Humanized care: A relationship of familiarity and affectivity

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Objective. This work sought to understand the meaning of humanized nursing care in the experience of participants, nurses, patients, and their relatives**. Methodology.** This was an interpretive phenomenological study based on in-depth interviews, which included 16 adult participants and was conducted in Medellín, Colombia, between December 2012 and March 2013. **Results.** The patient's situation, the nurses' communication skills, and the condition of both, as human beings, influence upon the words, gestures and attitudes during the nurse-patient relationship, where the presence, that which is done, and how it is done permit leaving an important impression on patients and their relatives. **Conclusion.** The interaction between patients and nurses goes through various stages until achieving the necessary empathy, compassion, affection, and familiarity to account for humanized care.

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

Cuidado humanizado: una relación de familiaridad y afectividad

Objetivo. Comprender el significado del cuidado humanizado de enfermería en la experiencia de los participantes, enfermeras, pacientes y sus familiares**. Metodología.** Estudio fenomenológico interpretativo basado en entrevistas en profundidad que incluyó a 16 participantes adultos, realizado en Medellín, Colombia, entre diciembre de 2012 y marzo de 2013. **Resultados.** La situación del paciente, las habilidades comunicativas de las enfermeras y la condición de ambos, como seres humanos, influyen en las palabras, gestos y actitudes durante la relación enfermera-paciente, en la cual la presencia, lo que se hace y la forma de hacerlo permiten dejar una importante huella en los pacientes y sus familiares. **Conclusión.** La interacción entre pacientes y enfermeras pasa por varias etapas hasta lograr la empatía, compasión, afecto y familiaridad necesarios para dar cuenta de un cuidado humanizado.

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

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Cuidado humanizado: uma relação de familiaridade e afetividade

Objetivo. Compreender o significado do cuidado humanizado de enfermagem na experiência dos participantes, enfermeiras, pacientes e seus familiares. **Metodologia.** Estudo fenomenológico interpretativo baseado em entrevistas em profundidade que incluiu a 16 participantes adultos, realizado em Medellín, Colômbia, entre dezembro de 2012 e março de 2013. **Resultados.** A situação do paciente, as habilidades comunicativas das enfermeiras e a condição de ambos, como seres humanos, influem nas palavras, gestos e atitudes durante a relação enfermeira-paciente, na qual a presença, o que se faz e a forma de fazê-lo permitem deixar uma importante impressão nos pacientes e seus familiares. **Conclusão.** A interação entre pacientes e enfermeiras passa por várias etapas até conseguir a empatia, compaixão, afeto e familiaridade necessários para dar conta de um cuidado humanizado.

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

Introduction

Nursing care is the essence and the object of study of nursing and due to this it is a central concept for the discipline. Precisely, this centrality has motivated multiple works to determine the attributes, dimensions, and meanings that permit its definition, which due to its dependence on the changing dynamics of nursing, from different theoretical approaches,[1] is not simple or static. The concept of care is "not very clear, insufficiently developed and limited by the theoretical perspectives that define it"[2] and because of this "interest on its definition has increased, as well as its analysis as concept and on granting it a broad philosophical base".[3]

Some theorists in nursing have highlighted conditions and attributes of care that are apparently understood in the concepts. Watson[4] refers to "transpersonal care" and proposes conditions considered essential for caring; Paterson and Zderad[5] proposed their "Humanistic nursing" theory to highlight said dimension in spite of having accepted that nursing, during its epistemological and ontological development, has a humanist dimension. Travelbee[6] highlights the "person-to-person" relationship and Peplau[7] proposes "interpersonal relationships" in nursing care, conditions that through definition are also considered involved in said care. Emphasizing on understanding humanized care, even when it may be considered that it is defined sufficiently in theoretical approaches, is justified due to the existing gap between theory and practice in the nursing practice in health institutions, which has led to the lack of coincidence between what care is and what it should be.

For Umenai *et al.*,[8] humanization and humanized care "involve communication and interaction aimed at self-transformation among individuals"; humanization is a concept "that can be applied to any aspect of care like disease, old age, impairment, education, and culture".[8] It is a complex matter that concerns nurses, given that nursing care may influence the success or failure of the treatment. It also concerns health institutions because, in spite of efforts to ensure it with the individuals hospitalized, complaints are frequent due to flaws in care and dehumanizing conditions. Dealing with humanized care establishes the pertinence of the study reported in this article, which is aimed at understanding its meanings in the experience of those participating in it, especially seen in light of the "humanized" attribute due to the importance it represents for nursing; on the one hand, achieving its comprehension and, on the other hand, making this type of practice a reality.

Methodology

Study with phenomenological approach, which included 16 adult individuals between 29 and 62 years of age, four men and 12 women, selected through purposeful sampling.[9] Six of them were professionals with prior experience as patients when they were hospitalized due to emergency situations, critical disease, or surgical intervention; seven were relatives of hospitalized patients, and three were nurses, who voluntarily accepted to participate without receiving economic compensation.

The in-depth interview was the technique to achieve information; it lasted between 1 and 1.5 hours. Each interview was given a code to protect participant confidentiality. This code adopted the letter N followed by the person's initials to identify the participating nurses; P was used for patients and S for their relatives. The participants were invited to share their experiences regarding care. The initial question was: Describe your care experience during the hospitalization per episode or episodes of your own illness or that of a family member – for patients and relatives; and: Describe your experience as caregiver with sick individuals and relatives in the hospital – for nurses. Thereafter, they were asked to describe the experience and the subsequent questions were specific for each of the interviews, depending on the contents of the information. The question: "what meaning do you assign to having been cared for or having been a caregiver in a humanized manner within the hospital setting?" motivated speaking specifically about the meanings of the phenomenon. A statement of the events during the care interactions that included thoughts, feelings, emotions, responses, behaviors, perceptions, self-interpretations, and the context that took place during the hospitalization was important to understand it. The data provided during the interviews were considered equally important, without giving them preponderance due to reasons of social power, wealth, educational level, or political importance of the individual expressing them.

The interpretative procedures of the hermeneutic phenomenology proposed by Cohen, Kahn, and Steeves[10] served to conduct the manual analysis of the information, which began in the first interview upon listening and reflecting on what was expressed to understand the meanings that could be validated with the participant. Then, the interviews were finally transcribed and the information was analyzed thoroughly through repeated readings, line by line, to have a general vision of that reported, the peculiarities of each experience, and to accomplish a dialectic movement between the whole and the parts.

The product of the review was the coding, thematic analysis, and determination of units of meaning and examples; additionally, recurring incidents or common themes were identified, as well as atypical or negative cases that did not fit the interpretative line and suggested variations in the analysis. Then, the significant themes and subthemes were separated and analytic memos and diagrams were made on each and on the relationships among them. Thereafter, a narrative described how the themes were understood in relation to the experience studied. The interpretation was validated permitting several of the participants to read it to determine its correspondence with what they wanted to say, ensure faithfulness and credibility in the analysis, recover that which was omitted, and improve the final description and internal validity[10]. Also, it was reviewed by the consultant, with PhD degree, and 10 members from the research group "Emergencies and disasters" from the Faculty of Nursing at Universidad de Antioquia, whose suggestions and recommendations served to improve the report and favor the external validity and confirmability.

To contribute to the applicability and transferability of the study, the results were presented in different audiences. The study was held in Medellín, Colombia between December 2012 and March 2013, with prior approval from the

ethics committee at the Faculty of Nursing at Universidad de Antioquia (Act CEI-FE 2012-4).

Results

The results permitted seeing the confluence of concepts among the participants and some theoretical approaches of the discipline in relationship to the indispensable attributes and characteristics for the work of nurses to be considered nursing care. One of these approaches is derived from the humanist current that grants it the humanized attribute, in full force for the interviewees: *That is the duty, you don't have to think about it, thus, it is how it must be and I don't see any other space there. I don't know what the nicest definition is, but this is how it must be* (P.G.M). Emphasis on the humanized approach of care motivates reflecting and analyzing the conducts and attitudes of nurses during care, highlighting their own humanity, that of the patient and of their relatives. Besides, it guides the way of proceeding by taking into account the indications of professionals and nurses and the conditions and specificities of patients and relatives to contribute to the harmony in care and wellbeing of patients and nurses: *we perform many actions that we nurses think are the ideal ones, but... have we consulted them with patients to see if that is what they want, if that is what they want; do we know that care must be individualized*? (N.J.T).

The participants recognize the presence of humanized care when the relationships with nurses take place by bearing in mind the type of experience they are having. This turns out crucial in the way of interacting, the language and oral or gestural expressions used to achieve the approach that enables caring and enhancing the necessary trust to ensure the care and even some adequate results in aspects that depend on the interaction, given that it should not be forgotten that many other professional and institutional circumstances also have their effect upon them: *...patients arrive due to an unforeseen event in their lives; they were well and suddenly got ill, something happened and the nurses must approach their level; let them know what you are going to do, who we are; treat them well, explain their rights to them because humanizing encompasses many aspects; I would say too many* (N.L.A).

Accordingly to what is reported in the interviews, an interaction framed within humanized care goes through different stages to achieve trust, know the problems and decide on the convenient interventions, not only to solve them but for them to agree with the likes, preferences, and demands of patients. Thus, nurses fulfill the first stage by demonstrating, on the one hand, their disposition and interest to participate in the solution of problems under the consideration of the patient as a human being and, on the other hand, the purpose of respecting their dignity: *not only do we need many orders and procedures or to have them supply us with medications, but for them to think of the person we are, of our humanity and dignity* (N.G). During this stage, nurses must be willing to go beyond the task and beyond fulfilling their duty to become interested in the real situation of the patient and the possible solutions. This is accomplished through patterns of aesthetic, personal, and ethical knowledge that complement the empirical pattern and permit selecting the best care options: *I understand that it is not about limiting oneself to doing things mechanically* (S.R.D).

During the second stage, nurses assume patient care by considering the ethical principles and their social and communicative skills to speak, listen, assess, and detect the problems and situations each faces. During this stage, it is important to exercise moderation and equilibrium to analyze situations, speak when necessary or remain silent when it is considered pertinent: *second, we must act with ethics and tact in managing circumstances; we must be prudent with our bodily language, expression and language; avoid expressions like babe, honey, and things like that* (P.G.M). Moderation permits nurses to be respectful of the autonomy and preferences of patients, without bursting in with dispositions pertaining to institutional protocols that can be postponed

or replaced, when there are no repercussions in care, to keep from causing disappointment and annoyance; grant them preponderance and recognize their leading role in care: *I think our obligation is to provide humanized care, even if we have contractual problems because that is not a problem the user has to receive* (P.M).

During the following stage, nurses show empathy toward patients, their families, and toward they situation being experienced. Certain attitudes and behaviors, language, and even non-verbal communication, like one's gaze and gestures, permit patients to know the nurse's attitudinal position and find emotional and spiritual affinity with the nurse; empathy in this relationship permits understanding the situation, problems, demands, and needs of patients and their relatives. Also, it permits offering support and help: *as of the first word nurses pronounce to their patients, we see if there will be empathy and that is important for their recovery; nurses must have empathy with patients and then try to treat them with medications and procedures* (S.D.E).

Additionally, empathy favor the possibility for patients to provoke feelings in nurses that move them to acting in their favor, actions that are desirable because they reflect the nurses' interests and the attributes of the care they provide: *they do things in, as the word expresses it, a humanized manner, more humane; I mean, fondly, with love; I got to see that they performed the procedures and many things with humane treatment; therefore, I think that it is about doing things with love and not merely doing them mechanically* (S.R.D).

Demonstrations of empathy and identifying with patients and their situation are followed by the relationship based on cordiality, warmth, compassion, kindness, and understanding motivated by, first, the high vulnerability of patients and the presence of physical and emotional suffering and, second, by the desire to help, which is transmitted into agreed-upon actions in the search for the patient's wellbeing: *If I see a person suffering with pain or hunger, I have to do whatever I can and whatever is available to me to make them better; that is compassion. If something is going to cause pain, we need to be careful and not do to the other what we would not like to be done to us* (P.G.M). According to the participants, compassion, as a care attribute, is reflected in the actions of nurses, on how they carry them out and on the feelings they invest in each actuation; on how they perceive human beings, understand their situation, and participate in solving problems: *compassion is not feeling pity, but understanding the other person's situation and doing everything possible for that person to get better; nurses must be interested in avoiding more pain and suffering and in doing things with love and – obviously – with ethics and the responsibility of doing things well* (P.G.M).

When you are clear about what to do and on the patient's participation in the care, the nurses' interventions are carried out in a pleasant manner for patients and their relatives and, of course, for themselves, that is, care is provided amid a familiar, warm, and friendly relationship that instills feelings of peace and trust. Hence, it is not about doing things for the sake of doing them mechanically to comply with the duty or assignment; rather, show interest in acting and propitiating a pleasant climate of warmth and respect: *...it is not merely about performing procedures, we must include that warmth that is possible to see in the relationship of the relatives with the patient, accomplishing that approach patients have with their families* (N.L.A).

Within this pleasant climate for the relationship, it is worth considering some details that have already been defined by theorists in nursing and whose importance is reinforced by the participants. These include privacy and respect for modesty, isolation from noise and unpleasant situations outside the patient's condition: *...one must be comprehensive in the social part; thereby, we must be very kind and provide patients privacy for many things; I like nursing, which is my profession and that is why I have to set out to be kind with others* (N.G.G).

Bearing in mind the crucial role played by nurses during the experiences of disease of patients

and their relatives, a relationship that leads to empathy, compassion, interest, and mutual affection will result in the recognition people grant to the profession and to those who practice it: …*we show that the care nurses offer patients and their relatives is definitely different from what they can receive from other personnel in the institution* (N.N.S). Also, it permits leaving a pleasant imprint on the people receiving care and on their relatives, who cherish the help received during difficult moments, like an experience of sickness, especially if it occurs in a way that it is perceived as pleasant, which motivates emotions, feelings, affection, and wellbeing, as in humanized care: *I felt respect for the way I saw their behavior with my son and with the rest of the patients; they treated them very well, they are humanized and I would say, this person has vocation and does it more out of liking, due to their sense of responsibility and humanity and not out of obligation* (S.D.E).

The relationships between nurses and patients are the way to conduct care and the means to making their attributes visible. Due to this, attitudes and behaviors during the interactions will be perceived and cherished by patients and their relatives, as well as it occurs with response time, opportunity in it, duration and quality of contacts. All this will help to reach conclusions and create meanings: *… humanization? It is how patients are approached, how they will be cared; listening to them and providing explanations; I think the way one can contribute is through more personalized work and that creates humanization, through listening and communication* (N.N.S). Thus, attitudes during the performance of care, the expertise and academic preparation contribute to nurses leaving an imprint or an image on the people they care for, who highlight characteristics that agree with the expectations, desires, and with a pleasant way of proceeding for those who receive it and satisfactory for those who offer it: …*I am a dreamer and would want to be as I like nurses, to work with patients everything that has to do with their healthcare part; I defend that nurses have to perform all the procedures the patients need with support from the aides, but nurses bear the responsibility and they have to perform the procedures* (N.L.A).

Also, the participants are important in the perception and description of a care experience because they value pleasant, warm and caring treatment to address people stricken by disease or who have a sick relative: …*everything was okay, quite well, especially because of their way of treating patients* (S.D.E). On the contrary, certain inconvenient attitudes (inconveniences) effectively distance nurses from patients and their relatives; besides, these hinder compliance with the work, which is based on communication, requests, and demand as some of the ways of knowing what patients need. These attitudes can be perceived by family members and patients as if they were ways of punishing or healing and are more related to non-personalized care than to humanized care: *I seems like they do things with more satisfaction when they know you are in pain; I remember her saying, oh holy virgin, help us!* (S.D).

The awareness of a task that does not respond to the true conditions of nursing leads to reflecting on the factors that have influenced to making the work of nurses not focused on its real object: *… and, what have we done badly, where are we with what we have to do, and is this happening? What are we going wrong, what are we failing at, why do we keep making mistakes, and does our recognition as professionals continue to be lost?* (N.G). Likewise, it is fitting to reflect upon the poor social recognition and the scarce visibility as a profession in front of patients, health institutions, and society due to the development of activities that do not reflect the spirit and purpose of the discipline, but which have represented distancing between nurses and patients with detriment of the mutual knowledge and trust that should contribute to productive care relationships in terms of accomplishing goals, solving and coping with problems: …*we are not visible to patients because we are always with monitors and apparatuses and trying to prolong life at all costs, inventing treatments, medications, and new techniques, but we forgot the basic that we are human beings like the patients (N.G).*

The reflection enables the search for the real causes of healthcare problems and for true solutions, avoiding excuses and justifications: *... we continue failing at the same and we keep complaining that there is no time; that we should not do other things that distance us from care; we believe that we have to bring the latest technology, have the cutting-edge equipment, and prepare the personnel, but the same keeps happening* (N.G). Due to all this, patients and relatives continue waiting for professional interventions aimed, in the first place, at detecting and solving problems and, in the second place, at establishing pleasant relationships, charged with emotions and feelings and accompanied by attitudes of joviality, interest for caring, concern and affection for the situation and for those experiencing it: *...basically, humanization is returning to those basic principles of cordiality and kindness, greeting and introducing oneself, asking the patient: who are you?, what is your social role?, what brought you to the situation you are enduring? ...and demonstrating interest and affection* (N.G).

Discussion

The humanized approach of care is part of their "ought to be". It is, thus, expressed by participants and proposed by some theorists because "patients, their relatives, and nurses are human beings", which is why healthcare has to do with a "subject-to-subject relationship, a meeting of subjectivities and, due to this, the classification of care as humanized depends on the quality of said relationship".[11] As an attribute of care, humanization demands from nurses "human skills to combine professional and technical aspects with the capacity to relate with those around them".[12] However, in current practice, one thing is the ought be and another is the reality of healthcare. Thus, "the need to implement reflexive processes about the principles, values, rights, and duties that govern the nursing exercise"[13] has been identified and bringing to the practice the attributes it has in theory, as in humanized care, which "supposes establishing an environment of humane care and a culture of respect and affection" that does not take the disease as the center of attention, but rather the human being"[13] as a subject and not as an object, recognizing the value, complexity, and subjectivity of individuals, avoiding their reifying upon assigning them labels due to the disease they are suffering. It also supposes knowing the emotions, feelings, and responses and what people at home do to perceive the contribution they can receive in a therapeutic relationship.[14]

Other important aspects reported in the literature and by the participants that contribute to humanized care include, first, integrating all the skills of nurses and going beyond technical aspects: "the term humanization is used when, besides improving care in its technical and scientific dimensions, the rights of patients are recognized with respect for their individuality, dignity, and autonomy within a subject-to-subject relationship".[11] Second, recognizing the centrality of the relationship with patients and how to carry it out, "avoiding prejudice, focusing on the patient, evaluating in depth, transmitting skills, sharing feelings, comforting, protecting, preserving dignity, informing, and facilitating ways of coping with transitions and unusual events".[15]

The interaction between nurses and patients supposes face-to-face presence. In addition, the participants recognize their centrality in care and refer to its existence and to the type of relationship, given that the mere physical presence is not sufficient; what is needed is a spiritual or psychic connection. This interaction is essential; "especially if it takes place within conditions of illness and incapacity to fend for oneself or to accomplish self-satisfaction of the needs".[5] Within the setting of humanistic nursing, this relationship is understood as a "harmonious experience with adequate use of shared time that humanizes requests and responses".[5]

The study results also coincide with proposals by authors in relation to the interaction with patients understood as "approaching at the level of patients", recognizing and helping them, "as

someone who exists and has value and worrying about them, showing interest for their condition, providing them with care, and displaying a solicitous attitude".[12] In other words, it is based on "hospitality understood as the capacity to welcome others respecting their differences".[16] The proposals by Levinás[17] help to understand the humanized nature when stating that in the relationship with another it is possible to "look at a face and from the moment we look, someone opens up to us, speaks to us, reveals something that goes beyond what is made visible. A face is not a mask and being a person means having one". For Boff,[18] "relationships of care are not of dominance over, but of coexistence"; they are also "not purely technical interventions; rather, they are interactions" which may be understood in terms of equality, without preponderance over the other participant.

However, in spite of the rich contribution made by knowledge in nursing, through the influence on how patients are perceived, the dominance of hospitals, and the medical hegemony in the practice nurses achieve a false security in performing procedures and in using technologies in care, leaving aside the discipline's theoretical approaches.[19] Additionally, they assume the medical scheme of intervening the disease, reducing care to a series of interventions without its own theoretical context, with the consequential subjugation to other professionals and an unfortunate loss of autonomy and ethics.[20] In this sense, scarce recognition of the importance of care by nurses and permitting accessory activities to dominate the principal task when complying with their functions has influenced on the type of current practice. Thus, "nurse satisfaction depends more on performing activities around the diagnosis and medical orders than on the application of theories from the discipline that bring dynamism to care, promote interactions, and consider patients as human beings".[20]

The perception of care, from the ethical point of view, suggested by participants, coincided with the statement by Pallazani:[12] currently, "humanization of action is required", by nurses and health institutions, "stimulating an existential attitude of responsible relationship toward the other individual in conditions of weakness or who belongs to a different culture or social level". Upon considering the importance of acceptance and respect for differences in care, it is pertinent to remember that nursing is based on an ethical framework and not on imposition. In this respect, Gracia[21] proposes that "ethics of nursing care has been adjusted to the specific pattern of the ethics of conviction"; however, it would even be recommended to rethink this focus because conviction "relates moral life with the direct application of principles and regulations to specific situations, without considering the circumstances and consequences".[21]

Putting humanized care into practice involves "breaking away from institutional routines",[11] which means considering them conditions to "adjust to the needs of patients to demonstrate being reasonable and flexible".[11] Nevertheless, this is a difficult suggestion to fulfill because nurses "prefer complying with certain norms than caring for individual and specific conditions of patients",[11] reflecting a lack of moderation and balance in their work. The same occurs when ignoring the singularity and individuality of patients to subject them to protocols, which does not contribute to humanized care either.

"Doing all the caring" means appropriating the task of nursing without excess in the delegation, which is presence by the patient and direct interaction. This interaction and the type of relationship that should exist are consigned in the Colombian legislation (Legislation 911 of 2004), which highlights the importance of communication and humanized interpersonal relationships between nursing professionals and the human being; the "presence" is also reported in the approaches contained in the *Nursing Intervention Classification* (NIC),[22] which considers specific care that which permits evaluating and caring for patients in satisfying their needs, carrying out care, and establishing face-to-face relationships to be present, accompany, console, and listen, assuming the responsibility to contribute to wellbeing.

This important role of nurses next to patients is recognized by the participants and by theorists like Piva *et al.,*[23] who propose that some nursing interventions can be considered aggressions by patients, such is the case of channeling veins and collecting samples for children. In cases like these, the nurse's role is crucial to diminish stress, but frequently, they do not have the necessary skills to help them confront said situation.

Empathy, proposed by the participants as requisite during the third stage of the nurse-patient interaction is understood as "the capacities to experience as one's own the feelings of others"[24] and being in their place to understand their experience. Moreover, it has been a frequent motive for discussion as an essential aspect in caregiving relationships and in nursing no consensus has been reached with respect to its definition and application in practice to establish significant relationships with patients and capture the subjectivity of the experiences,[24] a reason why it is absent in care relationships when nurses do not have the skills to use it or simply because it is not part of how they see others.

Compassion, as an attribute of care, is important because it permits nurses to approach the feelings, suffering, and joys of patients and even perceive them as their own. Lama[25] defines it as "feeling the other person's suffering, showing interest to help them and heal them and it grows with the commitment to their wellbeing", without the mediation of criteria of difference like "age, seriousness, race, or gender that move to basing, on that difference, the depth and interest for caring".[25]

In communicating with patients, gestures and non-verbal communication gain special importance, according to that reported by the participants, because, like words, these express the inner world and emotional experiences of nurses and patients. It is, thus, explained by Merleau Ponty[26] upon stating that "emotions and feelings fill the gestures" and because of that anger, happiness, disappointment may be reflected in them and are interpreted based on the experience of those who perceive them and grant them sense within an act of understanding and not of intellection or knowledge". Precisely, due to the individual differences between nurses and patients, the reading of gestures varies, provoking real or attributed perceptions with effect upon behaviors. In this sense, nurses use gestures to assess aspects of the patients; and patients, in turn, to evaluate the nurses' attitudes, disposition, and responses. Cyrulnik[27] coincides by highlighting the importance of gestures in communication upon indicating that "gestures and language show interest for the other person", permit expressing "affection and affinity"; gestures are a way of communicating, which encompass an intention with respect to the presence of the person or his/her situation and "marked by a relationship" between the person performing it and the person who perceives it[27] and can contribute to wellbeing or to discomfort. Thus, the interaction gives rise to a double assessment: nurses evaluate the health status, the physical and psychological responses of patients, and also perceive attitudes, the desire to help, and gestures of nurses. This mutuality is also given in the benefits and in the very care because caring for people reports satisfaction for nurses.

Conclusion

The nurse-patient interaction, framed within humanized care, goes through several stages that include, in the first stage, demonstrating willingness and interest to go beyond the simple task; in the second stage, caring with an ethical focus; in the third stage, demonstrating empathy, kindness, and understanding; and, lastly, through communication skills and a familiar approach, establishing relationships with patients, which take into consideration their conditions and their situation and which will serve as basis for an adequate selection of words, gestures, and attitudes that permit promoting trust, affection, and familiarity, as can be found in a relationship among relatives and which – additionally – reflects interest in the other person and for participating, always by their side, in the solution of problems. These interactions are carried out with the

conviction that both participants are human beings who contribute with their experiences, knowledge, and feelings. Interest for caring and receiving care, within this interaction, permits a double assessment, from patients to nurses and vice versa, from which some behaviors and responses from both participants depend on the care relationship.

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