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ORIGINAL ARTICLE

LIMITS AND POSSIBILITIES FOR EFFECTIVE HUMANIZED ASSISTANCE IN THE PERCEPTION OF HEALTH PROFESSIONALS

LIMITES E POSSIBILIDADES PARA EFETIVAÇÃO DA ASSISTÊNCIA HUMANIZADA NA PERCEPÇÃO DOS PROFISSIONAIS DE SAÚDE

LÍMITES Y POSIBILIDADES PARA EFECTIVACIÓN DE LA ASISTENCIA HUMANIZADA EN LA PERCEPCIÓN DE LOS PROFESIONALES DE SALUD

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ABSTRACT

Objective: to identify the possibilities and difficulties for the execution of humanized care in the hospital. ***Method:*** an exploratory and descriptive study of qualitative approach, accomplished with 31 health professionals from different categories of the Municipal Hospital Humberto de Queiroz de Pereiro/CE. For the production of data, semi-structured interviews were used and for analysis, content analysis technique, in the form of thematic analysis. The research had the project approved by the Research Ethics Committee, CAAE 0154.0.428.000-12. ***Result:*** many difficulties in realization of humanization were identified, where the most cited were the lack of a good professional relationship and the lack of infrastructure, materials and instruments, and many possibilities were mentioned. ***Conclusion:*** it is necessary to co-responsibility of teaching, care, management and social control, because with the activeness of the parties the execution of humanized care will be present. ***Descriptors:*** Humanization of Assistance; Health Professionals; Hospital Services.

RESUMO

Objetivo: identificar as possibilidades e dificuldades para efetivação da assistência humanizada no ambiente hospitalar. ***Método***: estudo exploratório e descritivo, de abordagem qualitativa, realizado com 31 profissionais de saúde de diferentes categorias do Hospital Municipal Humberto de Queiroz de Pereiro/CE. Para a produção de dados, foram utilizadas entrevistas semiestruturadas e, para análise, a Técnica de Análise de Conteúdo, na modalidade análise temática. A pesquisa teve o projeto aprovado pelo Comitê de Ética e Pesquisa, CAAE nº 0154.0.428.000-12. ***Resultado***: identificou-se uma multiplicidade de dificuldades para realização da humanização, os mais citados foram a falta de uma boa relação interprofissional e a carência de infraestrutura, materiais e instrumentos, ao passo que muitas possibilidades foram mencionadas. ***Conclusão***: faz-se necessária a corresponsabilidade entre ensino, atenção, gestão e controle social, pois com a atuação efetiva das partes a efetivação do cuidado humanizado se fará presente. ***Descritores*:** Humanização da Assistência; Profissionais da Saúde; Serviços Hospitalares.

RESUMEN

Objetivo: identificar las posibilidades y dificultades para efectuar la asistencia humanizada en el ambiente hospitalario. ***Método***: estudio exploratorio y descriptivo, de enfoque cualitativo, realizado con 31 profesionales de salud de diferentes categorías del Hospital Municipal Humberto de Queiroz de Pereiro/CE. Para la producción de datos, fueron utilizadas entrevistas semiestructuradas y para análisis la Técnica de Análisis de Contenido en la modalidad análisis temático. La investigación tuvo el proyecto aprobado por el Comité de Ética e Investigación, CAAE número 0154.0.428.000-12. ***Resultado***: se identificó una multiplicidad de dificultades para realización de la humanización, los más citados fueron la falta de una buena relación interprofesional y la carencia de infraestructura, materiales e instrumentos, donde muchas posibilidades fueron mencionadas. ***Conclusión***: se hace necesaria la corresponsabilidad entre enseñanza, atención, gestión y control social, pues con la actuación efectiva de las partes, efectuar el cuidado humanizado estará presente. ***Descriptores*:** Humanización de la Asistencia; Profesionales de la Salud; Servicios Hospitalarios.

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INTRODUCTION

Health services have been losing with great intensity the human dimension of care, especially the hospital that has historically been marked by reductionist actions, which are centered in the biological, the technical procedures and guided by hegemonic clinical model.[1] The subject, in this logic, is considered object of the professional action and as an object is depersonalized and treated equal to a matter that does not suffer, does not love, does not feel, does not have wills and dreams.[2]

Over the years, SUS (Unified Health System) was created, product of dissatisfaction and social struggles, legitimizing for population health as a right of every citizen, ensuring by public policies, as well as a service operating before the universality, comprehensiveness and equity. Therefore, it is proposed to ensure quality care, redirecting a care model.[3]

Meanwhile, it is important to note that the proposal of SUS has been going on in some areas, but in others it is still not real[4] because some setbacks remain rooted in health services, especially in the hospital environment, where rancidity is strongly present, since the actions developed in this space are mirrored in the clinical model, which focuses on the disease rather than the patient, and distance from the social determination of the health/disease.[5]

As a helped support to SUS assistance, the National Hospital Care Humanization Program (PNHAH) was established in 2000. Later in 2004, the Ministry of Health moves forward publishing the National Policy of Health Humanization in Brazil (PNH)[(6)], which defines the humanize care as "To offer quality care articulating the technological advances with welcoming, improving care environments and working conditions for professionals".[6,7] In this way, it is undeniable the importance of health professionals in the implementation of a new culture of care in hospitals, subsidized by the principles and guidelines of humanization.

The relevance of this study lies in the necessity to establish humanized care in this health space where curative, reductionist and individualized practices remain solidified and disjointed in other ways to intervene in the individual. In this way, patients benefit from a mechanized assistance that does not meet the real needs of life and health of the subjects, being at the mercy of a superficial care.

This study will contribute to a better understanding of the challenges and possibilities for its operation, providing opportunities to approach health professionals with the issue and the placement of this in society, for the humanization of health care in the hospital environment, being something that deserves to be reflected, debated and disseminated to its possible applicability in the service. Based on these facts, the aim of this study is:

- To identify, from the experience of health professionals, the possibilities and difficulties for the execution of humanized care in the hospital.

METHOD

Article crated from the monograph << ***Health care in the hospital environment based on humanization*** >> presented to the Graduate Program in Nursing, Advanced Campus Maria Elisa Maia de Albuquerque, from the University of Rio Grande do Norte, in Pau dos Ferros-RN, Brazil.

Exploratory and descriptive study of qualitative approach. The health professionals view about the difficulties and possibilities for realization of humanized care from their real experiences were explored, articulating production of discussion with the guiding principles of PNH.

The study place was the Hospital Humberto de Queiroz, in the municipality of Pereiro/CE. To carry out data collection, a semistructured interview was used with 31 health professionals, including doctors, nurses, biochemists, pharmacists, physical therapists, nursing assistants and technicians who met the following inclusion criteria: be professional health of the Municipal Hospital Humberto de Queiroz; be in operation for at least one year in the study place and to volunteer for research. Failure to meet these criteria resulted in the exclusion of professionals.

The research took place from June 2012 to December 2012, proceeded individually and according to the time available for health professionals. The interviews were recorded in electronic equipment like MP3 and transcribed. The identification of

participants´ speech was used with "PS" acronym, followed by numbers.

Data analysis was performed through the content analysis technique, in the thematic analysis mode, which prompted two categories: the multiple difficulties for the execution of humanized care - several views and professionals visualize possibilities of making humanized care - the new views, could contemplate the results of the study articulated to the humanization in health knowledge. Data on the sample characterization and obstacles to effect the humanization are presented in simple statistics, demonstrating the findings in tables with frequency and percentage.

The research project was approved by the Ethics and Research Committee of the State University of Rio Grande do Norte on CAAE No. 0154.0.428.000-12, on February 17, 2012.

RESULTS AND DISCUSSION

♦ Hospital and health professional´s characterization

The Municipal Hospital Humberto de Queiroz, located in Pereiro/CE is a general hospital of basic and medium complexity working 24 hours with spontaneous and referenced customer flow.[8] The unit has 20 beds, distributed as follows: eight beds in the clinic medical, eight beds in the surgical clinic, five beds in obstetrics with rooming and five pediatric beds. It has 50 registered health professionals and provides outpatient care, hospitalization, diagnosis and therapy support (SADT) and emergency, which are guaranteed by SUS.[8]

The study had the participation of 31 mid-level and high education health professionals, being 62% of the total staff of the hospital. The characteristics of the universe captured are shown in Table 1.

Table 1. Health professional´s characteristics.

Professional characteristics	N	%
Total of respondents	31	100
Men	8	25,8
Women	23	74,2
Age from 20 to 29 years old	6	19,35
Age from 30 to 40 years old	14	45,16
Older than 40 years old	11	35,48
Practice below 5 years	9	29,03
Practice between 5 and 10 years	9	29,03
Practice over than 10 years	13	41,93
Doctors	4	12,9
Nurses	4	12,9
Physiotherapists	3	9,67
Biochemists	3	9,67
Nursing Technicians	8	25,8
Nursing Assistant	8	25,8
Pharmaceutical	1	3,22

♦ The multiple difficulties for the execution of humanized care - several views

Many difficulties were pointed out by health professionals for the implementation of humanized care, showing several views that professionals were able to demonstrate for the statements in the interview.

In this perspective, it was found that 77.41% (24 professionals) visualize difficulties and 22.58% (seven professionals) say they encounter obstacles to promoting humanized care. Thus, it is clear that there is significant representation for the difficulties, and consequently many limiting factors were listed, which might help in questioning the subject under study.

Following (Table 2), the various limiting factors, cited by interviewees, for implementation of humanized care, which are configured as public health problems.

Table 2. Factors for implementation of humanized care.

Difficulty Humanization factors	n	%
Lack of a good relationship among professionals	14	38,88
Lack of physical infrastructure, materials and instruments	11	30,55
Lack of training for professionals	3	8,33
Great demand in health services	3	8,33
Lack of society awareness	2	5,55
The absence of counter-reference	1	2,77
Standardization of medicines	1	2,77
Little workforce	1	2,77

There were 36 responses obtained. The largest representation of the limiting factors of humanization was the lack of a good relationship among professionals and they with patients, which certainly will result in quality of care or health production and subjects.[9]

The answers that bring this aspect as difficulty, only prove how fragile is the health service under study, as interpersonal relationships are configured as factors by which they depend, mostly value linked to the education. The following statements reaffirm the explained in Table 2.

> *There is a great difficulty for promoting humanized care that is the lack of good interaction among health professionals, health facilities and the community. It is necessary to be a breakthrough in the sense that it has more respect and more compromise between the two segments: patients and professionals. (PS-4)*

> *There are many difficulties, as the distance that the nurse has of the patient in the hospital, for what we see is more technicians among patients, performing the procedures [...] detachment of the medical professional with the patient, making that the link is broken there when the patient enters into the sector, often the doctor does not even look at his face, asks for the name and then only prescribes and ready. So the headache becomes equal to everybody, no asking, to differentiate, to relate. (PS-8)*

In response to the difficulty of personal relationships, there is the detachment of otherness and thus of humanized practices because as some researchers[10] say "the unfavorable climate has progressively contributed to the relations of disrespect among the professionals and for generating a fragmented and increasingly dehumanized care".

The lack of physical infrastructure, materials and instruments, representing 30.55% of the answers, harms in potential, the quality of care. These factors are basic members in the provision of humanized care and, therefore, when absent, destabilize the service, professionals and the patient will have a difficult and probably insufficient care.

Therefore, "Rethinking care infrastructure is essential in terms of human resources, mainly providing conditions for the proper professional practice and subsidizing a safe, ethical and quality "[9:726]

On the lack of infrastructure, suitable materials and instruments, was mentioned as limits even to a lesser percentage, the little workforce and the great demand in health services, which corroborate the destabilization of the three segments: service, professional and patients. Thus, there is another problem for the health system, so that if demand is high and in return the manpower is scarce, the service condition will be impaired because, besides assisting all, certainly not all needs will be met by cooperating to the chaos in the public health service, which has a long way to ensure SUS principles and humanization of care.[11]

Os fatores limitantes apontados pelos entrevistados estão expostos nas presentes falas:

The limiting factors mentioned by respondents are exposed in these words:

> *The great demand that prevents you to serve well the patient, for example, I'm attending one person, but there are 30, 40 waiting. This ends up compromising the work, by which to meet all I need to direct the service and it undermines the attention because it ends up not being integral. (PS-1)*

> *Especially the huge demand and the limited time to meet with quality to everyone, regardless of the little workforce. Here, for example, is one nurse to serve more than 17 beds, so attention tends to be decreased. (PS-30)*

Some professionals have advanced in the discussion when associated the lack of training and society´s awareness as a barrier to the effectiveness of humanizing practices. From this perspective, there is the statement:

> *I believe that lack of training is a difficulty, another would be the lack of knowledge of the population about their rights, about what is right, for example, many patients come for consultation with the emergency cases that are clearly outpatient, that the services of primary care could solve. This ends up stressing the doctor and the nursing staff. Thus, the lack of awareness and knowledge of the population is a problem for the humane care. (PS-21)*

It is understandable that the low investment in the training of workers, particularly with regard to participatory management and teamwork, reduces the chances of a critical process, contextualized and creator of new actions in health as well as being essential for the patients to understand their rights and duties so that their autonomy and participation can be ensured.[6]

The PS-8 interviewed adds a present problem in health services and that causes a disruption of monitoring and continuity of care: the absence of counter-reference.

> *Another difficulty is the lack of counter-reference for patient´s monitoring, we reference and often have no answers. (PS-8)*

The humanized care is depreciated, the weaknesses of reference and counter-reference system adversely affect the principles of comprehensiveness and continuity of care, leading to an excessive concentration of medium and high complexity in a single system.[3] Without the counter-reference, the continuation treatment and information about the patient become unknown to other professionals, providing the mismatch with SUS policy and the humanization policy.

The standardization of medicines used in health services is also an obstacle, a fact that often prevents the professional meeting the patient in a personalized way, prescribing medications according to what is offered and not what is real need. This reality is advocated by humanized care entering on what is called vertical integration of care and standardization of regulations.

> *One limitation is the standardization of medication made by the Ministry, this already has a list of medicine that can be purchased and the resource has also been standardized, is that thing from top to bottom through the RENAME (National List of Essential Medicines), then comes a list with a spreadsheet ready with prices, and we will only apply with respect to the amount that will be required for the year, but it's all tied to standard drugs, noting that if you get away from the drug list that is to buy , you are punished for the oversight and the audit office. (PS-15)*

The issue of vertical integration of certain actions and standards is mainly in care, because in that case there is an adjustment to the actual needs of patients, with the forms of production and social reproduction.[5] PS-15 participant brings to the discussion the pharmacological matter, however, the vertical support is present in many contexts.

Faced with what was presented as limiting factors for humanizing practices, it is observed that the respondents show several views to the topic. However, it does not mean that humanization is impossible to be implemented in the reality of health care or even that obstacles be able to make the humanization a problem, because despite the many limits, we are backed by a health care system that even full of weaknesses, ensures comprehensive care by law, equitable and universal, which undoubtedly opens the way for that the difficulties are resolved and the possibilities happen. So many problems of the health system need to be reviewed, analyzed and discussed by professionals, managers and patients through a participatory management, committed to the social and SUS principles.

♦ Professionals visualize possibilities of making humanized care - the new views

It is noticed that the actors were able to raise new perspectives on the facilities found to carry out humanized practices, which are configured as important possibilities. Meanwhile, the views need to be better exploited and matured by professionals because although they have presented relevant responses to the process, they showed a very simplistic and elementary discussion to the matter in question, which contains a complex, contextual and comprehensive discussion mainly when it comes to the possibilities for humanized care in the hospital environment.

Using Table 3, the facilities pointed out by health professionals to promote humanization are shown, in total 36 responses.

Table 3. Possibilities for humanized care.

Possibilities for humanized care	n	%
Have the materials and tools needed	14	38,8
A good relationship with the professionals	7	19,4
Love of workers by the chosen profession	5	13,8
Willpower of professionals	5	13,8
The staff is trained and responsible	3	8,3
Professional experience	1	2,7
The management be present in service	1	2,7

The lack of materials and tools needed for conducting efficient care was noted by respondents as a difficulty to execute the humanization. Likewise, the presence of these resources is seen as possibilities for 38.8% of the findings that together with the 19.4% of responses, which depict the good relationship with the professionals show up as major facilitators to achieve the humanization, as identified in the reports:

> *Many facilities. There is no lack of medicines, materials and tools necessary for good care, there is organization, PPE are available to the professional, if there is any negligence is by the professional. The structure is good, transfers occur very easily because ambulances are available and the communication with the direction and the secretary is satisfactory. So for every need is soon resolved. The relationship with professionals is good, healthy and certainly facilitates the humanized care. (PS-6)*
>
> *A good relationship with my colleagues and with patients is a facility that I find to perform a more humane care. (PS-30)*

In a comparative analysis of the difficulties and possibilities pointed out, it is realized that two things are repeated, being understood either as possibilities or as difficulties. Thus, part of the respondents view the presence of materials, tools and a good relationship between co-workers, forming up then as possibilities for realization of humanization. But another part of the survey universe, say there is a lack of these resources and that there is not a good relationship.

From this perspective, it appears that the actors demonstrate different ways of analyzing reality, or even that professionals have difficulties to understand and explain what actually happens. It is also noted that even though there are those who consider the aspects under consideration as possibilities for humanized care, it is important that there is more investment, since, as it was made clear, there is also significant representation that discusses the lack of materials, tools and a healthy relationship in the workplace. Thus, it lets clear the need to invest in these supports for the development of humanized care, this reality also found in other studies:

> *65% of respondents wish to institutional changes that include a qualified staff and necessary materials that meet the demand in quantity and quality, to facilitate humanized care. They still aspire to communication and ongoing interaction among doctors and nurses in the discussion of cases of patients, facilitating knowledge of the condition to apply to implementations while maintaining a personalized and appropriate therapy for humanized care.*[12:257].

Even as possibilities two factors were observed, with the same percentage of the total responses and are very interconnected: love of the chosen profession and the workers willpower to carry out a humanized work. These aspects will certainly pave the way for that assistance be of quality competence and ethical, political and social commitment.

> *An important feature is the good will, the will of the professional to provide good care, because if the professional does not want, he can attend the best university to discuss humanization, it does not [...] so it meets the patient with ignorance, he pays no attention, no reports, no question. (PS-8)*
>
> *Love for my job, what I do, it makes me play a good job (E-9).*

For the above factors be kept over the years, it is crucial, within the dynamic service, something simple to implement and when present, make satisfactory results to both the professional as the care. Therefore, it is motivation, that is, to ensure the conditions for health professionals feeling encouraged to work and to engage with satisfaction all the functions that are their responsibility.

There are ample motivation strategies, such as respect the other for work relations; be solicitous; thank whenever you need someone; praise for the professional quality of the work and the effort; encourage professional development and the extra days off, which are fundamental for professionals to work with dedication, avoiding faults and unpleasantness.[12] Upon

the options presented, there are motivating attitudes that do not require much of health services, which can be implemented by the professionals in their daily work to carry out humanized actions.

A small representation put that experience was a facility, as well as the fact that the staff be trained and responsible. It is worth noting that even with little representation in the responses, these factors corroborate the humanization because experience provides professional maturity and security in developed practices, likewise, a well-prepared team facilitates the actions being reflections of a comprehensive care.

With only 2.7% of the statements (Table 3), there is the factor management as a possibility of humanization of health care, as it can be seen in the report:

> *The direction is very present, when we need, it does not put obstacles, facilitating us to provide a better care, more humane. (PS-22)*

Participatory management deserves to be mentioned in this discussion, PNH provides, in its general strategies, promoting actions that lead to worker participation in health decisions, so that they feel participants in the process. Then being a collective work in search of planned actions, strategic and resolving, implying thus in a better quality of management and therefore attention. In this perspective, "The proposed humanization supposes a collegial and participatory management model, based on a culture of communication".[6:18]

Some factors that are important for the execution of humanization were not visualized during the interview as the intersectoral approach in care; work in a well-run team, interdisciplinarity; the ambience in the service; the creation of links; improvement of working conditions; and the political commitment to population health.[6]

It is added that "Humanization should cover both objective questions (management, improvement and professional quality) and subjective questions (self-knowledge, empathy and interpersonal relationships) and the decent living conditions as goals to be pursued".[13]

Thus, as a possibility to humanization in hospitals, the formation of humanization Working Group (GTH) and the Committee of Humanization can still be entered, which will work disseminating the principles of humanization for all workers and fight for enabling environments the humanized actions to be present in the health service.[7]

Other criteria are highlighted in some research and can be considered as suggestions to be incremented in the studied reality: investment in organizations, creating more favorable and welcoming environments; creation of new protocols, aimed at training a less authoritarian and institutional culture focused on patient´s needs; combination of the public health approach to the medical and social approach; adherence to a hospital quality program; preserving the integrity of "being" perceived in its entirety and investment in architecture and hospital decoration.[1]

There are many mechanisms that provide humanization. However, they should be present in the hospital environment for the dynamic service to forward for humanizing practices. It is highlighted that for this design occurs, changes are needed in the health system, that with its own institutional gaps create barriers that block these suggestions.[12] In this process, it should be discusses the education of health professionals, because it sets while "key point" for the humanized actions are added in assisting patients.[11] Having this view, the professionals questioned about the training they had, in view of analyzing progress and setbacks, and differences were noted in the findings, as 97% of the participants mentioned that the training received contributed to the promotion of humanization and only 3% said no.

It is noteworthy that despite a significant majority report the contribution of education to the humanized care, none of the respondents could discuss the issue, so that only "yes or no" answer was obtained, being were unable to justify the claims and they proved to be unaware of the processes, the discussions and the paths that led them to develop health actions. The answers stating the collaboration of training for the development of humanizing practices have left gaps, as all professionals presented a limited understanding of the subject in focus.

In today´s educational area, it is urgent to reform the teaching/learning health process, since even with the socio-political changes in the last 20 years, is still rooted in pedagogical practices guided by

conservative and hegemonic models. Therefore, it takes as the most valuable diagnostic findings, treatment, prognosis and prophylaxis in health care.[14] Thus, some questions arise: where is the stimulus to the critical reflection? The production of subjectivity? The promotion of health education? Understanding the SUS policy and its principles?

By the absence of these aspects in the profile of health professionals and the need to have more skilled workers to work in SUS environments, the concept of health education appeared, which proposes an articulation between education - management - care and social control in training process.[14] Through the joint work between these segments, it will come out of the learning spaces, people qualified to work in various health care areas with a larger view of patients, the assistance and the possibilities of making the humanized care.

CONCLUSION

The study revealed the presence of many factors that hinder the humanized practices, and the lack of a good professional relationship and the lack of infrastructure, materials and implements as the most cited by respondents limits.

An innovative possibility is the responsibility of teaching, care, management and social control working together to conformation of humanization, so that the quality of care becomes a collective responsibility and not just health professionals.

In seeking to make changes, it is necessary to redirect the discourse of academic training, entering new issues to be problematized in learning spaces, integrating disciplines in the curriculum of universities that approximate the knowledge linked to SUS policy.

In this cause, our political representatives are integrated to the need for greater commitment to public health because, so there is humanization, it is necessary to provide technological, structural, motivational and organizational support.

Added to this context, the importance of raising awareness and qualify the management to improve the health spaces, making them fertile to the changes that are needed to achieve the humanization in order to allow good results all the participants.

REFERENCES

1. Mello IM. Humanização da assistência hospitalar no Brasil: conhecimentos básicos para estudantes e profissionais [monografia]. Univ de São Paulo [Internet]. 2008 [cited 2012 Sept 10]. Available from: http://www.hcnet.usp.br/humaniza/pdf/livro/livro_dra_inaia_Humanizacao_nos_Hospitais_do_Brasil.pdf

2. Silva ID, Silveira MFA. A humanização e a formação do profissional em fisioterapia. Ciênc saúde coletiva [Internet]. 2008 [cited 2013 Mar 3];16(1):1535-46. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232011000700089

3. Ministério da Saúde (Brasil), Conselho Nacional de Secretários de Saúde. SUS 20 anos. Brasília: Ministério da Saúde; 2009. 282 p.

4. Figueiredo N, Tonini T, organizadores. SUS e PSF para enfermagem: práticas para o cuidado em saúde coletiva. São Caetano do Sul: Yendis; 2007.

5. Goulart BNG, Chiari BM. Humanização das práticas do profissional de saúde: contribuições para reflexão. Ciênc saúde coletiva [Internet]. 2010 [cited 2013 Mar 1];15(1):255-68. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232010000100031&script=sci_arttext

6. Ferreira CL. Humanização e gestão estratégica numa instituição de pesquisa: o caso do IPEC [dissertação]. Esc nac de saúde pública Sergio Arouca; 2011.

7. Ministério da Saúde (Brasil). Política Nacional de Humanização. Brasília: Ministério da Saúde; 2004. 20 p.

8. Estabelecimentos de saúde. Cadastro Nacional de Estabelecimentos de Saúde [Internet]. 2013 [cited 2013 Jan 19]. Available from: http://cnes.datasus.gov.br/Exibe_Ficha_Estabelecimento.asp?VCo_Unidade=2310802705923&VEstado=23&VCodMunicipio=231080

9. Silva FD, Chernicharo IM, Silva RC, Ferreira MA. Discursos de enfermeiros sobre humanização na unidade de terapia intensiva. Esc Anna Nery [Internet]. 2012 [cited 2013 Dec 2];16(4):719-27. Available from: http://www.scielo.br/scielo.php?pid=S1414-81452012000400011&script=sci_arttext

10. Backes DS, Lunardi VL, Filho WDL. A humanização hospitalar como expressão da ética. Rev latino-americana enf [Internet]. 2006 [cited 2013 June 22];14(1):132-5. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S010411692006000100018&lng=pt&nrm=iso.

11. Andrade LM, Martins EC, Caetano JA, Soares E, Beserra EP. Atendimento humanizado nos serviços de emergência hospitalar na percepção do acompanhante. Rev eletr enf [Internet]. 2009 [cited 2013 Dec 2];11(1):151-7. Available from: http://www.fen.ufg.br/revista/v11/n1/pdf/v11n1a19.pdf.

12. Silva AG, Souza TTR, Marcelino K. Assistência de enfermagem humanizada: dificuldades encontradas por enfermeiros em hospital privado em São Paulo. Consc e saúde [Internet]. 2008 [cited 2012 Aug 22];7(2):251-9. Available from: http://www.uninove.br/PDFs/Publicacoes/conscientiae_saude/csaude_v7n2/cnsv7n2_3m.pdf

13. Chernicharo IM, Silva FS, Ferreira MA. Humanização no cuidado de enfermagem nas concepções de profissionais de enfermagem. Esc Anna Nery [Internet]. 2011 [cited 2013 Dec 2];15(4):686-93. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-81452011000400005

14. Ceccim RB, Feuerwerker L C M. O quadrilátero da formação para área da saúde: ensino, gestão, atenção e controle social. Physis: rev de saúde coletiva [Internet]. 2004 [cited 2012 Nov 10];14(1):41-65. Available from: http://www.scielo.br/pdf/physis/v14n1/v14n1a04.pdf

15. Mello IM. Humanização da assistência hospitalar no Brasil: conhecimentos básicos para estudantes e profissionais [monografia] [Internet]. São Paulo: Universidade de São Paulo; 2008 [cited 2012 Sept 10]. Available from: http://www.hcnet.usp.br/humaniza/pdf/livro/livro_dra_inaia_Humanizacao_nos_Hospitais_do_Brasil.pdf

16. Silva ID, Silveira MFA. A humanização e a formação do profissional em fisioterapia. Ciênc. saúde coletiva [Internet]. 2008 [cited 2013 Mar 3];16(1):1535-46. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232011000700089.

17. Ministério da Saúde (Brasil), Conselho Nacional de Secretários de Saúde. SUS 20 anos. Brasília: Ministério da Saúde; 2009. 282 p.

18. Figueiredo N, Tonini T, organizadores. SUS e PSF para enfermagem: práticas para o cuidado em saúde coletiva. São Caetano do Sul: Yendis; 2007.

19. Goulart BNG, Chiari BM. Humanização das práticas do profissional de saúde: contribuições para reflexão. Ciênc. saúde coletiva [Internet]. 2010 [cited 2013 Mar 1];15(1):255-68. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232010000100031&script=sci_arttext.

20. Ferreira CL. Humanização e gestão estratégica numa instituição de pesquisa: o caso do IPEC [dissertação]. Rio de Janeiro: Escola Nacional de Saúde Pública Sergio Arouca; 2011.

21. Ministério da Saúde (Brasil). Política Nacional de Humanização. Brasília: Ministério da Saúde; 2004. 20 p.

22. Estabelecimentos de saúde. Cadastro Nacional de Estabelecimentos de Saúde [Internet]. Brasília; 2013. [cited 2013 Jan 19]. Available from: http://cnes.datasus.gov.br/Exibe_Ficha_Estabelecimento.asp?VCo_Unidade=2310802705923&VEstado=23&VCodMunicipio=231080

23. Silva FD, Chernicharo IM, Silva RC, Ferreira MA. Discursos de enfermeiros sobre humanização na unidade de terapia intensiva. Esc Anna Nery [Internet]. 2012 [cited 2013 Dec 2];16(4):719-27. Available from: http://www.scielo.br/scielo.php?pid=S1414-81452012000400011&script=sci_arttext.

24. Backes DS, Lunardi VL, Filho WDL. A humanização hospitalar como expressão da ética. Rev Latino-Am Enfermagem [Internet]. 2006 [cited 2013 June 22];14(1):132-35. Available from: http://www.scielo.br/pdf/rlae/v14n1/v14n1a18.pdf.

25. Andrade LM, Martins EC, Caetano JA, Soares E, Beserra EP. Atendimento humanizado nos serviços de emergência hospitalar na percepção do acompanhante. Rev Eletr Enf [Internet]. 2009 [cited 2013 Dec 2];11(1):151-7. Available from: http://www.fen.ufg.br/revista/v11/n1/pdf/v11n1a19.pdf.

26. Silva AG, Souza TTR, Marcelino K. Assistência de enfermagem humanizada: dificuldades encontradas por enfermeiros em hospital privado em São Paulo. ConScientiae e Saúde [Internet]. 2008 [cited 2012 Aug 22];7(2):251-59. Available from: http://www.uninove.br/PDFs/Publicacoes/conscientiae_saude/csaude_v7n2/cnsv7n2_3m.pdf

27. Chernicharo IM, Silva FS, Ferreira MA. Humanização no cuidado de enfermagem nas concepções de profissionais de enfermagem. Esc Anna Nery [Internet]. 2011 [cited 2013 Dec 2];15(4):686-93. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-81452011000400005

28. Ceccim RB, Feuerwerker L C M. O quadrilátero da formação para área da saúde: ensino, gestão, atenção e controle social. Physis: Revista de Saúde Coletiva [Internet]. 2004 [cited 2012 Nov 10];14(1):41-65. Available from: http://www.scielo.br/pdf/physis/v14n1/v14n1a04.pdf

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