

## O tema da humanização na terapia intensiva em pesquisas na saúde

The humanization theme in intensive care in health studies

El tema de la terapia intensiva en investigaciones en salud

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### ABSTRACT

**Objective:** To systematize studies indexed in Medline and Scielo on humanization in Intensive Care Unit (ICU).

**Method:** A qualitative study with a systematic literature review. It was used studies from Scielo and Medline databases indexed from July 1990 to August 2015, with the key words: 'humanization' and 'intensive care unit'.

Inclusion criteria were: articles published until August 2015, which referred to the humanization in the ICU, and exclusion: bibliographic review articles. **Results:** It was analyzed 21 articles. It has come up some categories: Characterization of the studies analyzed; 'We are not machines, human is what we are'; and 'Actors and factors involved in health humanization process'.

**Conclusion:** Humanization in ICU is still a challenge, nursing is one of the areas that deals with this practice, the understanding that the humanization involves care, the processes and working conditions, there are several actors who produce and there are interferences in their production.

**Descriptors:** Humanization; Intensive Care Unit; Health care; Brazilian Unified Health System.

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## RESUMO

**Objetivo:** Sistematizar estudos indexados no Scielo e Medline, sobre humanização em Unidade de Terapia Intensiva. **Método:** Qualitativo, de revisão bibliográfica sistemática. Utilizado estudos nas bases Scielo e Medline, indexados de julho de 1990 a agosto de 2015, com os descritores: 'humanização' e 'unidades de terapia intensiva'. Os critérios de inclusão foram: artigos publicados até agosto de 2015, que faziam referência à humanização em UTI e de exclusão, os artigos de revisão bibliográfica. **Resultados:** Foram analisados 21 artigos. Chegou-se as categorias: Caracterização dos estudos analisados; 'Não somos máquina, humano é que somos'; e 'Atores(as) e fatores envolvidos no processo de humanização em saúde'. **Conclusão:** A humanização em UTI ainda é um desafio, a Enfermagem é uma das áreas que se ocupa com esta prática, o entendimento de que a humanização envolve assistência, os processos e condições de trabalho, vários são os atores produtores e que há interferentes na sua produção.

**Descritores:** Humanização, Unidade de terapia intensiva, Atenção à saúde, Sistema Único de Saúde.

## RESUMEN

**Objetivo:** Sistematizar estudios vinculados en Scielo y Medline, acerca de humanización en Unidad de Cuidados Intensivos. **Método:** Cualitativo, de revisión bibliográfica sistemática. Utilizado estudios en las bases Scielo y Medline, vinculados de julio de 1990 a agosto de 2015, con los descriptores: 'humanización' y 'unidade de cuidados intensivos'. Los criterios de inclusión fueron: artículos publicados hasta agosto de 2015, que hacían referencia a humanización en UCI y de exclusión, los artículos de revisión bibliográficos. **Resultados:** Fueron analizados 21 artículos. Se ha encontrado las categorías: Caracterización de los estudios analizados; 'No somos máquina, humano es lo que somos'; y 'Actores(as) y hechos involucrados en el proceso de humanización en salud'. **Conclusión:** La humanización en UCI aún es un desafío, la Enfermería es una de las áreas de que se ocupa con esta práctica, el entendimiento de que la humanización requiere asistencia, los procesos y condiciones de trabajo, varios son los actores productivos y hay interferentes en su producción.

**Descriptor:** Humanización, Unidad de Cuidados Intensivos, Atención a la salud, Sistema Único de Salud.

## INTRODUCTION

Intensive care as a hospital care device is located in Units or Centers of the same name given their characteristics and is part of the Unified Health System (SUS) in Brazil, under which it is incumbent to guarantee the right to health at all stages of life. To this end, actions and services of promotion, protection, recovery and health production are combined, from the perspective of integrality, according to the precepts of Humanization in Health.<sup>1,2</sup> The SUS is executed by the State and other federative entities, essentially public, with complementary participation of the private initiative.<sup>3</sup>

In Brazil, according to the Association of Brazilian Intensive Medicine (AMIB),<sup>4</sup> there are around 25,000 beds of Intensive Care Units (ICUs) distributed across all states, which indicates that in at least 403 municipalities there is some unit / intensive care unit.<sup>4</sup> The ICU is intended for people in critical health, who require continuous professional and specialized care, with appropriate training,

as well as specific technologies and materials for diagnostic, monitoring and treatment purposes.<sup>2</sup>

The ICUs differ in the public and are classified as adult ICU (age group over 18 years), pediatric (between 29 days and 14 years) and neonatal (0 to 28 days).<sup>2</sup> They are also considered according to the incorporation of technology, specialization of the team and the physical area available in types I, II and III.<sup>5</sup> The team should be composed according to the requirements that characterize each of the age groups and types.

The team must be integrated, at each shift, with at least one technician responsible, one day-care worker, one on-call; one nurse coordinator of the nursing team, nurse assistants; a physiotherapist coordinating the physiotherapy team, physiotherapists; nursing technicians; an administrative assistant of the unit; and staff for cleaning service, exclusive for this purpose.<sup>2</sup> From the services, the ICU must have at its disposal a full-time laboratory for clinical analysis, mobile X-ray apparatus, parenteral and enteral nutrition service, social service, among others.<sup>5</sup>

The ICU, like other health services, requires humanized management and attention. However, due to intermittent complaints of dehumanization, mainly from users and family members, followed by health workers,<sup>6</sup> the National Humanitarian Assistance Program (PNHAH) was launched in 2001 by the Ministry of Health.<sup>7</sup> The goal is to create a culture of humanization in hospitals, to qualify workers for a new concept of health care that values human life and citizenship.<sup>7</sup> Currently, the National Humanization Policy for Management and Attention in SUS (HumanizaSUS) is incorporated.<sup>8</sup>

According to this policy, humanizing consists in putting into practice the principles of SUS.<sup>8</sup> In order to do so, it aims to stimulate communication between managers, users and workers, in order to produce collective processes of coping with power relations, which often result in dehumanizing practices and attitudes, especially when they reduce the autonomy of health professionals, users (s) and family members.<sup>8</sup> Humanization is characterized by practices of dialogues, interaction, communication and expansion of democratization in relationships.

For adherence to HumanizaSUS, the hospital needs to observe some parameters, such as the existence of Humanization Working Groups (GTH), guarantee of an open visit through the presence of the companion and its social network, reception mechanisms such as reception and listening for the population, construction of care lines for de-hospitalization, aiming at alternatives to hospital practices, such as home care, assurance of continuity of care with system of flows, among others.<sup>3</sup>

However, even adhering to what is proposed by politics, this does not necessarily guarantee that Humanization occurs in the processes of work and attention. The use of equipment, technologies and the care techniques themselves, even those considered essential to the maintenance of life,

can be dehumanizing depending on how they are performed in the assistance of the users, co-extensive with the relatives.<sup>9</sup>

Likewise, health teams are confronted on a daily basis with issues related to the relationship with users and their families, death, working conditions, emotional exhaustion, double or prolonged working hours, situations that can cause sadness, stress, psychomotor diseases, among others, and which tend to have a direct impact on humanization in health in relation to the user, family and work relations.<sup>10</sup>

These situations, at the same time as they are effects, interfere in communication, dialogue and interaction between users, family and staff. To what extent will users and their families be empowered to face the health situation and dehumanizing practices in the relationship with this ICU 'environment'? As the team will be able to deal with the everyday situations that are inherent to it, in the absence of spaces and/or receive support that contributes to the management of the affections experienced in these relationships, in the practice of care and work among colleagues, management, users, family, among others?

This situation tends to affect the humanization of care production processes. Given this, it questions what research has pointed out about humanization in ICUs, being this the guiding question of the study. This is justified because it recognizes the power of the Humanization proposal in SUS to meet people's health needs, and in the work processes to perform care with resolutivity and guaranteed integrality in health.

Thus, this research aims to systematize studies on humanization in the Intensive Care Unit, indexed in the bases of Scielo and Medline, which, besides presenting the state of knowledge of this agenda, can contribute to humanization processes in care and work in the scope of ICUs, to meet the principles and guidelines of SUS, and, especially, the prerogative of integrality in health.

## METHOD

This is a qualitative, descriptive study, structured through a systematic bibliographical review, which shows and updates the academic contribution on humanization in ICU. This methodological perspective is constituted of data sources, that from the discussion between the authors results in systematization and final considerations.<sup>11</sup>

The systematic bibliographic review allows the researcher a dimension and comprehension of the body of knowledge related to a certain subject, rigorous and reliable evaluation of researches.<sup>12</sup> Thus, consolidating results obtained in previous studies on a given topic, facilitates identifying gaps in theory and practice for improvement and research opportunities.

To do so, we used the Electronic Eletronic Library Online (Scielo) and Medline databases, from indexed studies in the period from July 1990 to August 2015, using the descriptors 'humanization' (AND) (Intensive Care Units). Inclusion criteria were: all articles published up to August 2015

referring to humanization in the ICU, even if it was returned to the public or to specific workers, such as the neonatal and pediatric or adult ICU or nurses, etc. And of exclusion, the articles of bibliographical revision. Data collection took place in September 2015. It considered the available online studies, in full, published from July 1990 to August 2015, in the Scielo and Medline databases.

The year 1990 was considered to trigger the process of SUS implantation in Brazil, which for the integral care in guaranteeing the right to health demands a set of points in a care network, which includes hospital institutions with their units structures, as in the case of ICUs.

The data collection performed in Scielo and Medline perfected 37 articles. In the Scielo, 10 articles were found and in Medline 27. After applying the criteria listed for selection of the studies, of the 10 articles located in Scielo, seven were in line with the research theme. Of the 27 articles accessed in Medline, 14 were adapted to the theme and the rest were discarded. In this way, 21 articles were analyzed in total, made available in their respective databases.

After the careful reading of the 21 articles for data analysis, which included the characterization of the localized studies, the following information was collected in a table: database, year of publication, periodical, article title, authors, objective, methodology and main results. The articles were analyzed on what has been pointed out regarding the state of knowledge about humanization in intensive care.

## RESULTS AND DISCUSSION

After the detailed reading, exploration and analysis of the results obtained in the 21 articles selected from the criteria of this study, the themes were classified into three categories, nominated sequentially as: 'Characterization of the analyzed studies'; 'We are not machines, we are human'; and 'Actors and factors involved in the process of humanization in health'.

### Characterization of the analyzed studies

In order to situate the reader in relation to the findings and the meeting of the theme under study, the characterization of the articles found in both the collection bases will be done first. Regarding the year of publication, considering the period from July 1990 to August 2015, it can be observed that from 1990 to 1995 there were no published articles, from 1996 to 2000 only one publication, from 2001 to 2005 there were three publications. Already from 2006 to 2010, there was an increase in the number of publications, these were ten, and finally, from 2011 to mid-2015, a decline in production, with a publication in 2011, three in 2013, one in 2014 and two in The period of increase of the publications "talk" with the process and effects of what involves the precepts of Humanization in Health in hospitals, 8 in which from the same, predominates the elucidation of the need to use their devices.

In the journals in which the articles were published, four were in the *Revista Latino Americana de Enfermagem*, two in the *Brazilian Journal of Intensive Care*, two in the *Journal of the Nursing School of the University of São Paulo*, two in the *Revista de Enfermería Intensiva*, two in the *Revista Gaúcha de Enfermagem*, one in the *Revista Acta Médica Portuguesa*, two in the *Revista Ciência & Saúde Coletiva*, one in *Ciência y Enfermería*, one in *Psychology Studies*, one in the *Revista Acta Bioethica*, one in the *Revista Brasileira de Enfermagem*, one in *Revista de Enfermagem Escola Anna Nery* and one in the *Journal of Public Health*. It is noted that of the 13 journals in which they were published, seven were related to the nursing theme, two in collective health, one in medicine, one in psychology, one in intensivism and one in bioethics.

Of the authors, 54 were nurses, followed by 14 physicians, nine medical graduates, four psychologists, two social workers, two physiotherapists, one was a dentist and another a sociologist. The predominance of nurses corroborates the main agenda of the periodicals in which the articles were published. It is also pointed out that nursing has dealt with humanization in health as a perspective of practice and research, consistent with the precepts of this area of knowledge, collective health and SUS.

From the articles selected for this study, nine studies were carried out on the conception of humanization, followed by three on the experience of family members of ICU users, two on the profile of ICU nurses, and in the other themes, were found only one: family members' perception about humanization in ICU, stressors for ICU patients, reflections on nursing practice, conception of dysthanasia, euthanasia and orthopathy, bioethics in the doctor-patient relationship, illness and finitude, and strategy evaluation of humanization. However, it is important to point out that in some surveys, the subjects intertwined.

In the 21 articles located, in relation to the population, six were found where the population was composed of ICU nurses; five, by relatives of patients admitted to ICUs, four by the team/professionals working in neonatal ICU, three articles in which the study population was intended for staff/professionals working in ICUs other than neonatal, a study was with users over 18 years old, one with medical students, and one contemplated together users, family and staff.

As to the methodology used, 20 of the studies found were qualitative and one quantitative. Of the researches with the topic of humanization in ICU, studies predominated in Brazil. They are concentrated in capitals or large cities. The researches conducted in the Central West region were: three in São Paulo/SP, one in Ribeirão Preto/SP, three in Rio de Janeiro/RJ, and one in Goiás/GO; in the Northeast: two in Recife/PE, one in Bahia/BA, one in Fortaleza/CE, one in Vitória/ES, one in Serra/ES, and one in Natal/RN; and in the South: three - one in Londrina/PR, one in Curitiba/PR and one unspecified. Abroad, three studies were carried out, two in Spain - one in Terragona and one in Barcelona -, and the third in Portugal.

The characterization of the articles in this study, which involved year and periodical of publication, the formation of the authors, theme, population, methodology and location in the country and abroad, besides situating the reader (a), was a way to show the methodological course, as well as to present a cartography of the research with the theme of humanization in ICU.

### **'We are not machines, we are human'**

In the findings of this research, emphasis was placed on the conception of health workers about humanization in ICU. In a study about the meaning of the cultural aspect of humanized care in the ICU, the nursing team includes the beyond technique, love of neighbor as oneself, empathy, and respect for the user and family, as elements of dignity and humanization.<sup>13</sup> The authors also point out that, for that, it is necessary that the environment in the unit and hospital be pleasant, since it influences the well being of the people - user, team, family. They also inform that humanized care includes dialogue, information and attention singularization.

They also point out that Humanization is a discourse that did not take place, when the technique is valued at the expense of "mechanical actions, routine, focused on the execution of tasks. The patient, in these circumstances, is exposed to loss of identity and lack of privacy", as well as in the way that the caregiver is not cared for, in this case, the workers who end up experiencing stress situations the environment, work overload, low pay that refers to work in more than one institution, lack of support in situations of attachment to users and family members in situations that sensitize the team.<sup>13:141</sup>

Other authors, who have also stopped at the study of the conception of humanization by the workers of the Neonatal ICU, with respect to what is humanization in the care, show that they understand the same from an affective perspective, that involves the emotional aspects in the relation with the baby and at work in neonatology.<sup>13-4</sup> They also emphasize that the presence of the family in the case of the NICU is an important aspect in the process of humanization. In the understanding of the respondents, they are ways of opposing the biomedical, technician, health care model.<sup>13-4</sup>

Another study, which carried out a reflection on the humanization of health from the analysis of the term in the speech of nurses who work in the ICU, shows that they understand humanization in the relationship as holism.<sup>15</sup> That is, to consider the subject integrally, attention to the physiological, psychological, social and spiritual aspects of care, such as care that goes beyond the technical.<sup>13-4-5</sup> However, there is a lack of preparation in health training for humanized care.<sup>16</sup>

Research that has studied the meaning of ICU care shows that humanization may be related to the idea of seeking and preserving human dignity, since its opposite would be considered as dehumanization.<sup>17</sup> It points out some conditions that interfere in the production of humanized

care, such as professionals with low salaries, overload of activities, double or triple working days, difficulty in reconciling family and professional life.<sup>13,17</sup>

In a study about the perception of the nursing team about humanization in neonatal and pediatric ICU care, the results of other studies were reached, that to humanize is to consider the other as a whole (holistic), which includes the family and which consists of going beyond technical procedures.<sup>13-4-5</sup> They also point out that the link, interdisciplinary relationships, team autonomy and communication are humanizing practices and refer that the environment and work process influence humanization in health.<sup>13,17,18,19</sup>

Research that analyzed the senses and the limits lived by professionals in a neonatal ICU for the production of humanized care, presented as results that the interviewees attribute different meanings to humanization, such as humanized care, integral care, extended care with the participation of the family, as already mentioned in the results of the studies presented so far.<sup>20</sup>

Nurses tend to relate humanized care to their personal beliefs, which influence the meanings attributed to their experiences in the life and finite situations of the hospitalized persons and their relatives.<sup>16</sup> Workers are more influenced by the experience gained in the work than by the guidelines and goals prescribed by the HNP.<sup>20</sup>

Work influences the process of humanization. Study on the work in neonatal ICU showed that it is dynamic of pleasure and attrition. Pleasure related to the joy of hospital discharge from users, without sequelae, deficiencies or functional losses. And the wear and tear related to suffering, such as the death of a baby, relationship difficulties among workers, number of users per worker, limitation of physical space, and lack of material resources and equipment.<sup>20</sup> But even in these scenarios, wear and tear does not obfuscate the pleasure of working, especially when presented in ways of recognition that the work was successful.<sup>20</sup>

In a study carried out on the opinion of the nursing professional regarding the humanization of care for newborn at risk and relatives in neonatal ICU, the results show that they understand humanization as proximity to the user and family members by the nursing. Still, they understand humanization as welcoming, communication between staff and family, reducing anxieties, facilitating the 'being together' family and hospitalized, and the need to pay attention to the singularity.<sup>21</sup>

There are notes that work does not focus on the disease machine but on the human.<sup>13,14,21</sup> In this sense, the worker has spaces to expose his feelings about what he / she lives in daily life, working conditions, union of scientific knowledge with practice, ways of strengthening interpersonal relationships, which are not restricted to a Unit and which must compose the whole of an Institution. The process can be slow, according to individual and collective interests.<sup>21</sup> If there is room in the workplace for reflective practices about work, about oneself, about relationships with people, where

one can question oneself and generate changes in practices, it is a viable way of Humanization processes in Health.

And, in a study about the perception of the mothers who accompanied their children during the hospitalization in the Neonatal Unit, in relation to the humanization of the care, showed that corroborates with that pointed out by studies with health workers in the ICU that humanization is related to satisfaction and that among the elements is the cozy relationship, know the area of training of the worker and the environment, with adequate accommodation to stay with the person under care in an ICU, in this case, with the baby, which, for example, keeps specificities that differ from an adult ICU.<sup>22</sup>

The results of the studies that generate this category, 'I am not a machine, I am a human being', point to the meaning of humanization in the work process and in the relationship with users and relatives, of the non-cationisation of the human being, care or as an object in and of work, a part of a 'gear' in a hospital, but as actors in this process entitled to equal consideration, respect, dignity, according to the elements pointed out as essential to humanization in health in a relationship ethics with people's lives.

### **Actors and factors involved in the process of humanization in health**

The process of humanization in ICUs comprises several actors in their singularities, among them health workers, users, family members, companions, students and each one presents its peculiarities in this relation. The established sanitary responsibility of the implantation of the SUS urges that workers produce a humanized attention. And the main actor for whom it is intended is the user, followed by his/her family.

In order to be effective, humanized working conditions are necessary.<sup>17</sup> Low salaries lead the professional to other work hours, which is overloaded, can not reconcile work with family life and other affective ties, and this interferes with humanization of attention.<sup>17</sup> ICU work lacks adequate conditions for it, even though this does not obscure the worker's implication with humanization perspectives in attention, but interferes with them.<sup>20</sup>

The deficient implantation of humanization processes, by not considering the interdisciplinarity, communication and autonomy of the team, principles and guidelines, interfere in the management and attention.<sup>17,20,23</sup> Humanization also interferes with working time and health training. Study on the profile of nurses working in the ICU in a teaching hospital, showed that the mean age was 32 years and that around 67% had specialization and that the average working time in the institution was six years. These factors tend to contribute to the humanization of attention.<sup>24</sup> However, another study with nurses, regarding end-of-life users, points out that there is a lack of preparation to deal with people in these situations.<sup>16</sup> It adds to these conditions health training as one of the factors of interference.<sup>15</sup>

People hospitalized in ICU present stressful moments for a variety of reasons, such as the presence of strange equipment, alarms, lightness, tubes in the mouth and/or nose, pain, limitation of hand and/or arm movements the presence of venous access, being bitten by needles constantly, having to use oxygen, not being able to sleep, not having control of oneself, seeing family and friends only once a day, among others. Identifying these factors contributes to the performance of the team and family in the humanization in the ICU.<sup>24</sup>

Among the actions of humanization of the actors involved in the care, it is also important to ensure sufficient analgesia to the users, for example, in the case of those who report a higher degree of pain, give attention to the control of their pain and anxiety, explain about their health status and treatment in clear language, respect the privacy of the person and provide comfort and psychic and emotional support.<sup>24</sup>

The user is the main actor for the humanization action movement in the attention that is not detached from the work process and understands the family as well as actor in this process. Caring for these can generate security and a better understanding of the process your family is going through. Caring is one of the main functions of nursing, mainly within the ICUs and as actors in this process can contribute to Humanization.<sup>26</sup> For the family, the ICU is a difficult, painful experience, and seeks to approach your relative because of the fear of death.<sup>25</sup>

This family experience is characterized by fear, insecurity and the feeling of isolation of the family member who is hospitalized, but who rely on the health care provided by the team. Family members should be considered as allied to the treatment of the user and also deserving of humanized care.<sup>27</sup> The approach of the family members, valorization of their knowledge and their experiences, explaining to them about their doubts, understands the process of humanization in the ICU.<sup>28</sup>

Likewise, involvement with the user and the family is an essential aspect of humanizing. It is up to the team to work and discuss these aspects, avoiding or minimizing the distress, the feeling of impotence of users, family members and the team itself, in order to avoid the separation as a defense mechanism of this family actor.<sup>24</sup> Humanizing comprises several factors, among them, attention to bioethical aspects in intensive care.<sup>29</sup>

These situations are related to an ethics of commitment to life, which can integrate the quality of death. A study on the perception of nurses on dysthanasia, orthopniasis and euthanasia, who work in intensive care units of a large university hospital showed that there is a great desire to maintain the user's life, even if artificially, with equipment and medication, which characterizes dysthanasia. However, the authors point out that it can be a measure that brings more suffering, pain and agony to all - users, even in the conditions in which they are, family and even team.<sup>29</sup>

The art of dying well defies the loss of human dignity in its final process, seeking a commitment to promote the well-being of the person in his terminal stage and with the people of his relationship under the precepts of bioethics - autonomy, justice, beneficence and non-maleficence, such as the North for the practices, reflections and attitudes of professionals. However, in Brazil, there are legal impediments to this exercise of autonomy in relation to one's life or someone else's.<sup>29</sup>

Nursing workers, including those who carry out management and continuing education activities, are responsible for seeking and adopting respectful, ethical and responsible measures in order to seek humanization in the care process, resulting in the greatest possible benefit to the user.<sup>31</sup> Among all the factors that can contribute, in all work situations and care, is communication, through listening and dialogue with the hospitalized user and his network of affections. The action, with clarifications on their health situation, procedures, treatment, operation of the ICU, bioethical issues, high and post-discharge situation, in order to provide well-being and decrease the pain or suffering of these people in intensive and family care.<sup>29-30</sup>

Being in the ICU is not synonymous with dying, but it is a feeling that may be present. Given this, spaces for communicating these feelings are important.<sup>33</sup> Likewise, this prerogative of communication and dialogue also extends to the health team as a way of confronting and minimizing everyday difficulties at work, through dialogue, and through communication, as ways of sharing care, responsibilities and generating more collective and humanized strategies of care. Also, so that they are not engulfed by technology and realize where the machine ends and the person begins, so that they do not transform the relation with the machine into a mechanical act, and the user likewise.<sup>17</sup>

It is important to consider that, in the midst of complex devices and techniques, it is necessary to develop the human that is there, that is, not only a user who constantly needs to be monitored in his vital functions, but a unique human being, who needs care, not only in the physical aspect, but also in the emotional aspect, because he experiences a health situation that makes him experience the insecurity of being cured and the risk of death.<sup>27</sup> In this process, the hospitalized user's family in ICU should also be part of the universe of health care, however, many times, the family does not receive adequate attention, and ends up being forgotten and not contemplated by the acting team, where it should also be the focus of attention.<sup>25</sup>

Humanization in ICU involves the various actors and factors. The emphasis is for the user, the sense of the existence of the intensive therapy apparatus, but the same is not an isolated being in the world, so for humanization to occur it implies knowing your needs and desires and the involvement of the people with whom you relate, in this case, the family. In addition, the ICU environment is a composite of relational and instrumental technologies (such as equipment, procedures, etc.), and health workers, given working and

institutional conditions and / or life circumstances, are at the mercy of sometimes fail to reconcile both to the production of humanization in the ICU. And they are also actors in this process, the effects, or producers, of the most varied factors in the production of humanization in Health.

## CONCLUSION

The study reached the objective that was proposed, in the case of systematization of research indexed in the databases Scielo and Medline, on humanization in the Intensive Care Unit. It is shown that it is still a challenge, that Nursing is the area that has dealt with this theme, especially in what concerns the conception of humanization. They elucidate understandings about humanization, which is not restricted to welcoming with sympathy, but rather involves human relations, working conditions, listening spaces for all the actors involved, among them other elements. So that user and family are not objects in care, nor is the worker in the institutional cogs in an ICU. All of them are actors in the production process of Humanization in Health.

Some factors involved in the humanization of health are within the reach of the governmentality of health workers, however, not all, especially those involving working and living conditions, which in many situations interfere in this process. Sometimes, even in an adverse scenario, the humanity of each one turns to contribute to make people live, or, in dying with dignity, or to have another relation with finitude.

Finally, from the studies, humanization is not only health care, because it involves the work process in the complexity of its possibilities of feasibility, questions of bioethics and life itself. They also point out the elements involved and have interfered in the ways of their production, which, therefore, affect the lives of people, whether workers, users, family members, students, managers, among others. other, contributing in some way or not to the guarantee of integrality in health, as foreseen by SUS. Still, this study does not exhaust the question that opens possibilities for other investigations on humanization in the ICU.

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