Revista Bioética
Print version ISSN 1983-8042 | On-line version ISSN 1983-8034

Rev. Bioét. vol.34 Brasília 2026

Challenges of humanization in healthcare: a literature review

Marcel Ronaldo Morelli de Meira [1]

1. Centro Universitário São Camilo, São Paulo/SP, Brasil.

Abstract

This study presents a conceptual review on humanization in healthcare, with an emphasis on Brazilian scientific production linked to the fields of medical humanities and public health. The objective is to critically reflect on the challenges that permeate the implementation of humanization in the contemporary context. A narrative review methodology was adopted, encompassing 16 articles published since 2003, when the National Humanization Policy was established in Brazil, intensifying the debate on the topic. As a mode of action, humanization is characterized by the construction of more symmetrical relationships among the subjects involved in care and by the orientation of practices guided by welcoming, respect, and empathy. However, its implementation in the daily routine of health services is challenged by several factors, including the structural fragility of healthcare institutions, the persistent centrality of the biomedical model, and the increasing incorporation of technologies in the relationships between professionals and users.

Keywords: Humanization of assistance. Humanism. Delivery of health care. Ethics. Violence.

Resumo

Desafios da humanização nos cuidados em saúde: revisão da literatura

Este estudo apresenta revisão conceitual acerca da humanização no cuidado em saúde, com ênfase na produção científica brasileira vinculada às áreas das humanidades médicas e saúde coletiva. O objetivo é refletir criticamente sobre os desafios que permeiam a implementação da humanização no contexto contemporâneo. Adotou-se a metodologia de revisão narrativa, que contemplou 16 artigos publicados a partir de 2003, quando foi instituída, no Brasil, a Política Nacional de Humanização, que intensificou o debate em torno da temática. Enquanto modo de agir, a humanização caracteriza-se pela construção de relações mais simétricas entre os sujeitos envolvidos no cuidado e pela orientação de práticas pautadas por acolhimento, respeito e empatia. No entanto, sua efetivação no cotidiano dos serviços de saúde é tensionada por diversos desafios, entre os quais a fragilidade estrutural das instituições de saúde, a persistente centralidade do modelo biomédico e a crescente incorporação de tecnologias nas relações entre profissionais e usuários.

Palavras-chave: Humanização da assistência. Humanismo. Atenção à saúde. Ética. Violência.

Resumen

Desafíos de la humanización en la atención sanitaria: revisión de la literatura

Este estudio presenta una revisión conceptual sobre la humanización en la atención en salud, con énfasis en la producción científica brasileña vinculada a las áreas de las humanidades médicas y la salud colectiva. El objetivo es reflexionar críticamente sobre los desafíos que atraviesan la implementación de la humanización en el contexto contemporáneo. Se adoptó la metodología de revisión narrativa, que incluyó 16 artículos publicados desde 2003, cuando se instituyó en Brasil la Política Nacional de Humanización, intensificando el debate en torno al tema. Como modo de actuación, la humanización se caracteriza por la construcción de relaciones más simétricas entre los sujetos involucrados en el cuidado y por la orientación de prácticas basadas en la acogida, el respeto y la empatía. Sin embargo, su implementación en la rutina cotidiana de los servicios de salud se ve tensionada por diversos desafíos, entre los cuales se destacan la fragilidad estructural de las instituciones de salud, la persistente centralidad del modelo biomédico y la creciente incorporación de tecnologías en las relaciones entre profesionales y usuarios.

Palabras clave: Humanización de la atención. Humanismo. Atención a la salud. Ética. Violencia.

The author declares no conflicts of interest.

Research

The term "humanization" has been widely used in the field of healthcare, and despite encompassing a broad range of initiatives, the concept still lacks a clear definition. In general, humanization in healthcare refers to a model that values *technical quality while also recognizing patients' rights, subjectivity, and cultural backgrounds. It also involves valuing health professionals and fostering dialogue both within and between teams* [1].

The debate surrounding humanization in healthcare gained prominence in 2000, when the Brazilian Ministry of Health established the National Program for the Humanization of Hospital Care (PNHAH), the same year the topic was included on the agenda of the 11th National Health Conference. In 2003, the program was expanded into the National Humanization Policy (PNH), also known as Humaniza SUS [2].

According to Deslandes, practicing humanization in care means *opposing violence, since violence represents the antithesis of dialogue and the denial of the "other" in their humanity* [3]. In this sense, humanization stands in contrast to both physical and symbolic violence, the latter characterized as a form of care in which patients' needs and expectations are not properly understood.

Historically, the hierarchical organization of hospitals in the 19th century gave rise to circumstances that turned them into a "place of suffering," as described by Rios [4]. Although this model expanded access to care and enabled significant technical advances, the institutionalization of hospitals was grounded in a rigid organizational structure. This structure fostered practices characterized by strict *control, lack of recourse against decisions made by superiors, exclusively top-down communication, neglect of humanistic aspects, and authoritarian discipline. As a result, hospitals became environments where individuals were treated as objects, with little respect for their autonomy and a marked absence of solidarity* [5].

As a response, several hospitals began implementing initiatives described as "humanizing." These actions sought to create a more welcoming environment by means of recreational activities and improvements to the physical setting. As Rios notes [4], although such measures did not initially bring about significant changes in organizational structure or management, they helped mitigate suffering associated with the hospital environment. Overtime, however, the theme of humanization gained prominence, ultimately leading to more structural changes that effectively transformed the routines of both healthcare professionals and service users.

Humanization seeks to replace different forms of symbolic violence with a model *centered on communication and dialogue among users, health professionals, and managers, aiming to establish a "new culture of care"* [3].

Despite the polysemy and lack of clear conceptual boundaries surrounding what has come to be known as humanization, this approach may contribute to improving the quality of healthcare, as it represents a new model of communication and interpersonal relationships between professionals and patients.

In general, values underpinning humanization in healthcare include autonomy, justice, shared responsibility among individuals, the establishment of supportive bonds, and collective participation in the management process. In practice, this requires the incorporation of certain attitudes considered fundamental among those involved, such as welcoming practices, solidarity, otherness, and empathy [6].

In brief, humanizing healthcare entails: 1) valuing the subjective and social dimensions in both care and management practices; 2) ensuring users' access to health-related information; and 3) establishing supportive bonds and collective participation by means of participatory management, integrating professionals and users in this process [6].

However, the question that emerges from this debate is whether there is room to implement new practices aimed at humanizing healthcare. In Brazil, for example, one of the most important aspects to consider in the physician–patient relationship is social class, given that Brazilian society is marked by profound social inequality.

The authors' critique is not directed at supposedly dehumanized healthcare models, but rather at the various obstacles to the practical implementation of humanization. Deslandes and Mitre [7] reflect on its challenges by seeking to understand what may be considered the antithesis of humanization—that which "dehumanizes," "alienates," and "objectifies"—since humanization

presupposes a more symmetrical relationship among those involved in care.

Accordingly, the perspective adopted in this study approaches humanization in a broad sense, encompassing its different theoretical and operational dimensions. Above all, it is a philosophical perspective, according to which the humanization ideal represents a commitment of the health sciences to the realization of humanistic and democratic values related to the common good.

This study aims to reflect, by means of a critical review of the Brazilian literature, on challenges inherent to humanization in the delivery of healthcare. The analysis seeks to identify factors that hinder the effective implementation of this project, including the organization and physical infrastructure of health institutions, the predominance of the biomedical model in care practices, and the working conditions to which health professionals are subjected.

Method

To select the bibliographic material, the SciELO database was consulted using the descriptors "humanization of health," "humanization of care," and "humanization of healthcare."

The articles were selected throughout 2024, the period during which the research was conducted. The selection process initially considered the descriptor "humanization," followed by an analysis of article titles and authorship, prioritizing publications by Brazilian researchers recognized as leading scholars in the field of humanization in healthcare. Ultimately, 16 articles published from 2003 onward were included—the year in which the PNH was established, a milestone that fostered and expanded debate on the topic. These studies, which adopt different theoretical and methodological approaches, address specific aspects of humanization in healthcare and provide relevant contributions to this study. Editorials, manuscripts, and letters to the editor were excluded.

Discussion

The humanization of healthcare has been widely discussed in the Brazilian scientific literature, particularly following the establishment of the PNH, which consolidated the debate on the development of more comprehensive and user-centered care practices. The conceptual analysis presented in this study seeks to contribute to a better understanding of the multiple challenges that permeate the implementation of humanization in the contemporary context.

The selected articles were examined by means of a critical and systematic reading, guided by principles of thematic analysis, to identify and organize analytical categories representing the main tensions within the debate. This methodological strategy enabled not only the synthesis of findings but also the integration of different theoretical and practical dimensions related to humanization.

From this analysis, three central axes emerged: 1) the impact of the increasing incorporation of technologies on relationships between professionals and users; 2) the gap between guiding principles of the PNH and persistent structural weaknesses in the Brazilian Unified Health System (SUS); and 3) the recurrent prioritization of the biomedical model to the detriment of comprehensive and participatory care practices. Although analyzed separately, these axes are interdependent, as institutional weaknesses and the predominance of the biomedical paradigm shape the way technologies are incorporated and used in health services. The following discussion seeks to examine these aspects in greater depth and to highlight both barriers and possibilities for consolidating humanization in the Brazilian context.

Concepts of humanism and humanization in healthcare

Historically, the use of the term "humanization" has been associated with intellectual movements aimed at restoring and valuing fundamental principles of the human condition, particularly in contexts of humanitarian crisis. From a philosophical perspective, the concept of humanization traces back to the roots of humanism, an intellectual movement that emerged in the 15th century during the Italian Renaissance, characterized by its defense of human dignity and by viewing human beings as the measure of all things [4].

However, beyond its original meaning, the term has acquired new contours in contemporary times. The concept of humanization gained prominence amid a crisis of ethical frameworks that had previously prevailed. As Rios observes [4], social transformations brought about by multinational and globalized capitalism led to a reorganization of forms of sociability, marked by the expansion of the cultural industry, the service sector, finance, and information. By privileging ephemerality, consumerism, and individualism, these dynamics weakened utopian ideals of modernity, which had placed their hopes in the Enlightenment project and in the expectation of a better world grounded in scientific and technological progress.

It is also important to recall the horrors of the Holocaust and the rise of totalitarian governments in the second half of the 20th century, which led society to become disillusioned with politics and revolutionary ideas. Rather than seeking values in social and collective movements, individuals increasingly turned to a form of individualism intensified by consumerism. In contemporary society, one can observe the cult of the body, the overvaluation of physical appearance, the relentless reproduction of images, and hedonistic social behaviors, all of which unfold as spectacle.

In the sphere of social relations, intolerance and prejudice toward differences have further contributed to the erosion of ethical frameworks. As a counterpoint, from the second half of the 20th century onward, responses to this scenario began to emerge. Movements related to human rights, bioethics, citizenship, and environmental protection gradually gained prominence, inviting societies to construct new utopias.

In the field of healthcare, the concept of humanization incorporates principles established by the PNH, which comprises a set of guidelines that affirm: 1) recognition and autonomy of subjects involved in the production of health (workers, managers, and users); 2) increased shared responsibility among these actors in the production of health, along with the establishment of supportive bonds; 3) collective participation in the health management process; and 4) identification of social demands of users and workers, as well as a commitment to improving both care delivery and working conditions [7].

The PNH thus seeks to provide a foundation for transforming relationships between professionals and users by means of guiding principles such as welcoming practices, autonomy, protagonism, and shared responsibility. As Deslandes, Mitre, and Alves observe, *it is a policy that calls into question health practices grounded in the biomedical model, the primary epistemological framework underlying professional training* [8]. In general, the main goal of humanization in healthcare is to uphold *human dignity and respect for individual rights, as the human person must be regarded as a primary value, and considerations of dignity, freedom, and well-being should guide the relationship between patient and health professional* [9].

In other words, humanization principles in healthcare advocate, as an ideal, welcoming and patient-centered care aimed at counteracting the depersonalization to which SUS users are often subjected, while ensuring their rights and promoting collective participation in management processes. To this end, authentic listening is essential, requiring empathy from professionals; thus, those who seek to establish a humanized relationship with their patients must listen attentively.

However, several Brazilian studies have identified obstacles to the implementation of the PNH, including *issues related to the care environment, waiting times, and physical infrastructure, as well as factors affecting health workers, such as excessive workloads, fatigue, and the mechanization of work* [10]. In summary, for professionals to provide humanized care, adequate working conditions must be ensured.

Several authors have highlighted obstacles to the effective implementation of these programs. Deslandes [1], for example, discusses key challenges such as transforming the organizational culture of health institutions, reducing asymmetrical power relations between professionals and users, and overcoming the hegemony of utilitarian scientific objectivity—issues that will be addressed in the following section.

Impact of new technologies on the humanization of healthcare

Throughout the 19th and 20th centuries, many technological advances were incorporated

into healthcare at all levels of service delivery, whether in disease diagnosis or in patient rehabilitation. Currently, an intense phase of technological development is underway, marked by the use of artificial intelligence, telehealth, robotics, among others. At the same time, this scenario has raised several concerns, including users' access to such technologies, their cost to the health system, and the risk of reducing direct contact between patients and professionals. Nevertheless, it is neither possible nor appropriate to downplay or disregard the significant contributions that technological advances have made to the healthcare field.

According to Rios [4], the technicism that characterizes contemporary medical practice tends to overlook humanistic dimensions of care, despite the many achievements it has enabled. In her view, technological resources have expanded access to health services while simultaneously creating a gap between physician and patient [4]. In the author's words:

Technology, which is essential for increasing human survival and for drastically reducing suffering caused by health conditions, has become an intermediary that distances professionals from closer and more sustained contact with patients, not only because it streamlines care and increases productivity measured in numbers, but also because it fascinates and captures the interest of health professionals, particularly physicians [11].

In contemporary times, according to Rios [12], medical practice has come to resemble an assembly-line model which, combined with technological advances, has contributed to the erosion of the physician–patient relationship, now increasingly characterized as one between a company and a consumer.

In contrast, Deslandes and Mitre [7] challenge arguments that portray the use of technology as inherently detrimental to communication between professionals and users. They refer to critiques suggesting that clinical practice is being replaced by new technologies, thereby eliminating the encounter between subjects. However, in their view, this argument must be relativized, since contemporary culture is increasingly mediated by technology. Thus, technological innovations currently observed are not exclusive to medicine but are widely used across different spheres of everyday life.

For Deslandes and Mitre [7], new technologies used in healthcare are neither inherently beneficial nor inherently harmful. According to them, what matters most is understanding the role these technologies play in shaping relationships between subjects and in influencing quality of care. Therefore, it is essential to consider how technological interventions can be integrated into care practices, including listening, welcoming, and the shared experience with the other. To this end, their use must be guided by critical reflection, since technology alone does not guarantee successful treatment [7]. In other words, the use of health technologies should be grounded in ethical principles, not solely in technical considerations.

In this perspective, humanization is seen as capable of articulating technological advances with ethical and welcoming care. The PNH itself emphasizes the importance of reconciling technology with the human and relationship dimensions of care: technologies and organizational devices, particularly in a field such as health, do not function independently—their effectiveness is strongly influenced by the quality of the human factor and by relationships established between professionals and users in the care process [2]. To disregard possibilities arising from the use of new technologies in the humanization of healthcare would therefore mean overlooking their potential, such as technologies that enhance listening and the negotiation of behavioral and organizational norms [1]. If humanization presupposes the expansion of communication processes, its possible contributions to healthcare are undeniable.

Valorization of the biomedical model in health practices

It is necessary to reflect on assumptions underlying the biomedical model in healthcare. Particular attention should be given to critically examining its predominance in the education of health professionals, as it has served as the framework in which physician–patient relationships were historically constructed. These reflections

also apply to the training of professionals in nursing, psychology, nutrition, physical therapy, and other related fields. The model grounded in biomedical assumptions has become deeply embedded in educational institutions across undergraduate health programs.

Although the foundational knowledge underlying health practice is rooted in biomedical sciences, it is undeniable that such practice is shaped by the social contexts in which health and illness processes occur. Professional performance also depends on institutional conditions under which care is delivered. From this standpoint, medical practice is not only a technical practice but also a social one [13].

As Rios observes [14], in modern Western culture, medicine developed within a scientific-positivist framework that separated the physical and abstract dimensions of human existence and prioritized the biological over the psychosocial. According to the author, the benefits resulting from its technical advances secured its legitimacy; however, from the mid-20th century onward, social and health-related transformations generated new demands to which medicine had to adapt. This is because, according to the author, *when the human being was placed in the totality of their existence, as the center of attention in the health field, it became evident that these ruptures left great gaps in medical knowledge and revealed its limitations in addressing subjective dimensions of health and care* [14].

Schraiber [16] likewise highlights the classic division between the scientific-technological and the humanistic components of medical practice. She argues that this dichotomy has resulted in a hierarchy in which the scientific-technological component has come to prevail over the humanistic one. However, she acknowledges that, despite the hegemony of the scientific-technological model in clinical practice, it is essential to recognize the interactive nature of health practices and the particularities of each clinical case—dimensions that cannot be addressed solely by the technical application of scientific knowledge.

In this same vein, Ayres [17] underscores the importance of articulating technical intervention with a humanized model of care that fosters more symmetrical dialogue between professionals and service users, since personal and social dimensions cannot be disregarded as determinants of health and illness processes.

In response to such demands, the humanities were incorporated into medical education and practice several decades ago, enabling a broader understanding of diverse expressions of human suffering and sociocultural determinants of illness, as well as of communication skills and the construction of supportive bonds among individuals [18].

While mastery of biomedical disciplines remains essential for clinical practice, there has been an increasing effort in health professional education to incorporate courses and topics related to the humanities in order to integrate technical-scientific and humanistic knowledge. As a result, the humanities and the human and social sciences have gained greater prominence in the health field. Medical humanities, in particular, tend to focus on intersubjective human relationships, whereas the human and social sciences emphasize social determinants involved in health and disease processes.

Within the human and social sciences, disciplines aimed at understanding issues related to health and illness include anthropology, history, sociology, political science, philosophy, psychology, among others. These fields are also essential in specific areas of public health, such as social epidemiology, health planning and management, public policy, and health education. Medical humanities, in turn, are mainly concerned with *communicative relationships between physician and patient, as addressed in educational and ethical contexts, and more recently in the fields of clinical bioethics and research ethics* [19].

As Rios argues, it has been demonstrated that *health and care involve historical and cultural dimensions shaped by individuals' desires, and that medical humanities provide the necessary knowledge to bridge scientific practice with the lived world of patients* [20]. Accordingly, the inclusion of humanistic content in health curricula has become a broad consensus. While grounded in the biomedical model, such training seeks to expand it by emphasizing the need to consider not only the diseased organism but also the person and their subjectivity.

Obstacles to the humanization of healthcare

Another issue raised by scholars concerns the working conditions of health professionals, who are often unable to ensure humanized care because they are subjected to mechanized work processes that hinder the *development of critical and sensitive attitudes, as well as being frequently emotionally strained by continuous exposure to pain, suffering, death, and poverty* [21].

In this regard, Campos argues that there is currently *a process of bureaucratization—and, in many cases, even a coarsening—of interpersonal relationships within the SUS, whether among professionals or between professionals and users* [22]. In the health field, the author contends, it is common to reduce individuals to objects to be managed by clinical practice.

In this sense, social relations marked by significant imbalance of power between subjects tend to be characterized as dehumanizing, particularly when *the more powerful party exploits this advantage to disregard the interests and desires of the other, reducing them to objects to be manipulated according to their own interests* [23].

From this perspective, humanization cannot be effective without addressing the democratization of interpersonal relationships and, consequently, of health institutions themselves. Within the SUS, as Campos observes, humanization depends on *improving the system and shared management and extending it to each district, service, and everyday interaction* [23]. Mechanisms are therefore required to curb and prevent abuses of power, thereby making humanization feasible.

Humanization in healthcare must also *reconcile the scientific objectification of the health–disease–intervention process with new modes of practice that incorporate the subject and their history from diagnosis through intervention* [23]. At the intersubjective level, it may be argued that values of contemporary society have fostered an intensely individualistic culture, shaped by a *belief in a supposed self-sufficiency and a presumed healthy distrust of the other* [24].

From this standpoint, humanization cannot occur without the democratization of interpersonal relationships. Within the SUS, humanization depends on *improving shared management and extending it to each district, service, and everyday interaction* [25]. Hence, humanization presents itself as an alternative to abusive power relations, aiming to reinforce the democratic participation of the various actors involved, particularly service users.

Therefore, it is necessary to transform the operational logic of health institutions so that, rather than functioning as spaces that reproduce violence, they become *spaces of freedom capable of welcoming, supporting, sustaining, and giving meaning to the presence and actions of health professionals, managers, and patients, while acknowledging their subjective and singular dimensions* [25]. In summary, humanizing care requires favorable conditions for the production of care itself.

Final considerations

It is important to emphasize the fundamental relevance of the debate advanced by Brazilian scholars, as it enables critical reflection and fosters discussion of issues that problematize the very meaning of humanization in healthcare across its different dimensions. Deslandes [1] examined the various meanings attributed to the term, including its understanding as opposition to institutional violence; as quality of care articulated with technical excellence; as concern for the working conditions of health professionals; and as the expansion of communication between users and professionals. The possibilities and challenges that emerge from this debate are both vast and diverse.

The perspective adopted in this study approaches humanization in a broad sense, encompassing its different theoretical and methodological dimensions. It is fundamentally a philosophical perspective, according to which the ideal of humanization may be defined as a commitment of the health technosciences to ethical and democratic values.

The polysemy and conceptual flexibility of humanization have been widely debated among Brazilian scholars. They have also reflected on obstacles to implementing this project; namely, *a model of care that has long been hierarchical, fragmented, and grounded in a technical-bureaucratic logic* [26].

Perhaps the greatest challenge lies in fostering, among health professionals, a genuine interest in the patient. This is a difficult task, especially in contemporary times, when individualism and consumerism tend to prevail. Humanization therefore depends on *changes in individuals themselves and on the emphasis on values linked to the defense of life*[27]. It presents a real possibility for expanding the de-alienation of work processes and care delivery. Thus, the greatest challenge in times such as ours may be to rekindle humanism and, with it, the humanization of healthcare.

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Marcel Ronaldo Morelli de Meira – PhD student – marcel.morelli@prof.saocamilo-sp.br
0000-0001-7662-3819

Correspondence
Marcel Ronaldo Morelli de Meira – Rua Marina Ciufuli Zanfelice, 176, ap. 402, Bloco B, Água Branca, CEP 05040-000. São Paulo/SP, Brasil.

Data availability: All data used or generated in this study are described and presented in full in the body of the article.

Editor in charge: Dilza Teresinha Ambrós Ribeiro

Received: 1.24.2025
Revised: 1.28.2026
Approved: 2.6.2026

Research