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Description of the term humanization in care by nursing professionals

Caracterização do termo humanização na assistência por profissionais de enfermagem

Caracterización del termo humanización en la atención por profesionales de enfermería

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Abstract

Objective: To discover the sociodemographic data that characterize the professionals who participated in the research, to identify the meanings assigned by nursing professionals to the terms humanization and non-humanization and to analyze them in the light of the precepts of the National Humanization Policy. **Methods:** Exploratory descriptive method. A questionnaire with closed and open questions was applied to 70 nursing professionals. To analyze the material, statistical-descriptive resources and the content analysis technique were used. **Results:** Humanization is characterized bypersonal, subjective, moral, ethical and relational features. The valuation of technical procedures, the biomedical model and emerging problems in the area of health care characterize the non-humanization. **Conclusion:** It is concluded that nursing care in accordance with the precepts of the National Humanization Policy is in accordance with the meanings of the participants in the care, who should therefore be considered as co-authors in the health-disease process.

Keywords: Humanization of assistance; Nursing; Nursing, Team.

Resumo

Os objetivos deste estudo foram conhecer os dados sociodemográficos que caracterizam os profissionais participantes da pesquisa, identificar os significados atribuídos por profissionais de enfermagem aos termos humanização e não humanização e analisá-los à luz dos preceitos da Política Nacional de Humanização. **Métodos:** Exploratório-descritivo, com aplicação de questionários com perguntas fechadas e abertas a 70 profissionais de enfermagem. Para análise do material utilizaram-se recursos estatístico-descritivos e técnica de análise de conteúdo. **Resultados:** Aspectos pessoais, subjetivos, morais, éticos e relacionais caracterizam a humanização. A valorização da técnica procedimental, do modelo biomédico e dos problemas emergentes na área de atenção à saúde caracterizam a não humanização. Conclui-se que a assistência de enfermagem voltada aos preceitos da política nacional de humanização é aquela que vai ao encontro dos significados dos próprios partícipes do cuidado, devendo, portanto, ser considerada como coautora no processo saúde-doença.

Palavras-chave: Humanização da assistência; Enfermagem; Equipe de enfermagem.

Resumen

Objetivo: Conocer los datos sociales y demográficos que caracterizan los profesionales participantes de la investigación, identificar los significados atribuidos por profesionales de enfermería a los termos humanización y no humanización y analizarlos a la luz de los preceptos de la Política Nacional de Humanización. **Métodos:** Exploratorio-descriptivo, con aplicación de encuestas con preguntas cerradas y abiertas a 70 profesionales de enfermería. Análisis estadístico-descriptivo y de contenido. **Resultados:** Aspectos personales, subjetivos, morales, éticos y relacionales caracterizan la humanización. La valoración de la técnica procedimental, del modelo biomédico y de los problemas emergentes en el área de la atención a la salud caracterizan la no humanización. **Conclusión:** Se concluye que la atención de enfermería direccionada a los preceptos de la política nacional de humanización es aquella que se va al encuentro de los significados de los propios partícipes de la atención, debiendo, por lo tanto, ser considerados como coautores en el proceso salud-enfermedad.

Palabras-clave: Humanización de la atención; Enfermería; Grupo de enfermería.

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INTRODUCTION

In the literal sense of the word, humanization means the act or effect of humanizing, which in turn means "making human; granting human traits or conditions to; making benevolent, gentle; showing oneself benevolent, compassionate, generous"[1]. When we refer to humanization in interpersonal relations, we can recover these denotative senses of the word, that is, we can describe humanization as something innate in human beings, an instinctive feeling all humans possess, giving rise to acts and actions of charity, goodness, adopting the good as a precept of social relations. When considering different instances, however, the humanization concept becomes much broader.

In the philosophical sense, humanization is a term that originates in the philosophical current of Humanism[2], which aims to understand man and the understanding of man in society. In psychoanalysis, humanization relates to subjectivity issues. In the moral branch, the term can evoke humanitarian values, such as respect, solidarity, compassion and empathy[3].

In post-modern times, the use of the term humanization refers to movements to recover forgotten or succumbed human values due to the social reordering of the age, as a result of multinational capitalism and economic globalization[3]. In the light of this situation, in the mid-20th century, questions of human rights, bioethics, environmental protection and citizenship started to be discussed in response to this situation, proposing a reconstruction of reality.

In the health area, humanization was first discussed in the 1980's, when this term started to gain strength and adepts, due to the agreements of the anti-asylum struggle in Mental Health[4] and the feminist movement for the humanization of delivery and birth in Women's Health[5] that came to the surface, entailing significant repercussions that registered these moments as historical landmarks of the start of the discussion about humanization in health.

Since then, hospitals have started to develop so-called "humanizing" actions, which from the beginning were aimed at transforming the hospital environment through the implementation of play activities, leisure, entertainment or art and improvement in the services' physical appearance, but which neither reached the organization or management levels of the work nor people's lives[3]. Today, from different perspectives, humanization can be understood as: "Humanistic and ethical principle of conduct; Movement against institutional violence in health; Public policy for healthcare and management of the Unified Health System (SUS); Auxiliary method for participatory management; and Care technology in healthcare"[3:254].

In the context of public policies, in the year 2000, based on different humanization initiatives in healthcare practice, the Ministry of Health crated the National Program for the Humanization of Hospital Care (PNHAH)[6], aiming to disseminate the ideas of humanization with strong emphasis on the transformation of interpersonal relations, through the deepening of the subjective issues inherent in this type of relation, as well as to stimulate a new health practice, proposing improvements in the quality of care and in the work conditions.

As humanization comprises all healthcare levels and not just the hospital context, in 2003, the Ministry of Health reviewed the PNHAH and launched the National Humanization Policy (PNH), which covers the entire SUS network, involving transformations in the care and management models of health services and systems[7].

The PNH adopts humanization as a cross-sectional policy, that is, "as a set of principles and guidelines that turn into actions in different services, health practices and different instances of the system, characterizing a collective construction"[7]. In other words, the PNH proposes a participatory or co-management[8], in which the workers and users are included and valued in the health production process, implying a change in the users' care culture and in the management of the work processes.

Since then, the theme humanization in nursing care has started to gain room in the health context and, therefore, it is fundamental to understand how this theme is addressed in different nursing care spheres (hospital institutions, health services and the community), what meanings the nursing professionals are attributing to the term "humanization" and how these meanings influence their practices.

Therefore, the objectives in this research area to: Get to know the sociodemographic data that characterize the nursing professionals working in hospital care who participated in the research; to identify the meanings the nursing professionals attribute to the terms "humanization" and "non-humanization" and to analyze these meanings in the light of the premises of the National Humanization Policy.

METHOD

An exploratory and descriptive study was developed, involving nursing professionals from three sectors of a public and federal university hospital in the city of Rio de Janeiro, in June and July 2011.

The scenarios were chosen after a panoramic survey of the service heads and clinical and surgical hospitalization sectors. Due to structural modifications that demanded the reorganization of the hospital services, the decision was made to select those sectors that were fully operative during the months when the data were collected. Therefore, the following sectors were selected: Medical Clinic, Surgical Clinic and Intensive Care Unit (ICU).

The inclusion criteria were: male and female, active in direct care delivery to hospitalized users in the morning or afternoon shifts. The following exclusion criteria were applied: subjects exclusively working in management activities, or on leave of absence of any kind, or on holiday during the data collection period. Out of 116 professionals who complied with the inclusion criteria, 70 accepted to participate in the research.

For the data collection, an instrument was used with closed questions, for multiple choice, dichotomous or scale of importance answers, addressing sociodemographic variables and others related to the research question. The questionnaire also included open questions that allowed the professionals to discuss their conceptions in the choice of their options, if they found that appropriate.

A pilot test was applied to five professionals with a view to detecting their understanding about the questions and their applicability, after which the necessary adaptations were made. These professionals were not included in the research, and therefore disregarded.

The data obtained from the objective questions were processed through descriptive statistical analysis, using Epi Info software version 3.5.2 from December 2010, and presented in the form of tables and graphs, elaborated in Microsoft Excel 2010 for better visualization. Content analysis was applied to the data from the open questions, described as a complement to the analysis of the objective results.

In compliance with National Health Council Resolution 196/96, approval for the research project was obtained from the Research Ethics Committee at Anna Nery School of Nursing, Universidade Federal do Rio de Janeiro, protocol 098/2009. All subjects signed the Consent Form.

The authors of the excerpts transcribed from the open questions were identified through the letter N for nurse, T for nursing technician and A for nurse's aide, followed by the letter F for female or M for male, accompanied by Arabic numerals corresponding to the number of the questionnaire.

RESULTS

About the subjects' general characteristics

Table 1. Profile of the subjects according to gender, age range, state/city of origin, marital status, religion, profession, time since graduation and activity sector. Rio de Janeiro, 2011

Characteristics	N	%
Gender		
Female	60	85.7
Male	10	14.3
Total	70	100
Age Range (in years)		
18-28	15	21.4
29-39	17	24.3
40-49	18	25.7
50-60	19	27.1
61 years or older	1	1.4
Total	70	100

Continued Table 1.

Characteristics	N	%
State/City of origin		
Rio de Janeiro	56	80
Paraíba	3	4.3
Bahia	2	2.9
Rio Grande do Sul	1	1.4
Belém do Pará	1	1.4
Ceará	1	1.4
Minas Gerais	1	1.4
Salvador	1	1.4
São Luis	1	1.4
Not informed	3	4.3
Total	70	100
Marital Status		
Married	34	48.6
Single	19	27.1
Divorced	8	11.4
Lives with fixed partner	4	5.7
Widowed	4	5.7
Separated (consensual)	1	1.4
Total	70	100
Religion		
Catholic	30	42.9
Evangelic	25	35.7
Spiritist	5	7.1
Atheist	2	2.9
Messianic	1	1.4
Candomblé	1	1.4
Jehovah's Witness	1	1.4
Not informed	5	7.1
Total	70	100
Profession		
Nursing Technician	32	45.7
Nurse	25	35.7
Nurse's Aide	13	18.6
Total	70	100
Time since Graduation (in years)		
1-2	5	7.1
3-4	8	11.4
5-6	6	8.6

Continued Table 1.

Characteristics	N	%
6-7	5	7.1
8-9	6	8.6
10-11	9	12.9
More than 11	31	44.3
Total	70	100
Family Income (in minimum wages)		
Up to 1 MW	3	4.3
Between 1 and 2	5	7.1
Between 2 and 3 MW	8	11.4
Between 3 and 4 MW	7	10
Between 4 and 5 MW	9	12.9
Between 5 and 6 MW	11	15.7
Morethan 7 MW	27	38.6
Total	70	100
Activity sector		
Medical Clinic	39	55.7
ICU	16	22.9
Surgical Clinic	15	21.4
Total	70	100

Source: Info Version 3.5.2/2010.

Description of the study object (humanization) by the study participants

Figure 1. Distribution of variables that describe the term humanization by nursing professionals at a public federal university hospital in the city of Rio de Janeiro. 2011

What describes the term humanization	N	%
Practice of all professionals	69	88.6
Professional/client relation	60	85.7
Personal characteristics	54	77.1
Look at the needs	51	72.9
Dialogue	49	70
Attentive listening	43	61.4
Holistic view	26	37.1
Empathy	21	30
Moral and ethical values	17	24.3
Subjective issues	13	18.6
Others	3	4.3

Figure 2. Distribution of variables that do not describe the term humanization by nursing professionals at a public federal university hospital in the city of Rio de Janeiro. 2011

What does NOT describe the term humanization	N	%
Mechanic care	56	80
Treat the disease and not the human being	55	78.6
Lack of communication	54	77.1
Technique for the sake of the technique	31	44.3
Exhaustive hour load	23	32.9
Institutional problems	19	27.1
Material resources	19	27.1
Evident technology	15	21.4

DISCUSSION

Most participants were female, 60 (85.7%), while 10 (14.3%) were male, in accordance with the characteristics of the nursing profession. This characteristic is related to the history of the profession, as its organization demanded people with attributes that were considered intrinsic of the female nature, such as discrete, silent, charitable and unselfish care. The female gender issue in the Brazilian nursing profession is considered in the context of the Carlos Chagas Reform, in the 1920's, when the public health physician Carlos Chagas triggered the visit of a group of North American nurses to prepare nurses in order to promote the control of the poorest population through health surveillance and education. Then, the first exclusively female School of Nursing was created, which at the same time valued technical and unselfish care, considered as an extension of the female role at home, performing functions linked to care for other people[9].

Returning to the analysis of Table 1, no significant difference was found in the age range data of the study subjects, varying between 18 and 60 years. The significant majority comes from Rio de Janeiro (80%). The most prevalent marital status was married (48.6%), followed by single (27.1%). The following religions were declared: Catholic (42.9%), evangelic (35.7%), spiritist (7.1%), messianic, candomblé, Jehovah's witness (1.4% each). Lower incidence levels were found for participants who did not declare any religion (7.1%) and 2.9% described themselves as atheist. As regards the profession, 45.7% are nursing technicians, 35.7% nurses and 18.6% nurse's aides.

Considering the time since graduation, the prevalence of professionals who had graduate more than 11 years earlier was identified (44.3%). This situation calls for reflection and discussion as, if the PNH was implemented more or less nine years earlier, how did these professionals add these precepts

to their professional practices? How was this theme addressed in their education? Studies indicate that few investments in nursing are dedicated to the study of humanization in the teaching-learning process. Also, the education process is flawed with regard to humanization as a study focus in undergraduate programs[10,11].

Although this movement towards humanization exists, driven by public policies, not all professionals are aware of this situation and, therefore, it becomes even more difficult to modify their practices, which are rooted in values, concepts and attitudes that are compatible with their educational background. This does not mean that professionals who graduated before the implementation of the PNH are not aware of, have no knowledge about and do not apply the premises of the PNH in their practices, onthe opposite. It simply highlights the discussion about the importance of reflection, for the professionals who graduated before as well as after the PNH, and also for those who are still in their undergraduate or technical nursing program, about the valuation of the care subjects, as single, autonomous beings who need to play a protagonist role in the care and management decisions, permitting the co-authorship of clients, professionals and managers in the care process. Thus, the PNH is put in practice, making the nursing care problem-solving, effective and humanized.

Also regarding Table 1, the subjects' family income ranged between one and more than seven minimum wages, with most subjects being ranked in the category of more than seven minimum wages (38.6%). The subjects' distribution according to the activity sector was as follows: 39 subjects (55.7%) work at the medical clinic, 16 (22.9%) at the Intensive Care Unit-ICU and 15 (21.4%) at the surgical clinic.

The second part of the questionnaire included questions about how the nursing professionals understand and describe humanization and non-humanization in nursing care and its repercussions in care practice.

The first question in this second part of the questionnaire referred to whether the professionals, at some moment in his/her education or professional practice, got to know the word humanization. It was identified that 82.9% was familiar with the term, 12.9% partially knew it and 4.3% did not know it. Next, the subjects were asked to describe humanization and non-humanization, through a semi-open question with objective alternatives, accompanied by possibilities to discuss the theme.

Figure 1 reveals that humanization was described as a practice of all professionals (88.6%), as it is based on a professional/client relation (85.7%), includes personal characteristics (77.1%), looks at the needs (72.9%), uses dialogue (70%), attentive listening (61.4%), a holistic view (37.1%), empathy (30%), moral values (24.3%) and the inclusion of subjective issues (18.6%), among others.

Humanization as a practice of all professionals rescues one of the guiding principles of the National Humanization Policy, which is "the strengthening of multiprofessional teamwork, stimulating transdisciplinarity and grupality"[7]. Hence, when teamwork takes place based on the premises of humanization, valuing each subject who participates in care, identifying his/her skills and limitations and understanding that being in his/her social role, loaded with beliefs, values and conducts, health care starts to go beyond the "simple" maintenance and restoration of health and starts to include actions that consider the subjects in their individuality, visualizing the individual as a whole and not as parts of a machine that is going through maintenance.

Humanization as a relation between professional and client is frequently explored in health research on the theme, mainly in nursing[10-13]. It should be kept in mind that the art of care takes place through this relation between professional and clients. It becomes illogical to think of care without considering this type of relation, due to the fact that nursing care is directly correlated with care for the other, for a human being, who thinks and interacts with the context, whether through verbal, non-verbal or para-verbal means, but in constant interaction not only with fellow humans, but also with the surrounding nature. Therefore, this branch emerges once again in this study, demonstrating a strong trend to correlate humanization with personal, subjective issues, characteristic of rational and intellectualized human beings.

Therefore, the next branches that emerged in the choice of the professionals to describe humanization were: personal characteristics, looking at needs, dialogue, attentive listening and holistic view. "Looking", "talking" (related to dialogue), "listening" and "seeing" are human characteristics that physiologically permit human contact with the external world, allowing with social relations. The verbs "looking" and "seeing" should be highlighted, which can have different meanings based on each reader's interpretation. To give an example, one can look at a beautiful flower in the garden but not see a small ladybug sitting on it. This reference to the different meaning of the words was included exactly to be able to discuss the emerging dialectic relation between the terms "looking at the needs" and "holistic view". In this respect, the meaning the professionals attributed to looking as well as to the holistic view was understood as identifying and attending to the need, but within this view of the individual as a whole. This discussion is pertinent when it is questioned how a professional can describe a single term using two opposite situations.

Therefore, the content the professionals expressed about the theme is included, which confirms the understanding about this matter:

> *Respecting fellow human beings, respecting as a whole, the opinion, religion, thinking of the client. It means seeing the client as a whole, respecting his fears. (NF-02)*
>
> *Care given to the entire human being/patient, in a holistic way, never classified according to the disease, or with any "pre-concept". Verifying his needs and intervening wherever possible. (NF-32)*

He should be considered as a whole, however, also understanding his moments of fears, doubts, constraints. (TF-40)

It means treating the patient as a whole, not only the disease or the human body, but care to humanize my work, knowing that there is pain, cold, fear, all of these feelings in a single body. This being cannot be ignored, thus, high-quality care can be delivered and my work can be done efficiently. (AF-48)

Other descriptions of humanization were empathy, moral and ethical values, subjectivity and other issues that are part of moral and ethical values, but which needed highlighting as they appeared several times in the interviews, such as respect, citizenship and solidarity.

When one discusses empathy, almost associated, happening simultaneously, the idea of humanization emerges, due to the fact that, when an individual puts himself in another person's place, comprehension is possible and action in accordance with the subject's own expectations, permitting an encounter of values and conceptions. Moral and ethical values, then, dictate the best way to articulate care, and respect for the other, solidarity and the understanding of the civil rights of the subjects in the health-disease process permit the implementation of humanization in compliance with the premises of the PNH as a whole. Finally, but not less important, the professionals characterized the subjective issues as love, thinking, the valuation of the being, establishment of bonding, attention, wanting, understanding and kindness. Although not quantitatively relevant, these issues are strongly linked as a qualitative value, which appears in the subjects' discourse as issues inherent in humanization:

[What characterizes humanization in care is] Love for fellow humans. You need to put love in what you do. (TF-19).

I believe that humanization happens when you give attention, kindness, understanding. Otherwise, you will not understand how the patient is doing and why he is reacting that way. (AM-20).

In Figure 2, on the opposite, words/expressions/phrases are informed which the professionals did not describe as corresponding to the term humanization, such as: mechanic care (80%), treating the disease and not the human being (78.6%), lack of communication (77.1%), technique for the sake of the technique (44.3%), exhaustive hour load of work (32.9%), institutional problems (27.1%), material resources (27.1%) and evident technology (21.4%).

Both professionals and academics and faculty members criticize and inquire about these issues with regard to care humanization[10,12,13]. They observe that, as a result of the coldness of the mechanical act and the disequilibrium between the technique and the human factor, in combination with institutional problems (such as the exhaustive hour load and the quality and quantity of material resources), the identity and history of the individual are forgotten, characterizing depersonalized, fragmented and inhuman care that does not facilitate the implementation of humanization at all[11-14]. In this study, this situation took the form of cases the professionals want to modify in their reality, changes which, according to the professionals, will permit better care.

In this study, the professionals care that, first, infrastructural changes are needed (62.9%), followed by modifications in staff numbers (55.7%) to attend to the clients' demands, in the hour load (52.9%) and in the quality of materials (51.4%).

These matters should gain importance in the discussions among professionals, clients and managers as, when professionals meet conditions at their health service that favor their work process, they will constantly attempt to precipitate the level of the institution, that is, the requests for changes that emerge here gain a meaning intrinsic in these issues, which is the professional's satisfaction. This aspect can influence the quality of care positive or negatively, depending on how the professional will bear this situation, in combination with the double work journey, traffic in the city, personal problems, among so many other conflicting situations in our reality.

Good humanized care can only be delivered when material is available of good quality and staff who like what they do. (AF-15)

According to me, to be effective, humanized care should be "two-way", that is, professional/client and institution/professional. (AF-28)

Good use of time, resources and sufficient staff to respond to the clients' needs, also making the professional involved feel satisfied. (NF-34)

Care integrated with good technical, administrative and personnel support. (NF-35)

Hence, the conception of humanization not only focused on the client, but also on the professional gains relevance. This creates room for encounters between them, which permit the exchange of feelings and ideas, articulating strategies to achieve humanized care, as cited in one of the questionnaires.

The professional has to feel good. The institution needs to be concerned with that. First take care of the professionals. (NF-07)

Another interesting issue that emerged less frequently but is extremely relevant was the 'evident technology' as a variable that does not characterize humanization. Returning to the subjects' profile, it is observed that 39 of them (55.7%) work at the medical

clinic, 16 (22.9%) at the Intensive Care Unit (ICU) and 15 (21.4%) at the surgical clinic, contexts that somehow demand the use of technologies, focusing on hard technologies here, represented by concrete material, such as equipment, permanent or consumer furniture[15]. Despite this allusion to the fact that technology is strongly intertwined with dehumanization, studies have been deconstructing this idea, demonstrating that humanization and technology should be inextricable and complementary in favor of care[12,13,16].

It should be kept in mind that, in Figure 1 and Figure 2, the subjects could mark more than one option, so that the general total does not correspond to the total number of subjects and the relative total does not correspond to 100%.

FINAL CONSIDERATIONS

It is concluded that the nursing professionals described care humanization as a practice of all professionals, as it is based on a professional/client relation, includes personal characteristics, looks at the needs, involves dialogue, attentive listening, holistic view, empathy, moral and ethical values and includes subjective issues like love, thinking, the valuation of the being, bonding, attention, wanting, understanding and kindness.

On the opposite, the professionals characterize non-humanization as a mechanical act, treating the disease and not the human being, with a lack of communication, only acting based on technique, the exhaustive hour load, institutional problems, problems related to material resources and evidencing technology.

Therefore, it is proposed that humanized care in compliance with the principles of the National Humanization Policy comprises all participants in the care process, turning them into co-authors, protagonists of this process, including personal, subjective, moral, ethical and relational issues. Conducts that do not attend to these premises should be extinguished, such as those related to the valuation of procedures, mere "know-how" (as opposed to "how to do" - which adds the diversity of bio-psycho-socio-spiritual factors of care), the focus on the biomedical model and emerging problems in healthcare, which make it impossible to deliver high-quality care.

Therefore, further research is fundamental with a view to deepening these aspects in different care contexts, attempting to identify the convergences and divergences of these meanings, as well as to expand the debate among professionals, clients and managers about humanization, proposing strategies within the reach of each reality, so that all stakeholders understand the relevance of humanized practices that go beyond the manuals of the Ministry of Health but remain more focused on the field of thought than action.

This study is limited by the setback of the situation at the study hospital, which restricted the sectors for data collection. Nevertheless, the results are relevant as the proposed objectives were achieved, contributing to the fundamentals and the art of nursing care.

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