

Competencies for the humanization of health: evidence of content validity in the Chilean context.

Competencias para la humanización de la salud: evidencias de validez de contenido en el contexto chileno.

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Summary.

Introduction: Dehumanization in healthcare is a growing problem associated with technologization, fragmentation of care, and strains on the healthcare system, with effects on both users and professionals. Health sciences education requires competency frameworks that allow for the integration of humanization into the curriculum. **Objective:** To obtain content-based validity evidence for a humanization competency model in the Chilean context, as an initial step toward its operationalization. **Method:** A methodological study using the Delphi technique with three rounds and an interdisciplinary panel of 14 experts, selected through purposive sampling, was conducted. A seven-dimensional model was evaluated: scientific-technical, relational, emotional, ethical, spiritual, cultural, and managerial. Relevance and clarity were assessed using a Likert scale (1–5), with consensus defined as a median ≥ 4.0 and an interquartile range (IQR) ≤ 1 . Open-ended comments were analyzed thematically. **Results:** In the first round, the definitions of the seven competencies reached consensus, and the panel proposed 57 sub-competencies. In the second round, 106 sub-competencies were evaluated: 54 accepted, 45 under review, and 7 eliminated. Qualitative feedback was grouped into redundancy, semantic ambiguity, conceptual overlap, conceptual delimitation, need for operationalization, and cultural relevance, and guided the refinement of the sub-competencies. In the third round, 63 sub-competencies reached consensus: scientific-technical (10), relational (7), emotional (7), ethical (10), spiritual (10), cultural (9), and management (10). **Conclusions:** The findings provide initial evidence of content-based validity for a humanization competency framework contextualized to the Chilean context. The framework does not yet constitute a psychometrically validated instrument, but it offers a basis for guiding curricular integration, the formulation of learning outcomes, and future studies of operationalization and psychometric evaluation.

Keywords: humanization of care, professional competence, Delphi technique, content validity, curriculum, health education.

Resumen.

Introducción: La deshumanización en salud constituye un problema creciente asociado a la tecnificación, la fragmentación del cuidado y las tensiones del sistema sanitario, con efectos sobre usuarios y profesionales. La formación en ciencias de la salud requiere marcos de competencias que permitan integrar la humanización en el currículo. **Objetivo:** Obtener evidencia de validez basada en el contenido de un modelo de competencias en humanización en el contexto chileno, como etapa

inicial para su operacionalización. **Método:** Estudio metodológico con técnica Delphi de tres rondas y un panel interdisciplinario de 14 expertos, seleccionados mediante muestreo intencional. Se evaluó un modelo de siete dimensiones: científico-técnica, relacional, emocional, ética, espiritual, cultural y de gestión. La pertinencia y la claridad se valoraron con escala Likert (1–5), con consenso definido como mediana $\geq 4,0$ y rango intercuartílico (RIC) ≤ 1 . Los comentarios abiertos se analizaron temáticamente. **Resultados:** En la primera ronda, las definiciones de las siete competencias alcanzaron consenso y el panel propuso 57 subcompetencias. En la segunda ronda se evaluaron 106 subcompetencias: 54 aceptadas, 45 en revisión y 7 eliminadas. Los aportes cualitativos se agruparon en redundancia, ambigüedad semántica, solapamiento conceptual, delimitación conceptual, necesidad de operacionalización y pertinencia cultural, y orientaron la depuración del banco. En la tercera ronda, 63 subcompetencias alcanzaron consenso: científico-técnica (10), relacional (7), emocional (7), ética (10), espiritual (10), cultural (9) y gestión (10). **Conclusiones:** Los hallazgos aportan evidencia inicial de validez basada en el contenido para un marco de competencias en humanización contextualizado al ámbito chileno. El marco no constituye aún un instrumento psicométricamente validado, pero ofrece una base para orientar la integración curricular, la formulación de resultados de aprendizaje y futuros estudios de operacionalización y evaluación psicométrica.

Palabras clave: humanización de la atención, competencia profesional, técnica Delphi, validez de contenido, currículo, educación en salud.

1. Introduction

1.1 Dehumanization in the socio-health context

The dehumanization of healthcare is linked to the shift from the Hippocratic imperative to a functionalist and economic paradigm that prioritizes efficiency over the ethics of care. Combined with specialization and the techno-scientific hegemony, this change has fragmented care and reduced the user to a bearer of diagnoses, disconnected from their biopsychosocial and spiritual reality (1). Work-related factors also contribute to the dehumanization and self-dehumanization of professionals (2): lack of time, the stigma surrounding certain diseases, defenses against burnout, and reduced empathy. Its consequences include organizational deviation, psychological distress, and feeling like mere instruments of the system (3).

For users, services often feel impersonal, with the clinical case taking precedence over the lived experience, which is associated with dissatisfaction, lower adherence, and loss of trust. This is not just a perception: physicians have been observed to have greater activation of cognitive control networks and a lower empathic response to painful stimuli (4). Within healthcare teams, dehumanization can act as a coping mechanism for overload and suffering, normalizing depersonalized practices, with a greater impact on stigmatized, vulnerable, or comorbid users (5). Reversing this scenario also requires transforming the training of caregivers.

1.2 Training as a catalyst

The concern for holistic care is not recent. Carl Rogers' person-centered therapy (6) and, from the nursing perspective, Jean Watson's transpersonal caring theory, which revalued the spiritual and cultural dimensions of care (7), constitute early references for this perspective. From Paulo Freire's pedagogy, training is a catalyst for humanization, insofar as it does not seek to transfer knowledge, but rather to create the conditions for people to develop their ontological vocation of "being more" through critical reflection, dialogue, and transformative praxis (8).

Medical education, traditionally centered on the body as an object of study, faces the challenge of integrating the lived experience of the patient. In early clinical practice, students encounter a sick

body whose understanding requires attending to the narrative of the person inhabiting it and to the extraordinary vulnerability that illness implies. This demands training not only in technical knowledge but also in the empathic understanding of this vulnerability (9). Given that dehumanization is a multidimensional phenomenon, addressing it requires coordinated efforts of a psychological, educational, community, legal, and institutional nature (10). In this context, humanization should not be understood as an artifice or as the mere addition of kindness to the treatment. Health education with a humanization approach implies recognizing the patient as a subject of rights, promoting their autonomy, dignity, and individuality, and valuing the act of caring as an encounter between human beings shaped by contextual, cultural, and emotional factors (11). It also demands resisting and unlearning dehumanizing language in health education, which presents educators with the ethical responsibility of confronting Eurocentric educational systems and the dominant language that sustains dehumanization, in favor of forms of communication that teach justice, inclusion, and equity (12). The training of health professionals constitutes a privileged space for addressing humanization. However, for this aspiration to transcend the declarative level, it must be embodied in the curriculum.

1.3 The curriculum as a space for integrating non-technical skills

Labeling communication, interpersonal, ethical, and emotional competencies as “soft skills” relegates them to a secondary position compared to technical knowledge. This label establishes a false hierarchy between the technical and the human, inseparable dimensions that are crucial to the quality of care and patient safety. Therefore, integrating these skills into training is an ethical and professional imperative (13). However, their curricular presence is uneven: in Turkish medical schools, they are not always mandatory, and critical thinking, leadership, and teamwork are underrepresented (14). Furthermore, their teaching and assessment remain heterogeneous, requiring shared conceptual frameworks and validated instruments (15).

Humanistic training or practice is the intentional application of humanities knowledge in clinical contexts, proposed as a learning outcome and a bridge between the experiences of users and professionals (16). It thus constitutes the educational pathway that translates humanization into person-centered practices. Given the persistent tension between technical and humanistic training, which limits ethical, relational, and reflective competencies, humanization is proposed as a cross-cutting theme from the earliest stages of training (17–20). Evidence supports its benefits: modeling humanistic roles fosters awareness of professionalism, caring behaviors, and the transition to professional practice, while humanized care strengthens the therapeutic relationship and reduces violence and conflict in care settings (21–23). Integrating humanization into the curriculum requires a defined and contextualized competency framework. This framework allows for translating competencies into learning outcomes, distributing them across undergraduate, postgraduate, and continuing education, evaluating them, and training faculty.

1.4 Competencies for humanization

Humanization is not just a matter of attitude: humanistic care competence is multifactorial and is positively associated with emotional intelligence, suggesting that it can be developed through training (19). Technical-clinical skills, although indispensable, are insufficient for person-centered care; training must intentionally incorporate communication, emotional, ethical, and relational skills (24), integrating the humanities with educational methodologies that promote professional practice consistent with this purpose (25).

In the health field, competence is understood as a dynamic and integrative configuration of knowledge, skills, attitudes, and values that allows for effective, ethical, and context-adapted performance in real-world situations, oriented towards solving complex problems, making decisions, and continuously improving performance (26–29). Based on this, Bermejo et al., through a Delphi

study, proposed a humanization competency model that identifies seven dimensions: scientific-technical, relational, emotional, ethical, spiritual, cultural, and managerial, and that conceives of humanization as a set of transversal competencies expressed in professional and institutional practice (30) (Figure 1).



Figure 1. Model of competencies for health humanization.

This model was formulated as a conceptual proposal, and its relevance in other socio-health contexts had not been examined. In Chile, a contextualized humanization competency framework that could guide curriculum design or the future development of assessment instruments has not been documented. Addressing this gap requires, as a first step, obtaining evidence that the framework's content is relevant, clear, and representative of the construct in the new context. Consequently, the objective of this study was to analyze the conceptual relevance, contextual adequacy, and representativeness of the content of the humanization competency model proposed by Bermejo et al. (30) in the Chilean context, using structured expert judgment with the Delphi technique. The study provides evidence of content-based validity of the competency framework and constitutes the initial stage of a broader process aimed at its operationalization and the development of a self-assessment instrument, whose psychometric properties will be examined in subsequent phases.

2. Methods

2.1 Study design

This methodological study corresponds to the initial phase of a sequential process aimed at developing a competency framework for humanization in healthcare and, subsequently, a self-assessment instrument. In this stage, content-based validity evidence was generated, focusing on the conceptual relevance, contextual appropriateness, and representativeness of the competency model proposed by Bermejo et al. (30), through structured expert judgment. The design is based on the unified approach to validity proposed by the Standards for Educational and Psychological Testing (AERA, APA & NCME, 2014) (31), which conceives of validity as a cumulative process of gathering evidence intended to support interpretations derived from the intended use of an instrument. Among the sources of evidence described by these standards (content, response processes, internal structure, relationships with other variables, and consequences), this study addresses only the first. In particular, Standard 1.11 states that the process by which the construct's domain was defined and its components selected must be clearly documented, including the conceptual justification and the procedures used to ensure its representativeness. In accordance with this principle, the present phase focused on examining and delimiting the content domain of the construct "humanization

competencies," evaluating the sufficiency, clarity, and relevance of its subcomponents in a new professional context.

Since the original reference point was a conceptual model and not an operationalized instrument, the study did not constitute a test adaptation in the strict sense, nor did it include linguistic translation procedures. Instead, a systematic analysis of the construct's contextual relevance was developed, integrating expert panel review and the possibility of conceptual expansion when expert judgment identified gaps or emerging needs. This strategy is consistent with the use of the Delphi technique in the early stages of instrument development, aimed at strengthening the representativeness of the content before its future empirical operationalization (32). This phase does not provide evidence on internal structure, reliability, temporal stability, convergent or discriminant validity, or the psychometric functioning of items, since the framework has not yet been operationalized as an instrument; this evidence corresponds to later stages of the process. The focus was exclusively on ensuring that the resulting conceptual framework adequately and contextually represents the domain of the construct that will guide the instrument's development. Consequently, the consensus reached should be interpreted as the panel's agreement on the relevance and clarity of the content, and not as an external generalization or as a demonstration of measurement properties.

2.2 Delphi Method

The Delphi method was used, a structured, robust, and versatile technique for reaching consensus among experts on complex and multifaceted problems through multiple iterative rounds of consultation. This method has been widely used since the 1960s in various disciplines, including health, education, technology, and public policy (33). Its application allows for the iterative and anonymous collection of expert judgments, promoting individual reflection, progressive refinement, and a deeper understanding of perspectives, with the aim of harnessing collective intelligence and minimizing biases associated with dominance, hierarchy, or partiality among participants (34).

2.3 Participant Selection

An initial 33 experts from various disciplines in health, social sciences, and humanities were invited to participate through purposive sampling, prioritizing disciplinary diversity, professional experience, academic background, and involvement in areas such as health, humanization of care, and ethics. Inclusion criteria were: at least 10 years of professional experience; postgraduate training equivalent to a master's degree, doctorate, or medical specialty; and participation in scientific societies or academic bodies related to humanization in healthcare. Invitations were sent via institutional email, allowing 30 days for confirmation of participation. Ultimately, 14 experts participated (Table 1) out of the 33 invited (acceptance rate of 42.4%), with professional experience ranging from 10 to 45 years and postgraduate training in areas such as public health, bioethics, education, management, and social sciences. Diversity was ensured in terms of gender, educational level, and sector of practice (clinical, community, and academic). The panel brought together profiles linked to the different dimensions of the construct: clinical practice in high-complexity units, bioethics, spiritual support, anthropology and sociology, community work, disability, management of hospital humanization, long-term care, and university teaching. The panel size was considered adequate for the purposes of this phase. Methodological literature on the Delphi technique does not establish a single sample size and highlights that the quality of the consensus depends more on the expertise and heterogeneity of the participants than on their number (35, 36). However, the consensus obtained reflects the judgment of this panel and does not allow for population-level inferences.

Table 1. Sociodemographic and academic profile of the expert panel.

Profession	Sex	Academic degree	Post	Professional experience (years)	Age
Dentist / Art Therapist	M	M	Spiritual assistance through art	15–20	40–50
Occupational Therapist	M	M	Community program coordinator	10–15	30–40
Psychologist	M	M	Liaison Psychology Coordinator	15–20	30–40
Pediatrician	M	D	Pediatrician in intensive care unit	30–40	50–60
Journalist	M	M	Territorial manager in community program	10–15	40–50
Anthropologist / Sociologist	H	D	University lecturer / Researcher	25–30	50–60
Speech therapist	M	M	Disability Analyst / University Lecturer	25–30	40–50
Architect	M	M	Independent architect	15–20	30–40
Internal Medicine Physician	M	D	Medical specialist in Bioethics	40–45	60–70
Pediatrician	M	M	Pediatric cardiologist / In charge of spiritual support	30–35	50–60
Matron	M	M	University academic	15–20	30–40
Gynecologic oncologist	H	AND	Head of hospital humanization	30–35	60–70
Nurse	M	AND	Director of a residence for the elderly	35–40	60–70
Psychologist	H	D	University Academic - Researcher	15–20	40–50

Note: Academic degree: Master (M), Doctorate (D), Specialist (E).

2.4 Procedure

The number of rounds was not predetermined. It was determined according to three criteria: relevance (median ≥ 4.0), consensus (IQR ≤ 1.0), and information saturation (absence of new substantive contributions). The process concluded when these conditions were met, which occurred in the third round, applied asynchronously using institutional Microsoft Office 365 electronic forms.

2.4.1 First round

In the first round, two types of contributions were requested. First, the theoretical relevance and semantic clarity of the definitions of each of the seven general competencies (scientific-technical, relational, emotional, spiritual, ethical, cultural, and managerial) conceptualized by Bermejo et al. (30) were evaluated using a structured questionnaire with a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree). Second, the open suggestion method, commonly used in exploratory phases to gather qualitative input without inducing bias (35), was applied. Experts were asked to propose sub-competencies associated with each competency and to offer free-form observations. To prevent the proposals from being influenced by the reference model, participants were instructed not to consult the original study during this stage. The proposals were analyzed by the research team, who grouped them thematically and standardized their wording under the structure "Ability to...", ensuring formal uniformity without altering their conceptual content.

2.4.2 Second round

The second-round bank integrated the 57 sub-competencies proposed by the panel in the first round and the 49 indicators from the original model by Bermejo et al. (30), for a total of 105 items. Experts evaluated the relevance and clarity of wording of each item using the same 1-to-5 Likert scale. They also provided a space for open comments. For each item, the mean, standard deviation (SD), median, 25th–75th percentiles, and interquartile range (IQR) were calculated. Using these statistics, each item was classified into three categories (36):

- Accepted: median ≥ 4.0 and IQR ≤ 1 .
- Under review: median ≥ 4.0 and IQR > 1 , or median between 3.5 and 3.99.
- Eliminated: median < 3.5 , regardless of IQR.

Participants were informed beforehand that, in the event of redundant formulations, the one with the best indicators (highest median and lowest RIC) would be retained.

At the close of this round, the research team integrated the quantitative results with the thematic analysis of the open comments (see section 2.5) to refine the database. First, items classified as eliminated and those whose content conceptually corresponded to another competency (conceptual overlap) were excluded. Then, redundant formulations were merged, retaining the one with the best indicators and integrating, where relevant, the nuances of the discarded version. Finally, the items under review were reformulated to improve their clarity, scope, and observability.

2.4.3 Third round

In the third round, the 63 formulations resulting from the refinement process were evaluated. The experts reassessed them for relevance and clarity of writing, using the same scale and classification criteria. All formulations met the consensus criteria (median ≥ 4.0 and IQR ≤ 1 for both criteria), thus concluding the process.

2.5 Data Analysis

Descriptive statistics (mean, standard deviation, median, quartiles, and IQR) were used to assess the degree of consensus and the relevance of the sub-competencies in each round. The quantitative analysis was performed using Microsoft Excel (Office 365 version), which allowed for the classification of items according to the established criteria.

The open-ended comments were examined using inductive thematic analysis, following Braun and Clarke (37). They were first organized into a competency matrix, linking each comment to the corresponding item code: prefix B for the indicators of the original model and numbering without a prefix for the sub-competencies proposed by the panel. After repeated reading, the problems identified by the experts were coded, and the codes were grouped into six emergent categories:

redundancy, semantic ambiguity, conceptual overlap, conceptual delimitation, need for operationalization, and cultural relevance. The initial coding was performed by one researcher (AAO) and reviewed by the team, who discussed discrepancies until reaching a consensus. Each category was then compared with the relevant and wording statistics of the corresponding item. Thus, decisions to merge, delimit, reformulate, or eliminate items were based on the convergence between the qualitative judgment and the quantitative indicators. Decisions and their justification were recorded by competence, which ensures the traceability of changes (table 4).

To resolve overlaps, three criteria were applied. When two sub-competencies expressed the same content with different wording (redundancy), the version with the best indicators (highest median and lowest RIC) was retained, a criterion previously communicated to the panel. When relevant, complementary nuances from the discarded version were integrated into it. When the content of a sub-competency conceptually corresponded to another competency in the model (overlap between competencies), it was removed from the dimension in which it had been formulated or its scope was defined. For example, the panel noted that teamwork and leadership corresponded to relational rather than scientific-technical competencies, and the reference to supporting "people" in the management competency was limited to working with teams. Finally, conceptually similar sub-competencies with a distinct focus were maintained as separate items with wording that explicitly stated this difference, as was the case with the management of physical environments and digital processes.

The Delphi process was closed in the third round, a decision supported by the literature, where multiple studies have achieved consensus on health competencies in two or three rounds (30, 38, 39). In this study, the third round allowed all retained sub-competencies to reach the consensus criteria (median ≥ 4.0 and IQR ≤ 1.0 for both relevance and wording), which, together with the qualitative analysis, supported the relevance and clarity of the formulations in the Chilean context.

2.6 Reflexivity and bias control strategies

The research team consisted of professionals in the health and social sciences with postgraduate training, including master's and doctoral degrees. Members came from disciplines such as nursing, medicine, and health sciences, allowing for an interdisciplinary approach to the phenomenon under study. Some members of the research team had prior professional relationships with some of the participating experts, stemming from collaboration in non-profit scientific societies focused on humanizing healthcare. However, there were no hierarchical relationships or conflicts of interest that could compromise the independence of expert judgment. To mitigate potential biases associated with these relationships, the anonymity of responses was guaranteed in all rounds of the Delphi process, safeguarding confidentiality and preventing the research team from identifying participants.

To minimize methodological bias, several strategies were implemented. Regarding selection bias, inherent in purposive sampling, efforts were made to maximize the disciplinary and professional diversity of the panel, including experts from clinical, community, academic, and social fields, with experience ranging from 10 to 45 years. Voluntary participation was also ensured, without external incentives or pressure. To reduce bias associated with fatigue in lengthy and cognitively demanding evaluation processes, clear and standardized instructions were provided, recommending that participants respond under favorable time and environmental conditions. Furthermore, a permanent communication channel was established to address questions or requests during the process, promoting the quality and consistency of responses.

2.7 Ethical considerations

The study was approved by the ethics committee of the University of the Americas (Project ID CEC_FP_2024044). All participants signed informed consent prior to inclusion, and the anonymity and confidentiality of their responses were guaranteed throughout the process.

3. Results

3.1 First round

In the first round of the Delphi study, quantitative and qualitative assessments of the proposed competencies were collected and analyzed by experts. First, the conceptual relevance and clarity of the definitions for each competency were evaluated using descriptive statistics and consensus criteria (Table 2). The seven definitions obtained mean relevance scores between 4.14 and 4.88 and mean clarity scores between 4.43 and 4.75, with an IQR ≤ 1 in all cases. Second, the thematic analysis of the open-ended responses allowed for the identification and grouping of emerging sub-competencies (Table 3), guiding the adjustment, merging, or reformulation decisions that underpinned the second round, in which 56 new formulations proposed by the panel were incorporated.

3.2 Second round

The bank evaluated in the second round consisted of 106 sub-competencies: 57 proposed by the panel in the first round and 49 from the Bermejo et al. model (30). Of the total, 54 were accepted, 45 remained under review, and 7 were eliminated, so 99 sub-competencies continued in the process. The open comments focused on three aspects: repeated or very similar formulations between the original indicators and the panel's proposals, ambiguous or difficult-to-observe expressions, and content placed in competencies different from the one in which it had been formulated. Table 4 summarizes, for each competency, the panel's contributions, the problems identified, the decisions adopted, and the resulting modifications, along with the statistics for the items that motivated these decisions. To avoid redundancy by presenting successive versions with a high degree of similarity, the complete list from this round is not included. Redundancy was the most widespread problem, present in all seven competencies. It was resolved by retaining the formulation with the best indicators and integrating, when appropriate, the nuances of the discarded version. Semantic ambiguity affected expressions such as "sufficient," "mastery of one's energy," "world of meaning," "problem and mystery," "cosmopolitan vision," and "genuinely human values." These cases led to the elimination or reformulation of the affected items.

The need for operationalization guided the incorporation of observable criteria in the wording and the use of verbs such as execute, design, and manage. For example, expressions such as "demonstrating understanding and validation" (2.1) and "through dialogue, agreements, and follow-up" (2.6) were added, according to the final numbering in Table 5. Conceptual delimitation and cultural relevance allowed for narrowing the scope of some items, such as emotional conflicts (3.6) and team support (7.1). They also allowed for the replacement of potentially biased expressions, such as "vulnerable communities," with more inclusive formulations (6.9). Conceptual overlap led to the removal of content from the scientific-technical and cultural competencies that the panel considered belonged to other dimensions.

In addition to refining the framework, the panel expanded it with content not explicitly included in the original model, such as psychological first aid (3.7), self-compassion (5.6), and spiritual support during bereavement (5.10). Furthermore, the experts noted that some qualities, particularly in relational and spiritual competencies, are difficult to translate into units of measurement or learning outcomes.

3.3 Third round

Following the data refinement described in section 2.4, the 63 resulting formulations were re-evaluated in the third round using the same statistical criteria. All met the consensus criteria: 10 scientific-technical, 7 relational, 7 emotional, 10 ethical, 10 spiritual, 9 cultural, and 10 managerial (Table 5). They achieved a median ≥ 4 and $IQR \leq 1$ for both relevance and wording. Mean relevance scores ranged from 4.62 to 5.00, and mean wording scores ranged from 4.00 to 4.69.

Table 2. Evaluation of relevance and wording of competency definitions in the First Round.

Skills	Definition	Relevance				Drafting			
		Q1-Q3	RIC	M	DT	Q1-Q3	RIC	M	DT
Scientific and technical competence	A set of capabilities that allow the application of knowledge and practical skills in the technical and scientific field, integrating knowing and doing with precision and quality.	4.29	0.49	4.00–4.50	0.50	4.50	1.07	4.75–5.00	0.25
Competence relational	A set of skills that allow you to interact effectively with other people, establishing bonds based on communication, empathy, and mutual respect.	4.86	0.38	5.00–5.00	0.00	4.71	0.49	4.50–5.00	0.50
Emotional competence	A set of skills that facilitate the conscious management of one's own emotions and the understanding of those of others, promoting emotional balance and healthy relationships.	4.43	0.79	4.00–5.00	1.00	4.57	0.53	4.00–5.00	1.00
Competence ethics	A set of capabilities that allow one to act with integrity and resolve conflicts while respecting human rights, values, and dignity.	4.62	0.52	4.00–5.00	1.00	4.75	0.46	4.75–5.00	0.25
Spiritual competence	A set of capabilities that allow one to understand, respect and support one's own and others' symbolic and transcendent world, promoting well-being in situations of suffering and transcendence.	4.14	0.69	4.00–4.50	0.50	4.43	0.53	4.00–5.00	1.00
Competence cultural	A set of capabilities that allow one to adapt to and respond to cultural diversity, valuing differences and promoting inclusion and mutual respect.	4.75	0.46	4.75–5.00	0.25	4.75	0.46	4.75–5.00	0.25
Management competence	A set of capabilities that enable one to lead teams, manage resources, and make strategic decisions to efficiently achieve common goals.	4.88	0.35	5.00–5.00	0.00	4.75	0.46	4.75–5.00	0.25

Note: M = mean; Q1 = 1st quartile; Q2 = 2nd quartile (median); Q3 = 3rd quartile; SD = standard deviation; IQR = interquartile range.

Table 3. Summary of emerging sub-competencies by competition in the First Round.

Competence	Emerging sub-competency categories	Dominant conceptual focus	Methodological decision for the second round
Scientific-technical	Theoretical and practical mastery; critical thinking and problem-solving; ongoing professional development and continuous learning; research and innovation; evidence-based decision-making; systematic approach and appropriate professional practice	Professional excellence based on evidence, critical analysis, and continuous improvement	Merger and reformulation in operational sub-competencies
Relational	Empathy and compassion; active listening; effective and assertive communication; social skills; handling interviews and delivering difficult news; dialogic ability	Therapeutic bond and person-centered communication	Maintenance with semantic debugging
Emotional	Self-awareness; emotional regulation; stress, anger, and frustration management; recognizing one's own emotions; assertive emotional expression	Emotional self-regulation as the basis of humanized care	Integration into nuclear sub-competencies
Ethics	Ethical judgment and reflexivity; professional integrity; resolution of ethical dilemmas; grief management; professional principles and values; legal and bioethical framework; respect for dignity	Situated ethical deliberation and ethical professional conduct	Conceptual adjustment and normative explication
Cultural	Cultural awareness and adaptation; intercultural and human rights approach; diversity, gender, and otherness; intercultural mediation; sociocultural context and social determinants	Appropriate care in diverse contexts	Maintenance with transverse joint
Management	Strategic and transformational leadership; collaborative work; team management; decision-making; negotiation and conflict resolution; strategic vision and adaptability	Humanized leadership and care management	Reformulation and reduction by overlap
Spiritual	Self-knowledge and spiritual development; recognition and assessment of spiritual needs; spiritual resources and interventions; symbolism and rituals; respect and spiritual openness	Spiritual dimension of care and existential meaning	Maintenance with conceptual delimitation

Table 4. Summary of panel contributions, problems detected and decisions to modify sub-competencies by competency (Round 2).

Competence	Contribution/topic identified by the panel	Problem detected	Decision
Scientific-technical (16 → 10)	Teamwork and leadership "do not belong to technical skills, but rather to relational ones"; "enough, how much is that?" (B1.7); replace "Organization" with "the context in which one participates" (B1.5); make explicit what is meant by participatory methodologies and by "sustainable and ecological".	Conceptual overlap (B1.3: Md = 3.5; B1.4: M = 3.39); semantic ambiguity (B1.5, B1.7); redundancy (B1.1 ≈ 1.8; B1.2 ≈ 1.10; 1.16 ≈ 1.13); need for operationalization (1.11, 1.14).	Remove B1.3 and B1.4 due to low relevance; in redundant pairs, keep the one with the highest score; integrate 1.16 into 1.13; reformulate B1.5, B1.6, 1.11, 1.12, 1.14 and 1.15.

Relational (15 → 7)	"Some are found or appear to be repeated"; "qualities that are difficult to measure"; operationalization as learning outcomes is "difficult to achieve".	Redundancy between original indicators and panel proposals (2.1/2.8, 2.3/2.10, 2.4/2.11, 2.5/2.12, 2.6/2.13, 2.7/2.9); need for operationalization (B2.3: wording Md = 3, RIC = 2; B2.5: RIC = 2).	Merge pairs while retaining the highest-scoring version; B2.2 (empathy) is integrated into 2.9; 2.14 (agreements with family) is not retained in this dimension.
Emotional (14 → 7)	The evaluation assumes "pre-established theoretical frameworks", for example, primary and secondary emotions; avoid repeating "emotional" in the definition.	Semantic ambiguity (B3.4 "domain of their energy": wording M = 3.14; RIC = 2); redundancy (3.2/3.8, 3.3/3.10, 3.5/3.11, 3.6/3.13, 3.7/3.14); conceptual delimitation (B3.6 "conflicts" unspecified).	Remove B3.4; merge pairs; limit B3.6 to emotional conflicts; reorient 3.12 towards crisis intervention.
Ethics (16 → 10)	"The genuinely human" is "subjective and ambiguous"; specify "dilemmatic" and "prudent decisions"; 4.2, 4.3, 4.5 and 4.8 are difficult to measure; duplicates 4.1/4.8, 4.2/4.9 and 4.6/4.14.	Semantic ambiguity (B4.1; B4.3: RIC = 2); redundancy (three duplicate pairs); need for operationalization (B4.5: wording RIC = 1.5).	Merge duplicates; B4.3 is subsumed into 4.11; B4.5 is anchored into 4.12; reformulate B4.1, B4.6, B4.7, 4.10, 4.15 and 4.16.
Spiritual (17 → 10)	"I don't understand what you mean" 5.3 ("world of meaning") and 5.5 ("problem and mystery"); "there are several that are similar and can be merged"; their conversion to learning outcomes is "complex".	Semantic ambiguity (B5.3: Md = 3; B5.5: M = 3,14; Md = 3); redundancy (5.1/5.10/5.12, 5.2/5.9, 5.4/5.11, 5.6/5.15, 5.3/5.8).	Remove B5.3 and B5.5 (Md < 3.5); merge pairs keeping the one with the best score.
Cultural (12 → 9)	6.3, 6.6 and 6.7 are "extremely vague" ("cosmopolitan vision", "globalization", "for their own good"); 6.3 "could go into relational competition"; 6.12 "gives a bias" when talking about "vulnerable communities"; complementary medicine does not fit "respond to cultural diversity".	Semantic ambiguity (6.3: Md wording = 2; 6.6: Md = 2.5, RIC = 2.25); conceptual overlap (6.3 with Relational); cultural relevance (6.11, 6.12); redundancy (6.1/6.2).	Remove 6.3 and 6.6; merge 6.1 and 6.2; reformulate 6.7, 6.11 and 6.12.
Management (16 → 10)	"Efficiently" fails to measure the quality of leadership; orient 7.8 towards "leading feedback processes"; proposed wording adjustments for 7.2, 7.3, 7.10 and 7.12.	Conceptual delimitation (B7.2 "people" overlaps with Relational; RIC wording = 2.5); redundancy (B7.1/7.7, B7.3/7.16, 7.12/7.15); ambiguity (7.11 "interviews with a strategic purpose"; 7.13).	Remove B7.5, 7.11 and 7.13; merge pairs; limit B7.2 to teamwork.

Note: B = indicator of the original model by Bermejo et al. (30); numbers without prefixes = sub-competencies proposed by the panel in the First Round, according to their numbering in the Second Round bank. In parentheses in the Competency column: number of sub-competencies evaluated in the Second Round → number with consensus in the Third Round. Expressions in quotation marks are verbatim extracts from the panel's open comments. M = mean; Md = median; IQR = interquartile range (scale 1–5).

Table 5. Descriptive statistics of the third round of expert evaluation of sub-competencies according to criteria (relevance and writing).

Competence	Sub-competencies	Relevance				Drafting				Consensus
		M	DT	Q1-Q3	RIC	M	DT	Q1-Q3	RIC	
Scientific-technical	1.1 Ability to communicate technical information effectively and efficiently.	4.69	0.6	5-5-5	0	4.31	0.63	4-4-5	1	C
	1.2 Ability to execute technical procedures according to quality standards.	4.85	0.4	5-5-5	0	4.08	0.76	4-4-5	1	C
	1.3 Ability to stay updated on scientific evidence.	4.85	0.4	5-5-5	0	4.00	0.71	4-4-4	0	C
	1.4 Ability to act in accordance with the mission of the profession, adapting its application to the requirements and objectives of the specific context.	4.85	0.4	5-5-5	0	4.15	0.69	4-4-5	1	C
	1.5 Ability to adjust technical practices according to the specific resources and requirements of different professional contexts.	4.92	0.3	5-5-5	0	4.38	0.51	4-4-5	1	C
	1.6 Ability to manage scientific solutions integrating principles of sustainability and ecological responsibility.	5.00	0	5-5-5	0	4.08	0.64	4-4-4	0	C
	1.7 Ability to design participatory methodologies in the identification, analysis and resolution of technical problems.	4.85	0.4	5-5-5	0	4.23	0.6	4-4-5	1	C
	1.8 Ability to design and adapt innovative and inclusive technological solutions.	4.92	0.3	5-5-5	0	4.23	0.73	4-4-5	1	C
	1.9 Ability to manage security and mitigation protocols focused on protecting people in disasters.	4.77	0.4	5-5-5	0	4.00	0.71	4-4-4	0	C
	1.10 Ability to develop and execute technical-scientific research that contributes to the advancement of knowledge in the area of performance.	4.85	0.4	5-5-5	0	4.31	0.63	4-4-5	1	C
Relational	2.1 Ability to listen actively, demonstrating understanding and validation of the interlocutor's message.	4.77	0.4	5-5-5	0	4.15	0.38	4-4-4	0	C
	2.2 Ability to communicate assertively, ensuring clarity and respect in the interaction.	4.69	0.6	5-5-5	0	4.15	0.69	4-4-5	1	C
	2.3 Ability to personalize the	4.62	0.8	5-5-5	0	4.38	0.65	4-4-5	1	C

	therapeutic relationship based on the user and their context.									
	2.4 Ability to manage confrontation in a respectful and resolution-oriented manner.	4.69	0.6	5–5–5	0	4.08	0.64	4–4–4	0	C
	2.5 Ability to apply persuasion while respecting autonomy.	4.85	0.6	5–5–5	0	4.54	0.52	4–5–5	1	C
	2.6 Ability to strengthen therapeutic adherence through dialogue, agreements and follow-up.	4.69	0.6	5–5–5	0	4.69	0.48	4–5–5	1	C
	2.7 Ability to convey difficult news by applying effective communication protocols.	5.00	0	5–5–5	0	4.46	0.66	4–5–5	1	C
Emotional	3.1 Ability to identify primary and secondary emotions.	4.85	0.4	5–5–5	0	4.15	0.69	4–4–5	1	C
	3.2 Ability to recognize feelings and their impact on behavior.	4.77	0.4	5–5–5	0	4.38	0.51	4–4–5	1	C
	3.3 Ability to accept and validate feelings and emotions.	4.62	0.8	5–5–5	0	4.46	0.66	4–5–5	1	C
	3.4 Ability to express feelings and emotions assertively.	4.85	0.4	5–5–5	0	4.46	0.52	4–4–5	1	C
	3.5 Ability to remain calm and regulate emotions in stressful situations.	4.69	0.6	5–5–5	0	4.38	0.65	4–4–5	1	C
	3.6 Ability to competently manage emotional conflicts.	4.92	0.3	5–5–5	0	4.23	0.6	4–4–5	1	C
	3.7 Ability to provide support in emotional crises through the application of psychological first aid.	4.69	0.6	5–5–5	0	4.15	0.38	4–4–4	0	C
Ethics	4.1 Ability to act with consistency and respect for one's own values and those of others.	4.92	0.3	5–5–5	0	4.38	0.65	4–4–5	1	C
	4.2 Ability to identify ethical conflicts and the values at stake.	4.92	0.3	5–5–5	0	4.08	0.64	4–4–4	0	C
	4.3 Ability to analyze conflicts by applying legal and ethical regulations.	4.69	0.6	5–5–5	0	4.31	0.63	4–4–5	1	C
	4.4 Capacity for rational and balanced argumentation in ethical decision-making.	4.85	0.4	5–5–5	0	4.08	0.76	4–4–5	1	C
	4.5 Ability to guarantee confidentiality in the therapeutic alliance.	4.85	0.4	5–5–5	0	4.08	0.64	4–4–4	0	C
	4.6 Ability to resolve ethical conflicts with fairness, integrity and respect for human dignity.	4.77	0.6	5–5–5	0	4.00	0.58	4–4–4	0	C
	4.7 Ability to make prudent decisions and formulate	4.77	0.6	5–5–5	0	4.38	0.65	4–4–5	1	C

	consultations with the ethics committee when necessary.									
	4.8 Ability to apply deliberative methodologies in ethical decision-making.	4.77	0.4	5-5-5	0	4.54	0.52	4-5-5	1	C
	4.9 Ability to build a participatory therapeutic alliance with the user and/or family in the resolution of ethical dilemmas.	4.92	0.3	5-5-5	0	4.15	0.69	4-4-5	1	C
	4.10 Ability to identify and analyze ethical dilemmas in the use of technologies and digital environments.	4.85	0.4	5-5-5	0	4.31	0.48	4-4-5	1	C
Spiritual	5.1 Ability to recognize and respect the diverse forms of transcendence according to each person's perspective.	4.69	0.6	5-5-5	0	4.23	0.73	4-4-5	1	C
	5.2 Ability to reflect on the meaning of life.	4.85	0.4	5-5-5	0	4.54	0.52	4-5-5	1	C
	5.3 Ability to recognize and respect the transpersonal and transcendent in suffering, nature, art and human relationships.	4.77	0.4	5-5-5	0	4.15	0.69	4-4-5	1	C
	5.4 Ability to identify and facilitate the use of transpersonal, symbolic and spiritual resources.	4.85	0.4	5-5-5	0	4.31	0.75	4-4-5	1	C
	5.5 Ability to integrate traditional and anthropological approaches to suffering, health and dying.	4.92	0.3	5-5-5	0	4.46	0.52	4-4-5	1	C
	5.6 Ability to apply habits of self-compassion and self-care for personal and professional well-being.	4.62	0.8	5-5-5	0	4.38	0.77	4-5-5	1	C
	5.7 Ability to value and address spiritual needs.	4.77	0.6	5-5-5	0	4.15	0.69	4-4-5	1	C
	5.8 Ability to design and implement interventions in spiritual care.	4.77	0.4	5-5-5	0	4.31	0.75	4-4-5	1	C
	5.9 Ability to explore one's own symbolic and spiritual world.	4.77	0.4	5-5-5	0	4.31	0.63	4-4-5	1	C
	5.10 Ability to integrate spiritual perspectives in grief support.	4.77	0.4	5-5-5	0	4.31	0.75	4-4-5	1	C
Cultural	6.1 Ability to recognize and value the diversity of values and lifestyles.	4.92	0.3	5-5-5	0	4.08	0.76	4-4-5	1	C
	6.2 Ability to identify and analyze cultural components and their meanings.	4.85	0.4	5-5-5	0	4.08	0.76	4-4-5	1	C

	6.3 Ability to communicate and mediate in intercultural contexts.	4.77	0.4	5–5–5	0	4.31	0.63	4–4–5	1	C
	6.4 Ability to analyze the evolution of cultural identities in contexts of social change and globalization.	4.85	0.4	5–5–5	0	4.23	0.6	4–4–5	1	C
	6.5 Ability to integrate human rights and gender approaches into cultural analysis.	4.85	0.4	5–5–5	0	4.08	0.64	4–4–4	0	C
	6.6 Ability to promote diversity and inclusion in multicultural contexts.	4.85	0.4	5–5–5	0	4.23	0.6	4–4–5	1	C
	6.7 Ability to implement participatory and community-based methodologies.	4.85	0.4	5–5–5	0	4.08	0.49	4–4–4	0	C
	6.8 Ability to integrate ancestral knowledge and complementary medicine into health care.	4.92	0.3	5–5–5	0	4.15	0.8	4–4–5	1	C
	6.9 Ability to design cultural interventions adapted to and respectful of communities.	4.69	0.6	5–5–5	0	4.54	0.66	4–5–5	1	C
	7.1 Ability to accompany and provide effective support to teams.	4.92	0.3	5–5–5	0	4.31	0.63	4–4–5	1	C
	7.2 Ability to receive and provide constructive feedback from leadership.	4.77	0.4	5–5–5	0	4.23	0.73	4–4–5	1	C
	7.3 Ability to resolve conflicts in team management.	4.77	0.6	5–5–5	0	4.46	0.66	4–5–5	1	C
Management	7.4 Ability to make decisions and assess the impact.	4.69	0.6	5–5–5	0	4.31	0.63	4–4–5	1	C
	7.5 Ability to manage quality criteria in the profession and its indicators.	4.77	0.4	5–5–5	0	4.54	0.52	4–5–5	1	C
	7.6 Ability to manage person-centered face-to-face and digital processes.	4.77	0.4	5–5–5	0	4.23	0.6	4–4–5	1	C
	7.7 Ability to apply digital tools in management and strategic decision-making.	4.85	0.4	5–5–5	0	4.38	0.51	4–4–5	1	C
	7.8 Ability to manage the design and adaptation of physical environments focused on user experience.	4.62	0.8	5–5–5	0	4.54	0.52	4–5–5	1	C
	7.9 Leadership ability.	4.69	0.6	5–5–5	0	4.23	0.6	4–4–5	1	C
	7.10 Ability to manage interdisciplinary and intergenerational teams.	4.69	0.6	5–5–5	0	4.38	0.65	4–4–5	1	C

Note: M = mean; Q1 = 1st quartile; Q2 = 2nd quartile (median); Q3 = 3rd quartile; SD = standard deviation; IQR = interquartile range; C = consensus reached.

4. Discussion

4.1 Conceptual contribution of the contextualization of the model

The process developed was not limited to a semantic adaptation of the model by Bermejo et al. (30), but incorporated a conceptual expansion based on emerging sub-competencies of the Chilean panel. This approach is consistent with methodological research that combines obtaining content evidence with expanding or constructing components using a modified Delphi technique (40–42).

From a substantive perspective, the results are consistent with a conception of humanization as a comprehensive competency framework, rather than as an isolated individual attribute. Scientific and technical competence based on consensus aligns with international frameworks that emphasize information management and continuous updating based on evidence (29, 43), and the emphasis on adapting practices to different contexts is linked to public health approaches that prioritize flexibility and strategic workforce planning (27, 28). Relational competence, centered on active listening, assertive communication, and conflict management, converges with evidence in emergency medicine and interprofessional collaboration, where communication and collaborative roles are pillars of clinical performance (38, 44). Emotional sub-competencies related to identification, regulation, and support in crisis resonate with research that positions affective regulation as a requirement for safe and respectful care, especially in emergency and mental health settings (45), and with the importance of emotional management in socially vulnerable environments (28).

Ethical competence aligns with frameworks that prioritize respect, confidentiality, and prudent deliberation, consistent with the need for ethical communication to reduce structural barriers (39) and responsible decision-making in the face of complex dilemmas (46). Spiritual and cultural competences acquire particular relevance: the former, present in the original model (30), was expanded to include content such as self-compassion and bereavement support; the latter, which incorporates diversity, ancestral knowledge, and complementary medicine, engages with global health approaches focused on equity, inclusion, and intercultural sensitivity (44, 47). Finally, management competence indicates that humanization also depends on organizational and leadership capacities, in line with the literature that highlights intersectoral coordination and strategic decision-making in health governance (29, 48); the inclusion of digital management and the design of user-centered environments also reflects the need to integrate humanization and technological transformation.

4.2 Scope of content-based evidence

The consensus reached indicates that, for this panel, the 63 sub-competencies are relevant and formulated with sufficient clarity to represent the construct in the Chilean context. This is the evidence that the unified approach to validity assigns to content: documenting the definition of the domain and the representativeness of its components (31). The Delphi technique is a relevant resource at this stage, especially when combined with statistical criteria that allow for estimating the sufficiency of the consensus rather than absolute agreement (32). However, panel consensus does not equate to external generalization, nor does the relevance of content guarantee that it can be reliably measured: both require evidence from other sources.

4.3 Contribution of qualitative inputs

The qualitative contributions were crucial in transforming a broad and partially redundant set of formulations into a more refined framework. Their contribution can be described in five steps: expanding the model with content not originally explicitly stated, such as psychological first aid, self-compassion, and grief; defining the scope of vague items, such as emotional conflicts and team support; eliminating redundancies between the original indicators and the panel's proposals;

contextualizing formulations by replacing potentially stigmatizing expressions; and reorganizing overlapping content across competencies, such as teamwork and leadership. Thus, the expert judgment not only endorsed the relevance of the content but also reformulated it. The panel's observations regarding the difficulty of translating certain relational and spiritual qualities into units of measurement also foreshadow specific challenges for the operationalization phase.

4.4 Curricular implications

The resulting framework can contribute to the curricular integration of humanization. In contrast to the tendency to consider these competencies as “soft” and secondary (13) and their uneven and unsystematic presence in curricula (14,15), a framework with explicit definitions and sub-competencies offers a common language for formulating learning outcomes, distributing them throughout undergraduate and postgraduate training, guiding continuing education and faculty development, and designing future assessment strategies. The identification of training gaps in communication competencies in public health master's programs (49) and the proposal of humanistic practice as a learning outcome in medical education (21) illustrate the need for this type of framework. However, these applications represent possibilities that must be examined empirically: the present study does not provide evidence on the curricular implementation of the framework or on its educational impact.

5. Limitations

The results should be interpreted considering the limitations inherent to an initial development phase. First, the panel consisted of 14 experts selected through purposive sampling, which prioritizes expertise and disciplinary diversity over statistical representativeness; the consensus obtained reflects the judgment of this panel and does not allow the findings to be generalized to other professional populations. Second, the disciplinary heterogeneity, which enriched the assessment of the different dimensions of the construct, may have limited the depth of the analysis from the specific perspective of medical education. Third, only content-based validity evidence was generated, limited to the relevance and clarity of the sub-competencies; internal structure, reliability, stability, and relationships with other variables were not evaluated, so the framework should not be considered a psychometrically validated instrument. Furthermore, the consensus criteria (median ≥ 4.0 ; IQR ≤ 1) correspond to conventional thresholds of sufficient agreement and do not imply unanimity. Finally, the study did not examine the educational applicability of the framework or its formative impact. These issues, along with the empirical verification of the dimensionality and consistency of the expanded construct, constitute priority areas for the next stages of research.

6. Conclusions

- This study provides initial content-based validity evidence for a humanization competency framework contextualized to the Chilean context. Through a three-round Delphi process, an interdisciplinary panel reached consensus on 63 sub-competencies organized into seven dimensions (scientific-technical, relational, emotional, ethical, spiritual, cultural, and managerial), which supports the contextual relevance of the model proposed by Bermejo et al. (30) and, at the same time, allowed it to be expanded and refined based on expert judgment.
- The findings reinforce the understanding of humanization as an articulated set of capabilities that transcends individual attitudes and can be the subject of intentional training. The framework is not yet an assessment tool, but it provides a basis for guiding the formulation of learning outcomes, curricular integration in undergraduate, graduate, and continuing education, and subsequent operationalization and psychometric evaluation processes.

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