The meaning of humanized nursing care for those participating in it: Importance of efforts of nurses and healthcare institutions

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Objective. This study sought to understand this study sought to understand the meaning of the experience of humanized nursing care from the perspective of patients, relatives, and nurses. **Methods**.This was an interpretative phenomenological study that included 16 adult participants and which was based on in-depth interviews to gather the information and on the procedures proposed by Cohen, Kahn, and Steeves to analyze the information. **Results**. Efforts by healthcare institutions and nurses are key elements to advance from impersonal care toward humanized care because these will permit revising and eliminating the barriers present in the current exercise of caring. The results highlight the importance of the effort for humanized behavior from nurses, given that because they are human beings their behavior in the relationship with patients is not always have that connotation. **Conclusion.** Humanized care is not only supported on the human condition of nurses or on the institutional intentions, but on attitudes and on a disposition focused on the patient's wellbeing. Additionally, tensions in nursing care are solved through humanizing efforts.

Key words: humanization of assistance; nursing care; qualitative research.

El significado del cuidado de enfermería humanizado para quienes participan en él: importancia del esfuerzo de enfermeras e instituciones de salud

Objetivo. Comprender el significado de la experiencia de cuidado de enfermería humanizado desde la perspectiva de pacientes, familiares y enfermeras. **Métodos.** Estudio fenomenológico interpretativo que

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incluyó a 16 participantes adultos, el cual se basó en entrevistas en profundidad para la construcción de la información y en los procedimientos propuestos por Cohen, Kahn y Steeves para el análisis de la información. **Resultados.** Los esfuerzos por parte de las instituciones de salud y enfermeras son elementos claves para avanzar desde la atención impersonal hacia el cuidado humanizado, porque permitirá revisar y eliminar las barreras que se presentan en el ejercicio actual del cuidado. **Conclusión.** El cuidado humanizado no se apoya únicamente en la condición humana de las enfermeras o en intenciones institucionales sino en actitudes y en una disposición enfocada al bienestar del paciente. De otro lado, las tensiones en cuidado de enfermaría se resuelve con esfuerzos humanizadores.

Palabras clave: humanización de la atención; atención de enfermería; investigación cualitativa.

O significado do cuidado de enfermagem humanizado para quem participam nele: importância do esforço de enfermeiras e instituições de saúde

Objetivo. Compreender o significado da experiência de cuidado de enfermagem humanizado desde a perspectiva de pacientes, familiares e enfermeiras. **Métodos**. Estudo fenomenológico interpretativo que incluiu a 16 participantes adultos, o qual se baseou em entrevistas em profundidade para a construção da informação e nos procedimentos propostos por Cohen, Kahn e Steeves para a análise da informação. **Resultados**. Os esforços por parte das instituições de saúde e enfermeiras são elementos chaves para avançar desde a atenção impessoal ao cuidado humanizado, porque permitirá revisar e eliminar as barreiras que se apresentam no exercício atual do cuidado Se ressalta a importância do esforço por um comportamento humanizado por parte das enfermeiras devido a que pelo fato de ser seres humanos seu comportamento na relação com os pacientes não sempre tem essa conotação. **Conclusão.** O cuidado humanizado não se apoia unicamente na condição humana das enfermeiras ou em intenções institucionais senão em atitudes e em uma disposição enfocada ao bem-estar do paciente. De outro lado, as tensões em cuidado de enfermagem se resolve com esforços humanizadores.

Palavras chave: humanização da assistência; cuidados de enfermagem**;** pesquisa qualitativa.

Introduction

Analysis of the current situation of nursing care reveals the diverse difficulties to ensure ideal practice conditions. For Poblete *et al.,*[1] "in Latin America, it is necessary to look for the meaning of caring for people and the aspects that show deficiencies in its application, as is the case of patient-centered humanized care because it is difficult to maintain humanitarian values in caring in healthcare institutions where this care seems to become invisible due to the biomedical tasks focused on the disease", forgetting the importance of the relational, spiritual, and social aspects and of the physical, mental, and social wellbeing, which has not contributed to "transforming the inequitable conditions in which life develops".[2] Not in vain, the reemergence and persistence of diseases and avoidable deaths has been observed in big population groups, generally the poorest and ethnic minorities.[2] It is how interest has been stirred in academic and research settings for equity and right to health, health justice, humanization, and quality in the claim for a more humanized social system. Healthcare institutions offer conditions that contribute to the lack of humanization in care. Among other aspects, the following are mentioned: difficulties of access for patients and relatives, flaws in the availability and use of resources and the work environment for nurses. Within this framework of ideas, "efficiency of nurses is judged by the elaboration of reports and not by the performance of care, which leads to thinking that good nurses for institutions may not be good nurses for patients".[3]

It is interesting to see that attention is focused on the meaning of humanized care under conditions in which dehumanization problems emerge due to situations related to the interactions between

nurses and patients or dependents of healthcare institutions, as well as of the existing social and legal means; however, it is worth considering that in the work conducted by nurses true care may also be found, contextualized with nursing theories, humanized, safe, and quality care. It is this type of care which this article seeks to highlight, which permits reflecting how those directly involved perceive and experience it; besides, it permits contributing to the evidence of its benefits for patients and nurses considering that "to desire a reality and search for it we must have awareness of its value, approach it, know it better, and earnestly want to find it and fully assume it".[4] the concept of truth over humanized care must be agreed with the patients and their relatives and not only with the prevalence of the posture of nurses and representatives of the healthcare institutions and its convenience, given that "the validity of interpretations of care influenced by the healthcare institutions has not been convenient to respond to the purpose of nursing", as stated by Gordon.[5]

On the humanistic aspects of care some interpretations have been made, but the variations in contexts and the readings and interpretations of the phenomenon change, which is why conceptions of it exist that do not represent the objective reality and do not deplete its totality. Due to this, some may show variations such as understanding in isolated manner the technical or the relational of nursing or requiring a balance between them. The purpose of this work, therefore, consists in offering a contribution to the reflection to accomplish a representation that is as complete as possible of the reality of care. A new interpretation can generate others in the chain that permits developing the science of nursing, which is pertinent due to the changes in time, context, and people. Thus, this study sought to establish the meaning of humanized care in the experience of the people who participate in it as patients, relatives, or nurses.

Methods

This was a hermeneutic phenomenological study. The phenomenology permits the in-depth study of care, it's essential characteristics shared by different cultures in distinct historical phases,[1] as well as discovering the means of the different realities like the personal and the subjective in approaching human beings"[7] and highlight "how these are perceived" and experienced by the participants, without "retention of objectivity".[8] Also, it enables studying the realities whose nature and structure must be captured from the reference framework of the subject living and experiencing them, which is useful in studying phenomena that are rarely communicable, states Martínez.[9] The hermeneutic vision favors "understanding the practices and experiences and finding meanings"[10] and is important because it has contributed to understanding the history of nursing and identifying the phenomena implied in healthcare within a specific context in which beliefs, subjective experiences, and ideologies are considered. Its interest is aimed at evaluating the influence beliefs, experiences, and the environment have on the interpretation of the meanings given in life, health, disease, and death situations.[6]

A total of 16 adult individuals between 29 and 62 years of age were included; four men and 12 women. Of the participants, six were professionals in areas, like economics, engineering, and marketing, with prior experience as patients due to emergency situations, critical disease, or surgical intervention; seven were close relatives of hospitalized patients of which five were professionals working as teachers and secretaries and two as housekeepers; the other three were nurses working in healthcare institutions in the city of Medellín. All the participants lived in this city and voluntarily accepted to participate through consent, without receiving economic reward. Through purpose sampling,[11] the participants were selected for the requirements of the study – bearing in mind information saturation. Participants were contacted through the snowball technique and meetings were arranged through phone and personal contacts. The information was constructed through in-depth conversational interviews lasting between one and one and a half hour, carried out at the homes or workplace of

the participants, under conditions of privacy. The interviews were identified with a code to preserve confidentiality: the letter N followed by the initials of the name to identify nurse participants; the letter P for patients, and S for patients' relatives. The initial question: "Describe your experience in care during the hospitalization due to episodes of your own illness or that of a family member", for patients and relatives, and "Describe your experience as caregiver with sick persons and relatives in the hospital" for nurses, invited participants to describe their experiences. The following questions were specific to each of the interviews and dependent on the contents of the information.

Manual analysis of the information was based on the interpretative procedures of the hermeneutic phenomenology proposed by Cohen, Kahn, and Steeves.[12] This analysis was begun during the first interview upon listening and reflecting on what was being expressed to capture meanings that were validated with the participants. The interviews were faithfully transcribed and the researchers were immersed in the information through reiterated reading, line by line, to have a general vision of that reported and of the peculiarities of each experience. The product of this review sought to determine the units of meaning, coding, thematic analysis, and selection of samples or those portions of text with textual information. It also permitted identifying the presence of recurring incidents or of common themes. Thereafter, the themes and subthemes were separated and analytical memos and diagrams were prepared. Lastly, a narrative described how the themes were understood in relation to the experiences of the participants.

The interpretation was validated by allowing several participants to read it to determine its correspondence with what they wanted to say and ensure fidelity and credibility in the analysis.[9] A researcher with a PhD degree and vast research experience, and 10 members from the research group "Emergency and Disasters" from the Faculty of Nursing at Universidad de Antioquia revised the texts on the interpretation of the data. Additionally, suggestions and recommendations were made to improve the report and confirmability. Data were contrasted with the literature and the discussion. To contribute to the applicability and transferability of the study, the results were presented to different audiences. The study was conducted in Medellín, Colombia between December 2012 and March 2013, with approval from the ethics committee of the Faculty of Nursing at Universidad de Antioquia (Record. CEI-FE 2012-4**).** Regarding the participants, their autonomy, confidentiality, and freedom to participate was respected, as consigned in legal dispositions in effect for the relationship with people involved in studies of this nature.

Results

Humanizing institutional efforts

Interest for humanized nursing care has had support from two important pillars; in the first place, the disciplinary proposals from nursing that postulate the type of care, conditions, and favorable requisites for holistic and quality practice that responds to the physical, emotional, and social needs of the patients. In the second place, increased interest of institutions to offer humanized care, with adequate resources and optimal results for patients without losing sight of the economic profit, which seems to be the preponderant condition that guides their actions: *institutions speak of humanizing care and it would sound as in opposition to what care should be because we are human beings caring for human beings; so we should not be talking of humanizing care* (N.G). Thus, efforts to favor and ensure humanized nursing care strike sensitive zones and in spite of multiple efforts from theorists in nursing, disciplinary proposals and nursing work are insufficient, requiring an administrative organization in healthcare institutions to guide resources and decisions for humanized nursing care: *we need to address it from the different possible scenarios, according to the resources and limitations of institutions because everything must have a limit, with clear intentions of favoring care* (N.J.T). Due to this, a big step in

humanized care is represented in motivating the interest of institutional directors in favoring care; in fact, it is possible to observe some planning and dissemination efforts of humanizing programs pressured by the demands of patients, seeking for care to have the best results for the institutions, insurance carriers, patients, and the community: *I repeat that it is the administrative part of the institutions that has promoted that humanizing position in the staff* (N.N.S).

The orientation towards humanized care institutions begins by permitting access with the least restrictions possible to the people who need such, for health care to really be comprehensive and focused on problems and overcome the tendency to their partial solution, simply because the availability of resources privileges some activities leaving others aside; it is also worth mentioning the preponderant role of patients in care over the healthcare staff and over the capital: *it has been demonstrated that healthcare institutions are not only about profit; yes, they have to survive, but patients are the most important, for whom the institutions survive and we have to care for them in an integral and integrating manner* (N.J.T). Additionally, to ensure the best conditions for the practice, personnel, supplies, equipment, facilities, and a vast number of technological elements are necessary to monitor, diagnose, and intervene without leaving aside clear orientation on ways to proceed according to what is needed and recommended in each case: *this has to be a philosophy of life of the organizations to deploy all the actions, programs, and budgets that will be needed; also, to facilitate the factors and individuals that are important for the humanization to take place in the best sense* (N.J.T).

It is not enough to only considered number of people who are part of the work teams in the institutions, but that said staff must have a marked orientation to help and the necessary interest to advance toward the proposal of care that result novel compared to those in existence, where the interests of institutions have been adopted by their employees, above all in the search for capital, with the consequential detriment to the response to the needs of people: *making a careful and demanding selection of the personnel making sure that people do have the vocation and interest for doing things* (P.G.M). That is, it is not sufficient to destined money and carry out dissemination programs, it is necessary to motivate a change of attitude in professionals and the people who participate in caring; besides, they must aim their efforts for said purpose, controlling and supervising, maintained over time, to ensure adoption – through conviction – of the necessary behaviors for humanized care. It is also insufficient through humanization campaigns; rather, a culture must be developed for humanized care to be part of the disciplinary knowledge of nurses, of their common sense, as a collective construction: *nursing care is sometimes limited and everyone tries to speak of the quality of care, enablement, and accreditation and a paraphernalia of things is put together without considering a well-argued and well-mounted strategic platform* (N.G).

If necessary resources are available to guarantee humanized care, these must be used in the best manner, with ethical criteria, with the intention to favor people, and offer them the best well-being possible, according to the possibilities and limitations people have due to their conditions of vulnerability, that is, we should try to control disturbances due to the restriction of resources or denial of services and rights: *I think guidelines should be made from the administration to guide the treatment with patients and that people who work at that to set guidelines and complying with the norms; anyone not doing this cannot work in the institution; not in vain, in some institutions all the staff are in the same vein, in some of being very good and in others of not being as bad* (N.G.G).

Humanizing nurses' efforts

According to that stated by one of the participants, care that is not humanized is not nursing care, given that this concept involves non-deferrable and unavoidable levels of humanization that permit highlighting the condition and human dignity

of the individuals. Conversely, it is important to consider that human beings, due to the very condition of humans, are prone to behaviors that can be irrational, malicious, and cruel. Because of this humanized care requires the effort and intention from nurses and healthcare centers that derive the achievement of capital and profit from healthcare: *in spite of the institutional efforts, there are faults in care; which is why we had to try to fit into these new policies aimed at offering humanized and quality care* (N.G).

Humanized care supposes a sensitivity process in people who offer it to go beyond behaving as human beings to adopting the position of humanizers, with an orientation to do good for others and moved by feelings of compassion, solidarity, sympathy, respect, and the inclination toward the wellbeing of those who were sick and the state of dependence with the desire to strengthen them, help them, and keep them company: *logically, they must have a professional formation that leads them to act properly, with much objectivity and humanism in treating patients* (S.D.E). With respect to the nursing staff, participants consider that the number of nurses and nursing aides who are assigned care functions has been traditionally low or insufficient, according to the number of patients and the functions they must carry out: *then, for example, that there would be more staff* (P.G.M).

This position by the participant is important because it contains a contradiction to the prevailing administrative current in Colombia since the 1990s, which aimed to save in personnel costs, especially nurses, to increase profits, which led it to a notable deterioration in the quality of the services, increased errors, work overload, dehumanization of care, and dissatisfaction of nurses: *the policies of the institutions must be revised to have more personnel, that is, the necessary staff for nursing activities to not become a task of complying, but rather of enjoyment and the time needed to offer patients that humanized care* (N.J.T).

With respect to the type, number, and characteristics of the functions assigned to nurses in hospitals, study participants also expressed their concern because many of them correspond to the professional profile and others require much investment in time, which brings as a consequence the departure of nurses from care, from the defense of the rights of patients, from the exercise of leadership and supervision of delegated activities: *the work situation makes it so that institutions assigned nurses a series of responsibilities or activities that are not precisely those of caring* (N.G.G). Rational assignment of functions, in relation to the number of patients they must care for, is an aspect in which differences arise according to the severity of the patients, states of instability in bodily systems, and times required to carry out certain interventions. In addition, the exaggerated number of patients also represents an overload of functions and activities that contribute to failures and errors in care, dehumanization and deficient quality, and to states of fatigue and dissatisfaction for nurses and patients: *yes, I think the number of users or patients in clinics is too high for the amount of personnel they have, yes* (P.J.E).

In the current hospital scheme, contact between nurses and patients is not possible, there is no interaction and, hence, there is no nursing care or humanized or any other type of care because there are no possibilities of it being conducted in the distance, with the absence of nurses in the patient's unit. This also leads to poor sensitivity toward the patient's problems, which hinders compassion, solidarity, and sympathy necessary to offer help and support to people. This dedication of time tasks different from care has had important impact on how it is carried out, on the quality and humanization, and even on the attitudes of nurses who have come to believe that their functions are aimed at dealing more and more with administrative tasks with detriment of patient care: *I think it is too much workload that takes away from the relationship occurring between nurses and patients and with the family because you have very little space to interact with them, to do a great many other things due to many situations* (N.G.G).

The sum of factors, like not enough personnel and the overload of functions to nurses, has brought along a change in the interest toward which the execution of tasks is aimed and on the purposes of nursing work, yielding as a result a disjointed realization of tasks that responds in a higher degree to the institutional expectations than to comprehensive and humanized care, which should be aimed at solving the problems of patients: *currently, many institutions exist where humanized care is not possible because the work demands are quite high and only tasks are complied with*(N.J.T). Also, according to that expressed by the study participants, nurses and their proposals for care reflect submission toward the orientations of the healthcare institutions, which does not contribute to the defense of humanization. This situation makes it a priority to analyze the interference from institutions on nursing actions and, if necessary, struggle against that form of oppression established when nursing care is strictly subjected to the mandates of the power of the institutions, violating the disciplinary proposals and imposing ways of acting that do not respond to the conditions nursing care must have; this means looking to improve the working conditions of nurses and, most importantly, looking after the respect for the rights of patients and the care they need: *I have always said that the administrative part, on how they manage the system, has certain restrictions; but as a professional you have to enforce your concepts and the things in your job; you cannot permit administrators, in fact no one does, to come and tell you what to do; you decide what should be priority, if it is direct care of the patient or a great many administrative functions* (N.L.A).

The defense of humanized nursing care proposes a confrontation with the institutional guidelines. This situation may be less difficult if there is institutional will because it can be considered that the first obstacle has been eluded; the rest depends on the nurses' efforts, change of attitude, and adoption of clearly identified ways of proceeding toward the wellbeing of people and toward a practice according to their disciplinary proposals: *nursing is like the most important estate and the biggest in existence in every institution and many times quite undervalued* (N.J.T). Accomplishing for nursing care to become an important axis in institutions, with nursing as work group, would be a significant advance toward humanized care because it has the support, resources, and necessary conditions for its execution and implementation. The question emerges with respect to what would be those aspects that institutions must strengthen to make nursing care replace impersonal care and for humanization to be enhanced to provide preponderance to human dignity, with respect to the rights and centrality of people under care. Change is not easy and includes many aspects among which participants consider vital those that range from having sufficient resources and staff to the concern for the preparation and update of knowledge, routines, and protocols of the institution: *it deals with sensitizing the personnel, with proposing institutional norms of cordiality, kindness, dignified treatment of patients, treatment coherent with their needs* (N.G).

Taking humanized care into practice requires the sum of efforts by institutions and nurses within a structure that supports the proposals to implement care plans and courses of action based on theoretical and ethical approaches that favor nursing management and leadership. This is more compatible with a proposal of humanized care than those that sacrifice the wellbeing of nurses and patients and limit the resources and services with a clear orientation toward the search for profit: *I think care guidelines should be available from the administration and these should favor humanization* (N.G.G). It is also required to solve institutional problems, correct the lack of personal and work overload, and assign nurses the tasks that really correspond to them to enable the orientation toward direct care and toward the interaction with patients and their relatives. This condition seems to be easy to fulfill due to the growing demand for healthcare services, besides, sacrificing the profitability of services by hiring more qualified personnel seems not to be

in the pretensions of those guiding the destiny of healthcare institutions: *it is necessary to have sufficient personnel and there are institutions that currently lack such or have too many patients to take care of and do not manage to do it in humanized manner* (P.J.E).

What follows is to return to patients and their relatives, to be by their side, with the disposition to carry out care really focused on detecting and solving problems, providing emotional and social companionship, offering the necessary information to ensure adequate participation from the patient under care, improving treatment with people, quality, and humanization; considering the results and satisfaction of nurses and patients; all this is accomplished by promoting interaction with patients, communication, based on interest, identity, and respect: *working a lot with nurses from healthcare institutions on relations with patients and their families and promoting interactions; starting from there patient care can be improved and care becomes more humanized* (N.N.S). The new path toward nursing care is a challenge for healthcare institutions and nurses without leaving aside other professionals. Thus, joint efforts can make it possible for care to be provided with the most recommended attributes and best qualities, at people's reach, and in the capacity to offer the response expected by people, to recover health, to better cope with disability and limitations or to have a dignified and quiet death: *I think people have to assume their role independently of where they are and under what conditions they are because the institution cannot condition you to provide dehumanized service, don't you think?; you have to give the best way if you committed to do so and that is why you are there* (P.M).

Discussion

According to that found in this study, various aspects should be revised for the work of nurses to correspond to humanized care. On the one hand, some aspects are related to the nurses themselves, but others are propitiated by the healthcare institutions, like "inequality in the use of resources and in the solution to problems, which leads to the loss of life, to worsening the disease, to pain and physical and psychic suffering".[13] Within the disciplinary proposals of some theorists, humanization is recognized as an attribute of care; "that it is a reference of quality, immersed in their reason for being",[14] whose achievement and practice is entrusted to "nurses, administrators, and to the very patients"[15] and that it can be enhanced with contributions from "different perspectives".[15] However, the concern set forth in this study with respect to nurses as human beings not always being humanized and their care actions are not either in their totality is reinforced by Morín[16] upon proposing that "humans are rational and irrational beings, capable of moderation and excess, who laugh and cry, but know how to objectively recognize; humans are beings of violence and tenderness, of love and hatred". Also, Murillo[17] emphasizes on that one is not necessarily humanized by the fact of being human and it is a condition that must be accomplished when stating that "given that man is human, it is possible to humanize him and in doing so, we achieve his showing compassion for the misfortune of our fellow peers, to doeth good and be in tune with kindness and with good manners", but to accomplish this effort, dedication, and desire are required; "humanizing humans is making them benign" and within this transformation "good and evil, eternal conflict of human nature, could be solved in favor of the weak, the needy, of those who suffer, feel, and are sensitive to our actions".[17]

Moreno,[18] in turn, states – in a claim for humanization in care – that it has become a social need to adopt care practices that respond to this attribute because "the humanization of care recovered its essence in health services now that so much is being said of measuring processes of institutional quality; this is a fundamental criterion and it is primordial to express it clearly in the philosophical principles that guide the institutional work". The aforementioned will lead to rethinking the current orientation of healthcare institutions to achieving profit, more

than to the quality of service, which is why they impose conditions that result adverse for the care practice, an aspect also mentioned by Santa *et al.,* when they state that "capital brings with it a fragmentary and mechanical vision of man and makes nurses execute technical tasks under pressure in greater amounts and with less time.[19]

In relation to problems to care reported in the study, Gasull[20] coincides in stating that "quality care is more profitable for institutions" and the restrictions in care in terms of resources and services result more detrimental to patients, institutions, and nurses. However, for the same author, hospital directors are more concerned with economic management tan with the quality of care" and for this reason "the tendency has been followed that each task, defined meticulously, should be assigned to those individuals with the minimum level of skills necessary to perform it, which has meant that some activities pertaining to the work of nurses be delegated to unqualified auxiliary staff".

This institutional movement toward profit and the redistribution of nursing functions has represented "dissatisfaction and feelings of guilt due to the loss of direct care, for having to assume activities that are not part of their job description, and because of the scarce support from the institution to perform an autonomous role";[21] given the characteristics of nursing work. In another context, it is important to consider that nurses are satisfied with "the recognition of the professional autonomy, an adequate system to provide care, and a high degree of cohesion among work groups".[22] Alemán *et al.,*[23] also analyzed the conditions under which institutional care takes place when proposing that "investments taking place in the healthcare sector, added to deficient employment conditions and policies, exposure to occupational risk, discrimination, physical and psychological violence, insufficient wages, instability between work and life, excessive workloads, and limited possibilities for professional development have resulted in the deterioration of working conditions and influences negatively upon hiring and retention of healthcare professionals, productivity, results of institutions, and patient satisfaction". Bearing in mind all these adverse factors, the authors propose a strategy that seeks to provide healthy care environments for patients and nurses, which are denominated "*magnetic*" hospitals and which they conceive as "great institutions to work in and provide excellent nursing care to patients".[23]

The relationship of nurses with institutions, reported by the participants in the study, is also analyzed by Noddings,[24] by stating that "insisting on obedience to regulations and observance of rites contributes to the deterioration of genuine care". Likewise, Weinberg[25] states that due to the current situation, nurses have to "respond to the demands of patients in spite of the overload represented by the requirements of their work, even sacrificing their own personal care and the time required to take care of the small details that humanized care includes" and "they are not permitted to comply with patient-care activities due to having to meet institutional requirements and from other professionals and, due to this, contact with patients is limited to the basic or necessary, that is, to performing procedures on the physical plane". Thus, nurses are not allowed to perform the functions assigned to other lower-paid staff, preventing the approach between nurses and patients that make care possible; rather, they are assigned functions that could correspond to other types of employees, like administrators, secretaries, or auditors, who have no relation to direct care and do not even have a relation with the profession. Nurses are subjected to an overload of functions, which is why care conditions are deteriorated. According to Malvares and Castrillón,[26] "a shortage of nurses is reported throughout the world, along with decreased hiring of professional labor and unfavorable working conditions that provoke nurse mobility and dereliction of duty", without mentioning lack of motivation, lack of satisfaction, and failure in care.

The loss of "direct care" and lack of clarity in the roles and tasks performed induced by difficult labor conditions has influenced, according to Alcaraz *et al.*,[27] on patients and their relatives who do not distinguish who leads their care, nor identifying

the nurse as the person who provides direct care; which is another motive for the invisibility and lack of social recognition. Emphasis on humanization of care will permit escaping from the traditional approach that has guided the course of nursing toward interest for the disease and medical and institutional issues and not toward patients and their needs. For Stein *et al.,*[28] it is fitting to activate a humanization process centered on patients, revising values, feelings, and attitudes that guide the professionals' way of being to provide differentiated in humanized service, from a praxis committed to change, that is, creating an organizational culture centered on the sick human being and not on the disease". The social and professional relevance of nursing is promoted with the response to the needs of patients framed within the social or cultural conditions, as well as assuming the contradictions of the ideas and the norms that guide actions and being open for a constant reflection and revision.[13]

To conclude, these results permitted understanding two important aspects in relation to humanized care; in the first place, that healthcare institutions, according to how they guide their service offer, can exert positive or negative influence upon humanized care. This justifies identifying the contribution or interference institutions offer and carrying out humanizing efforts that complement those carried out by nurses to, as a whole, offer better possibilities of practicing humanized care. Institutional aspects like the necessary resources, interest for improving, sufficient personnel in amount and academic preparation, and rational assignment of functions to nurses related to their post were identified as necessary for humanized care. In the second place, humanized care is not only supported on the human condition of nurses, that is, they have enough with being human beings, to offer humanized care, but it is necessary to appropriate of the concept, give prominence to the inclination to doing good deeds and protecting over the innate human capacity of expressing hatred and causing damage. To accomplish this is necessary to have the conjunction of some fundamental aspects, like conducting important humanizing efforts that lead to the recognition of this inescapable condition of patients and relatives as human beings with all the implications of their dignity.

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