COMPREHENSIVE CARE AND HUMANIZATION IN HEALTH: REFLECTIONS ON CARE OUTCOMES FROM AN INTERDISCIPLINARY PERSPECTIVE

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Abstract: Comprehensive care and humanization are fundamental dimensions for improving the quality of healthcare, especially in healthcare systems marked by increasing specialization, technological incorporation, and fragmentation of professional practices. This article aims to reflect on the relationships between comprehensive care, humanization, and interdisciplinary care, considering their repercussions on care outcomes and the experience of individuals in health services. This is a reflective article, based on contemporary scientific productions on humanized care, comprehensiveness, human dignity, person-centered care, and the relationships established between users, families, and professionals. The reflection shows that humanization goes beyond individual attitudes of welcoming and cordiality, involving relational, ethical, clinical, structural, and organizational dimensions. From this perspective, comprehensiveness presupposes recognizing the person in their biological, psychological, social, and spiritual dimensions, while interdisciplinarity favors the articulation of different knowledge and practices around shared care needs. It is argued that the convergence of these elements can impact the quality of care, safety, autonomy, satisfaction, therapeutic relationships, and continuity of care. It is concluded that achieving better health outcomes requires overcoming fragmented models and strengthening interdisciplinary practices guided by dignity, listening, and person-centered care.

Keywords: Humanization of Care. Comprehensive Health Care. Interprofessional Relationships. Patient-Centered Care. Quality of Health Care.

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Introduction

The scientific and technological transformations that have occurred in recent decades have significantly expanded the diagnostic, therapeutic and care possibilities of health systems. The development of new technologies, the growing professional specialization and the improvement of resources for the monitoring of acute and chronic conditions have contributed to modify the capacity for intervention in the health-disease process. However, technical advances do not necessarily ensure that the care experience is comprehensive, humanized, or centered on the person's needs. On the contrary, the more complex the care system becomes, the greater the challenge of preventing the subject from being reduced to the disease, procedure or clinical need that motivated his or her entry into the service.

This tension becomes particularly evident when one considers that the quality of care cannot be evaluated exclusively by technical indicators or by the effectiveness of the procedures performed. The experience of the people who use the services is also an important dimension of quality. Al-Jabri, Turunen, and Kvist (2021) highlight that patients' perceptions provide important information about the overall quality of care, involving experiences with professionals, communication, responsiveness, care organization, and care management. In addition, when care is personalized and holistic, patients may show greater satisfaction and confidence, as well as greater willingness to follow the therapeutic plan established jointly with professionals.

In the Brazilian context, the humanization of care gained greater institutionality with the creation of the National Humanization Policy (NHP), instituted by the Ministry of Health in 2003, with the purpose of strengthening care and management practices based on valuing users, workers and managers of the Unified Health System (SUS). Based on principles such as welcoming, participation, co-responsibility, autonomy of the subjects and strengthening of teamwork, the PNH proposes the reorganization of care processes from an ethical, democratic perspective centered on people's needs. Thus, humanization is no longer understood as an isolated action or an individual

attribute of professionals, and becomes a transversal guideline for the organization of care networks and for the qualification of health care.

Thinking about comprehensive care requires, therefore, shifting the gaze from a predominantly biomedical understanding to a perspective capable of recognizing that falling ill produces repercussions that go beyond organic functioning. The person who needs care remains inserted in a history, in family and social relationships, in values, beliefs, expectations and concrete conditions of existence. Núñez-Sánchez, de la Calle Maldonado, and Castañera Ribé (2026) understand comprehensive care as a practice directed to the person in their entirety, articulating biological, psychological, social, and spiritual dimensions. In this conception, accompanying and caring presuppose presence, listening, co-responsibility and recognition of the dignity of those who are in a situation of vulnerability.

Dignity occupies a central position in this expanded understanding of care. Šip et al. (2023) point out that its preservation during hospitalization is related to autonomy, recognition of cultural and spiritual beliefs, and multidimensional consideration of the person. The authors advocate an approach centered on the patient and committed to its biopsychosocial and spiritual dimensions, involving professionals, patients and family members in the construction of a care environment that protects human dignity. Thus, humanizing does not only mean making professional contact more cordial, but recognizing the subject as a legitimate participant in decisions related to their own health.

This discussion becomes even more necessary in view of the risk that highly specialized and technologically mediated environments favor fragmented care relationships. When analyzing humanization in the context of intensive care, Kvande, Angel, and Nielsen (2022) identified the need to balance the technological domain with a holistic understanding of the person, including family members and social context. For the authors, humanization does not depend exclusively on the individual conduct of the professional, but is also presented as an organizational orientation capable of involving different actors in the health system.

Thus, one of the main contemporary challenges is not to reject technology or specialization, but to prevent both from replacing the human relationship that sustains care. Technology can

contribute to better clinical outcomes and greater safety, but it does not respond, in isolation, to the needs related to fear, autonomy, understanding of the disease, family relationships, expectations and meanings attributed to the disease. Humanization emerges precisely from the possibility of integrating technical-scientific competence and relational competence, avoiding a false opposition between clinical excellence and sensitivity to human needs.

In this scenario, interdisciplinarity takes on particular relevance. The complexity of the needs presented by people can hardly be contemplated by the isolated performance of a professional category. Comprehensive care requires circulation of information, communication, shared decision-making, and recognition of the complementarity of the different knowledge centers. This perspective is supported by the study by Al-Jabri, Turunen, and Kvist (2021), in which interdisciplinary collaboration integrates the dimensions used to assess patients' perceptions of the quality of hospital care.

However, the simple coexistence of different professionals in the same service does not necessarily characterize an interdisciplinary practice. When each professional center intervenes in a parallel and uncommunicative way, the patient can remain as a point of convergence for multiple interventions, but without effectively experiencing integrated care. In this logic, the fragmentation of knowledge can be transformed into fragmentation of the care experience itself. The challenge lies in making different knowledges dialogue around a shared care project, in which clinical and subjective needs are recognized without one dimension canceling out the other.

Humanization also needs to be understood beyond the individual disposition of professionals. Meneses-La-Riva, Suyo-Vega, and Fernández-Bedoya (2021) identify barriers that hinder the implementation of humanized care in services and highlight the importance of professional training for the development of communication, relational skills, human values, and safe environments. The authors themselves draw attention to care environments characterized by overload, insufficient resources and professional exhaustion, demonstrating that concrete working conditions interfere with the possibility of establishing humanized relationships.

This understanding is reinforced by Allande-Cussó et al. (2025), who place humanization

simultaneously in the relational, structural, and organizational dimensions. For the authors, humanizing implies advancing from a traditional model, predominantly biomedical and paternalistic, to person-centered care, capable of respecting choices and preferences and involving patients, family members, professionals, and managers. This change broadens the discussion because it demonstrates that the responsibility for humanization cannot fall exclusively on the professional who is directly at the bedside: it also depends on adequate resources, possible workloads, committed management and institutional cultures oriented towards care.

From this perspective, integrality, humanization and interdisciplinarity can be understood as interdependent dimensions. Comprehensiveness expands what needs to be recognized as a need; humanization ethically and relationally guides the way in which these needs are welcomed; and interdisciplinarity creates possibilities for different knowledge and skills to be articulated in more coherent care responses. Its effects can reach dimensions such as quality, safety, accessibility, autonomy, satisfaction, trust, and strengthening of therapeutic relationships, although the magnitude and nature of these outcomes still require empirical investigation in different contexts. Allande-Cussó et al. (2025) also highlight the need to expand the evaluation of the impact of humanization on health outcomes.

In view of these considerations, it is pertinent to discuss the extent to which contemporary care models have been able to transform the principles of comprehensiveness and humanization into concrete care practices, especially in scenarios in which different professionals, services and care levels simultaneously participate in the user's trajectory. More than conceptually defending humanized care, it is necessary to understand which relationships, working conditions, forms of organization and modes of interdisciplinary articulation favor its implementation and how these elements can have repercussions on the experience and results of care.

Thus, this article aims to reflect on the relationships between comprehensive care, humanization and interdisciplinary care, discussing their possible repercussions on care outcomes and on people's experience in health services. The reflection is based on the understanding that better

results do not depend exclusively on the availability of technologies or the isolated competence of each profession, but also on the capacity of services and teams to produce articulated, dignified, relational and effectively person-centered care.

Development

From care fragmentation to comprehensive care

Comprehensiveness of care is based on the recognition that health needs are not presented in a compartmentalized way. Although the organization of services and the training of professions have historically produced specialized fields of knowledge and intervention, the experience of illness remains integrated into the person's existence. Physical symptoms, emotional distress, family relationships, social conditions, values, beliefs, expectations, and the ability to participate in therapeutic decisions coexist and influence the way each individual experiences their health-disease process. In this sense, comprehensive care requires overcoming the logic according to which the care response ends when the immediate biological need is identified and treated.

This understanding is supported by the perspective presented by Núñez-Sánchez, de la Calle Maldonado, and Castañera Ribé (2026), for whom comprehensive care is directed to the person in its entirety and articulates biological, psychological, social, and spiritual dimensions. The authors relate this conception to accompaniment, understood as a practice marked by presence, listening, co-responsibility and recognition of the dignity of the person in a situation of vulnerability. In this way, care ceases to represent exclusively an intervention on a given clinical condition and starts to involve a relational and ethical response to the needs of the person who needs to be cared for.

This change in perspective is particularly important because the fragmentation of care does not result only from the existence of different specialties. It manifests itself when knowledge remains isolated, when communication between professionals is insufficient or when different interventions are carried out without articulation around the person's needs. It is possible, therefore, for a user

to be accompanied by several professionals and, even so, receive fragmented care. The number of categories involved in the care does not ensure, by itself, comprehensiveness.

From this point of view, comprehensiveness needs to be understood less as the sum of interventions and more as the ability to establish connections between them. This means recognizing that different needs demand different competencies, but that these competencies need to converge to a shared understanding of care. Interdisciplinarity gains meaning precisely at this point: not because of the dissolution of professional specificities, but because of the possibility of constructing responses that go beyond the limits of a single discipline.

The centrality of the person also modifies the position traditionally attributed to the user in the care relationship. If care is intended to be comprehensive, the recipient cannot exclusively occupy the place of recipient of professional decisions. Their knowledge about their own lives, preferences, experiences, values, and priorities need to be part of the decision-making process. Allande-Cussó et al. (2025) associate humanization with the transition from a traditional, biomedical, and often paternalistic model to a person-centered perspective that recognizes their autonomy, choices, and preferences.

Integrality, therefore, also presupposes recognizing autonomy without disregarding vulnerability. The condition of illness can increase dependencies and produce insecurities, but this does not eliminate the subject's ability to participate in their own care. Núñez-Sánchez, de la Calle Maldonado, and Castañera Ribé (2026) argue that vulnerability should not be understood simply as a disability or incapacity, but as a condition that makes ethical responsibility possible and necessary in the care relationship. From this perspective, protecting does not mean replacing the other in their choices, but offering conditions for them to remain recognized as a subject even in moments of greater fragility.

There is, in this movement, an important rupture with care oriented predominantly by productivity and standardization. Protocols, routines and technologies are indispensable to organize safe practices based on scientific knowledge; however, they cannot eliminate the singularity. Núñez-

Sánchez, de la Calle Maldonado and Castañera Ribé (2026) warn of contemporary relational models marked by productivity, fragmentation and acceleration, contrasting them with a culture of accompaniment capable of recovering the centrality of the person, of human presence and interdependence.

Thus, comprehensiveness is not opposed to technical excellence. On the contrary, it expands its meaning. Technically adequate care, but incapable of recognizing suffering, establishing understandable communication, considering preferences or articulating professionals and services, can produce important clinical responses without necessarily constituting a comprehensive care experience. The contemporary challenge is to associate technical precision, safety and effectiveness with the ability to recognize who is the person who receives that intervention and what needs accompany their clinical condition.

Humanization as an ethical, relational and organizational dimension of care

Humanization is often associated with cordiality, empathy, or a respectful way of communicating. Although these elements are indispensable, restricting the concept to interpersonal attitudes reduces its complexity and can transfer to each professional a responsibility that also belongs to health institutions and systems. Humanizing involves relationships, but it also involves working conditions, resources, organization of care processes, user participation and forms of management that enable or hinder person-centered practices.

Meneses-La-Riva, Suyo-Vega, and Fernández-Bedoya (2021) demonstrate that patients and professionals recognize the need to overcome existing barriers in services to strengthen humanized care. Among the elements emphasized are empathetic care experiences, respect for beliefs and customs, communication, relational skills, human values and the construction of safe environments. These aspects show that humanization is materialized in daily relationships, especially in the way professionals recognize, listen and respond to the needs presented.

Communication plays a decisive role in this process. It is not just about transmitting guidelines, but about creating conditions for understanding, expression of doubts, manifestation of preferences and participation. Excessively technical language, vertical communication and the absence of spaces for listening can increase the asymmetry between professionals and users. On the contrary, understandable communication and active listening favor bonds of trust and make it possible for the patient to participate more effectively in decisions related to their own care.

Humanization also involves recognizing the family as a relevant part of the illness experience, respecting the preferences and circumstances of each patient. Meneses-La-Riva, Suyo-Vega, and Fernández-Bedoya (2021) highlight the relationship between patient, family, and professional as a component of humanized care, encompassing emotional, spiritual, and educational information and support, in addition to the promotion of self-care and safe environments. In this way, care is no longer circumscribed to the procedure and starts to consider the relationships that sustain the person throughout their care trajectory.

This perspective is also directly related to dignity. Šip et al. (2023) understand the preservation of dignity during hospitalization from a multidimensional perspective, involving autonomy and recognition of the cultural, social, and spiritual dimensions of the person. The authors argue that professionals, patients and family members share responsibilities in building an environment that preserves the dignity of those who need care. Thus, dignity should not be perceived as an abstract concept, but as a principle that is concretely expressed in privacy, communication, respect, the possibility of choice and the way in which the subject is recognized during care.

However, expecting professionals to produce humanized relationships regardless of the conditions in which they work would be contradictory. Humanizing also requires institutional conditions to care. Allande-Cussó et al. (2025) organize this understanding into relational, structural, and organizational dimensions. In the relational dimension, therapeutic relationships, empathetic communication, trust, collaboration and patient participation stand out; in the structural, adequate human and material resources stand out; and, in the organizational field, they include protocols,

clinical trajectories, and a culture of collaboration between different disciplines.

This formulation is especially relevant because it prevents humanization from being converted into an isolated behavioral requirement directed at workers. It is not enough to ask professionals to be more welcoming when teams are insufficient, the workload makes adequate listening unfeasible, or organizational processes continuously fragment care. In this context, humanization also needs to reach those who care. Decent working conditions, permanent training, institutional support and collaborative relationships become part of the humanization project itself.

Therefore, humanizing means producing conditions for technical competence to be exercised without the person disappearing behind the diagnosis, technology or institutional demands. It also means recognizing that the quality of care relationships depends on decisions that go beyond the individual encounter between professional and patient. It is in this sense that humanization acquires an ethical and political dimension: it questions not only how the professional cares, but also how the services are organized to allow care to happen.

Interdisciplinarity as a possibility of integration and continuity of care

Interdisciplinarity represents one of the possible ways to transform integrality from an abstract principle into care practice. People with complex needs often move through different professionals, sectors and services. In this path, each category identifies problems and possibilities for intervention based on its field of knowledge. This diversity constitutes a power for care, as long as it is accompanied by communication and the shared construction of objectives.

It is important, however, to distinguish the presence of a multiprofessional team from the effectiveness of interdisciplinary work. Multiprofessional action can remain organized by parallel interventions, in which each professional evaluates and conducts what belongs to his or her field. The interdisciplinary perspective requires an additional movement: dialogue between knowledges, recognition of interdependencies and construction of decisions that simultaneously consider different

dimensions of the needs presented.

This articulation does not mean eliminating limits or professional competences. On the contrary, interdisciplinarity depends on the existence of specific knowledge, but requires that it be placed in relation. Care becomes more integrated when each professional understands not only their own intervention, but also how it connects to the decisions and actions of the other team members. In this way, the therapeutic project ceases to represent a succession of independent conducts and becomes a shared construction.

Allande-Cussó et al. (2025) emphasize the importance of promoting a culture of collaboration and teamwork among professionals from different disciplines, relating this articulation to the search for better results, patient well-being, satisfaction, and clinical efficiency. The authors also indicate communication, empathy and teamwork as relevant elements for positive patient experiences and for the quality of care.

Communication between professionals thus becomes a fundamental technology of interdisciplinary care. When relevant information remains restricted to certain categories or sectors, the possibility of disconnected decisions and fragmented care experiences increases. On the other hand, spaces for clinical discussion, shared planning, and structured communication favor a broader understanding of needs and allow different interventions to be organized around common goals.

The interdisciplinary perspective can also strengthen the continuity of care. Care does not necessarily end with the completion of a procedure, discharge from a certain sector or transfer to another service. For the person, the health-disease process maintains continuity, even though administratively it is divided between units, teams and levels of care. This difference between the continuity of the user experience and the institutional fragmentation of services constitutes a critical point for reflection on comprehensiveness.

From this perspective, continuity depends on what information, needs, risks, preferences, and care plans are able to accompany the person on his or her journey. When this does not occur, it is often up to the user or the family to reconstruct the clinical history and establish connections between

services that should work together. An effectively humanized care network should seek to reduce these ruptures, recognizing that transitions are also moments of care and not simple administrative displacements.

Accompaniment, as discussed by Núñez-Sánchez, de la Calle Maldonado and Castañera Ribé (2026), offers an interesting reflective key to understanding this continuity. The authors present it as a relational logic that puts the vulnerable person back at the center and opposes models that are excessively oriented by disease, technical efficiency or standardization. Although this concept does not replace the organizational mechanisms necessary for care coordination, it draws attention to a fundamental dimension: continuity also means that the person does not perceive himself abandoned between different stages of his or her journey.

In this way, interdisciplinarity can function as a link between integrality and humanization. It allows us to recognize that no profession alone responds to the totality of human needs and that the quality of care depends not only on the excellence of each intervention, but also on the quality of the connections established between them.

Comprehensive and humanized care and its repercussions on care outcomes

The discussion about humanization gains greater consistency when it goes beyond the normative field and approaches the results produced by care. It is not enough to say that humanizing is desirable; It is necessary to problematize the extent to which relational, structural, and organizational dimensions can have repercussions on quality, safety, experience, and other relevant outcomes for patients, families, professionals, and services.

In this sense, the user's perception is an important indicator. Al-Jabri, Turunen, and Kvist (2021) demonstrate that patients' evaluation of quality involves different components of the care experience and that their perceptions provide information about communication, responsiveness, relationships with professionals, and care management. The authors also argue that personalized and

holistic experiences can favor satisfaction, trust, and willingness to follow the agreed therapeutic plan.

The patient's experience, therefore, should not be understood as a secondary result in the face of the so-called clinical outcomes. Feeling heard, understanding the information received, trusting the team and participating in decisions are relevant components of the quality of care itself. An intervention can achieve a certain clinical objective and, simultaneously, produce an experience marked by insecurity, misunderstanding, or loss of autonomy. The humanized perspective questions precisely the idea that the success of care can be evaluated by a single dimension.

Meneses-La-Riva, Suyo-Vega, and Fernández-Bedoya (2021) associate humanized care with indicators related to the quality of care processes, safe environments, promotion of self-care, health education, and sustainability of care. These findings broaden the reflection on outcomes by demonstrating that relational aspects can be connected to behaviors and processes that are important for the continuity of care.

Autonomy is another relevant result. Person-centered care needs to produce conditions for the user to understand, participate and express their priorities. Humanizing, from this perspective, does not only mean offering emotional comfort, but also redistributing possibilities of participation in the clinical relationship. Empathetic and transparent communication, trust, and collaboration are pointed out in the model discussed by Allande-Cussó et al. (2025) as elements that can favor patient participation in decisions, satisfaction, and care results.

Security also needs to integrate this analysis. Humanization cannot be placed in opposition to clinical safety; Both need to coexist. Poor communication, low participation, overly rigid hierarchical relationships, and failures of articulation can limit the circulation of relevant information. For this reason, more open and collaborative relationships may constitute favorable conditions for the identification of needs and risks, although caution is needed not to establish causal relationships that the available studies have not yet demonstrated.

This caution is particularly important in view of the study by Allande-Cussó et al. (2025). As it is a study protocol, its propositions about the effects of humanization should not be presented as

proven results. The project was developed precisely to investigate the relationships between structural, organizational and relational dimensions and different outcomes, including patient experience, anxiety, sleep quality, pain and adverse events. Therefore, the attached literature supports the plausibility and relevance of investigating such relationships, but does not authorize the affirmation that all these outcomes are already causally established as a direct consequence of humanization.

This distinction strengthens, not weakens, reflection. Allande-Cussó et al. (2025) recognize that there is still a need to produce objective data on the relationship between humanization and health outcomes. This demonstrates an important gap: although there is broad ethical and care recognition of the need to humanize, the measurement of its effects remains a field to be deepened.

At the same time, this gap invites us to expand what is meant by outcome. If comprehensive care considers the person in his or her different dimensions, its results should not remain restricted to biomedical indicators either. Satisfaction, experience, autonomy, trust, quality of communication, continuity, family participation, emotional distress and perception of dignity can compose a more comprehensive assessment of the quality of care. This does not imply relativizing traditional clinical indicators, but recognizing that they represent only part of the care experience.

There is also an often forgotten dimension: the results related to the professionals themselves. It does not seem coherent to sustain a humanization policy directed only to the patient while workers experience environments that are incapable of offering adequate conditions for care. Núñez-Sánchez, de la Calle Maldonado, and Castañera Ribé (2026) relate the culture of accompaniment to the need for attention to the caregiver as well, indicating that environments based on more humane relationships can contribute to coping with experiences of isolation, depersonalization, and emotional exhaustion. Humanization, therefore, needs to reciprocally include those who receive and those who produce care.

At this point, a fundamental question emerges: is it possible to produce truly humanized care in organizational structures that dehumanize work? The answer seems to require abandoning the understanding of humanization as an exclusively individual attribute. Empathy, listening, and respect are indispensable, but they have limits when work processes make time, continuity, communication,

and collaboration unfeasible.

Contemporary models of humanization themselves point in this direction by integrating relational, structural, and organizational dimensions. Allande-Cussó et al. (2025) highlight that human and material resources, organization of flows, communication, and collaborative work need to be considered together. Therefore, better outcomes cannot be attributed only to the individual behavior of professionals, because they are produced within systems.

Comprehensive and humanized care must therefore be understood as a collective construction. It depends on the encounter between professional and user, but also on the relationships between professionals; the participation of families; working conditions; the organization of services; the articulation between different care points; and management models that recognize care as a process that is simultaneously technical, relational and ethical.

Reflection leads, finally, to an important change in the question of quality itself. Instead of just questioning "was the procedure performed correctly?", it is also necessary to ask: Have the person's needs been understood? Did she participate in the decisions? Was there communication between the professionals? Has his dignity been preserved? Was the family considered when relevant? Was the care continued? Did the structure offer conditions for professionals to take proper care?

It is in this set of issues that integrality, humanization and interdisciplinarity converge. The first prevents human need from being reduced to one dimension; the second preserves the centrality, dignity and participation of the person; and the third seeks to articulate the different knowledge necessary to respond to the complexity found. More than three independent concepts, they constitute complementary dimensions of the same care project: producing technically qualified care without losing sight of who is cared for, who cares and the relationships that make care possible.

Conclusion

The reflection developed allows us to understand that comprehensive care, humanization

and interdisciplinarity should not be treated as parallel or complementary dimensions of care, but as profoundly interdependent elements. Comprehensiveness broadens the view of the person's needs; humanization guides the ethical, relational and organizational way in which these needs are welcomed; and interdisciplinarity favors the articulation of the different knowledge necessary to respond to the complexity of the health-disease process.

In this sense, comprehensive care presupposes recognizing that the experience of illness is not limited to the biological body. Emotional, social, family, cultural and spiritual aspects participate in the way the person understands their condition, copes with the treatment and establishes relationships with professionals and health services. This understanding is supported by the perspective of Núñez-Sánchez, de la Calle Maldonado, and Castañera Ribé (2026), who situate comprehensive care in an approach focused on the totality of the person, valuing presence, listening, co-responsibility, and recognition of human dignity.

Humanization, in turn, is incompatible with an understanding restricted to the cordiality or individual attitude of the professional. Although empathy, respect, communication and bonding are essential, the production of truly humanized care also depends on structural and organizational conditions capable of sustaining good care relationships. Allande-Cussó et al. (2025) reinforce this perspective by understanding humanization from relational, structural, and organizational dimensions, including adequate resources, organization of processes, and strengthening of collaborative work between different disciplines.

This understanding is especially important because it prevents the responsibility for humanization from falling exclusively on those who are on the front line of care. Professionals subjected to overload, insufficient resources and fragmented processes find concrete limits to establish qualified listening, adequate communication and continuous monitoring. Thus, humanizing care also requires humanizing the conditions in which it is produced, recognizing that the quality of relationships between professionals, users and families is directly linked to the way services are organized.

Likewise, interdisciplinarity emerges as an important condition for overcoming fragmentation.

The mere presence of different professional categories does not guarantee integration. It is necessary for knowledge, information, and decisions to circulate among team members and be organized around shared needs and goals. When different types of knowledge remain isolated, the patient can receive multiple interventions without actually experiencing integrated care. Interdisciplinary collaboration allows transforming professional diversity into care complementarity.

Such articulation also has implications for the continuity of care. The trajectory of people through health services does not occur in a fragmented way from the point of view of those who experience the disease, although it is often divided between different sectors, specialties and levels of care. For this reason, a comprehensive and humanized model needs to reduce ruptures, favor communication between teams, and recognize transitions as constitutive parts of the care process itself.

With regard to outcomes, the studies analyzed point to the relevance of a broader understanding of care outcomes. Quality should not be measured exclusively by traditional clinical indicators. Patient experience, satisfaction, autonomy, trust, participation in decisions, communication, continuity, perceived safety, and preservation of dignity are also important outcomes of care. Al-Jabri, Turunen, and Kvist (2021) demonstrate that user perception is a relevant source for quality assessment and that personalized and holistic experiences can favor trust, satisfaction, and greater willingness to follow the care plan.

However, it is necessary to maintain caution in the interpretation of these relationships. Although the literature supports the relevance of humanization and comprehensiveness for the quality of care, not all outcomes can be presented as causally proven effects. The protocol by Allande-Cussó et al. (2025), for example, highlights precisely the need to empirically deepen the relationships between humanization and outcomes such as pain, anxiety, sleep quality, patient experience, and adverse events. This gap reveals an important field for future investigations.

Even so, the reflection shows that the quality of care does not depend only on technologies, protocols or isolated technical performance. It is also produced in relationships, communication,

the recognition of uniqueness, the ability to articulate knowledge and the existence of institutional structures that allow care with safety and dignity. Meneses-La-Riva, Suyo-Vega, and Fernández-Bedoya (2021) reinforce this understanding by highlighting the importance of empathy, relational skills, health education, trust, and professional training for the consolidation of humanized practices.

Thus, it is concluded that moving towards better outcomes in care requires overcoming fragmented and excessively disease-centered models, strengthening practices that recognize the person as a subject of care and professionals as members of a collective construction. Comprehensiveness, humanization and interdisciplinarity must permeate clinical practice, professional training, service management and the organization of care networks.

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