

Patient's perspective on health care in the Covid-19's context

Perspectiva do paciente sobre a assistência à saúde no contexto da Covid-19

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ABSTRACT This is a cross-sectional, descriptive and analytical study with a qualitative approach, with the aim to discuss the patient's perspective on health care to Covid-19 in the state of Rio de Janeiro. The participants were 160 patients with Covid-19 symptoms and/or diagnosis that looked for health care in the state of Rio de Janeiro. The data were collected through a self-applicable electronic questionnaire from July to October 2020, with its sampling being characterized with the SPSS version 26 software support, and the patient's perspective on health care data submitted to content thematic analysis. Three categories emerged among the results: Patient's satisfaction with health care; Patient's perspectives facing health care conducts and clinical practices; Patient's feelings expressed while facing Covid-19 regarding the care received, symptoms, and diagnosis. It was highlighted the absence of emotional support to the patient, besides human resources, structure and material deficits, which interfere in health care management. It must be taken into consideration that understanding the patient's perspective in health services can contribute to the quality improvement of health care.

KEYWORDS Coronavirus infections. Patient-centered care. Patient satisfaction. Delivery of health care. Personal health services.

RESUMO Trata-se de um estudo transversal, descritivo e analítico com abordagem qualitativa, que objetivou discutir a perspectiva do paciente sobre a assistência à saúde para Covid-19 no estado do Rio de Janeiro. Participaram 160 pacientes com sintomas e/ou diagnóstico de Covid-19 que procuram assistência à saúde no estado. Os dados foram coletados por meio de um questionário eletrônico autoaplicável no período de julho a outubro de 2020, sendo a amostra caracterizada com auxílio do software SPSS versão 26; e os dados referentes à perspectiva dos pacientes sobre a assistência à saúde, submetidos à análise temática de conteúdo. Dentre os resultados, emergiram três categorias: Satisfação do paciente sobre a assistência à saúde; Perspectivas do paciente diante das condutas e práticas clínicas no atendimento à saúde; Sentimentos expressados pelo paciente ante o atendimento à saúde, sintomas e diagnóstico para a Covid-19. Destacou-se a ausência de apoio e suporte emocional para o paciente, além de déficits dos recursos humanos, materiais e estrutura, interferindo no gerenciamento do cuidado de saúde. Considera-se que compreender a perspectiva dos pacientes atendidos nos serviços de saúde poderá contribuir para a melhoria da qualidade do atendimento nos serviços de saúde.

PALAVRAS-CHAVE Infecções por coronavírus. Assistência centrada no paciente. Satisfação do paciente. Assistência à saúde. Assistência individualizada de saúde.

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Introduction

The fight against the pandemic caused by the new coronavirus (Sars-CoV-2) led to the development of emergency contingency plans by national and international authorities, with the aim of reducing community spread, the overload of health systems and the mortality rate caused by Covid-19¹. The total lockdown and the expansion of the availability of beds for the care of patients with symptoms and/or diagnosis of Covid-19 were some of the government responses to the health crisis.

According to data from the Coronavirus2 Panel on August 25, 2021, Brazil has 20,614,866 confirmed cases and more than 575,000 deaths as a result of Covid-19, with an important burden on the health system, characterized by a lack of human, material and structural resources, which is reflected in the scarcity of beds and care for patients and families. Regarding the Southeast region, the state of Rio de Janeiro has the highest number of deaths, totaling 61,368 deaths in 1,104,215 reported cases, which represents a mortality rate of 355 deaths per 100,000 inhabitants.

One of the great challenges imposed by the pandemic refers to maintaining the quality of care in health services in response to emergencies, especially in developing countries. This response is configured in a complex, multifaceted process, related to a set of desirable characteristics in the provision of health care, which comprise the dimensions of quality of care, such as opportunity, safety, effectiveness, efficiency, equity and patient-centered care^{3,4}.

The participation of patients and their families is legitimate in the assessment of the quality of health services, as it considers the point of view of those who receive the care provided. Thus, valuing the patient's perspective in the process of evaluating health services is based on the idea of patient-centered care and stands out as one of the objectives proposed by the Institute of Medicine (IOM), in the plan to improve the quality of health care³.

Although no consensus has been reached on the definition of patient-centered care, the quality dimension can be understood as care that is respectful and unique, meeting the needs, preferences and values of the person assisted, with the guarantee that such values are guiding clinical decisions³. It is a complementary concept to the understanding of humanization of care⁵.

Patient-centered care has four basic principles: ensuring that people are treated with dignity, compassion and respect; provide coordinated care, support or treatment; offer personalized care, support or treatment; support people to recognize and develop their own skills and competences in order to lead an independent and fulfilling life⁶. Such principles can be considered great challenges when experiencing a global health crisis, unprecedented in current times, as the one caused by the Covid-19 pandemic.

Thus, it becomes relevant to understand patient satisfaction with the service, taking into account their expectations and experiences with the care received as important measures in the processes of evaluating and improving the quality of care within the scope of health services^{7,8}.

Thus, it is important to know the perspective of patients treated in the health system in the context of Covid-19, understanding the problems identified and that they may be different from those observed by health professionals in the exercise of their work activity. Considering the health situation caused by the new coronavirus, in which symptomatic people and/or with a confirmed diagnosis are isolated from their families due to the high potential for transmission, the principles of centered care may contribute to alleviating feelings such as fear and insecurity in the face of the unknown and that are shared by patients facing the disease.

In this sense, it is essential that health professionals understand what is important for each individual, in a holistic and unique

way, in order to make the best decisions about treatment, identifying also with the objectives that will be achieved⁶.

Considering the above, this study aims to discuss the patient's perspective on health care for Covid-19 in the state of Rio de Janeiro.

Material and methods

Study with a qualitative, descriptive approach and cross-sectional design, based on patient-centered care⁶. The steps of the Consolidated Criteria for Reporting Qualitative Research (Coreq)⁹ checklist were followed.

The scenario in the study was the health system of the state of Rio de Janeiro, located in the southeastern region of Brazil. It was chosen because it has the highest mortality rate from Covid-19 among the other states in the Southeast, totaling 61,605 deaths in 1,112,203 reported cases until August 25, 2021², which was worsened by the financial and health crisis of the state.

A total of 160 adult patients, of both sexes, with symptoms and/or diagnosis of Covid-19 participated in this study. It is recorded that 273 people responded to the invitation to participate, however, 63 declared themselves asymptomatic for Covid-19 and 50 reported that they did not seek care in health services. The inclusion criteria were: being over 18 years of age, having presented symptoms of Covid-19 and having sought care in public and/or private health services in the state of Rio de Janeiro during the Covid-19 pandemic. Individuals who sought health services for any reasons other than meeting the needs of Covid-19 symptoms were excluded.

The invitation to participants was carried out exclusively through social networks, in groups open to society, which addressed discussions about Covid-19 and groups from various other social segments hosted on Facebook and the WhatsApp application. The anonymity of the participants was maintained, using a code-name composed of the answer and number

referring to the order of the interviews, for example 'Response 1' and so on. The survey did not include personal data for later contact.

Data was collected from July to October 2020, through a self-administered electronic questionnaire prepared with the Google Forms tool. The questionnaire with open and closed questions included the following variables: sex, age, marital status, education, place of care for the first symptoms, region of residence in the state of Rio de Janeiro, if diagnostic testing for Covid-19 was carried out. Participants also answered the following questions: how do you feel about the symptoms/diagnosis of Covid-19? In case of discharge, were you instructed to remain in isolation for 14 days or did you receive any written guidance? In the event of hospitalization, were you advised on the conduct to be adopted by the health team? In case of hospitalization, were you able to receive news or have contact with your family? How did you consider your health care (adequate/inadequate)? Why?

The Free and Informed Consent Form (ICF) was made available through the access link to Google Forms before the participants answered the questions related to the study. Upon agreeing to participate, the participant marked the option 'I have read and I agree to participate in the research', migrating to the subsequent questions. Those who did not accept to participate had the form closed without any type of questioning or reprisals. Thus, the number of components that refused to participate in the study or the related motivations was not recorded. The researchers remained available throughout the data collection, clarifying the participants' doubts regarding the study and the ICF.

Data analysis was carried out in two stages, in which the quantitative variables referring to the profile of the participants were characterized with the aid of the Statistical Package for the Social Sciences (SPSS) software, version 26.0, using descriptive statistics through absolute and relative frequencies. Qualitative data referring to the patients' perspective

on health care were submitted to thematic content analysis¹⁰, comprising the pre-analysis phases; material exploration; treatment of results, inference and interpretation, emerging three categories: Patient satisfaction with health care; Perspectives of the patient in face of the conducts and clinical practices in health care; Feelings expressed by the patient regarding health care, symptoms and diagnosis for Covid-19.

All recommendations of Resolutions No. 466/2012 and No. 510/2016 of the National Health Council for research with human beings were followed, having been approved by the Research Ethics Committee EEAN/HESFA/UFRJ according to CAAE: 33591120.0.0000.5238 and Opinion 4,155,627 of July 15, 2020.

Results and discussion

Characterization of the participants

A total of 160 patients with symptoms and/or confirmed diagnosis for Covid-19 participated in this study. Of these, 67.3% were female, 49.1% were between 18 and 39 years old, 60.7% were married or in a stable relationship, 70% had completed higher education and 69.2% lived in the capital city of Rio de Janeiro. As for the area of work, 50.6% of the respondents belonged to the health area (*table 1*).

Of the total number of participants, 34.8% sought care in the private health service, 31.9% were cared for in the public service and 9.6% mentioned other forms of care, such as teleconsultation service, for example. Among those seeking care in health services, most participants were seen in hospitals (65.6%); regarding the testing for Covid-19 diagnosis, 73.2% (n=117) waited up to 59 minutes to be seen. Of the respondents, 81.8% (n=130) claimed to have performed the test for the detection of Covid-19, most of them collecting a nasopharyngeal/oropharyngeal swab (44.1%) (*table 2*).

Among the participants, 55.6% (n=89) sought care within three days after the onset of symptoms, 76.1% (n=102) of the individuals had a positive test result and 86.0% (n=135) returned home and remained in quarantine/social isolation. 10.8% were hospitalized (n=17); of these, 70.6% (n=12) reported having received guidance on the conduct to be adopted by the health team and 64.7% (n=11) received news or had contact with their family (data not shown in the table).

Among the negative feelings expressed by the respondents, fear (57.5%) and anguish regarding the disease (51.9%) stood out, in turn, positive feelings such as calm (14.4%) and hope (11.9%) emerged in the responses. The service was classified as adequate for 71.3% of the individuals (n=113).

Table 1. Sociodemographic characteristics of adults participating in the research, RJ, 2021

Variables	n	%
Gender		
Female	108	67.5
Male	52	32.5
Age		
18 to 39 years	78	48.7
40 to 59 years	71	44.4
60 years or more or more	10	6.3
Did not inform	1	0.6
Marital Status		
Single	43	26.9
Married/Stable union	97	60.7
Divorced	17	6.3
Widower	3	10.6
Education		
Complete primary education	3	1.9
Complete high school	45	28.1
complete higher education	40	25.0
Lato sensu postgraduate	48	30.0
Master's/PhD	24	15.0
Region of residence in the state of RJ		
Rio de Janeiro (capital)	110	69.2
Metropolitan region (excluding capital)	39	24.5
Coastal area	6	3.8
Others	4	2.5
Field of work during the pandemic		
Health	81	50.6
Education	9	5.6
Service provider	10	6.3
Autonomous	20	12.5

Source: Self elaborated (2021).

Table 2. Characteristics of individuals in relation to care in health units, RJ, 2021

Variables	N	%
Place of care when felt the first symptoms		
Primary Health Unit	22	13.8
Emergency care unit	13	8.1
Hospital	105	65.6
Telemedicine service	14	8.8
Others	6	3.7
Time to be served		
< 30 minutes	75	46.9
31 to 59 minutes	42	26.3
60 to 120 minutes	21	13.1
> 120 minutes	20	12.5
Could not inform	2	1.3
Diagnostic testing for Covid-19		
Yes	130	81.2
No	29	18.2
Could not inform	1	0.6
How do you feel about the symptoms/diagnosis of Covid-19?		
Fear	92	57.5
Anguish	83	51.9
Revolt	17	10.6
Calm	23	14.4
Tranquility	16	10.0
Hope	19	11.9
Confidence	16	10.0
Indifference	2	1.3
How do you rate the care you received at the Health Unit?		
Adequate	114	71.3
Inadequate	46	28.8

Source: Self elaborated (2021).

It was observed that, from the responses of the individuals in relation to the perspective on the care provided in health facilities, three

categories emerged for analysis. These categories were related to the prominent elements found in the participants' responses (*box 1*).

Box 1. Definition of analysis categories and elements considered, 2021

Category	Definition	Elements considered
Patient satisfaction with health care.	Defined as the patient's ability to judge the quality of care received, manifesting elements that, in their perspective, positively influence care ¹¹ .	Waiting time, professional-patient relationship, communication (within the guidance received).
Perspectives of the patient in the face of clinical conducts and practices in health care.	Defined as a set of actions developed and articulated in order to meet the patient's needs according to the specific knowledge of each health profession ¹² .	Structural aspects (diagnostic exams, tests); medication prescription, referrals, hospitalization and whether or not they received written documents/guidance.
Feelings expressed by the patient regarding health care, symptoms and diagnosis for Covid-19.	Understood by physical and emotional expressions described by patients in the context of the pandemic ¹³ .	Fear, anguish, revolt, tranquility, hope, confidence and calm.

Source: Self elaborated (2021).

It is important to emphasize the relationships between the categories that emerged from the analysis. That is, patient satisfaction is related to the quality of care, which, in turn, is influenced by structural aspects of the process (clinical conduct and practices) and by the relationship between health professionals and patients. These more objective aspects have repercussions on subjective findings that, in this case, are characterized by the expression of feelings of individuals that influence the way they perceive the care received, as discussed, presented and discussed below.

Patient satisfaction with health care

The quality of care necessarily permeates the satisfaction of the patient's needs. The patient's satisfaction with the care received, however, will be associated with his perspective on what he considers fair or equitable and will be expressed according to his expectations and attributes considered as relevant by him, generally shaped by previous experiences¹¹.

In this study, there was an appreciation of the cordiality and respect shown by health professionals at the time of care, as well as for the perceived feeling of reception:

I received a cordial, fast and humanized service. (Answer 72).

The health professionals did what they could, always treating me with respect. (Answer 111).

These evidences demonstrate the indicators of patient satisfaction, reception and patient expectations; interpersonal relationships, cordiality, among others. Furthermore, it expresses patient-centered care, which, in turn, is guided by a set of principles, among which respect and attention to physical and emotional needs are included¹⁴.

In this sense, patient-centered care, seen as a health care practice, converges with the idea of patient satisfaction, defined as a subject's underlying notion of the care received, which takes into account their expectations and previous experiences in similar situations⁸. In other words, patient-centered care is the necessary element that contributes to the production of patient satisfaction.

On the other hand, the devaluation of the symptoms or even the lack of empathy on the part of the professionals during the service pointed to a negative perspective:

The worst thing for me was that the people at the hospital didn't believe in my shortness of breath [...] the doctors said that my shortness of breath was panic or anxiety [...] I felt a lack of respect, especially because I have had a positive PCR result. (Answer 62).

The support and emotional back up offered to the patient and his family are essential for a positive perspective in relation to care and are intrinsic to adequate communication, which is vital both for a good relationship between them and for the confidence of the patient as he is co-responsible for his treatment. However – despite all the efforts of both parties to make themselves understood – the need for isolation, time limitations and the deprivation of the presence of loved ones, in order to prevent the spread of the virus, made communication between the health provider and the patient/family extremely difficult¹⁵.

Furthermore, clear information helps to minimize asymmetries between health professionals and patients, in addition to constituting pillars of patient-centered care – a fundamental and inseparable dimension of the quality of health care. In this study, the information provided by health professionals to patients was identified as an important aspect during care in health services. According to the results, clear and understandable information was recognized by the respondents as important and inherent elements of care, even producing feelings of satisfaction in relation to the service. On the other hand, respondents who reported having received unclear information, with no guidance, showed discontent.

The following highlights exemplify these findings:

I had excellent clinical and psychological assistance during the 18 days of hospitalization. My family felt safe and welcomed too. (Answer 31).

I was well informed of the positive result and received all the necessary and humanized resources and care. (Answer 136).

More information was lacking regarding a background treatment in case of worsening of symptoms. (Answer 65).

The adoption of 'extended social distancing' corroborated opinions issued by national and international experts and organizations¹⁶. Restrictive measures related to the current health context were adopted, which brought significant changes to the routine of people who had to adapt to the impositions of the pandemic¹⁷. An important adaptation that proved to be useful to reduce the exposure of both the patient and health professionals to the contagion of the virus was teleconsultation. This technological resource, which for some time has been occupying space in the area of assistance, has presented itself with great force in the midst of the pandemic. Telephone and video calls have been adopted worldwide, mainly for screening, diagnosis and monitoring of various pathologies¹⁸.

The imposition of a rapid transition from face-to-face consultations to remote consultations, due to the need for distance between patients and the health team, caused a disruptive innovation and, with regard to patient satisfaction, a quite positive one¹⁹. A similar result was observed in this study, as demonstrated by the highlighted lines:

It met my demand, even if it was not carried out in person. (Answer 119).

The doctor who assisted me by video was super attentive, even though I was still at the beginning of everything. (Answer 123).

Thus, during the current health context of the Covid-19 pandemic, the use of teleconsultation, once little considered by professionals and patients, is seen as a new model of care, operated through Information and Communication Technologies (ICT). It consists of a fundamental resource capable of guaranteeing timely care by providing technical guidelines for individuals who are in

social isolation, as well as for those residing in remote areas of the country. In addition, it facilitates the screening of serious cases and the continuous monitoring of individuals affected by the infection²⁰.

Perspectives of the patient in the face of clinical conducts and practices in health care

Decision-making in relation to clinical conduct and practices during health care must consider the best scientific evidence and the patient participation, which contributes to shared decision-making, understood as a basic premise for the quality of healthcare. However, such conducts may suffer interference due to structural limitations, historically known to exist in the Unified Health System (SUS), such as the scarcity of trained human resources to deal with high complexity patients; insufficient supplies and equipment; and an archaic infrastructure of health institutions²¹. These limitations were further exacerbated as a result of the health crisis caused by Covid-19²².

With regard to quality in health, Donabedian, one of the forerunners in the study of this theme, understands quality from three dimensions, namely: 1. Technique – relates to the updated application of scientific knowledge in solving the patient's problem; 2. Interpersonal – expresses the relationship between the service provider and the patient; and 3. Environmental – manifests the amenities offered to the patient²³.

With regard to the technical skill of professionals in the management of infection and recognition of signs and symptoms, the respondents were satisfied with the service, characterizing it as adequate:

The professionals immediately diagnosed the signs and symptoms, referring me directly to the test and advising me on isolation for 14 days. I think the entire care protocol was fulfilled. (Answer 55).

A positive judgment on the part of the patient regarding the clinical management of the infection by health professionals is perceived. Although such judgment is based on more empirical knowledge, built from sources of popular observations and news broadcast by the media, the trust placed in the professional who assisted him is implicit. This trust is understood as a set of expectations that patients place in the professionals who assist them²⁴. It is a subjective element, built from a loving relationship between both parties, always mediated by effective communication.

In this sense, an interdependence of the technical and interpersonal dimensions is implied for the quality of care. In the course of the pandemic, this relationship becomes even more evident, as the production of evidence on Covid-19 is still rare and fragile, which can lead to the compromise of the technical dimension of care and interpersonal relationships between health professionals and patients. In addition, the divergence of information generates confusion for both professionals and the population, as it hampers the behavioral cohesion that is so necessary in the fight against the pandemic.

On the other hand, other responses showed discontent in relation to the lack of structure in health institutions. The lack of resources directly interfered with the patient's perspective regarding the quality of care, as exemplified by the following excerpts:

The first service did not perform any tracking, and in the second the physician at work, without diagnosis, ordered me to break the quarantine, making me return to work. (Answer 1).

I had to go to a private laboratory to be tested to confirm my suspicions and to be properly medicated. When questioning the doctor, she said that she had nothing to do because the UPA does not have an exam for this diagnosis. (Answer 92).

The excerpts portray the existing structural limitations within the scope of health institutions that compromise, to some degree,

the correct clinical management of the infection by professionals. Understanding the structure as an aspect that influences the care process and health outcomes (service quality) is factual. From this perspective, the absence of diagnostic tests for Covid-19 can be seen as a structural gap in the service that influences the construction of relationships of trust, established between health professionals, patients and the organization.

Although official public health agencies and private companies propose different protocols for the diagnosis of Covid-19, at the time of this study, the differences between managers and local and national leaders regarding adequate planning for the prevention and control of the pandemic, and for the mass testing of populations to identify infected citizens, aggravated the health crisis in the SUS. This situation generated concern among health professionals and, above all, the population, due to the emphasis given by the media, since access to molecular tests would be an important health strategy for reducing contamination outbreaks, monitoring and controlling the new coronavirus. In addition to the often ineffective planning, there was skepticism on the part of society in relation to science, especially with regard to technologies to contain the advance of Covid-19, such as, for example, adequate vaccination for the population²⁵.

Respondents mentioned the unpreparedness of professionals who are on the front line, denoting concern about the care received and the use of Personal Protective Equipment (PPE) as barriers to avoid contagion of the disease: *“Inexperienced professional, closed the diagnosis for sinusitis, even though the clinic signals were of Covid and even more so in a pandemic”* (Response 3).

With the pandemic, the concern about the technical capacity of professionals working in patient care has become even more evident. There are several factors that can be brought to reflection on this very important issue, capable of compromising the quality and safety of the patient. Among these, we highlight the creation

of new hospital structures, which brought with it a massive growth in temporary hiring by health institutions to meet the increased demand for care; and the reduction in the number of health professionals who were absent from services because they were contaminated.

Although the increase in the number of personnel is a necessity of the service, the excessive hiring and without criteria inserts professionals who are technically unprepared to deal with highly complex patient profiles. Appropriate training in the context of Covid-19 is part of a set of essential actions for safe care, which preserves the principles of a patient-centered practice and which supports the control and containment of new outbreaks²⁶. Therefore, the provision of an effective and timely treatment will depend on a fundamental component: the existence of health professionals with skills and technical competences for the clinical management of Covid-19, according to the following excerpt: *“[...] in addition to the unpreparedness of professionals, that did not use PPE properly”* (Response 19).

The above answer signals the concern of patients related to the correct use of PPE by health professionals. Implicitly, the respondent refers to the discrepancy between the desired and the concrete. That is, it is expected that, during patient care, professionals use PPE correctly in order to mitigate contamination by infection among patients. However, the opposite is observed, influencing the way the patient perceives the quality of care. Thus, training that addresses the correct use of PPE and the correct techniques for dressing and undressing, associated with a routine of supervision of the services, are essential to increase the safety of both patients and health professionals.

With regard to the agility of service, respondents who claimed to have had a quick service showed greater satisfaction:

Medical guidance and referral to perform the exam in a private network occurred properly. (Answer 10).

I was very well attended at the hospital that I sought care, I did all the exams, I had all the guidelines. (Answer 137).

The need to fully implement the approach of a multidisciplinary team in health care is recognized. The work of this group provides the patient and family with a broader view of the problem by offering knowledge and motivation to overcome challenges²⁷.

However, it is also important to reiterate that many factors contribute to the psychological distress of healthcare professionals who provide direct frontline care to Covid-19 patients, such as emotional tension, physical exhaustion from long journeys and difficulties in dealing with losses – in addition to shortages of PPE, beds, medicines and mechanical ventilators²⁸.

Feelings expressed by the patient regarding health care, symptoms and diagnosis for Covid-19

The experiences lived by the participants before the provision of care in health facilities produced different feelings that ranged from loneliness and fear to security and trust. Considering that the investigation was carried out through electronic questionnaires in the course of a pandemic context, the speeches did not explore the objective aspects that corroborated the different states of subjectivity. However, some responses show evidence of a relationship between feelings characterized as positive and patient satisfaction with the care offered.

The feeling of tranquility and security when facing the disease was favored by the availability of health professionals to care for the patient, which showed empathy and acceptance of their needs, whether physical or emotional:

I had peace of mind, as they were always available for follow-up. (Answer 110).

I stayed in the ICU for 13 days, on high flow NIV. For several moments I asked to be intubated due to fatigue and dyspnea, but the multidisciplinary team with excellent performance did not allow it. I had excellent clinical and psychological assistance during the 18 days of hospitalization. My family and I felt safe and welcomed too. (Answer 31).

The speeches above highlight the family as an important element in the care process. Welcoming the needs of patients and family members in health production practices is presented as a set of essential actions that contribute to qualify and dignify care, in addition to changing the dynamics of care provided within the scope of health establishments to a patient-centered way²⁹.

The scientific literature presents family participation as a central principle related to patient safety and one of the vital strategies for promoting safe care. In this way, the permanence of the family next to the patient was impaired during the course of the pandemic in view of the need for distance to prevent the spread of Covid-19 within the scope of health establishments. Therefore, establishing strategies that promote the strengthening of communication between health professionals and family members, their insertion and reception during patient treatment is essential to ensure the quality and safety of clinical outcomes. Furthermore, 'involvement and support for family members and caregivers' constitutes one of the principles of patient-centered care practice – dimension of the quality of health-care. Evidence already shows that one of the greatest needs of families is to receive clear information about the health conditions of their relative³⁰.

Another feeling that emerged from the responses was trust, related to the quality of care provided by health professionals: *"I felt confident in the doctors who treated me"* (Response 145).

Trust is a subjective state, built from the relationship of approximation, exchange and mutual respect to beliefs, values, knowledge

and perspectives brought by the parties. Furthermore, ‘effective treatment developed by trusted professionals’ is one of the cornerstones of patient-centered care practice.

Trust is an important element in the relationship between the health professional and the patient, however, some factors contribute to its erosion during the health context of a pandemic, such as, for example, the increase in the dissemination of fake news, political interference in public health recommendations, conflicting decisions about the effectiveness of treatment plans, medical misinformation, pseudo-science and conspiracy theories. All these factors favor the dissemination of feelings of uncertainty and distrust in the social environment, contributing to the emergence of the ‘culture of fear’³¹, including among health professionals:

When I was in the room, the nursing team was afraid to get close and used my family members for support. (Answer 30).

Professionals are as nervous as we, the patients. Everything is new. Novelty brings fear. (Answer 99).

In the daily work, health professionals experience a mixture of fear and nervousness, generated by the tension and restlessness experienced by the risk of acquiring the infection, or even contaminating their family members. Furthermore, the lack of structure of health services and the work overload, caused by the increase in demand for care, with direct repercussions on the quality of health care offered, are exposed by the subjects: “*I was isolated and ‘abandoned’ in a room, where the team barely entered even when asked for help*” (Response 19).

The feeling of helplessness and abandonment reported by the patient is generated by the abrupt separation of all their affective bonds, from the moment of admission to their discharge. Contact is made only

with health professionals who, in turn, are stressed, tired and emotionally shaken with the losses experienced daily among professional colleagues, friends and family, which compromises the reception and the quality of care. In this sense, reception is a two-way street. That is, it is essential to guarantee to patients, in this period, strategies that minimize mental suffering and prevent potential psychiatric problems³², while health professionals also be embraced by the institution, so that they are psychologically prepared to provide emotional support to the patient, assuming an empathetic and respectful posture for all the needs of the individual affected by the infection during their period of hospitalization.

Important elements that shape the practice of patient-centered care were brought by one of the respondents as an appeal to doctors and other health professionals who care for individuals suspected and/or confirmed with the infection:

My appeal is: doctors, listen to the patient and don't just rely on exams, because Covid is a new disease and many things don't show up in exams yet. So, try to alleviate the patient's suffering by medicating him in the best possible way at the beginning of the disease so that he suffers as little as possible and recovers as quickly as possible. Because only those who had shortness of breath and extreme tiredness, know how desperate it is to feel that. (Answer 62).

The excerpt above legitimizes the patient’s participation as a fundamental element of care and capable of influencing his perspective on the quality of care. His insertion contributes in informing health professionals about important issues capable of interfering with clinical outcomes, in addition to being complementary to safe, effective and timely care.

In this sense, listening, mediated by effective communication, consists of a therapeutic resource and, at the same time, a

facilitator for the insertion of the patient in the care process. Its functionality mediates dialogue, strengthens trust, promotes physical comfort and emotional support, in addition to supporting the construction of a timely and co-responsible care plan³³.

Likewise, therapeutic listening is seen as a good practice³³, essential to strengthen ethical principles regarding decisions and conduct of clinical practices. Its implementation aims to preserve the autonomy and dignity of the patient, in addition to contributing to their participation in the sharing of decision-making processes related to their health.

In the context of the pandemic caused by Covid-19, qualified listening and the insertion of the patient in the construction of treatment plans were even more impaired, given the growing demand for care, reduced contingent of professionals and deficit in the structure of services. These factors influence, to some degree, the perspective of individuals who seek care in health services.

Study limitations

The main limitation of this study was a small number of respondents in relation to the total number of inhabitants in the city of Rio de Janeiro, which did not allow for inferences and contextual extrapolations. This difficulty in attracting volunteers is attributed to the time when the research was carried out, when the severity of the pandemic, as well as the saturation of the care network and the exhaustion of professionals, was not yet well perceived by the population.

The fact that the collection instrument was an electronic questionnaire may have hampered the acquisition of a greater number of participants, possibly due to the wearing down caused by the growing number of studies that used the same tool.

Another limitation was the participation in the research of a higher percentage of health professionals. This fact may be

related to the interest of these professionals to express the possible problems that occur during the care provided in the context of health facilities.

In order to try to minimize the possible biases that could be induced by the limitations presented, partnerships were sought to expand the dissemination of the research in Facebook communities and also sought to disseminate the research to other institutions not related to health professionals, such as WhatsApp groups from different groups.

Final considerations

Considering the patient's perspective on the care provided in health institutions in the state of Rio de Janeiro during the Covid-19 pandemic allowed us to identify important gaps arising from care. Such gaps are determinant aspects of quality that interfere, to some extent, in patient satisfaction with the care received, as well as in the manifestation of a diversity of feelings.

From the respondents' point of view, the problems identified were: deficit of support and emotional back up; fragmented communication with little participation of the patients and family members; deficits in human, material and structural resources, interfering with the timely management of health care; and professionals with few technical and relational skills. On the other hand, patients who received clear guidelines and who had their physical and emotional complaints accepted by professionals at the health unit highlighted that they felt more confident and calm. This emphasizes the relationship between the categories discussed in the study, expressed by the complementarity of objective aspects and subjective manifestations.

Knowledge and discussion of the patient's perspective on health care enable the problematization of important aspects that may contribute to care that has quality, is

safe and patient-centered, emphasizing the uniqueness and needs expressed by patients. In this context, it will also be up to include family members as a fundamental piece, contributing to adherence to the implemented therapy, and support for patients who face a diversity of feelings when receiving the diagnosis of Covid-19, experiencing social isolation and uncertainties related to a disease still little known.

Collaborators

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