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Humanized care; the case of patients subjected to chemotherapy

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Humanized care; the case of patients subjected to chemotherapy

Abstract

Objective. Herein, we seek to know the necessities of humanized care of patients subjected to chemotherapy. **Methodology**. The study was carried out with patients, of both sexes, diagnosed with different types of cancer who received chemotherapy treatment in an oncology unit of the city of Medellín, Colombia during 2011. A qualitative approach was used with tools from grounded theory; 23 interviews were conducted and a field diary was kept. During the analysis, codes were extracted that were subsequently grouped into categories that best represented the phenomenon studied. **Results**. Cancer patients subjected to chemotherapy have needs for humanized care. The emotional, spiritual, social, and affective necessities were highlighted as a consequence of the impact of the news of the diagnosis and the notorious physical changes confronted by these patients. The category of dehumanization of care emerged related to the information of the diagnosis and in the communication the personnel maintained with these patients. **Conclusion.** The cancer patient receiving chemotherapy is a seriously ill person, with necessities, who requires humanized care by the healthcare provider personnel.

Key words: oncology service, hospital; drug therapy; nursing care; humanization of assistance; communication.

Cuidado humanizado. El caso de los pacientes sometidos a quimioterapia

Resumen

Objetivo. Conocer las necesidades de cuidado humanizado de los pacientes sometidos a quimioterapia. **Metodología**. El estudio fue realizado con pacientes, de ambos sexos, diagnosticados con diferentes tipos de cáncer quienes recibían tratamiento de quimioterapia en una unidad oncológica de la ciudad de Medellín, Colombia en 2011. Se utilizó un enfoque cualitativo con herramientas de la teoría fundamentada; se realizaron 23

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entrevistas y se hizo diario de campo. En el análisis se extractaron códigos que posteriormente fueron agrupados en las categorías que mejor representaban el fenómeno estudiado. **Resultados**. Los pacientes con cáncer que están sometidos a quimioterapia tienen necesidades de cuidado humanizado. Se resaltaron las necesidades emocionales, espirituales, sociales y afectivas como consecuencia del impacto de la noticia del diagnóstico y los cambios físicos notorios a los que se enfrentan estos pacientes. Emergió la categoría de deshumanización del cuidado relacionada con la información del diagnóstico y en la comunicación que el personal mantuvo con estas personas. **Conclusión.** El paciente con cáncer que recibe quimioterapia es un ser gravemente enfermo, con necesidades, quien requiere un cuidado humanizado por parte del personal asistencial.

Palabras clave: servicio de oncología en hospital; quimioterapia; atención de enfermería; humanización de la atención; comunicación.

Cuidado humanizado. O caso dos pacientes submetidos a quimioterapia

Resumo

Objetivo. Conhecer as necessidades de cuidado humanizado dos pacientes submetidos a quimioterapia. **Metodologia.** O estudo foi realizado com pacientes, de ambos sexos, diagnosticados com diferentes tipos de câncer quem recebiam tratamento de quimioterapia numa unidade oncológica da cidade de Medellín, Colômbia em 2011. Utilizou-se um enfoque qualitativo com ferramentas da teoria fundamentada; realizaram-se 23 entrevistas e se fez diário de campo. Na análise se extrataram códigos que posteriormente foram agrupados nas categorias que melhor representavam o fenômeno estudado. **Resultados**. Os pacientes com câncer que estão submetidos a quimioterapia têm necessidades de cuidado humanizado. Ressaltaram-se as necessidades emocionais, espirituais, sociais e afetivas como consequência do impacto da notícia do diagnóstico e as mudanças físicas notórios aos que se enfrentam estes pacientes. Emergiu a categoria de desumanização do cuidado relacionada com a informação do diagnóstico e na comunicação que o pessoal manteve com estas pessoas. **Conclusão.** O paciente com câncer que recebe quimioterapia é um ser gravemente enfermo, com necessidades, quem requer um cuidado humanizado por parte do pessoal assistencial.

Palavras chave: serviço hospitalar de oncologia; quimioterapia; cuidados de enfermagem; humanização da assistência; comunicação.

Introduction

Care constitutes a very important part of comprehensive care. Humanized care permits recognizing the human beings as comprehensive beings, with dimensions that constitute them as persons, which are impossible to fraction. Likewise, it must be recognized that man is a free-thinking being and autonomous in decision making upon transcendental situations in life like disease and death.

To speak of humanized nursing care, it is important to define humanism, which in general terms is defined, according to Arroyo[1] as: "the attitude centered on human interest, in full development and wellbeing of integral beings in all their dimensions: biological, psychological, social, cultural, and spiritual; additionally, it implies respect to mans freedom to think, feel, and believe".[1] Authors, like Watson,[2] reaffirm the importance of those dimensions of the human being different from the biological dimensions when providing nursing care. They focus their theory on the nurse's capacity to transcend the purely biological sphere to the spiritual sphere;

this seeks a harmonic relation between the person´s mind and body, without ignoring that the human being is not only an organic body, but that it is founded by its spiritual part, immersed in its inner world, in the nature and interaction with others in its outer world.

Within the conceptual base, we adhere to the guidelines by Leininger and McFarland[3] who differentiate care "caring" from caring "care" with its terms in English: *care* refers to actions, attitudes, and practices to aid and help others toward a cure and wellbeing; *caring*, are those experiences or ideas that aid, support, and permit another with evident or anticipated necessities, to improve a human condition or life style; this is how the first is aimed at the perfection of a human condition, whether individual or collective, and the second is aimed at experiences that permit satisfying the necessities of the individual (...). According to the same authors, although "human care is universal", care could vary from one culture to another; in this case, we refer to caring for patients in a region of South America where values like affect and spirituality are important, as we will see throughout this work.

Oncology patients endure their disease as a rupture process with daily life, undergoing a depersonalization process, which includes the appearance of the "I cancer" and the recurrent idea of death. This loss of identity constitutes the start of a struggle-hope-resignation cycle that seems determined by the type of cancer, patient's age, and the seriousness of the disease; with those who conserve their social network having better confrontation capacity.[4] These people, when diagnosed with this disease, suffer an impact of such magnitude that it can even affect emotional and psychological areas. As it is known, the fact of enduring cancer leads individuals to developing feelings of loss, failure, and futility. Studies on the topic conducted from testimonies of cancer patients and from healthcare personnel, manifest dehumanization in nursing care, given that problems were found related to the alteration of spiritual and psychological necessities.[4]

Also, it has been described that one of every three patients has received little or no help when feeling sad, when losing control – of their emotions – or when feeling the need to talk with someone because of not knowing the purpose of chemotherapy.[6] It is of concern how a study in Peru found that activities carried out nurses with oncology patients are aimed mostly to satisfying biological necessities like comfort, feeding, elimination, hygiene, and sleep; while activities from the psychosocial environment like psychological preparation, emotional support, teaching the patient and the family, communication, religion-beliefs, and distraction patients consider are not being satisfied.[7] All the aforementioned clearly justifies the necessity to include the theory of humanized care in the nursing practice.[8]

This study was developed to learn the care needs of patients receiving chemotherapy, given that they require professional help that is more aware of the transcendence of care and of the implications when it is not provided in a "humanizing and humane" manner. Also, the study dealt with the necessities of human beings during said treatment phase, with a holistic approach.

Methodology

To know the meaning of people's life experiences, it was considered pertinent to conduct a qualitative research because of their attributes of permitting our approach to knowledge of biological, emotional, social, and spiritual necessities, in this case of the cancer patient; additionally, arriving at action guidelines to intervene said necessities that help improve coping with the disease course. The qualitative approach was selected based on the grounded theory. A total of 23 patients participated from a chemotherapy service in an oncology unit in the city of Medellín, Colombia during 2011. With prior verbal and written informed consent, semi-structured interviews were carried out lasting between 60 and 90 minutes, which followed a script of open questions.

From analyzing the interview material and some observations live and substantive codes emerged; thereafter, leading to the categories and subcategories of the study. The ethical aspects considered were the informed consent with voluntary and conscious commitment by the participants, confidentiality of the information, and its use for the exclusive purposes of the project. The results were returned to the individuals interviewed and to the participating healthcare institution.

Results

Hereinafter, the results of the research work will be exposed, which will be described according to the ordinances of qualitative research, according to the urgency of the categories. In any case, we sought to respond the research question and to the aim proposed.

Humanizing characteristics of attention and care

Within ideal humanized care, the following traits emerged: human quality – a characteristic of the individuals that is independent of their professional formation; affection, as a way of caring that is not restricted to only professionals; and equity as part of the ideals of care. Sensitization, truthfulness, commitment, and responsibility were aspects that emerged upon the inquiry on the ideal characteristics or on the qualities of professionals providing care. Also, spiritual and religious dimensions emerged strongly.

We started from several suppositions, namely, first that care is part of attention and, second that the ideal of care received is related to the qualities of the professionals who provide it. In the basis of the work we have the inquiry for the compliance of the ideals of care. The patients considered that human quality and affection constitute qualities and a way of caring perceived as personalized attention, which means being treated as people and not only as patients: *attention is personalized, nurses are very humane, they treat you as a patient and as a person* (E11:2). Also, equity is highlighted upon providing care, according to phrases like: *treatment should be equal for all* (E08:2) and provide *nonprofit care* (E14:2).

The following describe the characteristics and qualities the patients perceived as necessary in nursing personnel: those refer more to professional care and these to the person providing humanized care. According to the aforementioned, regarding the characteristics, psychological preparation and sensitization are important: *psychological preparation to understand the patient* (E20:4), *understand that with that disease people get angry, sad, nervous, and have many emotional changes* (E11:2), given that they realize what they are going through and can understand it and accept it instead of rejecting it, *the nurse must have sensitivity (...), and be more involved with the patient* (E22:4). Besides, nurses must be aware of the necessities in daily care, of that being in need of affection and company: *...I would like it if the nurse stayed talking to me a bit longer* (E04:2).

Other characteristics are: *commitment and responsibility.* Patients think that commitment is doing the work with love, but spontaneously, without pressures, whatever springs out; and responsibility is doing things well*: with timely care, that they don't make you wait long to administer the medication* (E07:2) *(...) explain the adverse effects of the treatment* (E05:1); *the nurse should know about medicine; have the capacity to tell patients how they are evolving...* (E05:1)

Patients highlighted: *affection offered and kindness* (E12:1), *affection when caring for the patient...*(E17:2) simplicity*, the nurse should not be ill tempered* (E08:2); respect: *the nurse needs to be encouraging, bad temper should not be reflected onto the patient* (E20:4); *... because problems should be left at home and it is not the patient's fault* (E05:1); *...nurse's need to be attentive and understanding* (E05:1); patience, *patient, because you sometimes do not*

understand anything of what you are told and they get irritated with you (E04:1); trust: *the biggest quality is trust, closeness with the patient...* (E18:4); compassion: *they need to be moved by the patient's pain* (E06:2); lack of interest, *provide nonprofit care;* and love, emerging from the data with two dimensions: *love toward the patient* (E02:2) and love of work: *work with love, wholeheartedly, without revulsion* (E02:7). These qualities highlight humanized care.

Spiritual and religious dimensions also emerged. For patients, closeness with God makes nurses more *spiritual,* some of them expect *that people who are closer to God to be more humane and this includes nurses* (E20:2). According to patients, some specific conditions exist for humanized care to occur; in that sense, they allude to said conditions categorically: *they should respect your space* (possibly referring to respect for your beliefs and customs); the nurses should be moved by the patient's pain, they should not get exasperated with the patient, they should be kind, care well, they should hide nothing from the patient about the diagnosis, they should understand the patient's bad temper.

It is, therefore, fundamental to recognize in the other person a unique, individualized being, who is undergoing a special stage of life that modifies his/her behavior, without their losing their values and the potential capacity to make decisions with respect to treatment and care, their likes should be respected*: ... Here, you are not asked what you like...* (E20:4). For that, nurses must have professional suitability and human sensitivity, as expressed by a patient, *that being must be different* (E20:4).

Bewilderment, disinformation, and confusion also emerge. Bewilderment was expressed by patients regarding their future with the disease, thus*: I got very sad and bewildered because I didn't know it was a lymphoma* (E01:2); *very sad because I don't know what is our future going to be, besides we far from home and from our children* (E03:2). *I just know I have cancer* (E06). *You don't know when you are going to get the ultimatum, I am worried about everything the cancer can cause in me* (E11:2) *... besides, the oncologist told me I must follow a strict diet for the cancer and here they are telling me to follow another diet and I don't have money to buy all that* (E13:2)

These testimonies show the bewilderment and confusion from the participants, which is preventable with caring actions. Patients show expressions of negation during different stages of the disease: *I look just like other people, I don't look sick* (E15:1); *I don't feel an discomfort* (E14:2); *chemotherapy has not affected me, the only thing is that my hemoglobin and white blood cells dropped and that is normal* (E20:2); *my defenses are okay – besides, I am seeing a bioenergetics specialist* (E15:2); *I don't need anybody to accompany...* (E14:2); within that negation, we can observe the evasion some patients have about the magnitude of the disease: *...I don't think about life or death...* (E20:2); *the important thing is to feel busy, to forget that he/she is sick* (15:1).

False illusion is part of negation with respect to its prognosis, filled with positive thoughts or with hope; that is, some think they will be cured, although their current status shows the opposite: *very relaxed, I know everything will end up well with God's help*, justification of the false illusion; *the physician told me the surgery was a success and that the chemotherapies were to prevent any relapse* (09:2); *I no longer have cancer, but I need a bone marrow transplant* (16:3); *...the left breast has 17 benign cysts, I am getting more chemotherapy to keep them from becoming malignant* (E11:2).

Patients seek refuge in a divinity (God) and place in His hands the future of their disease and its possible cure. The patients express it thus: *besides, with all this I am closer to God now that I am in this situation. I become stronger with God.* (E20:2); *...God is first, there is more time.* (E20:2); *...I feel God's support, I am spiritually at peace with my soul* (E18:3); *...Very relaxed and I know everything will be well with God's help*...(E09:2), *...but thank God we have these*

medications... (E21:2). Within the logic of this religiosity, negotiation with God is observed: *I have faith, I believe God provided the medicine to cure this cancer* (E18:3); ...*I experience cancer as a lesson, I do not question God, I take it as another opportunity to let me stay more time* (E18:2); *it is God's will* (E06:2); ...*and I say, my God, it is my destiny* (E18:2); this testimony alludes to accepting God's will (E06:2).

Communication

Necessities for communication are part of humanized care; the study found this important subcategory as part of care, given that its quality and professionalism are fundamental to perceive that care is humanized. The following are described from the ideal of communication to its absence. Patients expressed the great need to communicate and expose their hearts: *the human being [is] in a bed with so much need of having someone to open the heart to* (E18:4).

The communication ideal for patients is the opportunity to openly express feelings: *being able to share feelings* (E18:4); includes communication with the physician, whom they feel should report on the patient's evolution and should explain scientifically.... Also, it was found that explaining to the patient the sense of the treatment is one of the characteristics of good communication: ...*we were explained that chemotherapy was going to start to see how the disease would react* ... (E02:1) *the nurse would go and explain* (E02:1)...*we should be told of the adverse effects of the treatment* (E05:2). The explanation is also accepted in conference form, as expressed: *say a conference is given, if you can call it that* (E02:1); this is because these are communication strategies with different variations; in the field work, it was noted that educational talks were delivered that, sometimes, did not meet the quality criteria in the sense of the patients' state of weakness to receive it and of not checking their degree of understanding (DC: Aug. 21/09, E06:2). Characteristics of listening and understanding (E20:4) were fundamental for good communication.

Also, many references were made to the lack of communication; patients expressed that professionals do not tell, they only check; they do not explain, they only ask and there is no trust, as broadened by the expressions: *there is no (communication) and I think it is very important because it provides trust to express what I think and share the symptoms I am feeling*... (E07:2) that is, if communication existed there would be understanding of the pathological and therapeutic processes: *the physician has not told me about my evolution, and he can't be asked; even so, he talks with me* (E22:2). *The physician I had before did not tell me anything*... (E08:2) *he did not explain any procedure* (E02:2) *I don't trust the nurses*... (E20:6) ...*I don't feel confident to tell them what I feel* (E20:2) *they only ask what hurts me* (E20:4). We observed how patients identify the lack of confidence irradiated by the professionals. Consequently, deficient or "poor" communication is recognized when it is blocked or it is in one direction, imposed or intimidating, with the following variations: *the hematologist has not told me anything and I am afraid to ask him because he is very ill tempered and nasty* (E03:2) *the other day he shouted at my mother* (E01:1). Examples of one way information: *the physician told me I would be operated and then I would continue with radiotherapy and then we would start chemotherapy, that if I agreed* (E09:2) *the physician told me that if I agreed they would start chemotherapy* (E08:2) ...*you have to say yes* (E03:2). As mentioned, explanations are inherent to good communication and when it is lacking it becomes a barrier; this means that patients refrain from making the corresponding petition for explanations of which they have a right: *the truth is that no explanations are made, you cannot ask nor can family members, he knows a lot, but* ... (E20:4).

The phrase: *they greet me from outside* (E01:2) denotes the lack of physical contact that hinders communication, for example, when the nurse does not enter the patient's room. This evidences the need for dialogue with another being; however, it seems their presence does not occur; the very patients justify the nurse's absence, alluding to

the multiple activities that remove them from direct care, which is why they do not have time to talk with the patients: *they are always busy* (E19:2). Greeting from outside means establishing a physical barrier in the communication: *they do not enter even to say hello* (E02:2); there is no closeness, there is no time, as if at all hours they were in a rush and had no time to talk to the patient: *nurses are against the clock* (E18:2). With this attitude, they do not realize that communication is an important interaction tool in nursing care: bonds of trust and empathy are created, valuable information is received, doubts are cleared, and feelings are discovered and exchanged, whether it is verbal or nonverbal communication.

With respect to truthfulness, a component of communication, the participants request from the nurse: *to tell patients what they have, not to hide it* (E13:2) *to offer trust and solve doubts* (E11:2) *it is the …capacity to tell patients how they are evolving, explaining adverse effects*… (E05:1). This is how truthfulness is a reciprocal condition of humanized care, given that when patients feel they are being told the truth, they trust what is expressed by the professionals and take it seriously. In contrast, nurses fall into contradictions and incur in errors originated by medical behaviors of secrecy; a nurse expressed it thus: *there are some patients who do not know what they have and approaching them is more difficult, that is why sometimes we say something wrong* (E05:2).

Frequently, the person delivering the cancer diagnosis does not have enough preparation to provide this type of information, clear doubts or provide support in that situation, as shown by the following testimony: …*the patient was stunned, speechless, and as of that moment went into depression; all the patient does is cry and think he is going to die*… (E03:2).

Dehumanization

Dehumanized behaviors refer to physicians and nurses. Indifference and disillusionment were expressed in many ways: *there are nurses who do not like you as a patient, which is why I say we must humanize this some more* (E20:2); *they are not concerned if the patient is in pain or has turned a lot* (E2:2); another form is the reference to indifference and lack of interest… *it is not possible for the nurse not to perceive that human being's necessity* (E18:4); indifference includes negligence from the medical personnel: …*he did not even want to give me the letter to transfer me from the rural zone to the city; rather, he told me I could keep working* (E08:2); *I think he needs to walk in the patient's shoes because, who is suffering, having pain, enduring a disease? The patient* (E05:2). Also, some allude to bad care from the nursing personnel, a situation that has led some to extreme measures: …*gathered signatures from all the people who were present to complain of the bad care*… (E22:2); *they made her go around with the order, she had to fight with the EPS auditors* (E22:2); *the first days Mr. Pablo was green with pain and they wouldn't see him* (E22:2). Another dehumanizing behavior refers to treating adult patients like children, (infant treatment) which takes away the capacity to make decisions and ultimately constitutes a dehumanizing behavior and their diminished autonomy: *they talk softly off to a corner so I can't listen, because they think I don't know* (E04:1); *No, because they decide what they will do to me* (E04:2).

Patients claim, amid the dehumanization they feel, for professionals to be patient with them, to be told the truth, not to hide the truth from them: " …*with patience, because you sometimes do not understand what they tell you and they get upset with you*" (E04:1); *"tell the patients what they have, don´t hide it"*(E13:2).

Isolation and loneliness were identified as brought about by physicians and nurses, whose sole purpose is to try to isolate the patient unnecessarily, without permitting the company of even the closest relative, with the aggravating condition that the personnel also do not accompany the patient. This is seen in the testimonies: *my wife is always here with me, accompanying me, and the doctor…says that nobody should stay…* (E20:2); …*my wife cannot come early, and most of the*

times I am alone (E04:2); *for example, if the doctor... does not come to see me then nobody from the service enters to say hello.* (E20:2); *I would like it if they stayed a while longer to speak with me, given that I feel lonely* (E04:2). We found something that can represent extreme isolation in the sense of not wanting to come close to do the work, as stated by a patient: *doing the work with love, willingly, without repulsion* (E02:7).

Another dehumanizing behavior is the intimidation felt by patients: *if you express what you feel you could be cared for badly or with anger, it is best to stay quiet.* (E02:2); *I was being cared for in a bad way* (E02:1). Thus, patients feel intimidated by the nursing personnel if they complain about something that is not done right or with which they do not agree, then the best thing is to keep quiet, as explained by the participants: *if you express what you feel they could care for you badly or with anger*... (E02:3); at this moment, Jose stopped the interview to request that we leave out what was saying because he feared that he would be taken care in a bad way if they realized what he was doing (DC: 27 July 2009: E01:1).

Discrimination is also conceived as a form of dehumanized care: *I have prepaid medical insurance and my care has been excellent and fast, but it makes me sad to see people who have to wait so long for their treatment, but that is not the institution's fault* (E09:3). Interaction is one of the bases of professional humanized care, both from the point of view of nursing theories and from the testimonies received. Patients feel there is no contact, no time for interaction, no trust in nurses: *that situation of trust is no longer created, the nurse is no longer the person who has been in contact* (E18:4); *today, they have no time to interact with that human being* (E18:3); *that dehumanized us, the little time to integrate with the human being* (E18:4). These are evidence of the necessity for humanizing care.

Regarding science and technology, these are not innocuous or neutral, they can bring positive effects and, at the same time, bring about negative effects; according to what is expressed by the patients, as science advances, dehumanization also advances: *science and dehumanization advance at the same time* (E18:3); nurses run the risk of diminishing the time for interacting with the human being when working with so much technology: *previously, nurses did not have to operate so many things, so much technology and they could dedicate more time to patients* (E18:3).

Discussion

In this study, although the participating patients completely trusted the professionals in charge of care, they perceived dehumanization in the very institutions and in the actions of physicians and nurses; this becomes acute with the disillusionment and indifference toward pain or toward the personal situations of patients. Poor care is true dehumanization; patients have the need to have their rights respected, even with legal measures. Dehumanization exists when there is no interaction; in the testimonies and in the theory we observe that without interaction care lacks sense; in other words, it is not enough to have an institutional relationship and a nurse-patient relationship, the interaction constitutes a fundamental basis of the humanization of care.

The humanistic view of nursing theorists like Watson[2] is fundamental inasmuch as it changes the view of nursing care in hospital systems. In spite of the ideals regarding aiding, attention, and care, in practice dehumanization is manifested in many and varied forms; one of them is the intellectual and psychological distance in the nurse-patient relationship. Nurses fear or do not know how to face the situation of the patient's personality and dedicate more time to the patient's physical care for which the nurse has been better prepared. Another manifestation of this situation is the lack of indispensable human values for the helping relationship in care like respect, honesty, and responsibility.[9] With respect to the characteristics

of institutional dehumanization reported by the authors, as referred, there is the infant treatment that consists in treating the patients like children and discrimination, which is expressed when excellent and rapid care is practiced in selective manner according to the type of payment and healthcare provider affiliation, which constitutes a perversion made possible by the healthcare insurance system and affiliation.[10] Poblete and Valenzuela[11] show that the institutional instance constructs its own organizational structure and installs procedures and routines; with its internal ideology that favors or hinders processes of change, creates mechanisms and forms of regulating its own conflicts on a system of laws and norms. The same authors explain that hospital institutions are social subsystems that carry out the task of socializing individuals through pre-established guidelines and standards, adapting and integrating them to the system, to have them comply with roles established to maintain social control of the internal system. Nevertheless, according to the same authors, said institutional norms go against the concept according to which humanization presupposes an system of values, that is, a complex system of organization and civilization that respects the autonomy of individuals, diversity of ideas, expression and rescue of subjectivity. Thus, dehumanization can also be increased in care, given that nursing professionals lose freedom, given that they must always be subjected to internal norms of the institution that do not always point to humanization, because the for profit nature of healthcare institutions works against humanized care, with possible practical consequences of distancing from the ideals and the essence of the discipline. A possible explanation could be the pressure under which nurses perform their daily practice, which limits their freedom to act as professionals, according to the criteria with which they were trained to deliver good care, according to dispositions of the healthcare organizations. Thereby, patients perceive dehumanization from the behaviors or expectations the professionals do not satisfy. The behaviors take on various forms, in order of seriousness we found: indifference, disillusionment, infant treatment, isolation, discrimination, intimidation, and the expectations not satisfied by the interaction.

Hospital and Guallart[12] assign to the organization of healthcare institutions the responsibility of dehumanizing, given that they condition performance of professionals solely in terms of efficiency and effectiveness. It is similarly expressed by García and García[13] "the hospital is a dehumanizing structure"; the very culture acquired by healthcare professionals when confronting a great number of patients lead them to fell work overload and lack of motivation at work. Routine also distances them from communication with patients and hinders their capacity to perceive their needs, which are physiological and spiritual, emotional, among others. Technological progress, although of great help for the patient's biological care, can also remove nursing professionals from humanized care. The important demand made by patients on the organization for the latest in technology to help them cure their physical ailments or disease favor dehumanization and leave aside the interaction with the caregivers. Backes, Koerich, and Erdmann[14] state that for humanized care to occur we must consider a hospital environment guided by humane people with all their dimensions; additionally, "humanized care begins when the professional enters the patient's phenomenological field and is capable of detecting, feeling and interacting with the patient, that is, is capable of establishing a relationship of empathy centered on caring for the client and within an environment to perceive the other's experience and how it is being experienced by that other". Virginia Henderson, in her book the nature of nursing illustrated on the erroneous conception nurses have about the real needs of patients.[15]

Now, this research responds positively to the inquiry on the existence of necessities for humanized care specific for cancer patients subjected to chemotherapy. These necessities become visible in these patients who express them as the need for communication, company, affect, and listening, among others. According to our results, the life spheres needing greater

humanization are the affective, social (family), and spiritual. The need for humanization emerged because of its counterpart, in forms of dehumanization from the crucial moment of the news of the diagnosis in which communication with the physician and the nurse fails, given that patients perceive that they are not prepared and the impact of a disease of such magnitude is not foreseen. The ideal of the diagnostic news for the patients is centered on the human quality shown by the person delivering such diagnosis; it has to do with the subtleness with which it is said; that is, there must be preparation that includes form and content, among other aspects. Regarding the implications, the impact of the news affects the individuals in all their spheres; the fact of thinking about cancer is thinking about death.[9]

Given the situation of suffering from a chronic disease of serious connotations like cancer and of diverse degrees of dehumanization by professionals and institutions, patients use psychological mechanisms, spirituality, and the family. In the first place, among the psychological mechanisms there is negation, when alluding to what is real with the contrary; the false illusion that is part of the negation; depression can also be a coping strategy to very serious consequences, like contemplating suicidal thoughts. In the second place, the religious dimension constitutes an important resource in the lives of people who hold on to their beliefs, especially the god that guides their worship; in that god they find support and resignation and negotiate in the sense of promising a change of life style if their health is restored. According to Almeida and Praga,[16] religiosity constitutes a coping strategy and is an important part in the lives of the people, which reassures them insofar as it offers them spiritual comfort in a situation of disease like cancer. Finally, the family constitutes a transcendental support to confront what they are experiencing; with it, patients feel fulfilled and may not need further help. Also, the importance of the family is expressed by González and Constantino[18] as "(…) stipulated in official plans and programs, (…) as part of the integrality of the care provided, seeing the patient not as an isolated being, but as a member of cohabitation spaces both at the macro level, which refers to society, and at the micro level, which is the most immediate link established with the family".

The study also found the need for greater professional help and psychological intervention. Studies show that patients with greater psychological and social support have better quality of life with respect to those without it.[17] In conclusion, the results from this work show that specific needs for humanized care exist, which require implementing action strategies that permit providing care according to the professional's *ethos*, applied specifically to these patients in which their necessities have a higher expression, inasmuch as it is a devastating disease that requires invasive treatment. Said actions are also aimed at improving nursing care and the attention of all patients and in such case, establish the necessary corrections against dehumanizing attitudes.

Heluy de Castro *et al.*[19] call on the necessity to recognize not only the physical dimension, but also the other dimensions of that holistic being who is notoriously affected and who requires professional and institutional intervention.
In this study, communication was identified as the best tool to address the needs of patient care. When such is restricted or does not occur, it makes attention and care to be perceived as dehumanized. Through verbal or non-verbal communication, bonds of trust and empathy are created, valuable information is received, doubts are cleared, and feelings are discovered and exchanged. Communication constitutes the first step to develop bonds of trust with the patient and recognize what the patient feels and thinks, as emphasized by Padilla[20] "it is likely that patients do not express their concerns through verbal communication, until they develop a relationship of trust with the nursing professional, (…). Feelings not openly expressed are also invaluable to identify necessities; non-verbal elements have direct influence upon the listener, their presence can change or modify the final meaning of a given message". When communication is blocked due to lack of time, bad mood, indifference, shouting,

etc., not only is there interference on the speaker/listener's message, removing the possibilities for interaction and identification of necessities for humanized care that should characterize nursing. The need exists to develop bonds of trust with the patient, given that non-verbal communication can transmit more profound feelings than verbal communication, for example, as stated by Cinabal and Arce:[21] "when reaching out to the patient, tears are shed, a gaze of affection or anger is delivered", among others. With respect to communication, nursing theories also emphasize on the interaction; Sieloff *et al.,*[22] describe the individual as "an open system in which dynamic interactions among individuals, groups, and society are produced. Stemming from this idea, nursing is profiled as a process of interaction that includes exchange of information, perceptions, values, and beliefs to establish common objectives". According to the same authors, the healthy or ill person first needs to exchange personal information of all type with the rest and express their feelings and thought to someone they trust for many reasons like: externalizing their doubts, fears, anger; manifesting their joy with events that make them happy.

Veracity is part of communication; professionals must be truthful, such a characteristic guides patients to be aware of the current and changing course of the pathological and therapeutic processes and to have a relationship with the professional. If truthfulness is lacking, the purpose of communication is lost, given that it would be a raw truth or an inappropriate relationship. To this effect, Heluy de Castro *et al*.,[19] considered that "quality nursing care can alleviate the patient's anxiety, upon transmitting clear and sincere information; through effective therapeutic communication, which facilitates their confrontation of the health-disease process with more security and less fear".

According to that suggested by Watson,[23] when delivering humanized nursing care the being is approached in all his/her settings: the personal (mind and body), social and cultural, a "holistic" being as mentioned by Fawcett,[24] and Roy[25] continues: with feelings and emotions that change as the person interacts with his/her surroundings, which can be physical like the hospital, or in which he/she interacts as a person, the familiar or social. Besides, when speaking of the humanization theme we must profile within the care act the values or characteristics of nursing professionals that, like communication, permit interaction with that person being cared for. In this sense Max Neef[26] indicated that the interaction developed by the nursing professional with that person "cared" for, facilitates communication with that person, permits development of empathy, respect, responsibility, and support.

According to the aforementioned, this work accepts the following recommendations to improve nursing care by a Mexican organization:[27] 1) Maintain effective therapeutic communication with patients receiving care, explaining each procedure clearly and using simple language, easy to understand by users and their families; 2) Create an environment of trust with the person being "cared" for, allowing that person to express his/her doubts, feelings, and emotions; 3) Provide rapid and timely care, and in case of the contrary explain clearly the inconveniences of the delay to diminish anxiety for the person; 4) Provide information or education on matters appertaining to nursing required by the patient; 5) Recognize in the person a holistic being (approaching the person in all his/her dimensions – body, mind, and spirit); 6) Provide nursing care aimed at satisfying the basic needs of maintenance and conservation of life; 7) Understand the diverse emotional manifestations expressed by the patient through feelings (suffering, fear, uncertainty, among others); 8) Respect in patients their cultural values, ideologies, and capacity to perceive, think, and decide on their treatment and care; and 9) Develop quality nursing practice based on updated scientific, technical, and ethical knowledge. Application of the aforementioned recommendations should contribute to diminish the indifference, disillusionment, and expectations that do not satisfy the interaction.

Regarding the news, as shown by the results, it is a crucial moment impregnated with emotional

feelings and implicit consequences that deserve professional intervention. Buckman[28] proposes as strategies to deliver news of this nature six stages to follow, which we take up as recommendations: first, prepare the news, including the appropriate environment and language; second, inquire on what the patient knows or suspects; third, know what the patient wishes to know; fourth, provide information and solve doubts the person may have; fifth, be prepared for emotional reactions the patient and the professional may have; and sixth, take care and follow up measures with the patient.

Backes, Koerich, and Erdmann[14] stated that humanization needs a transformation process of the culture in healthcare organizations, which recognizes and values the biopsychosocial and cultural aspects of individuals by promoting actions that integrate human values to scientific values.

As a final conclusion of this study, it may be said that cancer patients receiving chemotherapy are seriously ill individuals, with necessities, requiring humanized care from the healthcare provider personnel. Further research on the theme is recommended, as well as calling on healthcare institutions to favor strategies that permit the development of humanization. In turn, motivating students to enhance it from formation; and nursing professionals to use the conceptual and tools and theories available in the discipline, to strengthen humanized nursing care and to conceive human beings comprehensively and as part of a society.

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