

Multidisciplinary team of intensive therapy: humanization and fragmentation of the work process

Equipe multiprofissional de terapia intensiva: humanização e fragmentação do processo de trabalho
Equipo multidisciplinario de cuidados intensivos: la humanización y fragmentación del proceso de trabajo

**Viviane Canhizares Evangelista¹, Thiago da Silva Domingos¹,
Fernanda Paula Cerântola Siqueira^{II}, Eliana Mara Braga^I**

^I Universidade Estadual Paulista Júlio de Mesquita Filho, Medical School of Botucatu,
Postgraduate Program in Nursing. Botucatu, São Paulo, Brazil.

^{II} Faculdade de Medicina de Marília, Nursing Course. Marília, São Paulo, Brazil.

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ABSTRACT

Objective: to understand the meaning of humanized care in intensive care units considering the experience of the multidisciplinary team. **Method:** descriptive and exploratory qualitative research. For this purpose, we conducted semi-structured interviews with 24 professionals of the health-care team, and, after transcription, we organized the qualitative data according to content analysis. **Results:** from two main categories, we were able to understand that humanized care is characterized in the actions of health-care: effective communication, team work, empathy, singularity, and integrality; and mischaracterized in the management processes, specifically in the fragmentation of the work process and health-care, in the precarious work conditions, and in differing conceptual aspects of the political proposal of humanization. **Conclusion:** care activities in intensive therapy are guided by the humanization of care and corroborate the hospital management as a challenge to be overcome to boost advances in the operationalization of this Brazilian policy.

Descriptors: Care Humanization; Critical Care; Health Team; Health Management; Work Conditions.

RESUMO

Objetivo: compreender o significado do cuidado humanizado em unidades de terapia intensiva considerando a vivência da equipe multiprofissional. **Método:** pesquisa descritiva e exploratória de caráter qualitativo. Para tanto, foram realizadas entrevistas semiestruturadas com 24 profissionais da equipe de saúde e, após transcrição, os dados qualitativos foram organizados segundo análise de conteúdo. **Resultados:** partindo de duas categorias principais, foi possível apreender que o cuidado humanizado é caracterizado nas ações de assistência à saúde: comunicação efetiva, trabalho em equipe, empatia, singularidade e integralidade; e descaracterizado nos processos de gestão, mais especificamente, na fragmentação do processo de trabalho e da assistência à saúde, na precarização das condições de trabalho e em aspectos conceituais discrepantes da proposta política da humanização.

Conclusão: ações assistenciais na terapia intensiva guiam-se pela humanização do cuidado e corroboram a gestão hospitalar enquanto desafio a ser superado para impulsionar avanços na operacionalização dessa política brasileira.

Descritores: Humanização da Assistência; Cuidados Críticos; Equipes de Saúde; Gestão em Saúde; Condições de Trabalho.

RESUMEN

Objetivo: comprender el significado del cuidado humanizado en unidades de cuidados intensivos teniendo en cuenta la experiencia del equipo multidisciplinario. **Método:** estudio descriptivo y exploratorio de carácter cualitativo. Por lo tanto, se llevaron a cabo las entrevistas semiestructuradas con 24 profesionales del equipo de salud y después de la transcripción, los datos cualitativos fueron organizados de acuerdo con el análisis de contenido. **Resultados:** de las dos categorías principales, fue posible entender que el cuidado humanizado se caracteriza en las acciones de atención a la salud: la comunicación efectiva, trabajo en equipo, la empatía, la singularidad y la integridad. El cuidado humanizado es caracterizado erróneamente en los procesos de gestión, más específicamente en la fragmentación del proceso de trabajo y el cuidado de la salud, en el deterioro

de las condiciones de trabajo y los aspectos conceptuales diferentes de la propuesta política de la humanización. **Conclusión:** las actividades de atención de la salud en cuidados intensivos son guiadas por la humanización de la atención y fortalecen la gestión del hospital como un desafío a superar para impulsar el progreso en la operacionalización de esta política brasileña.

Descripciones: Humanización de la Atención; Cuidados Críticos; Equipos de Salud; Gestión de la Salud; Condiciones de Trabajo.

CORRESPONDING AUTHOR

Viviane Canhizares Evangelista

E-mail: vi.evangelista@gmail.com

INTRODUCTION

The actions of humanization of health-care bring back the importance of discussing the quality of care offered to the users of the health-care system, understood here in the extended meaning of the word: patients and their family. In Brazil, this movement culminated in the formulation of the so called National Humanization Policy (PNH). Therefore, from 2003 on, when the referred policy was published, there was a radical change in the meaning and actions of the program related to the subject⁽¹⁾.

The search for a humanized care model began to occupy a wide dimension in the Brazilian Unified Health System (SUS), because the concept of humanization referred by PNH is committed to reduce the precariousness of the work in health-care and the established technical and bureaucratic knowledge that affect directly and negatively workers and users⁽²⁾.

Therefore, the guidelines of PNH represent an ethical, esthetic, and political commitment. Ethical, because it implies the reconfiguration of relations established between users, managers, and health-care workers; esthetic, because it includes creativity and sensibility to health production, originated from the intersubjective encounter of its protagonists; and political, because it refers to the social and institutional organization of the practices of care and management in the Brazilian health-care system^(1,3-4).

The hospital units are in the scope of PNH, previously identified as challenges to be overcome for constituting in their nature low permeability to changes. Besides, for being grounded on a solid structure of organization and management, hospitals have been showing fragmentation in interpersonal and work relations; impersonality and indetermination in care, bonds, and access to the information; inequality and lack of participation of workers in the management process⁽⁵⁾.

In this context, Intensive Care Units (ICU) are the reference place to offer critical, specialized, and uninterrupted care, having a multidisciplinary team designed to assist severe and recoverable patients. For this purpose, the technological density reaches its maximum level, and, as a result, executes a process of reduction of care, which affects the characteristics of the care offered to the users and their family, as well as in interpersonal relations⁽⁶⁾.

Considering the importance of humanized care, especially in ICUs, we present the following question: How does the multidisciplinary team understand the humanization of care when experiencing the daily work at an ICU?

OBJECTIVE

To understand the meaning of humanized care to the professionals of ICUs from the experience of a multidisciplinary team in a hospital school.

METHOD

Ethical aspects

The research met the ethical precepts considering the Resolution 196/96 of the National Health Council and National Research Ethics Committee, and it was approved by the Research Ethics Committee of the Medical School of Marília. The individuals agreed to participate in the research, and, after a personal invitation, they were requested to sign the Informed Consent Form⁽⁷⁾.

Type of Study

This is an exploratory, descriptive, and field research with qualitative approach⁽⁸⁾.

Methodological procedures: place, sample, collection, and analysis of data

This study was conducted in two ICUs of a hospital school in the inland of São Paulo State, Brazil. Together, they have 24 beds equally placed, designed to assist adult patients with clinical and surgical specialties with 98% average occupation. The team is composed by nurses, doctors, physiotherapists, nutritionists, psychologists, and social workers, scaled in three periods.

Guided by the intentional sample, the inclusion criterion was "higher education", composing a total of 25 professionals. 24 of them participated in the study, and one participant refused, without justification.

For data collection, we conducted a semi-structured interview, because it favors not only the description of social phenomena, but also their explanation and understanding of their totality, besides maintaining the conscious and active presence of the researcher in the process of information collection⁽⁷⁾.

Therefore, we used a tool organized in two parts: the first one characterizes the individuals, with variables such as age, sex, religion, professional category, time since graduation, time of work in ICUs, and number of employments; the second one was the interview with the guiding question: "How is your experience in the development of humanized health-care with patients hospitalized in ICUs, while acting in a multidisciplinary team?"

Data were collected between July, 20 and August 30, 2012, with previous scheduling, respecting the availability and timetable of participants. The interviews were conducted by the first author of this study, during the work shift, in a private place in the sector itself. The average duration was five minutes, varying from 2 minutes and 30 seconds to 11 minutes. The interviews were recorded in audio and completely transcribed.

The treatment of qualitative data was guided by the Content Analysis, a subject type, defined as a set of techniques of analysis of the communications, seeking to obtain, by systematic

and objective procedures of description of message content, indicators that allow the inference of knowledge related to the conditions of production/reception (inferred variables) of these messages. It is separated in three steps: pre-analysis, analytical description, and inferential interpretation⁽⁹⁾.

After the methodological procedures, we organized two categories, each one formed by a set of subcategories (Box 1), and they were presented with excerpts of the statements obtained (record units), indicated by the letter “K” followed by the numerical sequence that represents the order in which the interviews were conducted.

Box 1 – Description of the categories and subcategories of the study organized according to the content analysis, Marília, São Paulo, Brazil, 2012

Categories	Subcategories
Factors that characterize the humanized care from the conception of the multidisciplinary team	Humanized care and its relation to the effective communication with patients and their family.
	Humanized care and its relation to team work.
	Humanized care and its relation to empathy, singularity, and integrality.
Factors that mischaracterize the humanized care from the conception of multidisciplinary team	Mischaracterization of humanized care and its relation to the fragmentation of the process of work and healthcare.
	Mischaracterization of humanized care and its relation to the management of health-care services and conditions of work.
	Mischaracterization of humanized care and its mistaken conceptual relation.

RESULTS

Sociodemographic characteristics

Regarding sociodemographic characteristics of the studied population, 18 participants (75%) were females, 19 self-declared as Catholics, the average age was 50 years, varying from 25 to 55 years. There was no predominance related to professional category, with nine nurses (35.5%), seven doctors (29.2%), three physiotherapists (12.5%), two female nutritionists (8.4%), two female psychologists (8.4%) and one female social worker (4.2%). The graduation and working time were not homogenous, with average of ten and six years, respectively. Nine participants (62.5%) declared having double employment.

Category 1 – Factors that characterize humanized care from the conception of the multidisciplinary team

This category brings a conversion of discourses that represents the characteristics of humanized care designed under the aegis of the conception of the research participants. It is

possible to understand that the practice of humanized care is bounded to the daily life activities of health-care, emphasizing those that refer to interpersonal relationships.

Subcategory 1.1 – Humanized care and its relation to the effective communication with patients and their family

The excerpts bellow tell the commitment of the worker in providing moments in which patients can express themselves, setting communication as care outlined according to the individual needs of each patient and promoting well-being and decreasing anguish.

[...] to conscious patients we talk, we ask if they feel any pain, we ask him which is the side he feels more comfortable. We try to give space to the patient to communicate in the way he can. (K3)

I work in the morning, and we notice this preoccupation a lot, it is like this: we talk a lot, in some cases we ‘request’ the social service, we talk and try to always provide the best within the individuality of each patient (K4).

I see that people think a lot about process, papers and forget the human side. Ok, the medication is important, the bath is important, but you do not have the time to talk to the patient and, sometimes, he needs a minute to talk. (K11)

Sometimes, when the patient is intubated, we use written language, when the patient can write. This is for understanding that anguish that he is experiencing and he needs to express that. (K23)

The communication with the patient is a critical point to be explored as humanized care, because, according to the following statements, it is possible to understand that the conception about communication transits according to the conscious or unconscious state of the patient:

I promote my humanization like this, since I arrive and say “good morning”. Sometimes, the patient not even opens the eyes, I ask: “Open your eyes”. I talk with the patient even when he is sedated or in coma vigil. (K2)

Regarding the intensive therapy, especially, because people think that because a patient is sedated or in coma he is frequently not listening to the comments around the bed. (K6)

[...] I try to work in a humanized way considering the patient, but at the ICU it is a little complicated because of the fact that they come to us polytraumatized, intubated. It is hard to know what they are feeling, but when they begin to have the minimum level of consciousness, I try to notice feelings and if they are comfortable or not. (K5)

The communication was also an important way to humanize the care when it was offered to the family of the patients hospitalized in the ICU, with the objective of informing the context and clinical condition of the patient.

I try to imagine myself in the situation of that family; also in the way we give an information, in the best possible way, clear, but also not causing more anguish. (K14)

A conversation with the family during visiting hours, I already understand as humanization; trying to explain the situation to the family, who sometimes comes uninformed, and want to know what is going on with their family member. (K17)

I always go there, in person, and talk to the family; I never like to dismiss the family, for example, to go home without seeing the patient inside intensive care. I always like to give information regarding the unit status, what are the visiting hours. (K7)

The relation with the family has to be developed, especially during visiting hours. These are the moments we have more time to emphasize this humanitarian side. (K18)

Always with a qualified listening, it is humanizing in this sense, bringing this family closer. (K22)

A close reading of the previous speeches emphasizes the intention of the participants to the effective communication and qualified listening, which are essential factors to achieve the mutual objectives involved in the communicative process.

Subcategory 1.2 – Humanized care and its relation to team work

The link between the actions of different professionals and the necessary interaction between them makes clear a possible constitution inherent to the dynamicity intrinsic to team work. The statements below show that the referred organization of work in health-care meets the concept of humanized care in ICU.

In some moments when we fail, and our colleague ends up correcting, there comes the multidisciplinary team. So, we are always like this, contributing to the care that is a little flawed. I see that the team is very close, we work well together. (K10)

It is the moment that I also call my team to perform this act of humanization along with me, because by myself I do not go there and make a tube suction, sometimes I do it, but it involves an assistant or a nurse. So, to comfort a family, a family gets sick, I call a nurse; sometimes, there is a social worker in here, there is no team protocol to ensure this humanization act, it simply happens. (K15)

[...] it is a multidisciplinary visit and I see the preoccupation to be humanized. Some professionals are very detailed, especially those professionals that have the most physical contact with the patient, those of nursing are talking to the patient all the time. (K12)

Subcategory 1.3 – Humanized care and its relation to empathy, singularity, and integrality

The following excerpts represent the importance of empathy as a phenomenon inherent to the professional practice, which allows the workers to develop the humanization in the care offered in the context of the ICU to patients and their families.

As if the hospitalized person was you, right? To me this is to humanize. (K4)

I already had people of my family in the ICU and I know how distressing it is. I have been trying, for example, to assist everybody as if they were my family and I am just as careful to everyone. (K6)

When we know the background of their lives, we are more sensitive. The humanized process, in my personal experience, is imagining myself in the patient's place, having empathy; always having this thought: if I was in this patient's situation, tied, what would I feel? (K8)

I try to imagine myself in his place to imagine what he is feeling and what is he thinking about himself in that situation, bring him closer to me. I try to comfort him better, so that he does not feel only like a sick person, so I try to talk to him. (K12)

Regarding the singularity and integrality as expressions of humanized care, we point out the following excerpts that show the conceptions of workers of the multidisciplinary team:

[...] I see the patient in a complete way, I respect him, I give him conditions to recover as quick as possible; calling him by his name, respecting his privacy, meeting his needs, seeing what he needs, what interferes in the work and in the development of the disease while he is hospitalized. I do everything that I can to improve and comfort while he is in here. (K10)

[...] I do not see just the patient himself, I see everything that is around the patient... (K11)

I think that we have to think together, have a qualified listening and create a way to work with each patient in his singularity. (K23)

What must be done is speak and listen also to other professionals, understand what psychology, physiotherapy, nursing, and what medicine have to say about that patient. Everybody together, to be able to make it better. (K23)

Category 2 - Factors that mischaracterize humanized care from the concept of multidisciplinary team

The analysis of the empirical material enabled the survey and understanding of factors that weakened the practice of humanized care, and therefore it was possible to design the respective category.

Subcategory 2.1 - Mischaracterization of humanized care and its relation to the fragmentation of the work process organization and health-care.

The following excerpts show the negative consequences of the work process fragmentation on the practice of humanized care in the conception of health-care professionals.

They do it mechanically, they only do their job [...]. Sometimes it is so mechanical that the person does not realize that is not offering a humanized care. (K2)

Regarding the team, I think that it gets a little more complicated, because sometimes we end up not working as a team, each one does what has to do and goes to the next patient, so we end up not working together so much. (K13)

When I come here to work, to be in charge of the visit, I perform my care, they are protocolized cares, mechanical as we say: 'give this to the patient, because it is good for him'. So, my moment of humanization with the patients inside the ICU, it is extremely separated and distinct from that moment when I am working and protocolizing the things so that the unit works. (K15)

[...] it was always a very fragmented work, when a request comes for the psychology section it is because they are having a hard time, or because it is a difficult patient, or one with a difficult family, but never in a way to integrate and understand the suffering of the other and share. How can I make this humanized care? It comes like this, in a fragmented way. (K22)

Subcategory 2.2 – Mischaracterization of humanized care and its relation to the management of health services and work conditions

This subcategory allows us to understand that communication organized as vertical axis in the direction management-care and that processes of precariousness of health work weaken the practice of humanized care.

In the institution, the use of blackboard is mandatory in nursing supervision, so I think this human part is a little lost, because before the perceived how the patient was feeling and now they don't; it is a very technical thing: 'Oh! The patient had fever, such procedure was done, and it's over'. (K5)

We have some difficulties at the institutional level, regarding materials, number of employees. It goes to a certain point when we find many difficulties in providing this comprehensive care to the patient. I will not tell you that we work in a humanized way all the time, because, sometimes, we can barely stay beside the patients to talk and see their real needs, by lack of materials and employees. (K4)

Often, we don't have, for example, inputs, basic things for us to give the patient some comfort; we don't have sheets, towels, monitors and nursing staff. (K6)

It's not so humanized because our rush, the lack of time we have, sometimes, to perform a better care, a more complete care. (K13)

Subcategory 2.3 - Mischaracterization of humanized care and its mistaken conceptual relation

The humanization as a possibility of protocol organization of the process of work in health-care or as an ideological option of the professional were also concepts elucidated in the conceptions of the multidisciplinary team, and the following excerpts show these results:

I think that the team work is hard, because not everyone has the awareness. Why? Because we do not have protocol to work. So, each person has a thought and when you do not have a protocol, you cannot work, because the doctor thinks in a way, he has his ego, the physiotherapist thinks in a way, the nurse thinks in a way and the assistant thinks in another way, I think that it kind of lacks a protocol, so that we work in the same direction. Oh, it is humanized... but, what does humanized mean? (K11)

Since not everybody sees humanization, so, sometimes, I feel a certain difficulty. People sometimes understand in another way what I am doing and I also see it like that, that it really needed to be more frequent or more elaborated, because you want to do it, but your colleague has another thought. (K12)

To me the act of humanization is an act of feeling inherent to people. (K15)

DISCUSSION

One of the characteristics inherent to PNH is the trust in the successful actions of the many realms of SUS. This means that, as public policy, PNH has the commitment of appreciating the successful experiences, singularizing the services and teams and recovering the reenchantment of the concrete in the professionals involved in such processes^(1,10). This makes genuine the experience elaborated by the multidisciplinary team on the care offered by humanized care.

The communication, as one of the essential abilities for health-care, was in this research among the most expressive subcategories when considering the process of data saturation, which meets the results of previous researches⁽¹¹⁻¹²⁾. Additionally, it is a common action in the care field of the various professions that compose the multidisciplinary team in health-care, and it is recognized as a general ability disposed in the curricular guidelines for courses in the field of health⁽¹³⁻¹⁵⁾.

Even though it is considered an important professional ability, communication in health-care has fragilities that make its discussion even more contemporaneous. The results point out to the importance of explanation of the types of communication and exploration that health-care professionals make to send and decode messages. Therefore, verbal communication, represented by spoken and written words, may seem the main way we communicate; however, only 7% of the content of our messages are made by verbal channel. This implies that most of the messages shared is non-verbal, and thus, regardless of the patient's level of consciousness, there will always be a message to be decoded⁽¹⁶⁾. Therefore, the development of abilities in the field of communication in health-care represents a primordial factor to the practice and humanized care, especially to the team that works in ICU, where the occurrence of these cases, for several factors, is greater⁽¹⁷⁾.

Thus, communication is also important in the practice of humanized care, regarding the contact established with the family of the patients hospitalized in the ICU, which is in accordance with studies previously performed⁽¹⁷⁻¹⁸⁾. The results of this research point out that the commitment of the participants with effective communication and with active listening are essential factors to achieve mutual goals involved in the communicative process^(11,16). ICU workers offer these factors aiming some needs of the families that were identified in this research conducted by Puggina et al.⁽¹⁹⁾, such as knowing what are the patient's recovery chances, having their questions answered honestly, knowing which professionals are taking care of the patient, and receiving explanations that can be understood.

The effective communication – noticed in the preoccupation of transmitting a clear message with active listening, not increasing the anxiety level of the family, putting them in context, bringing them closer to the clinical condition of the patient hospitalized in ICU – differs from results of previous researches that present a bureaucratic, formal, and restrict contact between family and ICU health-care team⁽¹⁸⁾.

Working in multidisciplinary team represented, in this study, a way for the professionals to reach the practice of humanized care. Therefore, the “interaction” factor, integrated in this form of health work organization, brings up again communication representing the vehicle that enables the articulation of professional actions⁽²⁰⁾. Even though there are few studies that research the relation of multidisciplinary team work and humanization, we found in communication the theoretical bond that links these concepts⁽¹⁰⁾.

Along with PNH, there is a broadening of the scope of communication inside health-care services that occupies an important place in the normative boundaries that guide the practices of humanized care. It is about promoting, in the daily work of health-care, the circulation of knowledge that affect the sharing of power in the action of care. Thus, the transversality of communication is discussed, discouraging the verticality or horizontality in the micro-politics of health work, which deconstructs, respectively, the hierarchization and homogenization of speeches and of professionals⁽¹⁰⁾.

In this movement, speeches as “we work together” and “I involve an assistant or a nurse” connote the potentiality of a role taken by the participants of the research, in which experience and different knowledge, side by side, constitute the exchange during the practice of care, therefore, construction of knowledge intrinsic to the practice.

Still about the practice of humanized care, the literature review for this research points out that empathy, singularity, and integrality have been the most representative expressions of the way professionals of the multidisciplinary team conceive the practice of humanized care, and our results corroborate this foundation^(12,17,21-24).

The analysis of the empirical material produced in the subcategory that addresses the relation between humanized care and empathy is in accordance with the discussion of the cognitive compound of the multidimensional concept of empathy that, in this case, refers to the ability of the multidisciplinary team workers in interpreting and understanding the feelings and thoughts involved in the experience of the other person of the relationship. This ability has the requirements of recognition of emotions and interpersonal flexibility⁽²⁵⁻²⁶⁾.

The humanization of ICU care was researched by Mongiovi, Anjos, Soares, e Lago-Falcão⁽²²⁾ and it meets the results of this research when discussing the importance of the empathy, also as a constituent factor and concept. Other researches that involve health-care workers and users allow the identification of the connection between humanization of the care and empathy, representing an essential tool for the operationalization of this practice^(11,17-18,23).

Guiding the care aiming not only the technical goals means developing a professional technique that is sensitive to the integrality

and subjectivity as genuine methods^(24,27). Regarding these aspects, it is worth noting that the technological density inherent to ICU and the level of importance that the professionals attribute to them have been an object of discussion in the field of care, because they show impersonal characteristics, taking the professional away from the subjective field. The participants’ view, however, show the idea of using technological devices favoring the human dimension of care, that is, they are conceived as ways of care designed to the critical patient. Therefore, it is possible to see that humanized care contributes to the valorization of the “subjective” realm in the scope of intervention of the professionals of intensive therapy⁽²⁸⁾.

Fragmentation mischaracterize human care: the technique as way of acting in care and the alienating capture initiated by the organization of the work represent the complexity of this problem^(18,21). The common ground of these two sides of the fragmentation is represented by the specialization of knowledge, which reaches its maximum level at the ICU, and they are noticed in the disintegration of the multidisciplinary team and in the technicality of health-care⁽²⁸⁾. This implies a proportionally greater effort, involving management and health-care, to create actions that face this reality⁽³⁻⁴⁾.

With this movement, it is possible to see the operationalization of PNH taking shape as method from its guidelines – hosting, expansion of the clinic, democratic management, valorization of the worker, and ensuring users’ rights, and their principles – communicability, inseparability between management and care, and individuals as protagonists^(3,10).

Among these guidelines, the Expanded Clinic represents a way of confrontation, because it considers that the complexity of the health-care needs the approach of a multidisciplinary team. Therefore, places where the fragmentation of the work process can be discussed allow workers to think about the expanded understanding of the process of health and disease, sharing of diagnosis and interventions and health-care organized from the logic of reference teams and matrix support⁽³⁾.

It is a reliable alternative that guides the practice of humanized care and questions the structured and protocol knowledge, standing in dialogic processes that show dynamicity, participation, and solidarity. There is also the construction of a territory where they can transmit the wishes, the interests, and the needs of those involved – health-care workers and users constructing the co-responsibility, that is, individuals involved in the formulation and in the implementation of health-care practices^(10,29).

The process of precariousness of work and the hegemonic management rationality are phenomena that historically affect health services, and both are grounded in the technical and bureaucratic paradigm. It is interpreted by PNH as incoherent for a logic in which work, as a human activity, should not be performed in an automatic and protocol way^(1,30).

The co-management represents one of the guidelines of this politics, therefore specific orientations that serve as guideline for the organization and implementation of settings that produce interferences in health-care work, in the sense of a construction of a co-responsibility pact between users, workers, and managers⁽⁴⁾ affecting the achievement of individuals committed to the work and that of themselves, or still contributing to health and subjectivity⁽³⁰⁾.

From the perspective of co-management and its impacts in health-care service and in people involved, it is understood how the concept that optimizes the humanized care: creating conditions in which workers and users take the role, practice autonomy, and co-responsibility, understanding that humanization, as a strategy, is more involved in the construction of models of care and management in line with SUS than with the idea of humanizing human beings⁽¹⁰⁾.

Discussing humanization in health-care practices as a research object is still polemic for many reasons. One of them is that its concept recovers many meanings, which are sometimes antagonistic, which impairs an understanding that contributes to the mission of PNH. Another reason is the fact that when it was established as a policy, it was grounded in the radicalism of crossing SUS, confronting iatrogenies that came from practices of management rationality⁽⁵⁾.

The operationalization of humanized care is directly bounded to the conceptions of humanization, attributed by the professionals that compose the health-care team. From the view of the participants of this research, humanized care is involved with the construction of the protocols that capture the subjectivity of the professionals, making homogenous their respective characteristics that compose the diversity inherent to team work. This interpretation is directly linked to the fact that the humanization concept is still grounded on attitudes and feelings "*inherent to people*", making inhuman someone that does not express certain behavior. Even though they still live, these concepts do not matter to the objectives of humanization in the terms of PNH⁽⁵⁾.

Affirming humanization in the context of SUS policies brings out the responsibility of building another concept, that is fertile, as a territory that mischaracterizes humanized care as a "*moral prescription*", but also contributing to the expansion of the production of subjectivity of the professionals of health-care, understanding oneself and the others as a paradox. Therefore, the construction of humanized care, as a practice of multidisciplinary team, is improved as the health services create opportunities for spaces of construction and synthesis elaborated from

the diversity of the solid experiences of each worker⁽¹⁰⁾.

The limitation of this study refers to data collection. Because it was conducted in a health institution, it can impact the results as punctual characteristics that reflect the characteristics of the work process where the participants were inserted. Therefore, other researches that aim the views of professionals that work in ICUs of other hospital schools are still necessary to deeply reveal the challenges that PNH needs to face for its solidification and operationalization in the work process, establishing itself as a national health policy.

As results of this research, it is possible to state that the multidisciplinary health-care team understands the operationalization of the humanized care regarding the care offered to the patients and their families in the ICU context. Besides, the professionals that offer direct care understand that the organization and management of work processes centralize the critical point that impairs the practice of humanization in intensive therapy environments. Thus, it is possible to take the role before the need to create other ways of managing hospital institutions, putting into practice the guidelines proposed by PNH.

FINAL CONSIDERATIONS

The view of the multidisciplinary team on the development of the humanized care in the ICUs of a hospital school showed the factors that corroborated and impaired this practice. Therefore, the actions in daily work were the most representative moments for the professionals that operationalize the humanization of care and experience it in the effective communication with patients and families, with team work, and with establishment of empathy, singularity, and integrity.

The aim of this research allowed us to recognize, by the fragilities of the practice of humanized care by the multidisciplinary team in intensive care, that the greater challenge is still focused on causing impacts in the hardness of the organizational structure of hospitals, since the factors that impair this type of practice are the fragmentations of the work process, of management of health services, and of work conditions.

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