

Nursing students and teachers experiences and meanings of curricular integration of humanisation: A qualitative design

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Abstract

The dominance of the biomedical model in health education has impeded the integration of humanisation as a cross-cutting competency in nursing curricula. The present study aimed to explore the experiences and perceptions of faculty and students regarding a curricular innovation intended to incorporate humanisation competencies from the early stages of nursing education. A qualitative design was employed, using semi-structured interviews with six faculty members and eleven first- and fifth-year nursing students at a Chilean university. Data were collected between September and November 2024 and analysed using content analysis. The study is reported in accordance with the COREQ guidelines. Students who participated in the curricular intervention associated humanisation with specific tools and clinical experiences, whereas those who had not been exposed to the intervention described it mainly in terms of general attitudes, such as empathy. Faculty members identified institutional barriers and highlighted the importance of mentorship and supportive policies. The early and transversal integration of humanisation into the curriculum facilitated a more meaningful understanding and practice of person-centred care.

Keywords

curriculum development, humanisation care, nursing education, person-centred care, teaching strategies

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Introduction

In recent years, the increasing specialisation and technologisation of health services have significantly improved the safety and efficiency of care. However, a persistent and concerning phenomenon remains: the perception of dehumanisation in healthcare contexts.¹ This is reflected in cold and impersonal interactions between healthcare professionals and patients, undermining fundamental rights such as autonomy, dignity, beliefs, values and privacy. Contributing factors include insufficient competence in interpersonal skills and the absence of strategies for managing stress without compromising care quality.²

In nursing, humanised care is a core professional value because it encompasses not only technical expertise, but also empathy, sensitivity and respectful engagement. Nevertheless, nursing students often struggle to translate theoretical knowledge into practice due to the disconnect between academic and clinical environments, as well as challenges in interprofessional collaboration.³ Additionally, work overload can compromise nurse–patient communication, directly affecting the quality of care as perceived by patients. Studies have shown that patients value kindness, respect for beliefs and holistic attention, highlighting the

need to strengthen therapeutic relationships that address physical, emotional, social and cultural needs.^{4–7}

One structural factor contributing to dehumanisation is the dominant training model in health education. Across disciplines and contexts, curricula have historically prioritised biomedical approaches, thereby limiting the development of humanising competencies in future healthcare professionals,^{8,9} including nurses.¹⁰ High academic demands and a predominantly technical orientation in nursing education hinder the incorporation of interpersonal skills and self-care strategies into the learning process. The COVID-19 pandemic exacerbated these challenges by exposing the mental health vulnerability of both nursing students and professionals. The crisis not only strained the principles of holistic and empathetic care, but also revealed the insufficient

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preparation of training programmes to foster coping mechanisms and emotional resilience. As a result, high levels of depression,¹¹ moral distress and burnout were documented among these populations.¹² In Chile, the Superintendency of Higher Education reported a significant rise in complaints of harassment and mistreatment in 2023, underscoring the urgency of promoting safer and more humanised learning environments.¹³

Strengthening humanised care training has thus become a critical priority not only to improve patient interactions, but also to protect the emotional well-being of nursing students and staff. Humanisation in education could contribute to the prevention of psychological distress and even extreme outcomes such as suicide.¹⁴ Despite this, institutional gaps persist in academic and psychosocial support systems, highlighting the need to investigate how nursing education can foster a culture of respect and improve training conditions.^{15,16}

In response to these challenges, the Faculty of Nursing at the university under study implemented a curricular approach to enhance the comprehensive education of students by integrating competencies aimed at promoting humanised care. This initiative included a competency-based model, initially applied during the first two semesters through two disciplinary courses, inspired by the competency framework of Bermejo et al.^{17,18} Thus, this study aimed to evaluate the impact of this curricular innovation on students and faculty members by exploring their experiences and perceptions regarding humanised care training.

Methods

This study employed a qualitative design and was based on content analysis following Bardin's framework.¹⁹ To ensure methodological rigor and transparency, the study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ), using the Spanish translation and cross-cultural adaptation by Quemba-Mesa et al.²⁰

Context and setting

A curricula intervention was implemented in two first-year nursing courses at a Chilean university. The aim was to strengthen humanised care by integrating a competency-based model.¹⁷ Emotional, spiritual, relational and cultural competencies were incorporated alongside existing domains such as scientific-technical, ethical and managerial skills. The intervention was operationalised through workshops, role-playing and high-fidelity clinical simulations. Table 1 provides a comparative overview of learning outcomes and related competencies before and after the intervention.

Recruitment and participants

Participants were selected using a combination of purposive convenience sampling and snowball sampling, both appropriate for exploratory qualitative research aiming to capture diverse and context-specific perspectives. Inclusion criteria were: 1) being a first- or fifth-year nursing student currently enrolled in the programme or 2) being a faculty member with a minimum of 5 years of teaching experience in nursing.

Individuals who were unable to participate or declined to be recorded were excluded. The final sample consisted of six faculty members and eleven nursing students from first and fifth years, representing six campuses across three regions of Chile. This academic and geographical diversity enabled the inclusion of multiple perspectives on the humanisation training process.

Participants were invited via institutional email, which included information on the study's aims, voluntary nature of participation and ethical assurances concerning confidentiality. Those who agreed provided informed consent prior to the interviews. All interviews were conducted remotely using the university's Zoom platform (<https://www.zoom.com>). This sampling approach allowed the inclusion of participants with varying degrees of engagement in the humanisation curriculum, contributing both insider and peripheral insights to the analysis.

Data collection

Semi-structured interviews were conducted, lasting between 30 and 50 min. The interviews were carried out by fourth-year nursing students who served as co-investigators after receiving training in qualitative methodology and interviewing techniques. Interview guides were developed and pilot-tested for clarity and content, following the approach of Husband.²¹ To minimise potential bias, the principal investigator was not involved in the data collection process.

Data analysis

Data were analysed in two sequential stages. First, the co-investigators conducted descriptive coding of the interview transcripts. This was followed by a second stage of interpretive coding by the principal investigator. Units of meaning were identified, categorised, and analysed using MAXQDA software.²² An example of the coding framework, including meaning units, codes, emergent themes and participant perspectives, is presented in Table 2.

Ethical considerations

The study received ethical approval from the university's Research Ethics Committee (Project ID: CEC_FP_2024041). All participants provided informed consent, and all procedures were conducted in accordance with ethical research standards. Data confidentiality, protection, and secure storage were maintained throughout the research process.

Results

The results were organised by participant perspective. From the faculty perspective, the coding process (Figure 1) yielded six subthemes, which were then grouped into three overarching themes: 1) Meanings and challenges of humanisation, 2) Factors that facilitate or hinder humanisation in training and professional practice and 3) Humanisation training and the role of the nursing educator. These themes represented the educators' conceptualisations of humanised care, the

Table 1. Learning outcomes and related competencies pre- and post-intervention.

	Semester	Course	Learning outcome	Competencies
Pre-intervention learning outcome	First semester	Introduction to nursing studies	Identify basic concepts of health and public health in the national and international context Describe the main characteristics of the Chilean healthcare system and the organisation of its different levels of care Relate the different factors and social determinants that influence the population's health at a general level and within the national epidemiological reality Identify nursing models and theories and their importance in the development of the professional role	<i>Scientific-technical</i> <i>Scientific-technical, Management</i> <i>Scientific-technical, Cultural</i> <i>Scientific-technical, Ethics</i>
	Second semester	Nursing in the human life course	Identify the characteristics of individual growth and development in each stage of the life cycle as basic elements for nursing practice Understand the stages of the nursing process within the context of the life cycle Recognise the role of nursing professionals in leadership and effective oral and written communication within the deontological framework of the profession Apply basic nursing techniques and procedures in different stages of the life cycle Identify how care is manifested in different cultures and socio-health contexts, highlighting its anthropological relevance and its fundamental role in nursing practice and public health Recognise nursing as a discipline that, through its models and theories, actively defends and promotes human rights, ensuring dignity and equity in patient care Develop essential self-care and personal well-being skills that enable the creation of humanised contexts that care for individuals in their entirety Reflect on the role of nursing in social transformation, discussing how professionals can act as agents of change to improve quality of life and community health Explain the principles of humanisation in interactions with users through compassionate and person-centered care that recognises their individuality and socio-cultural context Explain the role of various disciplines within the healthcare environment, emphasising the importance of an interdisciplinary approach for comprehensive patient care Explain the characteristics of individual growth and development throughout the human life course as a fundamental element of the nursing care process Recognise the role of the nursing professional as a leader in effective communication and interdisciplinary collaboration in the nurse-user care relationship Demonstrate technical competencies and basic nursing procedures adapted to the specific demands of each stage of the life course, ensuring safe, dignified, and compassionate care Explain the stages of the nursing care process in the context of the human life course Apply the accompaniment relationship as a pillar of nursing practice, integrating humanisation principles to establish meaningful connections with users throughout the life course	<i>Scientific-technical</i> <i>Scientific-technical, Management and relational</i> <i>Scientific-technical, Cultural</i> <i>Scientific-technical, Ethics</i> <i>Scientific-technical</i> <i>Scientific-technical</i> <i>Scientific-technical, Management and relational</i> <i>Scientific-technical, Cultural</i> <i>Scientific-technical, Ethics</i> <i>Emotional and Spiritual</i> <i>Scientific-technical, Cultural</i> <i>Scientific-technical, Relational and cultural</i> <i>Management, Relational</i> <i>Scientific-technical</i> <i>Scientific-technical, Management and relational</i> <i>Scientific-technical, Ethics</i> <i>Scientific-technical Relational, Emotional, Spiritual</i>
	First semester	Introduction to nursing studies		
	Second semester	Nursing in the human life course		

Table 2. Overview process of analysis.

Meaning units	Codes	Emergent themes	Perspective
"... just asking the tutor how they prefer the child to be addressed. 'Do they call you Felipe? Do you like to be called Felipe?' ... These are such small things that others might overlook!"	Personalised care	<i>Perceived Concept of Humanisation</i>	Students
"... so that they feel that I am providing them with extra support beyond just treatment, and that they feel I am treating them as a human, as a person – not just giving them medical treatment. They should feel that I truly think about them as a person, as a patient."			
"... someone who is kind in every aspect, both professionally and personally, always willing to answer questions, like a professor."	Proximity with the student	<i>Teacher Qualities</i>	
"... and she had such a loving attitude that we felt like she was a mother to us."			

contextual barriers and enablers they encountered, and their perceived responsibilities in the educational process.

Meanings and challenges of humanisation (faculty)

Faculty members conceptualised humanisation in nursing as a comprehensive ethical and relational commitment that acknowledges the complexity of the human being. Unconditional acceptance was reflected in the recognition of patients' emotions and unique characteristics, while warmth and dignity were seen as fundamental in fostering a respectful care environment. Moreover, the notions of companionship, emotional connection, empathy and compassion were integrated into a form of care that transcends technical skills:

We must recognise practically all the values the patient holds, the patient's feelings, and the concerns they already carry with them. (Faculty member D06)

Faculty members conceptualised and warned that dehumanisation occurs when patients are reduced to mere objects. The objectification of the person was described as stripping individuals of their identity and dignity, while emotional disconnection and routinised behaviours indicated a distancing from affective care. This experience prompted a call to re-evaluate clinical practices and to reclaim both sensitivity and the intrinsic value of the person:

For me, dehumanisation is what is currently happening – where we stop treating each other as human beings and instead view patients merely as a disease or a hospital bed number ... We must stop seeing only the biological aspect; the patient is not just the cancer, not just the heart attack in bed four, but a person in all their dimensions. (Faculty member D05)

Factors that facilitate or hinder humanisation in training and professional practice

Faculty members identified obstacles that hindered the provision of truly humanised care. The lack of training prevented the integration of emotional dimensions, while the biomedical model continued to prevail over holistic approaches. Work overload and stress, together with negative role models and professional demotivation, were described as factors that undermined the quality of care. These challenges highlighted

the need for profound reforms to strengthen both affective support and educational guidance within healthcare contexts:

Talking about it sounds nice; we need to address emotions, spirituality, listen to the patient, and focus on psychological aspects, but what are the tools? Where do I start? Maybe, as professors, we are not psychologically prepared either. (Faculty member D06)

Faculty members valued the institutional support mechanisms that facilitated a more enriching educational experience. Student support departments were described as generating environments of well-being and containment, while scientific societies and extracurricular workshops broadened educational horizons. Humanisation policies were seen as strengthening identity and commitment, allowing university life to become an inclusive and sensitive space for both personal and professional development:

It is important to cover all areas of health, social sciences and, why not, all university disciplines. Today, it is not only associated with us but with a broader humanisation component. I believe it would be beneficial to create departmental instances that can work on modifying programme or contribute to our efforts. (Faculty member D02)

Humanisation training and the role of nursing educators

Educators emphasised that humanised nursing education was a core component of comprehensive nursing education. Structured spaces that promote interpersonal connection were seen as essential for fostering genuine interactions. The early implementation of approaches such as the Humanities model was regarded as laying a strong foundation for the development of humanistic competencies. Humanisation-based practices, integrated with quality standards, innovative methodologies and curricular design, were perceived as key to enabling transformative learning, merging theory and lived experience in each clinical encounter:

For the student not to see it as just another concept to incorporate, something in a checklist or because it is required. Instead, they should feel it, live it. Humanisation must be experienced – it

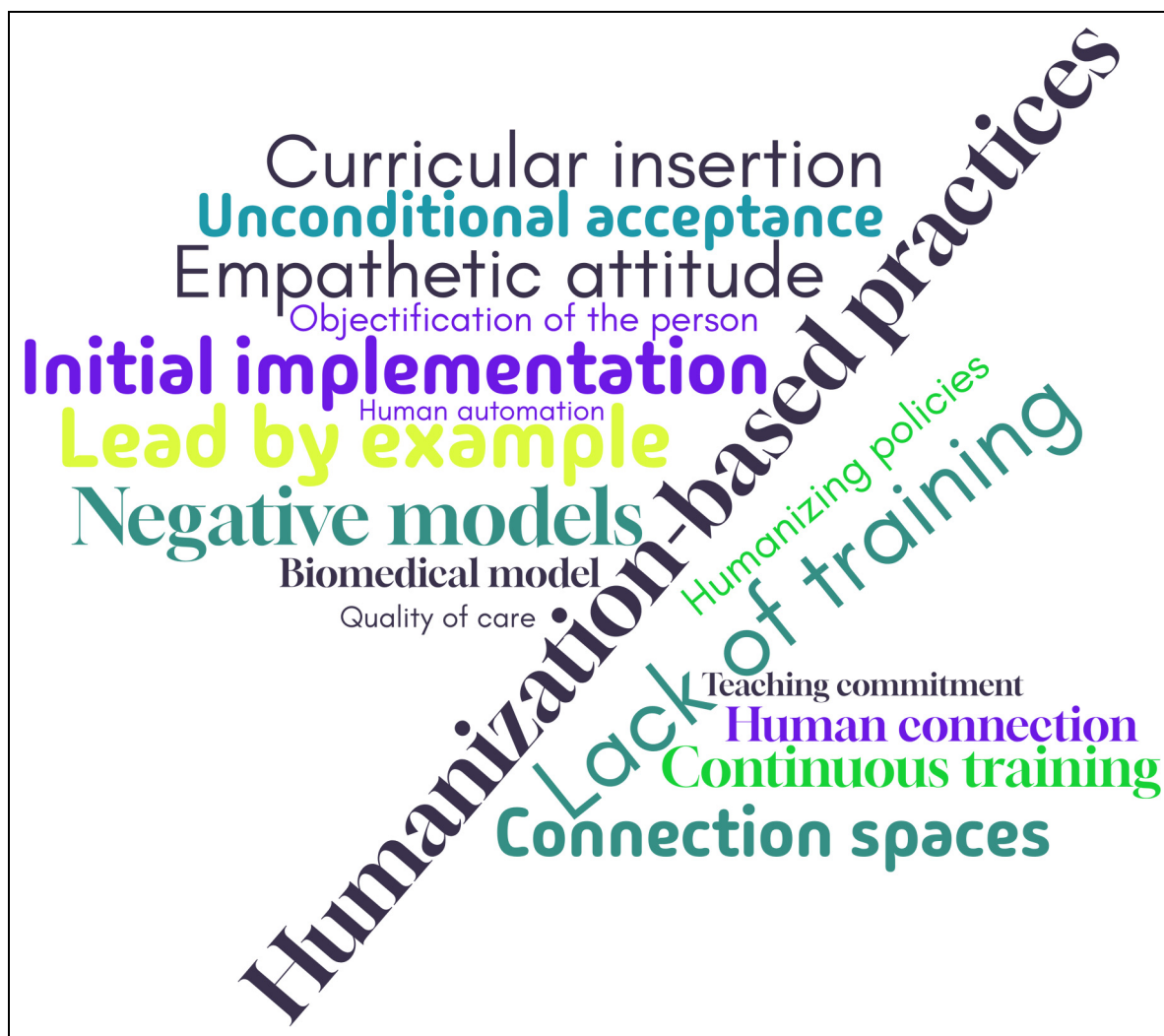


Figure 1. Codes, subthemes and main themes from faculty perspectives on humanisation.

starts with us, with our peers, with our colleagues. (Faculty member D05)

Educators described their qualities and role as extending beyond knowledge transmission, highlighting empathy as the foundation for building trust-based relationships. Ongoing teacher accompaniment and professional development were seen as intrinsically linked to the educator's responsibility to lead by example and demonstrate strong pedagogical commitment. These practices were viewed as inspirational and transformative, helping to cultivate learning environments where humanity and the holistic development of each student are prioritised:

I believe it is much more meaningful if we, as professors, also lead by example. It's not enough to say it – we must act accordingly. Looking at my students, learning their names – these small details help students feel connected, as an essential part of their training. (Faculty member D01)

Student perspectives on humanisation

The codes derived from the student interviews (Figure 2) led to the identification of seven subthemes, which were subsequently organised into three overarching themes: 1)

meanings and challenges of humanisation, 2) factors that promote or hinder humanisation and finally 3) training and the student's role in humanisation

These themes reflect students' interpretations of what humanised care means in their educational experience, the institutional and contextual factors that support or limit its development, and their own perceived role in fostering a humanised approach to nursing practice. It is important to note that only first-year students had received systematic curricular training in humanisation, through structured courses and methodologies integrated into the academic programme. In contrast, fifth-year students had been exposed only to isolated talks or extracurricular initiatives. This distinction shaped the way students from different levels perceived and articulated their understanding of humanised care.

Meanings and challenges of humanisation (students)

Students described and conceptualised humanised care as the recognition of a patient's personal history and emotional reality. They emphasised empathy and personalised attention as central elements, where dignity and effective communication serve to build respectful, trusting relationships. This perspective contrasted with the



Figure 2. Codes, subthemes and main themes from student perspectives on humanisation.

perceived coldness and detachment of purely technical approaches:

When treating a patient, for example, an elderly woman, I need to understand that she has a history and should be treated as I would like my grandmother to be treated. I must recognise that this person also has feelings and emotions. (First-year student P03)

And even the professors say: “Guys, put yourself in their place because it could be a relative, your mother, your grandmother, or even yourself someday”. (Fifth-year student Q05)

Students perceived and conceptualised dehumanisation in clinical settings where patients were reduced to routine tasks or impersonal identifiers. They associated apathy and depersonalisation with mistreatment, as well as with the rigid application of the biomedical model, which they felt inhibited the recognition of patients’ emotional and holistic needs:

Doing things just because I have to. Because it’s my job, and I get paid for it, but honestly, I don’t care about what the patient is feeling. (First-year student P05)

My grandmother passed away recently, and I also experienced it in the way the doctor informed me of her passing. It was a dehumanising experience, as they left her unattended in a room for a long time. (Fifth-year student Q05)

Factors that promoted or hindered humanisation

Students acknowledged that an adequate academic environment (e.g., institutional support) supported by policies that promote

humanisation, was essential. Comfortable physical spaces, supportive infrastructure, and institutional backing contributed to an atmosphere where values of care and respect were reinforced. These elements were seen to enhance students’ sense of well-being and promote a more integrative educational experience:

Children, well, now thanks to Emilio’s Law, everyone is accompanied; if they need anything, even the TV remote to distract themselves, those little details are instilled in us and add up. (First-year student P05)

Because on the fifth floor, they built little houses, which we call ‘the chicken coop,’ but they are very nice, and you can study there peacefully. (Fifth-year student Q05)

Students pointed out barriers to humanisation such as certain teaching resources and overly technical communication styles hindered humanised learning. The lack of adaptation in academic materials and the use of excessive technical jargon were viewed as obstacles to understanding the emotional and affective dimensions of patient care:

Manuals should be written more clearly, without so much technical jargon, so that the humanisation aspect is truly understood. (First-year student P05)

During my clinical practice, they told me, “Tone it down, this is too technical”, which made it difficult for me to understand and apply the concept of humanisation. (Fifth-year student Q01)

Training and the student’s role in humanisation

Students suggested that humanisation should be integrated transversally and from the early stages of the programme.

They recommended hands-on workshops and in-person activities that promote empathy and humanised care, ensuring that these values are embedded throughout their training in a sustained and experiential manner:

The university should implement this model from the first year since in many cases, it is introduced later; it is crucial to start early so that it becomes a habit. (First-year student P02)

A fully in-person workshop should be conducted from the beginning, so first-year students learn it and continue practising it until their final year. (Fifth-year student Q05)

From the students' perspective, the qualities of the educators such as being approachable and lead by example through their actions and professional experience. They expected their professors to demonstrate empathy, respect, and genuine vocation, helping to build a trusting environment that facilitates humanised learning:

The teacher must have sincerity and respect towards the student, creating an environment where they feel confident to express their needs. (First-year student P04)

I would like professors to have more closeness with students, without overstepping the student–teacher boundary. (Fifth-year student Q04)

Students described their role as active and collaborative, highlighting the importance of camaraderie, effective communication, and mutual responsibility. They emphasised that dialogue, participation, and peer support contribute to a learning environment where humanisation is present in every interaction:

If we have enough maturity, we must motivate our classmates so that together we promote an environment based on humanisation. (First-year student P05)

When a problem arises, we should discuss it and seek solutions without conflicts, creating a space for dialogue and mutual support. (Fifth-year student Q05)

Discussion

The literature has shown that, in the absence of systematic training, nursing students often develop a fragmented and superficial understanding of humanisation, frequently limited to general notions such as empathy or kindness.^{3,10} The present study expands on that observation by comparing students who participated in a structured curricular intervention with those whose exposure was limited to isolated sessions. The former group was able to connect the concept to specific pedagogical strategies and meaningful learning experiences, reinforcing the importance of introducing humanisation from the early stages of training and embedding it transversally throughout the curriculum.^{3,23}

Scholars have argued that the dominance of the biomedical model in health education marginalises the relational and ethical dimensions of care, reinforcing learning environments that prioritise technical efficiency.^{9,24} This tension was

clearly reflected in the accounts of both students and faculty, who described institutional cultures that continue to favour procedural and task-oriented care over human connection. The contradiction was particularly evident among participants who had not taken part in structured training, suggesting that isolated initiatives are insufficient to challenge deeply rooted technocentric norms within academic and clinical settings.^{8,24}

Structural and pedagogical barriers such as faculty overload, lack of specialised training, and weak articulation between theory and practice have been widely recognised as key obstacles to implementing humanisation in healthcare education.^{15,16} These issues were also present in our study. However, participants acknowledged the value of institutional support mechanisms, humanisation policies and extra-curricular wellbeing initiatives, particularly when combined with active methodologies such as clinical simulation, problem-based learning and guided reflection.^{8,16,25}

From a didactic perspective, recent studies have pointed out that the excessive use of technical language and inaccessible academic resources hinder the comprehension of humanised care, especially when not accompanied by strategies that foster affective competence.^{25,26} In the present study, students reported that rigid and overly technical teaching materials made it difficult to understand and apply a humanised approach. These findings reinforce the importance of the educator's role, which, according to multiple sources, should be coherent, empathetic and relational, serving as a model for the consolidation of humanistic values throughout the educational process.^{10,15,27}

Methodological considerations

This study was conducted within a single institution, which limits the transferability of findings. Convenience and snowball sampling may have introduced selection bias, favouring participants already interested in humanisation. Although student co-investigators were trained, their role may have influenced the depth of responses. Despite these limitations, the use of COREQ guidelines, triangulation and ongoing reflexivity strengthened the study's credibility.

Conclusions

The present study demonstrates that the curricular integration of humanisation in nursing education, when implemented intentionally, early and transversally, fosters a deeper and more applicable understanding of person-centred care. The comparative experiences between students with and without structured training highlight the importance of active methodologies, educator support and institutional backing in consolidating humanistic values. The findings underscore the need to promote educational environments that position the relational dimension of care as a core element of professional practice. It is recommended to strengthen faculty development in humanisation, revise pedagogical tools and design policies that support learning contexts aligned with these principles. Future research could explore the long-term effects of such interventions on clinical practice and graduates' professional wellbeing.

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Ethical approval

The project with ID: CEC_FP_2024041 was approved by the Scientific Ethics Committee of Universidad de las Américas. The study subjects provided their written and verbal consent before the recording of the online interview. The consents are securely stored by the principal investigator.

Author contributions

CA was responsible for the study design. KP and GS were responsible for data collection. KP, GS and CA were responsible for data analysis. KP and GD were responsible for drafting the manuscript. CA was responsible for manuscript development with critical intellectual content. KP, GS and CA were responsible for approving the final version of the manuscript submitted for publication

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