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SOCIAL REPRESENTATIONS OF HUMANIZATION IN HOSPITAL PEDIATRICS AMONG HEALTH PROFESSIONALS

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ABSTRACT. Humanization aims at transforming the institutional model of health by valuing the subjective, historical and socio-cultural aspects of health and disease processes. However, because it carries multiple meanings, its implementation has been a challenge in several public health services. Therefore, this study aimed to apprehend the social representations about humanization in pediatrics among health professionals who work in this context. It is a qualitative research, carried out in a university hospital in the northeast, with the participation of twelve health professionals from eight categories. To apprehend the data, a semi-structured interview was used, whose data were analyzed through thematic categorical analysis. The data allowed the construction of three thematic categories: the context of pediatrics, care practices and humanization. It was found that although it is gratifying to work in pediatrics, there are difficulties in the relationships between the professionals themselves and between the professionals and the caregivers of the children. Care practices are mainly supported by humanistic values expressed in affective ties and in the effective use of clinical reasoning and materials. Humanization, in turn, was represented predominantly by humanistic values, although there are some representational elements that refer to aspects of the National Humanization Policy. The absence of arguments based on the user's right to quality assistance was found. Therefore, it is necessary to take actions that can promote reflections and strategies in humanization, in order to promote new meanings in the way of thinking and concretizing the proposal of humanization in health.

Keywords: Humanization of assistance; social representation; pediatrics.

REPRESENTAÇÕES SOCIAIS DA HUMANIZAÇÃO EM PEDIATRIA HOSPITALAR ENTRE PROFISSIONAIS DE SAÚDE

RESUMO. A humanização visa a transformação do modelo institucional de saúde por meio da valorização dos aspectos subjetivos, históricos e socioculturais dos processos de saúde e doença. Entretanto, por carregar múltiplos sentidos, sua implementação tem sido um desafio em diversos serviços públicos de saúde. Diante disso, este trabalho teve como objetivo apreender as representações sociais sobre humanização na pediatria entre profissionais de saúde que atuam neste contexto. Trata-se de uma pesquisa qualitativa, realizada em um hospital universitário do nordeste, que contou com a participação de 12 profissionais de saúde de oito categorias. Para apreensão dos dados recorreu-se à entrevista semiestruturada, cujos dados foram analisados através da análise categorial temática. Os dados permitiram a construção de três categorias temáticas: o contexto da

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pediatria, práticas assistenciais e humanização. Constatou-se que embora seja gratificante trabalhar na pediatria, existem dificuldades nas relações entre os próprios profissionais e entre os profissionais e as cuidadoras das crianças. As práticas assistenciais respaldam-se principalmente em valores humanísticos expressos nas vinculações afetivas e no uso eficaz do raciocínio clínico e dos materiais. A humanização, por sua vez, foi representada predominantemente por valores humanísticos, embora existam alguns elementos representacionais que referenciem aspectos da Política Nacional de Humanização. Constatou-se a ausência de argumentos pautados no direito do usuário a uma assistência de qualidade. Fazem-se necessárias, portanto, ações que possam promover reflexões e estratégias em humanização, no sentido de favorecer ressignificações no modo de pensar e concretizar a proposta da humanização em saúde.
Palavras-chave: Humanização da assistência; representação social; pediatria.

REPRESENTACIONES SOCIALES DE LA HUMANIZACIÓN EN PEDIATRÍA HOSPITALARIA ENTRE PROFESIONALES DE LA SALUD

RESUMEN. La humanización tiene como objetivo transformar el modelo institucional de salud mediante la valoración de los aspectos subjetivos, históricos y socioculturales de los procesos de salud y enfermedad. Sin embargo, debido a que tiene múltiples significados, su implementación ha sido un desafío en varios servicios de salud pública. Por lo tanto, este estudio tuvo como objetivo aprehender las representaciones sociales de la humanización en pediatría entre los profesionales de la salud que trabajan en este contexto. Es una investigación cualitativa, realizada en un hospital universitario del noreste, con la participación de doce profesionales de la salud de ocho categorías. Para aprehender los datos, se utilizó una entrevista semiestructurada, cuyos datos se analizaron mediante análisis categórico temático. Los datos permitieron la construcción de tres categorías temáticas: el contexto de la pediatría, las prácticas de atención y la humanización. Se descubrió que, aunque es gratificante trabajar en pediatría, existen dificultades en las relaciones entre los propios profesionales y entre los profesionales y los cuidadores de los niños. Las prácticas de atención se basan principalmente en valores humanísticos expresados en lazos afectivos y en el uso efectivo del razonamiento clínico y los materiales. La humanización, a su vez, estuvo representada predominantemente por valores humanistas, aunque hay algunos elementos de representación que se refieren a aspectos de la Política Nacional de Humanización. Se encontró la ausencia de argumentos basados en el derecho del usuario a una asistencia de calidad. Por lo tanto, es necesario tomar acciones que puedan promover reflexiones y estrategias en humanización, a fin de promover nuevos significados en la forma de pensar y concretar la propuesta de humanización en salud.
Palabras clave: Humanización de la atención; representación social; pediatria.

Introduction

Implementing humanization in health care is a complex and multidimensional process carrying multiple discourses and practices. It is configured as a process of transformation of the institutional health model as it aims to recognize and value the subjective, historical, and

sociocultural aspects of everyone involved (Adorno, Martins, Mattos, Tyrrell, & Almeida, 2017).

Historical aspects of health portray the construction of an institutional culture imposed on the organization of health practices, characterized by scientific rationality and especially technique. Consequently, health action loses its caring perspective, and even with technological advances, it loses its power and effectiveness, as it also delegitimizes other health knowledge (Merhy & Feuerwerker, 2016).

Attitudes of lack of interest by the user and lack of engagement with the service, together with difficulties imposed by system limitations, gave rise to interest in studying and outlining the topic of humanization. The National Humanization Policy (NHP), created in 2003, aims to offer quality care, with coordination between technological advances, welcoming, and valuing intersubjectivity, in addition to improving environments and working conditions. To achieve its goal, the co-responsibility of the different actors must be increased, as well as a change in the culture of attention to users and management of work processes (Brasil, 2004).

Humanization acquires importance in the hospital context, as this environment causes a burden of suffering to emerge for both the patient and their family members, especially when the patient is a child. To this end, healthcare for this group must be understood as a priority field for humanized healthcare actions. Despite changes regarding the hospitalization of children in hospital environments, such as the presence of a companion during hospitalization and the recognition of their right to play, there are still difficulties in day-to-day care (Bergan, Bursztyn, Santos, & Tura, 2009).

Studies and investments in contexts for reflections and reordering of health actions are necessary, to break with the biologicist and medicalizing approach to health care, giving way to educational processes that enable and promote horizontal and dialectical practices. In this context, health actions can be studied through social representations, as they explain phenomena from a psychosocial perspective. Thus, when approaching humanization by articulating affective, cognitive, and social elements, social relations are highlighted and it is observed how they are present in the reality studied, showing the gaps to be filled for the effective implementation of the PNH (Moscovici, 2010; Chernicharo, Freitas, & Ferreira, 2013).

Therefore, Social Psychology, through the Theory of Social Representations (TSR) can contribute to this discussion as it allows us to understand the psychosocial aspects in the field of health. This theory makes it possible to understand the meanings that subjects give to health practices, as well as understand the actions of these subjects and the justification for their choice in light of the realities presented to them (Moscovici, 2010; Ferreira, 2016).

Therefore, as these are studies of psychosocial phenomena that represent the unique features of each group and each context, the study of social representations in the field of health allows the understanding of health and disease processes, considering different levels of analysis. Through dialogue between Human Sciences and Health, the analysis of health phenomena is believed to rescue the articulation between individual, group, institutional, and social aspects, contemplating the complexity inherent to the objects investigated.

The TRS was formulated by Moscovici to initially understand how scientific knowledge was apprehended by individuals and social groups. This theoretical proposal emphasizes the symbolic exchanges that exist in personal relationships, their social contexts, and their products: common sense theories (Moscovici, 2010). Thus, interpersonal relationships

enable the construction of shared knowledge, which undergoes constant transformations, adapting to changes in its generating group.

Furthermore, representations are considered to guide social practices, although they can also be products of social practices when new practices are instituted in a social group (Wolter & Sá, 2013). With this in mind, the process of representing objects becomes important in the formation of practices and guidelines for social communications.

In health, social representations are the result of the creation of collectively constructed subjectivities, based on everyday interactions and practices in the Unified Health System (SUS) (Bergan et al., 2009). Therefore, social representations reveal who the subject is, what they know, what type of service they offer, and how they construct the meaning of this service. In other words, the representations reveal the relationships established between humanization and the subjects (Barbosa, Teixeira, & Oliveira, 2016).

In Brazil, few studies have addressed humanization based on TSR. Freitas and Ferreira (2016), aiming to apprehend the meanings and representative practices of humanization in nursing training, found an emphasis on the issue of practical learning and the academic process of teaching and learning about humanization. Other studies (Chernicharo et al., 2013; Araújo & Ferreira, 2011; Andrade, Artmann, & Trindade, 2011; Silva et al., 2014; Silva, Oliveira, & Pereira, 2015) demonstrate how the theory can be fruitful, as they reveal consensual universes of the groups studied and, consequently, the respective institutional realities.

There is research that addresses the topic of humanization but does not use TSR as a theoretical contribution (Ferreira & Artmann, 2018; Machado & Soares, 2016) although it deals with the discourses built around this object. About the universe of pediatrics in the hospital, social representations related to other objects have been addressed (Oliveira & Borges, 2017; Bergan et al., 2009).

In this research proposal, the aim was to identify the network of meanings surrounding the social object ‘humanization’ in a group of professionals in the pediatric sector. The actions of professionals working in pediatrics are assumed to be based on technical knowledge, but also on social representations about humanization. Therefore, this study aimed to understand social representations about humanization in pediatrics among health professionals working in this sector.

Method

Trata-se de uma pesquisa exploratória e descritiva, com abordagem qualitativa, uma vez que a pesquisa qualitativa visa apresentar as perspectivas das pessoas, abrangendo as condições contextuais onde estão inseridas, explicando tais acontecimentos por meio de conceitos existentes (Yin, 2016).

A amostra de trabalhadores foi escolhida por quota, de modo a contemplar as diversas profissões pertencentes ao quadro permanente de profissionais da pediatria, contemplando um total de 12 participantes, sendo eles: um técnico de enfermagem, um auxiliar em enfermagem, dois enfermeiros, dois fisioterapeutas, uma assistente social, uma nutricionista, dois médicos, uma fonoaudióloga e uma brinquedista. Os critérios de inclusão dos trabalhadores foram: tempo de trabalho superior a seis meses no setor de pediatria, por constituir um período mínimo para atuação e engajamento; profissionais de ensino médio e superior.

Como instrumento de apreensão dos dados, foi utilizado um questionário sociodemográfico e laboral, assim como uma entrevista individual com roteiro

semiestruturado, This was an exploratory, descriptive, qualitative study, since qualitative research aims to present people's perspectives, covering the contextual conditions in which they are inserted, explaining such events through existing concepts (Yin, 2016).

The sample of workers was chosen by quota, in order to include the different professions belonging to the permanent staff of pediatric professionals, comprising a total of 12 participants, namely: a nursing technician, a nursing assistant, two nurses, two physical therapists, a social worker, a nutritionist, two physicians, a speech therapist, and a toy specialist. The workers' inclusion criteria were: working time of more than six months in the pediatrics sector, as it constitutes a minimum period for action and engagement; secondary and higher education professionals.

As an instrument for data collection, a sociodemographic and employment questionnaire was used, along with an individual interview with a semi-structured script, containing questions that include: the characterization of work in pediatrics, teamwork, the profile of the public served (patients and family members), and how humanization occurs in this context. To apprehend data about the participants' context and provide support for a better understanding of the social representations of humanization, as well as its production conditions, we decided to include questions related to daily work in pediatrics

The project of this research was authorized by the Research Ethics Committee of the Lauro Wanderley University Hospital, through CAAE: 07741119.6.0000.5183 and Opinion: 3.202.432. After said authorization, data collection began.

Professionals were invited to participate in the research during their work hours. A convenient time was scheduled and the interview was carried out individually, in rooms or wards that were available. After clarifications about the research, by reading the Informed Consent (TCLE), the signature was requested as well as their consent to the voice recording.

Sociodemographic and labor data were analyzed using descriptive statistics and used to characterize the participants. The interviews were analyzed using Thematic Content Analysis, proposed by Bardin (2011), which is characterized by a set of methodological instruments for analyzing communications aiming at the objective, systematic, and quantitative description of their contents and consequent construction of meanings. Thus, the thematic analysis included skimming reading, the choice of the corpus analysis, and the coding of registration units to form categories and subcategories.

Results and Discussion

Socio-labor data

Among the professionals interviewed, the majority (n=11) were female. Professional experience varied between six and 30 years. Regarding the time working in this pediatric unit, the minimum working time was seven months, reaching a maximum working time of 23 years, with an average of 7.54 years working in this service. The majority (n=7) had a work regime guided by a labor legislation entitled Consolidation of labor Laws (CLT) regime as a form of contract and were linked to the Brazilian Hospital Services Company. In general, the most cited weekly working hours were 30 hours (n= 5), the others were 36, 40, and 60 hours, all working day shifts in pediatrics. Only three stated that they had a tiring workload and five admitted that there was work overload.

Table 1. Socio-labor characterization of professionals

Variable	Categories	Frequency
Gender	Male	01
	Female	11
Age	20 to 30	01
	31 to 40	06
	41 to 50	04
	>= 51	01
Courses that address Humanization	Technician	01
	Graduate	01
	Specialist	07
	Masters	03
Years of activity	**YES**	08
	NO	04
Years studied in Pediatrics	6-10	03
	11-15	04
	16-20	03
	26-30	02
Tiring workload?	**0-5 years**	07
	6-10 years	01
	11-15	02
	16-20	01
	21-25	01
Work overload?	YES	03
	NO	09
Courses that address Humanization	YES	05
	NO	07

Source: The authors.

Thematic Categories

The analysis of the interviews allowed the construction of three thematic categories: The context of pediatrics; Care practices in pediatrics; and Humanization.

The context of pediatrics

This category addresses the specific context of pediatrics from the professionals' perspective and was divided into three subcategories, according to the content of the interviews, namely: Assessment of work dynamics, Specificities of work in pediatrics, and professional appreciation.

In the work dynamics assessment subcategory, everyday issues emerged such as the job description in pediatrics. Regarding the positive points, satisfaction with work stands out, understanding it as something rewarding, special, fun, and pleasurable, in addition to being a personal achievement, for example: "[…] it is pleasurable from the point of view that we are working with children. You are always having fun" (P4, physician, 12 years of experience). Another positive point highlighted concerns the bond with the child and their way of being: "[…] the bond with the child is sincere if they like you, they like you [...] if they don't, they show that they don't like you" (P1, physical therapist, 6 years of experience).

Regarding the negative points or difficulties of the work, although the majority of professionals stated that there were no difficulties, some questions emerged in relation to the lack of resources/structure at work, the difficulty in communicating with young children, the suffering during invasive procedures, and the death of a patient.

As for the specificities of work in pediatrics, the professionals mentioned some peculiarities, given that, according to them, involvement with children is greater than with adults. Children are more sincere and have a different degree of understanding of the health problem, which requires greater skill from the professional, in order to know how to deal with such users.

Due to the specificities of pediatrics, the professional needs to have the following characteristics: patience, dedication, attention, and liking children, as stated by P5 (nutritionist, 15 years of experience): "[…] it means liking, having empathy with the child, liking children". For them, people expect a professional working in pediatrics to know how to deal with children and have attention, competence, skill, patience, and sensitivity. These requirements, supported by the view of the fragility of children and young people, ultimately reinforce the importance of the affective dimension in the physician-patient relationship, justifying the emotional involvement of some professionals.

As with the context of pediatrics, there is also the relationship with companions, with professionals giving their opinion on the profiles of family members. Nine professionals attributed some characteristics to the companions, both positive and negative, such as: dedicated, responsible, patient, wonderful, negligent, rude, disrespectful towards professionals, rude, impatient, and stressed. A worker highlighted the description of the companions, considering them simple people, from the interior region, with low income and education. And another focused on the emotional side of the companions: "[…] they arrive more angry, others afraid, over time they acquire more trust in the team" (C11, nursing assistant, 30 years of experience).

The majority of caregivers are mothers and the characteristics attributed to them sometimes denote a blaming tone, which seems to divide caregivers into two groups, good and bad. They appear in an implicit logic of the pathologization of poverty, as included in the speech of P12 (physician, 15 years of experience): "[…] extremely ignorant mothers, both ignorant in the sense of not knowing [...] and ignorant of a lack of behavior most appropriate". This statement refers to an association between poverty and lack of education, which allows updating prejudice, without violating the principles of social desirability (Belfort, Barros, Gouveia, & Santos, 2015).

The data therefore suggests difficulties in relationships between staff and caregivers, reinforced by negative perceptions of companions, given that people's perception influences social interactions. It therefore indicates that assistance is also linked to social representations about users and their families, prepared by professionals. That said, humanized practice requires the transformation of some of these representations, especially those including prejudiced perceptions. Given this, the study on social representations of humanization must recognize the existence of a network of social representations about different social objects, even when a cut is made, choosing just one.

Still, in the context of work in pediatrics, the majority (n=8) stated that there is professional appreciation from co-workers or users, however, without recognition from management, as exemplified by the following statement: "[…] from colleagues. And not the issue of the hospital management [...] which I think we are not valued at all" (P11, nursing assistant, 30 years of experience).

Four professionals recognized that this appreciation sometimes occurs; two emphasized the lack of recognition of their work by the medical team and one professional claimed that patients and companions do not value the work of professionals. This perception refers to a persistent problem in the SUS, which is the devaluation of workers and the precariousness of work relationships, as pointed out by the Ministry of Health (Brasil, 2008). This is one of the policy's greatest challenges: guaranteeing working conditions and overcoming the fragmentation of the work process and relationships, in addition to promoting strategies to appreciate workers. The devaluation of work demonstrates weaknesses in the interpersonal relationships built in this context.

The hierarchical categorization the participants claim exists between the multidisciplinary team and the medical team indicates other aspects of relational obstacles: "[…] there are things that we say, that they will ask the physician or another professional again because they think we don't have their level of professionalism" (P3, nursing technician, 19 years of experience). "I see a division: the medical team is one and the multidisciplinary team is another, when in fact the term multi implies everyone" (P7, physical therapist, nine years of experience). The physician is still considered the main actor of care and possessor of legitimate knowledge. This vision is based on the socio-historical construction of medicine, in which the maximum knowledge is that of the physician, which generates conflicts with other team members, who lose their autonomy over decisions in their work (Moreda et al., 2019).

Regarding communication between the team, most participants admitted that communication about clinical cases did not exist or was weakened, occurring only in some situations that required greater team involvement. Most of the time, what occurred was isolated and individual communication between professional categories. Regarding the points to be improved in teamwork, it was unanimous that there was a need for greater interaction and discussion of multidisciplinary cases.

Although there are difficulties in interprofessional communication, in the team's assessment, positive aspects of the professionals were also mentioned, stating that there is a very good relationship (n=6), with respect for each other's work (n=3). The data allows us to say that, despite there being respect between workers, there is still a vertical relationship between team and users, and between physicians and other professionals. This situation contrasts with the NHP proposal, as it portrays a lack of respect and promotion of the autonomy and protagonism of subjects, in order to allow joint decisions.

The interprofessional team is the basis for humanized care. The absence of dialogic communication harms the quality of assistance, as it reinforces compartmentalized and

verticalized actions. Furthermore, when there is no understanding of work as a process, the scenario created favors the existence of conflicts, which can be veiled or explicit, "[…] involving hierarchies of knowledge and remuneration of the professionals' workforce" (Silveira & Silva, 2018, p. 104).

Care practices

This category concerns how the care provided is organized, both to patients and their companions, encompassing two subcategories: practices aimed at children/adolescents and practices aimed at caregivers.

Regarding professional practice aimed at children and adolescent patients, the participants mentioned some actions, such as: talking (n=6), respecting the moment (n=4), playing (n=4), distracting (n=1), and explaining the procedures (n=3), for example, "I step back, give them some time, and when they want, we do it" (P9, speech therapist, 15 years of experience). On the other hand, other attitudes were also highlighted, such as restraint (n=2) when carrying out the procedure and imposing and speaking firmly with older children (n=1), which can be exemplified in the statement: "What I say firmly is this, it's not shouting at the child, it's not treating the child badly: 'no, you have to let the saline in', 'no, but I don't want to', 'but you don't have to want to, it's for your good and it's over'" (P8, nursing assistant, 17 years of experience).

These data indicate that, despite pointing out attitudes consistent with good practice towards children and young people, sometimes professionals end up not knowing how to deal with these patients, assuming authoritarian positions. Postures like these can contribute to increased stress and non-collaborative attitudes on the part of children, who are already in a vulnerable situation in the face of illness and hospitalization. Understanding how each child and adolescent perceives and feels about their illness and hospitalization situation is essential for humanized care. Therefore professionals must offer emotional support to the patient, encouraging the resignification of the situation and enhancing coping strategies (Roças, 2018).

Professionals also recognize the need for practices aimed at family members accompanying children and adolescents through actions such as talking (n=3), providing support (n=2), calming (n=1), guiding (n=4), being empathetic (n=3), putting yourself in their shoes in this moment of suffering, as reported by P12 (physician, 15 years of experience): "[…] empathy [...] if you understand that that mother is suffering from the disease of the child and [...] ignorance of the potential of the disease, so, she has, in quotation marks, the right to react in various ways".

These actions reflect facets of humanized care, based on family understanding and appreciation. However, even though some practices signal a concern for the suffering companion, there was no consensus among professionals about the family assistance work carried out by the team.

Some did not identify consolidated assistance aimed at companions, while others pointed to precarious care, being an individual choice of the professional whether or not to provide this service, as P7 (physical therapist, 9 years of experience) says: "[…] still very fragile, as far as I know, no specific thing is offered to the companion". This reveals that assistance is still focused on the patient, centered on techniques, while family support remains in the background, depending on each professional.

The stay of the admitted child/adolescent's caregiver is a legal issue, in addition to being fundamental to supporting the child/adolescent in coping with this situation and

minimizing their negative feelings. Therefore, it is urgent to reorder the care modality, expanding the focus beyond the patient and their pathology, considering the family and their demands. Given this, care must be reorganized and focused on comprehensive actions, concerned with the uniqueness of the child/family, who have now become a single client (Quirino, Collet, & Neves, 2010).

Participants also report the existence of expectations and demands, on the part of companions, directed towards them: "[…] that we are responsible for the patient [...] that we have to go there and line the bed in the morning, provide guidance regarding food [...] because the companion is coming to reduce, I think, perhaps even the excess work we had" (P3, nursing technician, 19 years of experience).

The study subjects seem to understand that the companion must, in addition to complying with the legal issue of the child/adolescent's rights and being their emotional support, be a human resource and facilitating agent for the professionals' work (Lima et al., 2019). Although a relationship of cooperation and partnership between professionals and caregivers is desirable, it seems that any behavior on the part of the latter, who does not correspond to this work agent model, generates conflict and distances the team.

There is recognition that the family can actively participate in patient care, but, for them to feel strengthened in this care, they must also be supported by professionals, establishing bonds, trust, and accountability, through rich and dynamic intersubjective interactions. Thus, comprehensive care will be restored with a broader view of the family, making it part of the process and respecting the uniqueness of the child-family binomial (Quirino et al, 2010).

Humanization

The humanization category presents and discusses the meanings professionals give to health humanization in pediatrics. Concerning the definition of the humanization object, the representational elements encompassed three aspects: the ethical and moral issue (n=6); care practice (n=5), and aspects of the NHP (n=4).

The ethical and moral issue encompassed elements such as empathy, human beings, solidarity, and love, as portrayed in this statement: "[…] you put yourself in someone else's shoes [...]" (P10, nurse, 10 years of experience). And, equally, in this: "[…] trying to make care prevail, respect, you know, solidarity, love for others" (P2, social worker, 18 years of experience).

The practice of care concerns elements such as talking, giving comfort to the patient, not acting mechanically, using the toy library, and promoting well-being. The aspects of the NHP highlighted were: comprehensive care, seeing the patient as a whole, welcoming them, and having good communication. From an empathetic perspective, some professionals can see the need for comprehensive care, because, by putting themselves in someone else's shoes, they broaden their vision beyond the disease and understand the context in which these patients are inserted.

When talking about humanization, participants resorted to practices recognized as humanized, pointing to the issue of care, both in the technical and relational dimensions (n=11). They mentioned practices such as: paying attention, following protocols, talking, taking care of emotions, worrying about well-being, using the toy library, and celebrating commemorative dates. They referred to ethical and moral issues (n=3) when mentioning work with love, dedication, flexibility, empathy, and respect. Only three reported elements of the NHP such as comprehensive care, reception, and ambiance.

Importantly, when seeking to conceptualize the expression of humanization, the subjects brought more elements linked to ethics. When talking about their practices, participants emphasized practical aspects of care that promote the patient's psychological well-being. Humanized care, therefore, seems to be understood as an action that must be supported by ethical and moral values and by the recognition of the subjective dimension of patients, which points to the principle of comprehensiveness.

Although three professionals bring elements that are considered in the policy, such as issues relating to a horizontal relationship and integrality, there is still little direct reference to NHP elements in the professionals' statements. The discussion surrounding the user's right to quality care was also not highlighted in the professionals' reports, which contributes to the idea that humanization is characterized more as an individual stance and practice, to the detriment of the collective dimension.

In the studied context, adopting a humanized posture and practices is still challenging, as there are obstacles such as resistance from some professionals, the search for emotional distance, the absence of collective attitudes, and intersectoral actions, as reported by seven professionals. Resistance from professionals can even lead to attitudes of repression on the part of some co-workers towards those who carry out humanization: "[…] we even feel a little repressed from doing something about humanization, because while we are trying to do it, someone comes and does not support" (P3, nursing technician, 19 years of experience).

Often, these repressions are explained by the fact that the humanized attitude of one reveals the superficiality and indifference of many, which portrays a division between professionals who practice humanized care and others who do not, a situation also found by Araújo and Ferreira (2011).

Emotional withdrawal was mentioned as an obstacle by two participants since it is characterized as a strategy to not get attached and suffer in the face of users' illness processes. The lack of collective engagement by the team, according to three workers, makes it difficult to provide humanized care, as actions are based on individual initiatives, becoming restricted and weakened.

The lack of intersectoral actions was also indicated (n=1) as an obstacle to humanized care: "[…] this part of the broad view [...] I identify that each patient has a certain weakness in some aspect other than just Health [...] I don't know if we can handle that, of trying to humanize that issue [...] we depend on other things that are out of reach [...]" (P7, physical therapist, 9 years of experience).

The obstacles to humanization represent the praise of technicality and the biomedical model, bringing into play the myth of neutrality and scientific objectivity (Silva et al., 2015). Mota, Martins and Véras (2006) state that the dehumanizing dimension reduces subjects to objects of the technique, making them depersonalized based on a cold and objective investigation. Emotional detachment, as a strategy to protect oneself from the suffering resulting from patients' situations, points to the need to give new meaning to suffering, which often brings a burden of guilt and impotence to professionals (Viero et al., 2017).

Avoiding feeling fragile and remaining emotionally distant from the patient and their family reinforces vertical relationships and makes it difficult to achieve the humanization proposal that requires, above all, bonds between the actors. Intersectoral and network actions, in turn, guarantee comprehensive attention to users, leading to an expansion of understanding about humanization, anchored in transversality, one of the principles of the NHP (Ferreira & Artmann, 2018).

Strategies to strengthen humanization in the Pediatrics sector focused on encouraging more interprofessional communication/integration (n=4), with the occurrence of case discussions, and greater awareness among people (n=4), through courses, conversation circles, group activities, and meetings: "[…] courses on humanization because perhaps we know little" (P11, nursing assistant, 30 years of experience). Apparently, professionals admit that they know little, and recognize the need for greater investment in continuing health education on the topic of humanization.

As for the NHP, the respondents declared that they did not remember what the guidelines of this policy were about: "Of the guidelines, honestly, I don't remember anything, because I don't see it here" (P1, physical therapist, 6 years of experience). This corroborates Machado and Soares (2016), who pointed out the lack of knowledge, or only partial knowledge, of what the NHP is, its principles, guidelines, and guiding principles among the healthcare team.

The way in which the object is represented is influenced by the context in which the subjects are immersed, thus, if in the institution the assumptions of the NHP are not known or are discredited, its implementation becomes difficult, in addition to facilitating common sense about its failure is naturalized among professionals (Chernicharo et al., 2013). If workers are those who put the NHP into practice, making it functional, they need to have an adequate understanding of its assumptions; otherwise, "[…] they are restricted to the technical arrangement and do not transform reality, but maintain the current logic, with a more glamorous way" (Pereira & Ferreira Neto, 2015, p. 81).

NHP brings together discussions from management, the work/worker, and the focus on user care, and, although professionals have discussed the policy in courses that addressed the topic, what prevails in their reports is little articulated to what the NHP recommends, especially with regard to the field of law.

Similar data was identified by Andrade et al. (2011) when they realized that the representations of humanization for professionals were associated with humanistic conceptions and the qualification of care. In this way, they developed training on the topic and, after this moment, humanization was incorporated into the perspective of law, resulting in an expanded understanding of the principles of the SUS.

The health context, especially the hospital, as it has been demarcated by charitable actions, still brings these ethical and human values that, added to the aspects of humanization, such as reception and focus on the user's well-being, engender beliefs and attitudes anchored in the scope of assistentialism. The context of pediatrics that raises the idea of fragile children seems to favor the association of humanization with these values.

The figurative scheme of representations about humanization reveals that the main elements that give concreteness to the social representation of humanization, among the group of professionals studied, concern ethical and relational issues, as well as care practices that consider the subjective dimension of users. The other less expressive elements relate to aspects of the reified universe, such as the discourse of politics and the SUS. The representational elements of humanization are anchored, above all, in humanistic aspects that are quite common in common sense knowledge.

This practical knowledge of professionals, mainly constituted by representations of the consensual universe, of everyday life, but also incorporating the reified universe of scientific language, reveals the diversity of the field of the constitution of health representations. Therefore, using TSR in health studies can favor the understanding of the paradigmatic transformations that have occurred in this field, such as the adoption of

humanistic principles to the detriment of the biomedical clinical model (Oliveira & Gianasi, 2019).

Such social representation of humanization is linked to the socio-historical conditions of medicine and the values of the researched group. It denotes a context in which there are few institutional and individual efforts around the proposal of humanization as a health policy.

The absence of systematic practices involving political and academic discussions on the issue reinforces the idea of humanization as an individual choice, which is guided only by humanitarian values. Thus, those who rely on the biomedical model choose to relate to users by focusing only on the body to be treated.

Final considerations

The Theory of Social Representations contributed to understanding the symbolic universe related to humanization in pediatrics, demonstrating obstacles and possibilities of a psychosocial nature in the process of implementing the NHP. The process of humanization is something constant, there is no time when it will be completely consolidated, requiring daily practices and ongoing education that allow working on the meanings attributed to humanization and emphasizing the issue of the right to health.

The investigation of the pediatrics scenario revealed the need for skills to deal with the lack of structure and peculiarities of care for children, adolescents, and their families. It also allowed the identification of a network of social representations, including discourses about users and their caregivers, in addition to humanization. Although the network of representations was not the focus of this study, future research that can encompass this phenomenon is recommended.

Care practices revealed actions that are close to the proposal of humanization in health, but also authoritarian practices that harm it. There is recognition by some professionals of the importance of the subjective dimension and the need for practices that promote the patient's well-being, although some choose to neglect this aspect and maintain an emotional detachment.

Such practices are aligned with the social representation of humanization, which focuses on humanistic values and common sense knowledge that do not include political discussion. Humanization, therefore, becomes a personal choice. Differences in attitudes between professionals demonstrate that implementing a policy is a dynamic, permanent, and complex process, requiring interventions compatible with each context.

Talking about humanization, disregarding the scope of the right to health, is worrying and reinforces the idea that humanization actions concern individual and not collective movements, which makes public matters often understood as a favor, neglecting the right to quality healthcare for every citizen. This reality points to an abyss between what is intended with public policies and what is achieved in effective terms, as policies are made, but they do not reach the people.

Finally, it is necessary to expand the way of doing of NHP, building alternatives that consider differences and singularities, with humanization actions that must be supported by the group, through a committed attitude. Structural, social, and cultural changes in the field of health, aimed at humanized and quality care, can become agents in the process of expanding the symbolic field of social representations of the humanization of professionals.

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