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Humanized Management and Quality of Work Life in Health Care Services

Neide Moreira de Souza
Universidad de Ciencias Empresariales y Sociales

Suzana Santos da costa
Universidad de Ciencias Empresariales y Sociales

Suzana do Ceu da Silva Rodrigues Costa
Universidad de Ciencias Empresariales y Sociales

Michele Cavalcante Sabino
Faculdade Integrada e Instituto Souza

Grazielli Meneses Brito
Universidad de Ciencias Empresariales y Sociales

Cristiane da Silva Albuquerque
Universidad de Ciencias Empresariales y Sociales

Helena Maria Vianna Graça
Universidade Federal do Rio de Janeiro

Maria Teresa Pinheiro Ribeiro
Universidad de Ciencias Empresariales y Sociales

Abstract

Humanized management constitutes a strategic dimension of health care quality, as it integrates workers' dignity, patient safety, and institutional sustainability. This essay aims to discuss the relationship between humanized management and quality of work life, identifying organizational challenges and opportunities for transforming management practices. A theoretical-reflective approach was adopted, drawing on scientific literature and institutional documents addressing occupational health, leadership, professional participation, and burnout prevention. The analysis indicates that humanization cannot be restricted to welcoming and supporting patients; rather, it must also encompass working conditions, autonomy, professional recognition, equity, and protection against psychosocial risks. Excessive workloads, precarious employment arrangements, workplace violence, and hierarchical communication undermine health care teams and may compromise continuity of care. Conversely, participatory leadership, adequate staffing levels, institutional support, and

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context-sensitive process evaluation can foster safer and more collaborative work environments. It is argued that individual well-being initiatives are insufficient when disconnected from structural changes. The essay concludes that promoting quality of work life requires integrating health professionals' well-being into governance decisions through meaningful participation, clearly defined responsibilities, and continuous monitoring. Consolidating this perspective depends on sustained policies that address inequalities across professional groups and are guided by scientific evidence and labor rights in contemporary health care settings.

Keywords: Humanization of Care; Quality of Life; Occupational Health; Health Management; Health Personnel.

Introduction

Health care management faces a persistent tension between the need to ensure efficient clinical responses and the ethical obligation to preserve the dignity of those who provide and receive care. Humanization is not limited to courteous interactions during service delivery; it also involves working relationships, participation in decision-making, professional recognition, and institutional conditions that make safe care possible. In Brazil, the National Humanization Policy links the transformation of health care delivery to changes in management practices (BRASIL, 2013).

Quality of work life, in turn, extends beyond individual job satisfaction and encompasses workload, autonomy, schedule predictability, social protection, the physical work environment, and interpersonal relationships. In organizations characterized by high clinical responsibility, extended working hours, and frequent exposure to suffering, the absence of these conditions can turn professional commitment into a source of exhaustion. The job demands-resources model helps explain this imbalance (DEMEROUTI et al., 2001).

International literature has progressively shifted the debate away from isolated self-care strategies toward organizational responsibilities. Reviews of occupational burnout and documents issued by multilateral organizations emphasize that preventing psychosocial risks requires changes to work processes, leadership practices, and organizational structures, without placing the sole responsibility for work-related illness on individual employees (MASLACH; LEITER, 2016; MONTGOMERY et al., 2019; WORLD HEALTH ORGANIZATION, 2022).

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In this context, this essay aims to critically examine the relationship between humanized management and quality of work life in health care services, exploring their conceptual foundations, barriers, and implementation opportunities. It argues that team well-being is a dimension of health care quality and health system sustainability, rather than a peripheral benefit to be provided only when surplus resources are available (FRIEDMAN et al., 2023).

Methodology

This paper is an academic essay of a theoretical-reflective nature, drawing on scientific literature and institutional documents addressing humanization, occupational health, leadership, professional burnout, and the organization of work in health care. Publications with conceptual relevance and practical contributions to health service management were prioritized, including literature reviews, empirical studies, and guidelines issued by the World Health Organization, the International Labour Organization, and the Brazilian Ministry of Health.

The literature was selected purposively rather than systematically, based on the relevance of the texts to the argument developed in this essay. The sources were interpreted through thematic analysis, integrating three main areas: organizational conditions for care delivery, power relations and participation, and institutional strategies for promoting well-being. As this is not a systematic review, it does not claim to provide an exhaustive account of the literature, pooled estimates of effect, or a formal risk-of-bias assessment. The propositions presented are analytical and argumentative in nature.

Discussion

The first requirement of humanized management is to recognize that health care workers are not merely productive resources. They are individuals with knowledge, needs, and rights, whose lived experiences reveal problems that often remain invisible to administrative indicators. A humanization policy that focuses exclusively on relationships with patients while tolerating humiliation, discrimination, or insecurity among health professionals creates an institutional contradiction (BRASIL, 2013; FRIEDMAN et al., 2023).

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Work organization is a key determinant of quality of work life. Understaffed teams, constant interruptions, and demands that are incompatible with the time available create excessive workloads and undermine the provision of individualized care. The job demands-resources model demonstrates that autonomy, support, and adequate tools can buffer job demands, but this does not justify the indefinite maintenance of excessive workloads (DEMEROUTI et al., 2001).

Occupational burnout should be understood as a phenomenon associated with chronic working conditions rather than as a manifestation of individual weakness. Maslach and Leiter (2016) emphasize the importance of mismatches between individuals and their work environments, while Dall'Ora et al. (2020) describe factors associated with burnout in nursing. This perspective supports preventive interventions targeting the contexts in which work-related distress arises.

Leadership plays a decisive role in the everyday experiences of health care teams. Managers who communicate decision-making criteria, welcome questions, distribute responsibilities fairly, and encourage suggestions tend to foster trust and cooperation. However, training managers in active listening and communication must be accompanied by effective shared decision-making mechanisms; otherwise, participation may become merely symbolic (WORLD HEALTH ORGANIZATION, 2022).

Professional autonomy does not imply an absence of coordination. Rather, it means having the appropriate scope to adapt practices to patients' needs while maintaining adherence to safety protocols. Studies on empowerment in nursing associate access to information, support, and opportunities with the work environment and occupational strain, suggesting that the distribution of institutional power deserves as much attention as the distribution of tasks (LASCHINGER et al., 2001).

Working hours and rest periods should be incorporated into the strategic management agenda. Extended shifts, unpredictable scheduling, and difficulties balancing work and personal life can intensify fatigue and strain family relationships. Organizational responses must account for the need to maintain adequate health care coverage while also respecting human limits, ensuring transparent scheduling practices, and providing genuine opportunities for recovery (NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, 2019).

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Protecting mental health requires preventive measures, confidential access to care, and efforts to combat stigma. Joint documents issued by the WHO and the ILO recommend managing psychosocial risks within the workplace, training managers, and supporting workers experiencing mental health conditions. Providing psychological counseling without addressing harassment, violence, or excessive workloads constitutes an incomplete response (INTERNATIONAL LABOUR ORGANIZATION; WORLD HEALTH ORGANIZATION, 2022).

Occupational violence, including aggression perpetrated by patients, family members, or colleagues, must not be normalized as an inevitable part of health care work. Reporting protocols, post-incident support, and proportionate institutional responses are essential components of a culture of protection. International commitments to the rights of health workers emphasize harm prevention, inclusion, support, and the safeguarding of workers' rights (WORLD HEALTH ORGANIZATION, 2023).

Humanized management requires attention to internal inequalities. Differences in employment arrangements, gender, professional category, and hierarchical position can determine whose voices are heard and who bears the most demanding tasks. Equity requires transparent criteria for remuneration, career progression, professional development, and work allocation, as well as accessible channels for reporting discrimination without fear of retaliation (FRIEDMAN et al., 2023).

Continuing professional development can strengthen health care teams' capacity to respond to challenges, particularly when learning activities arise from problems identified within the services themselves. However, training initiatives alone cannot replace adequate staffing levels or investment in equipment. International reports on the nursing workforce address education, employment, and leadership as interdependent dimensions of health care capacity (WORLD HEALTH ORGANIZATION, 2020).

Performance indicators should avoid an exclusively quantitative understanding of productivity. Waiting times and service volumes are relevant, but they do not fully capture quality. Absenteeism, staff turnover, occupational accidents, perceptions of organizational justice, psychological safety, and patient satisfaction can be incorporated into a balanced performance dashboard, provided that the data are interpreted in context and are not used to blame vulnerable teams (MONTGOMERY et al., 2019).

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The experience of emergency departments illustrates the complexity of these relationships. Continuous exposure to critical situations and the need to make rapid decisions make peer support, supervision, and effective workflow organization essential. A meta-analysis of burnout among emergency nurses further underscores the importance of considering specific work settings and avoiding uniform solutions for services with different risk profiles (GÓMEZ-URQUIZA et al., 2017).

Interventions targeting burnout may combine individual and organizational measures, but the former should not serve as substitutes for the latter. A systematic review and meta-analysis identified effects of interventions designed to reduce physician burnout, although considerable heterogeneity was observed across approaches. From a management perspective, the central priority is to develop coherent strategies that can be evaluated and sustained over time (WEST et al., 2016).

In contexts of financial constraint, humanization is often presented as an additional cost. This interpretation overlooks the consequences of staff attrition, absenteeism, and deterioration in the organizational climate. Although costs and outcomes must be evaluated within each specific context, the literature on burnout and work-life integration suggests that institutional sustainability also depends on retaining a healthy and stable workforce (SHANAFELT et al., 2019).

Ultimately, establishing a humanized organizational culture depends on political commitment and administrative continuity. Assessing risks, negotiating priorities with workers' representatives, assigning responsibilities, and reviewing outcomes constitute more consistent approaches than occasional motivational campaigns. Occupational health policies and workplace protection programs provide frameworks for integrating these actions into health service governance (BRASIL, 2012; WORLD HEALTH ORGANIZATION; INTERNATIONAL LABOUR ORGANIZATION, 2021).

Conclusion

Humanized management and quality of work life are inseparable dimensions of health care services capable of delivering safe, ethical, and sustainable care. The arguments developed in this essay demonstrate that respect, participation, and professional recognition can only be effectively realized when supported by adequate material conditions, appropriate staffing levels, protection against occupational risks, and responsible leadership.

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Humanization should therefore be understood as a principle of institutional organization rather than an exclusively behavioral attribute of health professionals.

It is concluded that meaningful transformation requires sustained policies, participatory evaluation, and a commitment to equity across professional categories and employment arrangements. The main limitation of this essay lies in the narrative and nonsystematic nature of the literature selection, which precludes inferences regarding the magnitude of effects. Future research could evaluate organizational interventions across different levels of health care and identify combinations of measures capable of simultaneously improving workers' well-being and the quality of care.

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