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HUMANIZATION OF CARE IN PRIMARY CARE TO PEOPLE WITH NEOPLASIA: PERCEPTION OF NURSING PROFESSIONALS

HUMANIZAÇÃO DA ASSISTÊNCIA NA ATENÇÃO BÁSICA ÀS PESSOAS COM NEOPLASIA: PERCEPÇÃO DE PROFISSIONAIS DE ENFERMAGEM

HUMANIZACIÓN DE LA ASISTENCIA EN LA ATENCIÓN BÁSICA A LAS PERSONAS CON NEOPLASIA: PERCEPCIÓN DE PROFESIONALES DE ENFERMERÍA

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ABSTRACT

Objective: knowing the perception of nursing professionals working in primary care about the humanization of care for people with cancer. **Method:** descriptive, exploratory qualitative study conducted with nursing professionals who work in two primary health care services of a municipality in the state of Rio Grande do Sul. Data were collected from January to February 2013 through three focus groups and were submitted to discursive textual analysis. **Results:** three categories emerged: Specific and linear nursing care; Humanized care strategies used by nurses in primary care; Challenges to be overcome for the humanization of care in primary care. **Conclusion:** there is need to develop lifelong learning in health services in order to update professionals for the new logic of care. **Descriptors:** Primary Health Care; Humanization of Care; Oncology; Nursing.

RESUMO

Objetivo: conhecer a percepção de profissionais de enfermagem atuantes na atenção básica acerca da humanização da assistência às pessoas com neoplasias. **Método:** estudo descritivo, exploratório, com abordagem qualitativa, realizado com profissionais de enfermagem, atuantes em dois serviços de atenção básica à saúde de um município do interior do estado do Rio Grande do Sul. Os dados coletados no período de janeiro a fevereiro de 2013, por meio de três grupos focais, foram submetidos à análise textual discursiva. **Resultados:** emergiram três categorias: Cuidado de enfermagem pontual e linear; Estratégias de cuidado humanizado utilizadas pela enfermagem na atenção básica; Desafios a serem superados para a humanização do cuidado na atenção básica. **Conclusão:** é preciso desenvolver a educação permanente nos serviços de saúde a fim de atualizar os profissionais para as novas lógicas de atenção. **Descritores:** Atenção Primária à Saúde; Humanização da Assistência; Oncologia; Enfermagem.

RESUMEN

Objetivo: conocer la percepción de profesionales de enfermería actuantes en la atención básica acerca de la humanización de la asistencia a las personas con neoplasias. **Método:** estudio descriptivo, exploratorio, con enfoque cualitativo, realizado con profesionales de enfermería, actuantes en dos servicios de atención básica a la salud de un municipio del interior del estado de Rio Grande do Sul. Los datos recogidos en el período de enero a febrero de 2013, por medio de tres grupos focales, fueron sometidos al análisis textual discursivo. **Resultados:** surgieron tres categorías: Cuidado de enfermería puntual y linear; Estrategias de cuidado humanizado utilizadas por la enfermería en la atención básica; Desafíos a ser superados para la humanización del cuidado en la atención básica. **Conclusión:** es preciso desarrollar la educación permanente en los servicios de salud para actualizar a los profesionales para las nuevas lógicas de atención. **Descriptores:** Atención Primaria a la Salud; Humanización de la Asistencia; Oncología; Enfermería.

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INTRODUCTION

The theme of humanization has been addressed with greater emphasis from the deployment of the National Humanization Policy (Humaniza SUS) by the Ministry of Health, in 2003. This policy's guiding principles are the appreciation of subjective and social dimension in the practices of care and management in the Unified Health System (SUS); the commitment to the rights of the citizen; the construction of autonomy and leadership of collective subjects involved; and the strengthening of social control with participation in all SUS management levels.¹

In the health field, it arises in order to resize senses, resume comprehensive care and strengthen unique ways of care. In this context, the Ministry of Health (MOH), on March 28, 2006, approved the National Policy of Primary Care (PNAB in Portuguese), through Ordinance No. 648 /GM, establishing humanization as guiding principle of professional practices in primary care. The PNAB has as guiding principles the universality, accessibility, care coordination of the bond and continuity, integrity, accountability, humanization, equity and social participation.²

The ethical principles in health care are intrinsic to the process of humanization and mean, especially, to understand each person in their uniqueness, creating conditions to exercise the autonomy.³ Thus, the humanization of care goes beyond the disease dimension, values the physical and emotional aspect of each being, concerned to establish ties and develop comprehensive care.

Humanization also requires the inclusion of multidisciplinary teams, where each professional has their operations and integrates with others to develop comprehensive and humanized care. Self-knowledge of health professionals is important to establish appropriate interpersonal relationships to the care process, developing awareness of their limitations, weaknesses and potential.⁴

However, sometimes it is evidenced the unpreparedness of professionals to work according to the new logic of care, excessive demand and difficulties related to the organization of health services, which hinders the humanization of health care in different settings, especially the Family Health Strategy (FHS).³ In the FHS, the nurse is usually responsible for the leadership and coordination of the team⁵ and together with the team, they need to strategize to bring the

users closer to the health system, giving priority to comprehensive care, since it presupposes that the humanization of their practice is linked to the care process, culminating in the comprehensive care to the user's health.

Among the many diseases that affect the population, there is the cancer that, in recent decades, has gained more and more highlight, becoming a global public health problem, with an estimate of about 518,510 new cases in Brazil in the coming years.⁶ Given this context, the nurse must be prepared to deal with the interfaces of the disease to minimize the impacts and promote a healthy lifestyle in a unique and humanized manner.

The healthy living can be understood as a singular and multidimensional process. As a complex phenomenon, whose understanding implies the recognition of the environmental conditions in which the human being is inserted and in which they concretely experience their living.⁷

Some studies have been published regarding the humanization of care for people with cancer.⁸⁻⁹ However, there is a knowledge gap in relation to this theme in basic health care, which justifies the need and relevance of this study. This, in turn, contributes to health practices, especially those related to public and collective health.

Based on this, a question arises: what is the perception of nurses working in primary care about the humanization of care for people with cancer? As such, we aimed to know the perception of nurses working in primary care about the humanization of care for people with cancer.

METHOD

Exploratory, descriptive and qualitative study,¹⁰ conducted with nursing professionals who work in Basic Health Unit (BHU) and / or FHS in a municipality in the state of Rio Grande do Sul, which has approximately 70% of population covered by the FHS, 10 years ago.

The inclusion criteria were: being a nurse, nursing technician or nursing assistant and working in the BHU or in the FHS and having already assisted people with cancer. Exclusion criteria were: being on medical leave, maternity leave, vacation or not having assisted any person with cancer until the period of data collection. Four nurses met the inclusion criteria and composed the *corpus* of this study, of whom two were nurses (one from the FHS and the other from the BHU) and two were nursing assistants from the BHU.

Data were collected between January and February 2013, through the focus group technique (FG), which is characterized as a group that discusses about a particular topic, experienced and shared through common experiences, upon receiving appropriate stimuli for the debate. The choice of this data collection technique was due to its ability to promote group interaction, as the collective expression served as an element to explore and expand the understanding about the phenomenon under investigation.¹¹

The number of subjects is in agreement with the data collection using the FG technique, which suggests three to eight people, in order to facilitate moderation and analysis of transcripts¹¹. It should be noted also that, in qualitative research, the purpose of the sampling is not its quantitative representation, but the variety and depth of information.¹¹

A total of three meetings were carried out inside UBS's facilities, between the months of June and August 2013, each lasting about 120 minutes. At the first meeting of the focus group, there was the presentation of the participants, of the objective of the research and participants signed the Informed Consent Form (ICF). After, the group discussions were guided by the questions: for you, what is humanization of care? Do you think that your way of caring is humanized? Explain. Do you have contact with users with cancer? How is the nursing care to the user with cancer? Where do you assist this user?

At the second meeting, we resumed the synthesis of the issues discussed in the previous meeting and continued with the guiding questions: when does the care to the user with cancer occur? Does the service have a carefully structured protocol for that user? Do you have any trouble in meeting the user with cancer? What are the main singularities that you, as healthcare professionals, face in this user? In the third meeting, we presented the synthesis of the discussions of previous meetings, pointing the relevant points with participation of subjects.

The data were submitted to the discursive textual analysis technique,¹² which is organized around the following focuses: dismantling of texts or unitarization; establishing relations, categorization process; capturing the new emergent, a self-organizing process. Thus, the discursive textual analysis allows the emergence of new understandings based on self-organization, called metaphorically "storm of light", that illuminates the phenomena investigated,

enabling new understandings in the analysis.¹²

The ethical and legal precepts involving research with human beings were considered, according to Resolution 466/2012 of the Ministry of Health.¹³ After clarifying the research objectives and methodology, participants signed an Informed Consent Form in two copies, of which one stayed with the participant and the other with the researchers. We preserved the anonymity of participants by identifying them the letter "N" (Nursing), followed by a number, according to the interview order (N1, N2 ... N4). The research project was approved by the Ethics Committee of the Centro Universitario Franciscano under number 89895.

RESULTS

Of the professionals participating in the study, one has been working in the service for about five years, two for 10 to 15 years and one for more than 15 years. The organized and analyzed data revealed three categories: *Specific and linear nursing care; Humanized care strategies used by nurses in primary care; Challenges to be overcome for the humanization of care in primary care.*

♦ Specific and linear nursing care

One can see through a professional's report that the basic unit sometimes is used as a gateway to the hospital care and that, after the user is forwarded to diagnosis in the reference hospital, the professionals in primary care lose contact with him:

Sometimes when the patients arrive, they seek the health unit because it is the gateway to the health system. Sometimes they (patients) complain about something, a pain, a suspicion and are referred for diagnosis in the reference hospital and we lose contact [...]. (N1)

In the reports below, one can see that the care provided by nursing professionals, the study participants, is specific and linear, focused on the physical aspects, not on the biopsychosocial aspects of the human being:

[...] the only contact I have with the patient with cancer is the dressing, dressing guidelines and hygiene issues that they should take at home. (N3)

The focus is not in prevention but in the curative aspect, we often deal with the curative aspect [...]. (N4)

It is noticed in the accounts of professionals N1, N3 and N4 that users seek the service only for specific procedures. So, they go to the BHU to receive dressings after surgery, or due to side effects of medication:

Baratto F, Ferreira CLL, Ilha S et al.

[...] some patients return after surgery to do the dressings, or to check the side effect of some medication or due to other problem that is not related to cancer, but we just lose contact with patients. (N1)

[...] they (patients) come to do the dressing, to remove the stitches after a surgery. But almost all the monitoring of their treatment is done in the hospital. (N3)

Sometimes we talk, but the reference is there (hospital); they come here when they have something else, another type of care. (N4)

It is evident that there is no continuity of care provided in primary care and that the care model to the user is centered on the disease. It is noted that the look on health practices in the investigated reality, at least when it comes to people with cancer, is still based on the curative care model.

♦ Humanized care strategies used by nurses in primary care

When professionals were urged to speak in the group whether they performed humanized care, they stressed on the need to host this care. Following, there are some reports:

[...] humanization of care is to host, which is the first professional contact with the patient when he seeks the health unit for any type of care [...]. (N1)

[...] the nurse makes a host, talks, refers or not the user for the doctor [...]. (N4)

The nursing professionals recognize the listening and dialogue as important tools in providing care to patients with cancer, as described below:

[...] often, care is just to listen and pay attention, [...]. (N1)

During the host, nursing professionals must be able to listen, learn to talk to the patient and not just check the pressure itself. We already started doing this, we evaluate the clinical aspect, for example, and during the conversation with him (the user), we already start to realize that he needs something further, he needs professionals related to psychology, to the multidisciplinary team, so we refer him right here. (N4)

Professionals participating in this study recognize that the host does not just mean a cordial reception, but also the bond, the resoluteness of user needs and good professional performance. Empathy and the importance of knowing how to place themselves and take the necessary decisions were also considered necessary to conduct a quality care:

[...] we must always try to put ourselves in the patient's shoes [...]. (N3)

It is all about the empathy and the need to know how to place ourselves, thinking about

Humanization of care in primary care to people...

what the patient is feeling and knowing to refer the most serious cases [...]. (N4)

Often, care becomes a way to motivate the user and make them increase their self-esteem; professionals create link with the user [...] some used to come to the service to receive a saline solution, they think it gives them more strength, for us to give support [...]. (N1)

[...] I talk; we try to distract him (health user) so that he does not think too much about the disease itself. We tell him that tomorrow he will be better, that he has to fight, he has to have willpower, it is not because he is like this, with cancer, that his life will end. (N2)

The participant N3also notes that professionals should be involved, be interested and interact in a way that favors the health-disease process:

[...] we cannot say that we do not attach to them, because we do, I do dressings every day, so we have that bond, that experience every day with the patient and for me this is important; it is important to encourage them to increase self-esteem [...]. (N3)

From the professional's account, one can assume that the bond between user and nurse is inevitable, as often lies in the health service and can be thought of as important for the user to improve their self-esteem.

♦ Challenges to be overcome for the humanization of care in primary care

In the words of the nurses participating in this study, one can see that despite efforts, there are some impediments that can make the care ineffective, as described below:

[...] the FHS nurse identified the importance and need to address this issue of family support, but she still finds it difficult due to the few human resources that the program has [...]. (N1)

Actually, there is also lack of action by the FHS program, as I stated, because we are not being able to achieve all the objectives and responsibilities, but as soon as we have more doctors and nurses in the health unit, I believe it will be better and will have more this so-called contact with the patient [...]. (N4)

[...] a psychologist to go along in the visits; this we have been already questioning. (N2)

The nursing professionals emphasize the importance of having a multidisciplinary team and also to extend the service to the family. However, they mention that the lack of human resources is one of the reasons that make it difficult to meet the demand. It was also noted the difficulty that professional N4 has to conduct home visits, being restricted to actions within the unit due to the demand of

Baratto F, Ferreira CLL, Ilha S et al.

Humanization of care in primary care to people...

service and reduced staff, which hinders the work process. Following, the account:

Some visits I ended up doing, but we cannot do, there is no doctor in the unit, there is no technician, worker, so I'm not managing to go out. (N4)

In the health units, which are the focus of this study, the excess demand is considered by professionals as a difficulty for the humanization of care due to the lack of professionals in the team and the labor demand within the unit.

DISCUSSION

The PNAB is characterized by a set of health actions, at individual and collective level, which covers the promotion and protection of health, disease prevention, diagnosis, treatment, rehabilitation and health maintenance. Thus, primary care should be a gateway to the SUS.² However, if the act of referring the user to the specialized health center causes the lost of the link in primary care, as identified in this study, one can conclude that the care is restricted to the disease.

The primary care needs, in this context, to provide individual and collective support targeting the humanistic practices that consider the subject in their uniqueness, complexity and completeness. This approach contributes to the socio-cultural integration and health promotion for the prevention and treatment of diseases as well as to reduce damage or suffering that can harm people.²

Although one of the units in question has a FHS team, it is observed that the curative care model is still strongly present, which is inconsistent with the principles of PNAB. In this research, it is observed that patients with cancer receive a specific care, if they seek the service to perform a procedure, because it is not intended to track, monitor or prevent complications that may arise in the cancer disease process.

In oncology, the technical care is of utmost importance to the prognosis of the person. However, only this care model does not meet the psychological, emotional, social, cultural needs and beliefs inherent in every being. Thus, it is evident that the technical and the human knowledge need to be interconnected to provide better quality of life to the user.⁴

The person who is undergoing cancer treatment requires a more affectionate relationship, in which the approach and the bond benefit them, since through this care the nursing/ health staff has better conditions to understand user needs.¹⁴ However, according

to the reports of nursing professionals, it is clear that users under cancer treatment seek care only for specific procedures. This fact can be attributed, among other factors, to the services provided by professionals who have little contributed to change the perception of the community about the real importance of service as for health promotion and disease prevention.

The implementation of the PSF (Family Health Program), in the 90s, aimed to reverse the health care model through the change of the object of care, way of working and general organization of services, as well as reorganization of the healthcare practice in new bases and criteria, in accordance with the principles of the SUS.¹⁵ There were curricular changes in nursing graduate courses due to the result of the implementation of this system. However, although the discussions and the development of the education program of courses pointed to the principles and guidelines of SUS, there was still prevalence, in the 90s, of the hospital-centered approach of the predominant curriculum in the 80s.¹⁶

In this study, it is observed that the look on health practices, at least when it comes to people with cancer, is still grounded on the curative care model, centered on the old system. Thus, it becomes necessary to work with continuing education in health care, with the aim of professional development, improving the theoretical and practical knowledge to keep workers in line with the current healthcare system.

The nursing care plan to the user with cancer should prioritize the host with an ethical posture, that integrates the user as a protagonist in their therapeutic process, considering their culture, their knowledge and their ability to assess risks. In this perspective, the nursing staff is fundamental and reference in day care, responsible and manager of this process.¹⁴ Thus, the host should be understood as ethical, aesthetics and politic guideline that composes the way of producing health, as well as technological tool of intervention in listening skills, building bond, guarantee of access with accountability and resolution in services.¹⁷

The nursing professionals participating in this study recognize the listening and dialogue as important tools in providing care for patients with cancer. However, it can be seen that some institutions do not provide a suitable environment, human resources and sufficient quantitative and qualitative materials, which discourages the professional for a change of acting.³

Thus, it is necessary that the organization of the health service enables a qualified care to meet the users' needs. Managers should be aware of the real needs of services, and to adapt the structure of the units and the number of professionals to meet the needs.³

During the period of data collection, the teams were incomplete, there was no nursing technician. It is also noted that the nurse and the doctor of the FHS were restricted to actions within the unit due to the demand of the service, which hampered the work process. This is consistent with a study that aimed to analyze, in national literature, the scientific production on humanization in primary health care, highlighting the key points raised. In this, the authors state that to provide humanized care is necessary to invest in workers and provide conditions so that they can provide a quality work.¹⁸

However, when this does not occur, the professionals need to mobilize strategies so that the lack of resource problems do not become a hindrance for their activities, after all, this ends up fostering the idea of disengagement in caring for users. They need to advocate a humanized care and implement actions that will make all the social actors involved in the work process responsible for it.¹⁸

In this respect, the multidisciplinary care is an effective strategy for the quality of care because it allows comprehensive care with holistic vision of the patient and their context through appropriate actions of self-care, which in turn influences the positive coping and the feeling of safety, by the user, during the treatment.¹⁹ It is noteworthy is that nurses should look for strategies that foster autonomy and responsibility of the subjects involved in the health production process by building new spaces for meetings.²⁰ Thus, professionals and users would reach common goals in order to improve health care.

CONCLUSION

This study was considered satisfactory, since it was possible to know the perception of nurses working in primary care about the humanization of care for people with cancer. This research has limitations related to any qualitative study, particularly due to the small number of actual participants in the study. However, some points have contributed to realization of it. One of this is the data collection method using Focus Group, which expanded the discussions and at the same time provided the necessary deepening of the data to qualitative research.

It was observed that nursing care to people with cancer, in the investigated reality, remains restricted to the disease, which is not consistent with the principles of PNAB and the humanization policy. Thus, there is need to develop continuing education in health services in order to update professionals to the new logic of care.

The nursing professionals listed empathy, bonding and host as forms of humanized care they provide in the unit. However, we can see also that they develop a specific care, focused only on the subject, not in the collective, as recommended by health policies. Thus, it highlights the importance of expanding the care provided for beyond the subject, since, in oncology, the impacts of the disease permeate the individual and reach the family and community.

The study identified difficulties that nursing professionals find in implementing humanized care in the primary care model. The lack of human resources, the need to work with a multidisciplinary team and the importance of extending the care provided to the family were some of the important points mentioned as weaknesses that are still present in the system.

This study is relevant since it brought contributions for Nursing on the reality found in primary care for individuals with cancer, which led to the reflection of the reason why the FHS model sometimes does not show functionality. There is the need for further investment in research on this theme in order to contribute to the health practices so that they are more effective and humanized.

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