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Towards an ethics of care in public hospitals: a critical review of structural dehumanization

Hacia una ética del cuidado en hospitales públicos: revisión crítica de la deshumanización estructural

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Abstract

Clinical practice in public hospitals in Latin America is undergoing an institutional transformation that, in the name of efficiency, has eroded the ethical foundations of care. This article problematizes the dehu-

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manization of the clinical act, not as an anomaly, but as a symptom of an order that has displaced the patient from a moral subject to an object of management. It argues that the depersonalization of care responds to institutional frameworks that naturalize the subordination of dignity to performance indicators. Rethinking the healthcare system requires more than administrative reforms: it demands a profound epistemological and normative reconfiguration and the recovery of a situated ethics that recognizes human vulnerability. The rehumanization of health, understood as a political and ethical project, will only be possible by articulating a critique of the mechanisms of exclusion with proposals that restore the centrality of care as a relational, just, and transformative practice.

Keywords: depersonalization of care, critical bioethics, public health, institutional violence, clinical care.

1. Introduction

In recent decades, public hospitals have experienced growing pressure to optimize resources, standardize procedures, and meet performance indicators that, while pursuing greater efficiency, have simultaneously contributed to the dehumanization of clinical care. This situation has been exacerbated in contexts marked by fiscal austerity, particularly in Latin American countries since the 1990s, where neoliberal logic has deeply permeated health systems. In these environments, the therapeutic bond between professionals and patients tends to be diluted by automated routines, reduced consultation times, and impersonal protocols that marginalize the uniqueness of everyone. As a result, care practices emerge that prioritize risk management and institutional control over comprehensive and relational care. This depersonalization of the clinical act not only violates the rights of users but also erodes the ethical sense of the healthcare profession. It is therefore urgent to critically examine the structural conditions that shape these dynamics to rethink a model of care that is truly centered on the individual.

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From a theoretical perspective, the dehumanization of care can be—and perhaps should be—considered from different angles that question not only the what, but also the how and why of clinical practice. These are perspectives that problematize, at different levels, the growing medicalization, technical-instrumental rationality, and bureaucratic logic that permeates the healthcare system. Modern medical knowledge has shaped a "clinical gaze," a gaze that observes, measures, classifies... but in doing so, transforms the patient into an object (1). This is no small matter: in this gesture, subjectivity is reduced to a series of pathological signs. On the other hand, he argued that the normalization of the health crisis represents an exercise of biopower that colonizes the world of life; a critique that, when transferred to the health field, allows us to understand why administrative matters are so often prioritized over human dialogue (2). Another nuance: he proposes an ontological model of care, one that recognizes the coexistence of multiple realities in clinical practice and defends a situated, embodied ethics that is attentive to the body and the context (3). Together, these three entries allow us to see how certain epistemic logics—often invisible—structure forms of care that exclude essential dimensions of suffering: the emotional, the social, the existential. What cannot be measured is simply omitted.

Academic literature has identified several gaps in the understanding of the phenomenon of dehumanization in hospital settings, especially regarding the structural and organizational aspects that underpin it. While there are studies that address medical empathy or clinical communication, there is a perceived lack of work that critically intertwines the epistemological, political, and organizational levels in the same line of work. This shortcoming poses a significant scientific challenge, as it prevents a deeper analysis of the phenomenon in a holistic and proactive manner. Furthermore, despite the tensions that persist between the ethics of care and the demands of institutional efficiency, we are faced with normative dilemmas for which no clear solution is offered. In this sense, analyzing how exclusionary practices arise from a critical perspective allows us to address not only their origins but also presents an opportunity to consider transformative alternatives. The proposed review also falls within this framework, in a field that undoubtedly requires greater and better conceptual and empirical development.

In this sense, the implications of clinical dehumanization are highly relevant: they lead to a poorer quality of life for patients, increased avoidable suffering, lower motivation among healthcare staff, and a loss of confidence in the healthcare system itself. This post-pandemic period is particularly relevant for highlighting the vulnerability of healthcare systems and the urgent need to reevaluate them (4), based on an ethic that restores the relationship between the self and the other. Proposing guidelines that promote fair and dignified care will require not only changing individual practices but also disrupting the organizational and regulatory frameworks that support them. The ethics of care can make a decisive contribution to this process of reconfiguration, understood as a practical guide based on relational responsibility. In this way, analyzing the logic of exclusion in clinical practice can make it possible to imagine more humane and fair ways of inhabiting care.

Thus, the relevance of this study lies in the need to reexamine the structures that sustain the dehumanization of care in public hospitals, in a social context that demands more empathetic, fair, and viable healthcare systems. In other words, this research is a response to that demand, recovering theoretical and empirical approaches that allow for the development of a critical and proactive perspective. Exploring the conditions that make subject-oriented care possible is also a way of illuminating paths toward a clinical practice that recognizes human dignity. The relevance of the topic is not limited to a temporary urgency; it also represents a way of settling a historical debt to those who have been systematically overshadowed by inadequate institutional logic. Review and reflection on the ethical foundations of the healthcare system are therefore a condition imposed by the need to promote a transformation that can be effective and lasting.

The objective of this review is to critically analyze the dehumanization of clinical care in public hospitals; that is, to describe the epistemic, political, and organizational logics that shape exclusionary care practices, to propose bioethical guidelines that contribute to transforming the healthcare system. This objective is part of an attempt to articulate theoretical analysis with practical analysis, with the intention of contributing original thinking to the debate on the humanization of healthcare. The purpose of this practice is to pave the way for a profound reflection on the place of care in the institutional construction of the contemporary world and, in doing so, to open possibilities for fairer, more dignified, subject-centered care.

2. Theoretical perspectives: unraveling the dehumanization of care

Understanding the phenomenon of dehumanization in the field of health requires placing oneself within a critical genealogy that allows us to grasp not only its current expressions, but also the historical circumstances and epistemic conditions that have enabled its affirmation. Modern medicine is the result of the long march of the scientification of knowledge about the body, which has radically transformed the way in which illness, suffering, and care are understood. In this transition, the patient has been progressively displaced from the center of the clinical experience, replaced by an abstract figure: the case, the diagnosis, the number. Studies have shown how the medical apparatus has colonized fundamental dimensions of human existence—pain, death, fragility—imposing a technocratic view that, in many cases, silences other ways of understanding and accompanying suffering (1,5).

In this context, medical practice tends to favor a conception of the body as a biological object, often disregarding its lived, symbolic, and relational dimensions. However, multiple critical approaches have pointed out that the body, much more than a simple physiological

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support, is a conscious body, traversed by experience, cultural contexts, and social structures (6). By focusing almost exclusively on the body as a machine, medicine has contributed to making the body as a subject invisible, reinforcing an asymmetrical clinical relationship in which medical knowledge overlaps the patient's agency. This tension between body and subjectivity is not merely a theoretical problem: it manifests itself daily in clinical interactions where the patient's language ends up being subordinated, or even discarded, in favor of protocol, algorithms, and indicators.

This logic has been criticized from different perspectives, notably those that have questioned the limits of the traditional biomedical model. An approach strictly limited to the biological carries the danger of overlooking the psychological and social facets of care, resulting in segmented and simplistic assistance, rather than promoting humanization and respectful treatment from an ethical perspective (7). This criticism has been echoed in many institutional discourses, although it has rarely translated into fundamental practical changes. Clinical alienation, for its part, occurs when the patient ceases to be recognized as a moral subject, that is, as someone capable of narrating their experience, demanding recognition, and being heard (8). This loss of recognition not only affects the therapeutic bond but also erodes the very ethical basis of medicine. However, these aspects are often not even articulated with each other.

In this sense, it is pertinent to introduce the concept of institutional violence, understood as a critical category that allows us to highlight forms of domination that are not necessarily explicit or deliberate. It is a type of violence that conditions —and in many cases strips away— dignity and quality of care. Symbolic violence is described as the exercise of apparently neutral practices that are nevertheless laden with hierarchical meanings, devaluing patients and subordinating their experience to the codes of mainstream medicine (9). Structural violence, for its part, manifests itself as a set of material inequalities that determine who receives what type of care and under what conditions (10); it does not require direct acts of aggres-

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sion, but rather a system that operates under logics that perpetuate the exclusion of the most vulnerable. Finally, epistemic violence can be understood, in this context, as the systematic silencing of the patient's knowledge, their exclusion from decision-making processes, and the establishment of a model of knowledge that disregards their own understanding of the body, illness, and care (11).

Healthcare institutions, by positioning themselves as active agents in the production of meaning and the distribution of resources, are fully involved in this logic of exclusion. Under the imperative of standardization and efficiency, they tend to reduce the experience of illness to a set of clinical signs or an instrumental reading of laboratory results, ignoring the patient's stories, which are what give meaning to suffering and enable truly comprehensive care (12). This depersonalization not only distorts the user's experience: it also reproduces structural inequalities by rendering invisible those who do not fit into the system's normative models; indigenous people, migrants, patients with complex chronic diseases, among others.

In this context, it is necessary to return to the philosophical foundations of sharp bioethics, capable of questioning not only individual clinical dilemmas, but also the structures that generate them. Liberation bioethics, in line with Latin American thought, points toward a historically situated ethics committed to collective rights insofar as these imply transforming the structures where injustice in health is reproduced. This perspective does not refer to traditional normative ethics but rather assumes a political stance: health as a collective good in the face of a social structure that often denies or commodifies it.

From this perspective, the ethics of care recovers the idea of human interdependence as the foundation of all moral and political organization (13,14). Here, care is not limited to a professional function or an expression of individual pity; it is configured as a social responsibility that must be embodied in the institutions themselves. Recognizing vulnerability is not the same as paternalism: it implies accepting a shared human condition that requires public policies aimed at recognizing suffering and reorganizing priorities beyond the logic of performance.

In this sense, one of the most persistent ethical dilemmas is that between dignity and efficiency. The pressure to achieve quantitative and qualitative goals is often reflected in decisions that, while understandable from a management perspective, end up affecting the humanity of the patient. Limiting family access, standardizing end-of-life procedures, mechanizing interventions in agony... all of this can optimize certain operational parameters, of course, but it often does so at the expense of attention to the individual, listening empathy, and mutual respect (15). There are no simple solutions to this dilemma. But ignoring it is, in itself, a form of dehumanization: when dignity is systematically subordinated to efficiency, the healthcare system loses its raison d'être.

Thinking about dehumanization in healthcare from this perspective therefore implies a critique that is not only moral, but also epistemological, political, and structural. It is not a question of seeking individual culprits, but of questioning the frameworks that define what it means to care, who deserves to be cared for, and how we collectively distribute healthcare resources. In this process, the voice of the patient, the subjectivity of the professional, and institutional conditions must be considered in all their complexity if we truly aspire to a medicine that not only cures but also accompanies, recognizes, and dignifies.

3. Dehumanization as a structural device in public hospitals

The history of public hospitals in Peru cannot be understood without considering the political and economic transformations that, with the changes imposed since the end of the 20th century, ended up radically disrupting their institutional logic. The neoliberal reforms of the 1990s involved the introduction of a set of administrative criteria typical of organizations focused on efficiency and public spending restraint; a search for solutions to macroeconomic pressures that, however, ended up deteriorating the quality and warmth of clinical care (16). The commitment to rationalization led to the resurgence of management indicators and quantifiable goals, while those dimensions of care that could not be translated into accounting terms or evaluated institutionally took a back seat. Instability in hospital management, a result of the persistent politicization of these positions, was followed by an organizational culture that ended up consolidating a tacit acceptance of fragmentation and improvisation in practices (17).

This new hospital management regime has established a technical rationality that, far from being neutral, reconfigures the ways of acting and thinking of health professionals. There is a progressive loss of professional agency, where doctors, nurses, and other health workers must adapt to standardized protocols that often contravene their clinical judgment or ethical sensibilities. Productivity demands limit the possibility of building meaningful human relationships with patients and reduce the clinical act to a sequence of fragmented procedures, whose meaning is diluted in the urgency to meet targets. This situation not only affects the quality of care but also generates moral tensions that are difficult to process, especially for those trained in a person-centered ethic of care.

Job insecurity is, in this sense, a structural factor that directly influences the dehumanization of care. Temporary contracts, work overload, and resource shortages are not circumstantial phenomena, but rather constituent elements of a model that conceives of healthcare professionals as just another cog in the hospital's productive machinery. Burnout syndrome, widely documented among healthcare personnel, expresses not only physical or emotional exhaustion, but also a form of ethical suffering in the face of the impossibility of providing care that meets the moral demands of the profession (18,19). When time becomes a scarce resource and care a timed task, empathy becomes a luxury that many professionals cannot afford.

Within this logic, clinical productivity becomes the most relevant criterion, ahead of any other procedure for evaluating clinical practice. Commercial logic —imported from other productive sectors —transforms healthcare into a service, subject to the same rules of competition, efficiency, and performance. This model not only deteriorates working conditions but also profoundly affects the relationship with patients, who increasingly perceive care as mediated, fragmented, depersonalized, and rushed. As reflected in recent research, this gives rise to a clinical environment in which human relationships tend to lose their affectionate and symbolic character, blurring the experience of care in its deepest sense (20).

The concrete manifestations of this dehumanization are easily found at a wide variety of levels. The automation of clinical practices through rigid protocols limits the opportunity to respond specifically to each patient; it reduces care to a mechanical application of standardized knowledge (21). Communication between professionals and patients is often one-way, dominated by technical jargon, which contributes to an experience of care in which patients do not identify themselves as subjects, but rather as objects of intervention (22). This detached dynamic is not limited to strictly functional aspects: it affects the construction of meaning, preventing people's suffering from being narrated, symbolized, and, consequently, accompanied.

Indeed, one of the most worrying aspects of this dehumanization is the omission of the affective, symbolic, and narrative dimensions of suffering. The lack of conditions in hospital structures to accommodate the pain of those being cared for undermines the possibility of comprehensive care. Suffering is then forgotten in a more hidden dimension, as if it were a logistical nuisance, just another clinical variable, rather than a life experience that demands presence, time, and words (20).

The ethical and political effects of this situation are significant. The loss of institutional trust not only translates into a decrease in user satisfaction, but also into a weakening of their moral agency. A patient who does not feel listened to, who perceives indifference or lack of differentiation in their treatment, will find it difficult to play an active role in their care process. This forced passivity has an impact on both clinical outcomes and the subjective experience of the disease (23). Furthermore, the logic underlying this model —far from being neutral— tends to reproduce and deepen pre-existing inequalities. The most vulnerable populations, with the least ability to exert pressure or claim rights, are those who experience the failures of the system most acutely.

The delegitimization of public hospitals is therefore not just a perceptual phenomenon, but a sign of structural crisis, especially evident on the margins of society (24). Given this diagnosis, we must not only diagnose institutional illness but also ask ourselves what kind of care we are willing to sustain socially.

That is why the public hospital, as we have built it throughout history, finds itself in a situation that requires not only administrative reforms but also a reformulation of the aims of medicine, of the value of the human being in clinical practice, and of the material conditions that enable (or prevent) the exercise of ethical care.

4. Bioethical keys for a humanizing transformation

Today, in a healthcare context conditioned by demands for efficiency, standardization, and technification, which increasingly seem to shape clinical practice, it is necessary to rethink the relationship between the professional and the patient as an ethically just space. Reconfiguring the clinical encounter is not limited to achieving better communication or displaying courtesy: it implies an ontological-political shift in the very understanding of care. Recognizing those who suffer as subjects is not just a matter of informing them or preserving their privacy; it is, above all, listening to them, welcoming their words, and supporting their subjectivity in the midst of the adversity, uncertainty, or fragility they are experiencing (25). Listening is not a technique, but an ethical act that establishes a bond of trust and cooperation, which is absolutely central in primary care contexts, where closeness and continuity are fundamental values.

From this perspective, the notion of clinical hospitality takes on extraordinary value. It is not limited to simply welcoming the other but opens up to their way of suffering; a way linked to dignity and the need to receive care understood as a right, not as an optional quality or a concession. Thus, the clinic becomes a political and moral place, where meanings, ways of life, and priorities are contested. Hospitality is then linked to the foundations of public bioethics that does not reduce medical ethics to individual decision-making or morally neutral questionnaires, but incorporates processes of deliberation, community participation, and justice in the distribution of resources (26). The components of health and illness, of the human group and society, of health and struggle, cannot be thought of without their constitutive structural dimension: without recognizing the material conditions that allow —or prevent— a care relationship from being fully human.

For all these reasons, a clinical ethic based solely on general regulations or abstract principles, detached from the specific situation, is insufficient. The shift from an ethic of principlism to a situated ethic, as proposed by various critical positions, would allow clinical decisions to be anchored in the social and cultural reality of those who make them (27). This situated ethics does not renounce principles, but reinterprets them from lived experience, in light of the tensions and inequalities that shape the field of care. Within this framework, space is opened for a more equitable, more careful practice, less prone to ethical automatisms that ignore the real conditions of suffering and healing.

In this line, critical bioethics asserts itself as a tool of resistance against institutional logics that tend to render structural injustices invisible. Demanding structural justice in health implies holding institutions accountable not only for their administrative efficiency, but also for their capacity —or inability— to guarantee equitable distribution of care (28). Inequalities in access, quality of care, and working conditions for professionals are not anomalies of the system, but symptoms of an organization deeply permeated by power

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relations. Faced with this reality, critical bioethics does not limit itself to describing; it proposes to intervene, transforming the normative, organizational, and symbolic frameworks that shape what is possible in health.

However, such transformation cannot take place without a thorough review of training processes. Ethical training in the health sciences must be more than just a module within the curriculum: it must be a comprehensive experience that links theory with the concrete reality of the system, providing tools for critically reading the world and acting responsibly within it. In highly demanding contexts, where stress, overload, and ethical ambiguity are the order of the day, it is essential to offer students spaces for moral development and sensitivity to structural issues (29). Ethics is not learned solely from books, but through practice, shared reflection, and support that helps sustain meaning in the face of the difficulties inherent in clinical reality.

Fostering this moral reflexivity among professionals also requires institutional commitment. It is not enough to demand humanity from individuals if the structures dehumanize them. It is necessary to create conditions that make ethical practice possible: spaces for collective deliberation, instances of emotional support, organizational cultures that value care not only for the patient but also for the caregiver (25). Only in this way can a professional ethic be built that is not heroic but sustainable, that does not depend on exceptional willpower but on contexts that nurture and support it.

Ultimately, this commitment to a more ethical clinic cannot be separated from a broader proposal for health governance. The health system must be rethought from a democratic perspective, in which citizens are not merely recipients of services, but active agents in decisions that affect their lives and health. Democratic participation and citizen oversight strengthen the legitimacy of public policies and ensure that they respond to the real needs of the population (30). But this process cannot be limited to formal mechanisms; it must translate into transformative care policies that view health as a common good shaped by the social, economic, and cultural conditions of each community (26). Only then, from a public ethic that is not afraid to talk about justice, power, and transformation, will it be possible to imagine a truly humane health system.

5. Conclusions

Understanding the dehumanization of care in the health sector requires much more than a superficial review of what is happening today in clinical practice. Rather, it involves pausing to look closely—and with some discomfort—at the regimes of knowledge and power that sustain them, often naturalized to the point of becoming invisible. This research starts from a premise that, although seemingly obvious, is rarely stated with the necessary bluntness: modern medicine, clinging to a technocratic rationality, has gradually relegated the subjectivity of the patient. It has done so, without scandal, in the name of control, efficiency, and an objectivity that we would do well to begin to view with suspicion. This shift —and it is important to insist on this— is not a side effect or a miscalculation: it is embedded in the very heart of the biomedical apparatus. Its epistemic logic puts data before narrative, and algorithms where lived experience once stood. Recognizing this genealogy is not an academic luxury; it is, if anything, a minimum condition for questioning clinical care that, by disconnecting itself from the human texture of suffering, ends up reproducing forms of silent violence, disguised as technical rigor.

One of the most significant aspects of this work is its decision to uphold a situated bioethical critique, deliberately distancing itself from the universal normative models that still dominate much of the ethical discourse in health. Here, care is conceived from the vulnerability we all share —to a greater or lesser extent— and from a structural interdependence that is rarely acknowledged. Introducing notions such as epistemic, symbolic, and structural violence is not a rhetorical gesture, but a way of expanding the margins of what is ethically relevant. It is no longer enough to observe what happens between a professional and a patient: we must examine the institutional, cultural, and political frameworks that shape that relationship. In this light, care ceases to be a sequence of technical procedures —protocolized, measured, streamlined— and appears as a complex process, sometimes fragile, strained by moral conflicts, disputes over meaning, and material conditions that enable or stifle it.

This more porous view allows us not only to think more deeply about the phenomenon in question, but also to dismantle, with greater clarity, the institutional discourses that conceal it behind a facade of neutrality. From a more pragmatic perspective, the findings of this research invite us to rethink the ways in which clinical care is organized, especially in the field of public health.

Overcoming the dichotomy between efficiency and dignity is becoming urgent. We need to imagine management models where the human bond once again occupies a central place in the therapeutic act. To do this, we need to review how clinical work is evaluated, create institutional spaces for ethical deliberation, and guarantee working conditions that protect those who care from becoming trapped in the logic of performance. Clinical hospitality —that genuine openness to others, in their differences and suffering— is not presented here as a utopian ideal, but as a practice that must be sustained by the very structures of the system. Good intentions are not enough if the material conditions are not in place.

This work leaves open a dense and fertile agenda for future research. We must go beyond conceptual analysis and delve deeper into empirical studies that gather the voices of those who, from different places, pass through care settings marked by dehumanization. Not only to record the damage, but also to highlight emerging practices that attempt to rehumanize relationships, sometimes from the margins. It would also be key to explore how these logics are reconfigured in specific contexts: rural areas, indigenous communities, intercultural health spaces, where even more complex layers of epistemic exclusion and structural inequality are interwoven. Finally, there is an urgent need to review training processes in the health sciences. This is where the possibility of ethical care practice is shaped or deteriorates.

Thinking about clinical care from a critical ethical perspective is not an exercise in pessimism. Rather, it is an act of hope. Not a naive or decorative hope, but a lucid hope that sees structural violence for what it is but refuses to accept it as destiny. Committing to a more humane medicine is, at its core, committing to another way of being in the world: one in which dignity is not negotiated, but guaranteed. Especially for those bodies that history has ignored, relegated, and left behind. This commitment, however, is not only played out in the technical arena or in institutional corridors: it is played out, above all, in the shared horizon of the common good. In the collective will to sustain a healthcare system that not only cures, but also knows how to care, listen, accompany and, when necessary, transform.

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