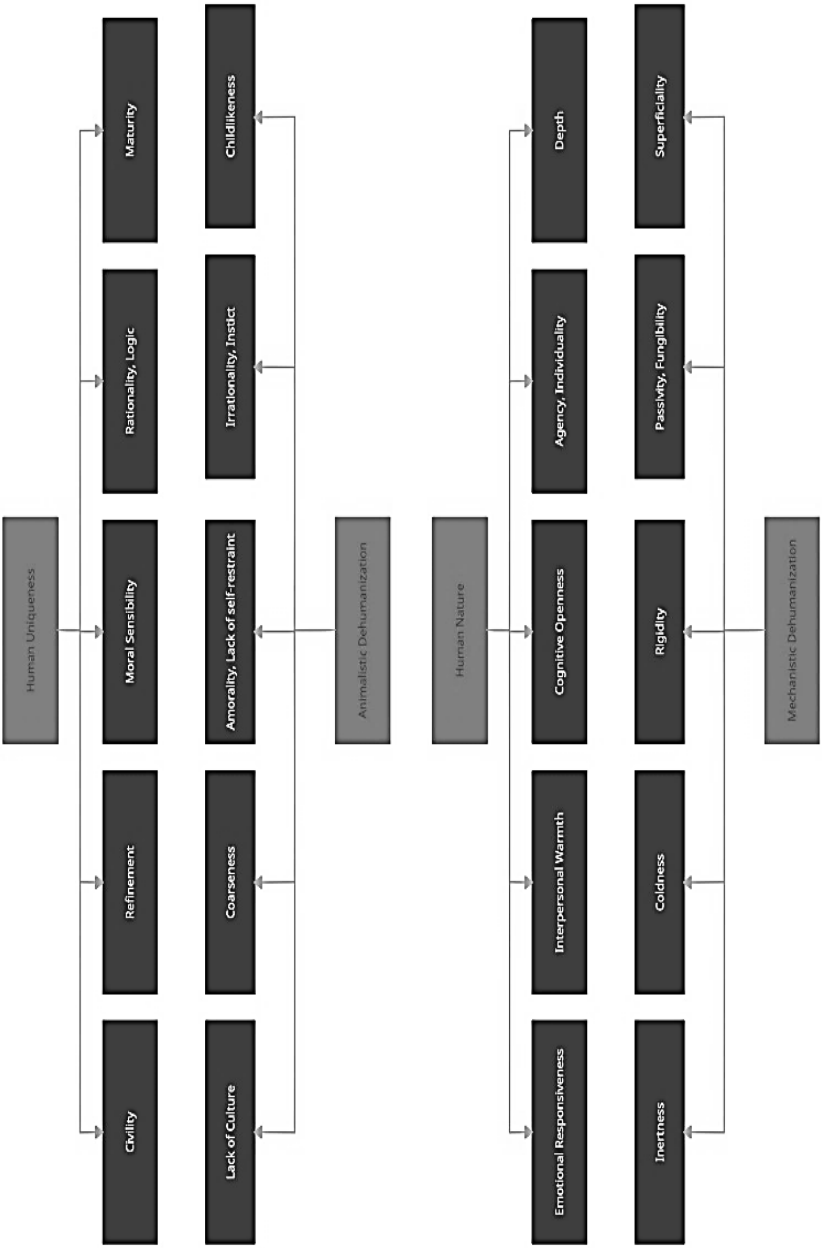
Human Uniqueness
Moral Sensibility
Rationality, Logic
Maturity
Refinement
Civility
Amorality, Lack of self-restraint
Irrationality, Instict
Childlikeness
Coarseness
Lack of Culture
Animalistic Dehumanization
Human Nature
Cognitive Openness
Agency, Individuality
Depth
Interpersonal Warmth
Emotional Responsiveness
Rigidity
Passivity, Fungibility
Superficiality
Coldness
Inertness
Mechanistic Dehumanization

Figure 1: Conceptual model contrasting Humanization and Dehumanization across two psychological dimensions. This diagram visually represents the dual dimensions through which individuals may be humanized or dehumanized, following the theoretical framework proposed by Haslam (2006). The Humanization axis encompasses traits that affirm the full humanity of a person, subdivided into:

> Human Uniqueness (HU): attributes that distinguish humans from animals, such as civility, refinement, moral sensibility, rationality, and maturity.
>
> Human Nature (HN): attributes seen as essential to human experience, including emotional responsiveness, warmth, cognitive flexibility, autonomy, and depth.

Dehumanization arises when these characteristics are denied:

> Animalistic Dehumanization entails the denial of Human Uniqueness, perceiving the individual as primitive, coarse, irrational, or morally deficient, thus aligning them metaphorically with animals.
>
> Mechanistic Dehumanization involves the denial of Human Nature, reducing the individual to an object-like or robotic state—cold, passive, fungible, and lacking emotional or psychological depth.

This framework is instrumental in understanding a variety of phenomena, including social exclusion, discrimination, abuse, and the erosion of empathy in institutional or clinical settings. It provides a lens through which one can analyze how certain groups are systematically denied moral consideration and treated as less than fully human.

It is important to distinguish **dehumanization** from mere efficiency or clinical detachment. A certain degree of detachment can be functionally necessary for clinicians performing high-stakes procedures (to focus on technical tasks), but dehumanization goes further – it involves a breach of the moral respect owed to the

patient as a person. Modern bioethics insists that patients be treated as persons, never *merely as objects*, echoing Immanuel Kant's imperative. When ICU practices violate patients' autonomy or ignore their subjective experience, they cross into ethically impermissible territory. Indeed, to **treat a patient "as a thing" without regard to their autonomy and feelings is to inflict a moral injury**, as feminist philosophers have noted. This moral dimension is not abstract: patients who feel dehumanized often report a deep sense of indignity and alienation. Critical care literature links dehumanizing care with **poorer patient outcomes**, including psychological trauma, reduced trust in healthcare providers, and lower satisfaction. In extreme cases, patients may develop lasting emotional scars from ICU stays where they felt invisible or degraded. Thus, dehumanization is not only a theoretical construct but a concrete challenge with ethical, psychological, and clinical ramifications.

How Dehumanization Manifests in the ICU

The ICU is often cited as a *"perfect storm"* for dehumanization because of the confluence of severe illness, high technology, and high-intensity care. Several ICU-specific factors contribute to making patients feel less than human:

- **Deep Sedation and Loss of Communication:** A hallmark of many ICU patients' experience is sedation for mechanical ventilation or comfort. While sedation can be medically necessary, it renders the patient unconscious or unable to speak and interact. Patients on ventilators often *"be unable to speak, be stripped naked, have strangers do things to their bodies… have tubes inserted into multiple orifices, [and]*

have their arms restrained", as one vivid account describes. This loss of the ability to communicate or even show personality means caregivers may begin to treat the patient as a passive object. The **lack of interaction** between patient and staff can lead to care that is highly technical but emotionally sterile. Nuti and Cappellini note that nursing care can become *"sterile, monotonous, and automatic"* when dealing with non-responsive, non-interactive patients. In such circumstances, the patient's humanity is present only in abstract – the focus shifts almost entirely to vital signs, test results, and the immediate biomedical tasks. Psychologically, this is an example of **mechanistic dehumanization**, whereby the patient is viewed like an inert object or a complex machine to be maintained. Sedation also commonly leads to delirium and amnesia, so patients may awaken with no memory of what was done to them; this further robs them of a sense of continuity and personal narrative, compounding the dehumanizing impact. Ethically, the inability of sedated patients to assert their wishes or feelings puts extra onus on clinicians to safeguard their dignity – yet the ICU's frenetic environment often leaves this duty unmet.

- **Physical Immobilization and Invasive Devices:** ICU patients are frequently confined to bed, whether due to weakness, paralysis, or deliberate restraints (to prevent removal of life-sustaining tubes). Many are attached to an array of invasive devices: endotracheal tubes, intravenous lines, catheters, feeding tubes, monitors. This scenario can make a patient feel more like a **"collection of symptoms and organs"** being treated, rather than a whole person. The

need for such devices can force patients into uncomfortable positions, often unclothed under flimsy gowns, with their normal boundaries violated routinely for medical care. The *standard hospital gown* itself has been shown to induce feelings of dehumanization – patients report feeling exposed and reduced in status when made to wear the undifferentiated gown instead of personal clothing. In the ICU, gowns, tubes, and immobilization all contribute to a sense of depersonalization. The patient's **agency** is effectively nullified: they cannot move, attend to basic bodily functions without assistance, or shield themselves from the continual invasions of privacy. From a psychological standpoint, this loss of autonomy and control is central to dehumanization, aligning with what philosophers describe as the *"objectification"* of persons (denial of autonomy, treating the body as violable and owned by others). Clinicians may become desensitized to the sight of restrained, inert patients surrounded by machines, but for the patient, this experience is profoundly disempowering.

- **Technological Environment and Alarm Fatigue:** The ICU is saturated with technology – ventilators, dialysis machines, infusion pumps, cardiac monitors – all of which produce a near-constant stream of noise and alerts. **Alarm fatigue** (the desensitization to frequent alarms) is a documented phenomenon in ICUs. From the patient's perspective, the ICU soundscape is a *"cacophony of disorienting bedside alarms whose meaning lies beyond them"*, contributing to confusion and a feeling of being lost in a machine world. From the staff perspective, the continuous

monitoring can shift attention away from the person and toward numbers on a screen. Care can become algorithm-driven and impersonal: titrating drugs to targets, responding to beeps, often with minimal communication to the patient. This is not to say that technology is bad – it is life-saving – but without deliberate humanization efforts, **mechanization of care** can eclipse compassion. Research in critical care ethics notes that an extreme focus on biomedical parameters can lead to *"impersonality of care and the sterility of assistance"*, which nurses themselves recognize as a root cause of dehumanization. In other words, when the ICU is run like a high-tech workshop, both patients and staff may start to perceive the patient as a **problem to be fixed** rather than a suffering person to be healed. The beeping monitor can metaphorically become more salient than the silent patient behind it.

- **Fragmented, Shift-Based Care and Anonymity:** ICU patients typically receive care from a large, rotating team of professionals. Nurses change every 8–12 hours; attending physicians rotate every week or two; specialists from consulting services come and go. While this ensures 24/7 expert care, it also means continuity is fragmented. A given patient might interact (to the extent they can) with dozens of individuals in a week, often without any single provider seeing themselves as *the primary caregiver* for the patient's overall personhood. This **shift-based continuity issue** can foster a sense of anonymity. As one article observes, critical illness puts patients at heightened risk of *anonymity* – becoming "the patient in Bed 4" with no one consistently knowing their life story or personal values.

Important personal details (the patient's preferred name, their hobbies or roles in life) may be unknown to staff, who are more likely to remember the patient's ventilator settings or lab results. Furthermore, communications tend to be hand-offs focusing on medical status, with little mention of the person's identity. The result is that the ICU patient can feel interchangeable. Indeed, qualitative studies have found patients and families often *"felt devalued or like a bother to the medical team, 'just a body in a bed'"*, when care was fragmented and impersonal. This stands in contrast to non-ICU settings where longer-term staff-patient relationships sometimes form, mitigating anonymity. In the ICU, the onus is on the care team to actively counteract anonymity (for example, via "get to know me" posters or patient diaries), but without such efforts, the default is a **depersonalizing assembly line** model of care. The ethical implication is a dilution of accountability: if *everyone* is in charge, perhaps *no one* truly takes responsibility for seeing the patient as a human being rather than a case.

- **Use of Personal Protective Equipment (PPE) and Barriers:** ICU staff, especially in infectious disease cases or during pandemics, often don layers of PPE – gowns, masks, face shields, gloves. These necessary protections unfortunately erect a physical and psychological barrier between caregiver and patient. The human face is partly hidden; touch is impeded by gloves; voices are muffled by masks. The COVID-19 pandemic, for instance, provided stark examples of how PPE, while protecting health, can also **dehumanize interactions**. Frontline reports noted the

"dehumanizing effects of providing care in personal protective equipment", with both patients and clinicians feeling a loss of personal connection. A sedated ICU patient who intermittently opens their eyes might see around them an alien landscape of faceless, gowned figures – more reminiscent of astronauts or automatons than empathic fellow humans. Even awake patients struggle to recognize or hear their caregivers behind layers of protection. This can increase fear and isolation, reinforcing the patient's sense of being an object of procedures rather than a partner in care. Clinicians, too, describe feeling **distanced and alienated** when full PPE prevents their normal bedside manner – a friendly smile, a reassuring touch on the shoulder – leading to a form of *self*-dehumanization or burnout (as they feel reduced to a task-performing robot). The ICU already requires some degree of barrier (infection control, etc.), but PPE amplifies it, making the challenge of humanizing care even greater. What should be a compassionate encounter can feel transactional and cold.

- **High Stress, Burnout, and Emotional Detachment:** The ICU's intensity takes a toll on healthcare providers, and their psychological state can, in turn, affect patients. Nurses and doctors in ICUs face life-and-death decisions, ethical dilemmas, and exposure to suffering on a daily basis. Over time, this can lead to **compassion fatigue** or burnout, where caregivers blunt their emotions as a coping mechanism. Studies have shown that stress is linked to increases in dehumanizing attitudes or behaviors by medical staff. For example, a cross-sectional survey of nurses by Cappellini *et al.* found that feelings of *anger*,

impatience, and apathy toward patients were not uncommon. Such emotions are indicators of a detached or depersonalized approach to patients. In fact, the study concluded that *"the root of dehumanization lies in [the] nurses' inability to feel emotions"* in combination with impersonal care routines. In other words, when clinicians become emotionally numb – sometimes as a self-protective response in a high-mortality environment – they may start treating patients in a perfunctory, indifferent way. This **self-dehumanization** (caregivers seeing themselves as just cogs in a machine) is dangerous because it directly undermines compassionate care. Ethically, caregivers have a duty of empathy, but burnout can rob them of the capacity to fulfill it. ICU staff might withdraw to a strictly professional, technical focus, avoiding emotional engagement with patients and families as a way to protect themselves. Unfortunately, from the patient's vantage point, this comes across as callousness or lack of concern – a clear form of dehumanizing treatment. The ICU ethos can thus inadvertently encourage a stoic, emotionless professionalism that, if unmitigated, leaves patients feeling uncared for as human beings.

In sum, the ICU environment – with its **unresponsive patients, high-tech apparatus, rotating staff, protective barriers, and immense stress** – contains multiple inherent drivers of dehumanization. Patients are acutely vulnerable: they often cannot speak or fight mistreatment, and their recollections may be hazy, meaning dehumanizing episodes can easily go unaddressed. The challenge, then, is recognizing these risk factors as the *first step* toward mitigating them. Critical care teams worldwide have

begun to acknowledge that *"some patients who experience critical illness may experience a loss of their humanity in the process"* and are calling for systematic efforts to **humanize the ICU**. Before exploring solutions (the focus of later chapters), it is crucial to understand how ICU dehumanization compares to, and often exceeds, the challenges in other healthcare settings.

ICU vs. Other Medical Settings: A Comparative Perspective

Dehumanization is not exclusive to intensive care units – it can occur in any medical setting. However, the ICU's unique characteristics tend to amplify the phenomenon. A comparative look at other settings (emergency departments, general hospital wards such as geriatric units, and oncology care, among others) helps to **highlight what makes the ICU distinct** in its vulnerability to dehumanizing dynamics.

Emergency Departments (EDs): Emergency medicine shares some of the ICU's fast-paced, high-stakes atmosphere, but ED encounters are typically brief and episodic. Dehumanization in the ED often stems from extreme time pressure, overcrowding, and the imperative to triage and treat quickly. Patients in an ED are frequently strangers to the staff, known initially by a chief complaint or as "the motor vehicle accident victim" or "the chest pain in bay 3." This necessary shorthand can nevertheless be de-individuating. There is little time to gather personal context or establish rapport. **Impersonal processes** like assigning numbers, placing the patient in a corridor due to lack of rooms, or hurriedly obtaining consent for procedures amid chaos can make patients feel like *"a case, not a person."* Furthermore, the ED has historically

been a setting of **high anonymity**: once stabilized, patients are handed off to inpatient units or discharged, meaning the ED team rarely follows the patient's story to its conclusion. Any dehumanizing experience in the ED (such as feeling ignored or spoken about in technical jargon) might never be revisited by the same providers. During the COVID-19 pandemic, ED staff faced added burdens of PPE and overwhelming caseloads; front-line reports describe how **wearing PPE in the ED compounded feelings of dehumanization**, making it harder for clinicians to connect with patients and for patients to recognize the people treating them. Burnout in emergency care, much like in ICUs, led some providers to emotional exhaustion, further risking detached or brusque interactions. However, one key difference is that because ED stays are short, patients (if conscious) might tolerate impersonal treatment as long as acute issues are addressed, whereas ICU patients endure days or weeks of such an environment. In the ICU, the cumulative effect of dehumanizing conditions day after day can be far more damaging to the patient's psyche.

General Hospital Wards and Geriatric Care: On a standard medical or surgical ward, patients are typically conscious and ambulatory sooner, and lengths of stay can vary from a few days to a few weeks. Dehumanization on the wards often relates to **institutional routines** and attitudes, especially for vulnerable populations like the elderly. In geriatric wards or nursing facilities, a form of dehumanization can arise from **ageism and paternalism**. Staff may speak to an elderly patient in a condescending tone, or disregard their input under an assumption that "the doctor/nurse knows best," thereby undermining the patient's personhood. Unlike the ICU, overt technological invasiveness is lower on a

ward, but subtler indignities occur: e.g. calling patients by their room number or diagnosis ("the hip fracture in 206"), or failing to respect privacy during basic care tasks. Studies in gerontology have noted that older adults are at risk of being implicitly dehumanized – treated as "less capable" or "senile" even when they are not. A telling example is provided by one patient's family: when an 85-year-old was hospitalized, some staff remarked *"he's had a good life – he's old"*, in effect minimizing his current suffering and individuality. Such remarks, which might be unthinkable in pediatrics, reflect an erosion of empathy that devalues the elderly person as a unique individual. What makes the ICU different is that *every* patient, regardless of age, may be treated in a task-focused way due to critical illness – but the **geriatric context adds an extra layer** of prejudice that can exacerbate dehumanization (the intersection of being old *and* critically ill can render patients almost invisible in terms of personhood). On the other hand, general wards sometimes allow more personal interaction: patients are awake, can voice concerns, and family presence is often greater, which can counteract dehumanization. Indeed, the comparative survey by Cappellini *et al.* revealed an interesting contrast: ICU nurses, perhaps aware of their patients' extreme vulnerability, often made *greater efforts to involve families in care*, whereas ward nurses sometimes viewed family involvement as an obstacle to routine. This suggests that ICU staff might, in certain respects, be more attuned to the importance of humanizing elements like family presence (because in ICU the family may represent the patient's voice or memories). In geriatric and other wards, however, when family or personal narratives are sidelined, patients can feel **standardized and ignored**, albeit through different mechanisms than in ICU (e.g. boredom, neglect, or lack