

## HUMANIZATION OF HEALTHCARE: PERCEPTION OF A NURSING TEAM IN A NEONATAL AND PAEDIATRIC INTENSIVE CARE UNIT

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### ABSTRACT

The humanization of healthcare is one of the key priorities of healthcare policies in Brazil, and directly reflects on the attitudes of user, employees and managers of health services. The aim of this study was to identify perception of the nursing team in terms of humanization of assistance in a neonatal and paediatric intensive care unit based on exploratory-descriptive research and a qualitative approach. A total of 11 members of a nursing team at the neonatal and paediatric intensive care unit of a hospital in southern Brazil participated in this study. Data was collected by means of semi structured interviews that were subsequently processed according to reference standards of thematic content analysis. This analysis resulted in three thematic categories: to humanize is to perceive the other as all-providing and all-supportive; bonding and communication as humanizing practices; and lack of ambience as a dehumanizing practice. Results showed that perception of the nursing team in relation to humanization is determined by the actual science and awareness of nursing care rather than specific acknowledgement of the National Humanization Policy.

**Descriptors:** Humanization of healthcare. Nursing care. Neonatal nursing. Paediatric nursing.

### RESUMO

*A humanização em saúde é uma das prioridades nas políticas de saúde no Brasil, implicando as atitudes dos usuários, trabalhadores e gestores dos serviços. Este estudo objetivou identificar a percepção da equipe de enfermagem sobre a humanização no cuidado em uma unidade de terapia intensiva neonatal e pediátrica. Trata-se de uma pesquisa exploratória, descritiva, com abordagem qualitativa. Participaram, do estudo, 11 integrantes da equipe de enfermagem da unidade de terapia intensiva neonatal e pediátrica de um hospital do sul do Brasil. A coleta de dados ocorreu por meio de entrevistas semiestruturadas, analisadas conforme referencial da análise de conteúdo temática. Emergiram três categorias temáticas: humanizar é ver o outro como um todo-acolher; o vínculo e a comunicação como práticas humanizadoras; e falta de ambiência como prática desumanizadora. Identificou-se que a compreensão da equipe de enfermagem sobre humanização pauta-se na própria ciência do cuidado de enfermagem, e não especificamente na Política Nacional de Humanização.*

**Descritores:** Humanização da assistência. Cuidados de enfermagem. Enfermagem neonatal. Enfermagem pediátrica.

**Título:** Percepção da equipe de enfermagem sobre humanização em unidade de tratamento intensivo neonatal e pediátrica.

### RESUMEN

*La humanización de la salud es una prioridad en las políticas de salud en Brasil, implicando en las actitudes de los usuarios, de los trabajadores y de los gerentes de los servicios. Este estudio tuvo como objetivo identificar la percepción del personal de enfermería sobre la humanización de la atención en una unidad de cuidados intensivos neonatales y pediátricos. Se trata de un estudio exploratorio, descriptivo, cualitativo. Los participantes fueron 11 miembros del personal de enfermería de la unidad de cuidados intensivos neonatales en un hospital pediátrico en el sur de Brasil. Los datos fueron recolectados a través de entrevistas semiestructuradas analizados a través del análisis de contenido temático. Surgieron tres temas: humanizar es ver al otro como un todo-acoger; la unión y la comunicación como prácticas de humanización y la falta de ambiente como práctica deshumanizante. Se identificó que la comprensión del personal de enfermería sobre la humanización se basa en su propia consciencia sobre los cuidados de enfermería y no específicamente en la Política Nacional de Humanización.*

**Descriptores:** Humanización de la atención. Atención de enfermería. Enfermería neonatal. Enfermería pediátrica.

**Título:** Percepción del equipo de enfermería acerca de la humanización en la unidad de cuidados intensivos neonatal y pediátrica.

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## INTRODUCTION

In the healthcare sector, concerns with issues related to the provision of public health services contributed to creation of the National Humanization Policy (PNH), in 2004. When this policy was launched, it represented an advancement and a huge challenge for professionals of the National Health Service (*Sistema Único de Saúde - SUS*), considering that the new requirement and feasibility of the policy demanded valorisation of users, employees and managers involved in the healthcare provision process. This valorisation is interwoven with the incentive for autonomy of these individuals, and increased levels of co-responsibility in the provision of health services. Consequently, measures to change models of assistance and work process management in different representative institutions of SUS were taken, based on the needs of citizens, commitment with the ambience, and improvements of work and assistance conditions<sup>(1)</sup>.

After eight years of its publication, however, implementation of the PNH in healthcare institutions has revealed weaknesses that contribute to the contenance of problems that encouraged its creation. These problems interfere with the practice of humanization of healthcare services include an understanding of this policy on behalf of professionals. A study conducted with nursing technicians in a neonatal intensive care unit (ICU) showed that the concept of humanization is chiefly linked to good relations between staff members of the care unit<sup>(2)</sup>.

In addition to this simplistic outlook of PNH, another undermining factor of its implementation is permanence of the biologicistic and fragmented practice of care in health services on behalf of both professionals and users<sup>(3)</sup>.

The desire to conduct this study arose from the academic and practice background of the authors in the children's and maternity healthcare services sector, especially in the intensive care environment, considering that neonatal and paediatric intensive care requires assistance based on technological equipment and constant monitoring under a level of stress that equally overburdens the professionals, the children and their parents. Given the specific nature of this practice, which targets the child, newborn babies and their families, under these circumstances, the relationship between all the parties involved can be affected. The topic of investigation was therefore determined as: What is the perception of the nursing

team of the neonatal and paediatric ICU in terms of humanization of this work process?

Investigation of this topic was considered important as a form of promoting an understanding of healthcare professionals on the PNH and the creation of strategies that facilitate the practice of humanization in a neonatal and paediatric intensive care environment. In this context, the aim of this study is to identify the perception of a nursing team on the humanization of care in a neonatal and paediatric intensive care unit.

## METHODOLOGY

This study is exploratory and descriptive with a qualitative approach. Selection of this study design was based on the need to acknowledge definitions, motives, aspirations, attitudes, beliefs and values to obtain a description of real experiences and phenomena that cannot be reduced to operationalization of variables<sup>(4)</sup>.

This study was conducted in the neonatal and paediatric ICU of a private hospital in a municipality of the southern region of Brazil. A total of 11 members of a nursing team participated in the study (three nurses and eight nursing technicians). An inclusion criteria was adopted for selection of participants, namely that the member had been in the nursing team for at least six months, as this period allows adequate adaptation of the collaborator in the institution in terms of routine and dynamics of the ICU. An exclusion criteria was also adopted, namely that the participant did not occupy a management position, considering that nurses with management positions in this institution are responsible for the entire children's and maternity unit and do not practice directly in the neonatal and paediatrics ICU.

To determine number of participants, the data saturation criteria was used, that is, when data became repetitive, collection was concluded<sup>(5)</sup>. Data was collected between September and October 2010, using a semi-structured interview technique<sup>(4)</sup>. Interviews were conducted in the facilities of the abovementioned unit, at previously scheduled times, taking care to preserve privacy and prevent interruptions. To ensure full utilization of data, the interviews were recorded and subsequently transcribed for analysis.

All transcriptions were analysed using the thematic content analysis method. This method

consists of three stages: pre-analysis; study of material; and treatment, inference and interpretation of obtained results<sup>(4)</sup>.

This study was approved by the Research Ethics Committee of the institution of origin of this study, according to decision 0109, with observance of Resolution 196/1996. All interviewees were notified on the aims of this study and the implications of their participation, and received guarantees of anonymity and the possibility of withdrawing from the study at any time. After accepting to participate in the study, they signed two copies of the Consent Agreement, one of which was handed to the interviewee and the other handed to the researcher.

## RESULTS AND DISCUSSION

Participants of this study were all women. In terms of academic background, seven professionals had completed secondary education and a nursing technician course; three participants had completed their higher education studies; and one professional claimed she had not completed her higher education studies. Average duration of qualification of the interviewees ranged from one to five years.

Data analysis of these individuals allowed the creation of three thematic categories: to humanize is to perceive the other as all-providing and all-supportive; bonding and communication as humanizing practices; and lack of ambience as a dehumanizing practice. These categories revealed constituent elements of perception on the humanization of care.

### To humanize is to perceive the other as all-providing and all-supportive

The aim of this category is to identify perception of the nursing team on humanization of healthcare. Statements of the participants showed that they perceive humanization as an assistance modality that is the result of knowledge and practice of several professional categories of healthcare provision. The key focus of this knowledge and practice is a broader perspective on the **care recipient**.

*[...] It is to look at the patient under a different light, not as if he were here just for simple routine care, as someone who is here to be considered as a whole. Here, in our sector, it's a little different because the patients are a bit younger and they do not respond to our requests [...] (H2).*

*It is to perceive the patient as a whole, not just to provide routine care and nothing else... comforting, looking at the patient holistically, chatting, in the case of paediatric patients, because they like playing and joking, to be outgoing so it does not become a bad environment. So that they can trust us (H5).*

For the participants, humanization is represented by the expression perception as a whole, differently, which means to provide care beyond the limits of technical procedure. This perception complies with the results of other studies<sup>(6)</sup> and enhances the idea that care, in spite of the required specialization, must be provided by a professional with a more complex, holistic outlook, who is capable of viewing the care recipient as a human being.

Humanization is perceived as the capacity to put oneself in the place of the other. The aim of this capacity on behalf of the professional is to understand the experiences and feelings of the patient and is considered the basis of empathy<sup>(6-8)</sup>. Similarly, the capacity to be empathic is based on the ability to place oneself in the position of others in order to perceive the world as it is perceived by others, and understand what others are feeling in order to understand their experiences<sup>(9)</sup>. Empathy is therefore the perception of the other under different circumstances and in a different way; it is to place oneself in the place of the other, as portrayed in the statements.

The PNH was created to support the challenge of adopting principles of the SUS to prioritize quality medical assistance. However, how is quality assistance defined in this policy? Quality involves changes at different levels, including organization, institutional work relations, conditions of service provision and the product offered to user, that is, quality is closely related to the concept of humanization.

Humanization is acknowledged as valorisation of the different subjects involved in the process of health services provision. Moreover, valorisation of these subjects suggests respect and understanding of the subjective and social aspects in all assistance and management practices of the SUS. It represents a way of including the not-me, which can feel strange to the subject, while also causing contentment, joy and well-being. Inclusion of the other is an ambiguous action that must be learned by the professional to enable co-existence with everything that is different<sup>(1)</sup>. The acquired ability to include the other, to value and respect other people, can be interpreted as empathy.

In the case of a child admitted at the neonatal and paediatric ICU, considering that a child is dependent on others, empathy is extended to the family member. The family is perceived as being part of humanized care directed towards the child, as revealed in statements H4 and H3:

*To humanize is to care for the patient with lots of affection, to have a holistic approach, not only for the child, but also for the colleagues and family, it is not merely doing the basic things, the routine work, it is to have lots of patience to explain everything to the parents (H4).*

*[...] Make sure the parents feel more confident so that when they leave, they can rest assured and know their child is in good hands (H3).*

ICUs are characteristically equipped with a technological arsenal and require professionals with technical and scientific training. This environment may seem frightening to family members of the children in care and consequently trigger a wide range of conflicts<sup>(10,11)</sup>. Difficulties detected in the current scenario for implementation of the PNH include interaction of teams and lack of preparation to deal with the subjective aspects of care. This lack of preparation is directly related to assistance based on the “treat em and street em” approach supported by the biomedical model<sup>(1)</sup>, which was not detected in this study.

According to the statements, the nursing team showed respect towards users of the ICU, revealing the presence of one of the principles that sustain the PNH. The nursing team additionally expressed their concern in perceiving the patient as a whole, in a holistic manner, which invalidates the model of assistance that exclusively focuses on illnesses. One of the forms of providing humanized care for patients and their families, and that is directly related to empathy, is quality care. For the interviewees, quality care is defined as:

*[...] caring [...]giving it your all [...] especially in paediatrics. I try to focus all my attention on the patient and the family member that is there, because for them the simple fact of being in the ICU is traumatizing (H11).*

*[...] doing your best for a patient and each patient is an individual. They don't all have the same problem, so, comforting, anything you can do to make a patient feel better, right? [...] if he is crying it's because something is not right, so you have to try to do something for him... Change his position, make the nest a little more welcoming (H3).*

This finding is different to that of another study<sup>(10)</sup> that additionally showed that parents are still not allowed to remain in neonatal ICUs in many Brazilian institutions. Quality care requires the creation of listening and reception areas that permit interaction between the user and the employee<sup>(1)</sup>, and acknowledgement of the needs of patients and their family members, and their resolution. It cannot be considered a moment or activity, but rather the practice of care that is present during the entire relationship between patients and the nursing team<sup>(11,12)</sup>.

Humanization actions in neonatal care should focus on respecting individualities, the assurance of technology that provides security for the newborn infant, and accommodation and care of the child and his or her family, with emphasis on care towards development and psyche in order to strengthen the bond between parents and babies during the hospital stay and after the patient's release<sup>(12,13)</sup>.

### **Bonding and communication as humanizing practices**

One of the key factors that contribute to humanization is the professional's capacity to establish a **bond**.

*[...] Strengthening the bond with a child and his or her parents to do a good job, because I am working with someone's life. Not only for the child, but also for my colleagues, for management, and, mainly, for the parents (H1).*

*Building a bond with the parents is important because you build a relation of trust...Even with the team, the bond is important (H3).*

The relationship between the team of professionals and the user can evolve towards a closer bond once the family feels comprehended and its needs are addressed. In the neonatal ICU, interaction of the healthcare professional with the parents should allow a greater understanding, on behalf of the parents, of this environment, which in turn contributes to success of treatment and acceptance of the child's hospital admission. This relationship with healthcare professionals can divert the perspective centred on the illness to an approach centred on the experience of the child and family, enabling greater presence, interest and concern with the parents to form a bond of complicity<sup>(10,12)</sup>.

Based on this perspective, creation and maintenance of the bond in relationships between the team, patient and family is essential in the intensive area environment. This bond, however, should not merely occur between professionals and users; it should also be extended to professional relationships. According to the PNH philosophy, quality care prioritizes the forming of networks and bonds between several professionals to enable integrality and valorisation of the subjects<sup>(1,13)</sup>.

Team work does not simply involve adding functions to achieve a common objective, which, in this case, is humanization. It also represents joining competencies, understanding differences and establishing an integrating and problematizing relational process that can restore truly human sentiments. This does not imply simple adaptation, accommodation or adjustment of professional differences, which are all symptoms of dehumanization. It implies perception of oneself and of the world, without absolutization, as a debate of ideas, development of the creative capacity and critical awareness, of fundamental elements that establish an authentic bond of interdependence and/or team dependence in the interdisciplinary environment<sup>(1,8)</sup>.

The creation of an authentic bond is essential, as opposed to the simple formation of a team, considering that a team can work together to achieve the same objective, which is to complete routine work, without establishing a bond between its members. The individuals that work together are different, with their own beliefs, thoughts and ideas that must be respected<sup>(9,14)</sup>. Moreover, the tense environment of an ICU can be an aggravating factor if there is no authentic bond, resulting in an inhumane and mechanistic practice.

Another factor that contributes to humanization is **communication**.

*Good communication makes it easier (H10).*

*Effective communication in the verbal and non-verbal sense makes it easier; with a work colleague, with the family... (H12).*

A team must essentially share the same objective so that all the members can achieve humanization in the provision of healthcare services<sup>(15)</sup>. Work relations and bonds that humans establish are not possible without efficient and effective communication. This communication involves the exchanging

of messages and fundamentally comprises a sender, the message itself, a meaning, and a context in which interaction can occur<sup>(16)</sup>. Adequate communication helps to diminish possible conflicts and clarify doubts, and is the basic instrument of effective nurse care. Only communication allows an understanding of the patient as a whole and identification of the effect a health problem may have on the patient. Nurses who know how to use adequate therapeutic communication techniques also have a favourable resource that provides a humanistic approach to communication and their interpersonal relationships<sup>(14)</sup>.

Communication therefore plays a fundamental role in humanized care and the demonstration of respect on behalf of the nursing team, which spends most time with the patient and family members. A good relationship between individuals is not possible without good communication. Studies on humanization of nurse care reveal that communication between healthcare professionals can lead to the humanization of practices and, consequently, to significant changes in the processes of work, problem-solving and quality of care, in addition to promoting universal health<sup>(17)</sup>.

### **Lack of ambience as a dehumanizing practice**

In this category, the nursing team mentioned difficulties related to the absence of planning for activities that enable humanized care within the work environment, such as lack of professional support and encouragement.

*Lack of psychological support for employees. You have to cope with your fears, your sadness and your stress alone (H12).*

*You have to find motivation alone, lift your own spirits. We end up focusing only on the process and forget to consider our colleagues, the patient and family member as a person (H9).*

This statement reveals the need for humanizing actions in relation to professionals, such as moments of reflection with the team and psychological support for professionals, as well as stimulus for motivation. In the PNH, as mentioned previously, lack of professional preparation is targeted as one of the factors that contribute to difficulties in applying the policy<sup>(1)</sup>, but what work conditions are provided to prepare this professional?

The PNH acknowledged that concern with the ambience facilitates the practice of this policy. This concern is based on the understanding that the physical hospital environment involves an area of social, professional and interpersonal relationships. These relationships are the foundation of quality care and decisive for interrelations between people and spaces, which, in this case, refers to employees and the work space<sup>(1)</sup>.

The creation of democratic debate environments for employees, receptiveness and listening to actors of this work process can contribute to autonomy and involvement of the professional who provides care<sup>(17)</sup>. Statements show that there is a need for construction of this space, in which professionals can also express their fears and limitations. This space represents an expression of care to the employees and encourages professionals to provide humanized care<sup>(1,7)</sup>.

In addition to the expressed lack of planning of actions that enable this care and receptivity, the **lack of adequate physical structure** that is compatible with the ambience of the PNH is also mentioned as a factor that limits humanized care in the neonatal and paediatric ICU. Some employees questioned their own capacity to assist patients in accordance with the precepts of humanization because they believe that their professional practice is not conducted in a work environment they consider humanized. Difficulties they mentioned are:

*[...] our physical structure is inappropriate of us, professionals, and we don't even have an appropriate place to change clothes or leave our belongings, and that eventually affects our motivation. It's discouraging (H8).*

*[...] the physical environment, the amount of things around us and our team itself, it's impossible not to create a stressful environment, it cannot be anything else other than a stressful environment (H2).*

Studies show that the correct application of humanization standards or actions in any hospital environment requires the appropriate physical and human structure, as overburdened people or environments without resources result in the natural tendency to mechanize nursing procedures, which is contrary to the ideal of humanization<sup>(7,12)</sup>. This is not about planning actions for a hospital of the future, but about building on what is already available<sup>(7,12)</sup>.

The topic of physical space is a source of significant discomfort for professionals, who feel constrained and exposed. The lack of physical hospital space is reported in other studies on implementation of the PNH<sup>(7,12)</sup>. In relation to hospital employees, support areas such as lounge and washing/eating areas should be appropriately arranged, either in a sufficient number or for all the professionals that work in the hospital, from receptionists to physicians<sup>(1)</sup>. Today, some professionals still believe that humanization should only exist for those who provide nursing care, and not for all employees of the institution<sup>(18)</sup>.

While humanization of healthcare is not restricted to the physical structure, the nursing team believes that a good physical structure provides a better work environment. Similarly, although the neonatal and paediatric ICU work process leads to constant physical and mental strain and involves factors that create obstacles for humanized assistance, the team seeks an ideal to provide care that is considered state-of-the-art in order to meet the needs of patients and their families, and tries to maintain a pleasant environment within the team.

## CONCLUSION

Results showed that perception of the nursing team in relation to humanization is determined by the actual science and awareness of nursing care rather than specific acknowledgement of the National Humanization Policy or changes in healthcare services for its implementation. Humanized care involves a holistic approach, quality assistance and receptivity, bonding relationships and communication. The PNH established these characteristics as being important for implementation of the policy, although they must be coupled with service management that, in turn, requires knowledge of government policies in relation to humanization, and the association of changes in service management.

The topic of physical structure, work environment and care was considered by the professionals as non-humanized due to lack of planning of actions that target humanization in the institution. These factors reinforce the lack of involvement of institutional management in the implementation of the PNH.

This study did not contain limitations that could compromise results. However, the develop-

ment of additional studies on this subject is recommended, with the application of different methods in different institutions.

This study is considered a contribution to the continuous process of discussion, implementation and consolidation of the PNH, especially to stimulate participation and valorisation of nursing which is essentially based on the concept of care.

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