Review

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Beyond individual virtue: Institutionalizing humanism, agency, and algorithmic governance in health systems

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SUMMARY: Humanistic values are usually treated as qualities of clinicians, although modern care is produced by organizations, financing arrangements, regulatory systems, and digital infrastructures. This conceptual and critical integrative review examines how humanistic tenets became embedded beyond the clinical encounter while drawing a boundary between humanistic tenets and health policy that is merely beneficial or efficient. Landmark scholarship, international frameworks, comparative healthcare-system studies, critical accounts of managerialism, and selected primary legal and governmental sources from the United States, United Kingdom, Japan, and China were synthesized by domains of responsibility rather than a presumed universal chronology. The framework distinguishes six non-interchangeable domains—physician, patient, population, organization, a person's life, and healthcare system—defined by different moral qualities, scales, temporal horizons, and governance mechanisms. Technology governance cuts across all six; technology itself is not a moral quality. The Japanese pathway illustrates the institutionalization of universal coverage before autonomy became comparably explicit, whereas China's recent trajectory is interpreted as compressed institutionalization across coverage, rights, quality, reforms in the provision of care, and aging. A humanistic healthcare system is proposed as an ideal and a directional continuum. Its core tenets are dignity, agency, attention to suffering, and responsiveness to person-defined life goals. Safety, equity, solidarity, participation, and trustworthiness acquire humanistic significance when they uphold those tenets rather than functioning only as performance objectives. Institutionalization can make humane care more reliable, but auditing, targets, and digital systems can also produce a predilection for procedures. Professional judgment, institutional capability, public accountability, and contestable technology must therefore remain mutually corrective.

Keywords: bioethics, organizational ethics, patient-centered care, universal health coverage, patient safety, algorithmic governance

1. Introduction

Modern medicine has acquired powers that earlier generations could scarcely imagine. The ethical paradox is that greater diagnostic precision, therapeutic options, data, and specialization can widen rather than close the gap between what a system can do and what a particular life requires.

The usual response is to ask clinicians for more empathy, communication, professionalism, or exposure to the humanities. Those responses remain indispensable, but they locate the remedy too narrowly. A compassionate clinician cannot, through character alone, fix an unpayable benefit, unsafe staffing, a fragmented referral pathway, an opaque algorithm, or a payment rule that rewards activity over patient-defined benefit. This review therefore advances a broader thesis: humanistic responsibility in modern medicine has expanded from a virtue expected of the physician to a capability expected of the healthcare system. Institutions are not literally compassionate persons. They can, however, make dignity, agency, justice, safety, participation, and attention to the meaning of illness more—or less—possible through law, financing, workflow, service design, and governance.

This review calls this process the layered institutionalization of humanistic values. 'Layered' is essential. The layers do not constitute a universal chronology in which autonomy replaces beneficence, or safety replaces justice. Older obligations persist while newer sites of responsibility are added. Nor does the framework claim that the medical humanities led universal coverage, the patient-safety movement, or integrated care.

These developments have distinct political, economic, professional, and social histories. The more modest and defensible claim is that they institutionalized values that overlap with the moral concerns of medicine and made those values less dependent on the discretion of a single clinician.

The argument is conceptual and historically informed rather than systematic. Landmark ethical texts, policy frameworks, critical counter-literatures, and comparative health-system scholarship are used to identify shifts in the location and machinery of responsibility. The United States, United Kingdom, Japan, and China serve as pathway cases rather than civilizational types. Their value lies in showing how comparable tenets may be upheld by different institutional means and emerge in different orders. Figure 1 summarizes the revised architecture: six responsibility domains extend from physician to healthcare system, while technology governance cuts across them rather than forming a final historical stage.

The problem has been described through suffering, illness narrative, narrative competence, the scope of medical humanities, patient-centered quality, people-centered services, high-quality healthcare systems, and AI governance (*1-12*). The respective literature is rarely read as a single institutional history. The central question of this review is therefore not whether medicine has become more or less humane in the abstract, but through what pathways humanistic values have become enshrined in law, organizations, financing, provision of care, and technology governance.

The term humanistic is used here in a deliberately restricted sense. Its core concerns are the moral standing and lived experience of persons: dignity and agency, attention to suffering, and responsiveness to the goals through which a life has meaning. Other values—including solidarity, equity, safety, participation, and trustworthiness—are not automatically humanistic merely because they are desirable. They enter this framework when they protect persons from domination, abandonment, avoidable harm, or exclusion. Institutionalization denotes the conversion of those tenets into durable rights, routines, resources, capabilities, and routes of accountability.

2. Conceptual and critical integrative review: Design and methods

This article is a conceptual and critical integrative review. Integrative reviews are appropriate when a question spans empirical, theoretical, historical, and policy literature and when the purpose is theory-building

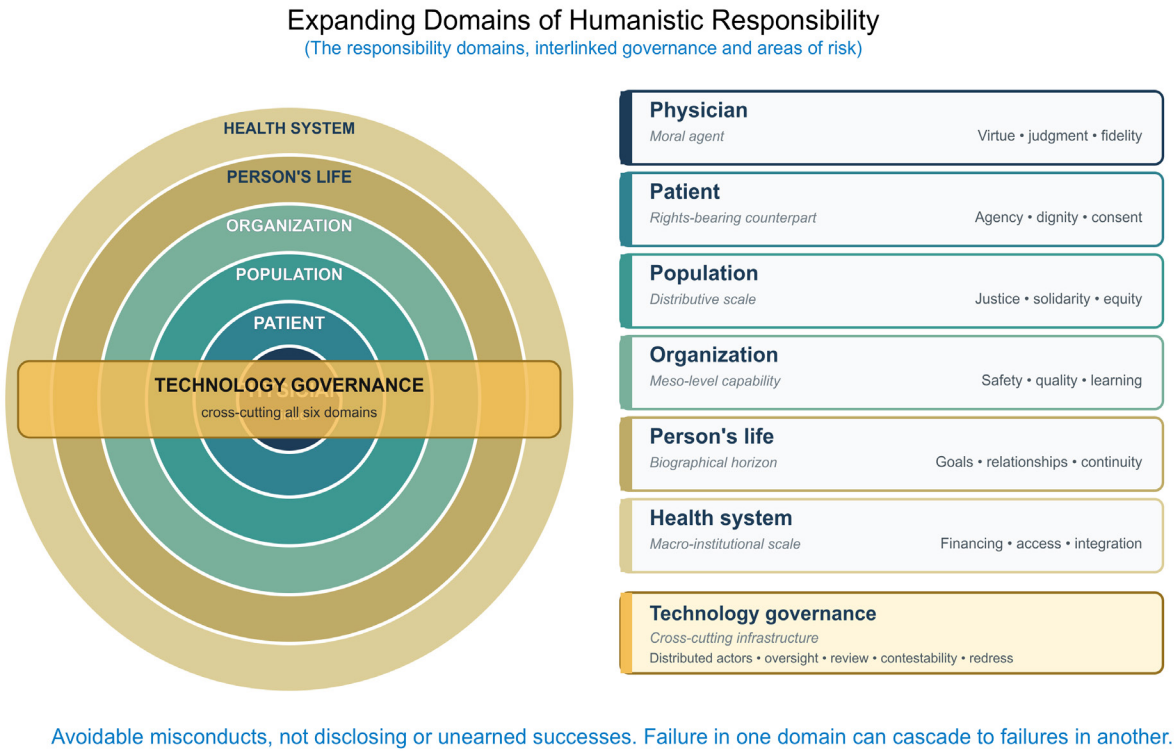


Figure 1. Expanding domains of humanistic responsibility in modern medicine. Six concentric domains depict analytically cumulative responsibilities, not temporal stages: physician and patient are relational loci; population is distributive; organization is meso-institutional; a person's life is a biographical and temporal horizon; and healthcare system is macro-institutional. The horizontal band represents technology governance as a cross-cutting layer that alters every domain. Technology is not an additional moral quality; responsibility remains with the distributed actors who design, procure, deploy, regulate, use, contest, and repair technical systems. Countries may institutionalize the domains in different orders.

and conceptual synthesis rather than estimation of a single effect (*13,14*). Review typologies distinguish this approach from systematic effectiveness reviews and scoping inventories (*15,16*). The review was designed to reconstruct concepts, institutional actors, tensions, and contrasting national pathways; it does not claim exhaustive retrieval or systematic-review status.

Targeted searches were conducted through August 12, 2026, using PubMed, Google Scholar, the World Health Organization (WHO) Institutional Repository, national legal and policy portals, and citation chaining. Search concepts combined humanism, medical humanities, professionalism, patient rights, informed consent, justice, solidarity, universal health coverage, patient safety, organizational ethics, shared decision-making, advance care planning (ACP), goal-oriented care, integrated or people-centered services, artificial intelligence governance, and the names of the four countries. To test rather than merely confirm the proposed framework, supplementary searches addressed managerialism, bureaucracy, auditing culture, ill-defined recipients of care, standardization, digital dehumanization, street-level implementation, community accountability, and decolonization. English-language conceptual and empirical scholarship was prioritized; no language restriction was applied to primary Japanese- and Chinese-language government sources. Searches were updated iteratively when comparison exposed a missing institutional actor, counterexample, or key convention.

Evidence was structured around eight areas: medical professionalism and ethics; patient rights and informed consent; justice, solidarity, and universal coverage; patient safety, improved quality of care, and organizational ethics; shared decision-making, ACP, and goal-oriented care; integrated and people-centered health services; comparative institutional development in the United States, United Kingdom, Japan, and China; and governance of AI for health purposes. The four countries were selected as cases of contrasting pathways: a plural market-oriented system, a tax-funded national service, a social-insurance system with unrestricted access, and a rapidly reforming large middle-income system. They are analytically informative rather than statistically representative.

Selection was purposive and iterative. Sources were retained when they (a) established a landmark ethical or institutional development; (b) provided a conceptual bridge between clinical and system responsibility; (c) documented a national policy pathway; or (d) challenged a simple sequential model. Milestones were included when a change in national legislation, financing, regulation, or provision of care made a relevant value more durable or contestable; dates denote formal events rather than uniform implementation or causal sufficiency. The final corpus privileges conceptual significance and primary documentation over bibliometric representativeness. Because this is not a systematic review, no pooled estimates, formal risk-of-bias assessment, or claim of literature saturation is made.

Analysis proceeded through constant comparison. For each source, the synthesis recorded the value at stake, bearer of responsibility, institutional actor, scale or temporal horizon, and characteristic failure mode. A domain was retained only if failure at that level could independently preclude humane care even when adjacent levels functioned well. Candidate categories were merged when they differed only in terminology and revised when national cases contradicted a linear sequence. Figure 1 presents the resulting architecture: six responsibility domains plus a cross-cutting technology-governance layer. It is a heuristic synthesis intended for empirical testing, not a deductively complete taxonomy.

3. Drawing the boundary: Core tenets, compatible goods, and exclusions

A framework that redescribes every beneficial reform as humanistic explains almost nothing. Its boundary must therefore be normative and institutional at once.

At the core are tenets applicable to persons as persons: recognition of equal dignity; preservation of meaningful agency; attention to suffering and vulnerability; and responsiveness to the relationships, projects, and goals that give a life its shape. These tenets distinguish humanistic evaluation from a generic assessment of technical performance. Equity, solidarity, safety, participation, and trustworthiness are compatible and often indispensable values, but their humanistic status is relational. A safety program is humanistic when it protects people from avoidable harm, listens after injury, discloses error, and deals with consequences; it is not made humanistic by a lower event rate alone. Universal coverage carries humanistic meaning when equal moral standing and protection from abandonment govern designed benefits, not simply when enrollment rises. The same distinction applies to participation that redefines participants rather than engaging in consultation, and to trustworthy technology that preserves agency rather than merely obtaining regulatory approval.

The exclusion test is intentionally demanding. A policy justified solely by throughput, financial solvency, institutional reputation, surveillance, or aggregate output is not humanistic, even if it is efficient. Nor does a mission statement frequently referencing dignity qualify when those affected cannot understand decisions, contest them, or seek remedy. Humanistic institutionalization requires both a person-regarding purpose and a credible mechanism through which that purpose constrains action.

The six domains are not interchangeable categories arranged for rhetorical symmetry. The physician is a moral agent whose judgment and character operate within a professional relationship. The patient is a counterpart imbued with rights whose agency can be respected or

overridden. Population identifies the distributive scale at which access, burdens, and benefits are allocated. Organization identifies the meso-level capacity that coordinates people, information, workflow, and learning. A person's life is a temporal and biographical horizon: it asks whether care comes with a cumulative burden and has relationships and goals rather than whether one isolated choice was offered. Healthcare system identifies the macro-institutional mechanisms—financing, eligibility, workforce, regulation, integration, and public accountability—that structure all local encounters. Their distinctness is revealed by dissociation: an autonomous choice may occur in an unjust coverage system; universal entitlement may coexist with an unsafe hospital; a high-performing organization may still provide care that conflicts with a person's priorities. Collapsing patient into a person's life would erase the difference between choosing and living with the consequences. Collapsing organization into healthcare system would erase the gap between national rules and local capabilities.

Technology does not add a seventh moral quality. Data systems, devices, and algorithms alter what can be seen, predicted, standardized, and contested in every domain. Their governance is therefore represented as a cross-cutting layer with accountable actors that include developers, data stewards, vendors, procurers, organizations, professionals, regulators, and members of the public who are affected.

4. Humanistic values before systems: Virtue, profession, and attention

For much of medical history, ethical responsibility had a visible center: the physician.

The Hippocratic tradition framed medicine through restraint, confidentiality, loyalty, and conduct; later virtue-based accounts located good care in character and practical wisdom. This physician-centered moral grammar should not be dismissed as paternalism in disguise. Clinical work still requires qualities that rules cannot supply. Suffering is not identical to disease, and recognizing it demands interpretive attention to the person whose world has been disrupted. Narrative medicine renewed this insight by treating attention, representation, and affiliation as clinical capacities rather than ornamental sensitivities. Medical humanities supplied a language with which to express meaning, mortality, embodiment, uncertainty, and asymmetry. Their enduring strength is moral perception. Their institutional weakness is contingency: humane care becomes fragile when workload, hierarchy, incentives, or fragmented information systematically oppose even well-considered judgment.

Its limitation was not excessive concern for character but insufficient control over the conditions in which character operated. A moral framework centered on the good physician can identify betrayal, cruelty, indifference, and incompetence. It is less able, by itself, to guarantee that patients can refuse treatment, that limited care is fairly distributed, or that an institution learns from recurrent harm. Reliance on virtue also creates fragility: humane care becomes contingent on the clinician who happens to be present. The subsequent history of modern medicine can therefore be read as an effort to retain professional virtue while adding institutional features that make respect and protection more reliable.

The classical and modern literature locates responsibility in the practitioner, the profession, or the moral relationship of care (*17–27*). This locus remains foundational: no organizational protocol can supply courage, practical wisdom, fidelity, or the interpretive attention required to recognize suffering. Its weakness is contingency. A system that depends on unusually virtuous clinicians cannot guarantee humane treatment when workload, hierarchy, incentives, and fragmented information systematically oppose it.

Professionalism also links the individual and the institution. A profession claims social authority in exchange for competence, service, integrity, and accountability. And yet professional self-regulation can protect patients or shield occupational power. The historical move beyond virtue did not make professionalism irrelevant; it subjected professional authority to external rights, public standards, and organizational oversight.

5. The patient imbued with rights

A decisive expansion occurred when the patient was redefined as an entity imbued with rights instead of a recipient of beneficence.

Research ethics supplied prominent institutional landmarks, including the Nuremberg Code, the Declaration of Helsinki, and the Belmont Report. These arose from different abuses and do not form one seamless genealogy with clinical consent. Alongside legal developments in bodily self-determination and patient-rights movements, however, they changed what professional good intention could justify. The ethical shift was more pronounced than the addition of a rubric. Beneficence asks whether a clinician has chosen wisely for the patient; a rights-based model adds a prior question—who is entitled to decide? Katz exposed silence as a structural feature of professional authority, while shared deliberation later treated patients and professionals as contributors of different knowledge. Autonomy did not displace beneficence, non-maleficence, or justice. It restricted the conditions under which professional judgment could substitute for the person's own agency.

Rights require institutional actors. Meaningful informed consent depends on information practices, documentation, interpreters, assessment of capacity, privacy protections, consultations on ethics, complaint processes, and avenues for redress. Research ethics

likewise requires scientifically and socially valuable protocols, fair selection, independent review, and continuing respect—not merely a signature. International human-rights instruments further connected autonomy to dignity, vulnerability, equality, and social responsibility. Humanistic tenets thus became partially procedural and legal. This produced its own risks: procedures can become rigid, and formal choice can obscure unequal power or constrained options. Nevertheless, the patient imbued with rights marks an enduring shift from trusting that clinicians will act humanely to requiring institutions to protect the concept of self-determination.

Research codes, court decisions, patient-rights instruments, and principlist bioethics collectively transformed consent from professional courtesy into an institutional requirement (*28–41*). Their histories differ and should not be collapsed: research protections responded to experimentation and abuse, while clinical consent developed through tort law, rights movements, and changes in professional practice. The shared institutional effect was to make benevolent intention insufficient justification for overriding a capable person's choices.

Rights can nonetheless become thin proceduralism. A signed form does not establish comprehension, voluntariness, feasible alternatives, or freedom from structural coercion. Relational and trust-based critiques show why agency depends on information, social position, language, accommodation of disability, time, and the credibility of institutions. Institutionalized autonomy must therefore include routes for supported decision-making, complaint, review, and redress—not documentation alone.

6. From individual ethics to social justice

Clinical ethics readily imagines one clinician and one patient. A healthcare system must also decide who is able to intercede in that encounter.

Universal health coverage (UHC) should not be redescribed simplistically as medical humanities. Its causes lie in political settlement, fiscal capacity, labor institutions, social movements, and state formation. But UHC can be understood as an institutional expression of several humanistic values: equal moral worth, a shared burden of financing, access to needed services, and protection from financial ruin. The WHO's financing framework makes clear that coverage involves the distribution of pooled resources and trade-offs among population coverage, services, and cost sharing. It is therefore not only an actuarial arrangement but a recurring decision about whose needs matter.

Coverage also illustrates why formal eligibility and actual access must be distinguished. A benefit may exist in law while distance, waiting time, disability, language, discrimination, informal payment, or poor-quality services make it unusable. Conversely, rapid access to technically available care may still expose households to impoverishment or offer interventions that do not satisfy needs. A humanistic interpretation of UHC must therefore attend to effective coverage: whether people can obtain acceptable, competent care without financial hardship. This moves the ethical analysis beyond the presence of an insurance card and towards the institutional circumstances under which equal status is an actionable capability. It also connects justice to quality. Offering disadvantaged populations nominal access to unsafe, disrespectful, or clinically ineffective services does not encourage solidarity; it distributes a diminished form of care.

Justice also complicates a purely autonomy-centered account of humane care. Unlimited responsiveness to one person's preferences can reduce opportunities for others when resources are finite. Daniels links fair access to the protection of normal opportunity, while Powers and Faden place health within a broader account of social justice and well-being. Public health ethics makes collective action, proportionality, transparency, and justification central because population policies distribute both benefits and burdens. The relevant moral quality is no longer only the choosing patient but the citizen or resident whose access depends on pooled institutions. Humanistic concern at this layer involves not closeness during the encounter, but whether anyone can intercede in the encounter.

The normative field widened when access to care, which became a public obligation rather than a private transaction. Constitutional tenets, human-rights instruments, the founding of the NHS, UHC policy, theories of health justice, public-health ethics, capabilities, and the Sustainable Development Goals all locate moral responsibility at the population and governmental levels (*42–54*). Universal coverage is not synonymous with humanistic care, but it can institutionalize equal moral worth, solidarity through the pooling of risk, access according to need, and protection from financial ruin.

Effective coverage is the relevant ethical standard. Formal eligibility can coexist with distance, waiting, discrimination, language barriers, catastrophic co-payment, or poor-quality care. Conversely, rapid technical access may deliver interventions that are unsafe or unresponsive to need. Justice therefore joins coverage to quality and makes resource allocation ethically apparent. Every system constrains care; the question is whether constraints are necessary, proportionate, transparent, revisable, and attentive to those who bear their burdens.

7. When humanistic reliability became an organizational responsibility

Patient safety moved responsibility from the purview of the individual to reliance on an organized effort.

Traditional responses to error often searched for the careless practitioner. Systems thinking instead examined how equipment, staffing, hierarchy, workflow,

communication, and organizational culture made harm possible or failed to prevent it. The shift did not absolve individuals; it recognized that exhortations to 'be more careful' cannot control hazards designed into care. Crossing the Quality Chasm then linked moral aspiration to system design through six aims—safe, effective, patient-centered, timely, efficient, and equitable—defined as expected aspects of care rather than optional virtues of exceptional clinicians. Donabedian's structure-process-outcome model offered a durable way to connect arrangements with performance. Quality improvement created an applied repertoire for embedding values in routine, even as measurement introduced new ethical problems of its own.

At this point, the consistent incorporation of humanistic values increasingly became an organizational effort. Safety depended on reporting systems and team communication; respect depended on privacy, access, and complaint procedures; equity depended on data and accountability; patient-centeredness depended on whether schedules, records, payment, and care pathways could respond to lives rather than isolated episodes. Accordingly, research on organizational ethics expanded beyond bedside consultation to examine an institution's mission, resource allocation, business conduct, leadership, and policies.

That institutional pivot also changed what counts as an ethical failure. Lack of an explanation may reflect an individual lapse, but it may also reflect appointment lengths, productivity targets, a poorly designed interpreter workflow, or records that ignore the patient's stated priorities. Repeated disrespect is rarely adequately explained by a collection of unrelated bad attitudes. It can be produced by architecture, queue management, visiting rules, billing practices, or the lack of accommodation for a disability. Once such patterns are evident, asking clinicians to compensate through goodwill alone transfers responsibility downward. Organizational ethics is therefore not simply clinical ethics conducted by a committee. It examines how policies distribute attention, discretion, burdens, and standing, and whether leaders create the material conditions under which professional obligations can be fulfilled.

The practical significance is evident when institutional redesign prevents harm at scale. Pronovost and his colleagues' work on catheter-related infections combined evidence, checklists, supply access, team norms, and measurement—demonstrating how safer care requires more than individual vigilance. Berwick's account of patient-centeredness similarly demanded that systems place the patient's needs at the center even when this challenges professional or organizational convenience. WHO's global patient-safety plan now treats safety as coordinated action across governments, organizations, clinicians, patients, and communities. Once harm is structurally produced, humane intent without organizational capability is ethically insufficient.

Patient safety, improvement of quality, organizational ethics, safety culture, learning-health-system ethics, resilience research, and the Francis Inquiry shifted analysis from isolated error to the structures that shape action (*55–69*). An institution can fail ethically even when no individual intends harm: appointment systems can curtail explanations, rigid procurement requirements can result in an unsafe baseline, productivity rules can crowd out deliberation, and fragmented records can obscure the achievement of goals. The Mid Staffordshire inquiry made this problem unusually evident by showing how a penchant for targets, poor listening, and failed governance could coexist with formal structures of care, and it prompted enhanced arrangements for inspections, openness, and candor in England. Repeated disrespect is rarely explained by a collection of unrelated attitudes.

This shift changes accountability. It neither excuses individual negligence nor treats organizations as persons. It recognizes distributed agency: leaders, boards, payers, regulators, designers, and clinical teams control different aspects of care. Organizational ethics is thus more than a hospital committee. It examines how policies distribute time, attention, discretion, risk, and standing, and whether the institution enables professionals to meet their obligations.

Table 1 summarizes the six responsibility domains and the cross-cutting technological layer, their normative emphases, institutional actors, and characteristic failure modes.

8. From patient choice to the life of the person

A patient may have rights and still be forced to choose among disparate clinical options.

Attention to the person's life changes the perspective from which care is evaluated. Patient-centered care includes a biopsychosocial view, recognition of the patient as a person, shared power, and a therapeutic alliance. Shared decision-making operationalizes part of this agenda by combining evidence about options with knowledge of what matters in a particular life. ACP adds time. Contemporary definitions emphasize an ongoing process of identifying values, discussing goals and preferences, communicating with trusted others, and revisiting choices as illness and circumstance change. Success is therefore not gauged by the filling out of documents. The more stringent test is whether care remains concordant with a person's goals when illness limits one's input, increases dependence, or makes trade-offs unavoidable.

Multimorbidity and population aging expose the limits of disease-centered performance. A guideline-consistent plan for each disease can produce a collectively burdensome regimen that serves no coherent life goal. Goal-oriented and patient-priorities approaches therefore ask what outcomes are preferable or to be avoided and then align interventions across conditions. This does not turn medicine into satisfying preferences; clinicians still

Table 1. Domains in the expanding architecture of humanistic responsibility

Domain	Normative emphasis	Institutional actors	Characteristic failure
Physician	Virtue, fidelity, compassion	Professional formation, codes, peer standards	Humane care depends on exceptional individuals
Patient	Autonomy, dignity, rights	Consent law, privacy, ethics review, complaint and redress	Procedural signatures without agency
Population	Justice, solidarity, equity	Pooling, eligibility, benefit design, public-health policy	Formal coverage without effective access
Organization	Safety, quality, accountability	Reporting, teamwork, measurement, leadership, learning systems	Blame, silence, a predilection for procedures
A person's life	Goals, relationships, continuity	SDM, ACP, multimorbidity and palliative-care pathways	Checklist completion without concordance
Healthcare system	Access, integration, governance	Primary care, financing, allocation, coordination, community participation	Fragmentation or unjust constraint
Technology governance (cross-cutting)	Distributed accountability across all domains	Developers, data stewards, vendors, procurement, institutions, professionals, regulators, affected publics	Moral off-loading, deskilling, surveillance, and scalable bias

judge feasibility, safety, and proportionality. It changes where moral attention is directed from an isolated decision to a life unfolding through care.

Japan provides a useful institutional illustration. The Ministry of Health, Labour and Welfare's revised guidance for decision-making in the final stage of life emphasizes the person's decision, repeated discussion, multidisciplinary care, relief of suffering, and reconsideration as wishes change. The vocabulary is often framed as ACP, decision-making support, or end-of-life care rather than 'medical humanities.' That difference is analytically important: humanistic values may be most consequential when they are incorporated into ordinary rules and expectations. The question is not whether a system frequently touts humanistic ideals but whether it provides continuity, time, and legitimate roles for persons and families to articulate what matters.

Institutionalization can nevertheless hollow out the practice it intends to protect. Consent can become a signature, shared decision-making a checklist, and advance care planning a document target—a form of box-ticking bioethics in which evidence that a task occurred substitutes for evidence that a person was heard. Defensive medicine may convert communication into liability management, while the burden of indicators can displace the unhurried listening on which interpretation depends. Standardization remains necessary for coordination and accountability, but documentation should facilitate the preservation of records, continuity, and deliberation rather than stand in for them. Measures should therefore examine comprehension, the opportunity to disagree, elicitation of goals, continuity across settings, and concordance between care and the person's priorities. Institutions are a necessary precursor but not sufficient as the ultimate result; repeated implementation in clinical settings, reflection, and revision keep routines connected to humanistic purposes.

Patient-centered care, shared decision-making, ACP, decision aids, evidence-based choice, goal-oriented care, multimorbidity practice, and palliative-care policy expand the focus of attention to a life rather than an isolated decision (*70–84*). The critical shift is one from only asking which option the patient selects to asking why that option matters within the context of relationships, burdens, identity, and future goals.

9. Different national pathways to institutionalization

Comparative analysis should resist treating national systems as moral embodiments. Labels such as market, Beveridge, Bismarck, or social insurance identify financing and governance patterns, not complete ethical cultures. Each country consists of multiple payers, providers, professions, laws, and local variations. Moreover, cultural explanations easily become circular: autonomy is attributed to individualism because the system emphasizes choice, and individualism is then inferred from the emphasis on choice. Law, political coalitions, professional power, payment, administrative capacity, and demographic change are more tractable pathway mechanisms.

In the United States, rights, professionalism, research oversight, litigation, assessment of quality, and consumer choice became prominent institutional factors. And yet a plural insurance system links access to public eligibility, employment, private coverage, and network rules. Comparative evidence continues to show the tension between high spending and differences in access and outcomes. The pathway therefore has a strong penchant for formal autonomy and organizational innovation

but is continually contested at the level of distributive justice. Market coordination does not eliminate the state; Medicare, Medicaid, regulation, tax subsidies, and public research are central. Nor does consumer choice guarantee meaningful agency when prices are opaque or coverage constrains options.

The United Kingdom institutionalized universalism through a tax-funded national service and made primary care an organizing entry point. The ethical significance of gatekeeping is ambiguous but not inherently anti-humanistic. It can limit the immediate choice of a specialist, and yet it can also provide continuity, prioritization by clinical need, and stewardship of shared resources. The NHS pathway joins individual dignity and involvement to a public ethic in which everyone counts and finite resources should be used fairly. Its recurrent problems—waiting, workforce strain, and capacity—show that humane entitlement to care must be matched by operational capability.

Japan demonstrates why the framework must be layered rather than sequential. Universal health insurance was achieved in 1961, before autonomy and informed consent became highly evident in Japanese bioethics and clinical policy. The system preserves comparatively broad patient choice and lacks a compulsory British-style GP gatekeeper, while national fee scheduling and price revision regulate costs and incentives for care providers. Its trajectory therefore placed social coverage and administrative price control before the later formalization of some patient-rights and shared-decision-making practices. Aging, hospital dependence, long-term care, and community-based integrated care have subsequently shifted responsibility in the direction of continuity and the person's life.

China illustrates compressed institutionalization. Expansion of basic insurance, patient-rights legislation, public-hospital reform, quality and safety regulation, strategic purchasing, enhancement of primary care, integrated provision of care, and aging-related care have advanced within a few decades. These layers do not move at the same speed. Broad coverage can coexist with regional inequality; legal rights with communication gaps; hospital capability with weak continuity; payment reform with incentives that remain difficult to align. The appropriate question is not whether China has imported a Western system but how multiple values are being simultaneously incorporated within a vast mixed system.

Across all four cases, common values are achieved *via* different institutional means. Autonomy may be upheld by courts, professional guidance, or statute; solidarity among the public by taxes or social insurance; safety by accreditation, reporting, or administrative regulation; and personhood by primary care, ACP, community integration, or long-term-care policy. Institutions can also conflict: free access may weaken coordination; gatekeeping may delay needed care; a uniform fee schedule may suppress prices while encouraging volume; market competition may mobilize investment while fragmenting accountability. A humanistic assessment must therefore ask not which national model is morally superior but how its arrangements convert values into reliable capabilities and how its trade-offs are justified.

Every system manages scarcity, even when rationing is not named explicitly. The relevant differences concern where constraints appear and who has the authority to impose them: price at the point of use, coverage exclusions, referral gates, waiting lists, workforce distribution, designed benefits, technology assessment, or payment schedules. These mechanisms have distinct ethical profiles. A visible queue can be politically contentious but publicly reviewable; a high deductible can preserve nominal choice while silently deterring care; free provider choice can respect preference while weakening continuity; and strict regional planning can improve distribution while narrowing local responsiveness. Comparative ethics should elucidate these constraints. The question is not whether a system limits choice, cost, or supply but whether the limitation is necessary, proportionate, transparent, revisable, and attentive to those who carry its burdens.

Comparative research on healthcare systems shows why national models should not be treated as moral embodiments (*85–97*). The United States, United Kingdom, Japan, and China combine financing, law, professional authority, public administration, and market mechanisms differently. Each model varies internally. Those examples are used here to identify institutional actors and ordering effects, not to rank cultures.

Primary sources support a selective milestone comparison. The United States pathway includes a clinical-rights milestone—Canterbury v Spence in 1972—alongside research ethics and quality-system events (*5,28,30,38,55,108*). In the United Kingdom, the 2013 Francis Inquiry marks a system-level reckoning with an organizational culture that allowed targets and institutional self-protection to displace listening, safety, and compassion (*69*). Japan's Ministry of Health, Labour and Welfare instituted universal insurance in 1961 and it publicly assumed the risk of long-term care through the 2000 Long-Term Care Insurance system and the 2002 Comprehensive Measures for the Promotion of Medical Safety (Iryō Anzen Suishin Sōgō Taisaku). The 2002 measures explicitly reframed safety from dependence on individual effort to a system-wide responsibility and required hospitals and clinics with beds to establish safety policies, internal reporting, committees, and staff training; designated hospitals also required safety managers, organizational elements, and consultation services. Later milestones include the 2007 end-of-life decision-making process guideline, its revisions, and health/long-term-care integration (*98–102*). Chinese primary sources document the 2009 reform framework, the 2015 hierarchical-care policy, the 2016 contracted family-doctor policy and Healthy China 2030, the 2018 regulation on

medical disputes, and statutory protection of dignity, privacy, and coordinated care in the Basic Healthcare and Health Promotion Law (*97,103–107*). The timeline additionally draws on the Common Rule and the three United Kingdom statutes governing capacity and service integration (*108–111*). These nodes are illustrative, not exhaustive.

Japan is the clearest reason to reject a universal sequence: social justice through UHC was institutionalized before autonomy gained some traction in national bioethical discourse. This review describes China's recent trajectory as 'compressed institutionalization': expansion of coverage, patient-rights legislation, safety regulations, payment reforms, restructuring of primary care, integration, and aging-related policies proceeded in overlapping decades. This is an interpretive concept proposed by the present review, not an established country classification. In both instances, formal rules can precede capability and national policy can coexist with regional and organizational variation.

Table 2 compares the institutional actors and tensions in the four pathways; Figure 2 displays selected milestones without implying a causal sequence.

10. Laying the groundwork for a humanistic healthcare system

The architecture yields a working definition but not a

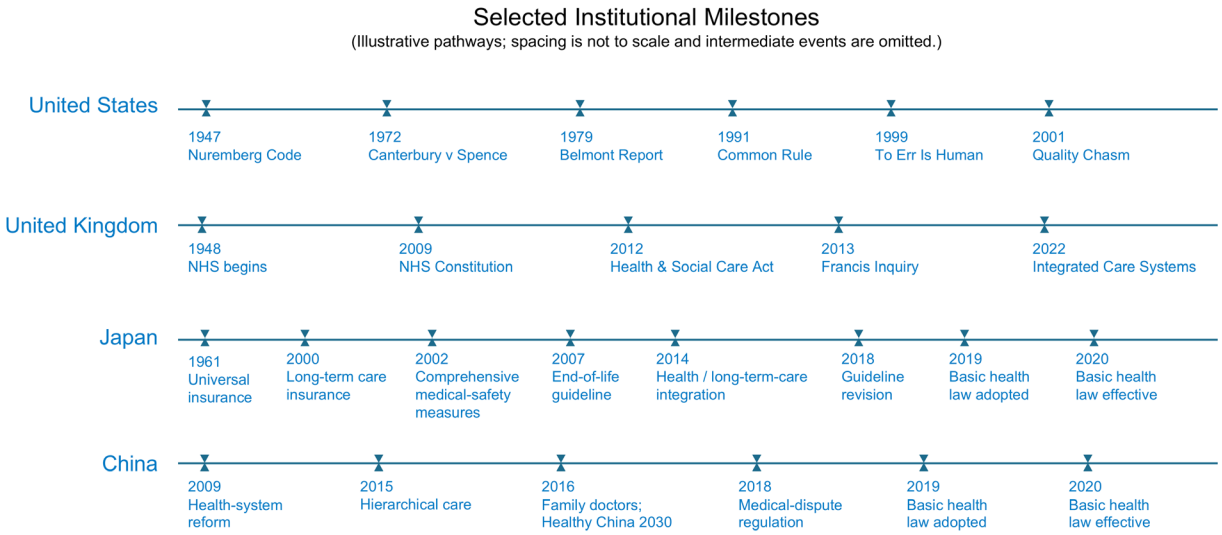


Figure 2. Selected institutional milestones in four national pathways. The timeline is illustrative and deliberately selective. The 1999 label denotes the release of To Err Is Human, cited in the 2000 National Academies Press edition. It is neither a stage model nor a claim of linear or sufficient causation. Dates identify formal policy or legal events rather than first local adoption, complete implementation, or demonstrated effects. The Japanese 2002 milestone is the Ministry of Health, Labour and Welfare's Comprehensive Measures for the Promotion of Medical Safety, which framed safety as a system-wide responsibility and specified organizational infrastructure. Intermediate revisions, including Japan's 2015 end-of-life guidance revision, are omitted. Japanese and Chinese milestones were checked against publicly accessible government materials in the original languages. Sources for Figure 2: (*5,28,30,38,45,46,55,69,89,90,97–111*).

Table 2. Illustrative national pathways for institutionalizing humanistic values

Pathway	United States	United Kingdom	Japan	China
Rights and agency	Canterbury, consent, research regulation	Statutory rights, NHS Constitution, capacity law	Professional and policy guidance; later explicit SDM/ACP	Statutory dignity, privacy, consent; uneven implementation
Justice and access	Plural public-private coverage	Tax-funded NHS universalism	1961 universal social insurance	Rapid expansion of basic insurance after 2009
Safety and quality	IOM-led systems movement; accreditation and measurement	Francis Inquiry; quality, safety, and candor in institutions	2002 Comprehensive Measures for Medical Safety; organizational duties	2018 dispute-prevention regulation; quality reform
Continuity and life goals	SDM/ACP initiatives within fragmented delivery	Primary-care gatekeeping and personalized care	2000 LTCI; end-of-life guidance; community integration	Hierarchical care, family-doctor contracting, integrated county systems
Dominant tension	Choice and innovation versus cost and inequity	Universalism and stewardship versus capacity and waiting	Free access versus coordination and hospital dependence	Broad coverage versus regional variation and hospital centrality

new label for every well-run service.

The WHO's framework on integrated, people-centered health services supplies the clearest policy analogue. It calls for a shift from systems designed around diseases and institutions to systems designed around people and communities, requiring changes in how services are funded, managed, and delivered. Subsequent guidance on continuity and coordination translates that orientation into practical relationships across time, providers, and settings. The Declaration of Astana similarly positions primary health care as a foundation for universal, integrated, accessible services and empowered communities. These are not simply communication reforms; they alter the architecture of care.

Integration must nevertheless be judged normatively. A highly integrated system could be efficient but coercive, coordinated but inattentive to dissent, or data-rich but discriminatory. Multilevel integration frameworks clarify the clinical, professional, organizational, and system dimensions involved, while quality research on healthcare systems insists that coverage without competent, respectful care is insufficient. Primary care reform likewise requires financing, workforce allocation, information, accountability, and ties to the community, not merely renaming a first-contact service. Humanistic design therefore combines capabilities with safeguards.

The framework suggests six evaluative questions. First, dignity: do routines recognize persons as more than illnesses, transactions, or risk scores? Second, agency: can people understand, influence, refuse, and reconsider decisions? Third, justice: are access, burdens, and benefits distributed fairly? Fourth, safety: does the organization anticipate, learn from, and redress harm? Fifth, life alignment: can care respond to goals, relationships, and a cumulative treatment burden? Sixth, accountability: can institutions explain how financing, prioritization, and technology shape outcomes, and can the people affected contest those decisions? These questions deliberately cross levels. A respectful encounter inside an exclusionary system is not enough; neither is universal access to unsafe or depersonalized care.

The practical implication is a shift from exhortation to design. Humanities education may encourage more profound insights and deliberate judgment, but organizations must give clinicians time, continuity, interpreters, functional teams, trustworthy data, and incentives compatible with humane care. Patient rights must be exercisable by people with limited literacy or power. A commitment to equity must appear in benefit design, geographic allocation, and quality measurement. ACP must be linked to records and emergency pathways. Complaints must produce learning. The test of a humanistic system is not whether every conflict disappears, but whether its structures make humane action more probable, evident, and accountable.

This definition also provides a starting point for research. The layers can be studied as formal tenets, organizational capabilities, and experienced outcomes. Researchers might examine whether legal rights are exercisable, whether safety training reaches the bedside, whether financing facilitates continuity, whether patient-reported priorities alter plans, and whether communities participate before decisions on allocation are reached. Comparative work should trace institutional actors and countervailing mechanisms rather than scoring countries on a single cultural scale. Longitudinal work could ask when a value is incorporated, when it is displaced by competing incentives, and how crises expose the difference between symbolic and operational tenets. Such inquiry would help prevent 'humanistic' from becoming a flattering label and instead make it a verifiable claim regarding system performance.

Continuity, primary care, multilevel integration, and quality system design provide the closest established policy foundations for the proposed concept (*6,7,112–116*). A humanistic healthcare system is one in which dignity, agency, equity, safety, participation, and person-defined goals are embedded not only in encounters but in organizational design, financing, resource allocation, provision of care, and governance. The term is developed here as a systematic analytical framework rather than attributed to the WHO, offered as a newly coined phrase, or presented as settled terminology.

The model identifies six cumulative responsibility domains—physician, patient, population, organization, a person's life, and healthcare system—plus technology governance as a cross-cutting layer. The domains are not ontologically identical. Physician and patient are relational loci; population is distributive; organization is meso-institutional; a person's life is a temporal-biographical horizon; and healthcare system is macro-institutional. The concentric arrangement in Figure 1 depicts analytical scope and accumulation, not chronology, stage progression, or a simple micro-to-macro ladder. A person's life is a clinical-biographical re-entry that reconnects institutional capability to the trajectory of someone's life. Technical systems run through every domain, reshaping bedside judgment, organizational workflow, financing, allocation, and public governance.

The concept also requires a boundary without creating a binary label. A humanistic healthcare system is an ideal and a directional continuum: real systems combine humanistic and dehumanizing features and must negotiate legitimate cost, capacity, public health interests, and distributive constraints. Dignity, agency, and person-defined life goals function as normative floors that cannot be overridden solely by efficiency, throughput, aggregate utility, or institutional revenue. A humanistic system is not one without trade-offs; it is one in which trade-offs are bounded by these normative floors and governed through transparent, proportionate, contestable, and revisable procedures. When values conflict, a more humanistic system makes reasons public, includes the

individuals affected, provides proportionate safeguards and compensation, permits contestation and appeal, remedies harm, and revises policy. Efficiency may serve humanistic ends when it frees up time or resources while respecting these floors; technically competent performance is not sufficient.

The framework also leads to operational questions and measurable constructs. Agency can be assessed with patient-reported shared-decision-making instruments such as the SDM-Q-9, comprehension checks, supported-choice availability, and exercisable appeals (*72,81*). Life alignment can be examined through documented goals, patient-reported outcomes and treatment burden, continuity, and concordance between the care delivered and the priorities expressed (*76,77*). Safety can be examined through a non-punitive reporting culture, learning cycles, disclosure, imposition of a duty of candor, and remediation (*55–69*). Measures should be interpreted together: a high rate of documentation without comprehension, trust, or concordance may indicate formalistic rather than humanistic performance. No single indicator should be treated as a performance target in isolation; potential measures need to be triangulated with qualitative experience, patient narratives, and a reflexive review of their behavioral effects.

Table 3 translates the ideal into evaluable domains and potential health-services indicators.

11. Algorithms and cross-cutting technology governance

Artificial intelligence makes distributed responsibility unusually apparent.

An algorithm may appear in one consultation, but its training data, included variables, interface, procurement, validation, monitoring, and update process are dispersed among developers, vendors, hospitals, payers, regulators, and governments. WHO guidance accordingly assigns duties across this network and emphasizes autonomy, well-being, safety, transparency, accountability, inclusiveness, equity, responsiveness, and sustainability. The central danger is moral off-loading: a technically mediated recommendation is treated as if no accountable person or institution selected its proxy, threshold, workflow, or acceptable error. The problem is not hypothetical. A widely used population-health algorithm reproduced racial inequality because expenditure stood in for health need. Black-box performance also creates a tension between predictive accuracy and reasons attributable to patients and professionals. Digital systems can therefore expand capabilities while limiting transparency, standing, or discretion.

A humanistic healthcare system therefore requires algorithmic accountability as a cross-cutting governance layer, not a specialized add-on. It should define which decisions may be delegated, preserve meaningful human review, test performance across affected groups, document intended use, monitor drift and downstream effects, provide routes for contestation and redress, and disclose when automation materially shapes care. Most importantly, it should ask whether the objective being optimized results in human benefit. Efficiency, utilization, revenue, and predicted risk are not self-justifying goals. The relevant question is whose life is improved, who has standing but is ignored, and who

Table 3. Proposed domains for evaluating a humanistic healthcare system

Domain	Core question	Illustrative indicators
Humanistic boundary	Are trade-offs constrained by normative floors and open to correction?	Published reasons; affected-party participation; equity impact assessment; appeal completion; remediation time
Dignity	Are persons recognized beyond diagnosis or transaction?	Respectful-care experience; privacy; discrimination; accommodation
Agency	Can people understand, influence, refuse, and revisit decisions?	SDM-Q-9 or CollaboRATE; teach-back comprehension; decision-aid reach; supported choice; appeal
Equity	Are access, burdens, and benefits distributed fairly?	Effective coverage; financial protection; geographic and group gaps
Safety	Does the system anticipate, learn from, and repair harm?	Non-punitive reporting climate; closed learning cycles; candor compliance; disclosure and remediation
Life alignment	Does care respond to goals, relationships, and a cumulative burden?	Goal-concordant care; patient-reported outcomes; continuity; treatment-burden measures
Participation	Do patients and communities shape design and allocation?	Co-design; governance representation; public justification
Accountability	Can institutional and algorithmic decisions be explained and contested?	Transparency; audit; human review; redress; monitoring

Note: Candidate measures should be triangulated with qualitative experience, patient narratives, and reflexive review of behavioral effects. No single indicator should be used as an isolated performance target.

bears the brunt of an error when the system scales.

Technology does not have moral qualities or automatically bear responsibility. The technological ecosystem denotes the distributed governance network of developers, data stewards, vendors, procurers, healthcare system leaders, professionals, regulators, and the members of the public that are affected that selects objectives and controls development, deployment, monitoring, and redress (*8,117–124*). Its responsibilities cut across all six domains rather than appearing only after them.

Three requirements are central. First, algorithmic objectives encode values: expenditure, utilization, throughput, predicted risk, and revenue are not self-justifying proxies for human benefit. Second, responsibility must not be off-loaded to a model when institutions selected the data, targets, workflow, and thresholds. Third, non-delegable decisions, meaningful human review, subgroup validation, monitoring, contestability, and redress must be specified. These requirements connect technological accountability to clinical judgment and system governance without turning AI ethics into a separate area of medicine.

12. From theory to system capability: Implementation challenges and strategic priorities

The synthesis can be stated as three propositions. Proposition 1—expansion: responsibility for humane care has extended beyond the individual clinician into relational, distributive, organizational, biographical, institutional, and technological domains. Proposition 2—institutionalization: humanistic values are more reliable when translated into rights, capabilities, financing arrangements, and accountability mechanisms, but institutionalization can also hollow them out. Proposition 3—plural pathways: there is no universal sequence or single model of a humanistic healthcare system; countries institutionalize overlapping values *via* different means and in different orders.

Some accounts of declining humanism at the bedside may overlook a change in visibility: obligations once described mainly as professional character have been translated into rights, organizational routines, coverage, safety systems, care pathways, and governance. This does not make dehumanization a category error. Institutionalized tenets and dehumanizing experiences can coexist, and modern institutions can produce new forms of distance, exclusion, surveillance, and moral harm. The framework therefore asks where responsibility is located and how reliably values are incorporated rather than inferring humane experience from the existence of policy.

Institutionalization also has deleterious effects that a humanistic framework must confront rather than treat as implementation noise. Auditing can convert complex care into what is documentable in a reporting system, while targets can redirect attention toward the measured proxy and away from the person whose need led to it. Standardization is similarly ambivalent: protocols encourage coordination and reduce unwarranted variation, and yet their local enactment redistributes discretion and may suppress contextual knowledge. Foucauldian analyses of targets has revealed the disciplinary effects of apparently neutral performance regimes; ethnography of Indian primary care has shown how unrealistic targets and punitive accountability can produce 'outward performance'—documentation that portends to describe achievement while organizational capability deteriorates (*125–128*). These critiques do not invalidate measurement. They establish a stronger design requirement: indicators must remain answerable to experience, encourage learning rather than theatrical compliance, and be withdrawable when their behavioral effects defeat their stated purpose.

The four pathway cases also place limits on the framework's global claim. High-capacity states can formalize rights, reporting, and appeal through legal and administrative infrastructures that are absent, plural, or donor-tailored elsewhere. Research on street-level bureaucracy in low- and middle-income countries has shown how frontline discretion mediates policy under scarcity; work in Nigeria has located people-centered governance across operational, collective, and constitutional levels; studies of community accountability caution that nominal participation does not reliably shift power; and decolonial scholarship asks who defines the values, evidence, and institutional model being exported (*129–132*). A humanistic healthcare system cannot therefore be a high-income template applied at lower cost. In settings where communities, informal providers, local governments, and external funders share authority, the relevant architecture may be polycentric. The framework's durable question is narrower and more portable: where does consequential power sit, how does it affect persons and populations, and what are the avenues for achieving standing, making revisions, and obtaining redress?

The framework also clarifies recurring false opposition. Gatekeeping is not inherently inhumane; it may facilitate continuity and stewardship or become an access barrier. Patient choice is not inherently humane; nominal freedom may coexist with unaffordable or fragmented options. Standardization can depersonalize, but it can also result in safety independent of records. Efficiency can crowd out attention, and yet waste can itself be unjust. Ethical evaluation must examine the design, justification, distributional consequences, and correctability of each mechanism.

The implication for education is not to replace humanities teaching with systems science. Clinicians need narrative, historical, ethical, and interpretive capacities precisely because institutions cannot anticipate every case. But education that asks individual clinicians to compensate for structurally unsustainable workloads or incoherent incentives results in a shifting of moral culpability. Professional dictates and institutional reform

should be treated as complements.

The relationship is also bidirectional. Supportive institutions safeguard time, standing, continuity, and psychological safety, making ordinary humane conduct more feasible and less dependent on heroism. And yet institutions can become unjust, rigid, or captured by financial and political interests. In such settings, moral courage, conscientious objection within professional limits, whistleblowing, collective advocacy, and solidarity with patients may become the final safeguards of humanistic value. Individual virtue does not replace system capability, but it can diagnose institutional failure, resist the normalization of harm, and prompt reform. System capacity and professional agency should therefore be understood as a recursive relationship: institutions cultivate or suppress virtue, while moral practitioners maintain, contest, and redesign institutions.

Trust is not an eighth domain. It is a cross-cutting relational outcome—and a fallible indicator—of successful institutionalization. Virtue may encourage trust in clinicians; exercisable rights and transparent redress may encourage trust in institutions; safety training may encourage organizational trustworthiness; solidarity may encourage confidence in fair pooling; and contestable technology may encourage warranted reliance. Trust should not be demanded from patients or the public, however. Systems must earn it through competence, honesty, inclusion, and redress, while remaining subject to scrutiny and appeal (*40,41,65,66*).

In research, the layers can be examined as formal tenets, organizational capabilities, and experienced outcomes. Future work should study whether rights are exercisable, safety training reaches the bedside, payment provides continuity, priorities alter plans, and communities participate before decisions om allocation are reached. Comparative work should track actors and countervailing mechanisms rather than score countries on a single cultural scale.

13. Limitations

This review is integrative and seeks to lay out a theory, but it is not exhaustive. Targeted searches, purposeful selection, and citation chaining cannot provide the coverage guarantees of a systematic review, and the corpus was not screened to estimate effects. Landmark English-language scholarship may privilege Anglo-American categories even though Japanese and Chinese primary policy documents and critical literature from lower-resource settings were consulted. The United States, United Kingdom, Japan, and China are contrasting pathway cases, not a representative global sample; scholarship from Africa and South Asia was used to challenge the model but cannot substitute for additional country histories. Figure 2 omits intermediate events—including Japan's 2015 revision of end-of-life decision-making guidance—and its dates do not document initial local adoption, uniform implementation, or causal effects. Institutionalization can occur locally before national policy or remain symbolic after legal enactment. Finally, the six-domain architecture and cross-cutting technology layer require validation with patients, families, clinicians, managers, communities, and policymakers, and particularly where governance is polycentric or resources are severely constrained.

14. Conclusion

Modern medicine has not simply transitioned from humanistic physicians to humanistic systems; responsibility for humane care has been distributed among clinicians, patients, institutions, financing arrangements, governance structures, and technological infrastructures. Professional virtue remains necessary, but it is joined by patient rights, social justice, organizational reliability, attention to a person's life, system governance, and accountable technology. These domains appear in different orders and through different national means; common values do not require a single model of a healthcare system.

A humanistic healthcare system is therefore an ideal and a directional continuum, not a binary designation. It protects normative floors of dignity, agency, and life alignment from being overridden solely by efficiency or revenue, while making unavoidable trade-offs transparent, proportionate, contestable, remediable, and revisable. Institutions are necessary but not sufficient: without humane implementation in clinical settings, they can degenerate into formalism; without institutional support, humane practice is vulnerable. The practical task is to align professional agency, organizational capability, public accountability, and technology governance so that care can be made humane by design and corrected when it is not.

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