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Perceptions of health professionals about humanization in intensive care unit adult

Percepções de profissionais de saúde sobre a humanização em unidade de terapia intensiva adulto

Percepciones de profesionales de la salud sobre humanización intensivo de adultos unidad de cuidados

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Abstract

Objective: To understand the perception of health professionals as the humanized care in a adult Intensive Care Unit (ICU). **Methods:** This qualitative study was conducted with 13 health professionals with higher education working in the ICU of a university hospital, in the north of Paraná State. The collection was made through semi-structured interviews and later submitted to content analysis, thematic modality. **Results:** Health professionals had difficulties in issuing a clear and objective definition of the concept of humanization. They also reported that routine added to the neurological level lowered the subjects and the enhancement of professional practice and influence the supply of humanized care. **Conclusion:** This study allowed the realization of a reflection based on the broad concept of humanization, combined with the daily difficulties that practitioners encounter in their applicability, showing a gap between theory and practice.

Keywords: Humanization of Assistance; Intensive Care Units; Intensive Care.

Resumo

Objetivo: Compreender a percepção dos profissionais de saúde quanto ao cuidado humanizado em uma Unidade de Terapia Intensiva Adulto (UTI). **Métodos:** Estudo de natureza qualitativa, realizado junto a 13 profissionais de saúde com ensino superior que atuam na UTI de um hospital universitário, na região norte do estado do Paraná. A coleta se deu por meio de entrevista semiestruturada e submetidas à análise de conteúdo, modalidade temática. **Resultados:** Os profissionais de saúde apresentaram dificuldades em emitirem uma definição clara e objetiva para o conceito de humanização. Relataram também que a rotina somada ao nível neurológico rebaixado das pessoas e a valorização do profissional interferem na prática e oferta do cuidado humanizado. **Conclusão:** O estudo possibilitou a realização de uma reflexão baseada no conceito amplo da humanização, articulado com as dificuldades cotidianas que os profissionais encontram em sua aplicabilidade, evidenciando um distanciamento entre a teoria e prática.

Palavras-chave: Humanização da assistência; Unidades de Terapia Intensiva; Cuidados intensivos.

Resumen

Objetivo: Conocer la percepción de los profesionales de la salud como la atención humanizada en una unidad de cuidados intensivos de adultos (UCI). **Métodos:** Este estudio cualitativo se llevó a cabo con 13 profesionales de la salud con la educación superior que trabajan en la UCI de un hospital universitário, en el norte del Estado de Paraná. La colección se hizo a través de entrevistas semi-estructuradas y posteriormente sometido a análisis de contenido, modalidad temática. **Resultados:** Los profesionales de salud tenían dificultades en la emisión de una definición clara y objetiva del concepto de humanización. También informaron de que la rutina añadido a nivel neurológico bajó los sujetos y la mejora de la práctica profesional e influir en el suministro de la atención humanizada. **Conclusión:** Este estudio permitió la realización de una reflexión basada en el amplio concepto de humanización, combinada con las dificultades diarias que los profesionales encuentran en su aplicabilidad, que muestra una brecha entre la teoría y la práctica.

Palabras clave: Humanización de la Atención; Unidades de Cuidados Intensivos; Cuidados Intensivos.

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INTRODUCTION

In the 50s, due to the technological development and the need to provide more advanced life support to seriously ill people, with valid health restoration opportunities, the Intensive Care Units were created (ICU). They are hospital units with qualified multidisciplinary teams and specific technologies for the continuous monitoring of the hospitalized individuals whose the seriousness of their health situation creates tension both for many users and the members of the health staff[1,2].

Given that the ICU's environment is full of hard technologies, some concerns then arise as for the humanization problematic. Usually, the discussion is about the dehumanizing practices in care are associated with allusions to human society with high technological development, where the use of machines are predominant and so are the objective data found by them, instead of the procedures associated with the direct care to users and the subjectivity that is characteristic in human relationships. Thus, the relationship between those who care and those who are cared ends up being as possibly additional, unnecessary or even absent[3,4].

In addition to that, the complexity of the care in this sector has required increasingly scientific expertise for the provision of assistance and therefore it points out that professional training is still based on the reductionist organismic model of the current practice in medicine[4]. This model is strongly focused on the biological cure of the body, and favors the disease and not the ill person. That contributes to the training of health professionals who do not value focused assistance to the health-disease dichotomy, in which the mental and physical aspects are inextricably linked to balance of restoration[1,5].

Due to the concern with all these issues related to the service provided to the population and in order to improve the quality of care with a humanistic look at the patients, it was launched in 2003, by the Ministry of Health, the National Policy of Humanization (NPH)[4]. The NPH proposes qualified care, with the articulation of technological advances to promote the improvement of care settings and working conditions of workers.

From this perspective, humanization is carried out separately and individually, by the multidisciplinary team, by restoring the right of users to preserve their dignity, and then include their participation, accountability and autonomy, which are essential elements for the humanization to be built[6]. Therefore, the care formats of caring in this scenario emerge reflections on the assistance provided by health professionals.

In the intensive care setting, assistance is carried out according to the scientific knowledge of the health professionals, and that is based on evolution of the ill person. Most of the data that comprise the state of health of the patient is available through technological machinery, such as care instruments, and that contributes for actions to be made only with the aid of technological apparatus. The care formats, therefore, should be put into consideration as for how the care that has been carried out by professionals is conducted[7-9].

Considering the humanization proposal in the healthcare environment, this study sought to understand the perception of health professionals regarding the humanization in an Intensive Care Unit for adults.

METHODS

It is a qualitative study, with explanatory aspects. It was held at the ICU for Adults from a university hospital in the north of Paraná state, in the southern region of Brazil. The unit has eight beds, serves clinical and surgical patients, of both sexes and aged from 14 years old and up. The average number of hospitalizations per month is around 60 customers. The team has 47 health professionals, where 10 are doctors, eight nurses, four physiotherapists, three pharmacists, two nutritionists and 20 nursing technicians. The weekly working hours of the servers is 36 hours that are divided in 6-hour shifts during the day and 12/60 hours in the evening (12 hours at work and 60 hours of rest) except for individuals working on duty regime. The institution has training plans and wages for their servers.

The inclusion criteria for participating in the survey were: being an effective member of the multidisciplinary team, with higher education, on the premise that they participate in the decision-making and care strategies and to have experience of over three months working at an ICU. From the total, 26 professionals did not meet the inclusion criteria: one was on vacation, two were away by a medical leave and three refused to participate in this study. Therefore, 13 health professionals were interviewed. Namely: three doctors, three physical therapists and seven nurses.

Data were collected in June, 2014 through semi-structured interview that consisted of the following guiding questions: What is the humanization of patient care in the intensive care unit for you? How do you perceive the humanization of patient care in your workplace? The interviews were conducted individually and previous scheduling, according to the health participants' availability, in a private room from the institution. They lasted about 15 minutos each. After the informed consent of the participants, the statements were recorded in a digital device.

For data analysis, the interviews were transcribed and then submitted to content, theme, modality and ethics. It is a set of techniques which allow inferences from objective content of the obtained from the speeches, and consisting of three phases: 1) pre-analysis, 2) use of data; 3) treatment of results, inference and interpretation[10].

In the first phase, the consecutive readings of the material was carried out in order to operationalize and systematize the data, aiming at deepening the information as much as possible, by underlining the points of interest. In the second stage, the data were organized according to the research objective and similarity of testimonials. In the third and final stage there was the inference and interpretation of the results found[10]. Thus, the categories identified were named as: "Humanization: a broad and polysemic concept" and "Between

theory and practice, the existing praxis: daily difficulties in the humanization process".

The development of the study met the requirements and ethical principles applicable in the country and the project was approved by the Ethics Committee for Human Research of the State University of Maringá (Opinion 687 231/2014; CAAE 24482913.7.0000.0104). All participants signed the Informed Consent in two copies. To differentiate and preserve their identities, the participant professionals were named as the brightest stars of the firmament: Sun, Sirius, Canopus, Vega, Capella, Rigel, Procyon, Archernar, Hadar, Antares, Spica, Regulus and Centauri.

RESULTS AND DISCUSSION

The study subjects were 13 healthcare workers with higher education, seven men and six women aged between 24 and 45 years. The time of experience in acting in the ICU of these professionals ranged from four months to 15 years. The statements guided the presentation of the results which was composed by two general categories. The first refers to the concept of humanization presented by the professionals as being of difficult interpretation due to the extent and polysemy of the term. The second describes the daily difficulties faced by the professionals in the ICU setting for the applicability and effectiveness of a humanized care.

Humanization of care: a broad and polysemic concept

By inviting health professionals to participate in this research, specifically at the moment when the theme of study was informed, it was noticed some resistance expressed by the facial expressions of amazement that most of them showed. This is confirmed by the number of professionals who refused to participate in the research. Among those who accepted it, it was perceived a certain discomfort in talking about the theme. So when they were asked about the humanization in the ICU, most of them present some difficulty in drawing up a definition on this theme, as shown in the following statements:

> *I can say that, if I have to talk about humanization, for me it will be a little difficult (Hadar, nurse).*
>
> *[...] I understand that it is a way of translating, of communication, of you being able to inform and be informed in different populations [...] I do not know, I do not know [laughs] (Sirius, doctor).*
>
> *The humanization of work in the ICU [silence] in physical therapy we have to at least see the patient as a whole, not only as for the respiratory part (Canopus, physiotherapist).*

The term humanization, in the past decade, became recurrent in the texts of the Heath Ministry and the Health State and City Departments. It similarly occurred in healthcare publications, as a set of actions aimed at qualifying the care of sick individuals. It has a polysemic characteristic once it refers to movements, concepts, actions of different historical backgrounds and points of views that are subject to various forms of interpretation[11-13].

Its conceptual compound is capable of being listed. This results in multifocal prospects of humanizes in health. This is typified as a difficult concept and a wide profile of the term itself, and can be verified in the speeches of the professionals interviewed. All horizons to which the humanization expands to end up fragmenting the concept, making it difficult to understand their focus and scope[12]. It is noticed that the theoretical and operational outlines used to designate humanization, are not yet universal in its scope and applicability. Perhaps because they are not fully demarcated, which hinders the formation of a pure and simple definition[14].

Therefore, it is plausible the difficulty of the subjects of this study to provide a pure and simple concept for the term "humanization". Such fact can be confirmed in the words of professionals from different conception verbalized:

> *Humanization is almost everything. It goes from making the patient aware of the procedures that will be done. Assisting him in something. To the issue of mentioning the prevision of materials because this is also part of the humanization. Because if there aren't any of them [medical materials], they won't be cared (Vega, nurse).*
>
> *For me, humanizing is any care inside or outside the ICU (Spica, doctor).*
>
> *Well, it means inserting the patient in the ICU context, making the environment comfortable, so they feel safe and well [...] I summarize it this way (Antares, nurse).*

Considering the different interpretations assigned to the theme of humanization, all statements relate to some aspect of the humanized care, which ranged from the environment conditions, maintenance of materials to offer a comprehensive care, to the human-centered care. However, the definitions provided are fragmented and some lines even confusing. This is justified also because the ICU's abstruse everyday life contributes to a care geared to technical procedures and the execution of tasks, in the detriment of a full and contextualized view of the human being that is being care. That, therefore, jeopardizes the effectiveness of the humanization practice[15].

In this sense, there is a need to carry out a critical and reflective approach to the concepts around the theme humanization of care, and their applicability in the ICU daily life, understanding it as a complex and multidimensional issue because it includes all human dimensions[14]. This reflection needs to stem from a do/think perspective that is guided by more humanitarian actions in order to develop a care that is full consciousness in the practice, teaching, theorizing and research[16].

In this sense, the construction of a humanized care needs to be collective and participatory, seeking to accept and respect

the values, beliefs, culture and life expectancies that are unique to each person, may that be the patient, family or the professionals[7]. It's also important to consider that communication and dialogue favor the development of care strategies, including the subjectivity of both the sick person and the professionals, where, as for the context of the NPH, enables the reorganization of the forms of care that are done[3,17].

Seeking effective ways to humanize the health practice, implies a critical approach to the theme as well as its technical and instrumental components, involving fundamentally the ethical-aesthetic-political dimensions that comprise it[18].

These dimensions are sidewalks in the structuring principles of the National Policy of Humanization; namely, the transversality of assistance, the inseparability of care and management, the affirmation of the role and autonomy of individuals and groups[8]. Transversality means to amplify the levels of communication between the subjects and services, aimed at the transformation of the power territories, changes in the knowledge boundaries and work relationships. Inseparability concerns the intrinsic relationship the between modes of care and the ways to manage them. The appropriation of the work and the affirmation of the role and autonomy of individuals refer to the development of co-responsibility attitudes for the promotion of health[13,19].

Substantially, the NPH aims to improve the dialogue between those involved in the health production process by promoting participatory management and stimulating resolutive practices. Thus, through these policies, these principles whose ethical-aesthetic-political dimensions are linked to the right of comprehensive care and defense of life, along with the regulation of the power relations and institutional democratization, can all be reaffirmed[20].

The ethical dimension appears linked to the process of adopting the defense of life and the right of everyone to the full development of care, whether, users, citizens or health workers. The aesthetic dimension refers to the invention of the rules that regulate life, and point to processes of creation that are specific of the men and their relationship with the other beings. The political dimension, that is inseparable from the ethical and aesthetic dimension, appears in the humanization in the scope of the power relationships and institutional democratization[11].

From this perspective, the concept of humanization can also be translated as a relentless pursuit of physical, psychological and spiritual comfort of sick people, their family and the health staff who dedicate themselves to their care. In the sense of trying to offer human conditions and act kindly, i.e., become good, affable, and acquire social and civilized habits[16], as can be seen in the statement below:

> *It means to be cautious and considerate and not treat the patient simply as person, but a being who needs care (Rigel, physiotherapist).*

All these assessments build the concept of humanization, confirming the its ambiguous character, whose definitions are varied and divergent. This aspect generates many debates and difficulties for its definition regarding the way that the concept should take in the scope of the politics[13].

However, reflecting on what humanization is and all its theoretical contours and then provide a definition for the subject is not an easy task, especially because the practice is often opposed to the theory. In this sense, in the second category the difficulties of daily work presented by the participants were organized, for the realization of the process of humanization.

Between theory and practice, the existing praxis: daily difficulties in the humanization process

In everyday practice the implementation of humanization does not seem simplistic, once it's difficult for health professionals to define it. The professionals expressed that the daily routine the ICU environment, the low neurological level and the unconsciousness/sedation state of hospitalized people, interfere directly to the practice of humanized care. This can be evidenced in the following lines:

> *Sometimes you end up forgetting that the patient can hear. You understand that most are* in *serious state, sedated, or in a coma. So many times you end up forgetting that there is a person there (Sun, nurse).*
>
> *We have a serious problem. We get to a point where we forget that the patient is a human being. We approach them and immediately start doing the procedures (Capella, physiotherapist).*
>
> *At the ICU we generally tend to automate our work. Doing our job becomes mechanical [...] and we end up forgetting the human aspect (Archernar, nurse).*
>
> *It's that routine thing, that automatic mode. We often forget that whoever is there is a human being. You, sooner or later, have to stop to go back and think, we need to work this issue out with ourselves and or staff every day (Procyon, nurse).*
>
> *You need to be more tactful in dealing with the patient in a coma, sedated. I personally don`t practice humanized care. I deal with mechanical parameters and do not give much attention to this human side of the patient (Centauri, doctor).*

As the reports of the professionals, the daily routine coupled with the high complexity of the ICU, the daily use of advanced technologies, and especially due to the state of unconsciousness of patients, they tends to automate the work, making the actions and care strategies contrary to the practices preconized advocated by the NPH. In the ICU, humanization is a set of initiatives aimed at producing health care, able to combine the best technology available to promote acceptance, ethical and cultural respect of sick people. It's having workspaces conducive to good technical exercise and satisfaction of health professionals and users[14].

In contrast, to meet the care needs of people admitted to the ICU, it is essential the appropriation of technologies that assist in the assessment of the patient, considering the physiological aspects, establishing the essential elements in the construction of strategies and care actions to be taken[7].

Thus, the technological apparatus in the ICU becomes a natural resource, which produces beneficial effects on the care. However, it is a method that causes addiction among professionals, to the information provided by the devices, and that leads to the distancing between professional and patient, and makes it difficult to capture subjective data of care and the integral needs of the user[7], as clearly represented by the speech of the doctor Centauri, who expresses the unconscious/sedation state as a reason for not practicing humanized care.

It is up to professionals to harmoniously use these technologies, as these features may not derail the interactive patient care, given that, even in a state of unconsciousness, the hospitalized person remains human[16]. Promoting a care environment that has its essence in the human being, where it's uniquely and socially constructed, depends directly on the ability of the professionals to understand it as such, especially when dealing with intensive care environments. It is understood that care is an ethical ideal, which gives the condition of humanity to people, because the human being lives the meaning of their own life through the care[21,22].

The fundamental aspect of the care is the shifting of ones interest for their own reality to another's, i.e., it as a way to face the reality of the another as a possibility of own reality. Therefore, the *way-of-being* of the care reveals the concrete way in which the human being is[16]. The connotation that care is beyond the existential aspect arises in that context. However, it is also relational, because the self is with one another and for one another, and this moves are addressed in a way both ways can complete each other. Therefore, care encompasses acts, behaviors and attitudes of those who care and those who receive the care[22].

Thus, to develop this ethical and relational competence based on professional experience in the care and humanization, it is necessary to generate moments of reflection as early as possible so that it can be consolidated in the environment practice and health services. The training of health professionals requires that the basis of academic concepts be expanded, where the understanding of the health-disease as a complex phenomenon may be applied and not limited to the biological field[23].

The expected result from this reflection in professional training is the consolidation of humanistic values in health work and the alliance between technical/technological competence and ethical/relational competence[14]. This is important because it will enable understanding and taking care of individuals widely, and not limited to theoretical discourses or disjointed health practices.

Nevertheless, the actions performed in the care vary according to the conditions in which the situations occur and the kind of relationship that is established. There are different types or different ways to care that vary in intensity. The way a professional cares for a patient will depend on the situation and how their involvement with the subject is[18].

Thus, it's important to highlight the need to humanize working conditions of these professionals, so that they can establish a better relationship for the provision of humanized care. The main challenge for this consolidation is creating strategies for its effectiveness[23]. This challenge is of particular significance when it comes to teaching and research reference institutions, once they accomplish their task of forming people and culture[14].

When the professionals were asked about how they see the humanization in the workplace, they stressed that professional development is directly related to the provision of humanized care. The professional who is undervalued, both financially and by the amount of tasks to be accomplished daily, they will not offer a humanized care, as observed in the statements:

> *Let's humanize all patient care, but this won't be a thought humanization, for example, for me to humanize the care to the patient I need to also be humanized (Hadar, nurse).*
>
> *Well, I think that valuing the professional, not only through money, but also with psychological support [...]. Well, It's a team that should perform a humanized monitoring, and think that on one side there is a patient who is human, but that on the other side there is someone else who is also human.(Regulus, physiotherapist).*
>
> *If I am valued in my work that will resonate in a better service, in the best humanization (Antares, nurse).*

It would be ironic and indeed inhuman to talk about humanization, while listening and participating in the management meetings. Not to mention the worker with overload functions and activities. Besides those with double shift or triple work which obviously generates physical and mental stress. Studies claim that such problems travel on the opposite way of humanization, once in order to offer a dignified ambience and care to patients, necessarily, professionals should also have decent working ambience[15,22]. That can bee confirmed in the speech of the therapist:

> *[...] To humanize the care, the worker must necessarily be inserted in a work environment that is also humanized. (Rigel, Physiotherapist).*

According to the NPH, the environment refers to the treatment of the physical space, understood as a social, professional space and of *interpersonal relationships* that should provide a more welcoming, problem-solving and human care[15,20]. However, this ideal environment is not the reality experienced by many health workers. It doesn't mean to omit the responsibility of the professional in offering a humanized and ethical care, but to propose a reflection about until what extent a professional space that is vulnerable to risks, whether physical and/or psychosocial

favor the promotion of a consistent environment for the desired humanization and that is the right of all users, whether, patients, professionals or managers[12,15].

It's necessary to discuss about the conditions where the health professionals have been working so that they, satisfied with their work environment, may be motivators and promoters of humanizing actions[23]. In this regard, the NPH aims at valuing the everyday life of health services, where the work process is the cornerstone for the proper enforcement of this policy. And that is because it's impossible to to change the way a humanized assistance is provided to users, without modifying its organization at first[11,24].

Therefore, it is necessary to develop new work strategies towards a better organization of the humanization in the ICU. It is essential to enable the questioning in the work process in health, creating devices that help professionals to be constantly questioning about the work process itself and their institutional organization[19].

These questions must focus on building collective spaces for the reflection and evaluation of everyday actions, putting then the work routine under analysis. Not only as for the non critical incorporation of material technologies, but also as for the clinical efficacy produced, the listening patterns, the relations established with the users, as for the institutional demands that focus on the professional, for example, the bureaucracy, the hiring of the minimum amount of professionals required for the service, the enhancement of professional salaries and the expansion of theoretical discussions on academic training[5,25].

How is is possible to speak in humanized care when the referencials remain reductionist and simplified?And, how to focus on providing care when it is still seized in a fragmented way and that often conceives the human being as an inanimate thing which receives the care passively[5]?

In this context, thinking of humanization in the intensive care aiming at the complete care of sick people, involves, in addition to differentiated technologies, trained and qualified professionals to perform the humanization as a set of different dimensions, features, events and movements that make up the extent of its concept, as well as the set of stars that comprise a constellation.

FINAL CONSIDERATIONS

This study enabled a reflection based on the polysemic and broad concept of the humanization in health, linked to the everyday difficulties that health professionals have to face in order to apply this policy, especially when it comes to the ICUs. Understanding humanization in complex care environments means accepting the dynamism of its organization in what concerns the health unit, the management, the working professionals and the users, as a place where them all the feed over and over the human and professional relationships/ interrelationships. It also means understanding the human being as a complex being, unique and able to (re) organize itself depending on the conditions and/or environment they are in and the relationships in which they build.

In ICU that was reference for this study, it is noteworthy that still prevails the technical and positivist care. That is, the complexity of care in the ICU setting is still concentrated in high technology, in order to first meet the biological needs of patients. However, according to the participants of the study, the conceptual problematic of humanization causes certain limitations in seeking modification of the care setting in health, as it derives from technical, relational, ethical and even environmental issues.

The interpretations produced from the collected data demonstrate that health professionals have some knowledge on the subject, in accordance to the directions provided by the NPH, even though in a dispersed manner. Such perception suggests a disconnection between the discourse of humanized care, recommended by the NPH and the care practice, which configure the praxis in the daily work routine.

Moreover, it's possible to add to the issue the lack of a broader reflection on the humanized health care, that originates in the professional training, as an attempt to enhance the process of developing ethical and moral skills to guide the future practice. It is perceived, equally, the importance of constant encouragement to those who are already institution practitioners by their professional valorization. As well as the implementation of discussions about the topic in order to clarify and systematize these actions, and the promotion of the discussion and exchange of experiences on the procedures that govern the daily lives of all involved in providing care in the ICU, in the sense of integrating theory and the practice.

From this perspective, a strategy widely used and that may have a positive effect on the team that was studied, are the rounds of conversation among professionals, with regular meetings to promote the sharing of experiences and knowledge of each professional as well as resolution of conflicts. Besides that, the conversation circles lead the multidisciplinary team to rethink the role of each member, triggering initiatives such as the process of humanization of the care.

Care technologies are key features in the patients' recovery. They require knowledge and training of professionals to their management so that they may contribute for the care. However, that should be done in a way where the care based on the subjective understanding of the patient's real needs aren't neglected, in order to guarantee the the implementation and exercise of a fully humanized care. So, it becomes necessary the search for new strategies that are able to involve complex, comprehensive care and the daily supply in this complex and dynamic environment of the ICU's.

We believe we have reached the goal of this study. Nevertheless, we recognize the need for further investments in professional training and subsequently in constant updates through lifelong learning in service.

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