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Humanization in Undergraduate Medical Education: The Brazilian Learner's Perspective

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***Keywords*— Humanization, Medical Humanities, Student, Medical Education.**

***Abstract*— The production of humanized health should consider the individual as a whole, taking into account their particularities and perspectives, in order to promote care with ethical, humanistic and clinical quality. The objective of this study is to evaluate, from the perspective of medical students, their perceptions and knowledge regarding humanistic training during medical school. This is a quantitative and qualitative exploratory research in the strict methodological sense of keeping the focus, the object of study, which was made with the students of the Medicine course from the second to the tenth periods of UNIFAMAZ, enrolled in the first semester of 2019. As an instrument of data collection, the structured questionnaire was used, and data obtained transcribed into LibreOffice®, elaborating the corpus for data processing. IRAMUTEQ was used for processing the text corpus. Regarding the absolute frequency of the words within the text corpus, evidence was obtained of the main terms: Patient (frequency of 86), doctor (frequency of 70), care (frequency of 44), empathy (frequency of 48), professional (frequency of 34), important(*

frequency of 35), human (frequency of 33), humanized (frequency of 25), relationship (frequency of 17), physical (frequency of 17), health (frequency of 25), treat (frequency of 15), treatment (frequency of 12), In most of the questionnaires these words considered high frequency, were exposed by the students, correlated with the true meaning for him of a good humanized care. In short, the insertion of the teaching of humanized medicine in the undergraduate course exerts on the student and future professional a reflective, motivational and conductive power about the subsequent medical practices.

I. INTRODUCTION

Humanization is a process that can occur in several areas, however, here the focus will be on health sciences, specifically in the formation and performance of the physician. The term "humanization" is widely discussed in health services and refers to several concepts, historical origins, and even different lines of thought, which allows for several interpretations about it. According to Barros and Passos (2018), for the dictionary of professional education in health: Humanization, in the field of public health policies, refers to the transformation of models of care and management in health services and systems, indicating the necessary construction of new relationships between users and workers and among them.

Humanization in health care is focused mainly on the production of health, observing the subject as a whole, in order to assist him in a very personal way, contemplating not only the disease as a causal factor, but its entire history, with the purpose not only investigative, but in order to promote the desired health, offering the patient or user a service with ethical, humanistic and at the same time, technical quality (BARROS; PASSOS, 2018).

There are many obstacles to the implementation of humanized health care in Brazil. Among them, the precarious conditions of care that both the professional and the patient are exposed to, the lack of material in health units, as well as the long working hours that professionals are subjected to, which makes their work increasingly exhausting, make this process even more difficult. The lack of humanity can be seen from the moment the patient tries to make an appointment, as well as in the long lines that form on the day of the service.

When humanization occurs, it creates better conditions for those who perform health care functions and also for the people who seek care. Observing this, in 2003, the Ministry of Health launched the National Humanization Policy (PNH), with the goal of seeking to put into practice the principles of the Unified Health System (SUS) in the daily lives of health services, producing effects on the ways of serving and caring for people (BRASIL, 2014, p. 10).

The NHP acts by facilitating and stimulating the relationship between managers, workers, and users, decentralizing the hierarchization of competencies with the purpose of inhibiting inhumane activities and practices that may compromise health service users. One of its highlights is the incessant work to combat any kind of violence generated by mistreatment, whether physical or psychological.

Currently, in Brazil, the training of medical students is determined by the National Curriculum Guidelines of the Ministry of Education (BRASIL, 2014, p. 10) and medical schools have introduced in their Pedagogical Projects integrating axes, among them the Medical Humanities, articulated to clinical practice. In the National Curriculum Guidelines for the Undergraduate Course in Medicine (DCNM), it is precisely stated in art. 3 that the physician upon graduation should have the following profile:

> The Medicine graduate will have general, humanistic, critical, reflective and ethical training, with the ability to act at different levels of health care, with actions to promote, prevent, recover and rehabilitate health, at individual and collective levels, with social responsibility and commitment to the defense of citizenship, human dignity, integral health of the human being and having as transversality in its practice, always, the social determination of the health and disease process (BRASIL, 2014, p. 11).

One realizes that in order to transform health, it is necessary to make changes in the construction process of the subjects of these practices. This will only be possible through the necessary qualification of professionals who

become protagonists of this history. The Centro Universitário da Amazônia (UNIFAMAZ), has inserted in its Pedagogical Project of the Medicine Course (PPCM) in its curricular matrix, since its implementation, among others, the axis Medical Humanities, with the objective of forming doctors with a humanistic view and prepared to act in the job market. This axis contemplates a:

> It will be developed by modules organized in themes in the areas of humanities, human rights, cultural diversity, ethics, bioethics, social aspects of health problems, communication of bad news, patient safety, and other themes focusing on respect for the human being and related to the formation of doctors in an interdisciplinary approach, sustained in a process of knowledge construction using active methodologies. The modules take place from the 1st to the 4th period. It is an axis that articulates with the modules of the IESCG, HC, and in the periods. Each module has 02 weekly hours, totaling 40 hours in the period, with relevant themes for the humanistic formation of the medical professional. The definition of the contents is done through meetings and workshops, where the teachers prepare the planning for the period. From there, the objectives of the unit are outlined (BRASIL, 2014, p. 11).

It is necessary to train health professionals for society to act as facilitators of the healing process, ensuring not only the satisfaction of the patient who seeks relief, but above all to see him as a human being.

II. JUSTIFICATION

The humanization of medicine is a very popular subject nowadays; today we seek a medicine based on the person and not only on the disease. Physician Gregorio Marañón was one of the main defenders and systematizers of the so-called *personalist medicine* (1887-1960). He listed the humanities as one of the *five sources of medical knowledge* and classified it as essential for a medicine centered on the person, presenting itself as a facilitator for the physician to enter the patient's personal dimension.

Considering and valuing the findings of science is essential to medicine; however, never before has so much been said about the need to humanize medicine and medical education, but there is still a lack of knowledge about what humanism is and what *humanizing medicine means.*

The implementation of the curricular guidelines for training aims to contribute to the innovation and quality of the pedagogical project, and should guide the curriculum of the Medicine Undergraduate Course towards an academic and professional profile of the graduates consistent with the country's health policies.

In the area of medical training, it is observed that this is a theme that still needs to be scientifically explored. Considering that the institution UNIFAMAZ, presents as a proposal an innovative curriculum, integrative, interdisciplinary with the use of active methodologies and includes in its curriculum an axis of medical humanities. And in its guiding principles, objectives and graduate profile the integrality and humanization of care as a differential in medical training, it is necessary to evaluate from the perspective of the actors to be trained their perceptions of the relevance and effectiveness.

Thus, the scientific relevance of this study theme is justified by the possible contribution to the Higher Education Institution (HEI) in humanistic education in the undergraduate medical course, with special attention to the students' point of view.

III. OBJECTIVES

3.1 GENERAL OBJECTIVE

To evaluate, from the perspective of medical students, their perceptions and knowledge regarding humanistic training during medical school.

3.1 SPECIFIC OBJECTIVES

To interpret how the student considers the relevance of the Medical Humanities axis in the physician's education.

To analyze the degree of knowledge of the students about the humanistic formation of the physician

To identify, from the students' point of view, the importance of humanized health care.

IV. MATERIALS AND METHODS

4.1 TYPE OF STUDY

This is a quantitative and qualitative exploratory research in the strict methodological sense of keeping as its focus, the object of study. The quantitative research is significant because it will help to characterize the intensity and degree of ownership inherent to the object. The qualitative study enables the analysis of individual and collective information, in categories and topics, allowing a broader understanding. For Oliveira (2008, p. 58), these two types of approach are not mutually exclusive, since, in opting for qualitative research, one can resort to quantitative data for a better analysis of the theme or vice-versa.

4.2 UNIVERSE AND SAMPLE

For the development of the research considering its objective was made with the students of the Medical course of UNIFAMAZ, enrolled in the first semester of 2019. Students from the second to tenth periods participated. The choice was intentional to meet the research objective and achieve diverse testimonies, involving students who studied Medical Humanities and students who have advanced and are in practice in health settings.

Chart 1 - The research universe

Participants	Universe	Sample
2	101	20
3	55	10
4	83	16
5	79	14
6	44	08
7	41	08
8	41	08
9	38	06
10	70	14
Total	552	104

Source: Medical course coordination/February/2019

4.3 LOCATION

The research was carried out at the Centro Universitário Metropolitano da Amazônia (UNIFAMAZ), located at Avenida Visconde de Souza Franco, 72, Bairro Reduto, in the city of Belém-PA, 66053-000 (APPENDIX A).

4.4 PERIOD

Data collection was conducted in the month of April 2019.

4.5 DATA COLLECTION INSTRUMENTS

As an instrument of data collection the structured questionnaire was used (APPENDIX B) that made it possible to obtain information about expectations, collect information from a large number of people in a relatively short space. According to Oliveira (2008, p. 83), the application of a questionnaire defined as a technique to obtain information about feelings, beliefs, expectations that the researcher wants to record to meet the objectives of his study, transcribed into the LibreOffice® program, preparing the *corpus* for data processing. The processing of the corpus content was done through the *software* IRAMUTEQ (Interface de R pour analyses Multidimensionnelles de Textes et de Questionneires) version 0.7 alpha2 (CARMAGO; JUSTO, 2013).

Among the possibilities of analysis by IRAMUTEQ, we chose the analysis of similarity and word clouds, since the similarity produces graphics that allow the identification of the distributional principle that concerns the possibility of lexical units occurring in combinations with others. The cloud analysis, on the other hand, starts from the premise of how words are organized and grouped graphically, taking into account their frequency of appearance, originating from the text *corpus.*

The data obtained through the *software* processing were analyzed by the researchers, and were interpreted and discussed in light of the theory of social representations and literature on the subject. The answers were transcribed and submitted to the methodological and theoretical processing of the findings in the light of the referential. The Informed Consent Form (Appendix C) requested permission to record the questionnaires.

4.6 ETHICAL ASPECTS

The research project respected the precepts of the Declaration of Helsinki and the Nuremberg Code, following the determinations of Resolution 466/2012 of the National Health Council and within the limits of the Code of Medical Ethics, and submitted the approval of the Research Ethics Committee (CAAE: 099019.2.0000.5701). It complied with the guidelines described in the Informed Consent Form. The researchers signed a term of commitment (APPENDIX D) as did the teacher responsible for the group's orientation (APPENDIX E). To participate in the research, the students signed an Informed Consent Form that guaranteed the confidentiality of the information and that the informant would not be identified in the final draft of the research report (Appendix C).

V. RESULTS AND DISCUSSION

The examination of the questionnaires generated two categories of analysis: 1) subjective and 2) objective.

5.1 SUBJECTIVE CATEGORY

The main findings in this category, referring to medical humanization, the relevance of the medical humanities axis for the formation of physicians, and relevant topics not covered in the axis, were organized by means of a table that indicates the number of the questionnaire applied to UNIFAMAZ students, and are in their entirety in the work's file bank (Chart 2).

Table 2 - Characterization of the answers to the questionnaires, subjective, applied to students from the 2nd to the 10th period of UNIFAMAZ, in which 104 questionnaires were applied. Legend of the code AL: student, 01: number of the student's questionnaire.

Code	Part of the research participants' reports (text corpus)
AL_01	Good doctor-patient relationship
AL_02	Friendliness. The doctor was very nice. It helps in the spirit. Just to have empathy. To understand the patient's side and not just the professional.
AL_03	It is having empathy for others. Although not so often, there have been doctors who have made me feel welcome and trust them. It directly implies in the patient's adherence to treatment, as well as feeling welcomed. Yes, because we must be human regardless of the conditions we are exposed to. The human being has the ability to change the environment he or she is in, as long as he or she sets out to do so.
AL_04	Treating the neighbor or the patient with a human eye, with empathy, taking a considerate care, being patient with the patient's "agony". The doctor was attentive, patient, and human. The psychological aspect interferes in the evolution of the pathology. It depends only on the doctor's will. It showed us the importance and the relevance of this theme for the formation. How to deal with adverse situations in the day to day routine of a doctor who works in the public health system.
AL_05	It's about having empathy with the patient. I didn't get it. Psychological. Because it depends on the average. It helps to treat people and not of illness. I can't identify.
AL_06	It is empathy. It involves the doctor looking at the patient and not just seeing the disease, but the sick human being. It increases adherence to treatment. Even in an unfavorable environment, empathy must exist. It is important for our training as health professionals. The mental health of medical students.
AL_07	Medical humanization is a broad theme that involves biopsychosocial and environmental characteristics aimed at the care of a human being, where focused care makes the difference in a good doctor-patient relationship. Centered care with a good doctor-patient relationship makes the patient trust the medical conduct more.
AL_08	It is the search for proper medicine.
AL_09	It is medical care that is focused on the person, rather than only on pathology. Indigenous care is important because it presents several situations that are relevant to medical training.
AL_10	Palliative care, elderly care.
AL_11	It is seeing the patient, before the disease. The doctor was concerned about me, not only about the disease, it is not always the physical disease that is making the patient sick. Humanization does not depend on technology, but on character. It is relevant because it reminds the students of their humanity and that of the patients. I have no suggestions
AL_12	It is the service that uses care, well-being, and attention with a biopsychosocial outlook.
AL_13	It's a friendlier interaction towards the patient, not only dealing with the disease, but all their anxieties surrounding the health-illness process. Maximum attention from the doctor towards me. For in most cases the patient just needs a word of comfort for his problem. That is the least that is expected of a consultation. PBL teaching, is giving us the experience that our professors did not have in the academic forefather. Everyone that I thought was important was covered.
AL_14	It is the ability to be sensitive, to deal with other people's illnesses, and to know how to treat and dialogue with the patient in a patient and caring way. Yes, it is extremely necessary to make us exercise from the beginning the

	importance of humanized care and its benefits for patient and professional. Deepening in follow-up, preventive care for the LGBT public
AL_15	It is the perception of the health professional about the intrinsic aspects of the individual, making it possible to provide individualized care that is sensitive to the needs of each individual. It enables reflection and preparation for actions or situations that may occur in the exercise of the medical profession.
AL_16	Medical humanization is patient-centered care. It's turning to the patient and not to the disease. When I was well attended, by a doctor who looked me in the eye. It can help in the good prognosis of patients. This depends on the doctor and his training. It is an axis that teaches us to see the patient with other eyes. There is no theme.
AL_17	It is looking at the patient with sensitivity, ethics and respect, always trying to seek the best and comfort for the family and patient. The doctor was patient, attentive, and looked at me as a whole and not just as what I was looking for. It makes it possible to get to know the patient better and then look for ways to speed up the healing process. Unfavorable environments make humanized care difficult because it consumes the professional. Medical Humanities is relevant for medical students because it allows them to reflect and teach about daily issues in the life of a doctor. Therefore, with medical humanities we can learn about patients' rights, ethics, and get the best management of patients and families. All the main points are covered in medical humanities, so I can't see if there are others so important that have not been covered in the classroom.
AL_18	Medical humanization is the process that all doctors need to use as a basis in their practice, seeking to be as accessible as possible to the patient. The doctors who treated me didn't give me the attention I needed. I believe that humanized care promotes adherence to treatment and ends up influencing the professional's conduct. I believe that contact with the discipline during graduation promotes familiarization and more effective learning.

Source: Part of the data obtained from the questionnaires applied. * The data inserted in the work are not in full, however, all the statements are in a database.

In this category, the similarity analysis and word cloud was performed through IRAMUTEQ, i.e., the set of texts from the transcription of open-ended questions from the questionnaire was analyzed, in which a list of semantically identical words was generated, and their relative frequencies were presented in the text corpus, and a word cloud with central and peripheral terms was generated, with the central and larger ones being the most relevant in the text corpus. The words 'Patient' and 'doctor' were the central terms, while the peripheral terms were 'humanized', 'professional', 'care', 'relationship', and 'form'. The words 'empathy', 'relationship', 'compliance', 'humanization', 'humanity', 'care', 'comfort', 'help', 'respect', and 'treatment' were derived from the central term 'patient'. Derived from the central term 'doctor', the related peripheral terms were 'attend', 'approach', 'medicine', 'social', 'neighbor', 'sick', and 'depend' (Figure 1).

Thus, the good 'doctor-patient' 'relationship' can be built in a 'humanized' and 'empathetic' way, by the 'axis' of Medical Humanities, which promotes the 'formation' in an 'important' way, 'developing' 'skills' in order to influence the 'care' in a 'caring' way, through the 'look' of the 'doctor'. Moreover, the 'patient', in great majority, does not adhere to the 'treatment' against a certain 'disease', thus diminishing the 'health' and the 'importance' of this one, influencing in a negative way the credibility of the medical care coming from a lack of 'condition' to 'influence', 'respect' the 'patient', determining the true form of the humanistic 'process' of care. In the second main derivation of figure 1, in which the word "doctor" is taken as the central secondary word, it is preceded by the word "humanity", since, for the "humanization" to occur, it is necessary the "formation" with information to avoid situations of distancing the doctor from "social" problems, for example.

Contemporarily, the doctor-patient relationship has been focused as a key aspect for the improvement of the quality of the health service and unfolds in several components, such as the personalization of the assistance, the humanization of the assistance and the right to information (ARDIGÒ, 1995), treated through themes as the degree of satisfaction of the user of the health service (ATKINSON, 1993; WILLIAMS, 1994; GATTINARA, et al, 1995; DUNFIELD, 1996; ROSENTHAL; SHANNON, 1997), the counselling - the counseling (BERT; QUADRINO, 1989), the doctor-patient communication (BRANCH et al., 1991; WHO, 1993), the suffering of the patient and the purpose of biomedicine (CASSEL, 2007) and the informed consent (SANTOSUOSSO, 1996).

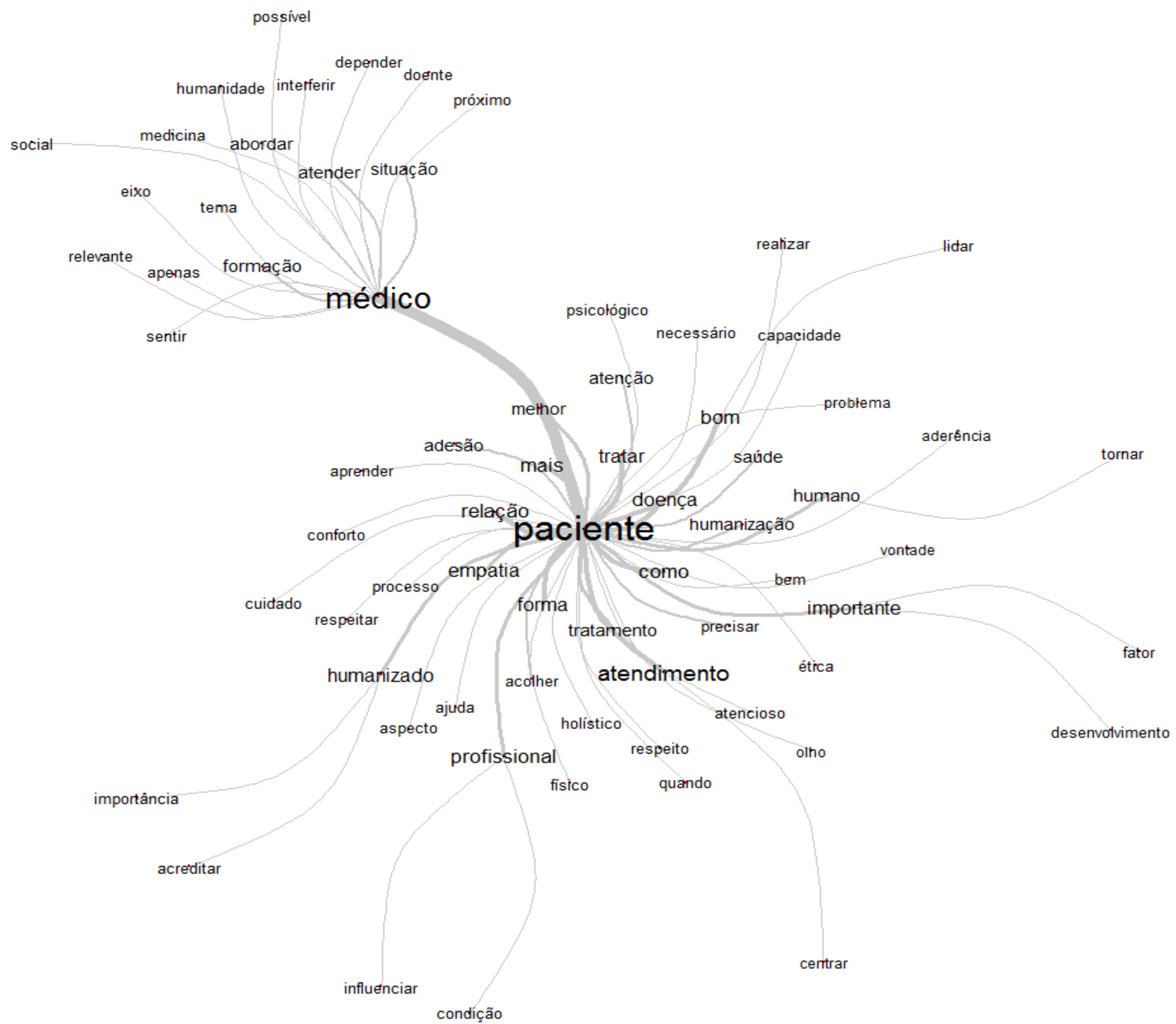


Fig.1 - Similarity analysis between the vocabularies. Belém-Pará-Brazil, 2019.

Source: IRAMUTEQ 0.7 alpha2 data processing.

Another important factor shown in the third branch of the clockwise direction in Figure 1, the word 'disease', 'health' and 'treat', which is interpreted by the biomedical conception as a deviation of biological variables from the norm. This model, based on a mechanistic perspective, considers complex phenomena as constituted by simple principles, i.e., cause-effect relationship, Cartesian distinction between mind and body, analysis of the body as a machine, minimizing social, psychological, and behavioral aspects. If, on the one hand, based on these principles, important transformations have been achieved since the 19th century, such as the birth of the clinic, Pasteur's germ theory, and even the recent successes in genetics, immunology, and biotechnology studies; on the other hand, the human, experiential, psychological, and cultural dimensions of the disease have been neglected. When it comes to verbal and non-verbal communication patterns, as well as the variety of communicational patterns, many problems arise in the doctor-patient relationship: a) the doctor's misunderstanding of the words used by the patient to express pain, suffering; b) the lack or difficulty in transmitting adequate information to the patient; c) the patient's difficulty in adhering to treatment (HELMAN, 1994).

With all of this mentioned, it should be understood that through the analysis of similarity, the real need for the importance of the axis of medical humanities for medical students is evident, which should follow a social and psychological approach, in which the academy is one of the main promoters for the propagation of humanized care.

Although most students and professors recognize that all medical disciplines, in practice, need to refer to humanistic knowledge in order to in fact care for the patient in integrality, the teaching of humanities has been disregarded from the central scope of medicine and meets with resistance (CAPRARA; FRANCO, 1999).

Figure 2 presents the word cloud derived from the text *corpus* obtained in the present investigation, remembering that the vocabulary words were organized according to the frequency they appear in the text processed by IRAMUTEQ (CARMAGO; JUSTO, 2013)**.**

Fig.2 - Word cloud of the text corpus. Belém-Pará-Brazil, 2019.

Source: IRAMUTEQ 0.7 alpha2 data processing.

In what is related to the vocabulary words and their absolute frequencies, within the text corpus of the students' interview, obtained evidence of the main terms: Patient (frequency of 86), physician (frequency of 70), care (frequency of 44), empathy (frequency of 48), professional (frequency of 34), important(frequency of 35), human (frequency of 33), humanized (frequency of 25), relationship (frequency of 17), physical (frequency of 17), health (frequency of 25), treat (frequency of 15), treatment (frequency of 12), In the vast majority of questionnaires these words considered high frequency, such as empathy, doctor and patient, were exposed by students, correlated with the true meaning for him of a good humanized care. A fragment taken from the AL_32 questionnaire, according to Chart 1, makes this premise explicit:

> *"It is the ability of the physician to have empathy and understand the patient, the patient in a biopsychosocial way" (Student 32).*

In addition, another intrinsic component of the semantic words in the questionnaires is the patient as a 'biopsychosocial' being. Given this fact, the "axis" of "medical humanities" is an important vehicle of the real role of the thematic axis in question, the word "care", which is often mentioned in the questionnaires conducted by students. In this context, it is worth demonstrating this view in the questionnaire, AL_34:

> *"The medical humanities axis enables the development of empathy and the training of emotional skills for improved care" (Student 34).*

On the other hand, the word 'holistic' is also focused on, by means of statistical data and through highly cited arguments, and most of them correlate it with humanized care, as in the example of questionnaires AL_38 and AL_42:

> *"Treating the patient well, especially with respect and holistically" (Student 38).*

> *"It's the doctor-patient variation, it's the doctor's way of looking at the patient as a whole, closer" (Student 42).*

As for the checks of holisticity, in face of medical practices, it is founded on philosophical principles that value efficiency, technique, and scientific knowledge, and deny any possibility of a metaphysical knowledge, deploying scientific realism. According to Almeida (1999), when studying the human body, Cartesianism produces a mechanism of forgetfulness that prevents us from mixing and confusing ourselves with the body, it creates the image that the body is a machine.

In fact, to be a doctor who recovers people not only from illness, but also from pain, fear, and helplessness, one must be able to move from intention to gesture that transforms the procedure into a medical act. To train professionals with this level of greatness, it is necessary to develop reason and sensitivity in medical training, the contribution of the humanities to medicine (RIOS; SCHRAIBER, 2014).

It can be stated, as revealed by the word cloud represented by Figure 2, that the term 'Physician' and 'Patient', the most cited and central word, can be considered

the one that best represents the scientific evidence that medical humanity is not centered only on being a physician, but, in fact, doing medicine for people in an integrative way. In the intermediary periphery of Figure 1 and Figure 2, the link between the words ethics and patient was evidenced. Related to the category Physician, which is one of the main links, as already mentioned, for a humanized care, since there is a possibility that medical education leaves the physician as the center and not the patient, and this relationship is based on an ethical conduct, which is the third semantic word that lists this link, as shown and cited by the questionnaire, AL_17:

> *"Medical humanities is relevant for medical students because it allows reflection and teaching about daily issues in the life of a doctor. Therefore, with medical humanities we can learn about patients' rights, ethics, and get the best management of patients and families" (Student 17).*

Thus, the analysis of the importance of the medical humanities axis by the students has been breaking the perspectives of society: from pre-logical, fragmented reasoning, to logical, formal reasoning. This becomes clear in the questionnaire study in question, specifically to the students who had contact with the medical humanities axis, which materializes a thought of the principle and perception of the students before this fact, in this case; the axis. The subject is active in the process of appropriation of objective reality (MOSCOVICI, 1990).

Empathy is the most present characteristic in the students' discourse, both for the definition of humanization and regarding the quality of the doctor-patient relationship in which empathy is a multidimensional construct (in the cognitive, behavioral and affective spheres), which acts as a resource for the regulation of social life, modified by culture and learning (FALCONE, et al., 2018).

> *"It's having empathy with the patient" (Student 5).*

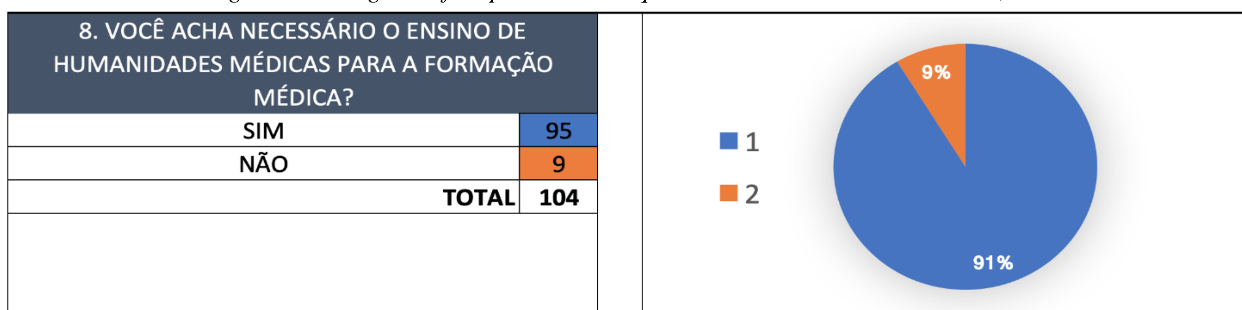
In this way, the conception of representations comprises a set of concepts, statements, and explanations through which the interpretation and even the construction of realities is carried out (JODELET, 1990).

Therefore, it should be understood that medical humanization has an imagetic character and the property of leaving interchangeable sensations, ideas and conceptual games, giving an autonomous and individualistic character, as well as a collective character to each group or individual. As for example in the doctor-patient relationship, in which each group and each individual constructs a relative perception of the subject.

5.2 OBJECTIVE CATEGORY

In addition, objective questions were elaborated in the questionnaire, in which Diagram 1 and Diagram 2 and their respective interpretations of the questions mentioned by the importance of humanization and insertion of humanities curricular units in the curricular structure of medical education in Brazil are outlined. Among them was the question about the perception of the student regarding the medical humanities axis for their training.

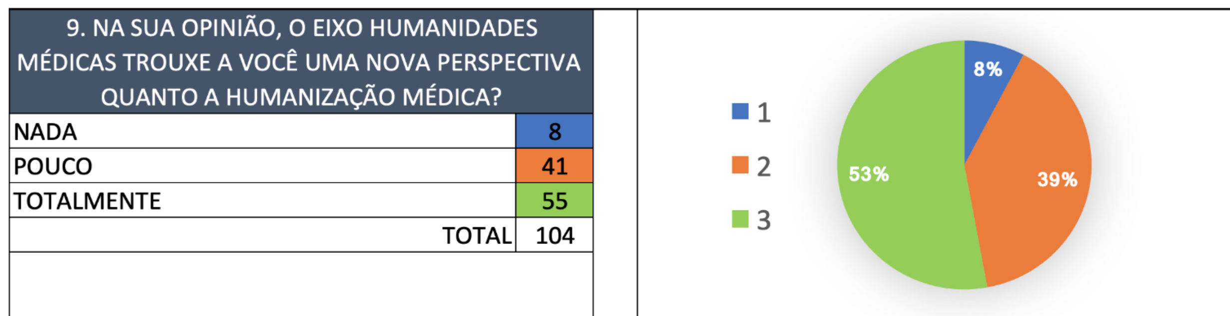
Diagram 1 - Diagram of responses to the questionnaire. Belém-Pará-Brazil, 2019.



8. VOCÊ ACHA NECESSÁRIO O ENSINO DE HUMANIDADES MÉDICAS PARA A FORMAÇÃO MÉDICA?	
SIM	95
NÃO	9
TOTAL	104

Source: Questionnaires distributed to UNIFAMAZ students.

Diagram 2 - Diagram of responses to the questionnaire. Belém-Pará-Brazil, 2019



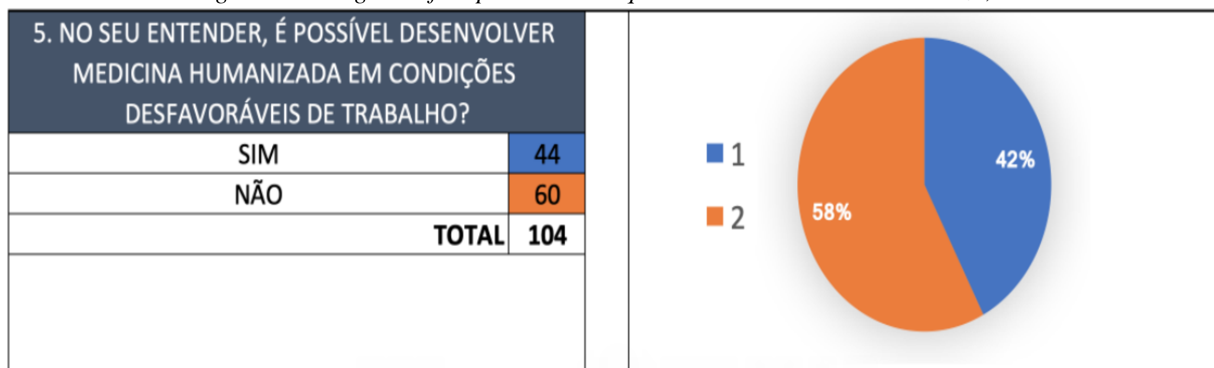
9. NA SUA OPINIÃO, O EIXO HUMANIDADES MÉDICAS TROUXE A VOCÊ UMA NOVA PERSPECTIVA QUANTO A HUMANIZAÇÃO MÉDICA?	
NADA	8
POUCO	41
TOTALMENTE	55
TOTAL	104

Source: Questionnaires distributed to UNIFAMAZ students

Diagrams 1 and 2 show the relevance of this axis for the students, in which 91% of the answers were "Yes", when asked: "Do you think the teaching of medical humanities is necessary for medical training? The perspective of the students in taking up the idea that the doctor-patient relationship is a key element in health care, humanization would be an element of relational quality, because it proposes a communicational process supported by dialogue. As these are skills that can be taught and learned, its development is recommended in medical schools (CAPRARA; FRANCO, 1999).

However, students often see them as uninteresting and dispensable, in part because, although fundamental to good medical practice, they are often addressed superficially in medical curricula. Diagram 3 shows students' responses when asked about the application of humanized medicine in unfavorable working conditions.

Diagram 3 - Diagram of responses to the questionnaire. Belém-Pará-Brazil, 2019.



5. NO SEU ENTENDER, É POSSÍVEL DESENVOLVER MEDICINA HUMANIZADA EM CONDIÇÕES DESFAVORÁVEIS DE TRABALHO?	
SIM	44
NÃO	60
TOTAL	104

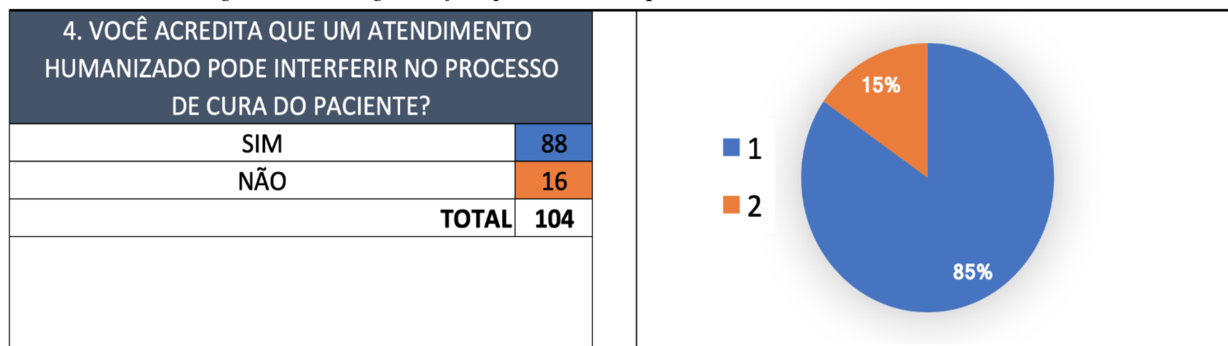
Source: Questionnaires distributed to UNIFAMAZ students.

According to Diagram 3, students associate non-humanized practices with the lack of structure of the environment, which should be focused on care. When faced with the precariousness of resources for their work - few beds, few professionals in the health team, fewer technological resources than desirable, among others. Finally, the students were asked about their perception of patient healing and the correlation with humanized medical care.

The humanization of care is part of a larger plan to achieve more efficiency, results, and possibilities for cure in health care facilities. When there is integration and more direct communication between patients and service users, health professionals, and the managers of hospitals, clinics, and medical institutions, a more humanized bond is created among all instances.

In this way, more respect and recognition is established between the parties involved, which only tend to reflect in a more effective care to those in need. Humanizing care means considering the existential needs of that person, attending them with solidarity, and being able to comfort them (VENTRIX, 2019).

Diagram 04 - Diagram of responses to the questionnaire. Belém-Pará-Brazil, 2019



4. VOCÊ ACREDITA QUE UM ATENDIMENTO HUMANIZADO PODE INTERFERIR NO PROCESSO DE CURA DO PACIENTE?	
SIM	88
NÃO	16
TOTAL	104

Source: Questionnaires distributed to UNIFAMAZ students

VI. CONCLUSION

In view of what was evidenced by the present study, the insertion of the teaching of humanized medicine in the undergraduate course exerts on the student and future professional a reflective, motivational, and guiding power about the subsequent medical practice.

The construction of the subject is a multifactorial process that receives cultural, social, affective, and sociological influences. Therefore, during medical graduation, students are unique subjects, the result of a series of processes that are not known. Humanized medical education is an addition to the processes of subject formation, who needs to be stimulated to observe the patient from a perspective that is often different from the reality in which he/she lives, making him/her a humanistic, critical, reflective and ethical professional, with the capacity to act at different levels of health care.

Empathy, understood in different ways, according to the view of different authors, stands out as a communicational skill that allows the understanding of the other and the communication of this understanding, was used by most of the students participating in this research to characterize humanized patient care, showing once again that learning this humanized form of medicine is also a tool used in medical practice to see the patient in a transcendent way, taking professional conduct to a sphere that goes beyond the logical and disease-centered thinking.

Given the answers obtained in the application of the questionnaires and already reported in the analysis of the study, it is concluded that the students consider the teaching of medical humanities important for their professional growth and performance, because they believe that the axis led them to reflect on daily issues of medical life, patient care, a differentiated view of illness interfering in the healing process, besides the motivational sense in producing a more humane and ethical medicine.

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