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SHORT REVIEW

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Proposal for the Universalization of Humanized Care in Health Centers: Oncological Individuals

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Abstract: Introduction: Cancer is the main public health problem in the world and is already among the top four causes of death before the age of 70 in most countries. In this context, the interest in quality in the care of cancer services is evident. Because of this, several techniques and methods for this measurement are beginning to emerge, but so far there is no valid and reliable methodological strategy of consensus among researchers, except for the HUMAS and QUALISUS (Brazil) scale. **Objective:** To present the main strategies and criteria to propose a standard model for the validation of humanized care of oncological individuals from Brazil to the world, based on HUMAS international and QUALISUS in Brazil. **Methods:** The present study followed a review model of the main national and international public health legislation from Brazil (QUALISUS), WHO (World Health Organization), Health Professional Humanization Scale (HUMAS), and scientific articles. **Results:** Due to the automation of care, the concept of humanization of care has been increasingly discussed in the scientific literature. Respect for the patient's dignity, uniqueness, individuality, and humanity, as well as adequate working conditions and sufficient human and material resources, are the key elements of the humanization of care that were highlighted in this study's proposal. The factors that can contribute the most to the humanization process are the affection in the service, the friendliness and the smile, and the ones that can make it more difficult are the bad mood, the noise, and the punctual non-attendance. **Conclusion:** This study presented the main strategies and criteria to propose a standard model for the validation of humanized care of oncological individuals from Brazil to the world, strongly pointing out that hospital humanization must be experienced and felt by all who work in the hospital and need to reflect on the care offered to clients and their families.

Keywords: Service, Reception, Humanization, Cancer patients, Service process.

1. Introduction

Cancer is the main public health problem in the world and is already among the top four causes of death before the age of 70 in most countries [1]. Cancer incidence and mortality are increasing worldwide, partly due to aging, population growth, as well as changes in the distribution and prevalence of cancer risk factors, especially those associated with socioeconomic development. There is a transition of the main types of cancer observed in developing countries, with a decline in the types of cancer associated with infections and an increase in the types of tumors associated with a sedentary lifestyle, inadequate diet, among others [1].

In this context, the interest in quality in the care of cancer services is evident [2-4]. Before, the evaluation was aimed at analyzing the costs of the activities developed, but in the 1980s, the user's opinion as a determining aspect in the judgment of quality began to stand out [5]. In Brazil, this change gains momentum with the creation of SUS. The evaluation of user satisfaction becomes important. It is not possible to evaluate the process without the user's involvement [6].

Due to satisfaction having a subjective character, several authors report difficulty in measuring it. Because of this, several techniques and methods for this measurement start to emerge, but so far there is no valid and reliable methodological strategy of consensus among researchers, except for the HUMAS [7] and QUALISUS (Brazil) scale, which can be an instrument easy to apply and codify to address the humanization of care, not only in research, but also in practice [6, 8].

2. Health Care Qualification Policy (QUALISUS)

The Qualification Policy for Health Care in the Unified Health System - QUALISUS was created to raise the level of quality of health care provided to the population by the Unified Health System, leading to greater user satisfaction with the system and legitimization of the health policy developed in Brazil [9].

According to QUALISUS, quality improvement must maintain the guarantee of equity and integrality in the health system, that is, in the population's access to all levels of assistance according to the needs of each citizen and in changing health practices. Also, improving the quality of health care provided to citizens requires, in addition to improving the technical dimension, improving the interpersonal dimension. The quality improvement will be summarized in a set of proposals for concrete changes in techniques and practices, but also a change in attitude, focusing on all these efforts on the users of the health system [10].

Still in this scenario, the dimensions of health quality are defined as resoluteness, efficacy, and effectiveness of health care, reduction of health risks, humanization of relationships between professionals and the health system with users, promptness in care and comfort in care citizens, the motivation of health professionals, social control by the population in the care and organization of the country's health system. Thus, QUALISUS 'lines of action are aimed at qualifying the urgency system, accessing and qualifying assistance of medium complexity, qualifying primary care, qualifying management, and regulating the health system [10, 11].

QUALISUS also highlights the prioritization of the emergency hospital door for admission to the hospital, implementation of user embracement, respect for users' rights, division of urgent and emergency care areas according to the patient's risk classification, improvement of diagnostic and therapeutic resolution, accountability and ensuring continuity of care [9, 10]. It also recommends welcoming, user rights, welcoming with risk assessment, organizing multiple waiting spaces due to complexity, making chairs comfortable, cleaning, drinking fountains, lighting, information, visual communication, air conditioning, etc., training the reception team in relational processes, ensure companion in consultations and in the observation / rear area, ensure adequate food for users who are under observation and hospitalized, establish open visits with scheduled times with caregivers, apply the Statute for the Elderly and Children and Adolescents, create a humanization group with defined work plan [10].

In this sense, welcoming the user is a technical-assistance action that presupposes a change in the professional / user relationship and its social network through technical, ethical, humanitarian, and solidarity parameters, recognizing the user as an active subject and participant in the process. health production [12]. The hosting technology with risk classification, presupposes the determination of agility in service based on the analysis, from the perspective of a pre-established protocol, of the user's degree of need, providing attention centered on the level of complexity and not on the order of arrival. In this way, a need assessment and classification is performed, distancing itself from the traditional concept of screening and its exclusionary practices, since all will be attended to [13].

Thus, the reception process with risk assessment, as proposed by this policy, will consist of the following steps: 1) the user, when looking for the Emergency Service, should go to the Reception Center which will have as objectives: direct and organize the flow through identifying the different demands of the user; determine the areas of care at the primary level, 2) welcoming patients and family members in demand for information about the care process, time and reason for waiting, 3) primary assessment, based on the situation protocol, complaint, forwarding the cases they need to the risk classification by the nurse [14].

Thus, the approach and use of the term "humanization" are very present in the health area. To corroborate all these questions, a study evaluated and validated the Health Professional Humanization Scale (HUMAS). The results of the analyzes confirm that the Health Professional Humanization Scale (HUMAS) has adequate validity and reliability and defines the humanization of care with a multidimensional profile, composed of affection, self-efficacy, emotional understanding, optimistic disposition, and sociability [7].

Therefore, the present study aimed to present the main strategies and criteria to propose a standard model for the validation of humanized care of oncological individuals from Brazil to the world, based on HUMAS international and QUALISUS from Brazil.

3. Methods

3.1 Study Design

The present study followed a review model of the main national and international public health legislation. After literary search criteria using the MeSH Terms that were cited in the item below on "Search strategies", a total of 43 official documents from Brazil (QUALISUS), WHO (World Health Organization), Health Professional Humanization Scale (HUMAS) and scientific articles were submitted to the eligibility analysis and, after that, 21 documents were selected.

3.2 Search Strategy and Information Sources

The search strategy was carried out in the Web of Science and Scopus indexed journals, PubMed, Cochrane Library, UNESCO, WHO, Ministry of Health (Brazil) website. MeSH Terms: *Service; Reception; Humanization; Cancer patients; Service process*, and use of "and" Booleans between MeSH terms and "or" among historical findings.

4. Development and Discussion

4.1 Proposal - Evaluation Dimensions

For the choice of dimensions to be used in the instrument to be elaborated, the contributions of some authors were based, among them, the definitions of Donabedian and Minayo stand out. Another source of information for this definition was the health service qualification policies, and it is worth highlighting the importance of QUALISUS. A study that subsidized this process in a very influential way was PRO-ADESS, which sought from a theoretical review and discussions to propose a new evaluation methodology and will be focused on the health services of Brazilians [10].

Because of this framework, and following the assumption that the instrument for assessing the quality of care provided by the hospital and by medical professionals and nurses, should not be based on the technical criterion to the patient's diagnostic, therapeutic, and healing capacity [15, 16]. Thus, the following dimensions were chosen to be evaluated:

a) respect for the rights of people, users, health services;

b) the reception provided by the service and the workers;

c) and the perception of the quality of care by users.

This ensures a subjective perspective made by users, focusing on their social relationships. The rights of individuals were defined in five main categories, defined as confidentiality, privacy in care, right to information, comfort, dignity, and courtesy [16].

Still, the reception provided by services and workers should be analyzed not as a screening, but as a continuous action that must occur in all places and moments of health care. The dimension of the perception of the quality of professional assistance by users will be constituted by the other two dimensions (respect for the rights of people and welcoming the user) concerning the professional/patient relationship, having the person as the object and not the disease. But, it also focuses on the fulfillment of the service routine and the evaluation of users regarding the service provided [10].

Also, the path traced to arrive at the elaboration of the instrument will pass through the construction of a matrix of analysis of the dimensions that had a purpose to give coherence to the formulated objectives and the elaboration of the instrument. This matrix will be constituted by the categories of analysis of the dimensions, their descriptors, the place to be evaluated, and the guiding question of construction of the instrument, according to the pre-defined model in the methodology of this study. The next step for the elaboration of the matrix will occur cumulatively from the qualitative dimensions adopted as respect for the users' rights, the reception provided by the unit and workers and perception of the quality of assistance by the users if the analytical categories and their description were defined [6, 7] (Table 1).

4.2 Development of the User Satisfaction Instrument

Therefore, for the preparation of the instrument, the questionnaire will be divided into two blocks. The first, user characterization, with some open questions or multiple-choice, for a better description. The second, measuring the user's perception of the quality of the service, divided into the evaluations of reception/reception/screening, emergency care, emergency, and general hospital evaluation. To characterize the users, we will try to ask questions that would be related to the evaluations of the service originated by the users, such as gender, year of birth, marital status, the city you live in, education, main occupation, race, religion, logistics until health unit, if there were companions if there was a referral.

Table 1 Elaboration of the matrix - qualitative dimensions.

DIMENSIONS	ANALYTICAL CATEGORIES	DESCRIPTORS
USERS' RIGHTS	Service privacy	No physical exposure to the patient.
	Right to information	Access to information about medical decisions about your diagnosis and treatment.
	Comfort	Environmental infrastructure conditions: • Adequacy of the furniture (bed, stretcher, chair, etc.); • Cleanliness of the environment; • Edible food; • Ventilation and ambient temperature; • Clean and adequate clothing; • Adequate lighting; • Presence of unpleasant noise.

Table 2 Questions that would be related to the evaluations of the service originated by the users.

✓ **Users' rights**
✓ **Reception**
✓ **Evaluation of reception / reception:**
✓ **São Are there enough chairs to accommodate everyone?**
✓ **Are the chairs comfortable?**
✓ **Is the environment clean?**
✓ **When you arrived at the hospital, were you treated in a kind and respectful manner?**
✓ **Is the environment ventilated?**
✓ **At the reception, were health professionals available to provide guidance and referrals whenever requested?**
✓ **Did you find any obstacles to entering the hospital?**
✓ **When you were examined, were you exposed to people other than healthcare professionals?**
✓ **Did the doctor who attended inform you about the problem you had and what treatment would you perform?**
✓ **Is the furniture well maintained?**
✓ **Is the environment clean?**
✓ **Does the environment have a pleasant temperature?**
✓ **When treated, did the professionals behave in a gentle and respectful manner?**
✓ **Whenever needed, did health professionals stand by to respond to your requests?**
✓ **During the entire period you were in the hospital, was the presence of a companion allowed?**
✓ **Did you feel confident in the professional who attended to tell you about the health problem?**
✓ **How do you evaluate the waiting time to be served?**

✓ **How do you evaluate the waiting times for laboratory and imaging tests?**
✓ **During the consultation, did the doctor listen carefully to your complaint?**
✓ **During the consultation, did the nurse listen carefully to your complaint?**
✓ **During the consultation, did the doctor examine you carefully and in detail?**
✓ **Did the doctor inform you about the diagnosis and treatment to be performed?**
✓ **Is the administration of medication by nursing carried out carefully?**
✓ **Does the head of nursing in the coordination of the auxiliary team guarantee adequate conduct?**
✓ **Are there enough doctors and nurses to ensure good care?**
✓ **In general, how do you evaluate the care provided by the hospital?**

From the guiding questions in the dimension evaluation matrix, the questions to be elaborated in the user satisfaction evaluation questionnaire will be formulated, colored according to the dimensions to be evaluated organized in the order form which they should be evaluated (Table 2) [6, 7].

4.3 Main Literary Findings to Support the Present Proposal

Due to the automation of care, the concept of 'humanization of care' has been increasingly discussed in the scientific literature. A systematic review study identified the key elements of humanization of care, investigating the perspectives of patients, patient caregivers, health professionals. 14 full-text articles were included in the review. Three main areas emerged (relational, organizational, structural) and 30 key elements (for example, relationship, holistic approach, adequate working conditions). As a result, several barriers were found to implement the humanization of care in all areas. Respect for the patient's dignity, uniqueness, individuality, and humanity, as well as adequate working conditions and sufficient human and material resources, is the most discussed key elements of humanization of care according to the different areas explored. Future studies that thoroughly examine strategies for implementing humanized care and quantitatively test its effectiveness are needed [17].

Another study carried out a reflection on humanization in health through a conceptual analysis of the term itself and the interpretation of the statements of nurses who work in the Intensive Care Unit. It was concluded that nurses have an intuitive view of the definition of humanization, understanding the need to perform holistic assistance in addition to mere technique and also covering the physiological, psychological, social, and spiritual aspects of care. However, they demonstrate the unpreparedness of professional training for the implementation of this humanized assistance [18].

Also, a quantitative, observational, and transversal study researched the work environment based on the ideals of humanization, through the analysis of the explanatory value of emotional intelligence and empathy in the nursing team. The sample consisted of 338 Spanish nurses with an average age of 32 years. The instruments used for analysis were the Health Professional Humanization Scale (HUMAS), the Brief Emotional Intelligence Inventory for Adults, and the Basic Empathy Scale (BES). The management of mood and stress - both components of emotional intelligence - and cognitive empathy explained more than half (51%) of the variability found in the humanization of care in a sample of nurses. In addition, the proposed mediation models emphasized the mediating role of cognitive empathy in managing stress and improving mood and its relationship with humanization [19].

Besides, a study analyzed the concept of humanization and pointed out the main aspects that contribute or hinder the humanization of hospital care, in the opinion of cancer patients. The factors that most contributed to humanization were the affection in the service, the friendliness, and the smile, and the ones that made it difficult were the bad mood, the noise, and the punctual non-attendance. Therefore, hospital humanization must be experienced and felt by everyone who works at the hospital and needs to be reflected in the care offered to the client and their families [20].

Another study analyzed the need for humanized care for patients undergoing chemotherapy. 23 interviews were conducted and a field diary was kept. As a result, it was shown that

cancer patients undergoing chemotherapy need humanized care. The emotional, spiritual, social, and affective needs were highlighted as a consequence of the impact of the news of the diagnosis and the notable physical changes faced by these patients. The dehumanization category of care was related to the diagnosis information and the communication that the team maintained with these patients [21].

5. Conclusion

Therefore, the present study presented the main strategies and criteria to propose a standard model for the validation of humanized care of oncological individuals from Brazil to the world, strongly pointing out that hospital humanization must be experienced and felt by all who work in the hospital and need to be reflected in the care offered to the client and their families.

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No additional data are available

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Not Applicable

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Yes

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