



## Research Article

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# Differences in Humanized Care Perceived by Hospitalized Patients from Urban and Rural Areas during the COVID-19 Pandemic: Evidence Collected in Peru

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## Abstract

*In recent years, the health crisis has encouraged modifications and revolutions in the training of nursing practitioners in humanized care. The study's objective was to assess the satisfaction indicator of humanized care in the health care environment in order to make improvements to the health care process. The segmentation of the demographic data allowed us to present more precise analyses, in which we were able to isolate the reports of patients from urban and rural areas, in order to later determine if there are differences between the perceptions of the groups. The study used across-sectional non-experimental descriptive design, with two groups of 200 patients from urban and rural areas hospitalized with COVID-19 symptoms. The dimensions of humanized nursing care were measured using a questionnaire. The findings demonstrate significant differences in the perception of humanized care received ( $p < 0.01$ ). On the one hand, patients from urban regions rated the humanized treatment they received as favorable in 37.7% of cases, moderately acceptable in 36.7% of cases, and unfavorable in 25.6% of cases. Patients from rural areas, on the other hand, rated humanized treatment as favorable in 20.4%, moderately acceptable in 41.4%, and unfavorable in 38.2%. We conclude that humanized care is essential for maintaining care activity independent of the patient's sociodemographic variables.*

**Keywords:** humanized care, rural areas, urban areas, public hospital, COVID-19, nurses, health care workers

## 1. Introduction

In health services, the coronavirus epidemic is linked to the set of viruses that can cause a multiplicity of diseases, ranging from a simple cold to serious illnesses, such as pneumonia, severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS). To curb the rapid

increase of the epidemic, international organizations such as The United Nations recommended isolation and/or confinement, the use of masks, social distancing and permanent hand washing to avoid contagion (Caputo et al., 2021; Casaccia et al., 2021; Mendez-Lopez et al., 2022; Valero Cedeño et al., 2020). In this regard, the clinical manifestations usually presented by COVID-19 disease are: dry cough, fever and fatigue, headaches, sore throat and muscle aches, diarrhea, nasal congestion, conjunctivitis, loss of sense of taste and smell, skin rashes, discoloration of fingers and toes (Bijur et al., 2022; Higginson et al., 2022; Kadirvelu et al., 2022; Pérez Abreu et al., 2020; Tegeler et al., 2022; Wong et al., 2022).

In this sense, in the hospitalization areas there was evidence of high rates of risk of death, due to the deterioration of the health condition of patients, so nurses deployed efforts to provide timely response to health care and provide emotional support to the situation of fear and uncertainty of the person for their health condition or death (Meneses-La-Riva et al., 2021; Podgorica et al., 2022; Quon et al., 2022). Faced with this situation, health personnel have presented exhaustion and loss of labor force but nevertheless, the commitment and responsibility have been imposed to provide safe and quality health services (Becerra-Medina et al., 2022; Noorland et al., 2021; Pérez Abreu et al., 2020; Son et al., 2022).

The World Health Organization has shown concern for humanizing health care, working for universal coverage of all individuals and communities, so that they can receive comprehensive, quality care without financial difficulties throughout their lives (Allande Cussó et al., 2021; Bao et al., 2021; Blanco-Nistal et al., 2021; Lopera, 2016). The aim is for health professionals worldwide to be committed to ensuring the right to health for all without distinction of any kind (Allande Cussó et al., 2021; Murray-García et al., 2021).

Providing humanized care in the hospital context is a complex process and is developed in a fragmented manner, although there is openness on the part of nurses to link it to daily care (Solórzano et al., 2019). However, the scarce human resources and work overload are limiting factors in providing quality care, warmth and greater commitment to users (Castelo-Rivas et al., 2020). In addition, when using protective equipment, nurses distance themselves from the patient, which becomes a limitation and thus an obstacle to humanizing care, especially in people in a dying situation (Marin-Corral et al., 2021; Velasco Bueno & La Calle, 2020). Therefore, it is necessary to reflect or innovate on new ways of assuming care, as human and close as possible, until the end of life to ensure well-being from a humanizing perspective (Allande Cussó et al., 2021; Blanco-Nistal et al., 2021).

Similarly, the humanized care perceived by patients and family is made up of dimensions such as: emotional support and availability for care, being an essential requirement for holistic care actions (Guerrero-Ramírez et al., 2017; Martín Delgado & García de Lorenzo y Mateos, 2017). However, the humanized care provided by the nurse on a daily basis requires professional competencies, soft skills and ethical skills to translate them into professional practice (Aghamohammadi et al., 2021; Bagherzadeh et al., 2021; Jamaludin et al., 2021; Maznieda et al., 2022; Morrell et al., 2020; Dos Santos et al., 2017). Thus, the incorporation of improvement plans, management strategies and continuous training are essential elements to generate human sensitivity in nursing personnel (Fernandes et al., 2022; White et al., 2021).

Therefore, nursing science and praxis emphasize that human care forms the basic core of nursing practice and demands as professionals to know how to be, know how to do and know how to act with ethical commitment, in addition to fostering relationships of understanding and respect to prioritize actions with concrete answers to problems, based on knowledge and firm judgment, being susceptible entities in the face of health problems (Fry et al., 2013). The fact that health services are seen as stressful and overcrowded places for patients, becomes a challenge that involves using coping strategies to avoid dehumanization in health areas (Garza-Hernández et al., 2020).

It is essential that the nursing professional provides a safe care environment, with timely and appropriate care, which helps to reduce potential stressors in the patient in order to sustain a relationship of trust of practical-scientific reach (Lopera B., 2016; Maeker & Maeker-Poquet, 2022).

Definitely, humanizing health implies recognizing the integrality of the nursing professional beyond clinical diagnoses, to identify the emotional, cultural and social needs that may affect health and well-being (Binfa et al., 2013; Carlosama et al., 2019; Ettenberger & Calderón Cifuentes, 2022; Morrell et al., 2020). These are aspects that should not only be addressed theoretically, but should be taught during the formative process in the classroom (Díaz-Rodríguez et al., 2020; Nunes & Gaspar, 2016). In addition, a nursing professional must have sufficient emotional and communication competencies to be able to provide humanized care, which can save lives (Alonso-Ovies & Heras la Calle, 2020; Gorayeb et al., 2013).

The evidence for the positive effects of humanized care is abundant. In China, a study that sampled 112 patients with mental disorders was able to determine that humanized nursing care contributes to the relief of negative emotions and improved quality of life of patients with mental disorders (Bao et al., 2021). In India, a research evidenced that adolescents who have HIV improve their level of self-esteem thanks to humanized care (Carlouise et al., 2019). Humanized care also allows the reduction of risks and complications during pregnancy, along with a decrease in maternal and infant mortality rates (Gimenes & Silva, 2021).

Due to the ample evidence of the benefits of humanized care, its practice has gained high recognition, so its constant measurement has become a common practice internationally (Beltrán Salazar, 2016a; Garza-Hernández et al., 2020; Lima et al., 2020; Monje et al., 2018; Vásquez Espinoza et al., 2022).

For this reason, the practice of humane care focuses on comprehensive assistance to the needs of the sick person, where the health professional is at the service of the patient (Gutiérrez Vásquez & Lázaro Alcántara, 2019). The characteristic features of humanization encompass listening skills, compassion, solidarity, humility, accompaniment, closeness, empathy, motivation and acceptance of the person (Lima et al., 2020; Dos Santos et al., 2017). In this way, perception encompasses the patient's individual experience of humanized care, which is related to the benefits or services offered by nurses, assuming gestures and attitudes that will help the patient to recover physical, psychological and spiritual health (Beltrán Salazar, 2016a, 2016b).

Watson's theory establishes four dimensions of humanized care (Cruz Riveros, 2020):

- a) Emotional support: which refers to the nurse's closeness to provide humane, cordial and friendly treatment to the patient to give comfort, confidence and emotional support.
- b) Proactivity, which includes the timely and adequate information provided by the nurse to the patient and family members about the evolution of the disease and the procedures performed.
- c) Nurse characteristics, which includes the work dynamics that the nurse develops when providing comprehensive care to the patient, to achieve their physical, psychosocial and spiritual well-being, putting into practice scientific knowledge and their own experience.
- d) Prioritization of the being cared for, which is focused on the holistic care provided by the nurse, where the well-being of the person prevails, with respect for their privacy, decisions and behavior.

Caring is to assist, to support the patient according to their problems and situations, it is to see the subject in a global way and get them to adopt techniques to preserve health and prevent diseases (Coşkun Şimşek et al., 2022; dos Santos et al., 2018). Faced with the threat of dehumanization and depersonalization of care due to administrative disorganization in most healthcare systems, the recovery of the spiritual, human and transpersonal dimension in the clinical, administrative, educational and research practice by nurses is considered of vital importance (Bautista-Rodríguez et al., 2015). Therefore, the humanization of care is a relevant theory and practice of global need, since it involves sensitivity of health professionals to vulnerable situations of patients with ethical and moral responsibility (Almanza-Rodríguez, 2020; Aquino et al., 2022; Elder et al., 2020; Navarrete-Correa et al., 2021; Silva et al., 2020).

Death is the final outcome of a historical and earthly life of the human being, which sometimes is not in the hands of a health professional to be able to avoid it, since it definitively concludes the

biological processes and social relationships of every person (Romero Massa et al., 2016). Therefore, end-of-life care practices of care nurses must meet the indispensable attributes of humanized care (Fernandes et al., 2022; Henao-Castaño & Quiñonez-Mora, 2019). The main characteristics of a nurse with humanized care are: attention for the human being, providing a professional-user relationship, subject of care, communication and holistic approach (Ospina Vanegas et al., 2020).

Undoubtedly, a serious illness is a factor that leads the patient to an alteration of his/her health, making him/her vulnerable and full of fears about the risk of losing his/her life (Calle & Lallemand, 2014; Hosseini et al., 2022; Luz et al., 2020). In this scenario, nurses must provide support to the sick person, since they interact with their various emotional aftershocks that, for the most part, may be negative (Melita-Rodríguez et al., 2021; Shimoinaba et al., 2021). Indeed, humanized care is the right route to raise the standards of quality care, as supported by Watson's theory that caring is the way to transmit trust between the nurse-patient for holistic care (Beltrán-Salazar, 2015). Similarly, the Transpersonal Theory of Care urges that nurses should provide close care to the patient, be competent and establish interpersonal relationships, whose purpose is to care for and preserve human dignity (Melita-Rodríguez et al., 2021).

The nurse caregiver needs to have competencies that guarantee quality care (Arriaga-García & Obregón-De La Torre, 2019; Marin-Corral et al., 2021), traits that should be oriented from the academic training of future nursing professionals, where teachers should be leaders of humanized care (Fernandes Garcia Severian et al., 2021; Phillips et al., 2015; Rosser et al., 2019; Santos & Siebert, 2001; Ugarte Chang, 2017). The psychoemotional accompaniment of patients and family members should be included in the scope. The implementation of humanized care contributes to elevate the development of comprehensive and effective health policies (Monje et al., 2018).

This study aims to evaluate the satisfaction indicator of humanized care in the health care setting with the purpose of adopting improvements in the health care process.

## 2. Materials and Methods

This study uses a cross-sectional non-experimental descriptive design. It was cross-sectional because the data was collected only once for each of the study subjects. The design was non-experimental because the data were collected in their environment, without any manipulation of the variable. Finally, it was descriptive because the variable and its dimensions were subject to counting for presentation as percentages. It is important to clarify that a statistical test (T-test) was subsequently developed to determine whether the measurements of each study group presented significant differences or not.

The survey technique was applied (in virtual modality), being viable for the collection of information to measure the objectives outlined. The population consisted of two groups: the first group was composed of 200 hospitalized patients from urban areas, while the second group was composed of patients from rural areas. All of them were attended in four hospitals located in Lima, the capital of Peru, between the months of June and November 2021, as recorded in the patient admission records. The context of the study was the hospital setting, in which four primary care centers were selected. These hospitals have the largest installed capacity of beds for patients in intensive care units in Peru (more than 100 each) so it receives a large number of patients from all over the country. This peculiar characteristic will allow us to collect the necessary data to test the study hypothesis, having in the same context both patients coming from urban areas (locals) and rural areas (patients from other provinces). The sampling technique used was simple random probability sampling. No further demographic information was collected because it was beyond the scope of the research objective.

The questionnaire on patient perception of the humanized care provided by the nursing team (Melita-Rodríguez et al., 2021) was applied and its content was adapted to fit the objectives of the study. This instrument consists of 22 items grouped into four dimensions: emotional support, proactivity, nurse characteristics and prioritization of the being cared for.

We established cut-off criteria for assigning high, medium and low scores to the sum of each respondent's answers. First, we subtracted the maximum obtainable score (22 items multiplied by the response of 3= 66 score) minus the minimum obtainable score (22 items multiplied by the response of 1= 22 score); resulting in 44 (this operation yields the class width). Then, the class width (44) was divided by the number of classes (favorable, moderately favorable, unfavorable = 3), resulting in 14.67. Finally, high, medium and low levels were defined according to Table 1. The grouped results obtained can reach a maximum total of 66 points and are divided into the following classes: favorable perception (52 to 66 points), moderately favorable (37 to 51 points), and unfavorable (22 to 36 points).

**Table 1:** Criteria for the definition of high, medium and low levels

Level	Calculated maximum value	Calculated maximum value	Calculated class interval	Rounded class interval
Favorable	$36.67 + 14.67 = 51.34$	$51.34 + 14.67 = 66$	[ 51.34 - 66 [	[ 52 - 66 [
Moderately favorable	$22 + 14.67 = 36.67$	$36.67 + 14.67 = 51.34$	[ 36.67 - 51.34 [	[ 37 - 51 [
Unfavorable	22	$22 + 14.67 = 36.67$	[ 22 - 36.67 [	[ 22 - 36 [

The level of perception of hospitalized COVID-19 patients on the humanized care received and its dimensions was calculated and expressed in Tables and Figures, always showing a segmentation by patient origin (urban or rural area).

In addition, the t-test was used to determine whether the measurements of each study group presented significant differences or not.

Finally, for each of the items, count results and percentages are provided in the last table (Table 4), so that the reader can identify differences between the study groups.

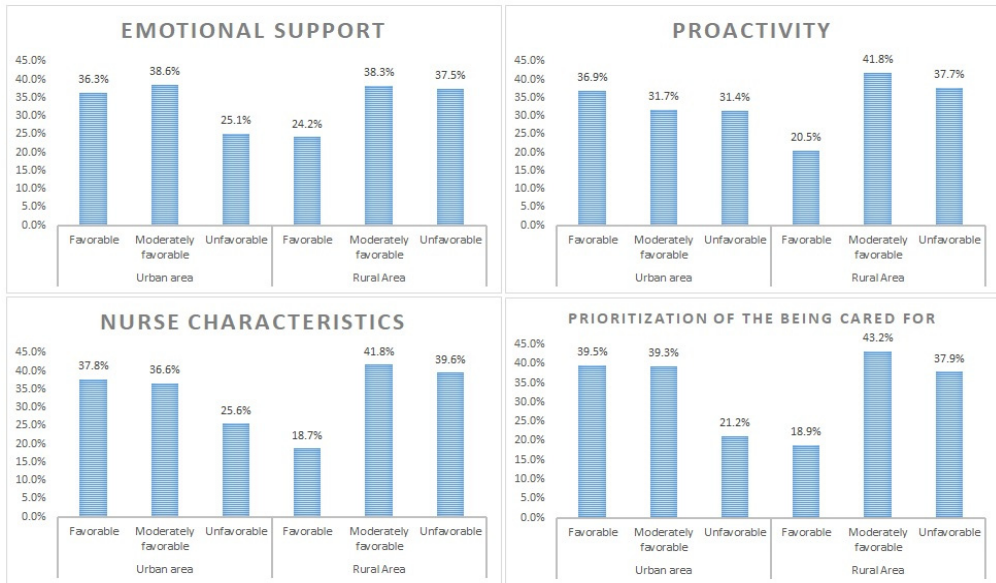
### 3. Results

The results shown in Table 2 denote large differences between the two study groups. On the one hand, the perception of humanized care by users from urban areas was favorable by 37.7%, moderately favorable by 36.7% and unfavorable by 25.6%. On the other hand, the sample from rural areas reported that it was favorable by 20.4%, moderately favorable by 41.4% and unfavorable by 38.2%.

**Table 2:** Level of perception of hospitalized COVID-19 patients on the humanized care received

Patients' perception of humanized care received	Origin			
	Urban area		Rural area	
	Count (n)	Percentage (%)	Count (n)	Percentage (%)
Favorable	76	37.7%	41	20.4%
Moderately favorable	73	36.7%	83	41.4%
Unfavorable	51	25.6%	76	38.2%
Total	200	100.0%	200	100.0%

The levels achieved in the dimensions of humanized care by patient origin were also analyzed (see Figure 1). The "emotional support" dimension was rated favorably by 36.3% of the sample from urban areas; in contrast, this same dimension was rated favorably by 24.2% of the population from rural areas. Something similar occurs in the dimensions "proactivity" (favorable evaluation by 36.9% of patients from urban areas and 20.5% of patients from rural areas), "nurse characteristics" (37.5% for urban areas, 18.7% for rural areas), and finally "prioritization of the being cared for" (39.5% for individuals from urban areas and 18.9% for those from rural areas).



**Figure 1:** Levels achieved in the dimensions of humanized care by patient origin were also analyzed

Levels achieved in the dimensions of humanized care, by patient's origin

In order to determine whether the means obtained show significant differences, we used the T-test. Table 3 details the mean, the standard deviation, the standard error of the mean, and the bilateral asymptotic significance result (p. value) for the T-test, as well as the sample size of each group.

**Table 3:** Mean, standard deviation, standard error of the mean, T test and sample

Area	Mean	Standard deviation	Standard error of the mean	T test (sig.)	Sample (n)
Urban	2.1250	0.78898	0.05579	< 0.01	200
Rural	1.8250	0.74643	0.05278		200

The average of the responses obtained from patients coming from urban areas was 2.1250, while the average of responses from patients coming from rural areas was 1.8250. As for the standard deviation and standard error of the mean, the values obtained in the samples coming from patients from urban areas were 0.78898 and 0.05579, while for those coming from rural areas they were 0.74643 and 0.05278, respectively. Since the bilateral asymptotic significance was less than 0.01, it is possible to determinate that there is a significant difference between the calculated means of both groups.

Finally, each of the results of the response count of the 22 items that make up the questionnaire was detailed in Table 4. In it, the reader can note the differences in the perception of the dimensions of humanized care in urban and rural areas. It can be noted that, regarding the perception of each of the dimensions of humanized care (emotional support, proactivity, nurse characteristics, and prioritization of the being cared for); the results given by the sample from the urban area were mostly moderately favorable or favorable. On the other hand, the sample from the rural area tended to perceive the care received as moderately favorable or unfavorable in the majority.

**Table 4:** Level of perception of hospitalized COVID-19 patients on the humanized care received, per item

Patients' perception of humanized care received	Urban area						Rural area					
	Favorable		Moderately favorable		Unfavorable		Favorable		Moderately favorable		Unfavorable	
	Count (n)	Percentage (%)	Count (n)	Percentage (%)	Count (n)	Percentage (%)	Count (n)	Percentage (%)	Count (n)	Percentage (%)	Count (n)	Percentage (%)
<b>Dimension: emotional support</b>												
1.- The nurse inspires confidence in you.	81	40.5%	67	33.5%	52	26.0%	42	21.0%	89	44.5%	69	34.5%
2.- The nurse accompanies you during medical procedures.	45	22.5%	128	64.0%	27	13.5%	56	28.0%	77	38.5%	67	33.5%
3.- The nurses make you feel close to them if you need it, they make you feel at ease.	99	49.5%	45	22.5%	56	28.0%	61	30.5%	69	34.5%	70	35.0%
4.- The nurse's care is loving and dedicated, you are treated with respect.	73	36.5%	65	32.5%	62	31.0%	38	19.0%	71	35.5%	91	45.5%
5.- The nurse asks about your state of mind, is understanding and respects your feelings.	65	32.5%	81	40.5%	54	27.0%	45	22.5%	77	38.5%	78	39.0%
<b>Dimension: proactivity</b>												
6.- The nurse identifies him/herself before providing care.	56	28%	78	39.0%	66	33.0%	39	19.5%	84	42.0%	77	38.5%
7.- The nurse answers your questions, doubts and concerns.	73	36.5%	67	33.5%	60	30.0%	43	21.5%	76	38.0%	81	40.5%
8.- The nurse gives instructions about your care, encouraging you to express what you feel.	91	45.5%	45	22.5%	64	32.0%	39	19.5%	92	46.0%	69	34.5%
9.- The information provided by the nurse contributes to your decision making.	71	35.5%	73	36.5%	56	28.0%	45	22.5%	89	44.5%	66	33%
10.- The nurse encourages you to call if you have problems, helps me understand my feelings.	78	39.0%	54	27.0%	68	34.0%	39	19.5%	77	38.5%	84	42.0%
<b>Dimension: nurse characteristics</b>												
11.- The nurse empathizes with you, allows you to express your feelings about your illness and treatment.	53	26.5%	96	48.0%	51	25.5%	34	17.0%	93	46.5%	73	36.5%
12.- The nurses are kind in the way they treat you.	86	43.0%	67	33.5%	47	23.5%	37	18.5%	72	36.0%	91	45.5%
13.- The nurses answers with what you want to know about my health/illness.	56	28.0%	102	51.0%	42	21.0%	40	20.0%	78	39.0%	82	41.0%
14.- The nurses are clear in communicating with you.	78	39.0%	61	30.5%	61	30.5%	32	16.0%	86	43.0%	82	41.0%
15.- The nurse gives you positive encouragement.	92	46.0%	68	34.0%	40	20.0%	39	19.5%	91	45.5%	70	35.0%
16.- The care the nurse gives you is committed and supportive.	89	44.5%	45	22.5%	66	33.0%	42	21.0%	81	40.5%	77	38.5%
<b>Dimension: prioritization of the being cared for</b>												
17.- The nurse is respectful.	83	41.5%	68	34.0%	49	24.5%	37	18.5%	72	36.0%	91	45.5%
18.- The nurse respects your privacy (e.g., uncovering you from the public)	65	32.5%	93	46.5%	42	21.0%	42	21.0%	61	30.5%	97	48.5%
19.- The nurse calls you by name.	70	35.0%	74	37.0%	56	28.0%	39	19.5%	95	47.5%	66	33.0%
20.- The nurse respects your decisions.	91	45.5%	72	36.0%	37	18.5%	35	17.5%	102	51.0%	63	31.5%
21.- The nurse keeps a close eye on your health status	100	50.0%	86	43.0%	14	7.0%	43	21.5%	97	48.5%	60	30.0%
22.- The nurse shows you that he/she understands my feelings of sadness or joy.	65	32.5%	79	39.5%	56	28.0%	31	15.5%	91	45.5%	78	39.0%

#### 4. Discussion

The general objective of the study was to evaluate the satisfaction indicator of humanized care in the health care setting with the purpose of adopting improvements in the health care process. In the research process, it was also possible to compare the perception of humanized care offered by nursing professionals to patients in urban and rural areas. The results show differences in the perception of care in both populations: in the case of urban residents, the results tend to be favorable, while for patients from rural areas the humanized care received tends to be unfavorable.

The results obtained differ to a certain extent from those reported by Blanco-Nistal et al. (2021) and Díaz-Rodríguez et al. (2020), who carried out similar evaluations in non-segmented populations. On the one hand, Blanco-Nistal et al. (2021) described an overall perception of humanized care of good at 94.1% despite the negative impact of COVID-19. On the other hand, Díaz-Rodríguez et al. (2020) indicated that more than half of the patients attended by nurses in hospitals in times of COVID-19 perceived good humanized care behaviors during their hospitalization. This could be due to other variables specific to the study setting (such as the characteristics of the person providing

humanized care, or of the patient receiving it), or even to differences in time or place of study.

In this sense, in hospitalization units of patients with COVID-19, high fear and risk of contagion have been evidenced in both the patient and the health personnel. However, despite the negative impact of the pandemic, it can be seen that health professionals responded to fight against this situation. It is important to take into account the indicators of the perception of humanized care of both urban and rural populations in order to strengthen skills in the daily care offered by the nurse in the various health scenarios.

Including cultural aspects such as language, religion, beliefs and customs in others favors effective communication; it is necessary to know the patients in order to know how to address situations that may be limiting to improve their health condition. The nurse should incorporate in his/her interventions a posture of interest, concern and continuous education on the process of self-care to include the patient and family in the recovery of their health, promoting fluid health communication to avoid distortion of the patient's perception.

Therefore, the characteristic features of humanization encompass listening skills, compassion, solidarity, humility, accompaniment, closeness, empathy, motivation and acceptance of the person (Guerrero-Ramírez et al., 2017). In this way, perception is the patient's individual experience of the humanized care of the benefits or services offered by nurses, through gestures and attitudes that will help him/her to recover physical, psychological and spiritual health (Meneses-La-Riva et al., 2021).

It is essential to monitor vital functions, but even the process of observation of the patient can be linked to humanizing actions (Lopera, 2016). Likewise, in the face of death, which is the final outcome of a historical and earthly life of the human being, it is necessary to maintain transpersonal and interpersonal relationships to provide the patient with a dignified death (Melita-Rodríguez et al., 2021).

A disease is a delicate situation that leads the patient to an alteration of his/her health, making him/her feel vulnerable and fragile in the moral and/or spiritual and immersing him/her in a condition of suffering, in addition to generating fear and fear at the risk of losing his/her life, which constitutes obstacles to communicate properly (Ugarte Chang, 2017). Consequently, the process of patient care in critical areas requires high cognitive, procedural and attitudinal competencies that will help nursing professionals to provide support for the stabilization and recovery of the health status of the person throughout the process of care intervention. The nurse must be able to interact with the patient's different emotional responses, most of which may be negative and could affect the patient's health.

Regarding the dimensions of humanized care (emotional support, proactivity, nurse characteristics and prioritization of the being cared for), the results obtained show differences in the perception of humanized care in most of the items, both in the urban and rural areas.

On the other hand, Almanza-Rodríguez (2020) argues that nursing professionals and the health team should articulate concrete care actions for patients hospitalized by COVID-19, as well as strengthen the isolation and care measures of the interdisciplinary team to reduce the risk of contagion and spread (Ospina Vanegas et al., 2020).

Emotional support is related to good human, cordial and friendly treatment that provides comfort and confidence to the patient to achieve their well-being and comfort during their hospital stay. However, the pandemic situation has led us to strict measures of social distancing and the use of protective equipment have limited the actions of humanized care (Marin-Corral et al., 2021). Proactivity includes activities related to the information provided by the nurse to the patient and family, in a clear and timely manner about the evolution of the disease, being positive about the procedures performed, since the purpose is to avoid further stress and concern. Therefore, the identification of the limitations and obstacles that the patient presents together with the feelings and emotions experienced about the disease that may interfere in the recovery process will help to reduce the possible problems of stress and anxiety, by establishing a patient-nurse relationship, and of practical-scientific scope (Lopera, 2016).

Indeed, humanizing health implies recognizing the integrality of the nursing professional



beyond clinical diagnoses, in order to identify the emotional and social needs that may affect their health and well-being. This is an aspect that has been left aside with the passage of time, which should not only be addressed theoretically, but should be taught in classrooms and health facilities, as spaces where health professionals are promoted to learn to treat people with responsibility, respect and in a comprehensive manner, with listening skills (Garza-Hernández et al., 2020). The nurse must have skills, emotional and communication competencies to offer humanized care (Gutiérrez Vásquez & Lázaro Alcántara, 2019).

Likewise, the nurse must cultivate humanistic values for the development of professional practice where she incorporates the scientific knowledge that will guide his/her work, since this scientific-humanistic relationship forms the core of the nursing doctrine (Almanza-Rodríguez, 2020).

There is a threat of dehumanization and depersonalization of health care, as a result of the administrative disorganization in most health systems, the lack of human resources and health personnel which is essential the recovery of the spiritual, human and transpersonal dimension in the clinical, administrative, educational and research exercise by nurses (Beltrán Salazar, 2016a). Therefore, health personnel, especially nursing professionals, deal daily with risky and unexpected situations, where the humanization of care is currently an argument of relevance and necessity, since it involves the ethical and moral responsibility of health professionals in order to sensitize them to the vulnerable moments brought by the patient (Almanza-Rodríguez, 2020).

In short, humanized care is a quality indicator that raises or improves patient satisfaction, as well as the standards of the services provided by the nurse in the health care setting. It is supported by Watson's theory, which argues that caring is a way of linking and connecting to transmit confidence in the assistance between the nurse and the patient, thus sustaining and applying the competencies or skills of caring, which are complemented by the human part, the relationship and affinity with the patient to achieve holistic care (dos Santos et al., 2018). In summary, human care should be fixed in the *raison d'être* of the nursing work, who cares and must care to ensure the quality of the care provided, in the dissimilar contexts of health services (Meneses-La-Riva et al., 2021).

Humanized care is not only supported by institutional intentions, but also by attitudes and disposition focused on the patient's well-being (Maeker & Maeker-Poquet, 2022; Meneses-La-Riva et al., 2021). The nursing staff in a high complexity hospital respects human dignity in the delivery of humanized care, mainly because of the way care is delivered on a day-to-day basis (Bao et al., 2021). Patients are subjects of care who wish to find wellness (Beltrán Salazar, 2016b; Etenberger & Calderón Cifuentes, 2022; Lima et al., 2020).

The role of nursing as an advocate for the patient's interests and as a communicating agent to maintain self-care (Nunes & Gaspar, 2016; Pablo Monje et al., 2018). Over the course of interaction time, nursing care becomes more visible to hospitalized patients by assisting with basic needs and relieving pain. However, the attributes and qualities of caring are love, commitment, empathy and sympathy, compassion, trust and competence, and confidentiality and privacy, which are employed in daily nursing practice to provide humanized and effective nursing care to individuals, families and groups.

It should be noted that humanization is an essential feature of health care, since it is established as the correlation of support and interrelation between the nurse-patient, whose link is to humanize the actions of care (Oviedo et al., 2020). However, Watson contributed much to the nursing profession, delimiting it not only as the professional who provides care, but as the person capable of identifying the emotional effect and the changes that a condition produces in the patient (Arriaga-García & Obregón-De La Torre, 2019). In addition, care must be based on a moral commitment and respect for the needs of others, which will enhance the human dignity and quality of life of the patient (Cajanding, 2016; Freitas et al., 2016; Sinclair et al., 2020).

Humanized care contributes to the relief of negative emotions and the improvement of patients' quality of life (Garza-Hernández et al., 2020; Lima et al., 2020; dos Santos et al., 2018). The results found are key to design the socio-educational intervention. Therefore, nursing care based on

humanization, which favors the reduction of risks and complications, is essential (Oviedo et al., 2020).

## 5. Conclusions

Nurses, in times of pandemic, have faced challenges in the face of adversity in direct and humanized care to the patient with symptoms hospitalized for COVID-19 symptoms. Nevertheless, patients in the study perceived differences in the perception of care in both populations: in the case of patients from urban areas, perceived humane care tended to be favorable; unfortunately, the levels of humane care of patients from rural areas was lower. This situation is worrisome, since care should be perceived as good by all patients, and differences such as these constitute limiting factors in sustaining patient care, an act that requires trust and the interpersonal-transpersonal relationship that makes the difference.

Likewise, nursing professionals are aware that in the face of the fragility and vulnerability of the disease, the person needs the improvement of the nurse's soft skills, technical and procedural competencies with new changes in the protocol of care. Nursing care and the application of the art of caring need to generate hospital environments based on law, integrity and equity in the right to health and care.

Finally, the nurse must promote in the workplace humanizing spaces accompanied by teamwork and strengthening interpersonal relationships to respond to adverse situations in the different critical care areas in times of pandemic. Likewise, health professionals should acquire preventive behaviours and conducts, especially in physical and emotional health, to continue the fight against disease and human pain of people worldwide.

The limitations found in this study were the patients' fear and distrust of the possible consequences of externalizing their opinions related to the care received, despite the fact that at all times they were provided with an atmosphere of security and trust.

We suggest conducting similar studies incorporating sociodemographic characteristics such as sex and age in order to understand the perception of humanized care from different points of view. This study did not consider these variables because they were beyond the scope of the research objective when the research process was initiated, so no such data were collected. Now, in order to deepen knowledge on this topic, it is necessary for future studies to include more specialized demographic data.

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