

Healthcare institutions do not favor care. Meaning of humanized care for people directly participating in it

Oscar Alberto Beltrán-Salazar¹

Healthcare institutions do not favor care. Meaning of humanized care for people directly participating in it

Objective. This study sought to understand the meaning of humanized care for those directly participating in it. **Methodology.** This was qualitative research with phenomenological interpretative approach conducted in Medellín, Colombia, during 2013. It included 16 participants among nurses, adult patients, and relatives. To gather the information, in-depth interviews were used; data analysis was performed manually according to the scheme proposed by Cohen, Kahn, and Steeves. **Results.** According to the participants, institutions do not favor humanized care due to the inaccessibility of services whose possible causes are, among others, excessive procedural red tape, lack of resources, and long waits. Additionally, they state that nurses' work overload keeps them away from the patients and prevents caring for them. **Conclusion.** For the participants in the study, the humanized care practice of humanized care is affected negatively, on one side, by the service offered by healthcare institutions; and, on the other, by the influence exerted upon nurses, which conditions, in turn, how care is delivered.

Las instituciones de salud no favorecen el cuidado. Significado del cuidado humanizado para las personas que participan directamente en él

Objetivo. Comprender el significado del cuidado humanizado para quienes participan directamente en él. **Metodología.** Investigación cualitativa con enfoque fenomenológico interpretativo realizado en Medellín, Colombia, en 2013. Incluyó 16 participantes entre enfermeras, pacientes adultos y familiares. Para el levantamiento de la información, se utilizó la entrevista en profundidad; el análisis de los datos se realizó en forma manual según esquema propuesto por Cohen, Kahn y Steeves. **Resultados.** Según los participantes, las instituciones no favorecen el cuidado humanizado debido a la inaccesibilidad de los servicios cuyas posibles causas son, entre otras, el exceso de trámites, la falta de recursos y las esperas prolongadas. Adicionalmente, afirman que la sobrecarga de trabajo de las enfermeras las aleja de los pacientes y les impide cuidarlos. **Conclusión.** Para los participantes del estudio, la

¹ RN, Ms.C, Ph.D candidate. Professor Universidad de Antioquia, UdeA. Calle 64 #53-09, Medellín; Colombia. email: oscar.beltran@udea.edu.co

Conflicts of interests: none.

Subventions: none.

Receipt date: Aug 12, 2013.

Approval date: Feb 10, 2014.

How to cite this article: Beltrán-Salazar OA. Healthcare institutions do not favor care. Meaning of humanized care for people directly participating in it. Invest Educ Enferm. 2014;32(2): 194-205.

práctica del cuidado humanizado está afectada negativamente, de un lado, por el servicio que ofrecen las instituciones de salud; y, por otro, por la influencia que ejerce sobre las enfermeras lo que condiciona, a su vez, la forma de llevar a cabo el cuidado.

Palabras clave: atención de enfermería, humanización de la atención, instituciones de salud, investigación cualitativa

As instituições de saúde não favorecem o cuidado. Significado do cuidado humanizado para as pessoas que participam diretamente nele

Objetivo. Compreender o significado do cuidado humanizado para quem participam diretamente nele. **Metodologia.** Investigação qualitativa com enfoque fenomenológico interpretativo realizado em Medellín, Colômbia, em 2013. Incluiu 16 participantes entre enfermeiras, pacientes adultos e familiares. Para o levantamento da informação, utilizou-se a entrevista em profundidade; a análise dos dados se realizou em forma manual segundo esquema proposto por Cohen, Kahn e Stevees. **Resultados.** Segundo os participantes, as instituições não favorecem o cuidado humanizado devido à inacessibilidade dos serviços cujas possíveis causas são, entre outras, o excesso de trâmites, a falta de recursos e as esperas prolongadas. Adicionalmente, afirmam que a sobrecarga de trabalho das enfermeiras as afasta dos pacientes e lhes impede cuidá-los. **Conclusão.** Para os participantes do estudo, a prática do cuidado humanizado está afetada negativamente, de um lado, pelo serviço que oferecem as instituições de saúde; e, por outro, pela influência que exerce sobre as enfermeiras o que condiciona, a sua vez, a forma de levar a cabo o cuidado.

Palavras chave: cuidados de enfermagem, humanização da assistência, instituições de saúde, pesquisa qualitativa.

Introduction

In the analysis on the conditions under which the care practice takes place, it is convenient to consider the influence of three spheres: the first, the social and legislative context; the second, the regulations regulating the healthcare institutions, and finally, the relationship of patients with nurses. The first two establish the rules of the game for care; the third is actually the path for its undertaking. Nodding¹ poses – what may seem surprising – that “nobody cares”, in spite of the organization in the social environment aimed at healthcare, about the funds destined for said purpose and about the consideration of the importance of care in itself, which is why human beings need and wish to care and be cared for. Also, the author indicates that many bureaucratic and legislative procedures in the delivery of services and the complaints and demands in

the healthcare sector reinforce her position with respect to the lack of care.

In relation to the hospitals, Parsons² suggests that “these are social subsystems, with rigid regulatory patterns that exert control on their personnel, molding and alienating their roles”. Precisely, this aspect has influenced on the transformation of care from “a social practice with altruistic and solidarity purposes, to an exercise based on business income with the consequential dehumanization of its procedures and objectives”.

According to Foucault,³ hospitals were conceived as “centers of medical formation and knowledge whose object of study is the disease without considering the patients’ individuality and integrity”. This biologist approach was transmitted

to the disciplines that deliver hospital services, among which we find nursing, “whose caring actions have been impoverished and even canceled by the medical hegemony”, as stated by Merhy.⁴ Because of this, “nursing has been frameworked within the biomedical approach, within its norms and routines” creating the optimal conditions for “comprehensive care to be misrepresented and distorted”.⁵ Not for nothing, according to Gordon,⁶ nurses have reported that they occupy a low level in the institutional hierarchical scale, given that they are ignored, are not respected, and their work is not recognized, visible, or rewarded.

This tendency to define functions and activities frameworked within a scheme where care and its holistic vision has been displaced by compliance with unrelated tasks, makes it difficult to think of assuring humanization, given that quite often institutional interest is centered on restricting services and obtaining the highest profit possible with the consequential sacrifice in quality. According to Watson,⁷ “the influence of the biomedical sciences limits the reach of care and favors shifting away from the paradigm of nursing for healthcare”. For the same author, “in hospitals, care must acquire a profound dimension that goes beyond a simple technique, of planning attention, receiving a shift, or carrying out day-to-day routine education”; consequently, care must advance to “being there with the other person, sharing their feelings and emotions”.⁸ However, in some institutions, the model of attention focused on curing and on the business has reduced the human being to the category of a disease to be eradicated or prevented in contraposition to the proposals in the nursing discipline, which are aimed at seeing patients as worthy human beings deserving of humanized care, based on person-to-person interactions.

True understanding of humanized healthcare has had an ambiguous position in the relationships between institutions and the members of the healthcare staff; on the one hand, frequent attempts have been made to implement hospital programs to promote humanization and quality of services offered for healthcare and wellbeing;⁹

on the other hand, there are the policies to accomplish commercial goods and profit by these institutions that have hindered the progress proposed in humanization.¹⁰ For their part, nurses have frequently expressed interest for participating in practices of humanized care, but in contraposition, assume behaviors that do not honor said pretensions, which cloud every attempt to accomplish the levels of quality and humanization required in care for its results to be optimal. Within this current order of ideas in institutions, “efficiency of nurses is judged by the preparation of reports and not by their delivery of care activities, which may lead to thinking that good nurses for institutions may not be so good for patients”.¹¹ This article is part of a phenomenological study carried out to analyze the factors affecting the care of patients that have been hospitalized and reveal the meanings of humanized care for the individuals who participate directly in it.

Methodology

This was a study with a phenomenological approach, which included 16 adult individuals between 29 and 62 years of age, four men and 12 women. Of these participants, six were professionals who had had experience as patients in the past when they were hospitalized for emergency situations, critical illness or for surgical interventions, seven were close relatives of patients hospitalized and another three were nurses, who voluntarily accepted to participate without receiving economic stimulus. Purposeful sampling¹² permitted selecting the best informants for the study's requirements.

The technique to obtain the information was the conversational in-depth interview lasting between 1 and 1.5 h; the interviews were identified with a code to safeguard confidentiality; said code adopted the letter N followed by the initials of the name to identify participating nurses, the letter P for patients and the letter S for patients' relatives. The participants were asked to share

their experiences in relation to care. The initial question: *Describe your experience with care during the hospitalization per episode or episodes of your illness or that of a relative.* – for patients and relatives; and, *Describe your experience as caretaker with sick individuals and relatives in the hospital.* – for nurses. Thereafter, these individuals were asked to describe their experience; then, the subsequent questions were formulated (specific for each interview, depending on the contents of the information), which emerged according to what was expressed, seeking to clarify concepts expressed. The question *For you, what does it mean to be cared for or care humanely in the hospital environment?* motivated to the participants to speak about the meanings of the phenomenon in specific manner.

A declaration of the events during the care interactions, which included thoughts, feelings, emotions, responses, and behaviors, was important to understand the hospitalization experience, as well as the perceptions and self-interpretations made by the participants. Also, the study sought the expression of perceptions on the care conditions in relation to the healthcare institutions where the experience took place.

Analysis of the information was performed manually based on interpretative procedures of the hermeneutic phenomenology proposed by Cohen, Kahn, and Steeves.¹³ As of the first interview, analysis was begun by listening and reflecting upon what was expressed to grasp meanings that could be validated with the very participant; the interviews were transcribed to the letter and then immersion was undertaken into the information through repeated readings to have a general view of what was reported and of the peculiarities of each experience, besides, seeking to find a dialectic movement between the whole and the parts.

The product of this revision was the encoding, thematic analysis, and determination of units of meaning and of samples or those portions of text with textual information. This permitted identifying the presence of recurring incidents or of common

themes, as well as the atypical or negative cases that did not fit into the interpretative line and showed variations in the analysis. Then, the themes and subthemes that were significant in the interviews were separated and analytic memos and diagrams on each and on the relationships among them; after this, a narrative was made to describe how the themes were understood with respect to the experiences of the participants. The interpretation was validated by permitting several of the participants to read the description to determine its correspondence with what they meant to say, ensure fidelity and credibility in the analysis, rescue whatever had been omitted, favor inferences, and improve the final description and the internal validity.¹⁴ These texts, produced from the interpretation of the data, were also revised by the advisor – with PhD degree and broad research experience – and 10 members of the “*Emergency and disasters*” research group in the Faculty of Nursing at Universidad de Antioquia, who made the respective suggestions and recommendations, which were kept in mind to improve the report and favor the external validity and confirmability.

To contribute to the applicability of the study, the results were presented to different audiences, which also contributed to the transferability. In all the interviews the data provided were considered equally important without assigning them preponderance for reasons of social power, wealth, educational level, or political importance of the interviewees. The study was conducted in Medellín, Colombia, between December 2012 and March 2013; it was approved by the Ethics Committee of the Faculty of Nursing at Universidad de Antioquia (Acta CEI-FE 2012-4).

Results

Healthcare institutions do not favor humanized care

As stated by the study participants, healthcare institutions play an important role with respect to

the care of individuals. In spite of that, they do not offer humanized or nursing healthcare in general, specifically due to conditions described in terms of “inaccessible care” for patients and, mainly, “work overload” with respect to nurses distorting the development of the work appertaining to their profession.

According to the descriptions by the participants, the operation of said institutions is focused with priority toward financial gains - profit when offering healthcare services and not toward satisfying the needs of the people; that is, they pay more attention to the ways of increasing income than to solving patients’ problems, which hinders the sufficient destination of resources to solve said problems, from a holistic view, *and that is why it is often not humanized, because institutions now, because of all the changing conditions, are thinking of profits and that concept must be changed. I believe it is already being shown that in the healthcare institutions it is not only profit; yes, they have to survive, but patients are most important, the people for which the institutions survive, which we have to care for in integral and integrating manner* (J.T).

On the contrary, interest in productivity and generation of profit leads to restricted attention, to “discharging” patients expeditiously, even when it is not under the best conditions; thus, accomplishing attention to a higher number of patients, diminishing the possibility of nurses approaching them. This reductionist approach, which seeks to increase capital and profit, leads to the denial of services and interventions – indicated and necessary-, which goes against the humanized care the people deserve.

Inaccessible care

Inaccessible care is described by the participants as the difficulties related to the lack of or restriction of resources to accomplish adequate care attention, as a consequence of excessive administrative procedures and because of the long waiting periods that hinder access to healthcare and nursing, which impacts upon the meaning

of said care. Regarding the lack of necessary resources or their selective use, the participants state that in healthcare institutions this situation is quite evident, which is reflected on the attention and diagnostic services available and the rapidity for their use in which case delays can bear consequences on the health of the individuals: *things happened that way because he was going to die and destiny won’t change; but if my father had been taken to another institution where at least resources had been available, where an EKG could have been done, a chest X-ray, or something to know what he had, perhaps the situation would have been different* (S.D).

It is also possible perceive restrictions in resources in some norms related to the assignment of employee functions, such as the number of patients per nurse or the obligation of responding for the tasks of other personnel (due to diverse circumstances like when having to cover for an absent coworker), besides low wages: *well, the healthcare system in Colombia is now very complex to manage; obviously, one knows there are many restrictions for the personnel and there are many functions nurses must fulfill; yes, I have to perform administrative tasks and respond for all the care functions* (N.L.A).

Besides the lack of resources or their restriction, denial influence of humanized care is reflected in institutions when they establish administrative procedures and requirements that must be fulfilled by people when soliciting certain services, which are frequently so varied that they lead to the inaccessibility of said services, which contributes to the deterioration of the conditions of humanization and quality of care: *the common theme among all those who treated him it was to categorize him or stigmatize him because of his age, because he was an elderly person who now had the right to die; but they never thought about the quality of life grandpa had and that efforts would be limited because he was so old, that was horrible. They wouldn’t even accept him in emergency* (S.R.D). The prevailing criteria for attention and the specificities in each

hospital area are perceived by patients and their relatives as obstacles that cause delays in care and favor worsening of the conditions presented during admission, which is not consistent with the patients' condition as human being: *my grandmother was taken to hospital room, which she shared with other patients and was left alone to wait for her death; just to wait for her to die and I asked if something could be done and was told that nothing could be done that it was December, that my grandmother was already 78 years old and that the operating room could not be used with an elderly person in case a younger person was admitted. For me, attention in that hospital and that situation were quite impressive* (S.C).

Response to the pressing needs felt by sick individuals and their relatives is not a privilege but a right recognized in legislation and more so if considering that, in many cases, this medical attention was paid for beforehand through affiliation to the social healthcare security system; however, a series of procedures must be fulfilled to access the medical attention: *one feels impotent by not being able to take the family member who is ill to an institution with all the resources, due to administrative problems* (S.D). However, there is no other option because the rigid administrative and bureaucratic processes in effect in hospitals establish the rules in medical attention and, consequently, the individuals' real needs or desires are not consulted: *one must be aware that the healthcare system and the hospitals have imposed a series of administrative procedures that have to be fulfilled to attended; papers must be filled out, authorizations must be obtained, and many other things* (P.A). Reasons that, from the point of view of hospital management, could be deemed as justified are perceived as dehumanized and even cruel by those enduring the experience of illness directly compromising relatives and which even endangers their lives. These administrative reasons upon which decisions on care are supported, both by insurance carriers and hospitals, to deny the rights to medical attention endanger the integrity and lives of people: *you knew more could have been done, but that it was not done through pure*

negligence and I was told that people reach a peak in which they get sick and get better or get sick and die and it was so (S.D).

The way healthcare takes place under these conditions is responsible for the wrong concept perceived of it by relatives and patients, which contributes, according to them, to creating certain "notoriety" with respect to certain healthcare institutions: *in fact, from that experience I learnt not to go to that clinic, unless it is strictly necessary, because I felt the attention was the worst. Regarding everyone there, it seemed horrible* (N.L.A). Also, it contributes to a mistaken view of the healthcare, prior experiences, or the information provided by friends and patients with similar experiences, which leads to rejecting institutions that do not offer the best conditions during hospitalization, that is, it is a determinant in the decisions made by people with respect to consultation in certain hospitals: *if I arrive at a hospital feeling ill and I am treated well right then and there I start getting better, but if I see negligence and apathy in the people that will influence my not recovering soon and you don't forget that and you don't want to go back there* (S.D.E).

Additionally, due to bureaucracy, people are subjected to a wait and postpone process in medical attention, which is reflected in long-term appointments, long lines, denials, red tape, cancelations of appointments and procedures, in all, all kinds of strategies are used, on occasions, to avoid delivering the service and, during others, to favor the non-necessity of the service – in many occasions, before the service is offered or the appointment is assigned, death occurs: *so the patient says; I am tired of how I am being treated, because every day you have to wait for authorizations, consultation, appointments are delayed; I don't want any more, I can't take it any longer* (N.G). In turn, all this also contributes to making healthcare simply inaccessible and with deficient results: *more than 16 hours waiting for a bed in ICU; in the clinic the experience was horrible, horrible, horrible* (P.G.M).

Long and frequent waiting periods present in how institutions orient medical attention mean

prolonging suffering and postponing the hope of receiving care. Under these conditions, more than helping with care, contributions are made to patients' discomfort by facilitating complications, exacerbation and aggravation of problems. It is thus expressed by a nurse participating in the study: *so rather than facilitating the recovery, sometimes, we are an obstacle because we do not guide patients and their relatives towards a place where they can be helped and where they can have the complementarity that helps them* (N.G.G). Thus, the nursing work is oriented to leaving aside the needs of patients to comply with the dehumanizing demands of the institutions.

Also, an ingrained habit exists of obligating the sick to endure the experiences of the disease under solitary and isolation conditions, which is why strict restrictions are imposed on visits and family companionship, which influence negatively on the perception of the healthcare institutions, as well as on the possibility of having better medical attention. Security personnel also play a preponderant role in this work, given that within their discretion they are who finally decide who enters or does not enter. In turn, because many healthcare institutions limit patient visits to a few hours: *for me that limitation there seems horrible; I feel that anyone who want to come in should come in, because for me family companionship is quite important and I do not agree with administrative management that visits should be restricted to a few hours; relatives with patients help things go better* (N.N.S).

Work overload

According to participants' descriptions, the role played by the institutions to put humanized care into practice is definitive, given that they can promote efforts and motivate personnel to adopt a way of proceeding aimed at the wellbeing of patients, toward compliance of ethical principles, and toward the preponderance of the human being over diseases, procedures, and costs. Nevertheless, establishing ways of proceeding that ignore patients' needs, which obligates nurses to focus on complying with institutional

demands aimed at obtaining profit: *humanizing care, I think it is easy if we did not have so many obstacles imposed by the institutions and if we were not convinced that we want to be nurses and love nursing and its theoretical wealth* (N.J.T). Likewise, the way of assigning functions, the number and complexity of tasks to be done influence on how these are carried out, on the work satisfaction, and on the conditions of stress present in the work nurses perform: *suddenly, one notes the stress because of all the things we have to do* (N.N.S).

The confluence of all these aspects yields a fractioned practice of care by nurses, given that their function is aimed at dissimilar tasks according to their preparation and formation, which leads to ignoring human beings in their comprehensiveness. On the contrary, processes must be aimed at contributing to the wellbeing of the people, which supposes work in all the spheres of human beings without fractioning, reducing, reifying, or partializing them: *Among the functions they have with patients speaking with them is not one of them; rather, it is going to them, injecting them or changing their diapers or any other thing that needs to be done* (P.J.E).

Upon this type of practice, patients and their relatives react – often angrily – and express their dissatisfaction with respect to care and services in general. It is a just claim that seeks to have the care practice revised, to analyze success cases and deviations to offer a better response to the needs of patients and their companions under more humanized conditions and with better criteria or quality standards: *I think that emerges more as critique made by the patients, who state that nurses do not approach them; they do not take enough time to be with us and talk about my diagnosis, my prognosis, my disease, and my treatment* (N.G.G). Nurses are also under the obligation of stating their defense of more dignified conditions that favor the care practice, that is, that it should be humanized and that it respects quality standards: *the nursing personnel should be motivated to reflect, because one is sometimes*

overwhelmed by the work environment, by what is now required of you in companies and what they expect is for you to be very productive and sometimes you have no settings to approach the patients (N.G.G).

It should not be ignored that some institutions make prodigious efforts to humanize their work and improve the delivery of healthcare services, but quite often the results are not those expected. In any case, it is a matter that not only appertains to nurses due to their direct contact with patients and their relatives, but, as can be noted, it also involves the very institutions, which supposes drastic changes in how healthcare services are offered: *Now, I think humanizing care or humanizing in general term must emerge as an initiative from the upper structures of organizations because that often stays as dreams, utopias of those of us who work in healthcare or of those of us who are in the lower levels of the organization (N.J.T).*

Discussion

Stemming from this study and according to the positions stated by the participants, it could be stated that institutions can influence, greatly, on the deficiencies arising in care and in healthcare services, which impacts ostensibly on low quality standards regarding care. This is the result of the confluence of several factors among which we could mention, on the one hand, restriction in services – which hinders people's access to humanized care; on the other hand, the persistent denial to medical attention; in addition, because the resolution of the problems of the people is based on a long wait. From a holistic view, it all bears a marked influence on the relationship between nurses and patients, hindering the achievement – and materialization – of care.

The results revealed that healthcare institutions had a negative effect on the conditions under which care is offered; this influence was marked by how the delivery of services was guided, where interest for profits prevailed along with the

reduction of resources that serve as the framework to achieve the activities inherent to institutions, as well as in the participation of professionals. In this respect, Hernández¹⁵ agrees upon suggesting that healthcare institutions in Colombia have assumed a marked motivation toward competition and a mercantilism approach; even obeying the guidelines of insurance carriers, which is why they often cross the line toward the violation of the fundamental rights of the people. The author also states that said institutions have been affected by deficient availability and inadequate use of resources that lead to serious difficulties in accessing services like delays, obstacles and excessive requisites for medical attention, staff deficits, little dedication to the quality of processes and restricted services. The claim is obvious: obtain the maximum profits possible. This creates propitious conditions in which attention does not respond to the needs of the people.

As a consequence of the aforementioned, on the one side, there is no respect for the rights of patients and their dignity as individuals is impaired; on the other, people are objectified, that is, they are converted into “means” to achieve monetary objectives, through direct income, through billing the State, or through payments from insurance companies. Thus, removed from the Kantian ideal of considering the human being an end in itself. Also, Echeverri¹⁶ refers to the difficulties of access of individuals when suggesting that healthcare services have not contributed to solving their problems or to satisfying their necessities to ensure acceptable levels of wellbeing and dignified life; on the contrary, they have delved into inequality and exclusion through segmentation of services and barriers to access. Besides, the author states that the institutional practice is not based on recognizing rights, on the contrary, it denies the fundamental rights of people, who because of this, must go from one institution to another, in a never-ending journey until they die or suffer complications and damages in the attempt to receive care, which by right, they should have – which has been known as the “journey of death”-. Also, with the intention of increasing economic performance indescribable levels have been

reached in the use of technology in care that, although often resulting necessary, have favored the marked increase of costs of medical attention and diminished possibilities of access.¹⁰ As a result of all this, vast sectors of the population have been excluded, which has led to a huge accumulation of frustrations amid failed attempts to offer quality healthcare services.¹⁵

In addition, some publications refer to conditions of negligence, low quality, and lack of humanization in care. In turn, these report that healthcare provider companies avoid offering the services agreed upon and, often, deny components of care to which patients should have rights, which is why the “promise representing the benefits plan offered by the insurance companies does not coincide with the services dispensed by the provider and much less with people’s expectations”.¹⁷ This systematic denial of services occurs because the emphasis of insurance companies and healthcare service provider institutions is not focused on solving health problems or on improving quality in attention, but on profits. All this has as a result, as stated by the same author, a marked dissatisfaction of the necessities of the people, increased uncertainty against health problems, and distress against the illness, the risk of death or disability, which contributes to the deterioration in the quality of life and in participation in work and productive activity.

Also, Borrero¹⁸ refers to the fact that nurses forget to get involved with the problems of the people because they must satisfy the institutional demands. The author states that they “are not aligned on the side of patients to favor solving their problems, but that they are on the side of institutions in their interest to obtain higher economic performance”. This form of fidelity for institutions by healthcare professionals should cause no surprise if it were not for the fact of forgetting issues that are important for care; one of them is that said care is considered a social practice covered by codes of ethics that regulate the work of healthcare professionals. For nursing in Colombia, legislation 911 of 1993 establishes that the practice of this profession must be

humanized, of quality, and in response to the necessities of the people.

As stated by Colliere,¹⁹ care can be “liberating or reducing” and seen in how it is carried out it can only be described as reducer because what is sought is to take advantage of the care giver, and even of the institutions, to value their image and promote their notoriety and social recognition, besides economic profit, in whose search all resources and additional time are sacrificed, without producing any benefit for the patients. The aforementioned may cause bias upon the denial or delay in the performance of vital procedures and interventions. This form of care is reducing for the care giver, for care itself, and for patients because their problems are not comprehensively solved; the response received is not to their liking or does not totally respond to their needs, which can contribute to aggravating problems more than to their solution. It cannot be ignored that faults in healthcare constitute a violation to the right to healthcare, recognized by the Colombian Constitutional Court as a fundamental right.

The operating scheme of healthcare institutions related to the care experiences reported by the participants is supported on bureaucracy, denominated by Weber²⁰ as an organization characterized by explicit and regularized procedures supported on a division of work, a vertical hierarchy of authority and impersonal relations aimed at precision, speed, regularity, exactitude, and efficiency and in whose hierarchical base the patient is at a scale that is more fitting of domination than of democratic processes. The set up of schedules for all activities is part of the nursing bureaucracy, which is raised not to achieve the best results related to patients, but to optimize nursing time and reduce efforts and costs.

For the nurses participating in the study, immersed within the current conditions of healthcare institutions, the care practice means confronting a work overload with a biomedical approach, based on mechanical tasks that do not permit interaction with patients and that, definitely, do

not enable carrying out the purpose of nursing, which leads them to completely invisible work and without the due institutional and social recognition.²¹ As consequences of this form of work performance there are, among others, professional dissatisfaction and distancing from the humanization of care.²²

Henderson *et al.*,²³ found that, although nurses are in charge of looking after the integrity of patients, they feel helpless. Besides, they complain when said integrity is threatened, given that due to multiple bureaucratic factors and to the work overload, the time nurses interact with patients is notably reduced. This yields a distorted vision of the true role of the nursing personnel, given that patients perceive that nurses are not available to answer to their requests. Under these conditions, they consider care as dehumanized, which entails certain devaluation of their condition as human beings. In contrast, Forsyth and MacKenzie²⁴ reported that nurses complain of the lack of opportunities to offer true and comprehensive care to patients, which is another amongst many motives for frustration, which has led them to leaving their work, which is why the authors consider it important to analyze the conditions in which nurses work and to make the necessary corrections for their work performance to agree with expectations.

The approach achieved based on the results reported by Almeida *et al.*,²⁵ is surprising with respect to that by putting humanized care into practice can involve “breaking institutional routines”. Regarding humanizing efforts, the participants suggest that some institutions have actually expressed said concern while others have used humanization as bait to attract the unsuspecting; it is a publicity measure that attracts people because with the history of abuse of healthcare institutions people tend to look for those that offer, aside from technological elements and other advances, more humane conditions that permits their avoiding the abuse and negligence prevailing in most of them. In this position, the study agrees with that reported by Santos *et al.*,²⁶ with respect to promoting family participation in care to favor humanization. It asserts that

“including the family in the care is an attribution of the nursing staff and permitting it reflects interest for relatives to remain by the patient’s side to participate in physical and psychological care, which requires forgetting current pretensions of restricting family companionship”.

Moreno²⁷ states that “humanization of medical attention recovered its essence in healthcare services now that there is so much talk of measuring processes of institutional quality; this is a fundamental criterion and it is why it is primordial to express it clearly in the philosophical principles that guide the institutional work, a position with which Gasull²⁸ agrees when stating that “some quality care would be profitable for institutions” and that contrary to belief, restrictions in medical attention in terms of resources and services prove more harmful than beneficial, both for patients and institutions and in turn for nurses who work in a restrictive environment in many aspects for care.

Conclusion

The denial influence of healthcare institutions in humanized care was understood twofold: the first is related to the difficulty of patients to access care - denominated inaccessible care, a condition that received contributions from the scarce availability and inadequate use of resources, delays, obstacles, and excessive requisites for admission, personnel deficit, little dedication to the quality of processes and complicated bureaucratic procedures that even entail the denial of medical attention and death. The second is related to dispositions on managing personnel that entail assigning nurses functions not related to care, which causes “distancing” from direct contact with patients, bringing carelessness, deficient quality and dehumanization of care. Hence, the optimal conditions of care not only depend on the continuous and persistent work of nurses and of the disciplinary contributions, but it should be noted how the hegemonic effect of healthcare institutions is neutralized or

channeled in obstructing care work. Although it is true that several attempts have been made in hospital and academic institutions to emphasize on the need to humanize care and respond to prevailing social conditions, it is also true that claims due to problems in the care practice are an everyday occurrence due to conditions of abuse and inefficiency by professionals and healthcare institutions.

References

1. Nodding N. *Caring: a feminine approach to ethics and moral education*. Los Angeles: University of California Press; 2003.
2. Parsons T, Bales R, Shils E. *Apuntes sobre la teoría de la acción*. Buenos Aires: Amorrortu; 1970.
3. Foucault M. *El nacimiento de la clínica: una arqueología de la mirada médica*. México D. F: Siglo XXI; 1991.
4. Merhy EE. *Saúde: a cartografia do trabalho vivo*. São Paulo: Hucitec; 2002.
5. Monticelli M, Elsen I. El hospital como una realidad clínica: una comprensión a partir del encuentro entre trabajadoras de enfermería y familias de un servicio de alojamiento conjunto. *Horiz Enferm*. 2004; 15(4):37-52.
6. Gordon S. The new cartesianism. Dividing mind and body and thus disembodiment care. En Nelson S, Gordon S. *The complexities of care. Nursing reconsidered*. Ithaca: IRL press; 2006. P.104-21.
7. Watson J. The theory of human caring. Retrospective and prospective. *Nurs Sci Q*. 1997; 10(1):49-52.
8. Watson J. *Nursing: the philosophy and science of caring*. Colorado: Colorado Associated University Press; 1985.
9. Brusco A. *Humanización de la asistencia al enfermo*. Madrid: Centro de Humanización de la Salud; 1998.
10. Echeverry ME. Derecho a la salud, estado y globalización. *Rev Fac Nac Salud Pública*. 2006; 24 (Especial):81-96.
11. Travelbee J. *Interpersonal Aspects of Nursing*. Philadelphia: Ed FA Davis; 1966.
12. De la Cuesta C. *Cuidado Artesanal. La invención ante la adversidad*. Medellín: Editorial Universidad de Antioquia; 2004.
13. Cohen M, Kahn D, Steeves R. *Hermeneutic phenomenological research. A practical guide for nurse research*. Londres: Saac Publications; 2000.
14. Miles M, Huberman M. *Qualitative data analysis*. 2nd ed. Thousand Oaks: Sage; 1994.
15. Hernández M. Bases morales de la reforma a la seguridad social en Colombia. Congreso Latinoamericano de Medicina Social. Buenos Aires; 17 a 21 de marzo 1997. Buenos Aires. Asociación Latinoamericana de Medicina Social; 1997.
16. Echeverri ME. Las reformas estructurales en América Latina y el derecho a la salud. *Rev Invest Soc*. 2007; 3(5):43-66.
17. Hernández M. El derecho a la salud en Colombia: obstáculos estructurales para su realización. *Rev Salud Pública*. 2000; 2(2):121-44.
18. Borrero YE. *Las reformas en el sector salud y los conflictos clasistas en Colombia: el caso de la ley 100/93 [Dissertation]*. Cali: Universidad del Valle; 2008.
19. Colliere F. *Promover la vida. De las prácticas de las mujeres cuidadoras a los cuidados de enfermería*. Madrid: Interamericana- Mc Graw-Hill; 1993.
20. Weber M. *Economía y sociedad*. México: Fondo de cultura económica; 1964.
21. Rodríguez A. *Enfermería ante la deshumanización: una necesidad por ser considerada desde la filosofía de Emmanuel Levinas*. *Enferm Costa Rica*. 2011; 32(1):37-42.
22. Santos SR, Nóbrega ML. A busca da interação teoria e prática no sistema de informação em enfermagem: enfoque na teoria fundamentada nos dados. *Rev Latinoam Enferm*. 2004; 12(3):460-8.
23. Henderson A, Van Eps MA, Pearson K, James K, Henderson P, Osborne Y. "Caring For" behaviors that indicate to patients that nurses "care about". *J Adv Nurs*. 2007; 60(2):146-53.
24. Forsyth S, MacKenzie H. A comparative analysis of contemporary nurses' discontents. *J Adv Nurs*. 2006; 56(2):209-16.

25. De Almeida I, Paes M J. Cuidado humanizado de enfermagem: o agir com respeito em um hospital universitário. *Rev Bras Enferm.* 2007; 60(5):546-51.
26. Santos TD, Aquino ACO, Chibante CLP, Espírito Santo FH. The nursing team and the family member accompanying adult patients in the hospital context. An exploratory study. *Invest Educ Enferm.* 2013; 31(2):218-25.
27. Moreno M.E. Humanización del cuidado: una meta enraizada en la esencia de enfermería. *Aquichan.* 2013; 13(2):146-7.
28. Gasull M. La ética del cuidar y la atención de enfermería. Barcelona: Universitat Oberta de Catalunya; 2005.