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The Patient Experience in Healthcare: A Qualitative Analysis of the Relational Dimensions of Care

A Experiência do Paciente no Cuidado em Saúde: Uma Análise Qualitativa das Dimensões Relacionais do Atendimento

La Experiencia del Paciente en la Atención de la Salud: Un Análisis Cualitativo de las Dimensiones Relacionales de la Atención

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Abstract:
INTRODUCTION: This study addresses the patient experience in healthcare, investigating how care is experienced and what effects it produces on the relationship with health services. Although negative situations, such as failures in care, are frequently discussed from a technical and legal perspective, these experiences also have subjective, emotional, and relational repercussions, influencing how the individual perceives the care received. OBJECTIVE: To investigate healthcare from the perspective of patients, identifying its main repercussions. METHOD: This is a qualitative research study, conducted through semi-structured interviews with participants who reported their experiences in healthcare. RESULTS/DISCUSSION: Data analysis allowed the identification of three central categories: the humanization of care, the importance of qualified listening, and the repercussions of these experiences on the patient's trust in the healthcare system. CONCLUSION: It is concluded that the patient experience in healthcare goes beyond the technical dimension, being profoundly influenced by emotional and relational aspects, which highlights the need for more humanized practices, based on listening and strengthening the bond and trust in the healthcare system.

Keywords: Malpractice; Doctor-Patient Relations; Humanization of Care.

Resumo:
INTRODUÇÃO: O presente estudo aborda a experiência do paciente no cuidado em saúde, investigando como o atendimento é vivenciado e quais efeitos produz na relação com os serviços de saúde. Embora situações negativas, como falhas no cuidado, sejam frequentemente discutidas sob a perspectiva técnica e jurídica, essas experiências também apresentam repercussões subjetivas, emocionais e relacionais, influenciando a forma como o indivíduo percebe o atendimento recebido. OBJETIVO: Investigar o cuidado em saúde sob a perspectiva dos pacientes, identificando suas principais repercussões. MÉTODO: Trata-se de uma pesquisa qualitativa, realizada por meio de entrevistas semiestruturadas com participantes que relataram suas experiências no atendimento em saúde. RESULTADOS/DISCUSSÃO: A análise dos dados permitiu a identificação de três categorias centrais: a humanização do atendimento, a importância da escuta qualificada e as repercussões dessas experiências na confiança do paciente no sistema de saúde. CONCLUSÃO: Conclui-se que a experiência do paciente no cuidado em saúde ultrapassa a dimensão técnica, sendo profundamente influenciada por aspectos emocionais e relacionais, o que evidencia a necessidade de práticas mais humanizadas, baseadas na escuta e no fortalecimento do vínculo e da confiança no sistema de saúde.

Palavras-chave: Imperícia; Relações Médico-Paciente; Humanização da Assistência.

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Resumen:

INTRODUCCIÓN: El presente estudio aborda la experiencia del paciente en la atención de la salud, investigando cómo se vive la atención y qué efectos produce en la relación con los servicios de salud. Aunque las situaciones negativas, como las fallas en la atención, suelen discutirse desde perspectivas técnicas y jurídicas, estas experiencias también presentan repercusiones subjetivas, emocionales y relacionales, influyendo en la forma en que el individuo percibe la atención recibida. OBJETIVO: Investigar la atención en salud desde la perspectiva de los pacientes, identificando sus principales repercusiones. MÉTODO: Se trata de una investigación cualitativa realizada mediante entrevistas semiestructuradas con participantes que relataron sus experiencias en la atención sanitaria. RESULTADOS/DISCUSIÓN: El análisis de los datos permitió identificar tres categorías centrales: la humanización de la atención, la importancia de la escucha cualificada y las repercusiones de estas experiencias en la confianza del paciente en el sistema de salud. CONCLUSIÓN: Se concluye que la experiencia del paciente en la atención de la salud supera la dimensión técnica, estando profundamente influenciada por aspectos emocionales y relacionales, lo que evidencia la necesidad de prácticas más humanizadas, basadas en la escucha y en el fortalecimiento del vínculo y de la confianza en el sistema de salud.

Palabras clave: Impericia; Relaciones Médico-Paciente; Humanización de la Atención**.**

1. Introduction

In the contemporary context of healthcare, the patient's experience in healthcare has become a central element in understanding the quality of care provided. Beyond technical and scientific aspects, the way users experience care involves subjective, emotional, and relational dimensions that directly influence their perception of healthcare services and the health-disease process itself.

In this scenario, although the debate on medical malpractice is traditionally framed within the legal sphere, it also reveals important implications for patients' experiences. In the legislative sphere, the legal duty of physicians has evolved significantly in recent times, while citizens' awareness of their rights has increased due to greater access to information. Within medical civil liability, concepts such as fault stand out, which, according to Novais, Moreira, and Cabral (2024, p. 344), is divided into two categories: intent and negligence, the latter being subdivided into incompetence, recklessness, and negligence. From a legal standpoint, these categories refer to poor outcomes of medical work, without the intention of producing them.

According to Lima (2023), among the main causes associated with these failures are the overload on the health system, lack of adequate training, financial pressures, limited resources, poor communication, and economic factors. These conditions demonstrate that such occurrences are not limited to the individual performance of the professional, but also reflect structural weaknesses in the health system. Negligence, in turn, can manifest itself in different

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forms, from mistreatment — such as physical and/or verbal violence, humiliation, restriction from the social environment, loss of autonomy, and deprivation of basic needs — to financial exploitation, producing significant effects on the lives of patients.

The repercussions of these experiences are far-reaching and can significantly affect the lives of patients and their families. Among the main consequences is the worsening of health status, since diagnostic errors, inappropriate medication prescriptions, or procedural failures can lead to serious complications, prolonged suffering, and even death. Furthermore, such situations can generate psychological, emotional, and financial harm for the individuals involved (Lima, Carolina, 2024).

In Brazil, the significant increase in lawsuits related to medical malpractice highlights the relevance of the issue. In just one year, there was a 506% increase in the number of lawsuits, rising from 12,268 in 2023 to 74,358 in 2024, according to data from the National Council of Justice (CNJ). These lawsuits are mostly associated with moral or material damages resulting from the provision of healthcare services. Furthermore, the unsatisfactory ethical training of physicians has been identified as a contributing factor to misconduct during professional practice (Bitencourt *et al.* , 2007).

However, when seeking healthcare assistance, the individual finds themselves in a vulnerable condition, occupying a position of dependence in relation to the professional, who is often physically and emotionally fragile (Carmes, Tesser and Cutolo, 2024). In this context, it becomes fundamental to consider not only the technical aspects of care, but also its human and relational dimensions, which refers to the concept of humanization.

The humanization of healthcare gained prominence within the Brazilian Unified Health System (SUS), especially with the consolidation of the National Humanization Policy (PNH), a result of social movements aimed at the redemocratization of Brazilian society (Corsino & Sei, 2019). This movement emerged as a response to a model of care historically marked by hierarchy, authoritarianism, and the centrality of medical knowledge, in which the patient was often reduced to an object of technical intervention. This process contributed to the precariousness of care relationships, favoring the naturalization of suffering, the reduction of professional accountability, and the distancing between users and health services (Rios, 2009; Neulls , 2016).

Furthermore, historical and social factors, such as discrimination based on race, ethnicity, and gender, also influence how care is offered, directly impacting the patient experience. When a user seeks the healthcare system, they aim not only for symptom resolution

but also for meaning to be given to their suffering, for their needs to be met, and for a sense of security to be built in the face of their situation.

Therefore, understanding the patient experience in healthcare becomes essential to improving the quality of care provided. In this sense, the present study aimed to investigate this phenomenon from the patients' perspective, identifying its main repercussions. Thus, it seeks to understand how these experiences are lived and how they influence the relationship with healthcare, especially regarding the humanization of care, the quality of listening, and the building or weakening of trust in the healthcare system.

2. Materials and Methods

It is generally agreed in the literature that research can be conceived as qualitative, quantitative, or mixed (qualitative -quantitative), each constituted by the approach adopted. In the case of this work, it is a qualitative research study. Creswell (2013) points out that qualitative investigations are characterized by the description and in-depth understanding of the subjective meanings and processes attributed to everyday experiences and practices, in a logic of discovery, with the essence being the analysis of the subjects' perspectives, interpreting phenomena in their natural environment.

In this sense, in qualitative research, the data are never self-evident (Demo, 1995), and their collection and analysis occur, especially, from the researcher's reflections, in a critical dialogue with the object analyzed. Data selection is an integral and inseparable part of the investigative process. The data were collected through semi-structured interviews, as shown in the appendix. During an interview, in addition to listening to a complex, profound, and potentially contradictory narrative, one is also thinking about what will be done next, analyzing the meanings of the interviewee's responses and seeking possible clarifications. This process is only possible with the aid of an appropriate interview guide.

Through interviews, seven people were heard, six of whom believed they had experienced some type of medical error, and the seventh, a doctor who addressed the issue more generally. Each dialogue lasted approximately 10 to 15 minutes and was transcribed in a secure location for the preparation of this project. Furthermore, using the content analysis advocated by Bardin, the data were decoded. According to Valle and Ferreira (2025), data produced in qualitative research need to be analyzed coherently, using techniques that allow for a reflective, comprehensive, and dynamic perspective.

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One of the qualitative data analysis techniques used in the field of education is content analysis (CA). Understood as a set of techniques that seeks to understand the meanings manifested by the subjects participating in a research project, the documents analyzed, and other forms of expression, CA has emerged as one of the most widely used methods in educational studies.

Content analysis, from Bardin's perspective, offers several important contributions to qualitative research in education, including a systematic and rigorous analysis of data, a deeper understanding of the phenomena studied, a flexible and adaptable approach, the possibility of identifying gaps in the literature, and data triangulation. The main limitations of content analysis for qualitative research in education include the risk of reductionism, excessive subjectivity in the construction of categories, difficulty in handling non-textual data, and limitations in generalizing the results.

It is important that the researcher be aware of these limitations when using content analysis in their research. This analysis technique is recognized and widely applied in social, human, and educational research by researchers seeking to understand the meanings of speech, transcending the criteria of objectivity of words and, through inference, constructing a broad interpretation and a connection with the theoretical framework (Minayo , 2014), based on the treatment of data aimed at identifying what is being said about the object of study. Research approved by the Ethics Committee under opinion number 8.051.914.

Table: Profile of Respondents

IDENTIFICATION	SEX

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Interviewee A	Feminine
Interviewee B	Feminine
Interviewee C	Feminine
Interviewee D	He preferred not to comment.
Interviewee E	Feminine
Interviewee F	Masculine
Interviewee G	Masculine

Source: Prepared by the author.

The data were recruited from a key informant. The key informant technique is a widely used method in qualitative research, especially in ethnographic studies and case studies. This approach consists of identifying and selecting individuals who possess specialized knowledge or significant experience about the phenomenon of interest.

These participants, known as key informants, are able to provide relevant insights and detailed information throughout the research process, contributing to a deeper understanding of the object of study. In this way, this strategy makes it possible to obtain richer, more contextualized data that is aligned with the reality being investigated.

3. Results and Discussion

This results and discussion section in qualitative research aims to present and interpret the data produced in light of the adopted theoretical framework, enabling the construction of meaning from the participants' experiences. Unlike quantitative approaches, this stage is not limited to the presentation of data, but involves an interpretive process that articulates discourse, analytical categories, and scientific literature, promoting a deeper understanding of the phenomenon studied. In this context, content analysis stands out as a methodological strategy capable of organizing and systematizing data, allowing the identification of relevant thematic categories and the production of well-founded inferences (González, 2020; Minayo , 2021; Siqueira *et al.* , 2024).

Below are the analysis categories as described in the method.

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a. The relationship between humanized care and quality of care.

Humanization is a difficult term to define, given its subjective, complex, and multidimensional nature. Within the context of healthcare, humanization, far more than just the clinical quality of professionals, demands quality of behavior. Portuguese dictionaries define the word "humanize" as: to make human, to civilize, to give human condition. Therefore, it is possible to say that humanization is a process that is constantly transforming and influenced by the context in which it occurs, being promoted and subjected to by humankind itself (Rizzoto MLF, 2002).

Given the need for changes in the services provided by the Brazilian Unified Health System (SUS), the Ministry of Health created the National Humanization Policy (PNH), or the Policy for Humanization of Care and Management in Health within the SUS (HumanizaSUS). Based on this proposal, humanization is defined as a policy, and no longer as a program, guiding principles and modes of operation in the relationships between the different actors in the SUS network. To humanize the relationship between service, health professional, and user, it is not enough to consider the issue of responsibility and respect, prerequisites for providing care. From the perspective of the PNH, the humanization of care and management practices in health must take into account humanity as a collective force that drives and directs the movement of public policies (Simões *et al.* , 2007).

Humanizing care goes beyond attending with cordiality and respect. It is recognizing the humanity in the other, in their capacity to think, act and interact, to express and exercise their autonomy in the face of lived situations. It is, above all, respecting the manifestation of feelings, desires and intentions (Minayo , 2004).

Regarding the matter, one of the participants commented:

Interviewee A: *"It's very important to be human. Not just trying to be professional and cold. To be human."*

This topic was also addressed by interviewee E:
"That's the kind of humanity a doctor needs to have."

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Humanization combines technical competence with human skills, such as empathy, cordiality, compassion, among others, so that the health professional acts with a humanistic and ethical basis in order to minimize aggression in health environments (Rios, 2009). However, the greatest difficulty lies in the applicability of this concept, as it involves professional culture.

Humanization has been discussed since the decision-making period regarding the healthcare model, which is why Primary Health Care was chosen. However, the fact that the system has a humanized approach, in itself, was not enough to meet the needs of the population. Thus, the clamor for better health practices from society culminated in the inclusion of the topic in the XI Health Conference in 2000. The main demands of the users referred to the qualification and expansion of "the welcoming, the effectiveness and the availability of services" (Souza; Mendes, 2009, p. 682).

> “Humanization is a collective construction that will only be possible with the exchange of knowledge; therefore, it determines that the work must be structured in multidisciplinary teams. Thus, the humanization network can be seen as a construction of citizenship, in which there is a valuing of all those involved in the health- disease process ” (Rodrigues; Garcia; Ribas, 2016, p. 67).

b. The importance of listening in healthcare.

Listening in the context of healthcare goes beyond the simple act of hearing. It is an active, ethical, and qualified practice that presupposes full attention to the user's discourse and sensitivity to capture not only words, but also emotions, silences, and implicit meanings. Qualified listening constitutes one of the pillars of humanization, as it makes it possible to understand the subject beyond the presented symptom, integrating subjective dimensions into clinical reasoning (Rios, 2009).

Within the Brazilian Unified Health System (SUS), reception, as guided by the National Humanization Policy, is intrinsically linked to listening. Welcoming means receiving the user responsibly , guaranteeing access and seeking to respond to their needs in a decisive manner. This practice reorganizes the work process by prioritizing initial listening as a risk classification tool and also as a strategy for building rapport. Thus, listening ceases to be a secondary act and takes on a central position in the production of care (Brazil, 2004).

Active listening contributes to more accurate diagnoses and more appropriate interventions, as it broadens the understanding of the patient's life context. Often, recurring complaints are not explained exclusively by biological factors, but are related to social, emotional, or family determinants. When the professional has the time and willingness to listen,

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they can identify aspects that would be overlooked in mechanized and quick consultations (Simões *et al.* , 2007).

Interviewee C:

"I think one thing a doctor needs to know is to listen before giving a diagnosis. Sometimes, there really is a physical illness, but it could be emotional. Nowadays, it's much more important to record it in the medical record than to treat the patient."

From an ethical standpoint, listening is recognizing the dignity of the other. The absence of listening can generate feelings of devaluation, abandonment, and distrust in the healthcare system. On the other hand, when the patient perceives that their voice is validated, trust in the team is strengthened and active participation in treatment is increased. This movement favors co-responsibility, an essential principle of comprehensive care (Waldow ; Borges, 2011).

Interviewee E:

"Sometimes, a person has nothing, but they need to be heard."

However, the practice of listening faces significant structural barriers, such as excessive demand, quantitative targets, and limited human resources. These factors can reduce consultation time and compromise the quality of interaction. In this scenario, the ongoing training of teams and the reorganization of care flows become necessary strategies to ensure that listening is effectively incorporated into the routine of services. It is essential that institutions promote an organizational culture that values dialogue and welcoming as central dimensions of care, and not as secondary elements. The implementation of protocols that ensure an adequate minimum consultation time and spaces for team discussion can also contribute to strengthening more sensitive and effective practices. In this way, listening ceases to be a theoretical ideal and becomes a concrete practice, supported by structural conditions and institutional commitment (Minayo , 2004).

Therefore, listening in healthcare is not a complement, but a structuring element of the quality of care. It humanizes relationships, improves clinical practice, strengthens bonds, and contributes to better therapeutic outcomes. Investing in listening is investing in the effectiveness and legitimacy of the healthcare system (Rodrigues; Garcia; Ribas, 2016).

c. Patient confidence in the healthcare system after negative experiences.

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Trust is a central element in the relationship between the user and the healthcare system. It is a subjective component, progressively built from experiences lived within the services. When a patient experiences negative situations, such as negligence, disrespect, excessive delays, or inadequate communication, institutional credibility is undermined and the therapeutic bond is weakened (Lima, 2023). Even with the rising number of reported errors, it is unknown what truly happens to the victims; Brazilian studies place greater emphasis on the number of complaints registered with regional medical councils (CRM), the disciplinary processes applied, the profile of the doctors denounced, and also present some important "rules" for doctors to avoid and prevent errors and avoid unpleasantness. In other words, the vast majority do not address the subjectivity and issues pertinent to the victims. Negative experiences can produce lasting effects, such as resistance to seeking the service again, low adherence to treatment, and the dissemination of negative perceptions in the community. Trust, once broken, is not easily restored. It depends on consistent actions that demonstrate commitment to quality, ethics, and respect for the user. Thus, humanization assumes a strategic role in rebuilding this relationship (Cruz Riveiros , 2020).

Interviewee F: *"I'm afraid of leaving a relative of mine, or myself, at the mercy of the public health system."*

Interviewee G: *“Man… I don’t have a problem with trusting less. I think I’ve always been suspicious. I’ve always known that there are professionals who are different from others. I can count on my fingers the professionals I trust, the ones I would want to be treated by.”*

Transparent communication and active listening are fundamental to restoring trust. When professionals acknowledge mistakes, clarify doubts, and demonstrate empathy in the face of suffering, space is created for rebuilding the relationship. The acknowledgment of error, when it occurs, should not be understood as institutional weakness, but as an ethical practice that strengthens the credibility of the system (Magalhães, 2023).

Furthermore, trust is directly related to the perception of effectiveness and acceptance. Services that guarantee continuity of care and easy access tend to generate greater security among users. The presence of integrated multidisciplinary teams also contributes to a more positive experience, as it expands the possibilities of responding to the needs presented. When the patient perceives that there is coordination between the different levels of care and that their

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demand will not be fragmented, the feeling of support and shared responsibility is strengthened. This integration favors more complete interventions and reduces the repetition of information, avoiding emotional strain. Thus, the efficient organization of the care network not only improves the quality of technical care but also consolidates bonds and reaffirms the credibility of the health system in the eyes of the population (Silva; Cruz; Silva, 2023).

From a collective perspective, trust in the health system is essential for the consolidation of public policies. A system that lacks credibility faces greater social resistance and less community participation. Therefore, investing in humanization, listening, and professional qualification is not only a matter of care but also strategic for the sustainability of the Brazilian Unified Health System (SUS). When the population recognizes the legitimacy of the actions developed by health services, there is greater adherence to preventive campaigns, follow-up programs, and proposed therapeutic guidelines. Trust strengthens social control and encourages active participation in decision-making spaces, such as health councils and conferences. In this way, institutional credibility becomes a structuring element for the effectiveness of public policies and for the maintenance of a universal, equitable, and comprehensive system (Souza; Mendes, 2009).

Interviewee A:

"I confess I was terrified when I received my diagnosis, but it's not just because of the cancer, it's because of the mistake that happened to me. She couldn't have made that mistake. I admit I was really worried about it, but I still trust her and I'm still seeing the same doctors today."

Thus, even after negative experiences, it is possible to rebuild trust through practices based on ethics, empathy, and shared responsibility. The humanization of care is therefore shown not only as a normative guideline, but as an indispensable condition for strengthening the bond between the population and the health system. Rebuilding trust requires, first and foremost, the recognition of existing weaknesses in care. When the user perceives that their complaints are validated and that there is institutional willingness to improve processes, an environment conducive to rapprochement is created. Transparency in information, clarity in communication, and respect for shared decisions contribute significantly to restoring the credibility of the service and minimizing feelings of insecurity or abandonment (Ferreira; Artmann, 2018).

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Practices that promote the patient's active participation in therapeutic planning reinforce feelings of belonging and self-worth. Co-responsibility in care broadens the mutual commitment between professional and user, transforming the care relationship into a partnership. This movement strengthens the bond and fosters greater adherence to the proposed guidelines, reducing the likelihood of new negative experiences resulting from communication failures or misaligned expectations. Finally, it is essential that the rebuilding of trust be understood as a continuous process, supported by consistent institutional policies and an organizational culture oriented towards humanized care. The consolidation of this collective commitment not only repairs weakened bonds but also prevents future ruptures, contributing to the construction of a more sensitive, ethical, and socially legitimate health system (Mendez Toledo, 2025).

Trust is a central element in the relationship between the user and the healthcare system. It is a subjective component, progressively built from experiences lived within the services. When the patient experiences negative situations, such as negligence, disrespect, excessive delays, or inadequate communication, institutional credibility is undermined and the therapeutic bond is weakened. Although reports of errors are on the rise, it is observed that the national literature, for the most part, prioritizes quantitative data, such as the number of complaints and lawsuits, to the detriment of understanding the subjective experiences of the victims (Lima, 2023).

Negative experiences can produce lasting effects, such as resistance to seeking the service again, low adherence to treatment, and the spread of negative perceptions in the social environment. Trust, once broken, is not easily restored, depending on consistent actions that demonstrate commitment to quality, ethics, and respect for the user. In this context, humanization assumes a strategic role in rebuilding this relationship (Cruz Riveros, 2020).

Furthermore, the loss of trust does not occur homogeneously among individuals. Some patients begin to completely avoid health services, delaying seeking care, which can worsen clinical conditions. Others develop a more vigilant stance, questioning professional conduct and seeking multiple opinions, which demonstrates difficulty in establishing a therapeutic bond. Such behaviors reveal significant ruptures in the relationship between patient and health system (Bell, SK *et al.* , 2020).

Another relevant aspect concerns the emotional impact of these experiences. Feelings such as fear, anxiety, insecurity, and distrust can emerge after negative experiences, directly influencing how the individual relates to future care. In this way, the damage goes beyond the

clinical dimension, also affecting psychological and subjective aspects, which reinforces the need for a more comprehensive approach to health care (Mazor , KM *et al.* , 2019).

In this sense, it becomes fundamental to adopt institutional strategies that aim not only at preventing errors, but also at the proper management of adverse situations. Practices such as transparent communication, post-event support, and patient follow-up can contribute to minimizing the effects and promoting the rebuilding of trust. Furthermore, continuous training of professionals in ethical and communication skills is essential to improve the relationships established in care (WHO, 2020).

It is important to highlight that trust is also directly related to the patient's perception of justice. When there is recognition of failures, accountability, and reparation, there is a greater possibility of re-establishing the bond. Conversely, withholding information or defensive postures tend to intensify suffering and consolidate distrust in the system (Finkelstein, A. *et al.* , 2024).

Thus, rebuilding trust must be understood as an ongoing process, involving both individual attitudes of professionals and structural changes in healthcare institutions. Investing in humanized practices, strengthening qualified listening, and promoting patient-centered care are fundamental measures to restore weakened bonds and ensure greater effectiveness in the care provided (Shannon, SE *et al.* , 2025).

5. Conclusion

This study made it possible to understand, from the patients' perspective, the effects of negligence, malpractice, and recklessness in the context of healthcare, showing that such occurrences go beyond technical failures, affecting the emotional, social, and relational dimensions of individuals. Data analysis identified three central themes: the humanization of care, the importance of qualified listening, and trust in the healthcare system after negative experiences. The results demonstrated that the absence of humanized practices and effective listening significantly contributes to the occurrence of negative experiences, weakening the bond between patient and professional and compromising the comprehensiveness of the care provided (Buss *et al.* , 2020).

Humanization has emerged as an essential element for quality care, going beyond technical competence and incorporating ethical, empathetic, and relational aspects. Similarly, active listening has been highlighted as a fundamental tool for a comprehensive understanding

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of the patient, contributing to more accurate diagnoses, greater adherence to treatment, and strengthening the therapeutic bond. Regarding trust in the healthcare system, it was observed that negative experiences can generate lasting effects, influencing users' behavior and their relationship with services. However, it was found that this trust can be rebuilt through practices based on transparency, empathy, and professional accountability, reinforcing the importance of patient-centered care (Cruz Riveros, 2020).

Furthermore, the findings of this study highlight the need for a reorganization of healthcare work processes, prioritizing not only technical efficiency but also the quality of the relationships established in care. The importance of listening, welcoming, and effective communication should be understood as a fundamental strategy for preventing errors and promoting more positive care experiences. In this sense, investment in continuing healthcare education, focused on developing the relational and ethical competencies of professionals, becomes essential, contributing to the consolidation of more humanized and effective practices (Novello *et al.* , 2024).

Therefore, it can be concluded that improving healthcare does not depend exclusively on technical advances, but also on strengthening human relationships in care. It is essential to invest in the ethical and communication training of professionals, as well as in the implementation of institutional policies that value humanization and listening as pillars of care. Finally, it is important to expand studies that consider the perspective of patients, contributing to a more comprehensive understanding of the effects of errors in healthcare and to the development of strategies that promote safer, more ethical, and patient-centered care, in addition to strengthening social trust in health systems (Paho , 2021).

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APPENDIX

1. Have you ever felt that you received careless or inadequate healthcare?

1. Have you ever had the impression that the healthcare professional was not sufficiently prepared for the procedure or diagnosis?
2. Do you believe you have ever suffered some kind of wrongdoing on the part of healthcare professionals due to lack of care, knowledge, or responsibility?
3. If you answered “Yes” to the previous questions, it was related

   What happened? Tell me about it.

Nowadays, after the event, do you feel you trust the healthcare system less? How has that impacted you?