Meneses de Amorim Gomes, Annatália; Rejane Ferreira Moura, Escolástica; Kay Nations, Marilyn;
Costa Feitosa Alves, Maria do Socorro
Etno-avaliação da humanização hospitalar pelo usuário do Sistema Único de Saúde (SUS) e seus
mediadores

Ethnic evaluation of hospital humanization by the users and their mediators*

ETNO-AVALIAÇÃO DA HUMANIZAÇÃO HOSPITALAR PELO USUÁRIO DO SUS E SEUS MEDIADORES

ETNO-EVALUACIÓN DE LA HUMANIZACIÓN HOSPITALARIA POR EL USUARIO DEL SUS Y SUS MEDIADORES

Annatália Meneses de Amorim Gomes[1] **, Escolástica Rejane Ferreira Moura**[2] **, Marilyn Kay Nations**[3] **, Maria do Socorro Costa Feitosa Alves**[4]

ABSTRACT

This study was aimed at evaluating the humanization of hospital care ethnically, as perceived by the hospitalized patients. Data were collected from 13 inpatients from January to July/2005 in a public hospital in Fortaleza, Ceará, Brazil, according to the *patient's circuit*. This analysis yielded the following categories: ethnic evaluation of the hospital structure and dynamics, hospital and professional image, human and technical competence. The subjects used multiple aspects to soften their opinions, unveiling factors named *mediators of the ethnical evaluation*. Such aspects were categorized into: conditions of the interview, socio-economic status, user's personality and religiousness, ironic speech, somber diagnosis and necessities met, and prior hospitalization experiences. The elements revealed by the patients are significant in order to encourage professionals and mediators to mobilize towards humanizing changes, including the user as a social and critical ethnic evaluator.

KEY WORDS

Anthropology, cultural.
Hospitalization.
Humanization of assistance.
Patient satisfaction.

RESUMO

A pesquisa teve por objetivo etno-avaliar a humanização da assistência hospitalar na percepção de usuários hospitalizados. Os dados foram coletados de janeiro a julho de 2005, em hospital público de Fortaleza-CE, por meio do *percurso do paciente*. Participaram 13 usuários hospitalizados. A análise foi realizada pela técnica de análise categorial, originando as categorias: etno-avaliação da estrutura e dinâmica hospitalar, da imagem hospitalar e da competência profissional humana e técnica. Os usuários utilizavam múltiplas facetas para suavizar suas opiniões, sendo desvelados fatores incluídos nessas facetas, denominados *mediadores da etno-avaliação*, e os categorizaram em: condições da entrevista, condição socioeconômica, personalidade e religiosidade do usuário, discurso irônico, diagnóstico sombrio e necessidades atendidas e experiência anterior de hospitalização. Elementos revelados pelos pacientes são significativos para mobilizar profissionais e gestores com vistas a mudanças que promovam a humanização e incluam o usuário como etno-avaliador crítico social.

DESCRITORES

Antropologia cultural.
Hospitalização.
Humanização da assistência.
Satisfação do paciente.

RESUMEN

La investigación tuvo por objetivo etno-evaluar la humanización de la asistencia hospitalaria según la percepción de los usuarios hospitalizados. Los datos fueron recolectados de enero a julio del 2005, en un hospital público de Fortaleza-CE, a través de la *opinión del paciente*. Participaron 13 usuarios hospitalizados. El análisis fue realizado por análisis de categorías: etno-evaluación de la estructura y dinámica hospitalaria, la imagen hospitalaria y la competencia profesional humana y técnica. Los usuarios utilizaron varias formas para suavizar sus opiniones, siendo mostrados factores denominados *mediadores de la etno-evaluación* catalogados como: condiciones de la entrevistas, condición socio-económica, personalidad y religiosidad del usuario, narración irónica, diagnóstico sombrío y necesidades atendidas y experiencia anterior a la hospitalización. Aspectos mencionados por los pacientes son significativos para movilizar profesionales y gestores para cambios que promuevan la humanización e incluyan al usuario como etno-evaluador crítico social.

DESCRIPTORES

Antropología cultural.
Hospitalización.
Humanización de la atención.
Satisfacción del paciente.

INTRODUCTION

In the 1960s, healthcare services incorporated quality management references that had been used in industrial fields so far[1]. In the 1970s, the first evaluation studies about the quality of health care were made, focusing on user satisfaction. From the 1980s onward, the amount of complaints and lawsuits related to healthcare services has increased, as well as demands to recover and acknowledge the unit of the user[2]. It was necessary to humanize the services, which emerged from the users' dissatisfaction, and made the Ministry of Health – *Ministério da Saúde (MS)* – to elaborate the National Humanization Policy – *Política Nacional de Humanização (PNH)*[3]. In spite of several initiatives aimed at improving the humanization of healthcare services, such as the reorientation of the user-based healthcare model, the increase of quality programs and accreditation systems, the creation of the PNH, the establishment of consumer services, there are still obstacles for humanized healthcare.

In recent years, studies have evaluated hospital services according to the users' perspectives with a predominantly quantitative focus, which creates a gap according to humanization[4]. The senses, meanings and experiences of hospitalized users are not commonly evaluated, even when it is indispensable to apprehend their subjectivity, since they aggregate the spheres of experiences and emotions. These cannot be quantified, because they express singularities[5].

Humanization has a polysemic concept, because its interpretative possibilities vary from the common sense of being good to a person who suffers to essentialist readings to a revisited humanism, open to the singularity of each human experience, its needs and rooted in ethics at the same time[6]. Therefore, this study was proposed to comprehend humanization in the common sense perspective, by discussing the cultural bases, the expectations of users and their representations. In this context, Anthropology inserts the importance of the social subjective in the qualitative evaluation, offering instruments for its apprehension and highlighting ethnic evaluation. Such a method enables the in-depth apprehension of the meanings perceived by the hospitalized users about humanization.

As such, this article was elaborated to evaluate the humanization of hospital services ethnically, according to the perception of hospitalized patients.

> Humanization has a polysemic concept, because its interpretative possibilities vary from the common sense of being good to a person who suffers to essentialist readings to a revisited humanism, open to the singularity of each human experience, its needs and rooted in ethics at the same time.

METHOD

This is a qualitative research based on ethnic evaluation. The dimension of the meanings, aspirations, attitudes, beliefs and values express the common language in everyday life, which is the object of the qualitative approach[7]. *Ethnic* corresponds to the culture, symbols and senses of individuals or groups. Ethnography allows one to access the world and knowledge of the other. Therefore, using it in this study permitted unveiling cultural senses and meanings of the participants about hospital humanization[8].

Data collection happened from January through June 2005, at a tertiary general public hospital in Fortaleza – CE. This institution serves education, research and healthcare purposes and is a referral in Obstetrics statewide, having 276 beds distributed among 29 medical specialties.

Thirteen inpatients participated in the study, selected according to the criteria: The first person in line at the hospital reception, being mindful not to repeat the reason for hospitalization in order to broaden the diversity of cases and sectors of internment. When this occurred, the next patient in line was approached. Patients with mental disorders or under 16 years old were excluded, by recommendation of the Review Board.

A combination of techniques (free observation, participant observation and ethnographic interview) was created to apprehend the hospitalization experience, and named *patient's circuit*[9]. Free observation was performed in the first three months and the significant elements were registered in a field diary. The 13 selected inpatients were monitored from admission to discharge, furthering the contact and comprehension about hospitalization, based on participant observation and in-depth ethnographic interviews, which helped in the free description of the events. The monitoring time with the patients varied from seven hours to 60 days. The shortest period (seven hours) was the case of a patient submitted to uterine biopsy. Circuits lasting less than seven days were those of patients with the following conditions: normal childbirth (two days), vaginal aesthetic surgery (three days), extraction of a node from the patient's foot (three days); thyroidotomy (five days). One patient with arthralgia was monitored for 10 days; A high-risk delivery at *Casa da Gestante* (an annex of the hospital, which houses high risk pregnant women living in areas where access to high-complexity services is difficult) (12 days) and one bariatric surgery (14 days). For more than one month, a patient with cutaneous leishmaniosis was monitored (30 days), the mother of a preterm baby in the Kangaroo Mother project (39 days), and a patient hospitalized for pulmonary biopsy (45 days). One patient undergoing hysterectomy was monitored for two months.

The ethnographic interviews were mixed with the users' free narratives about the hospitalization, oriented by the following guiding questions: *Tell me about your hospital stay; Describe what it was like to be hospitalized; De-*

Ethnic evaluation of hospital humanization
by the users and their mediators
Gomes AMA, Moura ERF, Nations MK, Alves MSCF

Rev Esc Enferm USP
2008; 42(4):633-41
www.ee.usp.br/reeusp/

635

scribe the memorable events; *From your admission until this moment, what would you like to highlight? What else would you like to say about your hospital stay?* The interviews were recorded and happened at the infirmary or nearby areas, according to the environment and the physical conditions of the users, and also at their homes. These were transcribed integrally by sponsored students and validated by the researchers. Meetings with each patient occurred until their statements were saturated, i.e. until the point when the interview stopped registering new facts, ideas and thoughts[10].

The interviews were held at the nursing wards, which had up to six beds, some with air-conditioning and good physical conditions, while others had poor ventilation and lighting. Part of the interviews happened in places near the wards (such as hallways or gardens), always respecting the availability and privacy of the respondents. On two occasions, the interviews were held at the respondents' homes. This happened because their hospital discharge had not been previously informed to the researchers. Placing microphones near the patient's mouth made it easier for them to maintain privacy and guaranteed good recording quality.

The data were organized according to the content category analysis[11]. Pre-analysis involved floating readings, aiming to group the information clusters; next, the exploration of the material by repeatedly reading the transcriptions, allowing for the identification of meanings and defining data groupings in categories. Two hundred twenty-five units of meaning emerged, grouped into: ethnic evaluation of the hospital structure and dynamics; ethnic evaluation of the hospital image; and ethnic evaluation of the human and technical professional competence.

The users were perceived to use several aspects to soften their opinions and criticism about hospitalization when the cognitive process used to evaluate the service was explored. Cognitive process is the execution of structural functions of the representation (idea or image conceived about the world or something), linked to knowledge about a given object[12]. In this process, the testimonies were re-read, aiming to unveil the factors included in those aspects, named *mediators of the ethnic evaluation*[9]. These aspects were categorized into: conditions of the interview, socio-economic status, user's personality and religiousness, ironic discourse, somber diagnosis and necessities met, and prior hospitalization experiences. Finally, the data were processed and interpreted. The testimonies presented in the text are followed by pseudonyms in order to preserve the participants' identity, followed by age and type of pathology or procedure.

The study followed the recommendations of the National Health Council Resolution 196/96, which deals with research involving human beings[13]. Each participant signed the term of consent after the explanation of the research objectives. The research project was submitted and approved by the Review Board of Hospital Geral de Fortaleza, register #111106-04.

RESULTS AND DISCUSSION

Four patients in this study were male and nine were female. Age varied between 16 and 93 years. As for education, six respondents were illiterate or had not completed basic education; one had finished elementary school, and six were either studying at or concluded high school. Two participants lived in the countryside of the state of Ceará, and the others in the outskirts of Fortaleza. All participants mentioned a low-income economic situation. Ten participants were hospitalized for the first time, and three for the second time, at the study hospital.

Ethnic evaluation of the hospital structure and dynamics

Some of the wards were considered uncomfortable because of the heat and internal noise caused by the renovations underway at the hospital, added to the external noise of traffic. The long distance between the ward and the nurses' station (the place where patients' registries and care are coordinated), the number of beds that was higher than the physical capacity of the wards and bathrooms that were inadequate for obese users marked the physical scenario of the hospital as *inhuman*. Improvisations and lack of internal signage caused geographic disorientation for users and family members. Hospitalized patients were kept in the hallways due to lack of beds. A high-risk pregnant woman remained on a stretcher inside a bathroom, waiting for delivery. She said:

> There were people who went there to use it [referring to the bathroom]. Almost nobody listened to me. Later I was taken to the suffering room [mentioning the pre-delivery room] and then to a deactivated delivery room, without lighting. I shrank. (Emilia, 21 years old, high-risk pregnant woman).

Broken materials and equipment postponed procedures. Some beds were not able to lift the patients' upper or lower limbs, making it difficult to change position and feel comfortable. Some of the mattresses were worn out, and the lining was plastic, a warm material.

Precarious infrastructure was perceived as *luck* or *bad luck* by some users:

> I had a bit of bad luck, the devices were broken and they [referring to the physicians] don't know when it'll be fixed" (Mario, 42, bariatric surgery).

This condition caused anxiety in patients awaiting surgery, and those who could afford private services would require them so as to speed up the surgical procedures. The users believed that there were *thousands and thousands of worse services*. One professional, who *treated them well* when they had access to the exam or care, attributed it to *luck*, like in a *lottery*.

The use of computers in the scheduling and examination areas did not significantly contribute to reduce the wait, and made it impossible to re-schedule appointments on

the same day, causing emotional distress, financial expenses with transportation and lethargy in clinical monitoring, according to Mario and Julia:

> If you come in early and the doctor doesn't show up, you have to wait 12 or 13 hours to reschedule the appointment or come back the next day. It's not that the lady [referring to the employee in charge of scheduling] doesn't want to do it, it's the system that won't accept it. It doesn't work, they couldn't do it (Mario, 42, bariatric surgery)

> Every time I came here the computer was jinxed, that's why my pre-natal card has so few scheduled appointments. (Julia, 16, normal delivery pregnant woman).

The introduction of computerized information technology impairs the quality of the healthcare professional-user relation, emphasizing the professional-machine relation over information and conversation among people, which corroborates the results of the present study[14].

The wait at the reception was long and the users remained uncertain about receiving care, because there was no satisfactory communication from the employees. Bureaucracy was excessive and information was scarce, even for users who followed the protocol to undergo surgery:

> It was chaotic, a hassle, I waited there from 11 AM to 7 PM and was not told that I'd need a blood donor. I could have lost the chance to be admitted and a day of rest at work (Silvana, 22, aesthetic vaginal surgery).

The wait for exams and their results was also morose. The wait for a heart exam ranged from one to two years, and 20 to 30 days for result delivery, making healthcare *very difficult* and the public system a *rather weak healthcare network*. Even when scheduled, the exam was not guaranteed, which made the patients tense. Some users thought about giving up due to the access difficulties, and others sought options to overcome this obstacle, having external exams or seeking help from *acquaintances* with influence at the hospital. This accessibility problem was analyzed by the users because of lack of criteria for the organization of lines and privileges for the employees' *friends*. The patients who complained about this action, however, also used the same resources to circumvent hospital care impediments. Due to the inexistence of criteria for risk evaluation at the emergency room, the users decided the priority of care among themselves, based on human solidarity (Field journal). These data corroborate a study about the governance of the Single Health System – *Sistema Único de Saúde – SUS* in Brazil, performed in six states, including Ceará, and 17 cities chosen among these six states, revealing that "most units have serious difficulties to maintain facilities and equipment, with unfavorable repercussions for the quality and efficiency of healthcare. The facilities are usually in bad condition[15].

The employees did not comply with the work hours for outpatient care, which increased waiting times. About this fact, most users expressed it as *part of life* since, as there were no other options, they accepted it, conformed. Two users, however, were angry about the lack of beds, entering the hospital dependencies to verify if it was true (Field journal).

Patients who did not belong to the city manager's political party had their transportation to Fortaleza denied. This situation goes against the principles of the SUS, as care and access conditions are hampered by interests and difficulties that jeopardize patients' rights[16]. Compliance with the legal procedures that guarantee access and integrality are some of the challenges to be overcome in order to attain humanized healthcare[17].

In order to guarantee the safety of the users' belongings, they were allowed only to bring in objects that were extremely necessary, while the remainder was kept at the safekeeping sector. The users did not always comply with this routine, keeping their personal effects, which required them to be constantly vigilant and often harmed their rest and sleep.

Ethnic evaluation of the hospital image

The hospital was defined as a *threatening place,* attributed to the fear of *getting an itch* – one of the users kept her towel on her own bed so she would not touch the belongings of other patients, becoming infected. Such a threat was also revealed as fear of losing her child:

> I was really afraid of my baby dying without receiving care […] when I knew I'd be coming to Fortaleza – Hail, Mary! (Silvia, 30, puerpera of the Kangaroo Mother Project).

This report depicts the fear of not having access to the service, causing fear and search for support in religion – *Hail, Mary.*

Another image of the hospital was that of a *prison*, confinement, compared to the condition of being a *prisoner.* This metaphor was associated to wearing clothes that were striped and numbered, barred windows and the norms imposed by the hospital. Such a reality corresponds to what is defined as *total institutions*, i.e. residences or workplaces where people are segregated from society, remaining inside, isolated and formally managed[18]. The control of human necessities happens through organization, which was observed as the patients being forbidden to leave the hospital, keeping them away from daily life in the outer world and causing ruptures in family and social bonds.

One of the users at *Casa da gestante* reported that, when dressed with one of the hospital's striped uniforms while being *taken* to have an examination in another healthcare unit by a nurse, she *awed* people, who compared her to an inmate under police vigilance. The standardized clothes in pink hues were labeled *Barbie clothes*, and those in yellow hues were compared to *street sweepers'* uniforms, as a way of reproaching the hospital routine, which imposes models and ruptures with the patients' individuality. These symbols confirmed the idea that the users evaluate hospital-

Ethnic evaluation of hospital humanization
by the users and their mediators
Gomes AMA, Moura ERF, Nations MK, Alves MSCF

Rev Esc Enferm USP
2008; 42(4):633-41
www.ee.usp.br/reeusp/

637

ization ethnically, based on socio-cultural factors, values, psychological states, gender, expectations and civil awareness[6].

The presence of a hawk (a bird of prey) in the *pracinha* (an internal area of the hospital that allows for sunbathing and contact with a garden) made the puerperae afraid, because the bird

rips the heads of people, it has ripped the head of many (Silvia, 30, puerpera of the Kangaroo Mother Project).

This patient did not enjoy this humanization space with her newborn child, fearful that something worse could happen. This aspect is only revealed when one interacts with the intimacy of hospitalization, creating spaces to get to know its working dynamics. However, the importance of these social spaces is noted, as *territories for encounters*[3].

Ethnic evaluation of the technical and human professional competence

Characterized by attitudes and ways of communicating and informing, human competence was the most highlighted component in ethnic evaluation of hospital humanization. Technical competence was associated with healthcare skills and actions, and was also shown as an important prerequisite for humanized practices.

The narratives predominantly depicted attitudes of indifference, rudeness and negligence, power associated to financial status and individual actions, not focused on teamwork. Others recognized dialogue and commitment in some professionals, especially one of the nurses who prayed with the users and an occupational therapist who promoted artistic activities.

Communication was not favorable, since the patients were not called by their names or looked at with interest, and the language used was incomprehensible to most of them (Field journal). The encounter with alterity, which would allow for dialogue and negotiation of actions, was hindered by the precarious work conditions, multiple shifts and low value conferred to the worker. These factors caused indifference in the professionals, preventing them from establishing full interaction with the patients, based on respect, welcoming, talking and bonding[19].

Norms and routines for bandage changing, scalp changing, medicating and feeding were partially followed. Bathing was demanded at times when the patient did not want to, and the patients could not wear their own clothes. The lack of individuality and the imposition of norms were thus detected, disrespecting the patient's autonomy and decision. By ignoring the unique expressions of the subjects and their culture, hospital organization imposes a mass routine to deliver care to the patients[16]. A study with 23 puerperae living jointly in the south of the country identified representations of fear, submission to institutional routines and the healthcare team, causing a mixed reaction of accommodation and resistance to the impersonal way they are treated[20].

The stretcher bearers carried the patients awkwardly, with excessive strength, *carelessly*, expressed in the hesitation of a user:

Today I felt unprotected, even though I was being carried by such strong men, who could have been a bit more considerate (Eva, 50, submitted to total hysterectomy).

Narratives of the users, in the different moments of the circuit, exhibited levels of satisfaction that were excellent *(Five stars, 100%, VIP, There's nothing missing)*, good (*beautiful, cool, nice*) and bad (*very poor, it's a cad, Hail, Mary!, For charity!),* showing that the subjects formulate their own personal way of evaluating and categorizing hospitalization.

Mediators of ethnic evaluation

Conditions of the interview

The presence of healthcare professionals, at certain moments of the interviews, blocked the users' discourse, who stuttered, shifted in bed, looked away or even stopped talking. In these circumstances, the recorder was turned off, while the interviewee manifested signs, requesting pauses or changing topics. Later, the focus of the interview was retrieved.

Placing the microphone near the user's mouth allowed for adequate voice recording, which allowed the interview to go on at a low voice volume, respecting the privacy of the respondent who did not feel embarrassed in the presence of other patients at the ward, with the conversation flowing normally. This context did not alter the testimonies of the participants, even though the space was shared with other people.

The use of the ethnographic interview with guiding questions encouraging the subject to speak freely, the contact with experienced feelings and critical thoughts, welcoming their narrative and monitoring them in the *patient's circuit*[9], promoted the expression of reserved ideas and thoughts. The guiding questions were repeated at different moments of the interview, which led to answers that had not been given before. Although careful, the researchers were not exempt of the substance permeating the *between us*, characterized by intersubjectivity and interpretations, which sometimes brought them closer, and other times distanced them from the moral world of the users.

Socio-economic condition, personality and religiousness of the study subjects

The respective conditions arbitrate the critical positioning of the users in the face of reality, since they classify the public healthcare service as their only option. Therefore, at times, *any type of care is better than no care.* This reasoning was brought to the researchers' attention by a pregnant woman, when stating her opinion about the silence of the women in view of the long wait at obstetric nursing:

638   **Rev Esc Enferm USP**
          2008; 42(4):633-41
          www.ee.usp.br/reeusp/

Ethnic evaluation of hospital humanization
by the users and their mediators
Gomes AMA, Moura ERF, Nations MK, Alves MSCF

in public hospitals there are more poor people, the person has no education, and then they think that speaking out [referring to claiming their rights] is wrong (Amélia, 25, pregnant woman with preeclampsia).

This behavior is strengthened in function of the unpredictability of the professional's response, from whom the patient *could receive aggressive words*, or the fear of being harmed:

sometimes you complain about something, the guy does not think he's doing it wrong and can even cause us damage (Mano, 93, patient with cutaneous leishmaniosis).

This fear was also identified by the diminutive terms: *that little sequence number, little problem, little spice*, among others. Interrupted statements were also present, as well as body expressions like fidgeting fingers and feet, in a demonstration of *fear* of talking about something that would go against the image of the hospital.

For some of the respondents, not complaining is part of the personality of the individuals, of how they stand in the face of daily life. The *I'm a conformist* type was identified; the one who *does not get distressed*, when they stated that such attitudes were harmful, showing patience out of prudence; the type who *does not like to complain or be complained about;* and the one who *does not complain about himself.* One of the users, even considering himself passive, exclaimed:

I know we have the right to complain! (Mano, 93, patient with cutaneous leishmaniosis).

In other situations, the attitudes observed were of accommodation in the face of the difficulties by comparing them to worse situations, despite the denial of the rights of the hospitalized users:

It's like this everywhere… there are thousands and thousands that are worse (Maria, 55, gynecological patient).

One of the users attributes her personal perseverance to the satisfaction with the treatment when fighting for her health:

As for the hospital, it was very good and I'm satisfied for myself, because I really looked for it. Wow, I had bad service at first, but I went on […] One of the doctors said it was a pre-cancer, and then I received better care (Eva, 50, submitted to total hysterectomy).

Although most users had passively manifested themselves about the aforementioned factors, anger and indignation were also revealed. These feelings were contained by the need for care and institutional power. Being immersed in this hospital universe for seven months permitted the observation of four episodes when users took active stances. Each piece of criticism, however, was softened with excuses:

Then, I don't know if that was because I needed it, or if it really had to be like that, I don't understand anesthesia,

since it was spinal, he had to pierce it three times (Solange, 43, hospitalized for thyroidoctomy)

[...] but that was not a problem for me, really [referring to a shameful situation]. I think I wouldn't even mention it, I'm saying it because you [the researcher] need to know (Edna, 50, submitted to total hysterectomy)

Religiousness also mediated ethnic evaluation, since the recovery of health and length of the surgery, for example, were mostly attributed to divine will, and cure was granted by the power of God, manifested through the physicians. One patient manifested the idea that she was *hospitalized in the heart of Our Lady* (Eva, 50, submitted to total hysterectomy). Another patient stated:

We feel satisfied when the doctor says the exams are all right; we have faith in the power of God, because He is the one who heals. (Mano, 93, patient with cutaneous leishmaniosis).

Culture needs to be understood, not only based on the uniqueness of people, but also on influences individuals inherit in society, which are reflected in how they see the world, judge and relate with others in their midst[21]. A *Guiding beacon in the perspective of humanization* is care in conformity with users' necessities, demands and expectations, contextualized in their social and cultural world, and this implies including the user's perspective in the evaluation of the services[5].

Ironic discourse

Ironic discourse can be used in either subtle or explicit ways. The user criticizes the situations and people through the duplicity of ironic statements[22]. The testimonies presented below illustrate this type of mediation, where *yes* means *no* and vice-versa:

I'll invite mr. Lucio [referring to the State Governor at the time] to come here and see the apartment. The small bed is very beautiful, it's cutting-edge. A little bed, beautifully narrow, people weigh almost two hundred kilos, they have to lie down here [*beautiful* actually means *ugly*].

Blessed obesity [dissatisfaction with obesity]

And the greatest thing is that they lost my HIV exam [*greatest* meaning his anger about the loss of the exam] (Mario, 42, bariatric surgery patient).

On another occasion, a user received care that displeased him, but, when he expressed himself to the professional, he showed opposite feelings, stating that everything was fine:

I can see that she [referring to an employee] is not doing it because she wants to, but I pretend everything is ok. There are some things we don't like, but we have to accept and like it. I can't even say these things, you know (Mano, 93, patient with cutaneous leishmaniosis).

Although the user was satisfied with the hospitalization at first, he revealed the truth as the trusting bonds between

Ethnic evaluation of hospital humanization
by the users and their mediators
Gomes AMA, Moura ERF, Nations MK, Alves MSCF

Rev Esc Enferm USP
2008; 42(4):633-41
www.ee.usp.br/reeusp/
639

the researchers and users became more solid. These revelations were found between the lines of their discourse, in *unsaid* phrases, in comparisons and criticism about the public healthcare service and the more reserved narratives. Irony, metaphors and speeches with implied criticisms are truly hidden scripts of resistance against the dominant and authoritarian power the user finds at the hospital [22].

Somber diagnosis and necessities met

The concerns of one user with the possibility of a *somber* diagnosis, such as *that cancer disease*, involved him in such a way that the difficulties of the hospitalization became secondary. In these cases, hospitalization was experienced in function of his greater problem, *the big problem,* and other events around it were less importance.

When the baby, so anticipated, was born, she felt better with the treatment, underwent her surgery or exams: with the prediction of discharge, the user tended to *forget* the negative moments of the *patient's circuit*[9]:

> At the time I felt angry, but it was over later. It's like the doctor said – when you're outside, you wait, wait, but when you're in, you take a little shower, get calmer and it passes. Really, after I was in, they had already operated me, that's it! (Silvana, 21, vaginal aesthetic surgery).

> Each moment was memorable and will be registered in my memory. We'll never forget it. Surely, today I'm feeling happy, everything is wonderful, a wonderful hospital, because I'm leaving today, right? (Amelia, 25, patient with preeclampsia).

Therefore, what was *bad* becomes *good*, even if *inhuman* situations are experienced in the *patient's circuit*[9]. The evaluation of user satisfaction, based only on the quantitative logic of evaluation, will not notice the mentioned elements, detecting an unreal satisfaction. The social relations in the hospital environment are complex, conflicting and cover multiple and contradictory interests. Therefore, to understand the hospitalized patients' meanings, it is necessary to understand this specific micro-reality associated to macro-structural issues[23].

Previous hospitalization experience

This condition offered comparative elements for the judgments of patients. Some users, even if not referring to previous hospitalizations, expressed their experiences as outpatients as a parameter for comparison. Thus, whether the service was public or private, or whether the user had been hospitalized before, there were aspects that could go unnoticed, or situations and impositions that could be accepted for not knowing a similar reality.

The long hospital stay was a mediator because, while the users adapted to the environment, their complaints about the routines or their intention to return to their families or work also increased. The users were shown to be multi-faceted, with multiple histories and experiences that modulate and imply their understanding of hospitalization. This cultural plurality and diversity needs to be considered in the relation with these subjects, along with what one intends to know about their meanings and senses for hospital humanization, in order to retrieve their autonomy and make them the core of human healthcare[5].

FINAL CONSIDERATIONS

This research allowed us to perceive the many perspectives of the study subjects with the ethnic evaluation of hospital humanization, i.e. the humanization was shown to be related to the hospital structure and dynamics, its image and technical and human professional competence. Hence, a myriad of human experiences surfaced, manifested in the multiplicity of meanings and senses for each interviewee, resulting in heterogeneity, complexity, diversity and cultural differences.

Another aspect worth of note were the mediators of the ethnic evaluation, identified as elements capable of modifying the subjects' opinions, such as: the conditions the interviews were held in, socio-economic conditions, personality and religiousness of the interviewees; ironic discourse; somber diagnosis and necessities met; and previous hospitalization experiences.

In this context, the idea that the users lack the necessary competence to evaluate humanization was denied. Knowledge and evaluation logic belong to different domains, which makes the users' accumulated experience to grant them the capacity of establishing their evaluation indicators, as seen in the several dimensions that they noted in their ethnic evaluations.

It is concluded that the elements reviewed by the interviewees are significant to mobilize professionals and managers towards transformations that can humanize hospitalization and include the user as a socially critical ethnic evaluator.

The study presented no limiting factor. The continuous interaction between the researcher and the participants, from their arrival until their discharge (the *patient's circuit*) improved the subjects' trust, providing the necessary range for the proposed goal and showing a density of contents that were diverse and rich in interpretations.

Future studies are suggested in the perspective of the ethnic hospital evaluation in other healthcare services, with the purpose of understanding each reality and listening to the users in several environments, so as to really deliver humanized care.

640 **Rev Esc Enferm USP**
2008; 42(4):633-41
www.ee.usp.br/reeusp/

Ethnic evaluation of hospital humanization
by the users and their mediators
Gomes AMA, Moura ERF, Nations MK, Alves MSCF

REFERENCES

1. Deming WE. Qualidade: a revolução da administração. Rio de Janeiro: Marques Saraiva; 1990.

2. Serapioni M. Avaliação da qualidade em saúde: a contribuição da sociologia da saúde para a superação da polarização entre a visão dos usuários e a perspectiva dos profissionais. Saúde Debate. 1999;23(53):81-92.

3. Brasil. Ministério da Saúde. Secretaria Executiva. HUMANIZA-SUS: Política Nacional de Humanização. Documento base. Brasília; 2006.

4. Esperidião MA, Bomfim LA. Avaliação de satisfação de usuários: considerações teórico-conceituais. Cad Saúde Pública. 2006;22(6):1267-76.

5. Santos-Filho SB. Perspectivas de avaliação na política nacional de humanização em saúde: aspectos conceituais e metodológicos. Ciênc Saúde Coletiva. 2007;12(4):999-1010.

6. Deslandes SF. O projeto ético-político da humanização: conceitos, métodos e identidade. Interface Comun Saúde Educ. 2005;9(17):401- 3.

7. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 7ª ed. São Paulo: Hucitec; 2000.

8. Spradley JP. The ethnographic interview. New York: Holt, Rinehart and Winston; 1979.

9. Nations MK, Gomes AMA. Cuidado, *cavalo batizado* e crítica da conduta profissional pelo paciente-cidadão hospitalizado no Nordeste brasileiro. Cad Saúde Pública. 2007;23(9):2103-12.

10. Gaskell G. Entrevistas individuais e grupais. In: Bauer MW, Gaskell G, editores. Pesquisa qualitativa com texto, imagem e som: um manual prático. Petrópolis: Vozes; 2002. p. 64-89.

11. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 1977.

12. Nóbrega SM. Sobre a teoria das representações sociais. In: Moreira ASP, Jesvino JC, organizadores. Representações sociais: teoria e prática. João Pessoa: Ed. Universitária/UFPB; 2003. p. 51-80.

13. Conselho Nacional de Saúde. Resolução n. 196, de 10 de outubro de 1996. Dispõe sobre diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Bioética. 1996;4(2 Supl):15-25

14. Maciel-Lima SM. Acolhimento solidário ou atropelamento? A qualidade na relação profissional de saúde e paciente face à tecnologia informacional. Cad Saúde Pública. 2004;20 (2): 502-11.

15. Banco Mundial. Governança no Sistema Único de Saúde (SUS) no Brasil: melhorando a qualidade do gasto público e gestão de recursos. Relatório nº 36601-BR. Brasília; 2007.

16. Brasil. Ministério da Saúde. Carta dos Direitos dos Usuários da Saúde. Brasília; 2006.

17. Vecina Neto G, Malik AM. Tendências na assistência hospitalar. Ciênc Saúde Coletiva. 2007;12(4):825-39.

18. Goffman E. Manicômios, prisões e conventos. São Paulo: Perspectiva; 2003.

19. Backes DS, Lunardi Filho WD, Lunardi VL. O processo de humanização do ambiente hospitalar centrado no trabalhador. Rev Esc Enferm USP. 2006;40(2):221-7.

20. Soares AVN, Silva IA. Representações de puérperas sobre o sistema alojamento conjunto: do abandono ao acolhimento. Rev Esc Enferm USP. 2003;37(2):72-80.

21. Budó MLD, Nicolini D, Resta DG, Buttenbender E, Pippi MC, Ressel LB. A cultura permeando os sentimentos e reações frente à dor. Rev Esc Enferm USP. 2007;41(1):36-43.

22. Hutcheon L. Teoria e política da ironia. Belo Horizonte: UFMG; 2000.

23. Bosi MLM, Affonso KC. Direito à saúde e participação popular: confrontando as perspectivas de profissionais e usuários da rede pública de serviços de saúde. In: Bosi MLM, Mercado-Martínez FJ, organizadores. Pesquisa qualitativa de serviços de saúde. Petrópolis: Vozes; 2004. p. 451-79.

Correspondence addressed to: Escolástica Rejane Ferreira Moura
Av. Filomeno Gomes, 80 - Ap. 401 - Jacarecanga
CEP 60010-280 - Fortaleza, CE, Brazil