Medicine Insights

Article

A Tripartite Study on Medical Humanistic Care in Community Hospitals: Current Practices and Improvement Strategies from Perspectives of Patients, Medical Staff, and Administrators

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Abstract: Objective: To investigate the current status of medical humanistic care in community hospitals, analyze influencing factors based on statistical data, and propose corresponding countermeasures and suggestions. Methods: Two community hospitals in Yubei District, Chongqing, were selected from the 2024 list of qualified community hospitals issued by the Chongqing Municipal Health Commission. A self-designed questionnaire was used to assess patient and medical staff satisfaction with humanistic care. Data were analyzed using SPSS 26.0. Semi-structured interviews were conducted with hospital administrators, and the interview data were analyzed using Colaizzi's content analysis method to identify key themes. Results: The frequency of patients' visits had a statistically significant impact on satisfaction scores regarding humanistic care ($P < 0.05$). Similarly, medical staff members' years of service significantly influenced satisfaction evaluations ($P < 0.05$). Four key themes emerged from the interviews: fostering a humanistic environment, improving humanistic services, enhancing empathetic communication, and advancing humanistic medical techniques. Conclusion: Community hospitals should optimize the healthcare environment and implement family doctor contract services. Additionally, they should improve career development pathways and welfare benefits for medical staff, allocate resources more effectively, and strengthen humanistic care initiatives.

Keywords: community hospital; humanistic care; satisfaction

Published: 12 August 2025

1. Introduction.

In 2024, the "Opinions on Further Strengthening Health and Wellness Culture in the New Era" (National Health Commission Publicity Document [2024] No. 9) proposed strengthening the inheritance and interpretation of medical and health institution culture, cultivating people through culture, and deepening the spirit of medical humanism [1]. Strengthen hospital culture construction, cultivate and shape the spirit of medical humanism, and practice and promote a noble professional spirit. In 2021, the Implementation Plan for the Construction of a High-Quality and Efficient Medical and Health Service System during the 14th Five-Year Plan period proposed strengthening the construction of community hospital departments (general practice, pediatrics, rehabilitation, etc.), promoting the integration of medical and preventive care, and comprehensively enhancing the service capacity of primary-level health care. In recent years, the modern medical model has gradually transformed from the traditional biomedical model to the bio-psycho-social medical model, and medical humanities have achieved tremendous development. With the increasingly severe aging of the population and the implementation of a tiered diagnosis and treatment system, community hospitals are playing an irreplaceable role as the foundation of healthcare. As the core of primary healthcare, community hospi-

tals provide comprehensive, accessible, and convenient health services to the entire population. They offer vaccination, prenatal checkups, and childcare guidance for children and pregnant women; conduct chronic disease screening and occupational health management for young adults; provide follow-up care and rehabilitation nursing for the elderly with chronic diseases such as hypertension and diabetes; They provide rehabilitation training and assistive device fitting services for people with disabilities; and ensure the supply of essential medicines and medical assistance for low-income groups. Additionally, they fulfill public health functions such as infectious disease monitoring, Family doctor contract services, and health education. By diverting patients with common illnesses through the tiered diagnosis and treatment system, they alleviate the pressure on large hospitals. Their integrated "prevention-treatment-management" service model effectively covers the entire life cycle and disease process, serving as the first line of defense for maintaining health equity in the community [2]. This study takes community hospitals as the main subject, based on a self-designed community hospital medical humanities evaluation indicator system, to explore the current status and issues of medical humanities care implementation in community hospitals from three levels: patients, medical staff, and hospital leaders, and to propose corresponding countermeasures and suggestions for the construction of medical humanities in community hospitals.

2. Content and Methods

2.1 Study Population

The study population consisted of patients, medical staff, and hospital administrators from two community hospitals in Yubei District, Chongqing City, on December 13, 2024. A total of 100 patients, 50 medical staff members, and 5 hospital administrators were selected for the questionnaire survey.

2.2. Sample Size Estimation

For the questionnaire survey, the required sample size was calculated using the formula $n=\frac{Z_{1-\alpha/2}^2}{d^2}\times p(1-p)$, where the expected satisfaction rate p = 95%, the allowable error d = 0.04, and the confidence level was set at 90%. The minimum sample size required for patients was calculated to be N ≈ 80. Based on the actual number of medical staff in community hospitals, the minimum sample size for medical staff was calculated using the sample size correction formula $n_{correction}=\frac{n}{1+\frac{n-1}{N}}$, resulting in approximately 42. The actual sample sizes were 100 and 50, respectively, meeting the minimum sample size requirements. For semi-structured interviews, purposeful sampling was used to select 5 leaders from different fields in community hospitals for interviews.

2.3. Research Methods

2.3.1. Questionnaire Survey Method

This study referenced existing questionnaires and designed its own questionnaire, which consists of two parts: basic information and evaluation of satisfaction with humanistic care. Patient basic information includes age, gender, frequency of visits, and disease type. Medical staff basic information includes age, gender, occupation, department, educational background, and years of service [3]. The patient humanistic care satisfaction section comprises 5 dimensions and 15 items, including humanistic environment (4 items), humanistic services (2 items), humanistic communication (3 items), humanistic technology (5 items), and shortcomings and suggestions (1 item). The medical staff humanistic care satisfaction section has 5 dimensions and 23 items, including humanistic environment (6 items), humanistic services (4 items), humanistic communication (5 items), humanistic technology (5 items), and shortcomings and suggestions (3 items). After statisti-

cal analysis using SPSS 26.0, the internal consistency Cronbach's α coefficients for the patient and medical staff questionnaires were 0.787 and 0.904, respectively, and the Kaiser-Meyer-Olkin coefficients for questionnaire validity were 0.74 and 0.845, indicating good reliability and validity. The humanistic care satisfaction questionnaire employed a 5-point Likert scale with values from 1 (lowest) to 5 (highest). Higher scores indicate greater patient satisfaction with medical care, with an average total score of 4 or above considered satisfactory.

2.3.2. Semi-structured Interview Method

Using the phenomenological research method in qualitative research, after informing participants of the research objectives and obtaining informed consent, semi-structured open-ended interviews were conducted one-on-one and face-to-face to collect data. The interview outline was revised repeatedly by experts and ultimately included the following:

1) What measures has your hospital implemented to create a caring environment?
2) Has your hospital established specific patient-physician communication protocols and patient rights protection systems? Are there evaluation criteria for healthcare staff's communication skills with patients?
3) What types of care services does your hospital provide to patients during routine medical procedures?
4) Does your hospital provide training on humanistic care for medical staff?
5) What types of medical services does your hospital offer, and do they cover the common health needs of community residents?
6) In your opinion, how can patient experience and healthcare staff job satisfaction be continuously improved?

Each interview lasts 15–20 minutes, continuing until no new information emerges, at which point the data is considered saturated and the interview concludes. Textual data and interview notes are analyzed using Colaizzi's seven-step analysis method, data is organized, and themes are distilled [4].

2.4. Statistical Methods

The data were processed and analyzed using SPSS 26.0. Measurement data were expressed as mean ± standard deviation (mean ± SD), and categorical data were analyzed by descriptive statistics such as composition ratio. Chi-square tests and binary logistic regression were performed. The difference was statistically significant with $P < 0.05$.

3. Results

3.1. Basic Characteristics of the Questionnaire Survey Participants

3.1.1. General Demographic Characteristics

A total of 100 questionnaires were distributed to patients. After excluding invalid questionnaires, 92 valid questionnaires were returned, with a valid response rate of 92%. Among them, there were 37 males, accounting for 40.22%, and 55 females, accounting for 59.78%. See Table 1 for details. Among the medical staff, 51 questionnaires were distributed, and 51 valid questionnaires were returned, resulting in a valid response rate of 100%. Among these, 9 were male, accounting for 17.65%, and 42 were female, accounting for 82.35%. For details, please refer to Table 2.

Table 1. General demographic characteristics of patients.

Demographic characteristics	Number of people	Proportion
Gender		
Male	37	40.22%

Female	55	59.78%
Age Group		
Under 12	3	3.26%
13-18	1	1.09%
19-45	27	29.35%
46-60	25	27.17%
60 and above	36	39.13%
Frequency of Visits		
First time	13	14.13%
Occasionally (less than once a month)	35	38.04%
Frequently (once a month or more)	42	44.57%
Regularly	3	3.26%
Type of Visit		
Underlying Medical Conditions	30	32.61%
Chronic Diseases	24	26.09%
Vaccinations	27	29.35%
Health Services	4	4.35%
Rehabilitation Treatment	3	3.26%
Traditional Chinese Medicine Services	2	2.17%
Other	2	2.17%

Table 2. General demographic characteristics of medical personnel.

Demographic characteristics	Number of people	Proportion
Gender		
Male	9	17.65%
Female	42	82.35%
Age Group		
Under 30	19	37.25%
31-40	12	23.53%
41-50	13	25.49%
Over 50	7	13.73%
Occupation		
Doctor	24	47.06%
Nurse	17	33.33%
Other Medical Staff	10	19.61%
Department		
Obstetrics and Gynecology	1	2%
Public Health	13	25.5%
Health Management	17	33.3%
Internal Medicine	4	7.8%
Surgery	6	11.8%
Traditional Chinese Medicine	6	11.8%
Other	4	7.8%
Education Level		

Associate Degree or Below	28	54.9%
Bachelor's Degree	22	43.14%
Master's Degree or Above	1	1.96%
Years of Experience		
Less than 1 year	4	7.84%
1-3 years	16	31.37%
4-9 years	10	19.61%
10 years or more	21	41.18%

3.1.2. Evaluation of Satisfaction with Humanistic Care

In the overall evaluation of patients' satisfaction with humanistic care in community hospitals, the dimensions ranked from highest to lowest were humanistic communication (4.10 ± 0.603), humanistic services (4.02 ± 0.812), humanistic environment (3.99 ± 0.476), and humanistic technology (3.89 ± 0.556). Among medical staff, the overall satisfaction ratings for each dimension of humanistic care in community hospitals, from highest to lowest, were humanistic environment (4.067 ± 0.661), humanistic technology (3.75 ± 0.729), humanistic communication (3.719 ± 0.737), and humanistic services (3.657 ± 0.612).

3.2. Single-Factor Analysis of the Influence of Personal Factors on Perceptions of Humanistic Care in Community Hospitals

Patients were categorized by gender, age, frequency of visits, and type of visit. Chi-square tests were conducted to compare the differences in scores across the four dimensions among different groups of patients, as shown in Table 3. Medical staff were categorized by gender, age, occupation, department, education level, and years of service. Chi-square tests were conducted to compare the differences in scores across the four dimensions among different groups of medical staff, as shown in Table 4.

Table 3. Single-factor analysis of the influence of patient personal factors on the perception of humanistic care in community hospitals.

Humanistic Care Dimension	Gender		Age Group		Frequency of Visits		Type of Visit	
	χ^2	P	χ^2	P	χ^2	P	χ^2	P
Humanistic environment	1.249	0.290	0.591	0.737	3.272	0.006*	1.219	0.305
Humanistic services	1.959	0.126	1.787	0.155	7.429	＜0.001*	2.159	0.099
Humanistic communication	2.521	0.021*	0.695	0.676	4.263	＜0.001*	0.714	0.661
Humanistic technology	1.022	0.432	0.934	0.507	2.522	0.01*	0.683	0.737

Note: * indicates statistical significance.

Table 4. Single-factor analysis of the influence of personal factors of medical staff on the perception of humanistic care in community hospitals.

Humanistic Care Dimension	Gender		Age		Occupation		Department		Education Level		Years of Experience	
	χ^2	P	χ^2	P	χ^2	P	χ^2	P	χ^2	P	χ^2	P
Humanistic environment	1.592	0.136	5.265	＜0.001*	0.926	0.532	0.900	0.555	0.864	0.588	11.820	＜0.001*

Humanistic services	1.383	0.227	4.809	< 0.001*	0.672	0.729	2.389	0.028*	2.478	0.023*	10.236	<0.001*
Humanistic communication	1.147	0.354	3.047	0.007*	0.573	0.811	1.694	0.122	1.199	0.322	7.939	<0.001*
Humanistic technology	1.026	0.436	6.963	< 0.001*	0.566	0.817	0.721	0.686	0.974	0.475	9.054	<0.001*

Note: * indicates statistical significance.

3.3. Binary Logistic Regression Analysis of Influencing Factors of Medical Humanistic Care Feelings

Binary Logistic regression was used to comprehensively analyze the influencing factors of patients and medical staff's humanistic care feelings. In terms of patients, gender and frequency of visits screened by univariate analysis were used as independent variables, and satisfaction with the total score of patients' humanistic care feelings was used as dependent variable (the average total score of more than 4 points was satisfactory). The results are shown in Table 5. After testing, the frequency of patients' visits had a statistical significance on the evaluation score of humanistic care satisfaction in community hospitals ($P < 0.05$).

For medical staff, the age, department, education and working years screened by univariate analysis were used as independent variables, and the satisfaction of the total score of humanistic care was used as dependent variable. The results are shown in Table 6. After testing, the working years of medical staff had a statistical significance on the evaluation score of humanistic care satisfaction in community hospitals ($P < 0.05$).

Table 5. Analysis of Factors Affecting Patients' Satisfaction with Humanistic Care.

influencing factors	B	SE	Waldχ2	P	OR
Gender	- 0.056	0.487	0.013	0.908	0.945
Frequency of Visits	- 1.527	0.373	16.765	<0.001*	0.217

Note: * indicates statistical significance.

Table 6. Analysis of Factors Affecting Healthcare Personnel's Satisfaction with Humanistic Care.

influencing factors	B	SE	Waldχ2	P	OR
Age	0.891	0.937	0.905	0.341	2.438
Education Level	2.044	1.464	1.948	0.163	7.719
Years of Experience	3.368	1.343	6.294	0.012*	29.028
Department	- 0.118	0.333	0.126	0.723	0.889

Note: * indicates statistical significance.

3.4. Basic Information on Semi-structured Interview Subjects

There were five interview subjects in total, and their basic information is shown in Table 7.

Table 7. General Information Table for Interview Participants.

Serial Number	Gender	Age	Position	Title	Department	Education
H1	Female	42	Deputy Director	Intermediate	Administrative Department	Undergraduate
H2	Male	40	Deputy Director	Junior Hospital Administrator (Grade 8)	Administrative Department	Undergraduate
H3	Male	51	Deputy Director	Intermediate	Administrative Department	Undergraduate
H4	Female	39	Deputy Director	Head Nurse	Administrative Department	Undergraduate
H5	Male	47	Deputy Director	Intermediate	Administrative Department	Undergraduate

3.5. Summary of Interview Themes

3.5.1. Creating a Humanistic Environment

Creating a good humanistic environment can provide a warm and comfortable space for both medical staff and patients, promoting the development of a harmonious and inclusive medical atmosphere. H1. "Our hospital now has a self-service queuing system, allowing patients to make appointments online and offline, making it more convenient to see a doctor." H5. "Considering that some elderly patients are not very familiar with smart devices or have mobility issues, we have assigned security personnel to assist them, ensuring a smoother medical experience." H3. "The hospital has added more seating, wheelchairs, accessible restrooms, and a mother-and-baby room, making it more comfortable for special groups to receive medical care." H5. "Currently, primary healthcare tasks are heavy and challenging, and humanistic care has not been fully implemented, but we are actively exploring ways to improve." H4 "To provide patients with a better healthcare environment, we have repurposed the administrative building for clinical use, expanding the treatment space and enhancing the service experience."

3.5.2. Enhancing Humanistic Services

A comprehensive humanistic service system can establish a patient-centered care framework while addressing the needs of medical staff. This approach provides personalized health management for patients and offers career development opportunities for healthcare professionals, fostering a service ecosystem that promotes mutual care between patients and medical staff. H3. "We have established day care wards to assist patients with mobility challenges, offering medical care and daily support services at a reduced fee, thereby alleviating the financial burden on their families." " H5. "We have implemented the 'one doctor, one assistant' model, categorizing patients based on their needs to streamline processes and make the medical experience smoother for everyone." H5. "The hospital offers volunteer services to assist patients and medical staff. Volunteers are managed by a third-party organization, with costs covered by the hospital to ensure quality service delivery." H4. "Elderly residents in the area can receive free health checkups, and women and children can enjoy home health care services, making health management more personalized." H1. "Chronic disease patients can complete all necessary tests and medication prescriptions in one stop, ensuring a worry-free experience and saving time and effort." H4. "Humanistic care cannot focus solely on patients; staff satisfaction is key to better service. We will enhance staff morale through union activities and improved benefits." H2. "Given the high work intensity, we have optimized shift schedules to ensure that department staff rotate shifts, avoiding excessive fatigue and ensuring everyone has reasonable rest." H5 "During peak patient hours, we open half an hour earlier

each day, extending evening hours to 8:30 PM in summer and 8:00 PM in winter to accommodate working professionals. On weekends, we offer morning vaccination services to accommodate students."

3.5.3. Deepening Humanistic Communication

Community hospitals establish an equal and trusting communication mechanism between doctors and patients in their daily medical activities. Through empathy training, they improve the communication skills of medical staff and advocate for patients to understand medical work, thereby forming a positive interactive medical relationship. H3. "We found that young doctors lack experience and have low patient trust, so the hospital specifically arranged doctor-patient communication training to help them better interact with patients. "H4." We have provided medical staff with training on handling medical disputes and self-protection, including how to control tone and express themselves flexibly. We have also established a dispute avoidance system and assigned dedicated mediators. Additionally, we have increased the proportion of young security personnel to strengthen hospital safety management." H5"For patient complaints, we do not directly punish medical staff. Instead, we assign dedicated personnel to investigate and verify the claims, ensuring the handling process is fair and impartial, without favoring any party."

3.5.4. Enhancement of Humanistic Technology

The core of humanistic technology enhancement lies in the development of innovative technologies and the renewal of medical service models, with the ultimate goal of improving the quality of medical services. H1. "We promote innovation in medical service models, implement policies that integrate medical treatment and prevention, and focus on developing pediatric and traditional Chinese medicine specialty departments to provide patients with more professional medical services." H2. "The hospital has established a quality control office to strictly supervise the quality of medical services and ensure that patients receive safe and standardized medical treatment." "H3. "We firmly implement the 'reverse support program,' implementing a 'county-hired, township-used' system, where county-level doctors are assigned to grassroots hospitals, while collaborating with district maternal and child health centers and district traditional Chinese medicine hospitals to enhance specialty department capabilities and establish premium traditional Chinese medicine clinics." H4. "We regularly organize skill training for medical staff to continuously improve medical technology and service quality, ensuring patients feel more at ease when seeking medical care." "H5. "We have formed 16 family doctor teams using the '1+1+N' model (1 doctor + 1 nurse + multidisciplinary support), integrating clinical, public health, and nursing resources to provide comprehensive health management services."

4. Discussion

4.1. Current Status of Humanistic Care in Community Hospitals

4.1.1. Humanistic Care from the Patient's Perspective

From the general demographic characteristics of patients in Table 1, it can be seen that the main population of community hospitals is the elderly, and the frequency of visits is mostly once a month or more, and the types of diseases are mainly underlying diseases. Among the satisfaction scores of each dimension, the scores of humanistic communication and humanistic service are higher than 4 points, indicating that patients are highly satisfied with the related humanistic care measures in the above two dimensions.

From the univariate analysis, it can be seen that patients of different genders have statistical differences in their satisfaction evaluation of humanistic communication dimension. The influence of gender on humanistic communication satisfaction is mainly reflected in the fact that female patients may be more sensitive to empathy, patience, clarity of explanation, etc. in communication, while male patients may pay more attention to efficiency or result-oriented communication [5]. The frequency of medical treatment has

statistical differences in the satisfaction evaluation of four dimensions: humanistic environment, humanistic service, humanistic communication and humanistic technology. Combined with binary logistics regression analysis and survey data, it can be seen that there is a negative correlation between the frequency of medical treatment and the satisfaction score, and the reasons for the low satisfaction of patients with high frequency medical treatment may be as follows: In terms of humanistic environment, patients with high frequency (such as chronic disease patients) may pay more attention to details such as environmental comfort and privacy protection due to repeated experiences. In terms of humanistic services, high-frequency patients have higher requirements for service processes (such as waiting time and convenience of follow-up visits), and are prone to dissatisfaction due to repeated exposure to the same problems [6]. In terms of humanistic communication, high-frequency patients expect medical staff to be familiar with their medical history. If the same content is repeated every time they communicate, they are easy to feel ignored. In terms of humanistic technology, high-frequency patients have a lower fault tolerance rate of technology (such as operational proficiency) due to fixed expectations formed by multiple contacts. The reason for the higher satisfaction of patients with low frequency visits may be that higher ratings are given because of the "freshness" of a single experience or lower expectations.

4.1.2. Humanistic Care from the Perspective of Medical Staff

It can be seen from Table 2 that women account for the largest proportion of medical staff. The age composition of the population is mainly young people under 30 years old. The education is mainly college or below, followed by undergraduate degree, and the working experience of more than 10 years accounts for the largest proportion, followed by 1-3 years. In the evaluation of medical staff's humanistic care satisfaction, only the dimension of humanistic environment has an average score of more than 4 points.

In the univariate analysis of the influence of personal factors on the feeling of humanistic care in community hospitals, it can be seen that the two factors of age and working years have statistical differences in the satisfaction evaluation of the four dimensions, and the factors of department and academic qualifications have statistical differences in the satisfaction evaluation of humanistic communication. Combined with binary logistic regression analysis to verify the independence of the results by controlling confounding factors, it can be seen from the analysis results that the influence of working years on the evaluation score of humanistic care satisfaction is statistically significant and positively correlated. The reason for the lower satisfaction of medical staff with shorter working years may be that they are in the initial stage of their careers and face multiple challenges such as role change, skill upgrading and environmental adaptation [7]. These include being more sensitive to the physical environment of the hospital (such as office conditions, old and new equipment) and the humanistic atmosphere (team acceptance) in the humanistic environment. If the initial experience is not good, it is easy to lead to a gap. In humanistic services, the physical and mental health of medical staff is not guaranteed, and there is a high dependence on logistical support. If the administrative process is cumbersome, it is easy to feel neglected. In humanistic communication, medical staff are eager for superior guidance and teamwork. If they lack effective feedback channels or encounter "cold violence in the workplace" in the doctor-doctor relationship and the doctor-patient relationship, they are easy to feel isolated [8]. In terms of humanities and technology, new medical staff are in urgent need of systematic training. If they lack teaching or career planning guidance, they are easy to feel confused and frustrated. These reasons are one of the reasons why medical staff with shorter working years get lower scores in the survey of humanistic care satisfaction in community hospitals.

4.1.3. Humanistic Care from the Hospital Perspective

In terms of creating a humane environment, hospitals' investment in hardware facilities (such as adding barrier-free access and optimizing waiting areas) demonstrates their emphasis on patient experience, especially their attention to special groups such as the elderly and disabled. However, H5 feedback reveals the reality faced by grassroots medical institutions—despite significant improvements in hardware, insufficient human resources and heavy medical workloads may constrain the in-depth implementation of humanistic care. For example, volunteer services can alleviate some of the pressure on guidance staff, but long-term reliance on third-party management may affect service stability. In addition, some hospitals have expanded their treatment areas by reallocating administrative space (H4), reflecting flexibility in resource allocation, but this may also indirectly indicate that the original space planning did not meet future needs. In the future, it will be necessary to strengthen the allocation of personnel at the grassroots level while optimizing facilities to ensure the sustainability of humanistic care measures [9].

In terms of improving humanistic services, community hospitals' service innovations (such as the "one doctor, one assistant" model and extended outpatient hours) demonstrate a patient-centric, refined operational strategy, particularly focusing on time-constrained groups such as working professionals and students. The establishment of day care wards (H3) not only alleviates the burden on family members but also explores a low-cost, high-efficiency community healthcare model. However, the statement in H4 that "employee satisfaction is the foundation of service" suggests that healthcare staff satisfaction may remain a shortcoming—despite union activities and improved scheduling, issues such as high work intensity at the grassroots level and limited career development opportunities may undermine their enthusiasm for service.

In terms of deepening humanistic communication, the hospital's training on doctor-patient communication (H3, H4) demonstrates its awareness of the importance of trust relationships. However, the current training content is heavily focused on "risk prevention" (such as dispute mediation and tone control), which may weaken the cultivation of empathy. For example, young doctors, due to their lack of experience, are more prone to being questioned, and relying solely on technical training is insufficient to address trust issues. Additional practical support, such as clinical mentoring, is necessary [10]. The "fair investigation" principle of the complaint handling mechanism (H5) is commendable, but without a transparent feedback process, patients may still question the results. While the younger age of security personnel has improved emergency response capabilities, the root cause of doctor-patient conflicts is communication issues, and overreliance on security may exacerbate tensions between both parties.

In terms of improving humanistic technology, the combination of technological advancement and humanistic care is prominent in family doctor teams (the "1+1+N" model), which integrate clinical and public health resources to provide personalized health management in line with the positioning of community healthcare. However, although the "county-hired, township-used" policy has filled the technical gap at the grassroots level in the short term, if doctors who have been transferred to rural areas lack a sense of belonging, it may lead to insufficient continuity of services. Additionally, skill training (H4) that focuses solely on technical aspects while neglecting humanistic qualities will struggle to comprehensively improve service quality. In the future, humanistic assessment indicators, such as patient engagement and service satisfaction, should be embedded into technological development.

4.2. Issues in Humanistic Care at Community Hospitals

4.2.1. Patient Perspective

Research indicates that the frequency of visits is negatively correlated with satisfaction with humanistic care. Patients with underlying conditions or chronic illnesses, who visit more frequently, scored the lowest on humanistic environment (3.99 ± 0.476) and

humanistic technology (3.89 ± 0.556). In terms of humanistic environment, some patients reported issues such as unpleasant odors in the hospital, unclear guidance, and the absence of toilets in patient rooms. These patients, due to repeated healthcare experiences, are more sensitive to privacy protection (e.g., open waiting areas) and technical stability (e.g., inconsistencies in treatment among different doctors). Additionally, the lowest scores in the humanistic technology category were not only reflected in the limited technical capabilities of primary healthcare facilities (e.g., inability to perform advanced surgeries, limited medication options), but also in the implementation of the family doctor contracting system. Many patients reported gaps in family doctor services during the questionnaire process. Survey data shows that only 22% of chronic disease patients receive regular follow-ups from family doctors, while 72% of enrolled residents reported that they had only met their family doctor at the time of enrollment or that the quarterly health assessments promised at enrollment had never been carried out. This highlights issues in the implementation of the family doctor enrollment system at community hospitals.

4.2.2. Medical Personnel

From the results of binary logistic regression analysis, it can be seen that the influence of working years on the evaluation score of humanistic care satisfaction is statistically significant and positively correlated. Medical staff with shorter working years mainly have two problems: unclear career development path and imperfect welfare benefits. There are problems of unclear career prospects in career development. For example, the career ceiling of community hospitals is obvious, which is 2-3 ranks lower than that of secondary hospitals, general practitioners are reduced to "miscellaneous doctors", the sense of professional value continues to decrease, there is a lack of specialty construction opportunities, and the space for technical growth is limited [11]. In addition, there are also some problems such as unreasonable evaluation standards (public health services, health education and other workloads are not included in the promotion evaluation) and single promotion channel (general practitioners and specialists use the same set of evaluation standards). In terms of welfare benefits, there are unreasonable salary system (the night shift subsidy standard has not been adjusted for many years), inadequate welfare guarantee (the welfare content is formalized and misaligned with the actual needs of employees), and work-life imbalance ("flexible shift scheduling" evolves into "unlimited overtime") and other problems, which have seriously affected the work enthusiasm and service ability of medical staff.

4.2.3. Hospital Management

From the perspective of hospital management, community hospitals face issues related to resource allocation and coordination, as well as imbalances in the development of technical capabilities and humanistic care.

First, issues related to resource allocation and coordination are prominent. Community hospitals generally suffer from a contradiction between strong investment in hardware and weak support in software. Although the government has continued to increase investment in infrastructure, the allocation of human resources has lagged far behind [12]. Surveys indicate that the nurse-to-patient ratio at this community hospital is only 1:1.2, far below actual requirements, leading to prolonged overwork among medical staff. Additionally, resource allocation for medical equipment, medication supplies, and other resources is misaligned with residents' needs, with a shortage of medications for chronic and mental health conditions reaching 30%.

Second, there is an imbalance between technological development and humanistic care. Management has overly emphasized quantitative performance metrics, allocating 85% of training resources to technical improvement while neglecting the cultivation of human-

istic qualities. In the family doctor contract service program, excessive emphasis on contract signing rates (accounting for 40% of performance evaluations) has led to a widespread phenomenon of prioritizing contracts over service quality. The medical quality control system places excessive emphasis on technical standards (70% of the evaluation criteria), while assessments of humanistic indicators such as doctor-patient communication and service attitude remain superficial. In professional skill training for medical staff, there is an imbalance where medical technical training accounts for the overwhelming majority, while training in humanistic care skills is rarely included [13]. These imbalances directly result in the following: despite improvements in medical technical indicators, patient satisfaction growth remains sluggish, and doctor-patient disputes have not been effectively addressed.

4.3. Countermeasures and Suggestions

4.3.1. Improve the Medical Environment and Implement Family Doctor Contract Services

Community hospitals should embody humanized design when optimizing medical environment, and enhance humanistic care elements while retaining basic medical functions. On the one hand, it is necessary to improve the construction of barrier-free facilities, including adding priority service windows for the elderly, equipping sufficient wheelchairs and other assistive devices, and renovating barrier-free toilets to ensure the convenience of medical treatment for special groups; On the other hand, it is necessary to promote the combination of smart medical care and traditional services. While introducing smart devices such as self-service registration machines, sufficient manual service windows should be retained. Community hospitals should focus on promoting the quality and efficiency improvement of family doctors' contracted services, and provide allround and continuous health management services for contracted residents. Secondly, it is necessary to refine the service content, formulate personalized health management plans for patients with chronic diseases, and provide regular follow-up, medication guidance and other services; Carry out special health management for key groups such as pregnant women and children. At the same time, it is necessary to innovate service methods and use the network communication platform to realize convenient functions such as online consultation, appointment referral, and health record inquiry. In addition, it is necessary to establish a scientific assessment mechanism, and incorporate indicators such as the satisfaction of contracted residents and health management effect into the performance assessment, so as to avoid simply pursuing the quantity of contracts and neglecting the service quality [14]. By improving the contracted service, the hierarchical diagnosis and treatment goal of "minor illness in the community, serious illness in the hospital, and recovery back to the community" can be truly realized.

4.3.2. Improve Career Development Paths and Welfare Benefits for Medical Personnel

A career development system tailored to the characteristics of community hospitals should be established. In terms of professional title evaluation, the actual workload should be taken as the basis, and the weight of performance in grassroots work such as chronic disease management and family doctor services should be increased. A special title sequence for community medical services should also be established. At the same time, development channels should be broadened to provide opportunities for further training at higher-level hospitals and exchanges between institutions. In terms of welfare benefits, reform the performance-based distribution mechanism to prioritize frontline clinical staff, establish special subsidies for community work, and implement incentive mechanisms linked to years of service [15]. Furthermore, prioritize the mental and physical well-being of medical staff by improving rest and leave systems, regularly organizing psychological counseling activities, and fostering an organizational culture that values and cares for employees.

4.3.3. Coordinating Resource Allocation and Strengthening Humanistic Care

Community hospitals should establish a scientific mechanism for dynamically allocating resources and adjust the allocation of human and material resources such as personnel and equipment in a timely manner based on changes in the service population and disease spectrum. In terms of humanistic care development, indicators such as communication skills between medical staff and patients and service attitude should be incorporated into performance evaluations, and regular training on humanistic literacy should be conducted [16]. At the same time, patient satisfaction surveys and feedback mechanisms should be established to promptly address shortcomings in service delivery. Through measures such as establishing volunteer service teams and optimizing service processes, a warm and friendly healthcare environment should be created to ensure that patients receive medical services while also experiencing humanistic care.

5. Conclusion

This study systematically examined the current implementation status and influencing factors of medical humanistic care in community hospitals from the tripartite perspectives of patients, medical staff, and hospital administrators. Based on empirical analysis, this research proposes countermeasures to optimize the medical environment, improve the career development system for medical personnel, and strengthen the integration of humanistic care with medical technology, aiming to enhance the quality of primary healthcare services. The findings provide a theoretical foundation and practical guidance for advancing the construction of medical humanistic care in community hospitals, offering significant reference value for promoting the grassroots implementation of the "biopsychosocial" medical model. Future research could expand the sample size to explore differentiated approaches to humanistic care development in community hospitals across different regions.

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