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INFORMATION GIVING IN BAHRAIN HOSPITAL:
A STUDY OF THE VIEWS OF PATIENTS, DOCTORS AND NURSES

BY

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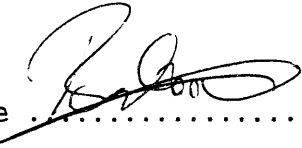
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fulfilment for the degree of Master of Nursing.

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DECLARATION

I declare that the work embodied in this dissertation is entirely my own independent investigation, unless otherwise stated, and that it has not been submitted in whole or part in candidature previously for any degree, nor concurrently being considered for any other degree.

Signature of Candidate 

Date September 1993

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ABSTRACT

This research explores patients' perceptions of the information they receive during their hospital stay. It also explores doctors' and nurses' perceptions of the practice of information giving to patients. This descriptive study uses a combination of interviews and questionnaires as tools for the data collection. A convenience sample of 56 patients, 29 doctors and 40 nurses participated in the study.

The study reveals several interesting findings, using descriptive statistics and content analysis of patients' nurses and doctors' views, . The patients seemed initially satisfied when asked to rate their general perceptions about the information they had received but they were not satisfied with all the specific information they received about their health problems, physical examination, investigations, medication, operation, pre and post operative information, the ward routine and facilities. The findings also reveal that patients did not receive adequate discharge advice and that most patients needed more information about different aspects of their care.

The views of the doctors and nurses differed from those of the patients. The doctors and nurses were initially less satisfied about their general perceptions on the information patients received. However, concerning their views on the specific information patients received on different aspects of their care, they seemed to be more satisfied. They perceived the patients to be the main reason for lack of information but their suggestions for improving the practice of information giving were primarily concerned with their own performance as professionals. Some tentative recommendations for improving the practice of information giving are made.

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CHAPTER ONE

INTRODUCTION

Although talking is fundamentally a simple process which, most of the time, comes naturally, it can become complex and difficult, especially when talking to the sick, the dying or the bereaved. In other words, the complexity can become greater, depending on the circumstances surrounding the individuals who are engaged in talking. The patients and their health care providers are one such group of individuals, who are constantly facing pressures of not being able to talk at ease. On the one hand, the patient who has just learnt that he has developed a serious disease and, on the other hand, the doctors or the nurses who have to cope with breaking the bad news or who simply do not know how to break the bad news. It can be even worse when both the patients and the nurses or doctors come from culturally different backgrounds, when they do not possess the language to be able to talk freely or communicate clearly and meaningfully.

In hospitals, problems of communication are often observed but instead of doctors and nurses receiving the blame, the fault often falls on the patients. As one authority put it:

"The clinicians say that what is said to patients is frequently not understood and forgotten. These problems are often referred to as 'failures' of patients' comprehension and memory".

He then continued to say:

"It is obvious that patients are not at fault. If a message is not understood by its intended audience, it is more rational, if blame must be attached at all, to blame the originator of the message for not making it comprehensible in the first place".

Ley (1988, p. xi).

This research will be concerned with the problem of patients' lack of receiving adequate information concerning their health status and their surrounding environment while being in hospital. It will also simultaneously explore the views of doctors and nurses about the same aspect of patient care. Studies which aim at exploring areas of concern to patients and improving patients' satisfaction are desirable goals in their own right.

Faulkner (1984) acknowledged that, traditionally, it is the doctor's responsibility to give information to the patients about their disease and treatment. Faulkner also added that patients continue to complain about lack of information mainly because doctors are not always available when patients have enquiries, which leaves the nurse, who is constantly available to meet the patients' need for information. Also, the patients' need for knowledge does not necessarily involve elaborate details.

Both medical and nursing authorities in the general field of communication, and specifically in the field of provision of information to patients, have emphasised the importance and, for some, the benefits of effective, adequate and efficient communication. This has been, and still is, attracting a great deal of attention, but unfortunately researches still show that one of the common complaints made by patients is lack of communication (Cartwright, 1964; Raphael, 1969; Ley 1972; Hayward, 1975).

The benefits of giving information cannot be over-emphasised. Many studies show that the patients approve of being told about their illness, even if what they are told is 'bad news'. Ley (1982) reviewed 15 studies dated between 1950 and 1980 and revealed that information ranged between being

diagnosed as having cancer to the side effects of drugs. He found that most of the patients in these studies approved of being told.

The reported benefits of giving information to patients, which are backed by numerous research findings are that giving information to patients will:

1. Increase patients' knowledge and recall
2. Increase patients' satisfaction
3. Increase patients' compliance
4. Provide genuinely informed consent
5. Lead to quicker and less stressful recovery.

(Ley 1988, p. 157).

In addition, the patients' sense of 'control' can be maintained and enhanced by providing adequate information, and the power of decision making will fall on the patient. Patients should have the ultimate 'say' about matters pertaining to their own health.

Patients in the State of Bahrain, where this research took place, seemed to experience lack of information and moreover no studies could be found to assess the true nature of the problem. The Bahrainese doctors and nurses are eager to find ways of improving the provision of health care and one way of implementing this is to conduct studies in the areas of need. The results of this research, plus others, can perhaps help in exploring and assessing aspects of patients' care and ultimately provide recommendations for the improvement of services.

In 1992, Bahrain through the dedication of its nurses, was designated as a World Health Organisation Collaborating Centre for nursing development,

which looks at ways and means of improving the nursing profession, not only in Bahrain but within the region. The focus of this research could stimulate the interest to conduct similar studies in other countries of the region.

JUSTIFICATION FOR THE STUDY

From a preliminary literature review, it was clear that the benefit of giving adequate information to patients has enormous implications for the level of compliance of patients, the power of decision making and the satisfaction which patient experienced, which ultimately helps to promote faster recovery. To give such 'adequate' information one has to be fluent in using the language. Unfortunately, in the State of Bahrain, nurses and doctors are all trained in English, patients' records are maintained in English and much of the interaction between doctors and nurses take place in English. 70% of the nurses are non-nationals who do not know the Arabic language except for a few basic words, these nurses are mainly from India, the Philippines and other countries. The Bahraini nurses constitute around 30% of the total nursing manpower, they too interact with the non-national nurses in English. On the other hand, the patients are a mixture of all levels of society, the old, the young, the educated, the non-educated, the poor, and the middle classes; few are from the rich class as they utilise the private hospitals or seek treatment in western countries and America. The language barrier, therefore, could play a part in the inadequacy of communication between patients and nurses.

Whilst looking at the literature, some authors build one study on another, and recommend further studies of the phenomenon from a different angle. The reason for this is to put the problem in the perspective of what has already been done. In Bahrain no studies have been undertaken in the area of patients' information so, in a sense, one does not know where patients stand in terms of adequacy or inadequacy of information they receive. A study in this area is therefore strongly needed.

Personal observation shows that, on the one hand, patients complain of not knowing what is wrong with them or not knowing the results of the tests, and on the other hand nurses, who usually spend most of their time with patients, cannot reveal information regarding illness, investigation results, prognosis, etc., which causes frustrations and lack of confidence in nurses and nursing care.

In Bahrain, like many other countries, the medical profession is one that is highly prestigious, respected and possesses a great deal of power, so patients hesitate to enquire, present an opinion, or help in decision making. In an article written by the Chief Editor of the Bahrain Medical Bulletin, Al Bareeq (1989), revealed that many cases of medical litigations were pending in the courts of Bahrain. He added that this problem was beginning to spread faster and that it needed to be controlled, and it was time for physicians to think seriously about their patient care. He reminded the physicians of the Code of Ethics and stated that doctors should develop good patient rapport, treat patients as humans instead of 'cases,' and spend enough time with the patients. He then added that adequate communication could be the key to avoid some problems which end up as medical litigations.

So, language barrier, power differences, nurses' lack of ability to inform patients of their problems and patients' complaints are all seen as justification to conduct research in this area, and find out where we stand and what can be done about it.

RESEARCH TITLE

Information Giving in Bahrain Hospital: A Study of the Views of Patients Doctors and Nurses.

RESEARCH AIM

1. To assess patients' perceptions of the information they receive during their hospital stay.
2. To explore doctors' and nurses' views of the giving of information to patients during their hospital stay.

SPECIFIC OBJECTIVES

1. Design an interview guide to assess patients' perceptions on the information they receive in hospital.
2. Use the data collected by the interview guide to identify the types of information received by a sample of 40 patients in a Bahrain hospital.
3. Identify the perceptions/views of patients about the adequacy of information they receive.
4. Design a questionnaire to explore the views of a group of 30 doctors and 40 nurses on the type of information patients receive in hospital.

5. Identify the perceptions/views of doctors and nurses towards the adequacy of information received by patients in hospital.

RESEARCH QUESTIONS

1. What are the general perceptions and attitudes of patients, doctors and nurses about the information patients receive in this hospital?
2. How do patients view the information they receive concerning their health problems, the tests and investigations, medication, operations and ward routines and facilities?
3. How do doctors/nurses view the information they give concerning patients' health problems, tests and investigations, medication, operations and ward routines and facilities?
4. What are the views of patients, doctors and nurses on who provides information to patients during their hospital stay?
5. Do patients want more information?
6. What reasons do doctors and nurses give for not adequately informing patients?
7. How do doctors and nurses see the procedure of information giving being improved?

DEFINITION OF TERMS

Information:

Is defined as the verbal communication of instructions and advices given to patients by doctors and nurses, these instructions concern the patients' health problems, prognosis, medication, operations, investigations and ward routines/facilities.

Patients:

Are adult male, female, Bahraini, non-Bahraini patients who are discharged after spending a minimum of seven days in the hospital. These patients are conscious and able to communicate clearly in either Arabic or English. They are either admitted to a medical or surgical ward in SMC.

Doctors:

Are male, female, Bahraini, non-Bahraini doctors who are of different ranks, i.e. Consultants, senior house officers, or junior house officers, who are currently working in either a medical or surgical ward in SMC.

Nurses:

Are male, female, Bahraini, non-Bahraini nurses who are of different ranks, i.e. sister in charge, acting in charge, or staff nurse, who are currently working in either a medical or surgical ward in the SMC.

CHAPTER TWO

LITERATURE REVIEW

The literature on communication between patients and health care providers and, more specifically, on provision of health related information, has grown immensely over the last two decades (Ley, 1988). However, it is still one of the most unresolved patient problems, and one that is causing the most complaints by patients or their relatives. (Cartwright, 1964; Raphael, 1969; Parkin, 1976; Dunkelman, 1979, Hawkins, 1979).

The existing body of knowledge on interpersonal communication is enormous, but the parameters of this literature review will focus on relevant literature about patients' need for health related information. It will therefore exclude literature on specific communication skills, counselling skills and the use of skills for patients' health education.

The appropriate literature review was thought to be, first, to look at the existing general literature on patients/doctors and patients/nurses communication, aspects of transcultural communication, and to then explore the references on power relations between patients and their health care providers. It will also cover literature on patients' need for information, which will specifically explore questions addressed by researchers, such as 'Do patients need information?', 'What is the level of patients' satisfaction and understanding of the information they receive?' and, finally, the literature review will explore some relevant studies on the benefits of giving information, such as the impact of giving information on the recovery of patients, on their compliance and on the knowledge of specific aspects of their health care.

COMMUNICATION: PATIENTS' VIEWS

It is now three decades since Hugh-Jones et al (1964) conducted a survey of all patients admitted (N = 275) as emergencies at King's College Hospital during the months of August, September, November and December of 1962 and February and March of 1963 was carried out. Anxieties in the hospital, accommodation, food, visiting hours, and noise were some of the problem areas perceived by patients.

A major section was on communication and the researchers wanted to find out whether patients knew the identity of people 'in white' i.e. who was who, and whether patients were told what was wrong with them. The methodology used was to survey patients' views whilst in hospital and one month after discharge from hospital.

The results showed that 65 patients out of the total sample wanted more information, and also that the less satisfied the patients were with the information given, the less accurate they were in producing the correct diagnosis. However, even some of the satisfied patients were giving a wrong diagnosis, and this implies a failure of communication. The researcher stated:

"It is a common complaint that patients are not getting sufficient details about their illness. We thought that we took particular trouble to explain to patients the nature of their illness and its implications".

Hugh-Jones et al (1964)

Although this study did not use a representative sample of general hospital patients, nor did it resort to more rigorous statistical tests, attempts

were made to present the objective views of the patients by having the interviews conducted by social workers, therefore limiting the interviewers' bias, acknowledging the fact that the sample was only representative of the hospital under study.

Another well known study is the survey of patients' views about their stay in hospital conducted by Raphael (1969). Some 1,348 patients from ten different medical, surgical, orthopaedic and gynaecological hospital wards participated in answering questionnaires distributed during the last day or two on the wards. The questionnaires included questions on the overall contentment, ward and equipment, sanitary accommodation, meals, activities and care, including obtaining information and the best and worst of hospital life.

Patients' remarks on each of the above aspects of hospital service were grouped and categorized as favourable comments and critical comments. Since the interest of this literature search is on communication with patients, only the results of this aspect of Raphael's survey will be addressed.

There were six specific questions which dealt with the aspect of care of patients. One of them, however, specifically focussed on patients' need for information and asked: "Were you told enough about your illness and your treatment?" The results from 110 comments were 15 favourable and 95 critical. Some comments made by the patients included:

"I was told nothing about my treatment and this worried me".

"I would like to know what caused the miscarriage, to avoid another".

"Doctors are inclined to treat patients as completely stupid, would not give even elementary information any reasonably intelligent patient wants to know".

(Raphael 1969. p. 37).

Such comments, so frequent, and expressed with such feeling, were thought by the author to show clearly that more information, and explanations of tests and treatments were perhaps the most needed.

"The old-fashioned 'don't you worry - let us do the worrying for you' idea is not accepted by many in these days of better education and dislike of paternalism".

(Raphael 1969, p. 38).

Almost two decades later, such remarks from doctors and nurses still exist as 'common classical reassurances'

Raphael's study acknowledged some of the drawbacks to the validity of the results. The survey method is not believed to be the best, as opposed to interviewing, or even direct observation, but then these latter methods are costly and could be very difficult to execute on 1,348 patients. Another drawback was that neither the hospitals nor the patient samples were selected at random. Nevertheless, the large number of patients in this study could reduce the subjectivity of smaller samples.

Studies on the problems of doctor-patient communication are not only confined to the U.K. In the United States, Korsch and Negrete (1972) reported their findings on the same problem. The research took place in the Children's Hospital of Los Angeles, in association with the University of Southern California School of Medicine. The methodology used in this research was different to the studies reviewed earlier. This study examined

the doctor-patient communication process itself. This was accomplished by audio-recording the entire interviews of 800 mothers who brought their children to a paediatric clinic and, afterwards, members of the research team would interview the mothers to learn how they responded to the doctors' instructions, what they expected and what were their reactions to the visits. Also, these mothers were followed up (within fourteen days) to see whether or not they had complied with the physicians' orders.

A number of controlled procedure variables were implemented on the setting and the procedure to minimize risk of bias. The visits were new in the sense that these mothers brought their children with an acute illness not diagnosed or treated before by the same physician. Another method used as a control was to omit the tape recording of 300 visits and only use the interviews. This was, of course, a tactic used to get around the fact that perhaps the tape recording might cause the doctors to depart from their usual style.

The findings of the mothers' visits immediately afterwards were not very satisfying. Of the entire group, 40% were highly satisfied, 36% moderately satisfied, 11% moderately dissatisfied and 13% highly dissatisfied. Almost one fifth of the entire group felt that they had not received a clear statement of what was wrong with their baby and almost half of the mothers were still wondering when they left the doctors what had caused their child's illness.

A frequent cause of disappointment for the mothers was the physician's total disregard of her account of what chiefly worried her about her child's illness. They were not given the opportunity nor were they encouraged. Many mothers reported that the doctors were strictly

business-like in their approach.

The author reported that a significant finding in this study was that in some recordings the doctor-patient conversation came to a distinct breaking point, after which no real communication took place and one or the other participant was reduced to mechanical 'uh -huhs' or 'yes's'.

Addressing the problem of doctor-patient communication a little further in time, Decastro (1972) explored, in a study of 200 parents upon discharge, their views on (1) their level of satisfaction with the adequacy of the explanations given and the attention paid to their worries and (2) their understanding of the diagnosis, the expected direction of the illness, the treatment prescribed and, finally, the importance of a return visit.

This study used questionnaires which were to be filled in by the parents, and patient charts were also reviewed. The study, however, did not say how the sample was drawn, nor did it explain the method used to analyse the data. The figures within the study were presented in percentages and one might think that descriptive statistics were used.

The results of the mothers' level of satisfaction and their knowledge of diagnosis, duration of illness, treatment and return visit were interesting in that they did not correlate in any way. Most mothers stated that the doctors' explanation was adequate (92%) and that their anxieties were relieved (91%), yet their specific knowledge of diagnosis, expected duration of illness, the treatment prescribed and the importance of the return visits was inadequate.

No comments or explanations were offered by the author. However, this is

not a very uncommon finding. In the previous study, the 40% who were satisfied when asked how they felt about the doctors' performance were not so satisfied when more specific questions about their encounters with the doctors were asked. In Decastro's study, factors influencing the mothers' satisfaction were not explained. For example, mothers with children suffering from a less serious problem might express satisfaction more readily than mothers of children with more serious illnesses.

Another study in the U.K. by Reynolds (1978) reported patients' views about communication in hospital. One hundred patients were interviewed in four surgical wards in a large teaching hospital, the Bristol Royal Infirmary. The methodology used by this author was to interview patients when being admitted to the hospital. The sequence of questions employed by this author was from specific to more general questions about communications in hospital. This might be a wise decision as patients may tend to state positive remarks about health care workers if they are asked a general question right at the beginning of the study.

The interview questions consisted of four major sections, one on the information booklet, the second on recall of investigations, the third on chest x-ray examination and the fourth on patients' opinions of the information given about their investigations. In sections 1, 2 and 3, all the questions were asked by a single interviewer, but section 4 was filled in by the patients themselves. The interviews were also completed by a general discussion on the patients' opinions of the quality of communication between doctors and patients in the hospital.

A brief report of the first sections revealed that 66% of the patients had never seen the information booklet. Of those who saw it, the majority

thought it was useful. 85 patients answered 'No' to the question 'Did anyone explain to you what was going on during the test?' and 82 out of the 100 patients answered 'No' to the question 'Do you know the result of the chest x-ray?'.

Other interesting findings that correlate to the findings of other studies were on the patients' opinions about the quality of communication in hospital. Reynolds found some diverse opinions, but certain themes were observed. For example, patients disliked the way in which they were excluded from discussions by doctors who talked among themselves, using incomprehensible medical words. Such behaviour was regarded as insulting.

A patient in this study commented:

"We are not morons, Education has advanced and I think you should be treated as an intelligent person".

Another commonly held view of the patients in this study was that, unless the patient asked questions, he or she would not be given information. Many patients did not know much about their diagnosis. The author stated clearly that patients feared the unknown much more than they feared the truth about their illness. One patient stated:

"I should like to know, even if it is unpleasant".

and another said:

"I will have more peace of mind".

Finally, a comment which was reported in this study and was made by the older patients was that they left their lives in the doctors' hands and let them (the doctors) do what they wanted to do. After all, it was for their own (the patients') good.

This study, like some others, failed to state whether the sample was randomly drawn or not. The use of one interviewer may have positive or negative effects. The author acknowledges that the greatest potential source of bias lay in the phrasing of the questions in section four, for example 'Are you dis-satisfied?' may have produced answers which expressed dis-satisfaction but source of bias was guarded against to a certain extent by asking positively phrased questions to half the patients, such as 'Are you satisfied?' and negatively phrased from the other half of patients.

So far, the literature review has focussed on a sample of studies conducted in the 60's and 70's but this does not mean that the interest of researchers in the field of patient-doctor communication has diminished. As it will become evident in this literature review, the problem was still existing in the 80's and 90's.

On a more specific aspect of patient-doctor communication, Wilkinson (1989) conducted an experimental study on the amount of time patients spent during a consultation. The sample consisted of 100 consecutive patients seen in an urban general practice in Cardiff and patients whose native tongue was not English were excluded.

The patients' flow of speech was uninterrupted and timed with a glance at an obscured wristwatch. The end of the patient's account was usually indicated by a non-verbal cue. The flow of the description of a symptom

continued after further focussed questions, for example, if the doctor asked 'Could you tell me more about the headaches?'. This part of the history was not included in the timing.

The findings showed that 89 patients spoke for less than one and a half minutes and 42 spoke for less than 20 seconds. According to the researcher, this timing was even shorter than the times in the previous studies. However, the findings did not surprise the researcher, who added that consultation in general practice dealt with minor illness and preventive care and the patients are well known to their family doctors. This continuity of care can lead to shorter consultations.

POWER DIFFERENCES BETWEEN PATIENTS AND DOCTORS AND OTHER MEMBERS OF THE HEALTH CARE TEAM

Three decades ago, Cartwright (1964) found that the patients in her study were more critical about the difficulty of obtaining information than any other aspects of their hospital care. Cartwright thought that this serious failure was both obscured and accentuated by the patients' acceptance of authoritarian views and practices, their low levels of expectation and their reluctance to question hospital staff.

The unpleasant, depersonalized feelings from which patients suffer were addressed by Steel and Morton (1978) in a study to improve care in hospital in the U.K. They recorded criticism of patients about the ward rounds and the conduct of those taking part in them. The authors added that these rounds were conducted without regard for the patients' feelings and dignity, and caused embarrassment, anxiety and distress.

Taylor (1979) in her review of researches, added that patients cope with depersonalising loss of control by assuming 'good patients behaviour' or 'bad patient behaviour'. She suggested that some 'good patients' might actually be in a state of anxious or depressed helplessness, whereas 'bad patients' were exhibiting anger and reaction against the perceived removal of freedom. Fletcher (1980) suggested that doctors' attitudes have a role in the existence of the problem. Some doctors still think it is bad for patients to know too much about their diagnosis and treatment. To the doctors, a 'good' patient is the one who does what he is told, without question.

Fletcher also suggested that many patients have an almost blind respect for the doctors and this, combined with their anxiety about the outcome of their illness, inhibits asking questions in the consultation.

In contrast, recommendations that patients be given increasing control over their health care were probably the reason for a study conducted by Fischbach et al (1980). They studied a convenience sample of 20 patients and 4 health care professionals during a one year project to assess the impact of sharing the records between patients and doctors. The patients suffered chronic illness, hypertension, congestive heart failure or diabetes mellitus. The instrument used was the Problem Orientated Medical record (POMR) as a matrix for the mutual contract that occurred during patients' visits. A list of mutually formulated problems would be written and an emphasis put on designing a mutually accepted plan of action that, according to the patient, best suited him/her. Patients then kept their own handwritten copy of the co-authored report and were required to bring this report on every visit.

The conclusion of this exploratory project, according to the author, did not carry statistical weight. However, the researcher stated that co-authorship of the records is an effective means of conveying more complete, accurate and understandable information to both the patients and care providers. The patients' perspectives are heard and appreciated. This offers an alternative to the traditional mode of instruction of active teacher/passive pupil.

However, other researchers, such as Shenkin and Warner (1973) cited in Fischbach (1980) found problems with the use of this method in managing terminal illness and on psychosomatic disorders and the time doctors and patients spend together.

In other studies addressing the concept of control, Dennis (1987) researched a sample of medical-surgical patients in a military medical hospital. She found that patients wanted to know, understand and be given information about topics related to the reasons for their hospitalization, including diagnostic tests, treatment and surgery. They also wished to know the future lifestyle implications of their diagnosis and the patients were particularly keen to know whether their conditions were improving or deteriorating.

Dennis (1990) studied another sample of 30 medical-surgical patients in an attempt to replicate her previous study. The instrument used for this study was a Client Control Q - Set, which was developed by the author. These were a set of 45 items which are crossed by the patients and represent control over hospitalization events. For example, activities of daily living, where an item may state: 'Wear my own pyjamas or nightgown'. The patients were required to sort out these items and this was then followed by an

interview. The reasons which influenced the particular sorting of items were coded as 'most important', 'most unimportant' and 'neutral'. This study was conducted when the patients had been hospitalized on the third or fifth day.

The results as, presented by the researcher, stated that unquestionably the strongest similarity among all the factors across all the samples was the importance which patients attached to having information about issues related to their hospitalization, such as the status of their condition, the reasons for and results of their diagnostic tests, and how they might feel during tests, or after surgery.

Power difference does not just exist between doctors and patients, it also exists between doctors and nurses. Porter (1991) conducted a research to examine the power relationship between doctors and nurses and used a participant observation method in an intensive care unit in a large hospital in Ireland, with some comparative observation carried out in a general medical ward. The researcher, who observed and documented his observations for three months, categorized the interactions that took place between doctors and nurses as unproblematic subordination to formal overt decision making.

He concluded that one of the most striking findings was the deceptive nature of nursing subordination. The use of unproblematic subordination and the playing of the doctor-nurse game was belied by considerable nursing input into decision making.

Around the same phenomenon some years later, Busby and Gilchrist (1992) obtained the views of 33 consultants, 14 nurses and 8 patients and observed

three ward rounds in order to determine the nature of present ward round functioning and the role nurses play in such rounds. The instruments used were an observation schedule of the medical round, a semi-structured patient interview and a consultant and nurse questionnaire. Amongst the results of this study, it was found that patients' opinions were very rarely, or never, asked for during ward rounds. With regard to obtaining information, patients expressed a negative view of asking the nurses.

The researchers also concluded that the ward rounds were not conducted in a democratic fashion, medical staff dominated and other health professionals had little involvement. The nurses were seen to be primarily involved in providing information for medical staff.

These studies were reviewed and presented at this point to show the negative impact of power differences on nurses and, subsequently, on the patients, who have to interact with nurses for most of their hospitalization period.

NURSES AND PROVISION OF INFORMATION

So far, the above studies suggest, and indeed some prove, that medical and nursing staff do not give priority to good communication and information giving. Faulkner (1984), who believed that nurses had a clear responsibility for meeting patients' need for information, conducted a study to find out how nurses dealt with situations which called for information for patients. The sample was a group of nursing students from two Colleges at different periods of their training and a sample of 25 sisters and 12 staff nurses, the latter group being added to see if their function as role models and their experienced views would be any different.

The methodology was that students were given real patient case studies, some diagnosed as having carcinoma and the others coronary heart disease. These were then followed by a questionnaire with open-ended questions. Six categories were used to rate the pattern of responses: 1. true; 2. partially true; 3. false; 4. non-directive; 5. refer and 6. avoid. Examples of the questions which followed the case histories were 'What are the pills for?' or 'I am not going to get over this, am I?'

The findings, as reported by the author, showed no statistical differences between the groups and it seemed that neither cancer nor coronary patients could be sure of getting consistent, useful or relevant answers to their questions, unless the nurses were clear on what the patient had been told before. The author added that there was little evidence of a common policy which nurses adhere to in terms of giving information. It seems that as student nurses become senior, they tend to match the pattern of answers of trained staff.

Some years later, one role of the nurse is to be regarded as a resource person (Peplau, 1988). Peplau saw nurses as functioning well as resource persons in situations where health information was needed. She added that: 'Nurses viewed themselves as a source of supply of knowledge and technical procedures and had taught much that was necessary for improving patient and community health', (Peplau, 1988, p. 47).

This raises the question of how nurses perceive themselves as providers of information to patients. Morrison and Burnard (1989) studied a group of 84 nursing students and trained nurses to see how they viewed their own interpersonal skills. The researchers used Six Category Intervention Analysis.

These categories consisted of prescriptive, informative confronting, cathartic, catalytic and supportive. The findings of this study concluded that nurses tended to perceive themselves as being more authoritative in which the informative category was founded. The nurses in this study perceived themselves as being skilled in giving information and less facilitative in their interpersonal relationships.

The authors suggested that the findings that the trained nurses perceived themselves as being skilled in giving information might be as a result of developed teaching on information giving and research.

The studies and opinions presented on how effective nurses are in relation to providing information to patients are inconclusive. Some support the idea that nurses are providing information while others not. This is an area which requires to be studied in much greater depth.

NURSING PATIENTS FROM DIFFERENT CULTURES

Transcultural nursing was developed primarily in the United States of America by Madeline Leininger in the 1970's, as increasing numbers of patients came from other cultures. In San Francisco, for example, there are mini-countries, such as Chinatown, Little Vietnam, Japan Town and many others. Some city blocks resemble Ireland, the Philippines, Italy and other western and eastern countries. Elderly people can live within such a community and never learn the English language.

Some of the blocks to communication that are encountered by American nurses are patients who do not speak English. Rothenburger (1990) held the opinion that some patients may be excessively compliant or, on the other extreme,

use combative behaviour, which are mechanisms patients employ in a frustrating situation with very limited communication.

Language barrier: Kubricht and Clark (1982) in a study interviewing foreign patients and their nurses, found that communication was considered to be the outstanding nursing problem, specifically nurses' inability to explain hospital routines, to understand the immediate needs of patients, to provide health teaching and explanations, to obtain health histories, or even to assist the patient with diet selection. Nurses in this study also expressed feelings of frustration and inadequacy when attempting to meet the patients' psychological needs.

Black (1987) presented his views on the fact that health care providers should broaden their minds about certain cultural beliefs of ethnic groups in Britain. He added that the health services failed to understand and provide for Asian patients. However, Baxter (1988) added that many nurses who are committed to providing individualised patient care from a multi-racial perspective find it hard to turn commitment into practice. According to Baxter, learning about patients' cultural backgrounds is time consuming and may be impractical.

Medical Jargon: Medical terms and abbreviations are often used in bedside conferences, and many of these are highly technical. Korsch and Negrete (1972) as part of their findings on communication, found that the use of jargon was strongly confirmed. Terms such as 'nausea', 'peristalsis' and 'Coombs titre' were strange to the patients. A 'lumbar puncture' was interpreted as meaning an operation to drain the lungs and a reference to 'incubation period' was taken to signify the length of time the sick child was to be kept in bed. In Korsch's study, more than half the cases recorded

that the physicians resorted to medical jargon.

Another interesting study was conducted by Boyle (1970) in a hospital in Glasgow. The researcher wanted to see the difference between patients' and doctors' interpretations of some common medical terms. The sample consisted of 234 patients attending various out-patient clinics for the first time, and a group of 35 physicians and surgeons participated as a control group.

The method used was a multiple choice questionnaire, including commonly used terms such as 'arthritis', 'heartburn', 'palpitations' and organs such as 'the heart', 'the stomach', 'the kidneys'. For identifying the organs diagrams were provided in which the patients had to select the appropriate placement of the organ. The results showed that there were significant differences between the majority of doctors' definitions and the number of patients agreeing with those definitions, in all cases except the term 'a good appetite'.

The results of the positioning of the organs on the illustrations, as perceived by the patients, were also presented. 58.8% thought that the stomach covered all the abdominal region, 48.7% thought that the kidneys were placed in the groin, 43.5% thought that the liver was in the lower abdominal region.

The researcher acknowledged some drawbacks of this study, such as random guessing of the right choice of answers and the levels of patient education and vocabulary performance. Nevertheless, Boyle stated that the study offered some further verifications of other studies confirming that medical jargon caused a great deal of misunderstandings.

GIVING INFORMATION WHICH MIGHT CAUSE ADVERSE EFFECTS

A number of investigations have enquired into the effects of providing patients with the kind of information that could, in theory, cause adverse effects. These have included telling patients that they had cancer, giving patients detailed information of the risks of investigative procedures or certain type of drugs (Faden 1981; Ley 1988).

Four decades ago Fitts and Ravdin (1953) conducted a study to find out what physicians in Philadelphia told patients with cancer. A questionnaire was designed and the doctors had to choose from: 1. 'I always tell the patient he has cancer', 2. 'I never tell the patient he has cancer', 3. 'I usually tell the patient he has cancer but do not under certain circumstances', 4. 'I usually do not tell the patient he has cancer but do tell under certain circumstances'. The sample consisted of doctors, radiologists, dermatologists, surgeons, gynaecologists and interns. The questionnaires were mailed to 444 doctors and 89% were returned.

The results of the study showed conclusively that the doctors in this sample in general did not tell the patients that they had cancer. However, the most striking variation concerned the dermatologists. 94% of the dermatologists either always or usually told their patients they had cancer. The authors explained this difference by the fact that this type of cancer has a more favourable prognosis. The other specialists treating visceral cancer did not tell because they considered the prognosis unfavourable.

In the same decade, other researchers examined the reactions of cancer patients on being told their diagnosis. Atkin-Swan and Eason (1959) in the

U.K. observed 231 cancer patients who had been told, and were recorded as being told, whilst an interview of medical history was taking place. The study also sought the views of the family doctors of those patients who had been told (35 cases). Patients were also interviewed a second time (41 cases) from one to two and a half years after having been told, in order to compare their delayed reactions.

These reactions were recorded as 'approval' or 'denial' that they had been told', 'disapproval' and 'inconclusive'. The results showed that most of the patients, 61 male and 92 female, approved of being told, only 17% of female patients disapproved. In relation to the patients' delayed reactions, of the total (41) who were followed up, 35 had not changed and still approved of being told.

The researchers concluded that: "Fortified by the notion of public education, frankness with patients has become easier and the customary atmosphere of 'therapeutic deception' has been replaced by a refreshing honesty, advantageous to doctors and patients alike".

A little further in time, Oken (1961) conducted a study in Chicago by sending questionnaires and interviewing 219 physicians in order to study their policies about telling patients they had cancer. 90% indicated a preference for not telling. The researcher added that although the majority of the physicians indicated that clinical experience was a major determinant, the results of the study did not have conclusive findings between telling and experience or the doctors' age.

The researcher further added that inconsistencies and resistance to change were found to be more related to emotion-laden, priori personal judgements

more than anything else. He concluded that doctors' personalities, feelings and attitudes played a major role in determining the manner in which they communicated with and treated their patients, and only by knowing one's irrational attitudes and proceeding to acquire knowledge can medicine advance.

Alfidi (1971) conducted a study to determine patients' reactions to disclosure of complications of angiographic procedures. He used two types of consent forms and a list of questions for two groups of patients. Their informed consents included possible complication, even the very rare ones, such as death. Alfidi's results were very promising. He concluded that the majority of the patients (208 out of 232) desired the information and that very few patients (9) refused to go ahead with the procedure after reading the consent form.

In contrast to Oken's study, Novak (1979) conducted a survey of 699 physicians. His tool was an 18-item structured questionnaire and his findings showed that 98% of the physicians reported that their general policies were to tell the patient. A further two thirds of the sample said that they rarely or never made exceptions to this rule. Issues such as how to tell, how much to tell and when to tell were further discussed in this study.

A more recent study in which nurses' views were also determined was conducted by Slevin et al (1990). They compared the views on chemotherapy of patients with cancer with those of a matched control group, cancer specialists, general practitioners, radiologists and cancer nurses. The sample size was 100 patients who were on cytotoxic chemotherapy, 60 cancer doctors, 790 randomly chosen general practitioners and 303 randomly chosen cancer nurses. The study took place in a medical oncology unit of a London

teaching hospital.

The researcher wanted to find out how the respondents' (patients, matched control, oncologist, general practitioner, radiologist and nurses) accepted intensive and mild treatments with a supposed minimum chance of effectiveness. The specific questions concerned cure only by 1%, prolonging life (by three months) and relief of symptoms by 1% only.

The results were that most patients were willing to accept radical treatment for a very small chance of benefit, while doctors and nurses were less likely to accept radical treatment for minimal benefit. This finding, according to the researcher, suggested that a high degree of toxicity is acceptable, even if only a slight chance of cure is offered. It also has implications for treatment options.

Finally, Ley (1988) concluded, after reviewing similar studies which revealed consistent results, that the predicted or potential adverse reactions to giving patients full information do not often occur. In general, people want to know about their health status, even when the news is bad.

EFFECTS OF LACK OF INFORMATION ON:

1. PATIENTS' SATISFACTION

Ley (1982) reviewed a number of British studies of patients' satisfaction with communication. The ranges of percentages of patients' dissatisfaction were 11 - 65%, with a median of approximately 25%. He also presented similar ranges in countries other than the U.K. and concluded that the

problem of patients' dissatisfaction with communication is not limited to a given type of patient, nor is it limited to only one country, nor is there any evidence in the study results to suggest that the problem is decreasing as time passes.

Engstrom (1984) conducted a research concerning the patients' need for, and satisfaction with, the information they received in hospital. Her study addressed some other questions, such as the patients' understanding of information, who provided the information and what attitude did the patients have toward the care they received in the hospital? The sample consisted of two groups of patients: group 1 consisting of 60 patients was interviewed once during the ward stay and 14 days after discharge, group 2 (60 patients) was interviewed only after discharge.

The interview guide used consisted of questions concerning the patients' diagnosis, prognosis, medical examination, medications, routines/facilities, investigations and their results. Her results in relation to the patients' satisfaction were not very promising as 51% were dissatisfied with the information concerning their prognosis, 49% were dissatisfied with the physical examination, more specifically concerning what the doctors did and why. 48% of patients were dissatisfied concerning the information they received about their medicine and 47% were dissatisfied about the information given to them about the cause or causes of their problems.

Engstrom concluded that there was a lack of functioning routines for systematic surveying of the patients' needs for medical and general information.

In contrast to the previous studies, Daniel's (1989) research aimed at investigating the quality and effect of pre-discharge information given to cardiac surgery patients and their families. The quality of information was assessed in terms of whether the patient felt satisfied with what he had been given. A questionnaire was sent to a group of 50 patients who were discharged 6 - 8 weeks after cardiac surgery. The part of the questionnaire which concerned patients' satisfaction was given four alternatives, ranging from 'Yes completely' to 'totally inadequate'.

The results showed that 47% of patients were completely satisfied, with a further 35% being on the whole satisfied, and 18% said they would have liked more information. No one in this sample reported being totally unsatisfied. The information patients received was on topics related to sex, alcohol, exercise, smoking, diet, etc.

The author concluded by stating that, despite the study's drawbacks, the provision of information and preparation of patients for discharge in this sample were good and showed a positive influence in the patients' knowledge and behaviour.

PATIENTS' COMPLIANCE

A number of studies have shown the relationship between adequacy of information and compliance. Parkin et al (1976) studied non-compliance of prescribed drugs after discharge. The study sample consisted of 130 discharged patients from general medical wards in four hospitals and the method used was an interview in the patients' homes. All the questions were pertaining to the medication the patients were using.

The researchers found that 46 of the sample did not have a clear understanding of the regimen (non-comprehension) and 20 of the remaining 84 understood the instructions but did not comply. Patients in this study were using some complex potent drugs, such as digoxin, diuretics and anticoagulants. The researchers also concluded that when complex drug regimens comprising several drugs were prescribed, one of the main factors for non-compliance in this study was the fact that some patients who were on the drugs before admission reverted to the dosages they had been taking, ignoring the new modifications.

In another research by George et al (1983) prescription leaflets were prepared for two types of drugs; penicillin and a non-steroidal anti-inflammatory drug. The written information included the name of the drug, its nature, purpose, contra-indications and precautions, plus other important information. The leaflets were then issued to 56 patients prescribed with penicillin and 43 patients prescribed the anti-inflammatory. They were interviewed between 4 - 10 days later and their responses were compared to two other groups of patients who were not given the leaflets.

The results showed that patients who received a leaflet were more likely to

be completely satisfied with their treatment and with the information they had been given. However, in the group of patients who were on the anti-inflammatory drugs and who did receive the leaflets, seven patients did not comply. The researchers presented no explanation and indicated that, given the size of the sample, no conclusion could be drawn.

Abdul Jabbar and Al-Shammari (1993) conducted a one year prospective study on 104 Saudi epileptic patients, in order to assess the degree of anti-epileptic drug compliance. They found that 30.8%, that is, one third of patients were non-compliant. A logistic regression equation comparing the data indicated that a low level of education and adverse effects of the disease on patients were the most important significant factors for poor compliance.

The researchers also indicated that patients with low levels of education were reluctant to take the drugs when they were seizure-free. Continuity should be encouraged at the time of the first prescription and should be reinforced on subsequent follow-ups.

Another effect of lack of adequate information is that on patients' recovery, and perhaps one of the studies which revealed the importance of provision of information to patients is that of Hayward (1975). This study, or group of studies, used an experimental design and was conducted in the U.K. in both urban and rural hospitals.

The researcher used several tools to measure patients' perception of pain, their need for analgesics and the nursing information given to these patients prior to surgery. The patients' level of anxiety was first

measured on admission, their subjective states were then measured post-operatively using a five point scale, which included the use of pain thermometer, the patients' mood and morale, feelings of nausea/vomiting, patterns of sleep and an assessment of patients' appetites.

Two groups of 68 patients were equally divided between the experimental and control groups. One group received pre-operative information and the other did not. The results showed a significant difference in the amount of analgesics consumed by uninformed patients to those who had received pre-operative information. The author further stated that: "30 minutes spent at the pre-operative stage might be seen as an 'investment' which has a profitable sequel.

Finally, in this literature review a variety of methodologies were observed. These included surveys with the use of questionnaires, interviews, audiotaping and observation. Some studies were conducted with much more rigour than others, some addressed the patients as a target group, and others nurses and doctors. A few combined patients, doctors and nurses.

These studies have proved beyond doubt that patients' need for information and the lack of health care providers to satisfy this need is a major problem. A previous preliminary review and this research review has helped the researcher to understand the problem more clearly and to transform initial ideas and hunches into a clear problem which needed to be researched.

CHAPTER THREE

RESEARCH METHODOLOGY

In this section, a description of the subjects, the setting in which the study was conducted, the data collection tools, i.e. the interview guides and the questionnaires, the translation of the instruments into the patients' native language, the training of the interviewer, the pilot work and the conduct and design of the main study will be presented.

In addition, the methods used for data analysis, the ethical considerations and measures taken to ensure reliability and validity will be described.

DESCRIPTION OF THE SUBJECTS

PATIENTS - A convenience sample of 40 patients were initially planned to be the main subjects of this research but, due to the excellent co-operation of the hospital personnel and the patients, the number was increased to 60 patients. These were adult, male and female, who at the time of conducting the research were admitted to medical and surgical wards of the Salmaniya Medical Centre in Bahrain.

In view of the limitations of the convenience (non probability) sampling, certain criteria which were laid down for the patients limited some chance of bias. One of these criteria was that patients should be a discharged patient or a patient who had spent up to seven days or more in the hospital. This criterion was to make sure that patients had spent enough time in the hospital to be able to present their views on the amount and quality of information they had received in the hospital.

Given the fact that the total medical/surgical patients' population is constantly changing, surgical patients in particular, it was very difficult to resort to a probability sampling method, and maybe virtually impossible, to draw a sampling frame of all the discharged medical/surgical patients ahead of time because of on the spot decision making, and changes in the patients' general condition. By this, the researcher means that even if a patient is discharged, a sudden change in his/her condition might make the doctor reconsider the discharge.

Despite these criteria and the difficulties of obtaining a pre-planned discharge sample frame, not all patients had the opportunity to be selected and this is acknowledged to be one of the major drawbacks of a convenience sample (Morse, 1986).

To give the patients in all the wards the opportunity to be selected, a list of the wards was made and 2 - 3 patients from each ward were interviewed. I.C.U., C.C.U, A.K.U. and Burns Units were excluded, because of the general condition of the patients in these units and their inability to tolerate the pressures of a 30 minute interview.

The other criteria for the selection of the sample were that the patients must be fully conscious, able to respond in either Arabic or English and not in any pain or distress.

THE DOCTORS AND NURSES - The doctors' sample consisted of 30 medical and surgical doctors working in the units in which the patients were admitted, together with a group of 40 nurses. The sample was a convenience one, due to the limitations and the constraints of time.

Unlike the patients' sample, no criteria or restrictions were placed on the doctors' and nurses' sample. They were Bahraini, non Bahraini doctors of any age group, with different ranks and years of experience.

For both the samples (patients and doctors/nurses) the researcher had no direct approach for selection. The response rate was very good: 56 patients, 29 doctors and 40 nurses.

THE SETTING

This research took place in Salmaniya Medical Centre, one of the largest teaching hospitals in the State of Bahrain. This hospital will be referred to as SMC in this chapter and in coming chapters. SMC has 611 beds, 215 surgical beds and 158 medical, and the hospital caters for any residents of Bahrain.

It is important to note that in Bahrain a little over 30% of the general population are non Bahrainis, most from far eastern countries such as India, Pakistan and The Philippines, who constitute part of the labour and workforce. 70% of the nursing manpower are from these countries, Indian nurses constituting the largest percentage. Less than 50% of the physicians are also non Bahraini. These figures were extracted from the Health Statistical Abstract (1990).

The actual patients' interviews were carried out at the bedside, but for some walking patients interviews were completed in the rest room. The doctors and nurses' questionnaires were handed to them by the Chief Consultants for both the medical and surgical units, and by the Senior Nursing Officers. They were instructed to fill in the questionnaires at

home and bring them in the following day.

DATA COLLECTION METHODS

It has been suggested by many researchers that when a researcher sets out to explore a subject area, then the best way is to ask direct questions (Brenner et al, 1985; Pilot and Hungler 1983; Cormack 1991). The use of a research interview is encouraged by researchers (Oppenheim, 1992) but, at the same time, it is acknowledged to be the research method which requires high interpersonal skills and is a task of daunting complexity, which requires:

"Putting the respondent at ease, asking questions in an interested manner, noting down the responses without upsetting the conversational flow, giving support without introducing bias".

(Oppenheim, 1992, p. 65)

The same researcher presented some advantages of the interviewing technique. He added that when respondents wish to say what they think in greater richness and spontaneity, then obviously the use of open-ended questions or open-ended probes will be most appropriate.

In this study, it was imperative to ask such questions and allow the patients to say how they felt about the problem and how much more information they needed on specific areas of their health management.

The second advantage of the use of interviewing is that this technique has a very good response rate. A third advantage is that the interviewer can give a prepared explanation of the purpose of the study more convincingly than a covering letter can. It can also reach less well educated

respondents. Another important advantage is that this method is suitable for sensitive issues, where verbal and non verbal cues are observed and included.

On the other hand, some disadvantages are acknowledged by researchers. Interviews are more time consuming and more expensive, especially if processing open-ended questions rather than closed ended ones. Another potential problem in the use of interviewing is the problem of different interpretations of respondents, which means that the question may have different meanings for different respondents (Pilot and Hungler, 1983; Oppenheim, 1992).

THE PATIENTS' INTERVIEW GUIDE

The aim of this research was to explore and assess patients' needs and perceptions of the information they received in hospital. It was necessary to ask questions which addressed patients' general attitudes towards the problem and their true opinions of some factual information (for example, whether or not they were given pre-operative information).

To begin with, a covering letter (see appendix v) was presented in exactly the same manner to all the patients. In this letter the need for a true and honest opinion concerning the information they received whilst being in hospital was conveyed to the patients. The letter also stated the purpose of the study, the anonymity and the voluntary nature of the study.

Some of the actual questions were derived from a previous study by Engstrom (1984). Permission was sought (see appendix ii) and a modified version was developed but, basically, the questions addressed the same wide parameters.

These included the patients' general perceptions about the information, and these questions consisted of 7 items in the form of a 5-point rating scale, i.e. the patients' needs, satisfaction, comprehensiveness, adequacy, clarity and detailed versus minimum detailed information.

The remainder of the questions were designed to see how patients viewed the information given to them concerning the diagnosis, prognosis, causes of illness, the physical examination, the diagnostic tests, the medication, the operation (only applying to surgical patients) the ward routines, and the ward/hospital facilities. They consisted of 51 questions very simply worded and received a response of 'yes' or 'no', uncertain' or 'does not apply'.

Three more questions were included, one on who provided the information to the patients and two open-ended questions on discharge advice and on the patients' need for specific information before going home. For these two latter questions the patients' responses were written down in full at the time and then verified with the patients.

Finally, the interview had four questions on the patients' demographic data, such as sex, age and educational status. These were left until the end.

The interview guide was of appropriate length, taking an average 25 minutes to complete, and moreover, most of the patients were discharged, waiting to go home, or those who were not in any form of distress or pain.

After the interview was over, the interviewer asked the sister in charge questions related to the patients' diagnosis, their medications, the type

of operation/investigations the patients had had. This was to confirm what the patients had said with what was actually written in the patients' notes.

DOCTORS' AND NURSES' QUESTIONNAIRE

Questionnaires have also been recognized as being an important tool in research (Youngman, 1978; Pilot and Hungler, 1983). Some of their advantages lie in the fact that questionnaires are less costly, are able to gain access to larger samples, more anonymous than direct interviews, less threatening and probably less biased (Cormack, 1991).

On the other hand, these advantages need to be balanced against some disadvantages, such as misunderstanding a question, no possibility of probing, or observing the non-verbal cues, actual interactions between the researcher and the subjects are lacking, and subjects may decide not to respond and discard the questionnaire. Some researchers feel that, unless well constructed and tested, questionnaires can lack rigour (Cormack, 1991; Oppenheim, 1992).

After studying the advantages and disadvantages, the researcher decided to use a questionnaire as the research instrument for the doctors' and nurses' sample. It was basically a self-administered questionnaire. The questions were the same as those used in the patients' interview guide, but with wording modifications, so as to address the doctors' and nurses' opinions about how they perceived the practice of giving of information.

The major components were some closed ended questions with 'yes', 'no' or 'uncertain' answers, and a rating scale consisting of 7 questions and some

open-ended questions, (see Appendix v)

The doctors' and nurses' questionnaires were prepared in two different colours to limit any confusion. They began with a covering letter in which the purpose of the study, the anonymity and the voluntary aspect of their participation in the study were explained (see appendices vi and vii). The questionnaire began with questions concerning their demographic data, including present rank, gender, age, years of experience, nationality and spoken language.

The second section was on doctors/nurses' general perceptions concerning the information patients receive, with minor wording modifications. For example, if the question addressed to patients read 'How much information do you think you understand?' the same question, when addressed to the doctors and nurses would read 'How much information do you think patients understand?'.

The third section contained questions concerning the doctors/nurses' views in regard to whether or not patients received information concerning their diagnosis, prognosis, cause of their illness, the physical examination, their tests and investigations, medications, operation and after care or discharge information.

There was also a question on who provided the information and, finally, two open-ended questions on the reasons for not informing patients and how information giving could be improved. On the nurses' questionnaire only, an added section on ward routines and facilities was included as it is a nursing responsibility to provide information concerning these to patients.

The approach and instruments used ensured that both quantitative and qualitative data were collected. In the quantitative side of the study, highly structured questions were asked and on the qualitative side, patients, doctors and nurses were able to give their views and opinions in open-ended questions.

As mentioned earlier, the objectives of this study were to explore the situation in relation to giving information to patients. It was therefore imperative not only to assess the views of the patients but also of the doctors and nurses who provided the information. In this way, a more complete picture could be achieved.

ETHICAL CONSIDERATIONS

The first question the researcher asked herself was whether a research in this area was necessary. The answer was 'yes', given the justification that it was very important to start exploring this problem and, based on the results, employ some strategies to address the problem.

The responsibilities of nurse researchers are recognized in moral codes, and clear guidelines are laid down by the American Nurses' Association (ANA) the Canadian Nurses' Association (CNA) and the Royal College of Nursing in the U.K. (Cormack, 1991). The guidelines were very strictly adhered to in this research.

During the planning stage, requests were sought from the SMC in Bahrain to conduct this research. The requests were required from the senior nursing officials and the medical officials (Appendix iii). Also during the planning stage, the researcher laid down some guidelines which were implemented during the study.

All possible action was taken to prevent the violation of patients' rights to private information. A covering letter, which explained fully to every patient, included the identity of the researcher and the fact that this research was part of an academic requirement. The purpose of the research, the voluntary nature of the participation, and the required time for interview, were also explained. Patients were also told that there were no right or wrong answers and their honest and true opinions about the information they had received during their hospital stay were needed.

Patients were also given the choice of refraining from answering a

question which they might find difficult. The letter emphasised and stressed the anonymous nature of the interview.

Although an informed consent is ethically preferred, particularly for studies which have an experimental design, or phenomenological qualitative studies in which the direction that the researcher will take is sometimes uncertain, in this research it was not possible to ask every patient to sign. However, a clear question asked 'Do you agree to participate in this study?' and if the patient said 'Yes' then the interview commenced. Only one patient of the whole sample stated that he did not wish to participate and felt that the period he spent in the hospital did not give him enough knowledge of the situation. Of course, this patient's view was respected.

During the actual interview, it was also important to behave professionally, but not 'too professionally', to allow patients to feel reassured and express their views freely. In one interview this 'relaxed encounter' made the patient divert into personal family problems which were not addressing the question. This was observed with an open-ended question and it is acknowledged by researchers that the listening ear of a researcher actually stimulates disclosures (Ramos 1989). It was necessary to ask the question again and allow the patient to re-focus.

In the SMC Hospital it is not a normal, everyday scene to have a person coming to the patient and asking questions about care and management received. It was therefore necessary to anticipate the patients' anxieties concerning the interview and to reassure them that if a question was not clear, they should ask for clarification. This happened with a few patients, who asked 'What do you mean?' or 'I don't understand the question'.

This research did not offer extrinsic rewards but the researcher thanked the participants for their time and honest opinions.

VALIDITY AND RELIABILITY

Validity refers to the degree to which an instrument measures what it is supposed to be measuring, and an ideal measuring instrument is one that results in measures that are relevant, accurate, objective, sensitive, uni-dimensional and efficient (Pilot and Hungler, 1983). This ideal is difficult and impossible to attain for beginners in research. The reasons are varied and include lack of experience in research, the nature of the problem which is to be studied and the inadequate sampling design.

Studies in the nursing field often measure views and opinions. They are usually the behavioural type, which makes reliability difficult to maintain but, in relation to validity, it is assumed that what the respondents say is true. Brink and Wood (1988) presented sources of error that can be found in any phase of the research process, i.e. in the research questions, in the instruments, in the sampling or in the coding and data analysis. Oppenheim (1992) warned the researcher of two types of error, the random error, which is a benign type of error but which should be identified and reduced, and the more serious type, the systematic error, which produces severe bias to the results.

In this research, the sample was not a representative sample and therefore the findings cannot be generalized. However, when it came to looking at whether the interview method was the best or the only method to explore the problem and asking the question 'Could there be any other method which the researcher did not consider?', the answer is 'Yes' and other methods, such

as observation, especially participant observation, might have given a more true, valid picture of what exactly goes on, and whether nurses and doctors provide information or not? A better method could be the combination of interviewing patients and participant observation but unfortunately the limitations of time did not allow the researcher to consider any other method for this study.

Despite the drawbacks in the study, the researcher can only support the findings by the fact that what are presented are genuine views and opinions of the patients to direct, straightforward, clear questions on their need for information. This is considered to be face validity, one of the lowest levels of validation. The other types of validity, such as content validity were checked unofficially with other doctors and nurses to see if the questions were, to a certain extent, representative of the type of question one might ask if one needs to explore patients' opinions on the problem of information giving. Also, Ley (1988), Engstrom (1984) and some of the researchers mentioned in the literature review asked patients somewhat similar questions.

Nevertheless, it is acknowledged that the best method was to observe on the scene, having more than one observer, and provide sufficient time to allow for the real picture to emerge. Reliability is the extent to which repeated measurement yields the same result (Pilot and Hungler, 1983). Engstrom (1984) reported that the reliability of an instrument was estimated by a test - retest and a control group. She found that only 1% of the total 400 estimations altered their estimation. So, the researcher can safely say that some parts of the instrument used in this research are reliable.

The open-ended questions were analysed and their results given to another researcher in order to see if the emergent themes were representative of the patients' responses. This could be considered as a means of coding reliability.

TRANSLATION OF THE PATIENTS' INTERVIEW GUIDE

Before the actual pilot study, it was decided that the questionnaire should be in English as the doctors and nurses were fluent in the English language and, indeed, some might be British by nationality or origin.

However, it was necessary to translate the patients' interview guide and their covering letter into the Arabic language. The translation process began in Cardiff and three individuals were involved one being the researcher herself, another a PhD candidate who had been working as a part-time translator of English television programmes to Arabic in the State of Bahrain, and the third person was a senior nursing lecturer in Bahrain. The translators were also required to provide their views on the content of the questions, whether or not they made sense - it was of particular importance to receive this information from the translator who was not a nurse and who could view the questionnaire from an outsider's point of view.

The translations took place independently of each other. Some good remarks were received. For example: they felt that some information was trivial and unimportant for patients to know, such as being informed about the nurses' round times, or the tea times, and, from the point of view of an Arab, this made sense, as tea times are not given as much importance as they are in the U.K. The Arab people prefer their Arabic coffee rather than tea.

Another remark was made by the non-nurse translator, who felt that if he was a patient and was asked whether or not he was informed "about how the operation was going to be performed", this would not be part of his expectation and therefore it might not be the expectation of other Bahraini patients.

All these remarks and the actual translations were combined, analysed and then produced in their pre-final format, awaiting the pilot test.

THE TRAINING OF INTERVIEWERS

During the early planning stages of this research, the researcher decided to have one or two interviewers to assist in the data collection besides herself. The reasons for this decision were - fear of not completing all the interviews on time and that the systematic type of errors which are usually inherent in the use of one interviewer could be guarded against. This is also named 'interviewer effect' or 'interviewer bias.' (Oppenheim, 1992, p.87).

The Chairperson of the nursing department in the College of Health Sciences in Bahrain was approached for this purpose, and she suggested some faculty members who might be able to help outside their working hours and who were interested and qualified. Looking at the sample size it was decided to have one interviewer plus the main researcher.

The second interviewer was the Head of the Associate Degree Nursing Programme at the College of Health Sciences. She holds a Master in Nursing from the United States, and she has contributed in research both locally

and regionally. Her interest in the research problem was expressed.

During the first meeting, a briefing was given on the objectives and aims of this research, a copy of the proposal, the patients' interview guide and the doctors/nurses' questionnaires were given, which were to be further discussed on the following day.

During the second session, a more detailed discussion ensued and the questions were looked at and views and opinions were raised. Probing techniques were rehearsed by role playing the position of patient and interviewer interchangeably. It was agreed that, due to the responsibilities of the second interviewer, only a limited number of interviews would be given to her (10-15), and that the majority of interviews would be conducted by the researcher.

A written instruction and an interviewing schedule was drawn up and given to the interviewer (Appendix iv). Copies of the patients' interview guide with the necessary clip board and the rating scale colour cards were also given to her.

Both interviewers began the pilot study on the same day. This took three days to complete, and at the end of each day there was a debriefing of how things had gone. The interviewers spent an hour a day discussing the pro's and con's of the interview guide.

It became apparent during these discussions that even the closed ended questions required some appropriate probing. For example, if a respondent said 'yes' to the question ... "Do you know what is your health problem?" the interviewer still needed to make certain that the patient really knew

what was wrong with him by further asking ... "Well do you mind if I ask, what is your problem?", and the respondent may say "Oh, I have a chest problem". The interviewer would then ask "Do you know what kind of chest problem?" and the respondent might either say "Well... I really don't know" or he might say "I have asthma, bronchitis, or tuberculosis." The interviewer would then ask "How did you come to know that you have Tuberculosis?" and the respondent might say "The doctor told me". Of course this does not mean that the patient knows what Tuberculosis is but that the doctor had said something about the diagnosis to this patient.

This kind of probing was necessary and appropriate to the research questions. Other questions which presented some difficulties were reviewed and those which were ambiguous were further clarified.

PILOT STUDY

It was decided to conduct a pilot study because of the importance of this step in research. As Prescott (1989) states:

"Pilot work serves to guide the development of a research plan instead of being a test to the already developed plan".

The main reason for conducting a pilot study was to assess the feasibility of the interview guide and the questionnaire. How effective these instruments would be in allowing the respondents to express their honest and true opinions regarding the information they receive during their hospital stay.

Another reason for conducting the pilot study was to guard as much as possible against any spurious negative or positive responses which might in turn affect the reliability and validity of the research.

Finally, conducting a pilot study was to give the researcher a feeling of confidence, a feeling of how it would be to actually face patients, ask questions and expect responses. To see the general atmosphere and whether there would be distractions or if patients would refuse to participate.

The pilot sample consisted of three female patients and three male patients from medical and surgical wards. They were suffering from medical conditions such as myocardial infarction, respiratory disorders and rheumatoid arthritis. Their ages ranged from 19 to 60 years. The study took place in Bahrain, in the same hospital in which the main study was to take place, making sure that the pilot sample fulfilled all the criteria as laid down for the main sample group.

Meeting this requirement in the pilot study has been recommended by Van Ort (1981) and Oppenheim (1992) who believed that, in principle, respondents in pilot studies should be as similar as possible to those in the main enquiry.

The ethical considerations laid down for the main sample were applied to the pilot sample to the fullest extent.

At this point, the researcher will shed some light on some aspects of the pilot study which required the implementation of some changes in the main study:

RESULTS OF PILOT STUDY

The Sample - In the proposal, there had been no limit on the ages of the patients, but it became evident from the pilot study that interviewing elderly patients was very difficult as they were either unable to see well or to hear well. So, given the fact that patients were to be interviewed at the bedside, it was difficult to raise one's voice while reading the questions out loud. It was also impossible for some elderly patients to see the rating scale cards.

The decision concerning the age of the patients who would participate in the research was therefore changed to include patients from fifteen up to the age of 60.

Initially, the sample size was 40 patients and this number was thought to be sufficient, given the constraints of time but, during the pilot study,

the interviewers were able to complete three interviews within two hours so it was decided that, if things commenced smoothly, the sample size could be increased to 60 patients.

The Instruments - In the patients' interview guide, the rating scale on patients' general perceptions and attitudes towards the information they received consisted of five questions. One of these was on the level of understanding of the information the patients received and during the pilot analysis this specific question did not correlate with the rest of the questions on the rating scale. The patients mostly gave this a 4 or a 5, which meant that they understood what was being told to them. Apparently, the pilot sample interpreted this question as their own level of understanding but the question was intended to find out whether the information given to them was 'understandable.' However, it was decided to keep the question, mainly because one of the common excuses which nurses and doctors give for not adequately informing patients is that the patients do not understand what is being told to them. On the other hand, two questions were added on the issue of 'understandability' of information given to patients, one on the clarity and another on whether or not the information given was complete or incomplete.

Question No. 4 in the rating scale had two components, i.e. how satisfied patients were with the 'information' and 'care' received by patients. A patient very cleverly pointed out an error in the construction of the question, and said: "For the first part of the question I will rate it as 3 and the second part, which is on the care I received, I will rate as 5". It became evident that this item needed modification and the decision was made to delete the second part of the question as it was not within the objective of this research.

The sequence of the questions was discussed with the second interviewer and it was decided to put the rating scale questions at the end for half of the pilot sample and at the beginning of the interview guide for the other half of the pilot sample. This decision was made based on the views of the interviewers that maybe the respondents would be unsure of the meanings of the rating scale questions but, as it turned out that there was no difference, it was decided to keep the rating scale questions at the beginning.

Still on the aspect of the adequacy of the instruments, questions numbered from 8 to 50 were to be responded to by a 'yes', 'no' or 'uncertain' and it became clear that these choices of answers were not sufficient to cover all possible answers which patients might give. For example, a Christian patient was asked 'Were you told about the prayer direction?' Obviously, this question applied to Muslim patients only and for this patient a 'yes', 'no' or 'uncertain' would not apply, so a 'not applicable' alternative was added.

Under section 5 of the interview guide, which was on information given to patients concerning their medication, it became obvious during the pilot study that Bahraini patients rarely knew the names of their drugs because they were in English and often difficult to pronounce, particularly for lay persons. It was decided to ask this question in a different way, which included asking the patients if they knew how many tablets they were taking and which colour responded to which drug action.

Confirmation of Patients' Responses - Concerning the patients' diagnosis, type of operation, medication and investigation, it became clear after the

pilot study, that the information which patients had already received needed, to a certain extent, to be confirmed by the interviewer with the sister in charge after the interview was over. This was important because it would reveal whether patients understood what they had been told or whether there were any gaps in their understanding.

Patients Verbatim Responses - Although the interview was highly structured, sometimes patients just like to talk and elaborate on specific issues. For example, when patients were asked the question 'Were you told about what to expect before, during and after the test?' they would not just reply 'no' but would go on to say 'I developed some discomfort and pain' or 'I got a sore throat after the laryngoscopy.' These important remarks were not neglected and after the pilot study, the interviewer decided to write them as patients' verbatim responses.

Interview Timing - The timing for the pilot interviews ranged somewhere between 10.a.m. and 2.00 p.m. and these timings did not impose any difficulties on the patients or the interviewers. It was felt to be the most convenient timing as discharged patients left the wards after 2.00 p.m.

Coding The Responses - During the pilot study and before the final typing of the Arabic version of the patients' interview guide, the interviewers discussed the coding of questions. It was decided to allocate English numbers to each answer category, even though the actual wording of the questions was in Arabic. This procedure, which is recommended by research authors, (Pilot and Hungler, 1983; Oppenheim 1992), was done to avoid later inconveniences of coding and data entering.

THE DOCTORS' AND NURSES' PILOT TEST

Because the sample size for the doctors and nurses was smaller, the pilot study size was also smaller. Four doctors and four nurses were piloted from both medical and surgical wards, Bahraini and non-Bahraini. Their ranks ranged between consultants to house officers, sister-in-charge to staff nurses and their years of experience ranged between 10 - 16 years for the doctors and 2 - 10 years for the nurses. They were able to complete the questionnaires fully and with some expressing their interest in the research, not requiring many changes except adding the two questions to the rating scale of the patients' interview guide.

Finally, despite the detection of some problems and the incorporation of necessary changes, some aspects of the main study did have faults, as will be addressed later. The researcher acknowledges that, being a student, the excitement of wanting to get on with the main study, and the lack of experience in conducting pilot studies could have been the reason for not correcting all the defects.

It was noted that:

"Questionnaires do not emerge fully-fledged; they have to be created or adapted, fashioned and developed to maturity after many abortive test flights".

(Oppenheim 1992, p. 47).

CONDUCT OF THE MAIN STUDY

After completion of the planning stage for this research, which included the agreement of the Ethical Committee, the translation of the instruments, the training of the interviewer, the pilot testing and the final reproduction of the reviewed research instrument, it was time to conduct the actual research. Both the researcher and the second interviewer began on the same day in the last week of March and continued until the second week of April 1993. The interviews took place between 11.00 a.m. and 3.00 p.m. These hours were most suitable as the majority of doctors' rounds had finished and the wards were less disturbed by visitors.

The interviewers were equipped with the necessary interview guides, both in Arabic and English, just in case a non-Arabic speaking patient might be ready for discharge. Coloured show cards were also provided which were professionally prepared and had the answer categories typed in large block letters. They were to be handed to the patients with instructions on how to use them. They were planned in advance and were found to be very useful during the pilot study (Appendix viii).

There were several sets of cards for the different response categories, to spare the researchers the inconvenience of continually handing in cards. They were arranged in proper sequence, clipped with a roller binder so that the patient had to roll the card over when he gave the appropriate response for a given question. The show cards were prepared in both the Arabic and English language.

The interviewers were assigned specific wards each morning and first approached the sister in charge or acting in charge to ascertain which

patients were ready for discharge. They then enquired about these patients, whether they knew either Arabic or English and their ages and general condition. If suitable patients who met the criteria for the study were found, the sister then escorted the interviewers to the patients, introduced the interviewer and left.

Most of the interviews took place near the patients' bedsides, some in the patients' private rooms and others in the patients' resting room, provided no other patients were nearby. The necessary privacy was maintained at all times. The interviewers were dressed casually, carrying only a file with the necessary papers.

The interviews began with greeting the patients, asking permission to screen the bed and to sit down facing the patient. The interviewers then introduced themselves by their full names and position, then the contents of the covering letter were either read or stated, making sure that eye contact was maintained. The researcher found that this initial stage was crucial in developing a rapport and ensuring patients' co-operation.

The anonymity, confidentiality and the voluntary participation were clearly emphasised and stressed. In some interviews patients were made comfortable by raising the upper end of the bed, placing pillows behind their backs and, in almost all the interviews, the interviewer was seated at a slightly lower level than the patients. Questions such as 'Do you feel comfortable?' or 'Do you need anything before we start?' were asked to limit distractions. The sister in charge was also told that the patient would be engaged in the interview for approximately 25 - 30 minutes, to make sure that the patients were not disturbed.

Once the patients had agreed to participate, the interviews started. The patients were first given the cards and instructed on how to use them. These cards remained in the patients' hands during the entire interviewing time. The patients were also clearly instructed to stop the interview and ask questions at any time they wished.

The actual interviews began by asking the patients their general perceptions on the information they had received so far. It was important to remind the patients to relate their responses to this particular admission and not prior hospitalization. The first seven questions were designed in a 5 - point rating scale, with the numbers 1 - 5 clearly typed in boxes on the show cards. so the interview would, for example read the question: 'How satisfied are you with the information given to you concerning your health problem?' The patients would meanwhile be looking down at the card which read at one end 'completely satisfied' and at the other end 'completely unsatisfied'. The patients then gave the figure that most suited their views, and the interviewer placed a tick in the box representing the figure given by the patients.

The second set of questions was introduced to the patients by saying 'Now I would like to ask about..... and these questions will require you to answer by a 'yes' 'no' or 'uncertain'. The patients were also given a show card on which these alternatives were clearly written.

For example, a question in this section might be 'Do you know what your problem is? or 'What kind of illness are you suffering from?' The patients would then either say 'yes', 'no' or 'uncertain'. At this point, it was necessary to explain the follow-up probing techniques which were used. The interviewers would ask 'Well, do you mind if I ask what is your problem?'.
.

Most patients did not mind stating what their problems were and then the patients' verbatim were recorded.

Another example was a question on patients' knowledge about their prognosis. The interviewer asked 'Do you know whether your problem will disappear or become worse in the future?' If the patients replied 'Yes', then it was important to ask 'How do you know that the problem will disappear?' If they replied 'Well, the doctors told me' then the interviewer would further ask 'What did they say?'. The patients then repeated exactly what they had heard from their doctors and all their responses were recorded. Another patient who might have replied: 'Well, I know myself that I am getting better .. I don't need any doctor to tell me that' would clearly reveal that his answer was 'no' to the question.

Another tactic used for probing was the use of non verbal cues, such as head nodding or just listening and allowing the patient to talk. Some questions required that the the patients remembered what had happened a few days before. These questions were phrased: 'Please try to remember, on the day of your admission, were you examined by a doctor?' If the patients answered 'yes' then the interviewer asked 'Will you tell me about it?' rather than asking 'Did the doctor explain to you about...?' Many patients were able to respond to the non-directive question much more easily than direct questions.

The question order was not altered and questions were asked in the same order for all the patients. The language was more or less the same as that written on the interview guide, because the Arabic reading language is slightly different to the spoken language. This point was also clarified to patients at the beginning of the interview and the patients were reassured

that they could ask if unclear about a word or sentences. After a while, the interviewer felt that the patients, particularly those with some years of schooling, preferred the 'written Arabic'.

The questions were completed by using adequate prompt probing, whenever necessary. Some questions seemed trivial and unimportant for some patients, such as those related to ward facilities and routines. The patients would, for example, say: "Well there is no need for the nurses to show me where the toilets are, I can find them myself". This would mean that the nurses did not give ward orientation to the patients. On the other hand, one patient said: 'No, no one showed me where the water cooler was, I found it myself when I got very thirsty'.

Although the interview guide was a structured one, these comments by the patients were very important as they provided a richer, more meaningful understanding of the existing problem.

The interviewing was concluded by two open-ended questions in which patients' verbatums were specifically verified with the patients, and the demographic data, which included the patient's age, education, etc.

The interviewers expressed their thanks and, before leaving, the patients were asked if they needed anything.

On the whole, the interviews went very smoothly, they were systematic but not too rigid and each patient was responded to in the manner most suitable for that patient. The patients were relaxed, smiling and very co-operative. very few situational problems were encountered, such as an angry patient who wanted to ventilate, or a patient who found the services in the

hospital to be 'very good, 'excellent', 'no problem'.

Finally, the interviewer referred to the sister in charge to confirm the information given by the patients about diagnosis, operation, investigations and medication. The interviewer then went to another ward to conduct another interview.

DOCTORS' AND NURSES' QUESTIONNAIRES

Simultaneously, the researcher distributed copies of the doctors' and nurses' questionnaires to the Chief Medical and Surgical Consultants and to the senior nursing officers. They were requested to give these questionnaires to the doctors and nurses, making sure that they were of different ranks, different nationalities and they were asked to fill them in at home independently and return them the following day. The completed questionnaires were then given to the secretaries of both departments for the researcher to collect.

The nursing sample was very prompt in returning the questionnaires, which is evident by the 100% return rate, while the doctors' sample caused some delay in returning the questionnaires. A word of reminder was conveyed, however, and 95% of the doctors returned the questionnaires.

CHAPTER FOUR

DATA ANALYSIS

In this research, the data were collected using quantitative and qualitative methods, with the emphasis being on the quantitative one, and for this reason, the data required to be analysed using both methods.

Descriptive statistics were used for the quantitative data by resorting to a computer programme called the Minitab. Descriptive statistics were most appropriate to meet the objectives of the study.

The interview guide and the questionnaires were coded manually, all the raw data of the patients, doctors and nurses were transferred on to separate graphic sheets before being entered into the computer. Different types of data were obtained, the 'yes' and 'no' answers produced nominal data and the five-point rating scale produced ordinal data.

Where appropriate, the descriptive statistics consisted of calculating means and frequencies, despite the inadequate sample size, (patients N = 56, doctors N = 29 and nurses N = 40). It was difficult to present the frequencies in any method other than percentages so that the three groups could be compared on some questions. Errors of calculations were guarded against by the use of computer and double checking was performed on all the data, no question was discarded.

The open-ended questions which constituted the qualitative data were analysed using content analysis. The researcher resorted to methods used by

many researchers which basically have similar steps (Pilot and Hungler, 1983; Oppenheim, 1992).

THE FINDINGS

SECTION I - Sample Characteristics

The Patients - The total number of patients was 56. They were all in-patients admitted to the Salmaniya Medical Centre in the State of Bahrain, 37 male and 19 female. The gender difference represented the total male admissions (N = 1043) and female admissions (N = 681) to medical/surgical wards in SMC during the month of April, 1993, when the patients' interviews were conducted. (Information obtained from Admission Bureau Office at SMC).

The patients' ages ranged between 16 - 61, with a mean age of 35.2 years. They were 80% Bahraini and 20% non-Bahraini. 48% were admitted to medical wards and 52% to surgical wards. The mean number of days in which patients (combined medical and surgical) stayed in the hospital was 10 days, and 55% of the sample were discharged patients at the time of interview. Table 1 summarizes the patients' characteristics.

TABLE 1 PATIENTS' CHARACTERISTICS (N = 56)

VARIABLES	FREQ. DISTRIBUTION (%)	Mean Score
<u>Age</u>		35.2
16 - 24	12.5%	
25 - 34	34%	
35 - 44	16%	
45 - 54	16%	
55 - 64	12.5%	
<u>Gender</u>		
Male	66%	
Female	34%	
<u>Nationality</u>		
Bahrainee	80%	
Non-Bahrainee	20%	
<u>Place of Admission</u>		
Medical	48%	
Surgical	52%	
<u>Days in Hospital</u>		10.3
<u>Discharged at the time of Interview</u>	55%	
<u>Not Discharged at the time of Interview</u>	45%	

The patients' actual diagnoses, as reported by the nurse in charge, were varied. In the surgical wards, patients suffered from many conditions which required surgery, some minor problems such as the fixing of fractured bones, appendicectomies, haemorrhoids, pilonidal sinus, and hernias, to some more serious conditions, such as road traffic accidents with multiple injuries, removal of gall-bladder stones, hepatic cystectomy, vagotomy and laparotomy. In the medical wards patients who participated in the study suffered from respiratory conditions, such as pneumonia, bronchial asthma

and tuberculosis, or heart conditions such as myocardial infarction or hypertension, or diabetes. Some patients suffered from hepatitis or urinary tract infections and quite a few patients suffered from sickle cell anaemia, which is a type of anaemia very common to the Mediterranean regions.

The patients' educational status was thought to be an important characteristic to include in this study. 10% were illiterate, 9% had finished only four years of schooling and were below primary, 9% primary, 20% intermediate, 32% secondary, which is an equivalent to high school, 18% were undergraduates and 2% of the patients had postgraduate qualifications, as is shown in Figure 1.

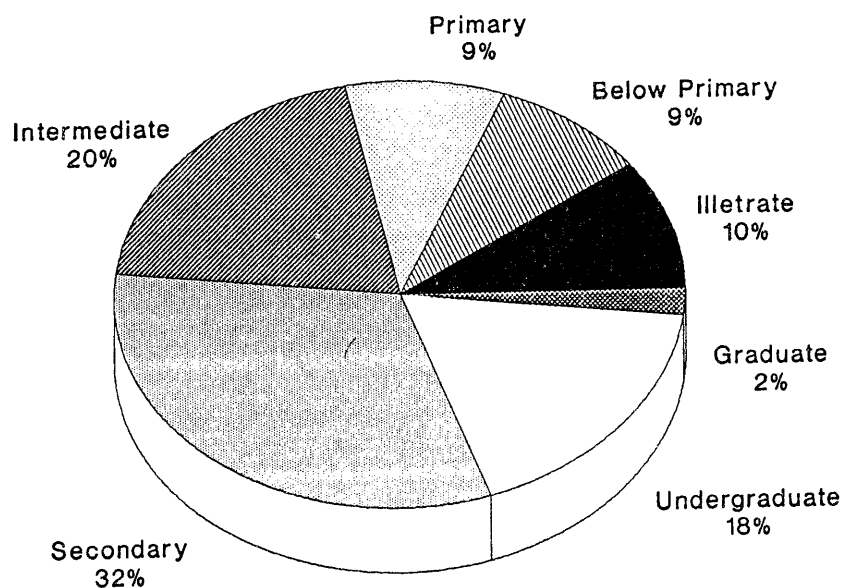


Figure 1 - Frequency Distribution of Patients' Educational Status

The Doctors - The doctors' sample consisted of 29 doctors, 81% male and 19% female, 72% Bahraini, 28% non-Bahraini, their age group ranged between 25 and 55, with the majority falling in the age group of 36 - 45 years. The doctors' working specialities were 59% medical and 41% surgical and their mean number of years experience was 14.5 years.

The doctors' sample was also described in relation to their rank, and there were 41% consultants, 37% senior house officers and house officers and 21% junior doctors. In relation to the language, the doctors spoke fluently, 86% spoke Arabic, 97% spoke English, 17% Indian and 17% spoke other languages, such as Persian and French.

The Nurses - The nurses' sample consisted of 40 nurses, 38% male and 62% female, 32.5% were Bahraini and 67.5% non-Bahrainis. 45% were from medical wards and 55% from surgical wards. Their ranks were distributed into 27.5% nurses in charge and 72.5% staff nurses. The difference between the percentages of Bahraini nurses and non-Bahraini nurses presents an actual existing difference in the Ministry of Health, Bahraini nurses constituting 30% while non-Bahraini nurses 70%.

The language of the nurses was thought to be an important factor in nurse-patient communication. 75% of the nurses spoke Arabic, 100% spoke English, 62.5% Indian and 22.5% spoke other languages, mainly Philippino. The doctors' and nurses' characteristics are presented in Tables 2 and 3.

TABLE 2 DOCTORS' AND NURSES' CHARACTERISTICS

Variables	Doctors N = 29	Nurses N = 40
<u>Age</u>		
25 - 35	38%	57.5%
36 - 45	41%	30%
46 - 55	21%	12.5%
<u>Gender</u>		
Male	81%	38%
Female	19%	62%
<u>Nationality</u>		
Bahrainee	72%	32.5%
Non-Bahrainee	28%	67.5%
<u>Speciality</u>		
Medical	59%	45%
Surgical	41%	55%
<u>Years Experience</u>	Mean = 14.5	Mean = 11.5
<u>Doctors'/Nurses' Rank</u>		
Consultant	41%	Charge Nurses 12.5%
S.H.O. and H.O.	38%	Staff Nurses 72.5%
Junior doctor	21%	

TABLE 3 FREQUENCY DISTRIBUTION OF DOCTORS'/NURSES' SPOKEN LANGUAGE

Sample	Arabic	English	Indian	Others *
Doctors (N = 29)	86.2%	96.5%	17.2%	17.2%
Nurses (N = 40)	75%	100%	62.5%	22.5%

* Others include Persian, Philippino and French.

SECTION II Perceptions of Information

Seven questions were asked of patients, doctors and nurses. These questions were constructed on a 5-point rating scale. They addressed, for example, the patients' satisfaction, understanding and adequacy of information. The higher the score, the more positive perception the individual patient, doctors or nurse had on that specific aspect of information. For example, the question on satisfaction stated: "How satisfied are you with the information given to you concerning your health problem?" The patients had to rate their satisfaction on a 5-point rating scale, in which 1 meant 'completely unsatisfied' and 5 meant 'completely satisfied'.

The interpretation of this finding applied to all the other questions except for the question which addressed the patients' need for information. This specific question stated: "How large is your need for information?" The patients had to select a number between 1 and 5 in which 1 represented 'a very small need' and 5 represented a 'very large need'. The patients' mean score on this question was higher than that of the doctors and nurses, which meant that the patients needed more information, and this in fact reflected a negative perception rather than a positive one.

The results were consistent, but different. The overall mean scores are presented in Figures 2 and 3. The patients' mean scores ranged between 2.8 to 4.7, while the doctors' ranged between 2.5 to 2.9 and the nurses between 2.8 and 4.2. The consistency is apparent in almost all the questions. The doctors and nurses seemed to have lower mean scores than the patients and this means that, overall, the patients reported more satisfaction with the information they received than the doctors and nurses.

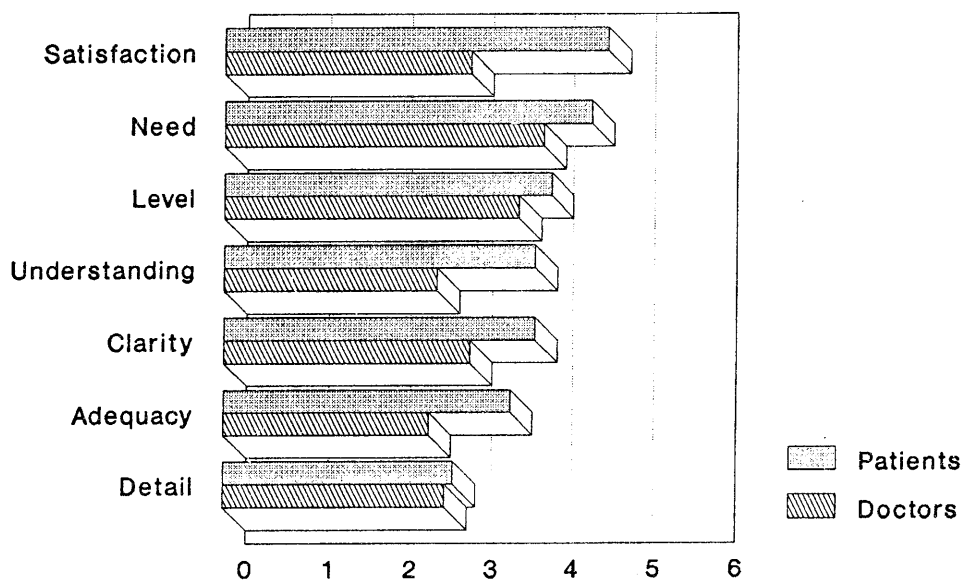


Figure 2 Mean Score of Patients' (N = 56) and Doctors' (N = 29) Perceptions of Information.

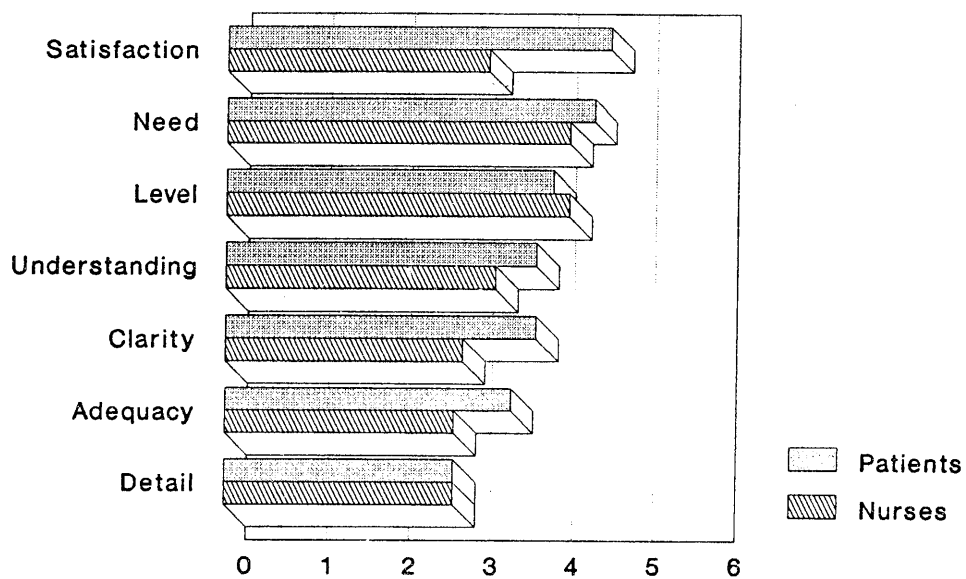


Figure 3 Mean Score of Patients' (N = 56) and Nurses' (N = 40) Perceptions of Information.

SECTION III Specific Information on:

Diagnosis, Prognosis and Cause of Illness

In this section of the questionnaire, the patients' and doctors' answers were analysed and presented in frequency terms. 75% of the patients stated they had received adequate information on the diagnosis, while 65.5% of the doctors thought that the patients had received information on the diagnosis. For the prognosis, also more patients (44.6%) than doctors (41.3%) thought they had received information on the prognosis, but in relation to causes of illness, only 28.5% of patients thought that they had received information, compared to 62% of the doctors (see Figure 4).

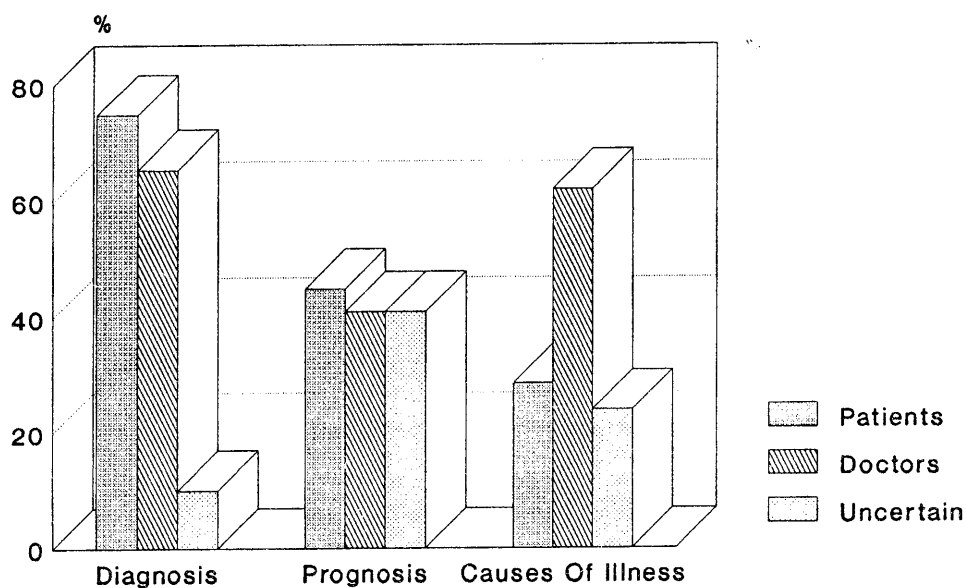


Figure 4 Frequency Comparison of Patients and Doctors' Views and Uncertain Views of Doctors on Information Received on Diagnosis, Prognosis and Causes of Illness.

It is important to note that quite a number of doctors answered as 'uncertain' for these questions, ranging from 10% to 41%, which meant that they were not sure whether patients received information on the diagnosis, prognosis or the cause of their illness or not.

The Physical Examination

The frequency comparison of patients' views on the information they received while being examined on Day 1 after their admission, to those of doctors and nurses, showed a different picture. Only 29% of the patients, compared to 34% doctors and nurses, and 50% of the nurses thought they received information on the physical examination.

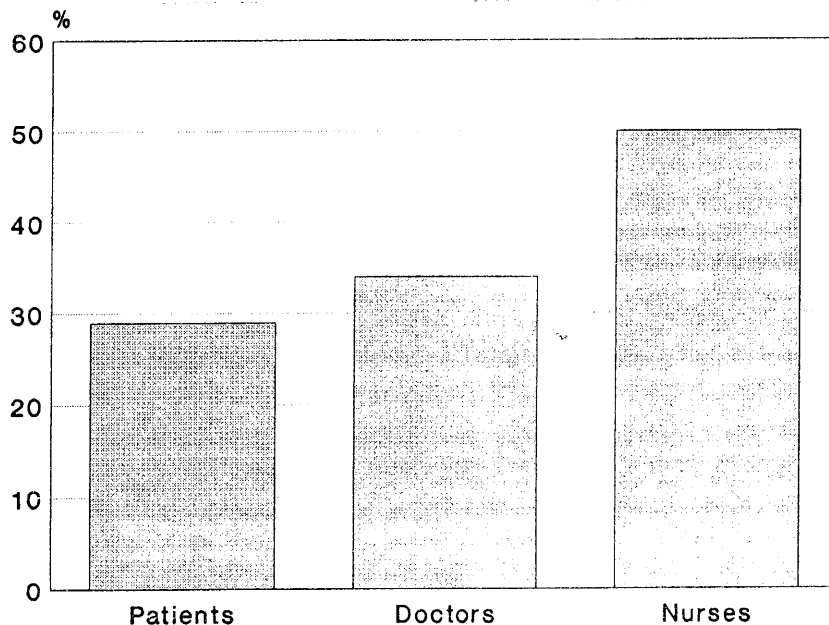


Figure 5 Frequency Distribution of Patients', Doctors' and Nurses' Views on Information Received on the Physical Examination.

The Tests and Investigations

The types of investigations the patients required were analyzed. Nearly all the patients had blood tests and 75% had x-rays, 18% had CT scanning, 18% had ultrasound tests, 7% had biopsies, 38% had ECGs and 9% had different types of endoscopies. The question related to this aspect were once more to be answered by a 'yes', 'no' or 'uncertain. The patients' results were consistently lower than those of the doctors and nurses. The specific question was on why and how, and the results of tests and investigations,

only 12.5%, 11% and 25% of patients respectively said they had received information, while 48%, 52% and 72% of doctors respectively thought that patients had received information. The nurses also thought that many patients knew why and how the tests were performed, but fewer nurses than doctors thought patients knew the results of their tests. See Figure 6.

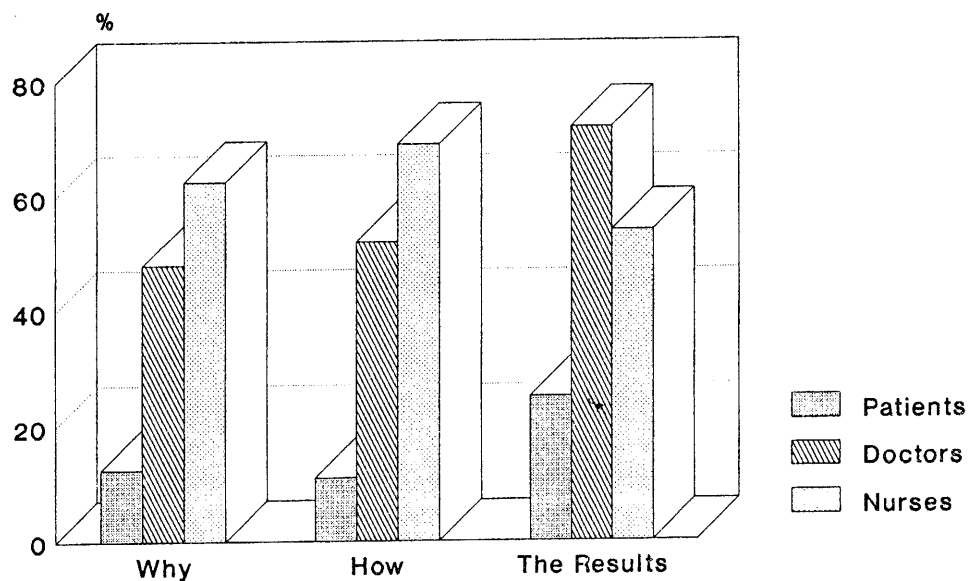


Figure 6 Frequency Comparisons of Patients', Doctors' and Nurses' Views on Information Received on Tests and Investigations.

In the above section of the questionnaire, quite a number of doctors and nurses (10% and 30%) were uncertain whether the patients received information on the tests and investigations or not.

The Medication

The patients were asked if they knew the names of their drugs, the reasons why they took the drugs and the possible side effects. Only 18% of the patients knew the names of their drugs, while 41% of the doctors and 20% of the nurses thought the patients had received information on the names of

their drugs. On the reasons for taking the drugs, 51% of patients, compared to 28% doctors and 23% nurses, thought they knew why they were taking the drug. Very few patients (4%) received any information on the possible side effects (see Figure 7). Quite a few doctors, (38%) were uncertain whether patients received information about their medication and 20% of the nurses were uncertain also.

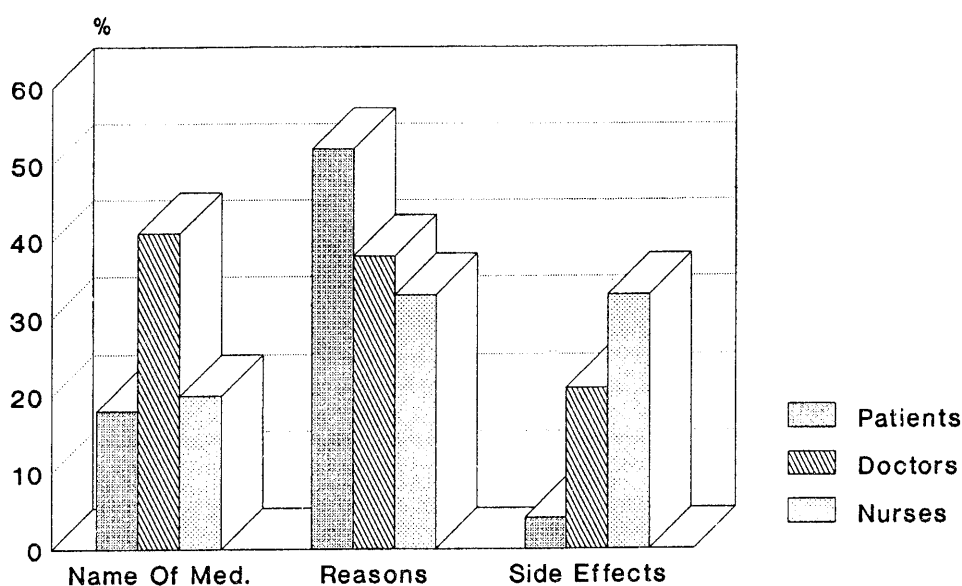


Figure 7 Frequency Comparison of Patients', Doctors' and Nurses' Views on Information Received on the Medication.

It was important to note the types of medication these patients were taking and this information was reported by the nurse in charge. The medications were varied, depending on whether the patients were suffering from a medical or surgical condition, and the range of drugs included cardiac drugs, such as digoxin and vasodilators, anti-hypertensives, heparin, anti-TB drugs, insulin, etc. Quite a number of surgical patients were on painkillers and a range of antibiotics.

The Operation

The patients were asked if they knew what operation that had had and why the operation was needed, the results of the operation and the consent form, 65.5% were told what operation they had had, 72% knew why the operation was needed, 38% were told the result of the operation and 96% were told about the consent form. The figures were much higher for the doctors and nurses, who thought that more patients were given information about their operations. See Figure 8.

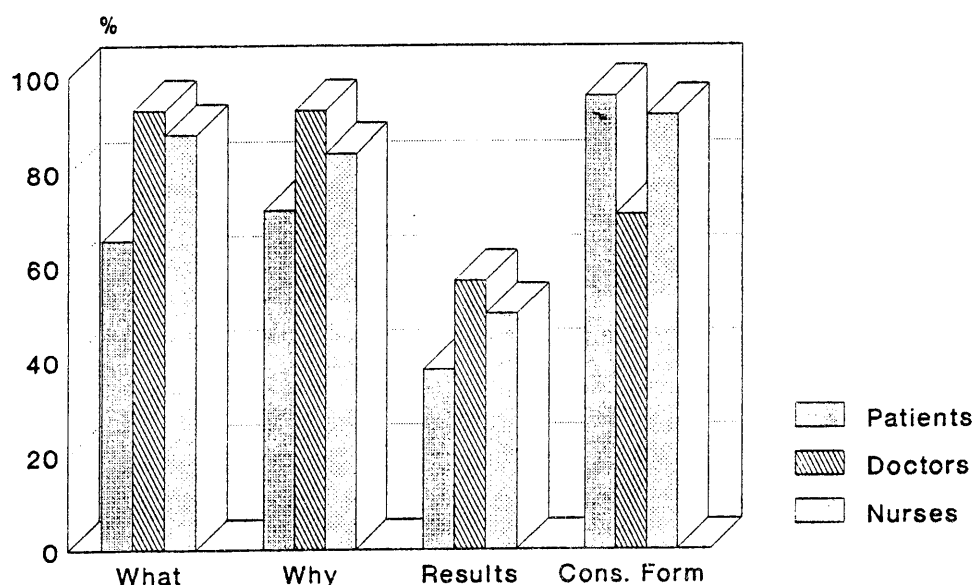


Figure 8 Frequency Comparison of Patients' (N = 29), Doctors' (N = 17) and Nurses' (N = 26) Views on Information Received About the Operation.

It is important to note that these percentages were calculated by considering only those patients (N = 29) who were admitted to surgical wards and the surgical doctors (N = 14) and nurses (N = 26).

The Pre and Post Operative Care

For the pre and post operative information only the surgical nurses and doctors were compared with the surgical patients. The questions are shown in Figure 9 and the number in percentage terms of patients who thought they had received information on specific pre and post operative care. The area in which patients received most of the information was about the need for fasting and the area in which they were least informed was post-operative pain and the possibility of nausea and vomiting.

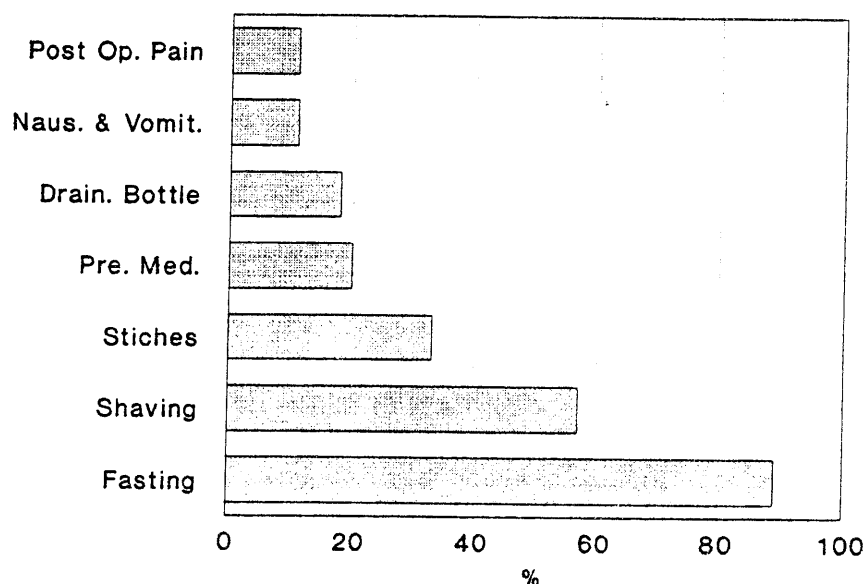


Figure 9 Frequency Distribution of Patients' (N = 29) Views on Received Pre and Post Operative Information.

While this figure only reveals the patients' views, the nurses and doctors' views on the question whether patients were informed about what to expect before and after surgery were analysed and it was found that 36% of doctors and 36% of nurses believed that the patients were informed. The rest did not.

The Ward Routines and Facilities

Figure 10 reveals all the information concerning ward routines and facilities which were asked of patients and nurses. It is obvious that the patients thought they had received little information, while the nurses thought they had provided most of the information. The figure shows, in order of rank, the areas in which the patients received most information and where they received the least.

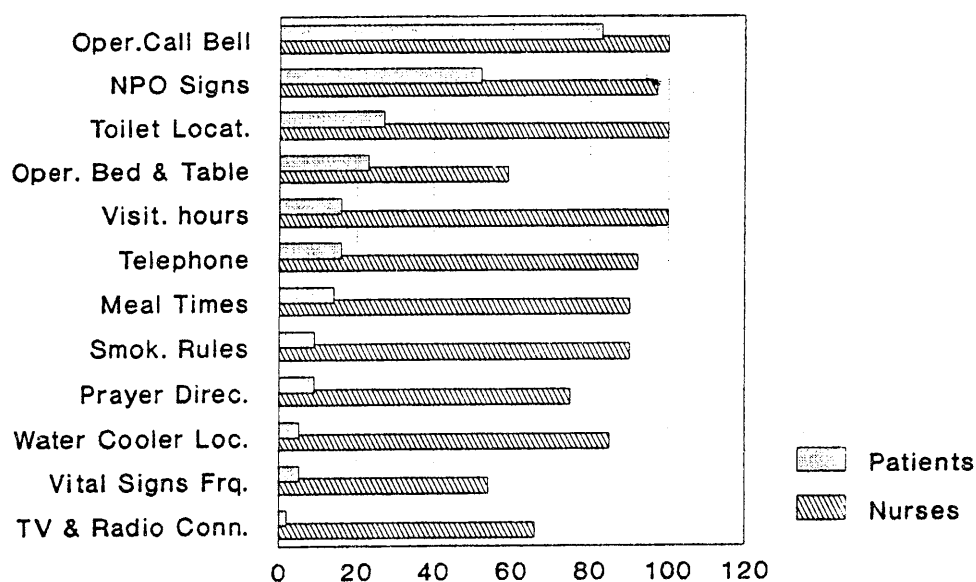


Figure 10 Frequency Comparison of Patients' and Nurses' Views
Concerning Received Information on Ward Routines and
Facilities.

SECTION IV Who Provides Information?

It was important to find out the patients' views in comparison to the doctors' and nurses' views on who provided information to the patients while they were admitted to hospital. Figure 11 compares the views of patients to those of doctors and nurses. In summary, less patients thought they received information from any of the health team members, while consistently the doctors and nurses thought that the patients received more information.

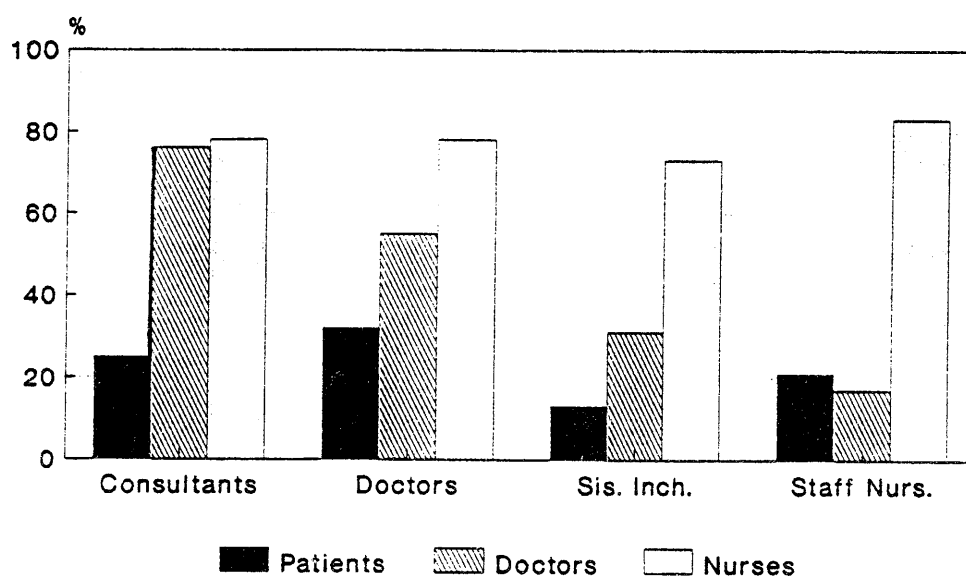


Figure 11 Frequency Comparison of Patients', Doctors' and Nurses' Views Concerning Received Information from Different Sources.

It is a common perception of doctors and nurses that patients receive information which is usually 'wrong' information from their relatives or other patients. The results in Figure 12 show that the patient sample did not state they had received information from their relatives or other patients.

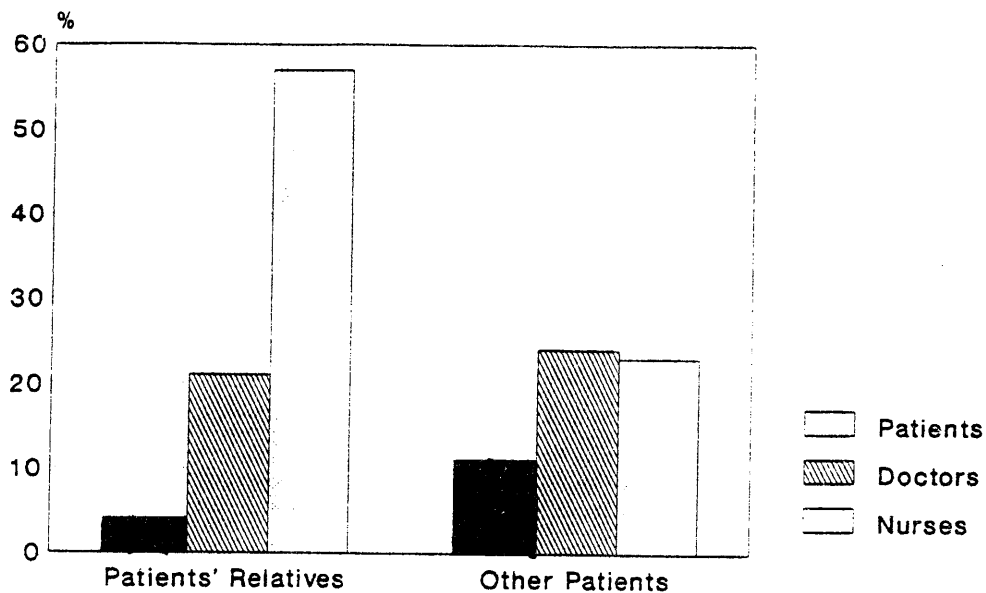


Figure 12 Frequency Comparison of Patients' Doctors' and Nurses' Views Concerning Received Information from Different Sources.

It is important to note that 34% of the patients stated that they had received no information from any source.

SECTION V Discharge Advice and the Need for More Information

The patients were asked two open-ended questions, the first being on discharge advice. They were asked whether they had received any advice concerning their medication, food, activities, rest and follow-up appointments. A content analysis procedure followed and a total of 65 patients' statements were listed. Their statements were showing whether they either received information or did not. The results are presented in percentage terms; 62% of the patients had received no advice at the time of interview, 38% had received some advice on diet, activities, need for physiotherapy, appointments and follow-ups. See Figure 13.

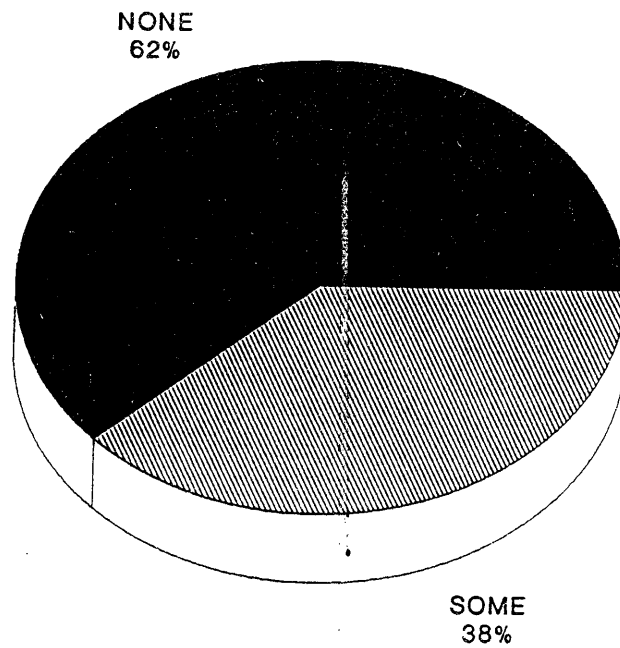


Figure 13 Frequency Distribution of Patients' Views Concerning the
Received Discharge Advice.

The results of the second question, as shown in Figure 14, were on the patients' needs and desire for information. The same procedure was followed as for the first question. 86% of the patients wanted more information, while 14% stated that they did not need any information. The information mainly needed was about their diagnosis, prognosis and the causes of their illness and on health related enquiries or health maintenance and promotion issues.

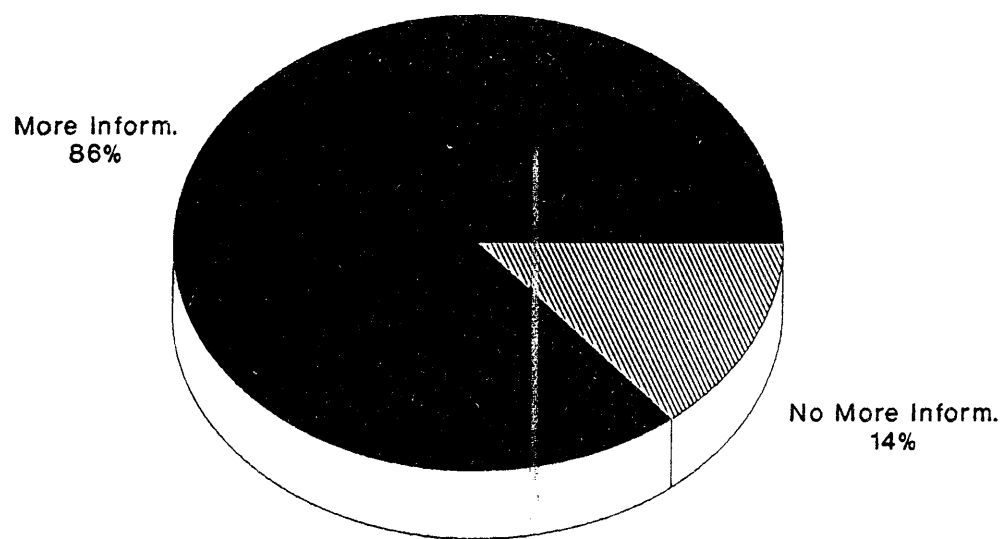


Figure 14 Frequency Distribution of Patients' Need for More Information

SECTION VI - Nurses' Reasons for Not Informing Patients

The nurses were also asked two open-ended questions. One asked 'What are some of the reasons, (if any) for not informing patients?' Most of the 40 nurses answered the question clearly, only 4 chose not to answer. The same content analysis procedure was followed and a total of 85 reasons were listed. These were grouped under the following themes:

1. Patients' related reasons
2. Nurses' related reasons
3. Doctors' related reasons
4. Administrative related reasons
5. No reasons

More than half of the reasons (58%) were patient related, which meant that

the nurses perceived that the reasons for not informing patients were related to the patients themselves. Some of these reasons were: the patients' inability to understand, uneducated, and the patients' general condition, i.e. confused, not fully orientated, unconscious, etc. Other reasons were that bad news might lead to shock or physical disturbances. Bahraini patients are culturally known not to tolerate bad news and should not be informed.

Then there were the nurses' related reasons, which constituted only 18% of the total reasons. The reasons for not informing patients were perceived by nurses to be related to the nurses themselves. Examples were: "lack of initiative, language barrier, lack of knowledge in giving information, the nurses' fears of problems, lack of time, and some stated that nurses should not give information on diagnosis or prognosis".

Following the nurses' related reasons, there were the administrative related reasons (16%). Nurses stated reasons such as less nurses per ward, work overload, the hospital policy, administrative rules and that senior nurse administrators did not give importance to talking to patients.

The nurses in this sample perceived that 6% of the reasons were related to the doctors. These were: "doctors do not want nurses to give information, the consultants are too busy, doctors do not give proper, adequate information", etc.

Finally, two nurses of the 40 thought that there were no reasons for not informing patients.

Nurses' Views on How to Improve Information-Giving

The second open-ended question asked 'From your experience as a nurse, how do you see the giving of information being improved?'

The same procedure was followed in analysing the results of this question, The nurses perceived that the way to improve information giving is by the involvement of all parties, i.e. the patient, the nurses, the doctors and the administration. A total of 75 suggestions emerged and these were grouped under the following themes:

1. Suggestions to the nurses
2. Suggestions to the administration
3. Suggestions to the doctors
4. Suggestions to the patients.

Unlike the previous question, where most of the reasons were related to the patients, here the majority of suggestions were addressed to the nurses. Examples of the suggestions were: 'Nurses should develop initiative, improve knowledge of the subject matter, minimize language barriers by appropriate recruiting, improve reporting, improve communication, meet with relatives, and provide information on ward lay-out, facilities and how to identify nurses. They should become assertive and spend more time with patients'.

The suggestions to the administration which constituted the second majority, included: 'Provide more nurses per shift, provide leaflets for patients with foreign languages, nurse/patient assignments to be clarified, establish joint doctor/nurses teams for providing information, improve

in-service training, reduce the nurses' workload, support and recognize nurses' roles, initiate mandatory rules for provision of information and improve facilities to spare nurses more time to spend with the patients'.

The suggestions to the doctors were that: 'Doctors should explain to the patient, should become aware of the nurses' responsibilities, consultants should see their patients more often, doctors should provide prompt information and provide a history of the patients to the staff'.

Finally, there was only one suggestion to the patient and that was: 'Patients need to co-operate more with nurses and doctors'.

SECTION VII Doctors' Reasons For Not Informing patients

The doctors were also asked the same two open-ended questions. The first one stated: 'What are some of the reasons (if any) for not informing patients?' The procedure used to analyse the results of this question was similar to the one used to analyse the same question given to the nurses. A list of 76 reasons emerged and these were grouped under the following themes:

1. Patient related reasons
2. Patients' family related reasons
3. Doctors' related reasons
4. Administrative related reasons.
5. No related reasons

It was interesting to find that, similar to the nurses' views, the doctors

also perceived that the majority of reasons for not informing the patients were because of the patients themselves. More than half of the reasons, 56%, were patient-related reasons. Examples of these reasons were: 'the physical, psychological status of the patients, patients being very seriously ill, confused, comatose, unconscious, psychotic, or if a patient had a poor prognosis and suffering from an incurable illness, such as cancer.

The low levels of education and lack of understanding were seen to be another group of reasons, also the patients' unresponsiveness and passivity, i.e. not questioning the doctors or, on the other hand, the patients' inability to accept the truth or being shocked. Finally, some doctors stated that the language barrier was a reason for not being able to inform patients.

The second group of reasons were the family-related one, which constituted 10%. These included: 'The family's wish not to tell, relatives' interference or, on the other hand, either the unresponsiveness of some relatives or simply the unavailability of relatives during the morning hours'.

The doctors' related reasons for not informing patients constituted 28% of the reasons. These were: 'doctor's habit not to inform, doctors too busy, lack of time, language barrier, no definite diagnosis or prognosis, doctors' inadequate knowledge, limited experience, inadequate communication skills and, finally, lack of human respect and failure to recognise patients as active partners in care'.

The administrative related reasons were: 'work overload, increased numbers

of patients in clinics and, finally, absence of mandatory rules regarding patient information'. Very few doctors thought that the administration was causing doctors not to inform the patients (5%).

Lastly, only 1% of the total reasons stated 'There is no reason for not informing patients'.

Doctors' Views on How To Improve Information-Giving

The second open-ended question stated: 'From your experience as a doctor, how do you see the giving of information being improved?

Again, almost all the doctors answered this question. The suggestions given by the doctors were analysed. They were listed and grouped and a total of 50 suggestions emerged. These were grouped under the following themes:

1. Suggestions to doctors
2. Suggestions to administration/other health team members
3. Suggestions to the patients.

The suggestions to the doctors constituted the majority (68%) which meant that doctors in this sample saw that the solutions to the problem of not informing patients lay with the doctors themselves. The suggestions were further categorized as being either general, specific technical/practical, or attitudinal. Examples of the general suggestions were: 'Improve doctor/patient relationships, improve communication with patients, improve doctors' knowledge, co-operate with other health team members, and liaison between doctors. Examples of the more specific, practical suggestions were: to use a simple informative way, to provide information a step at a

time, to allow more time for patients, to set time aside for relatives' enquiries, and to use a compulsory discharge summary or follow-up cards. Lastly, examples of the attitudinal suggestions were: 'To tell the truth to patients, be patient, and to set an example for junior doctors.

The results of the administrative suggestions were also further categorized to include: 'Improving rules and regulations, improving personnel, improving knowledge and awareness and some general miscellaneous'. To improve rules, the doctors suggested initiating mandatory rules for providing information and to improve the personnel they suggested providing well informed personnel at all times. The researcher was unsure what they meant by this and wondered whether these personnel should be nurses or health workers, but then some doctors specifically stated: 'Provide more social workers/nurses'. Examples of statements for the improvement of knowledge and awareness were 'Provide leaflets, posters on the walls, encourage the use of Societies, such as the Diabetic Society, improve health education and training and, finally, the general attitudinal statements were: 'To improve the sense of humanity of the staff and improve the doctors' situations'.

There was only one suggestion to patients relating to improving information giving. This stated: 'Improving the educational level of patients'.

CHAPTER FIVE

DISCUSSION

The results showed a strange, but not an unusual picture which reflected the personal perceptions of patients, doctors and nurses. Bearing in mind the limitations of the study, the researcher will try to interpret and provide possible explanations of the findings, in the light of findings from similar studies. In doing so, the researcher will also try to answer the original questions asked in the research.

GENERAL PERCEPTION OF INFORMATION

One of the first questions this research asked was, generally speaking, how patients, doctors and nurses viewed the practice of information-giving. Contrary to the researcher's expectations that patients were not satisfied with the information they received, they turned out to be fairly satisfied, as was evident by their mean scores, which were consistently higher than those of the doctors and nurses. However, on closer examination of the findings of this question, one could see an emerging trend from being 'most satisfied' with some information to being 'a little less satisfied' with other information.

The questions were on satisfaction, need, level of understanding, adequacy, clarity and details and within these general questions some were 'more general' than others. When patients were asked 'Were you satisfied with the information you received?' they tended to say that they were satisfied. This stands true with the doctors' and the nurses' views, despite their being proportionally less satisfied, but when the question was more specific, such as 'Do you think the information you received is detailed

enough or clear?' the patients, doctors and nurses tended to give it lower mean scores.

This trend from higher to lower mean scores, which is evident in Figures 2 and 3 would not have emerged if, during the pilot study a few more 'specific' questions were not added. The researcher could see that the patients in the pilot study were satisfied and thought that there must be something wrong with the question, so by adding the questions on clarity and detail, different responses were observed. These responses were consistent in all three sample groups.

This raises the issue of construction of questions and, in essence, the validity of the findings, and whether patients are stating their true opinions! This section of the research instrument was borrowed, as stated earlier, from a research conducted by Engstrom (1984) who also found that patients appeared to be more satisfied when asked general questions. De Castro (1972) found that patients were more satisfied when asked general questions, but when asked specific questions they were not so satisfied, so these findings are not unusual.

The question is why these researchers continued to ask this type of general questions and why not at least begin with specific questions and then move on to more general ones, as was tried by Reynolds (1978) who followed a sequence of more specific to more general questions.

In this research, the sequencing of the general questions was experimental during the pilot study. However, given the size of the pilot study, no response differences could be detected. Then, the question that the researcher asked was 'How will patients react if they are faced with

specific questions right at the beginning of the interview? Some patients might feel threatened and, if this occurred, the researcher could jeopardize the development of a rapport with a patient, which is essential for the patient's co-operation throughout the interview.

Another interesting finding was that patients in this research, despite being from different cultures and religious backgrounds, believed the same as patients in studies conducted in other parts of the world. The stereotyped behaviour of being 'a good patient' is a means of coping with depersonalizing loss of control in environments in which individuals of different power hierarchies interact together.

The research findings provided answers to the initial research questions on the general perceptions of patients, doctors and nurses about the information patients received in hospital. The patients seemed to be more satisfied than the doctors and nurses, but within this general satisfaction, the patients, doctors and nurses seemed to respond more favourably to the 'more general' questions than the 'more specific' questions.

PATIENTS' VIEWS CONCERNING THEIR HEALTH PROBLEMS

The specific questions which addressed patients' knowledge of their health problems concerned the diagnosis, causes of the illness and the prognosis. The results were still more favourable from the patients' point of view, especially concerning the diagnosis. Most patients stated that they knew what their problems were but a closer look at the patients' answers might provide a different picture, particularly that 25% of the patients did not know what their problem was. Of those who stated that they knew what was the problem, half were surgical patients who had had either an

appendicectomy or fixing of fractured bone, etc. who, by virtue of the problem itself, knew what they were suffering from. The medical patients, on the other hand, despite knowing their diagnosis, such as diabetes, hypertension or chest and heart problems, knew this by name only, as evidenced by their knowledge of the prognosis and causes of illness.

45% and 28.5% of patients knew their prognosis and causes of their illness, respectively, as opposed to 75% who knew the diagnosis. With further probing and presenting of patients' verbatim responses, their knowledge of this problem became more clear. Patients who suffered from chronic illness, such as sickle cell anaemia knew that they suffered from this and could even state the name of their disease in English, but some did not know the prognosis of their disease, as was evident by a patient who stated:

"My brother told me that there is a cure for my problem in other countries".

These patients apparently knew the name of their problem and probably knew it was hereditary or that it was a genetic disorder, yet they believed, or wanted to believe, that there was a cure somewhere in the world. This wrong impression has serious consequences on the patients' attitudes towards their problems, on how to prevent attacks and on how they should live with a chronic disease.

What good would it be to know the name of the problem when less than half of the patients knew what their prognoses were or the causes of their illnesses?

The doctors' views on the patients' knowledge of their problems were

inconsistent, with 65.5% thinking that patients knew their diagnoses, 41% thought that the patients knew their prognoses and an equal number of doctors were uncertain whether the patients did in fact know. 61% thought that patients knew the causes of their illnesses and, referring back to Figure 4, this inconsistency is apparent. The researcher wondered why the doctors would be uncertain whether or not a patient knew his prognosis and the cause of illness, when it was the responsibility of the doctors to inform patients. One of the possible explanations was that maybe the sample of doctors were mostly junior, but this was not the case as the majority were consultants and senior house officers (combined 79%). Another explanation would be that maybe the doctors knew that the patients were not receiving information on their prognoses and causes of illness, but were not able to state this frankly as 'No'. Instead, the next more reasonable, less threatening choice was 'uncertain', or it was possible that the doctors thought that someone else had informed the patients. However, in that case, their answers would have mostly been 'Yes', because the question stated 'Do you think patients are receiving information concerning...?'

The findings of this section of the research were consistent with other researchers, such as Hugh-Jones (1964), Raphael (1969) and with Engstrom (1984) who found that the majority of patients in their sample did not receive information on the diagnosis or prognosis of their illness.

THE PHYSICAL EXAMINATION

As the questions began to change into more specific types, the patients' views on information began to change also. Only 25% of the patients stated that they had received any information while being examined on admission to the ward. Following further probing, some of the patients' statements were

as follows:

"The doctor did not say anything. He examined me and then straight went to the notes to write".

"They examined me, took some blood and did not come back".

"They examined me for a quarter of an hour and then they started talking amongst themselves".

"I asked the sister what are they saying, I can't understand English".

"He explained but not enough".

These were some of the quoted statements of patients during the interviews, and it is obvious that they were not given information while being examined.

The doctors' views seem to agree with those of the patients as only 39% of the doctors thought that the patients had received information on the physical examination. 21% of the doctors were uncertain whether the patients had been informed or not and a similar explanation as that for the previous question can be offered here. Another explanation is that often patients are admitted through Accident and Emergency or out-patient clinics and in those cases, maybe the doctors were not certain whether the admitting doctor had provided explanations or not. However, in the hospital in which this study was conducted the same doctors who looked after the patients on the wards were assigned specific Accident and Emergency and out-patient days, which negates the possibility of the doctors not knowing whether the patients had received explanations on admission.

Once more, contrary to the researcher's expectations, half of the nurses

thought that the patients had received information while being examined. This is not consistent with the patients' views, nor with the doctors'. A possible explanation could be that the majority of nurses were non-Bahrainee and if the doctors were discussing matters in Arabic, which is nearly always the case, then they might have thought that the doctors were providing explanations to the patients. However, the flow and direction of communication between doctors and patients is different to that between the doctors themselves and surely the nurses would observe that the patients were not being given explanations while being examined.

In this specific question and in some other questions, the nurses tended to support the doctors' views or, at least if not, both doctors and nurses' views seemed to be more consistent, which puzzled the researcher and possible explanations are difficult to present.

TESTS AND INVESTIGATIONS

As mentioned previously, the patients underwent a variety of tests and investigations, some invasive and others non-invasive but, as is shown in Figure 6, very few patients, compared to doctors and nurses, said they had received information. The specific questions were on whether patients were informed about the reason for the tests, how the tests were going to be performed and whether they had been informed about the results. The interesting findings, while probing for further explanations, were that from those few patients who stated they knew the results of their tests, their comments were:

"Yes, I know the results, the doctor said it's O.K."

The patients were satisfied by the general reassurance which to them meant that the whole result was informed, even with investigations such as gastroscopy, where the doctors could offer explanations of their visual findings.

Presenting an example of the patients' verbatim responses in relation to the explanations offered to patients before the tests, a patient stated:

"They put down the scope without any explanation".

It was interesting to hear patients' statements, particularly when they referred to the health care personnel in plural terms, 'they' rather than 'he' or 'she'. The researcher thinks that when patients are not cared for as individuals who know specifically their doctors' or nurses' names, and who cannot during an investigation distinguish their doctors from people in white, then it becomes natural to refer to the health care team as 'they'.

The results again supported the fact that doctors and nurses thought that the patients received adequate information about the tests and investigations. However, the nurses agreed less with the doctors on the results of tests. The doctors believed that the patients received information on the results of tests more so than the nurses and an explanation of this difference is that patients often asked the nurses if the results of their tests were ready or not. This constant enquiring could have led the nurses to think that some patients were not receiving information on the results of their tests.

There was a large discrepancy between what patients thought and what doctors and nurses thought in relation to why and how the tests were going

to be performed. Concerning how the tests would be performed, the researcher, during the course of one interview with a patient who seemed satisfied with the information he had received concerning the colonoscopy which had been performed four days before, asked what specific explanation he had received. The patient replied:

"The doctor told me just before the test that I needed to have some sort of spray in my mouth".

He continued to say:

"I think it was some form of anaesthesia to make me sleep."

It was this latter information that puzzled the researcher, because an anaesthetic spray is done for investigations such as bronchoscopy or gastroscopy. The researcher later found from the sister in charge that the patient had had a gastroscopy and not a colonoscopy. This particular patient was posted for discharge at the time of interview with a diagnosis of duodenal ulcer but the patient thought he had a lower intestinal ulcer. This vast discrepancy between what the doctors and nurses knew and what the patient knew has serious implications on how a patient takes care of his health. In this case, for example, adjusting dietary intake would be very important. These findings are again not uncommon, Reynolds (1978), Hawkins (1979) and Engstrom (1984) found that patients were not given adequate explanations concerning tests, investigations and results. The nurses in SMC hospital are provided with clear guidelines for informing patients who require tests and investigations, yet patients in this sample did not receive information. It is obvious that the nurses failed to implement this important aspect of nursing care.

THE MEDICATIONS

A very small percentage of patients (18%) knew the names of their drugs and a little over half the patients knew the reasons for taking the drugs. Very few patients (4%) had received any information concerning the side effects of their drugs.

Overall, the doctors' and nurses' views tended to agree with those of the patients. Comments made by patients were interesting and consistent with the findings, especially on the reasons for taking medication, for example:

"I take four and a half tablets, one for the stomach one for my heart and the injection is for my diabetes".

"The big tablets are for my asthma, the small white ones which make my face puffy are for my chest problems".

The researcher later found that the 'big' tablets were aminophyllin and the small white ones were prednisolone. The patient was correct in knowing the reasons for taking his tablets but this is expected from patients who suffer from chronic conditions. These patients know their tablets very well, not by name but by shape, colour and size.

It was interesting to find that some of the younger patients were knowledgeable about the names of their medications. They were keen to learn the names of their drugs. For example, during an interview a patient took out a notebook and said:

"You see, I asked the nurse about the names of my injections. I wrote them in English. I am on NPH and actropid".

On the other hand, quite a few patients made critical comments about their medications. For example:

"I saw a different capsule among my tablets but I was not told what it is for".

"I was on three tablets but today suddenly they gave me seven. I don't know why..."

Another serious issue which was discovered about the medication was the fact that only 4% of patients were given information on the side effects of drugs, such as anti TB drugs or heparin, which tend to have obnoxious side effects. Anti TB drugs can make patients very sick, causing severe vomiting and some may cause problems in the liver or kidneys. Heparin, on the other hand, causes bleeding from the gums or other parts of the body and patients need to be adequately informed of the side effects, as many patients fail to comply.

Deviations from prescribed drugs and their consequences are supported by Parkin (1976), Mazzullo (1974), George et al (1983), Aljabbar (1993), Boyd (1974)

THE OPERATION

As this research addressed surgical patients, it was important to ask questions on their operations. The specific questions were mainly on the type of operation, the reasons for and the results of, and the patients' consent forms. 66% of the patients stated that they had received information on this type of question but, with further probing, patients

had difficulty in describing their operations. A patient who was brought to hospital following a road traffic accident was interviewed on the 20th day and stated:

"The doctor opened my abdomen and stopped the bleeding sites."

This patient had sustained massive lacerations of his spleen and needed a splenectomy and stitching of part of his lower intestine. This information was gathered from the sister in charge after the interview. It is clear that this patient, who had been posted for discharge would go home not knowing that his spleen was out. Moreover, he developed, as a post-operative complication, a right lower lobe collapse of the lung which he also had not been told about.

72% of the patients were satisfied with the information they had received concerning the reasons for surgery. Statements such as:

"The doctor said it is better if I had the surgery", or:

"The pain will only go away if I did the operation".

The researcher interpreted the high percentage of patients who were informed of the reasons for surgery as the amount of persuasion with which doctors tried to convince patients that surgery should be undergone. Patients are often reluctant when first informed that they need surgery. Only 38% of patients were told. Patients quoted statements such as :

"The doctor told me it's O.K. or:

"The operation was successful".

Again, very general statements.

In relation to the consent forms, 96% of the patients signed themselves for their surgery. Even the youngest patient in this sample, who was 16, signed herself, which is uncommon as parents usually sign for their children's operations. None of the patients were instructed to read the form and when the patients were asked why they did not read it, they said:

"The doctors were in a hurry",

or

"They did not ask me to read it".

The researcher must, however, acknowledge a drawback in the phrasing of the question concerning the consent form. Instead of the question asking whether patients had received any information concerning this form, they were merely asked if they had signed a consent form which, as it turned out, all patients had signed, and this explained the positive responses.

The doctors and nurses once again had consistently higher scores, which meant that they thought the patients were informed. 93% of doctors and 88% of nurses said that the patients had received information on the type of operation, 93% of doctors and 88% of nurses thought that patients had been informed of the reason for the operation and more than half of the doctors and nurses thought that patients were told about the results of their operation. 71% of doctors and 92% of nurses thought that patients had received information concerning the consent form.

The discrepancy between the doctors' views and those of the patients could only be because the doctors honestly believed that they had provided the information, but what they failed to realize was that general reassurances did not satisfy patients, who required more precise information. For a few patients only the doctor explained about the operation by actually drawing the site on paper and providing more detailed information.

From these results, it appeared that patients seemed fairly satisfied with the information they had received concerning the type and reasons for their operation, but they were not satisfied with the information concerning the results of their operation. Dunkelman (1979) found very similar results but no interpretations were offered.

PRE AND POST OPERATIVE INFORMATION

The specific questions on pre and post operative information concerned the need for fasting, shaving, pre medication, post operative stitches, drainage bottles, pain, and nausea and vomiting. The number of patients who stated that they had received information on the above was varied. 89% of the patients who underwent surgery (N = 29) received information on the need to fast, 57% on shaving, 33% on stitches, 20% on pre medication, 18% on drainage bottles, 11% on post-operative pain and 11% on the possibility of developing nausea and vomiting.

It was necessary to find out how much information the patients received and whether or not any of the pre and post operative procedures were described. In relation to shaving, some examples of patients' statements are quoted as follows:

"I was told I need a shave at the same time when the nurse brought the trolley".

"The nurses took me without explanation to the treatment room".

"A nurse took me the first time and then another nurse shaved me again the following day".

Despite the fact that half of the patients stated that they had received information on shaving, it seemed that the information was given on the spot. None of the patients stated that they were informed about the reason for shaving. One patient was shaved twice. It seemed that the first nurse did not do a good job so the patient needed to be shaved again, without offering apologies for disturbing the patient twice.

Most patients (89%) stated that they had received information on fasting. The nurses had instructed them not to eat or drink after 10.00 p.m. on the evening before surgery. It appeared that patients were given precise, clear information about fasting and the one possible explanation is the negative consequences which would result from nurses failing to give such clear precise instructions. The operation could be cancelled and the nurses could be reprimanded or even suspended.

Concerning the stitches, 33% of the patients stated they had been informed but again a close look into what they were told was necessary to find out how much they had been told. A patient who suffered from cancer of the oesophagus stated:

"I thought the incision was going to be small and in the centre of my abdomen but it turned out to be a very long one starting from my chest all the way to

my abdomen".

Another patient, who underwent surgery to his stomach by means of holes through the abdominal wall, said:

"I thought I will have two openings but I saw five plaster sites after the surgery".

One lady said:

"I did not anticipate this big incision. I thought it will only be on the right side".

This patient required an incision right across the abdomen to remove a hepatic cyst. It is clear that these patients were informed but they were not informed precisely. The consequences could be serious. The patient who suffered from cancer of the oesophagus was not informed of his condition and the large incision might have added to his suspicions. The lady with the incision across her abdomen might have worried about the deformity which would result later.

A serious remark was made by a patient who had an incision on the lower back to remove a pilonidal abscess. This young patient, who apparently was not informed of the size or shape of the wound, stood on a chair and tried to see his wound in the bathroom mirror. This patient could have sustained a fall, with serious results.

Information concerning pre and post operative medication was only received by 20% of the patients who needed surgery. The procedure which was followed at the SMC is that once the ward was notified by a telephone call to send the patient to theatre, two nurses took the pre-medications, which were

usually two separate injections, one atropin and another either pethedin or morphine, to the patient who was ready to go to theatre. The patient was given the injections and sent from the ward. Patients who underwent surgery for the first time did not expect the injections. One said:

"No one told me, I said what is this?".

The 20% of patients who received information apparently received it on the spot, not knowing what the medication was and why they had received the injections. An unanticipated injection at a time when patients are anxious about impending surgery will add to the patients' distress and will reflect inhumane attitudes of staff. This was also observed from the comments made by patients about the post operative need for tubes, drainage bottles or the expected pain and vomiting. These comments were quoted as:

"I came back from surgery to find a tube in my nose, no one told me".

"Fifteen days after the surgery the pains got relieved".

"I vomited four times after the surgery".

"No one told me about the vomiting. I ate my meal and vomited".

It is apparent that patients need to anticipate what is expected after surgery. Dennis' (1990) study supports the above need.

The doctors and nurses were asked if the patients received information on what to expect prior and after surgery. 36% of doctors and 36% of nurses thought patients had received information so, in a sense, the doctors and

nurses did acknowledge the fact that very few patients were adequately informed. Their opinion here reflects the nature of this specific question, which was a general one.

THE WARD ROUTINES AND FACILITIES

The discrepancies observed in Figure 10 between the patients' and nurses' views on the information received concerning ward routines and facilities were vast. On the one hand, the patients stated that they had received the most information on how and when to operate the call bell and on the overhead signs such as 'bed rest' or the 'NPO' signs, and on the other hand, the nurses thought the patients had received information concerning everything about the ward routines and facilities.

On examining the patients' responses, the researcher could see that, to begin with, the patients did not appear to be concerned about this information. Comments such as:

"I know these things."

or

"I don't need anyone to tell me, I know the visiting hours".

The researcher had to ask the patients to recall whether or not this information was given to them on admission. An interpretation of some patients' lack of interest in this question could be that they were more worried about their diagnosis or prognosis than knowing the smoking rules of the hospital or the visiting hours. In this research, the patients were overall not satisfied with the information given concerning their direct

health problems so it is understandable that they were not so worried that information concerning routines and facilities was not provided.

On the other hand, in trying to provide an interpretation of the nurses' responses, the researcher found difficulty in explaining the high scores. The researcher's expectations were that the nurses would provide lower scores also, because if patients did not appear to be interested or did not demand this information, the nurses might feel that they need not give it. However, an opposite result was observed and the nurses thought that patients had been given the information.

It is possible that, like many direct, specific questions, the nurses felt threatened by the questions. It would perhaps have been wiser if the question on ward routines and facilities had been presented as a general question such as the one given on pre and post operative care.

It was observed in the SMC that instructions concerning the use of the call bell were reinforced by senior nursing officers who visited the wards regularly for the daily ward rounds. It is therefore possible that emphasis was put on giving instructions concerning the call bell.

Despite the fact that the patients did not seem to be concerned about this information, some did make important comments which could not be ignored. For example, concerning the meals, some patients stated:

"I was not able to eat for two days, then they changed the food".

"You see, I like vegetarian food, but no one asked me".

"When I got thirsty, I went to search for the water cooler".

Another patient who had had surgery on his lower back said:

"I asked my wife to bring the children and I went down to see them".

This patient apparently did not know about the rules for children's visiting, nor was he informed. Another interesting remark made by a patient was that they were awakened very early in the morning, at 5.00 or 6.00 a.m. to check their vital signs. Only 5% of the patients stated that they had been informed of the times for checking their vital signs.

On looking at the rules and regulations of the SMC, it was clearly stated that any patient who wished to bring in his own radio or television must have the appliance checked for safety reasons. The questions concerning radio and TV were asked only of those patients who had one near the bed at the time of interview. The following remarks were noted:

"Two days after we connected the TV, some one came to check it".

"I tried to fix the plug but it would not go in".

The patients' ignorance of the dangers surrounding them should be anticipated by nurses and adequate prior instruction should be given. In a hospital where the oxygen supply is centralized and walled, any leak near a patient who smokes could have fatal consequences. The researcher found that the remarks made by patients proved that information concerning ward routines and facilities was very important and should not be ignored by the

nurses.

So far, all the findings which were discussed have addressed the original research questions on how patients, doctors and nurses viewed the information patients received concerning their health problems, their physical examination, tests and investigations, medication, operation and ward routines and facilities. The results showed that initially the patients seemed to be satisfied about the information they received but when they were asked specific questions, they were found not to be satisfied.

The doctors and nurses, on the other hand, thought that patients had received information on almost all the above mentioned aspects, although on the initial general perception questions, the doctors and nurses were found to be less satisfied than patients about the information given.

WHO PROVIDES THE INFORMATION?

Another question to which this research intended to find an answer was on who provided information to patients. 25% of the patients stated that they had received information from the consultants, 32% from the doctors, 13% from the sister in charge and 21% from the staff nurses. 34% of the patients stated that they had received no information from any source. A common criticism which was raised constantly was that patients get answers to their enquiries only when they ask. This comment was made by patients in Reynolds' (1978) study. The remarks made by these patients especially related to when they were asked whether or not they had received information from the consultants:

"He comes little bit and goes".

"The doctor did not talk at all with me"

"He did not come much".

"I would not recognize him even if I see him".

"In two weeks I saw him only once".

"He explains to the people who accompany him but not to me".

Another finding was that the majority of patients (95%) thought they had received information from only one source, either from the doctors, the nurses or other patients, while the doctors and nurses thought they had

received information from more than one source. This probably explains why many doctors, and indeed nurses, were uncertain about whether patients had received information concerning the different aspects of care, because they thought that some one else was giving the information. Some remarks made by the doctors and nurses were:

"Patients receive information from many sources, it depends really on the information, if it's concerning the patient's diagnosis or treatment then the doctors provide the information".

This was observed in Figure 11. 76% of doctors thought that the consultants gave the information, 55% the doctors, 31% the sisters and 17% thought that nurses gave the information. However, the nurses' views were somewhat different. They thought that the patients had received most of their information from the nurses (83%) and then from the doctors and the sisters in charge.

The patients' views were consistent with the previous findings, which clearly showed that patients were not satisfied on the whole with the information they had received concerning the different aspects of their hospitalization.

Engstrom (1984) found similar results in her study on information concerning patients' diagnoses, prognoses, investigations, results and medication given by doctors, while information on examinations, departmental facilities and equipment were given by nurses.

In this study, patients were not required to state who gave what information, rather a general question was asked of patients on who they thought had provided them with most of the information.

A common belief is held amongst health professionals that patients are usually pressured and influenced by the views of other patients and their relatives. In this research, however, this was not observed. Figure 12 clearly showed that less patients than doctors and nurses stated they had received information from their relatives or other patients.

The researcher believes that the consequence of these results is that if the doctors and nurses operated on a false belief that patients are receiving information from different sources, then they would not take responsibility for informing the patients, which leaves the patients uninformed.

DISCHARGE ADVICE

Towards the end of the interview, the patients were asked an open-ended question on what information they had received concerning discharge advice. Content analysis of patients' statements revealed that 62% stated they had received no advice and 38% had received some advice. Of those patients who had not received any discharge advice, some said:

"Not yet, maybe they will before I leave the ward".

This meant that patients knew the hospital policy which in this case meant that the nurses provided the patients with their medication, follow-up dates and sick leave forms just before leaving the ward. However this policy was not known by all the patients, as was evident by the remarks made by one patient:

"I am a bit worried, it's our exam, I missed it, I don't know whether the doctor wrote for me a sick leave form to give to the school."

Obviously, for a younger patient who had missed her examinations and who was worried whether the doctor had provided her with the necessary forms, instructions on medication or other important 'last minute' advice might not be fully and adequately understood.

On the other hand, it was interesting to see that those who had been given information did remember it explicitly and were able to recall the exact words that they were told. One patient expressed her gratitude to the dietitian, who had explained very well about which food patients should eat and which they should avoid. The dietitian also gave the patient written instructions.

Patients were able to recall the words of advice given to them, even when such advice was general and vague, such as:

"Do not walk too much on your leg"

"The doctor told me to stop fatty food".

The researcher must acknowledge the fact that the phrasing of the question could have biased the patients' responses. The question covered a range of necessary discharge information which not all patients necessarily needed. For example, patients who came for surgery might not require medication and therefore their responses would be negative. This also applied to the information concerning food. Not all minor surgical patients needed information concerning their food. According to Oppenheim (1992) this error

in the construction of a question is referred to as a double-barrelled question, the respondents are left in a 'quandary' if they want to say 'yes' to one part of the question but 'no' to another.

Another drawback in this question was its timing. It would best have been asked after discharge when the patients were at home, to allow them to recall what information was given as they left the ward, but this might then pose other difficulties, such as lack of interest and participation.

The doctors' and nurses' views again were very different from those of the patients. 72% of the doctors and 79% of the nurses thought the patients had received discharge advice concerning how to take care of their health, rest, sick leave and follow-up appointments. The researcher interprets the nurses' views to be possibly true as many patients had not been given the information at the time of interview but might have been given this before leaving the ward, which places a question mark on when is the best time to offer advice to patients.

PATIENTS' NEED FOR MORE INFORMATION

86% of the patients wanted more information, while 14% of patients stated that they did not need any more information. From those who needed more information, half of their remarks concerned their diagnosis, prognosis and causes of illness, which meant that these were the major areas in which information was needed. Examples of statements concerning the diagnosis were:

"I need to know what is my problem"

"What do I exactly suffer from?"

or

"Where did I bleed from?"

A sample of the patients' statements which were under the category of 'prognosis' were:

"I need to know was the operation successful or not"

"Will my problem last or go away?"

"Will my problem get completely cured"

Concerning the need to obtain information regarding the causes of their illness, patients asked:

"Why is my liver inflamed?"

"How did I get this illness?"

"My hand hurts - I want to know why".

The other half of the statements concerned the patients' health related enquiries and health maintenance and health promotion. For example, the patients wished to enquire about the results of their investigations, when they would be allowed to go home, who would change the dressings and whether they would have to go back to the hospital or visit the clinic nearer to their homes, how long it would take for their wounds to heal, when would the stitches be out and whether they would have to go on

injections for life.

Finally, examples of statements concerning health maintenance and promotion included questions such as the kind of life programme they should follow, how to cope with the illness, how to avoid getting the attacks, the type of food to eat and to avoid, and whether stress would affect them. These very reasonable, intelligent patient needs were far from being the needs of patients who lacked understanding or who were labelled by the doctors and nurses in this study as being 'uneducated'.

The significant finding in this section was that patients needed information on the diagnosis and prognosis of their illness, yet their need for the diagnosis, did not correlate with an earlier question in which patients were simply asked 'Do you know what is your problem?' and the majority said 'yes' (75%). The explanation the researcher finds for this discrepancy is that the patients knew what their problems were, for instance diabetes mellitus, hypertension or sickle cell anaemia, but they did not know what these illnesses really meant and they wanted to know more than just the name of their illnesses.

The patients' needs on the prognosis of their illness correlated with the earlier direct question which asked: 'Do you know if your problem will get worse or go away?' More than half of the patients did not know this and therefore they answered 'No' (55%) and it became evident in this section also that many patients did not know the prognosis of their illness.

The results of this question and the previous one answer the research question and show that the patients had many enquiries related to their illness or operation but they were not asked by the doctors or nurses. The

patients themselves did not ask, or perhaps many did, but in any case most of the patients ended up going home with all these unanswered questions on their minds. It is also evident from the results of this section that patients were rarely given instructions or advice on how to maintain or promote their health once they were out of hospital.

THE DOCTORS' AND NURSES' REASONS FOR NOT INFORMING PATIENTS

To gain further insight into the doctors' and nurses' attitudes towards the problem, two open-ended questions were asked. These questions were worded in general terms and the first asked the doctors and nurses to indicate any reasons for not informing patients. As explained earlier, the questions were analysed by the method of content analysis. Some interesting themes emerged, consisting of patient related reasons, patients' family related reasons, doctors related reasons, nurses related reasons and administrative related reasons.

Most of the reasons stated by the doctors and nurses fell under the patient related theme and a list of all these reasons is provided in Appendices vi and vii. Examples of these reasons were:

"The physical status of the patient, i.e. very ill or confused".

"Malignant, incurable illness"

"Low level of education, lack of understanding"

Language barrier"

"Unresponsiveness of patients or patients' passivity".

These constitute the majority of reasons, which show that the doctors and

nurses in this sample blamed the inadequacy of giving information on the patients. In other words, it was because of the patients that the doctors and nurses were unable to provide information. When the researcher closely examined the reasons given a different interpretation emerged.

Most of the doctors and nurses referred to the general physical and psychological status of the patients as reasons for not informing them. Statements such as 'confused' 'unconscious' or 'comatose' were made. It is logic and common sense that doctors would not inform patients in these states so why were these reasons given in the first place? The explanation that the researcher can offer is that these were faulty reasons which acted as a form of defensive attitude for the inadequacy which the doctors and nurses felt for not informing patients.

Another reason which was given was the inadequate level of education and understanding of the patients. Looking back at Figure 1, it can be seen that the patients' level of education was adequate, only 10% being illiterate. One would assume then that these reasons referred to the older patients who may have been uneducated in the formal sense, but then again, the elderly patients had their life experience and are individuals who have the right to receive information. A little over 50% of the patients were either high school or university graduates. This old, out-dated reason was given in the past by doctors and still is given today. It is again a faulty assumption which doctors and nurses act upon and need to be made aware of.

Another reason given by the doctors only was 'family related'. Examples of their statements were:

"The family's wish not to tell

"Relatives' interference".

In Bahrain, the families play an important role in the patients' lives. It could be true that relatives, interfere, refuse and even argue with doctors but the question is, if patients and relatives are well informed, why would the relatives need to interfere, argue or refuse?

Some reasons reflected 'good patients' and 'bad patients' and were mentioned for both the patients and their families. Statements such as 'refusal' and unresponsiveness' or 'patients do not question' clearly represent good and bad patients, which authors such as Taylor (1979) suggested to be means for coping, and that actually these patients and their relatives are expressing in their own ways some form of depression or anger.

The doctors related reasons constituted a smaller proportion of the overall reasons. These were:

"Doctors' habit not to tell"

"Too busy, lack of time".

"Lack of human respect"

"Inadequate knowledge or experience"

"Inadequate communication skills"

Some of the nurses related reasons were:

"Lack of initiative"

"Language barrier"

"Nurses' fear of problems".

Although similar doctors and nurses related reasons could be observed, it was the different reasons which interested the researcher. While doctors took the blame themselves, the nurses seemed to demonstrate some form of helplessness and lack of control. On looking back at the sample of nurses, the majority were foreign nurses, mainly from Asian countries and these nurses might have feared losing their jobs if they interfered or provided information. If the researcher's assumptions are correct, then the situation is a very unhealthy one. In the centre of the 'doctors - nurses game' the patients are the most affected, (Porter, 1991).

On looking at some of the nurses' statements in relation to the doctors related reasons, one could say more certainly that the nurses experienced helplessness. These statements included:

"Doctors do not want nurses to give information"

"Doctors should only explain".

The other group of reasons given by doctors and nurses was under the theme of administrative related reasons and again more nurses than doctors put the blame on the administration. Reasons such as:

"Less nurses per ward"

"Work overload"

"Absence of mandatory rules"

"Talking/explaining are not given importance".

Referring back to the reasons given by the nurses as opposed to those given

by doctors, the nurses tended to say that the administration did not allow the nurses to inform patients, which again reinforces the assumption of the nurses' lack of control and feelings of helplessness.

In summary, the initial research question was answered by both doctors and nurses and both provided many reasons for not informing patients which, in essence, reflected their acknowledgement of an existing problem. Both doctors and nurses put most of the blame for the lack of giving information on the patients. The researcher's assumption is that the doctors and nurses operate on some faulty assumptions, such as the patients' lack of education and understanding and lack of interest, which were clearly unsubstantiated by the results of the patients' intelligent statements on their need for more information.

The nurses, doctors and administrative related reasons reflected the nurses' lack of power, which should be addressed more extensively if the health care team wishes to improve the procedure of information giving.

DOCTORS' AND NURSES' VIEWS ON HOW TO IMPROVE INFORMATION GIVING

The last research question was on how the doctors and nurses perceived the practice of information giving being improved, and in other words, how they saw the problem being solved. Again, almost all the doctors and nurses provided interesting answers to this question, which reflected their interest in trying to improve the practice of information giving. However, this time a different picture emerged.

Although analysis of doctors' and nurses' question was performed separately, the discussion will be focussed on both doctors' and nurses'

views because very little differences were observed.

Their suggestions were grouped under four themes and these themes included suggestions to the patients, the doctors, the nurses and finally suggestions to the administration.

Most of the suggestions provided by the doctors and nurses were addressed to themselves. This sudden change between the results of the previous question, in which the doctors and nurses thought the reasons for not informing patients were mainly because of the patients, and the results of this question in which the doctors and nurses suggested changed in themselves was very inconsistent and distant from the researcher's expectations.

The suggestions were further analysed. These were either to improve doctors and nurses' knowledge, and attitudes, or simply some practical suggestions. Some examples were:

"Improve awareness and training"

"Improve doctor/nurses' knowledge of the subject matter"

"Use simple, informative way"

"Provide information a step at a time, use simple words"

"Spend more time with the patients".

Some of the suggestions given by the nurses were:

"Nurses should develop initiative and become more assertive".

It seems as if some nurses realized the lack of control and the power

differences between nurses and doctors and wished to see this situation change.

The suggestions given to the administration were mainly to improve patients' knowledge by providing leaflets, films, posters on hospital routines and layout, especially for non-Arabic speaking patients, improving doctors and nurse shortages, establishing joint doctors/nurses teams for the provision of information, and improving the in-service training of nurses and doctors in communication skills.

The suggestions given to patients by the doctors were that the patients' level of education should be improved and by the nurses that patients should co-operate better. Many of the suggestions given were too general and did not state how they could be specifically implemented, but nevertheless, these suggestions were mostly addressed to the doctors and nurses. This finding correlates with the initial results of the doctors and nurses' general perceptions about the information given, in which both doctors and nurses expressed their dissatisfaction with the adequacy of information given to patients.

The interpretation of the results of this question was that doctors and nurses did accept blame but were not able to come out and say this when faced with a direct question, i.e. 'What are the reasons for...?' When they were given a somewhat indirect question, they took the blame and presented numerous suggestions addressed to doctors and nurses to improve the situation. This again referred to the phrasing of questions, specific versus general, direct versus indirect, and the responses these types of question could elicit.

Finally, the above interpretations provided answers to the last question in this research, and, as it was presented, the doctors and nurses thought that the best way to improve the practice of information giving lay within themselves. They felt they should improve their knowledge about interpersonal communication skills and knowledge of patients' problems, improve their attitudes, and treat the patients as active members in their own care. Suggestions were also addressed to the medical and nursing administration.

CHAPTER SIX

LIMITATIONS OF THE STUDY

The limitations of this study began to surface right from the initial stages of data collection and to the later stages of the analysis of findings. The limitations will be presented in relation to the research methodology, the research instrument, the sample and the validity and reliability of this research.

Although the researcher resorted to the interview method and the use of questionnaires, which are considered to be some of the common methods used in research, the researcher believes that there are better methods to study the problem. One such is the observation method, either as complete participant or complete observer. The advantages would be that the researcher would get to see the real situation and the data collected could be either independent from the respondents' answers or used to strengthen the findings of the patients' interviews.

Refining of the instruments was needed to delete questions which provided trivial information, and some of the questions on ward routines and facilities, could have been cut down. For example, the question on the timing of nurses' and doctors' rounds was difficult for the patients to recall. The patients' interview guide could be criticized for failing to add the same open-ended questions on the reasons for not informing and how information-giving could be improved, which were given to the doctors and nurse. It would have been interesting to see the the patients' views as well.

The use of a non probability convenience sample imposed great restrictions

on the findings which, in this case could only apply to patients, doctors and nurses who participated in this study.

The study used descriptive statistics by calculating frequency distributions and means. This was felt to be suitable for the type of nominal and ordinal data used in this study. However, Hicks (1990) stated that for any particular research design there is a choice of a parametric or non-parametric test from which to select. The researcher acknowledges the fact that from the choice of a non-parametric test, such as the chi-square, none was used.

Finally, the researcher acknowledges the fact that she did not use better strategies of validity and reliability to test the research instruments and the findings.

CONCLUSION

A great deal of evidence exists on the fact that patients generally wish to know as much as possible about their condition and that, on the whole, informed patients exhibit more satisfaction and better recovery. Unfortunately, patients in Bahrain, like patients in other countries, face the chronic problem of lack of information. The complex hospital environment, with lack of control and the 'power differences' of the health care team play an important factor in perpetuating such a problem.

The findings of this study revealed the fact that the patients' sample did not receive adequate information concerning their health problem, the physical examination, the investigations, medication, operation and the ward routines and facilities. The patients' need for more information

They also desired more information on how to maintain and promote their health status. Although the findings can only be applied to this research sample, the researcher believes that other patients may have the same experience.

The research intended to acquire a broader picture of the problem, and the views of a sample of doctors and nurses were studied. It seems that the doctors and nurses were satisfied with their practice of information giving. However, they too acknowledged the existence of a problem and provided some useful suggestions to solving the lack of information.

RECOMMENDATIONS

As the sample in this research was a non-probability (convenience) sample, the results cannot be generalized on wider populations of hospital patients. Therefore there is a need for further studies using a probability sampling method on a larger scale. Furthermore, there is a need to conduct research resorting to different methodologies or a combination of methodologies, such as interviews and observation.

This study revealed in general terms the perceptions of groups of patients, doctors and nurses about the practice of information-giving and although it identified that a problem existed, it did not disclose other aspects of the problem, such as the quality of information patients received during ward rounds, what and how much information patients received on admission, what information was given by nurses and how the nurses conducted their rounds, how much information the patients received in other departments of the hospital such as the Accident and Emergency and outpatients clinics and whether such information was different from that given to in-patients. The

problem of lack of information is complex and requires more than one study to draw a more objective picture of the problem.

INCREASING PATIENTS' AWARENESS

It may sound strange to recommend or suggest strategies to change patients' attitudes but, as patients were the primary focus of this preliminary research they cannot be excluded from the suggestions addressed to the rest of the health care team members. In fact excluding patients is the major cause of the problem.

Health care officials can find the means to increase patients' awareness of their rights. This can be done by conducting surveys to assess public opinion on how they perceive the issue of information giving. Do people want to know? Is the assumption that Bahraini patients do not want to be told about their health problems correct? The results of such surveys could be used as a base for initiating policies on the provision of information.

Restoring patients' control over their environment while in hospital not only improves their physical and psychological wellbeing, but could also encourage patients to demand their right to receive information. Patients are often grouped and labelled as 'co-operative' or 'unco-operative' or 'good' and 'bad'. This is reinforced by hospital staff for the smooth running of ward routines and regulations.

Patients should be given control over the aspects of care which they can assume alone. Implementing strategies for self help for chronic hospital patients who are alert and ambulatory, such as making beds or getting their own meals, or even taking their own medicines, could restore the patients'

control. Patients could also be encouraged to participate in those activities which they cannot manage alone, for example the pouring of solution into the gallipots while the nurse does the dressing. Initiating and encouraging such an environment could help patients seek more information whenever the need arises.

RECOMMENDATIONS TO THE NURSES

Being ill in hospital causes anxiety and stress in most patients. They go through some events which are particularly stressful and the nurses can play an important role in alleviating stress. For example, some patients find admission to hospital more stressful than anything else, especially if it is their first admission and nurses must provide clear information on the facilities, the ward layout, the usual events, meal times, and the names of the nurses and try to introduce new patients to the other patients. This information requires that nurses and patients understand each other through a common language which will help the patients to feel more at ease and able to ask for further information.

As it stands in the SMC, there are written guidelines for nurses to convey to patients on specific information concerning the investigations but what the nursing administration fails to realise is that the majority of nurses are non-Arabic speaking or their Arabic vocabulary is restricted. The instructions provided in the procedure guidelines require fluency in the language. There is a need for translation of these guidelines into the Arabic language in the form of leaflets to be given to patients as and when they require investigations. On the other hand, nurses need to take Arabic classes in order to improve their language skills.

Bahrainee nurses constituted nearly one third of the nurses sample in this study and, despite the fact that they did have the necessary language, they needed to improve their communication and interpersonal skills and this should be incorporated in the nurse training curriculum.

The nurses' submissiveness could be improved by providing assertive training sessions which could be organized by the department of the in-service training. It must be said that the nurses at the SMC are mostly non-Bahrainees who might fear for their jobs and security. Their consistent approval of the doctors' views and their satisfaction with the way in which patients were given information could be an evidence of their submissiveness.

RECOMMENDATIONS TO THE DOCTORS

Authors such as Ley (1988) have shown that doctors can improve patients' recall and understanding of what they are told. Some suggestions he made to the doctors include:

1. Patients tend to remember the first statement made better than later ones.
2. Patients remember things said in simple language
3. Using the method of 'explicit categorization', that is telling the patient the sort of information the doctors are going to give before they actually give it. For example "First, I will tell you about your operation, then about the possible risks involved..."

"Now your operation is..."

4. Repetition and putting emphasis on an important piece of information can improve recall.

5. Provision of specific advice can be better remembered than general advice, such as, for example, "You must walk up and down the corridor for 10 - 15 minutes twice every day with the help of a walker", rather than "Don't walk too much on your leg for four weeks!".

6. Requesting patients to repeat what has been said to them is another means for improving recall and understanding.

However, the above advice requires that doctors attend training sessions which would offer adequate time for practising specific skills. As mentioned in this study, doctors need to be more sensitive to patients' needs, spend more time with them and encourage patients to ask questions. Doctors also need to assess individual patients' degree of receptiveness to information and avoid generalizing that all patients will be affected by the harmful effects of being told. Authors, such as Faden et al (1981) proved that patients want detailed disclosure and this provides beneficial rather than harmful effects.

RECOMMENDATIONS TO THE ADMINISTRATION

Both the medical and nursing administration should study the possibility of

establishing a 'health care team' which could mainly consist of medical and nursing staff and other paramedical members, such as dietitians and physiotherapists, for providing information to patients. This recommendation could be strengthened by the introduction of information sheets, in which patients' enquiries and the information given could be recorded and maintained.

This joint effort could, in the long run, prove to yield more patient satisfaction, compliance and even faster recovery. It could also solve the chronic problem of 'lack of time' about which doctors complain. The need for other health care members to provide information was, after all, one of the doctors' suggestions in this research.

The second recommendation was to reinforce the rules and regulations concerning the practice of information giving. The nurses and doctors in this research suggested the introduction of mandatory rules concerning the information given to patients.

Finally, the administration could provide the means for producing pamphlets or instruction booklets on a variety of aspects of patient care

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APPENDIX 1

Our Ref: BA-M/HCO'D

Birgitta Engstorm,
Department of Neurology,
University of Umea,
S-901 85 Umea,
Sweden.

17th February 1993

Dear Ms. Engstorm,

I have read your research article on 'The patients' need for information during hospital stay'. I am impressed by the rigor of your study and wish to undertake similar research. My study will be slightly modified, but for the patient's interview guide, I was wondering if you would be willing to let me use part of your interview questions, especially the ones on patient's subjective views in regard to need for, understanding of, and the adequacy of information they receive in the hospital.

Please let me know if this is acceptable to you, I will of course acknowledge the source and send you a copy of my research results when I finish the study.

I thank you very much for your co-operation in advance and look forward to hearing from you.

Yours sincerely,



Batool Al-Muhandis

Batool Al-Muhandis
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School of Nursing Studies
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1th March 1993

Dear Mr. Al-Muhandis,

Thank you for your kind letter. I am very glad that you are interested in my interview questions. I look forward to read your research when you have finished the study.

Good luck with your work!

Yours sincerely,

Birgitta Engström

Birgitta Engström, R.N., Ph. D (med),
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APPENDIX iii

SALMANIYA MEDICAL CENTER
OFFICE OF THE CHIEF OF MEDICAL STAFF

SMC/MH/ev/ 20th /93

February 8, 1993

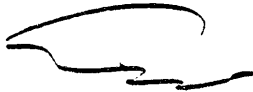
Mrs. Khadija Al Goud
Principal Nursing Officer
Salmaniya Medical Center.

Dear Mrs. Goud,

This is in reference to your letter dated 6.2.93 regarding Mrs. Al Muhandis request for conducting a study at SMC. The Chief of Medical Staff does not have any objection for it, please inform her accordingly.

Thank you.

Yours sincerely,



M.K. Al-Haddad, FRC Psych.
Chief of Medical Staff
Salmaniya Medical Center.

INSTRUCTIONS FOR THE INTERVIEWERS

1. First make certain with the sister in charge in the wards assigned to you, that the patient fits the criteria, i.e.
 - Fully conscious
 - Able to communicate fully either in Arabic or English
 - Not in pain or distress
 - Being discharged
 - Or stayed in the hospital for a week or more.
2. Go to the patient with the sister or the nurse, allow them to introduce you to the patient.
3. Do a quick assessment, see if patient is awake, seems to be alright and not in any form of distress.
4. Take permission from the patient to screen the bed, sit down and introduce self and the study.
5. Make sure patient agrees or disagrees to participate. If disagrees - leave and go to the second discharged patient.
6. If patients agree to participate start the interview, use adequate probing.
7. If patients seem to drag on, very tactically try to end the interview, but make sure all the questions are answered.
8. take the name of the patient's diagnosis, his medications and major investigations from the nurse in charge after the interview. Note them on the interview sheet.
9. If any significant verbatim, please note that down too.
10. Repeat the same in ward B, of the wards assigned to you.

INTERVIEWING SCHEDULE

<u>LEVEL</u>	<u>WARD</u>	<u>NO. OF PATIENT</u>	<u>INTERVIEWER</u>
1	11,12	2 in each ward	Ameena Abdulla
2	21,22,23	2 in each ward	Ameena Abdulla
4	41,42,43,46	2-3 patients in each ward	Batool Al-Muhandis
5	53,54,56	2-3 patients in each ward	Batool Al-Muhandis
6	62,66	3 patients in each ward	Batool Al-Muhandis

Interviewers to be finished by 12th of April, 1993

PATIENT'S INTERVIEW GUIDE

PATIENTS NEED FOR INFORMATION DURING THEIR HOSPITAL STAY

Conducted by:

Batool Al-Muhandis

INTERVIEWER:

Before the interview begins, determine that the patient is:

- 1. Fully conscious.**
- 2. Able to respond fully in either Arabic or English.**
- 3. Being discharged or have spent more than a week in the hospital.**
- 4. The responses must be pertaining to this admission and not to previous ones.**

Dear Patient,

My name is _____, I am a student studying for a Masters degree in nursing in the United Kingdom. I would like to ask you some questions about the information you received during your stay in hospital.

The purpose of this study is to find out how patients feel about the information they receive and to use the results to assess the practice of information giving. The interview will last 30 - 45 minutes. About 40 patients are participating in this study. Your name will not be revealed to anyone and will not appear on this paper or anywhere else.

I appreciate very much your participation in this study but please feel free to state if you agree or disagree to participate:

I agree to participate

I disagree to participate*

There are no right or wrong answers to the questions, and if there is anything that you do not understand I will be happy to explain also.

If there is a question or questions which you would rather not answer, you are not obliged to do so.

"CLARIFY THE MEANING OF THE TERM INFORMATION"

Information related to patients diagnosis, prognosis, physical examination, medication, tests and investigations, hospital routines, facilities and equipment.

* If patient disagrees to participate, stop the interview without any questions.

SECTION 1

Patients general perception of the information they receive

RESP. NO.

Q1 How large is your need for information?

VERY SMALL

VERY LARGE

1	2	3	4	5
---	---	---	---	---

Q2 Do you think you are getting adequate or inadequate information?

VERY INADEQUATE

VERY ADEQUATE

1	2	3	4	5
---	---	---	---	---

Q3 Do you think you understand the information given to you?

UNDERSTAND NONE
OF THE INFORMATION

UNDERSTAND ALL
OF THE INFORMATION

1	2	3	4	5
---	---	---	---	---

Q4 How satisfied are you with the information given to you concerning your health problems and the care you received?

COMPLETELY
UNSATISFIED

COMPLETELY
SATISFIED

1	2	3	4	5
---	---	---	---	---

Q5 Concerning your health status do you think you should be informed about:

NOTHING

EVERYTHING

1	2	3	4	5
---	---	---	---	---

Q.6 Do you receive clear information concerning your health?

Totally unclear

Very clear

-----	-----	-----	-----	-----
1	2	3	4	5
-----	-----	-----	-----	-----

Q.7 Are the information you receive explained to you in:

Minimum detail

Full detail

-----	-----	-----	-----	-----
1	2	3	4	5
-----	-----	-----	-----	-----

SECTION 2

Do you think you received information about:

	Yes	No	Uncertain
Q8 What your problem is, or what kind of illness you are suffering from?	☐	☐	☐
Q9 What might be the cause of your illness?	☐	☐	☐
Q10 Whether your problem (illness) will disappear or become worse in the future?	☐	☐	☐

SECTION 3

Q11 Were you told during the physical examination what it was about and why?	☐	☐	☐
--	--------------------------	--------------------------	--------------------------

Q12 Did you undergo any of the following tests or investigations?

12.1 Blood tests	☐	☐	☐
12.2 X-rays	☐	☐	☐
12.3 Scans	☐	☐	☐
12.4 Ultrasounds	☐	☐	☐
12.5 Biopsies	☐	☐	☐
12.6 E.C.G.'s	☐	☐	☐
12.7 Endoscopies	☐	☐	☐
12.8 Others	☐	☐	☐

Q13 Did you know why the tests/investigation needed to be done?	☐	☐	☐
---	--------------------------	--------------------------	--------------------------

Q14 Were you told how the test/investigation was going to be carried out	☐	☐	☐
--	--------------------------	--------------------------	--------------------------

Q15 Do you know the results of the test?	☐	☐	☐
--	--------------------------	--------------------------	--------------------------

Q16 Were you told of any associated pain or discomforts?	☐	☐	☐
--	--------------------------	--------------------------	--------------------------

SECTION 4

QUESTIONS 14 - 26 APPLY TO PATIENTS WHO HAVE UNDERGONE AN OPERATION

	Yes	No	Uncertain
Q17 Do you know what operation you had?	☐	☐	☐
Q18 Were you told why you needed an operation?	☐	☐	☐
Q19 Were you told how the operation was going to be performed?	☐	☐	☐
Were you told what to expect before and after the operation? For example:			
Q20 Withholding food and drink for a number of hours (fasting)	☐	☐	☐
Q21 Premedication/getting sedative injections	☐	☐	☐
Q22 Shaving of the area of operation	☐	☐	☐
Were you told about the possibility of having:			
Q23 Post operative pain	☐	☐	☐
Q24 Nausea/Vomiting	☐	☐	☐
Q25 Intravenous drip	☐	☐	☐
Q26 Redi Vac/Drainage tubes	☐	☐	☐
Q27 Stitches	☐	☐	☐
Q28 Were you told the results of the operation?	☐	☐	☐
Q29 Did you give consent for the operation?	☐	☐	☐

SECTION 5

What do you know about your medication in relation to:

	Yes	No	Uncertain
Q30 Name of your medicine(s)	☐	☐	☐
Q31 Reasons for taking the medicine	☐	☐	☐
Q32 How to take the medicine, for example duration/frequencies	☐	☐	☐
Q33 Do you know if there are any side-effects for the medicine?	☐	☐	☐

SECTION 6

During this admission, were you given information about:

Q34 Time/type of meals?	☐	☐	☐
Q35 Doctors rounds?	☐	☐	☐
Q36 Nurses rounds?	☐	☐	☐
Q37 Visiting hours/children's visiting?	☐	☐	☐
Q38 Medication times?	☐	☐	☐
Q39 Times for checking vital signs and blood pressure?	☐	☐	☐
Q40 Tea times?	☐	☐	☐

SECTION 7

During this admission, were you told about any of the following facilities in the ward or hospital:

	Yes	No	Uncertain
Q. 41 Type/Location of toilets?	☐	☐	☐
Q. 42 Location of water cooler?	☐	☐	☐
Q. 43 Telephones?	☐	☐	☐
Q. 44 T.V. and radio appliances?	☐	☐	☐
Q. 45 Location of the hospital's main restaurant/canteen?	☐	☐	☐
Q. 46 Smoking rules/areas?	☐	☐	☐
Q. 47 How to operate bed and bedside table?	☐	☐	☐
Q. 48 How and when to operate the call bell?	☐	☐	☐
Q. 49 Over head light?	☐	☐	☐
Q. 50 Purposes of over head signs, e.g. NPO, bed rest, etc.	☐	☐	☐
Q. 51 Prayer direction?	☐	☐	☐

SECTION 8

Generally speaking, who provided you with information? Was it from:

	Yes	No	Uncertain
Q52 The consultant?	☐	☐	☐
Q53 The doctors?	☐	☐	☐
Q54 The sister in charge?	☐	☐	☐
Q55 The nurses?	☐	☐	☐
Q56 Your family members?	☐	☐	☐
Q57 Other patients?	☐	☐	☐

SECTION 9

Q58 Now that you are going home, did you receive information on your medication, food, work, follow-ups, or anything else?

Verbatim " _____

_____ "

Q59 Is there any information concerning your health problem, the investigations, your medication or anything else that you would like to know?

Verbatim " _____

_____ "

SECTION 10

I will need to ask you a few personal questions if you do not mind.

Q'60 What is your age?

YEARS

Q.61 How many years of schooling did you have?

61.1 Below primary

61.2 Primary

61.3 Intermediate

61.4 Secondary

61.5 Undergraduate

61.6 Graduate

61.7 Others

Q 62 Patient's Nationality?

BAHRAINEE	NON BAHRAINEE
-----------	---------------

Q.63 Patient's Gender.

MALE	FEMALE
------	--------

Q'64 Date of Interview

		1993
--	--	------

Q'65 Time of Interview

_____ A.M. _____ P.M.

NAME OF INTERVIEWER:

THANK YOU VERY MUCH FOR PARTICIPATING
IN THIS STUDY

NURSES QUESTIONNAIRE

PATIENTS NEED FOR INFORMATION DURING THEIR HOSPITAL STAY

Dear Nurse,

My name is Batool Al-Muhandis and I am a nurse who is working on a Masters thesis at the University of Wales, in the U.K. I would like you to read this questionnaire and answer the questions, it will take approximately 20 - 30 minutes to complete.

The questionnaire is on the patients need for information during their hospital stay. The purpose of this study is to explore how you feel about the information patients receive and to use this information to assess the practice of information giving. Please read the questionnaire and give your opinions and experiences as honestly as you can.

You may wish to know that this questionnaire is anonymous, i.e. you need not put your name on it and your participation is completely voluntary which means that you are free to withdraw from participation in the study. You may also like to know that 20 nurses are participating in this study, plus a group of patients and doctors.

You will see the word INFORMATION in the questionnaire. It refers to information concerning patients diagnosis, prognosis, operation, medication, physical examination and ward facilities and routines.

PLEASE RETURN THE COMPLETED QUESTIONNAIRE TO THE WARD CLERK AND THANK YOU VERY MUCH FOR PARTICIPATING.

SECTION 1

RESP. NO.

Q1 What is your present rank?

Sister in charge

☐

Acting in charge

☐

Staff Nurse

☐

Q2 Indicate your Gender.

MALE

FEMALE

Q3 Indicate your age.

25 - 30

☐

31 - 35

☐

36 - 40

☐

41 - 45

☐

46 - 50

☐

Q4 Indicate your present working area

MEDICAL

SURGICAL

MIXED

Q5 How many years have you been a nurse?

YEARS

Q6 What is your Nationality?

BAHRAINEE

NON BAHRAINEE

Q7 What languages can you speak fluently?

Arabic

☐

English

☐

Indian

☐

Philippino

☐

Other

☐

If other please indicate: _____

SECTION 2

Q8 In your view, how large is the patients need for information?

VERY SMALL

VERY LARGE

1	2	3	4	5
---	---	---	---	---

Q9 Do you think patients are getting adequate or inadequate information?

VERY INADEQUATE

VERY ADEQUATE

1	2	3	4	5
---	---	---	---	---

Q10 How much information do you think patients understand?

NONE

ALL

1	2	3	4	5
---	---	---	---	---

Q11 Do you think patients should be informed about:

NOTHING

EVERYTHING

1	2	3	4	5
---	---	---	---	---

Q12 How satisfied do you think patients are concerning the information they receive?

DISSATISFIED

FULLY SATISFIED

1	2	3	4	5
---	---	---	---	---

Q.13

Do you think patients receive clear information concerning their health?

Totally unclear

Very clear

1	2	3	4	5
---	---	---	---	---

Q.14

Do you think the information patients receive are explained to them in:

Minimum detail

Full detail

1	2	3	4	5
---	---	---	---	---

Do you think patients receive adequate information about:

Yes No Uncertain

Q15	Their illness, health problem, i.e. diagnosis?	☐	☐	☐
Q16	Whether their symptoms would disappear, or get worse, i.e. their prognosis?	☐	☐	☐
Q17	Their physical examination, how it is done and why it is done?	☐	☐	☐
Q18	Their investigations/tests, for example, blood, x-rays, ECG's or endoscopies, how they are going to be carried out?	☐	☐	☐
Q19	Why the investigations/tests are carried out?	☐	☐	☐
Q20	What to expect after the investigations, e.g. pain, discomfort?	☐	☐	☐
Q21	The results of the investigations or tests?	☐	☐	☐
Q22	Their medications, e.g. what are the names of their medicines?	☐	☐	☐
Q23	The reasons for ordering the medications?	☐	☐	☐
Q24	How to take the medicine, e.g. frequencies, duration?	☐	☐	☐
Q25	The possible side effects of the medicine?	☐	☐	☐

QUESTIONS 24 - 28 APPLY TO YOU ONLY IF YOU ARE CARING FOR SURGICAL PATIENTS
--

Do you think patients receive adequate information about:

	Yes	No	Uncertain
Q26 What operation they will undergo?	☐	☐	☐
Q27 Why the operation is needed?	☐	☐	☐
Q28 What to expect after the operation, e.g. post-op pain, tubes, drainage bottles and stitches?	☐	☐	☐
Q29 What are the results of the operation?	☐	☐	☐
Q30 Their consent form?	☐	☐	☐

Concerning the ward routines, do you think patients receive information concerning:

Q31 Time/type of meals?	☐	☐	☐
Q32 Doctors rounds?	☐	☐	☐
Q33 Nurses rounds?	☐	☐	☐
Q34 Visiting hours/children's visiting?	☐	☐	☐
Q35 Medication times?	☐	☐	☐
Q36 Times for checking vital signs and blood pressure?	☐	☐	☐
Q37 Tea times?	☐	☐	☐

Concerning the ward facilities, do you think patients receive information concerning:

Yes No Uncertain

Q38 Type/Location of toilets?

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q39 Location of water cooler?

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q40 Telephones?

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q41 T.V. and radio appliances?

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q42 Location of the hospital's main
restaurant/canteen?

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q43 Smoking rules/areas?

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q44 How to operate bed and bedside table?

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q45 How and when to operate the call bell?

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q46 Over head light?

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q47 Purposes of over head signs, e.g. NPO,
bed rest, etc.

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q48 Prayer direction?

☐	☐	☐
--------------------------	--------------------------	--------------------------

The aftercare and discharge information, for example:

Q49 How should the patient take care of his/her health?

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q50 How much rest. sick leave patients can have?

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q51 Their need for follow-ups?

☐	☐	☐
--------------------------	--------------------------	--------------------------

Q52 Who do you think provides information to patients?

52.1 The consulting doctor

52.2 The doctors

52.3 The sister in charge

52.4 The nurses

52.5 The practical nurses

52.6 The patient's relatives

52.7 Other patients

Add any comments if you wish: _____

Q53 What are some of the reasons (if any) for not informing patients?

1. _____

2. _____

3. _____

How

Q54 From your experience as a nurse how do you see the giving of information ~~can~~ be improved?

1. _____

2. _____

3. _____

DOCTORS QUESTIONNAIRE

PATIENTS NEED FOR INFORMATION DURING THEIR HOSPITAL STAY

Dear Doctor,

My name is Batool Al-Muhandis and I am a nurse lecturer who is working on a Masters thesis at the University of Wales in the U.K. I would like you to read this questionnaire and answer the questions, it will take approximately 20 - 30 minutes to complete.

The purpose of this study is to find out how you feel about the information patients receive and to use this information to assess the practice of information giving. Please read the questionnaire and give your opinions and experiences as honestly as you can.

You may wish to know that this questionnaire is anonymous, i.e. you need not put your name on it and your participation is completely voluntary which means that you are free to withdraw from participation in the study. You may also like to know that 20 doctors are participating in this study, plus a group of patients and nurses.

You will see the word INFORMATION in the questionnaire. It refers to information concerning patients diagnosis, prognosis, operation, medication, physical examination, discharge and follow up care.

PLEASE RETURN THE COMPLETED QUESTIONNAIRE TO THE SECRETARY OF EITHER THE MEDICAL OR SURGICAL UNITS, DEPENDING ON WHERE YOU ARE CURRENTLY WORKING.

SECTION 1

RESP. N

Q1 What is your present rank?

Consultant ☐

Senior House Officer ☐

House Officer ☐

Junior House Officer ☐

Q2 Indicate your Gender.

MALE

FEMALE

Q3 Indicate your age.

25 - 30 ☐

31 - 35 ☐

36 - 40 ☐

41 - 45 ☐

46 - 50 ☐

Q4 Indicate your present working area

MEDICAL

SURGICAL

Q5 How many years have you been a doctor?

YEARS

Q6 What is your Nationality?

BAHRAINEE

NON BAHRAINEE

Q7 What languages can you speak fluently?

Arabic ☐

English ☐

Indian ☐

Others ☐

If other please indicate: _____

SECTION 2

Q8 In your view, how large is the patients need for information?

VERY SMALL

VERY LARGE

1	2	3	4	5
---	---	---	---	---

Q9 Do you think patients are getting adequate or inadequate information?

VERY INADEQUATE

VERY ADEQUATE

1	2	3	4	5
---	---	---	---	---

Q10 How much information do you think patients understand?

NONE

ALL

1	2	3	4	5
---	---	---	---	---

Q11 Do you think patients should be informed about:

NOTHING

EVERYTHING

1	2	3	4	5
---	---	---	---	---

Q12 How satisfied do you think patients are concerning the information they receive?

DISSATISFIED

FULLY SATISFIED

1	2	3	4	5
---	---	---	---	---

Q.13 Do you think patients receive clear information concerning their health?

Totally unclear

Very clear

1	2	3	4	5
---	---	---	---	---

Q.14 Do you think the information patients receive are explained to them in:

Minimum detail

Full detail

1	2	3	4	5
---	---	---	---	---

Do you think patients receive adequate information about:

Yes No Uncertain

Q15 Their illness, health problem,
i.e. what is their diagnosis?

☐☐☐

Q16 What might be the cause(s) of their
illness?

☐☐☐

Q17 Whether their symptoms would disappear, or
get worse, i.e. their prognosis?

☐☐☐

Q18 Their physical examination, how it is done
and why it is done?

☐☐☐

Q19 What investigations/tests, for example blood,
x-rays, ECG's patients require?

☐☐☐

Q20 How the investigations/tests are going to be
performed?

☐☐☐

Q21 Why the investigations/tests are needed?

☐☐☐

Q22 The results of the investigations or tests?

☐☐☐

Q23 The names/types of their medications?

☐☐☐

Q24 Why the medications are ordered?

☐☐☐

Q25 The possible side effects of the medications?

☐☐☐

QUESTIONS 24 - 29 APPLY TO YOU ONLY IF YOU ARE TREATING SURGICAL PATIENTS
--

Do you think patients receive adequate information about:

	Yes	No	Uncertain
Q26 What operation they will undergo?	☐	☐	☐
Q27 Why the operation is needed?	☐	☐	☐
Q28 What to expect after the operation, e.g. post-op pain, tubes, drainage bottles and stitches?	☐	☐	☐
Q29 What are the results of the operation?	☐	☐	☐
Q30 What possible complications the operation has?	☐	☐	☐
Q31 Their consent form?	☐	☐	☐

The aftercare and discharge information, for example:

Q32 How the patient should take care of his/her health?	☐	☐	☐
Q33 How much rest/sick leave patients can have?	☐	☐	☐
Q34 Their need for follow-ups?	☐	☐	☐

Q.35 Who do you think provides information to patients?

35.1. The consultant

35.2. The senior house officer

35.3 The house officer

35.4 The the junior house officer

35.5. The sister in charge

35.6 The nurses

35.7 The patient's relatives

35.8 Other patients

Add any comments if you wish: _____

Q.36 What are some of the reasons (if any) for not informing patients?

1. _____

2. _____

3. _____

Q.37 From your experience as a doctor how do you see the giving of information being improved?

1. _____

2. _____

3. _____

THANK YOU VERY MUCH FOR PARTICIPATING IN THIS STUDY

APPENDIX viii

Examples of the 5-point rating scale which was printed on show cards.

Very Small

Very Large

1	2	3	4	5
---	---	---	---	---

Completely
Unsatisfied

Completely
Satisfied

1	2	3	4	5
---	---	---	---	---

Very Inadequate

Very Adequate

1	2	3	4	5
---	---	---	---	---

Show Cards for the Questions which Required:

yes	no	uncertain
-----	----	-----------