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Pronouncements on humanization: professionals and users in a complex health institution

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Abstract *This paper presents the pronouncements on humanization of professionals and users of a health care and research institution. Interviews were conducted with 16 professionals and 44 users. The analytical method employed was the Discourse of the Collective Subject, the results of which were discussed based on the theoretical framework presented, which includes the Theory of communicative action of Habermas and recognized authors in the public health area. The findings point to the importance of the set of hard, light-hard and light technologies for humanized practice. The articulation role played by communicative action was highlighted both for the creation of a network of professionals and in the relationship between professionals and patients. The practice of research was considered by professionals and users as a factor that increases the quality of care and contributes to humanization. Care at the institute was considered good, both by practitioners and users, who emphasized the importance of problem resolution for humanization. The professionals highlighted the working conditions and the autonomy of professionals and patients, with the appreciation of each person's knowledge. The intersectoral work revealed itself to be an important challenge for the Brazilian Health System (SUS).*

Key words *Humanization, Communicative action, Conversation networks, Public health SUS*

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Introduction

The implementation of Brazil's Unified Health System (SUS, acronym in Portuguese) undergoes moments in which priorities change, placing greater or lesser emphasis on one principle or another according to strategies or policy options[1]. Brazil's National Humanization Policy (*Política Nacional de Humanização - PNH*) reaffirms the need to invest not only in the expansion of the network and access, but also in the quality of care. Mattos[1] highlights that humanization is central to health policy, despite not being among the core principles of the SUS.

Humanizing practices to promote better quality care and the respect and dignity of service users and healthcare workers was a major component of healthcare reform. Various measures have been taken by the government to promote humanization within the SUS, particularly in maternity and child health services[2-5]. Humanization prioritizes, first and foremost, the quality of healthcare and user satisfaction, followed by issues related to healthcare professionals[3]. Regardless of programs or policy, humanizing practices have always found their niche in healthcare services.

Created in 2003, the PNH seeks to encourage the adoption of humanizing practices within the SUS[6,7]. However, the humanizing and participatory practices that this policy advocates were already present within various services, serving as inspiration for its creation. This article analyzes the discourse of healthcare professionals and service users to gain an insight into the perceptions they hold of humanization and humanizing practices beyond any formal knowledge they might have of humanization policies.

Health organizations are professional, and therefore complex, organizations[8], given the autonomy of health care professionals afforded by the specificity of their knowledge. In such a context, where professionals typically participate in decision-making, mutual adjustment is the preferred coordination mechanism[8]. The target institution of this study, a teaching and research hospital that offers masters and PhD programs, is particularly complex and therefore requires communicative management methods[9]. The communicative spaces that permeate healthcare practices enable the development of a humanizing culture through communicative action[5].

Ensuring access to comprehensive healthcare through health care networks requires the involvement of workers, managers and service users in the work processes that have historically made up the SUS[10]. Given the importance of the relationships between care providers, the effective integration of healthcare professionals into a wider network of services and interdisciplinarity are essential elements of humanizing practice[6].

In Brazil, humanizing practices are regarded as *relational technologies*3;11 and the concept of humanization is closely linked to comprehensiveness[1,11] as a means of upholding this set of principles[3]. The discussion of humanization places changing practices and quality of care at the center of the debate[1-3].

But how can we humanize care? It is through this 'how' that humanization captures the changes in care practices necessary to achieve quality care. Accordingly, care and care management are inextricably linked[5], in so far as work processes transform not only practices, but also the subjects involved in these processes[3]. The work process and process of subjectification are linked in a circular relationship, which may either be virtuous, producing positive health outcomes for both healthcare professionals and service users, or cause the subjects - and the health system itself - to become sick, resulting in poor treatment or total lack of proper care.

Far from being static, the SUS is subject to constant modification and the complexities of public health in a country of continental proportions like Brazil require a constant search for new solutions. Problematizing the role healthcare professionals play in building this network, paying due regard to the comprehensiveness of healthcare, is critical to improving the way the system works.

Humanization and communication

According to Habermas' Theory of Communicative Action, language is assigned the function of intersubjective mediation, enabling human actors to achieve shared understanding by judging shared validity claims in order to coordinate actions[12]. Habermas describes three distinct worlds that relate with each other through the "lifeworld": the objective world, corresponding to things that exist in the physical world; the social world, which is linked to the social and cultural norms of social groups; and the subjective world of inner feelings and perceptions. Composed of culture, society and personality, intertwined with one another through language, the lifeworld represents the terrain of the pre-interpretations that

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guide our actions. Day-to-day actions are performed in two distinct spheres: the system and the lifeworld. The latter is a medium of dialogic space and is reproduced through communicative action, while the system is characterized by instrumental and strategic action[12-14].

This understanding forms the basis for the discussions of several authors[5,15-17] who have conducted assessments of humanizing care initiatives. *Acolhimento-diálogo* (dialogue-based welcoming), for example, helps to form *redes de conversações* (conversation networks) that guide users on a pathway through the services[15], while *Clínica Ampliada* (expanded care) combines traditional clinical care with a patient-centered approach, taking the focus of clinical intervention beyond disease to include the patient and his/her context[16]. Merhy[17] describes healthcare as the *shared intersection* between service user and health worker, which continually materializes in the form of living work in progress and should be grounded in a user-centered approach and, in our view, be necessarily anchored to language[5].

We understand care provision as a process involving hard, soft-hard and soft technology[17]. Communicative action promotes the linkage to and coordination of care and includes all types of technology, since communicative action is the only action capable of articulating the different worlds mentioned above and their respective types of action. Although hard technology requires a type of instrumental action related to strategic contexts of action, it does not prescind from communicative action, since the adoption of a given technology in a healthcare setting calls for consensus on how and when to use it, obtained for example through linguistically mediated protocols. Thus, although humanizing practices are often associated with soft (relational) technology, they cannot prescind from the good use of hard and soft-hard technology, without which the quality of care, a theme at the heart of the PNH, would be compromised.

This article discusses humanization drawing on discourses on the theme proffered by healthcare professionals and service users from two laboratories in a leading teaching and research hospital.

Study design

The study that forms the basis of this article comprises a postgraduate research project undertaken as part of a wider study conducted at the Evandro Chagas Clinical Research Institute (*Instituto de Pesquisa Clínica Evandro Chagas* -IPEC) – formerly called the National Institute of infectology (*Instituto Nacional de Infectologia* – INI) – entitled *Humanização nos serviços de saúde: gestão estratégica no trabalho, produção de saúde e análise cultural* (Humanization in health services: strategic management at work, care provision and cultural analysis) and coordinated by Elizabeth Artmann, researcher at IPEC. The study was approved by the Ethics Committees of the National School of Public Health (*Escola Nacional de Saúde Pública* - ENSP), on 07/9/2007 (application number: 360/07), and IPEC, on 11/29/2007.

Drawing on Habermas' theory of communicative action, the study focused on conversation networks as the key cross-cutting theme[5,15], addressing humanization in the light of the fragmentation of healthcare and of the communicative dimension inherent in the area[12-14]. The study design was anchored in the theoretical framework underpinning the strategic management approach *Démarche Stratégique*[9,18], in which communication, solidarity and interdisciplinarity – major premises of humanization – are viewed as essential components of healthcare.

Semi-structured interviews were conducted with healthcare professionals and service users working/receiving treatment at IPEC's mycology and clinical dermatology laboratories between September and October 2013. The laboratories were chosen according to the role they played in the institution and their working partnerships based on suggestions made by the directors of the hospital. A total of 16 healthcare professionals – six from the clinical dermatology laboratory and 10 from the mycology laboratory – and 44 service users participated in the study. Nine support workers were also interviewed, comprising five nurses, two social workers, and two psychologists.

Participant observation workshops were also conducted in the laboratories, providing a space in which the researcher was able to build a closer relationship with participants and make observations in the field. The data obtained from these discussions was used to complement the data from the interviews.

The service users were randomly selected in the waiting room on alternate days and shifts in order to cover all the periods worked by the various professionals. The only inclusion criterion was that participants should be receiving treatment at the laboratories under study. Participa-

tion was voluntary and all participants signed an informed consent form. Interviews were halted when data saturation was reached.

The interviews were analyzed using the method *Discurso do Sujeito Coletivo* (Discourse of the Collective Subject)[19,20], which suggests that the discourse of the subject is intertwined with the institutional context, enabling the emergence of the social representations[21] that circulate this world. Discourse of the Collective Subject (DCS) comprises four methodological components:

A. Key expressions (KE): literally-transcribed passages describing content and representing discursive arguments, which constitute the raw material for elaborating the discourses of the collective subject.

B. Central Ideas (CIs): reveal the essential elements of the discursive content by identifying the central ideas of each statement.

C. Discourse of the Collective Subject (DCS): unification of key expressions that have central ideas with a similar or complementary meaning to clarify a way of thinking about a fact, norm or human conduct. It is part of the imaginary of a group of people or social actors and, from a Habermasian perspective, permits the researcher to capture the fragments of the lifeworld shared by these actors.

D. Anchoring: comprises the assumptions, theories, concepts or ideologies that underpin the discourse, which may be expressed through clear linguistic markers or underlie day-to-day practices.

Based on an analysis of the individual discourses, collective discourses were elaborated using similar key expressions (KE) that appeared in the statements grouped into central ideas (CI)[19,20]. Anchoring was performed drawing on the theoretical framework and relevant social representations.

The representations in the individual statements or discourses are part of the lifeworld, often in an uncritical way, revealed through anchoring, which are, as Habermas would say, often uncritical, are part of the lifeworld. Through the DCS method, those representations are revealed through anchoring. It is important to note that the meaning of discourse adopted here is the same as that adopted by the DCS explained above.

For the purposes of this study, we selected two questions that brought important reflections for thinking humanization and healthcare based on the work developed at IPEC/INI: 1. '*What do you understand by humanization?*', which was answered by the healthcare professionals; and 2. '*For you, what is being well taken care of?*', which was put to the service users. It is important to note that, in accordance with the DCS methodology[19,20], different questions were used for healthcare professionals and service users to avoid inducing institutional discourse and make sure the participants felt free to use expressions that are part of their world. Furthermore, the semi-structured interview technique also allows interviewees to articulate their thoughts with greater fluency and affords greater flexibility than other methods.

Results

Discourse of the Collective Subject (DCS): healthcare professionals

The polysemic nature of the term humanization is evident from the large number of different ideas expressed in the interviews with healthcare professionals, from which 16 collective discourses were identified. Chart 1 shows these discourses organized alongside the central ideas, some of which are complementary.

The following section discusses these results anchored in the theoretical framework outlined above to obtain a better understanding of the content of these varying discourses.

Discourse A.1 addresses the notion of conversation networks, highlighting the roles played by the different actors involved in healthcare - healthcare professionals and service users alike – who interact, thus contributing towards decision-making. It also reveals the dynamic nature of this network, which, by listening to patients, helps enable them to actively participate in their care[15] and the coordination of actions[22]. It emphasizes the collaboration of various types of professionals who contribute towards decision-making, although treatment is clinically-oriented given the types of problems treated.

Discourse B.1 provides another meaning for the term humanization, addressing another aspect of networking: creating linkages between different health services through referral and counter-referral in situations where the service does not offer the appropriate treatment to ensure that the patient receives the proper care. In this sense, humanization aims to ensure the provision of comprehensive care through the effective management of existing patient flows, making referrals that result in effective health out-

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Chart 1. Discourses related to the question What do you understand by humanization? (healthcare professionals).

Central Ideas	DCS
A. Humanization is the relationship between healthcare actors, interaction between professionals.	A.1: *It's the relationship with other healthcare agents, it's all about networking, it's doctors listening to nurses, or doctors listening to nursing assistants, or the attendant who sometimes makes appropriate and fair observations enhancing the quality of patient care. So, I think that humanized care is the interaction between all these professionals, all actors involved, including the client on the front line. I think that it's a great process, having an answer that we can pass on to another professional, like the clinician, who sometimes needs support given the amount of decisions that have to be made.*
B. Humanization is networking to ensure that patients are not left without care.	B.1: *It's us from the hospital trying to provide the best care possible to our patients. Trying to help them in the best way we can. And if we are unable to provide treatment, try to provide better advice to patients so they don't end up having to go from place to place. Firstly, it's putting yourself in the patients' situation, even if you can't offer what they need, try the best you can to refer them to a place where they can get treatment, so they don't feel lost. Usually, us from social services see both treatment and non-treatment related problems, such as the state of the service network.*
C. Humanization is workers having good conditions to carry out their work, with freedom and other things that facilitate well-being within the service.	C.1: *What do I think in terms of humanization? A job where workers should have job quality, be respected. Where they should have the necessary conditions to do their job. Other than that, freedom. I think that's what humanization basically is, having all the necessary conditions: job quality is fundamental; respect, individual creative capacity, not being influenced by those in charge, the professional actually working for him/herself and being happy. So, as the word says, something to do with interaction, the pleasure of doing what you like, good things; humanization, something that promotes your well-being in your job.*
D. Humanization is taking time to listen to the patient.	D.1: *One of the great tragedies that we see in patient care, not only in Brazil but throughout the world, is lack of time for people, for listening to what the patient has to say. So, in my understanding, it's providing the patient with quality care, and not only using technical resources, but also listening to what the patient has to say, examining, given the opportunity to give feedback whenever he/she has a problem. So it's like a movement, a different way of providing care. I think it's knowing how to listen to the patient, knowing their name, knowing through building a bond, through the family, treating them with respect because usually they are already in a difficult situation, already sick, fragile. It requires something else, a certain awareness on the part of the professional to deal with these people, know how to listen, because sometimes they open up to you.*
E. Humanization is putting human beings at the center of care.	E.1: *Look, I think that regardless of the activity we are talking about, the human being should be the center of care. I reckon it's something like not thinking about what you're doing as something that is isolated, stagnant and mechanical. That it's going to reflect some way on someone and that this someone is the thing oriented towards the center, a man, a human being.*
F. Humanization is welcoming and treating the patient like a human being who needs help, not like a client.	F.1: *Humanization is providing a service thinking more about people, about human beings. For example: in hospital, patients should be treated as human being who need help, not as a client; as people, not as a number. It's kind of redundant. Really make the doctor-patient relationship more human, rather than a prescriber-patient relationship. So we make every effort to make people feel welcome and comfortable, treat patients as human beings, to be warm, patient and know how to approach (the patient).*
G. Humanization is caring, giving the attention and information that the patient needs.	G.1: *I think it's related to the manner in which com you deal with the public in general, a better service for the public. Meeting their needs, meeting expectations within the possibilities provided by the service in the best way possible, seeing (the patient) as a human being in need who is lacking care in the health sense. The first approach, the first eye contact with the patient, he/she is thirsty for someone who listen to what is wrong with them and anxious to obtain information or care and, generally, has some kind of problem that he/she would like someone to take care of.*

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Chart 1. continuation

Central Ideas	DCS
H. Humanization is being concerned about others, preventing pain	H.1: *Humanization is being concerned with the well-being of others. This is even more evident for those who work in health care, because you are dealing with the patient. So you need to know how to approach the patient; consider his/her knowledge and whether he/she is feeling pain or not; because, in our case, we take samples, so we scrape the patients' wounds and that causes a certain amount of discomfort. So we have to know how to deal with them.*
I. Humanization is providing the patient with the type of treatment you would like to receive.	I.1: *Well, I think humanization is treating your fellow man/woman as yourself, providing others with the treatment that you would like to receive. It's about manner, the way you look at things and try to help. Providing the same care that you would give to your family, with maximum attention. Treat everyone well, treat everybody in the same way. Someone may be in need today, but tomorrow it could be you. It's putting yourself in the patient's shoes, it's like someone bringing you a complaint and you having the capacity to put yourself in their situation with that problem, understanding the context surrounding that problem, and how you would react in such a situation. We try to do that, treat (people) well and be well-treated.*
J. Humanization is stripping yourself of prejudice to provide quality care.	J.1: *So, I think humanization is the following: stripping yourself of all prejudice with a view to improving the quality of care.*
K. Humanization is helping teach (patients) to fish, rather than give them fish, not being paternalistic.	K.1: *It's a way of helping, but you don't help someone by doing what he and she is capable of doing, so, rather than giving them fish, we have to help people by teaching them to fish. I see a lot of professionals who confuse humanization with paternalism, taking away all responsibility, infantilizing patients. For me, that's not humanization.*
L. Humanization is seeing the whole patient, beyond his/her illness.	L.1: *Understanding the whole patient, that he/she is not just an illness, that he/she has problems and that we need to understand the whole picture, see the subject as a whole, be sensitive to his/her suffering, while not being paternalistic. The approach envisions the provision of quality care across all its various aspects, focusing more on health than illness. The way I see it, the traditional disease-oriented approach treats a particular problem, effectively casting aside other problems. So humanization is when the patient arrives here and we attempt to understand the whole (person), and not just look at him/her as a "patient".*
M. Humanization is tailoring treatment to the patient's context.	M.1: *We know that one of the major problems associated with HIV is the large number of medications related to a number of problems with infections, They can often have a complicated social life, so we try to adapt in the best way we can so that they come here because they like it, not out of obligation to help them feel better. We don't manage to do this with everybody, of course, because many live on the streets and access is difficult.*
N. Humanization is building a bond with the patient.	N.1: *It's building a bond with the patient. I think it's about caring in a different truly more humanized, way. Humanization is a word that describes the work of ambulatório de adesão (care adherence), which involves active listening. We seek to truly listen to the patient in order to provide the best treatment. They have their privacy, they create a strong bond with us, because they call from home, we call them. So there are two aspects, not only them seeking treatment, but also us: when they fail to turn up we become concerned. It's not about the patient arriving and us explaining like a robot that it's the medication and that's it. We are truly concerned about our patients' well-being, from the minute they arrive to when they don't come. We never give up on them.*

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comes[7]. This meaning of humanization reveals a broader understanding of the term and patient care, highlighting the linkages with other services and openness towards the external environment,

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Chart 1. continuation

Central Ideas	DCS
O. Humanization is having a more humanized perspective that encompasses the institution as a whole, including the well-being of both patients and professionals.	O.1: *Humanization is a term that is more for facilitating "that" type of treatment, providing the same treatment for everyone, improving quality of life, for both the patient and healthcare worker, since humanization is confused with patient well-being. I think, today, humanization is about both patient and worker well-being, encompassing the institution as a whole, delivering quality treatment that benefits everyone. There is in fact a government program that aims to raise awareness within the institution itself of the importance of adopting a more humanized approach with both patients and healthcare professionals throughout the entire institution.*
P. Humanization is having a multidisciplinary perspective and being attentive to the support network.	P.1: *In my understanding, humanization is referring to the patient by their name, listening to each individual case. Here, treatment is multidisciplinary. Patients should seek out social services, regardless of whether they need them or not, to understand their rights and duties and clear up any doubts about treatment and the institution. I think this encompasses the concept of humanization. Looking at the psychological aspects to see if patients are receiving counseling and other specialized treatments, whether the family is supporting the patient, their social security status, patients' housing and family circumstances, health. We look at the patient not just as a patient and his/her disease, Because he/she is part of a whole.*

exemplifying one of the principles laid out by the PNH – the cross-cutting nature of health services, which presupposes that the health system is an organized network[3,7].

The vision of humanization shown by discourse C.1 is oriented towards health workers and the conditions they need to carry their work with quality, respect and freedom. Promoting the dignity of health workers is one the main lines of action of the PNH[6,7,23]. This discourse places special emphasis on freedom, which is related to autonomy, a socially recognized aspect of this concept. As we have seen, this is an essential and incisive feature of professional organizations[8], particularly in the laboratories under study, which boast highly specialized professionals.

It is important to note that the majority of DCSs about humanization address the relationship between healthcare professionals and service users. These discourses are complementary and contain the following central ideas that highlight the uniqueness of this relationship: ensuring patients are involved in their treatment through active listening, clarification and respect; empathy between health worker and service users and treating others the way you would like to be treated; building a *link* with the patient; and professionals who champion quality care tailored to the specific needs of patients. These types of humanizing practices are strongly associated with relational technologies, reflecting current practice in Brazil[3,5,11].

Discourse D.1 highlights the importance of taking time to listen to what the patient has to say and enabling patient participation in the treatment process. According to Habermas, the communication process involves a reciprocal flow and there is an active aspect to listening[24], given that subjects are only able to engage in communicative action because they share pretensions of validity concerning the lifeworld[5].

Discourse E.1 addresses another way of including service users, emphasizing the importance of not seeing practices and procedures in isolation and placing patients at the center of care adopting a patient-centered approach that prioritizes patient well-being[17]. It is interesting to note that this discourse contains key expressions contained in statements made by professionals who do not having frequent contact with patients and but , despite this, who do not hesitate to place service users at the center of care, which shows that they know their work context well.

Discourse F.1 emphasizes that the doctor-patient relationship should be more humane and that the patient should be treated as a person in need rather than a client. This is an allusion to technically based relationships, where patients are often treated as service 'consumers'. These professionals point out that humanized care goes

well beyond this, requiring healthcare workers and institutions to make patients feel comfortable and welcome. Discourse G.1 adds the notion of caring, highlighting the importance of listening to patient needs and expectations. For Ayres[25], restorative care takes place at this junction, where doctors place their technical knowledge at the service of patient needs, acknowledging their otherness.

Discourse H.1 mentions concern for others and the importance of attempting to understand what they are feeling and preventing pain, reflecting an other-oriented approach. In a similar vein, discourse I.1 contains the expression "putting yourself in the patient's shoes", highlighting the importance of identifying with the patient and empathy. The central idea of this discourse is providing the patient with the type of treatment you would like to receive, thus ensuring that everyone receives good care. Complementing this idea, discourse J.1 states that humanization is stripping yourself of all prejudice with a view to improving the quality of care. This remains a challenge despite the following understanding of humanization of the SUS outlined by the baseline document for the PNH: "defense of SUS that recognizes the diversity of the Brazilian people and provides the same treatment for everyone without distinction as to race/color, origin, gender and sexual orientation"[7].

Discourse K.1 highlights the idea of respecting patient autonomy, which is one of the underlying principles of the PNH laid out in the 2008 baseline document[7]. This discourse is anchored in the popular expression 'give a man a fish and you feed him for a day; teach a man to fish and you feed him for a lifetime' and is theoretically grounded in the keywords "paternalism", "infantilize" and "responsibility". We can therefore say that humanized care should promote autonomy by recognizing "the other" and his/her responsibilities and knowledge of him/her self. In early emotional development, where one is absolutely dependent on another's care, it is the maternal gaze that establishes a difference between mother and child by revealing to the child his/her ability to affect others. Even after achieving independence it is necessary to accept that it is not absolute, since the subject is constantly relating to others and therefore continues to need the recognition of others to confirm his/her existence[26]. Paternalism and infantilizing patients or, as is popularly said, "giving a man a fish", are ways of depriving the patient of the opportunity to participate in his/her treatment process, denying the existence of otherness. Honneth[27] distinguishes between three spheres of recognition: love, which refers to affective relations; social order, which legitimizes the freedom and autonomy of people as legal subjects; and solidarity, which confers individuals the capacity for social interaction, respecting their particularities and the particularities of others. Interaction between subjects, where everyone has the same opportunity to participate, presupposes recognition and generates more autonomous subjects, which promotes the care of the self[25].

In discourse L.1 humanization is understood as considering the patient as a whole, beyond the disease, as conceived by *Clínica Ampliada*, pooling the body and care services together with the uniqueness of the subject and the context in which he/she lives[16]. Thus, as expressed in the above-cited discourse, *Clínica Ampliada* expands the traditional vision of care adding new elements to the therapeutic relationship[5,28].

Discourse M.1 falls within this logic of expanded care, suggesting that treatment should be tailored to patient context, which includes psychosocial aspects, exemplified by the case of patients with HIV, a disease which has major social and emotional consequences, and the precarious financial situation of many patients who seek public health services. The discourse also highlights the challenges posed by the precarious living conditions of some patients, which hinder access to healthcare, highlighting the limitations of the health system and need to for an intersectoral approach to care. In this respect, while it is necessary to widen the frame of reference of health workers to meet patient care needs, there is also a need to recognize the individual limitations of these professionals[7,15,29], showing that the provision of more comprehensive and effective care along the lines of the care models of welfare states continues to be a major policy challenge. Magalhães and Bodstein[30] show that the effectiveness of social programs depends on an intricate network involving decision makers, managers, technicians and the population and the mobilization of resources, forming a complex multi-sectoral arrangement. They highlight that it is impossible to tackle complex problems such as healthcare using sectoral approaches, which are doomed to fail because they do not recognize the multiple dimensions of the needs of the population[30,31].

In the same vein as discourses L.1 and M.1, discourse P.1 highlights the importance of having a multidisciplinary perspective and being atten-

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tive to the support network, associating humanization with comprehensiveness. According to Mattos[1,32], despite its polysemic nature, the term comprehensiveness implicitly rejects reductionism. A comprehensive approach to care requires a broad vision of both the patient, together with his/her needs, and care practices, drawing on, for example, other disciplines and services. In this respect, Camargo Júnior[29] draws attention to the risk of confusing comprehensiveness with wholeness, which can lead to *comprehensive medicalization* and loss of autonomy.

Campos[16] addresses the importance of building a bond with the patient expressed by discourse N.1. Creating *links* is essential for building a relationship of trust between the patient and health professional and contributes toward the continuity of treatment. This discourse highlights certain attitudes of healthcare professionals, such as taking time to listen and interest in the patient's treatment, that favor bond building. Artmann and Rivera[5] highlight that *link* is a core device of humanized care strategy consolidation.

Discourse O.1 highlights the importance of valuing the well-being of both service users and professionals and presents a broad conception of humanization, highlighting the overarching cultural features of the institution. This definition alludes to a cross-cutting institutional culture, supported by the PNH as a way of promoting networking, connecting healthcare professionals and service users through a humanizing mentality and, consequently, practices grounded in common values. Drawing on Habermas, Artmann and Rivera[5] explain that, as one of the structural components of the lifeworld, culture conditions our perspectives and actions through symbolic configurations and assumptions stemming from the historical tradition of groups. The authors support a communicative model of cultural evolution that enables the emergence of new discourses, including humanization.

This discourse also differs because it draws attention to the need to address the working conditions of health workers[4] and, more especially, considers both sides: that of the health professional and that of the service user. The baseline document for the PNH[7] highlights that the undervaluation of health workers is a continuing problem in the SUS and confirms that promoting improved working conditions is one of the challenges of this policy, defining humanization as "the valorization of the different subjects involved in the health production process: service users, workers and managers." Given that health workers and service users are the main actors engaged in the health process, each should be taken into consideration by actions aimed at improving care. As highlighted above, the large majority of discourses about humanization refer to the relationship between these actors, showing that humanization occurs at this interface and that the actions oriented towards one influence the other. With respect to service users, the provision of quality care, humanized care is achieved by combining available resources with relational technologies. However, as subjects involved in both care provision and management, health professionals need to have good working conditions to be able to deliver quality care[3]. It is this perspective therefore that underlies the discussions surrounding changes in practices; after all, change can only occur when the work process is also a process that produces subjects who are healthy and, therefore, able to produce health[4].

The humanization of healthcare seeks to improve the quality of care by promoting change in both practices and the subjects, valuing the types of relationships that promote the active participation of both healthcare professionals and service users in the care process[3,4]. Participatory management mechanisms and coresponsibility are ways of promoting joint engagement in care work, ensuring they take a more active role and favoring the formation of networks.

In this respect, Benevides and Passos[3] highlight that humanization should be incorporated as core component of the system, while Hennington[4] suggests that the role of healthcare professionals should be rethought, confirming that they should be seen as key actors in the development of a humanized care network grounded in solidarity.

Discourse of the Collective Subject (DCS): service users

Chart 2 shows the DCSs based on the results of interviews with the 44 service users.

Nine different discourses were identified in the interviews with the service users. Discourse A.2 mentions the high quality of patient care at Fiocruz, showing that this opinion is held even by those who have health insurance, revealing a social representation of health services where the quality of care provided by private health services is seen to be better than that of public services. In discourse H.2, being well taken care of is seen as timely booking of medical appointments and respecting appointment times, showing that

Chart 2. Discourses related to the question For you, what is being well taken care of? (service users).

Central Ideas	DCS
A. Being well taken care of is what happens at Fiocruz/ IPEC, better than other places.	A.2: *I've always thought they provide a good standard of service here. Here, thank God I came here, is marvelous! It's a paradise here! I really recommend it. If there is a way of being treated in Fiocruz then go, because it's really good there, despite having health insurance out there.*
B. Being well taken care of is being made to feel comfortable and welcome, where everyone shows concern, care and kindness.	B.2: *It's a helpful and interested doctor who is truly concerned with the patient, who really wishes you succeed in what you are doing, which I haven't seen in other public services, just here. It's being human, isn't it? From person to person, receiving care, attention, kindness. The doctors here are really pleasant and helpful; the service in the reception. And they treat us right, the way we ask to be treated, in the same way I'm talking here to you; cos sometimes we go to certain places where the service is bad, not very reassuring.*
C. Being well taken care of is having access to good resources.	C.2: *Being well taken care of is service with good resources. I wish the president of the republic would allocate enough doctors and enough of this medication, because people can't afford to buy it, that there were enough hospitals, health centers, good doctors, examinations and that they gave us medication, you know? It encompasses everything: you having the resources for what you want, you having an answer to what you want and the service you want. I get the medications here, which are really expensive.*
D. Being well taken care of is the doctor having expertise and competence.	D.2: *Being well taken care of is the doctor paying attention, knowing the focus, being responsible for what he/she does, assessing the case, researching, studying, being interested in your case, in your diagnosis, what the problem is and how to solve it, it's reassuring. So it's doctors giving attention, trying to find out why the wound won't close, won't heal. I like to arrive at the hospital, have the doctor see me and say what I've got. Outside you go home felling pain, like I have on various occasions, nobody saw me, saying that they didn't even know what it was. So being well taken care of is the doctor being good, knowing that the doctor is good, has knowledge about what you have.*
E. It's welcoming tailored to the needs of each patient.	E.2: *That's what good treatment is to me. I think medical care should really worry about that, when it's a child it should be one type (of treatment), an adult, someone with more schooling, another, you know. That kind of treatment, a minimal level of commitment to people, of treatment, consideration for age. A type of treatment that you don't see much in other institutions. Here we see this type of care with more underprivileged people, who don't have much schooling and need to be explained things, to be made to feel more comfortable.*
F. Being well taken care of is being heard and having your needs understood.	P.2: *For me, being well treated is them (health professionals) knowing my needs and being able to assist me with that. That when you ask for something the doctor knows what you are asking and makes an effort so it works, because sometimes you don't get that response. So, it's giving attention to my needs, not me arriving and them giving the information that they think necessary. It's understanding the patient's situation, being heard, people explaining things to you. Here the doctor talked to me, listened to me, reassured me, they gave me attention, heard my case.*
G. Being well taken care of is the health professional using clear language and clearing up doubts.	G.2: *Being well taken care of is clearing up doubts, because we are laymen. I arrive here with a problem, it's pointless the doctor explaining things using technical terms, because I won't understand anything. So for me, an attentive doctor is one who manages to make me understand what's happening, who gives me feedback on everything. Because I think healthcare professionals should explain things. They studied and that's what they are here for, to see us and clear up doubts. I work with the public and always seek to explain as much as I can and, when I don't know something, I try to find someone who does. I think all services should be like that.*

it continues

lengthy waiting times are common even in private clinics, revealing the same social representation as discourse A.2, i.e. that private services are better than public services.

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Chart 2. continuation

Central Ideas	DCS
H. Being well taken care of is not taking too long to make an appointment and respecting appointment times.	H.2: *Being well taken care of is taking as little time as possible. It was really quick here, it didn't take long, a one-week wait. In fact, the first step towards being respectful is the appointment time. You see doctors make appointments every 15 minutes and take half an hour. So I think being well taken care of is you finding helpful people and respecting appointment times, coming for an appointment and everything being right, being seen in order of arrival, making an appointment and not like waiting for two or three hours to be seen; which happens not only in the public service, as is well known, but we also experience it first-hand in private clinics. You wait even when you pay!*
I. Being well taken care of is having your problem solved.	I.2: *Being well taken care of is going to the doctor, him asking what's wrong, telling him and him giving us a prescription and explaining how to take it, isn't it? It's the doctor paying attention to me and solving my problem. It's essential that the medication the doctor prescribes has effect; because sometimes the doctor can be very helpful but it doesn't have any effect at all. For example, I'm in pain, the doctor sees me, gives me a medication that's right for me, I get better. So I've been well taken care of, the medication worked.*

Discourse B.2 refers to soft technology, valuing the fact that doctors are genuinely concerned about patient well-being and highlighting an underlying assumption of communicative action, which is speaker authenticity, requiring the subjects involved in the interaction to be sincere in their pursuit of a common purpose[5]. The discourse also highlights the different ways in which the speaker is treated, showing that healthcare professionals are generally good-humored, kind and polite. The statement *person to person* also suggests that one of the characteristics of a good patient care is horizontal relationships between healthcare professionals and service users, highlighting another requisite of communicative action: non-coercion, which enables the active participation of tall actors within a nonhierarchical interaction in the search for consensus.

Discourse C.2 mentions the importance of having access to "good resources", which encompasses good doctors, medications and examinations, emphasizing the provision of free medications.

Discourse D.2 highlights that doctor should be interested in the case, in discovering the patient's problem and carrying out research to provide a diagnosis and solve the problem, emphasizing the importance of professional competence. This discourse refers to soft-hard technology[17], since it addresses professional knowledge and underscores the importance of specialized knowledge[16]. The three discourses mentioned above (B.2, C.2 and D.2) show that a good patient care requires access to three types of technology - soft, soft-hard and hard, represented in the discourses by relational technology, professional knowledge and material resources, respectively[33].

Discourse E.2 addresses tailoring patient care to individual needs and characteristics, such as age and schooling, which can be anchored in the PNH guidelines, which promote the valorization of the subjective and collective dimensions of care practices and the management of the SUS, supporting the rights and needs associated with these dimensions[7]. Expanded care[16] also addresses this issue, combining traditional clinical care with the Clinic of the Subject, to provide individualized care tailored to the specific needs of each case[7,28].

Discourse F.2 addresses the theme of communication between doctors and service users, underlining the importance of listening to patients and understanding their needs rather than imposing what the doctor regards as important on the patient to be able to provide adequate care. This discourse highlights the importance of patient knowledge and of the recognition of this knowledge by healthcare professionals. It also highlights the importance of establishing a genuine dialogue between patients and professionals, which requires real listening and real responding to the patient, which according to Teixeira[15] are important elements of effective healthcare professional-service user communication and welcoming, the latter of which should take into account user concerns and involve active listening[7].

Discourse G.2 highlights the importance of using clear nontechnical language that is understandable to the patient and clearing up doubts. This discourse highlights the assumption of intelligibility[14], which states that the language used should be understood by all participants in the conversation. This discourse and the one before it (F.2) complement each other and involve some of the elements of communicative action as, through their shared lifeworld and seeking mutually acceptable validity claims, health professionals and service users negotiate and reach a noncoercive understanding, building consensuses in pursuit of the continuity of treatment[5,14].

Discourse I.2 concerns *resolutividade* ("resolvability", or the capacity of health services to solve individual health problems), highlighting the importance of the treatment having an effect and the patient being cured of the illness. This is the ultimate goal of all patient care: solve the patient's problem and promote health by improving the quality of life. According to Benevides and Passos[3], the position of service users in the debate about the humanization of the SUS is historically tied to claiming their rights or, in other words, to *atenção com acolhimento e de modo resolutivo* (welcoming and resolutive patient care)[3].

On balance, it can be said that the service users interviewed in this study associate good patient care with the type of treatment they receive at IPEC, highlighting the high standard of care provided by professionals and interest in solving problems based on active listening and research.

Final Considerations

According to the collective discourses elaborated from the interviews conducted with healthcare professionals and service users, we can affirm that good patient care depends on the balanced use of three types of technology, all of which play an important role in humanizing practices: hard technology, soft-hard and soft[17,33].

Although in Brazil humanization has traditionally been associated with relational (soft) technologies[11] and the majority of the DCSs of the professionals highlighted the importance of this type of technology, the interviewees, particularly service users, also underlined the importance of the "resolvability" of patient care, which requires articulation between the three types of technology mentioned above.

Research, which demands special attention to work processes, was highlighted by both professionals and service users as a factor that contributes to quality of care and, therefore, to humanization. Another study[34] also highlighted that the ethical aspects of clinical research were factors that were capable of contributing to humanization.

The service users equated the patient care provided at IPEC with humanized care, suggesting that it stands out from other services from the SUS network and private services, highlighting the superiority of its service over other services.

The healthcare professionals emphasized working conditions and professional and patient autonomy, valuing the knowledge of the "other". They also highlighted the importance of teamwork and the limitations of the patient care provided by the institution, suggesting the need for an intersectoral approach and greater integration into the network.

Collaborations

LR Ferreira participated in the conception of the study, the collection and analysis of the data and carried out the final writing of the article. And Artmann participated in the design of the study, data analysis and article writing.

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